AGENDA FOR

LOCALITY BOARD

Contact: Please visit https://gmintegratedcare.org.uk/meetings-and-events for all information and papers

To: All Members of Locality Board

Councillors : E O'Brien (Chair), L Smith and T Tariq

Dear Member/Colleague

Locality Board

You are invited to attend a meeting of the Locality Board which will be held as follows:-

Date:	Monday, 2 December 2024
Place:	Bury Town Hall
Time:	4.00 pm
Briefing Facilities:	If Opposition Members and Co-opted Members require briefing on any particular item on the Agenda, the appropriate Director/Senior Officer originating the related report should be contacted.
Notes:	

Agenda Item 1

Agenda

Locality Board – Meeting in Public

Date: 02nd December 2024

Time: 4.00 pm – 6.00 pm

Venue: Microsoft Teams Chair: Dr Fines

Full agenda pack begins on next page.

Date and time of next meeting
Monday, 06th January 2024 at 4.00 pm to be held in person

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 27th 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.

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Agenda

Locality Board – Meeting in Public (in person)

Date: 2 December 2024

Time: 4.00 pm – 6.00 pm

Venue: Council Chamber, Bury Town Hall

Chair: Cllr O'Brien

Item No.	Time	Duration	Subject	Paper Verbal	For Approval Discussion Information	By Whom
1.0	4.00 – 4.05	5 mins	Welcome, apologies and quoracy	Verbal	Information	Chair
2.0			Declarations of Interest	Paper	Information	Chair
3.0			Minutes of previous meeting held on 4th November 2024 and action log • Ratification of decisions made at the Locality Board meeting on 4th November 2024 (Bury Contract Oversight and Estates items)	Paper	Approval	Chair
4.0			Public questions	Verbal	Discussion	Chair
Place Based Lead Update						
5.0	4.05 – 4.15	10 mins	Key Issues in Bury	Paper	Discussion	Lynne Ridsdale
Locality Board Priorities						
6.0	4.15-4.25	10 mins	PCFT Service Mapping Summary	Paper	Discussion	Sarah Preedy
7.0	4.25-4.40	15 mins	Elective Waiting Times Update	Paper	Discussion	Joanna Fawcus/Will Blandamer
8.0	4.40-4.50	10 mins	Children & Young People Delivery Plan update	Paper	Discussion	Will Blandamer
9.0	4.50-5.05	15 mins	Locality /Sustainability Plan Update	Paper	Discussion	Will Blandamer/ Kath Wynne-

						Jones
Integrated Delivery Collaborative Update						
10.0	5.05-5.10	5 mins	Integrated Delivery Collaborative Update	Paper	Discussion	Kath Wynne-Jones
11.0	5.10-5.15	5 mins	Performance Report	Paper	Discussion	Kath Wynne-Jones
12.0	5.15-5.25	10 mins	Risk Report	Paper	Discussion	Kath Wynne-Jones
Updates						
13.0	5.25-5.35	10 mins	Strategic Finance Group Update	Paper	Discussion	Simon O'Hare
14.0	5.35-5.40	5 mins	Population Health and Wellbeing update	Paper	Information	Jon Hobday
Committee/Meeting updates						
15.0	5.40-5.45	5 mins	Primary Care Commissioning Committee update	Paper	Information	Adrian Crook
16.0	5.45-5.50	5 mins	System Assurance Committee update	Paper	Information	Cathy Fines
Closing Items						
17.0	5.55 – 6.00	5 mins	Any Other Business		Verbal	
18.0	_____	_____	**Date and time of next meeting in public - Monday, 6th January 2025, 4.00 - 6.00pm on Teams**		_____	

Meeting: Locality Board			
Meeting Date	2nd December 2024	**Action**	Consider
Item No.	2	**Confidential**	No
Title	Declarations of Interest		
Presented By	Chair of the Locality Board		
Author	Emma Kennett, Head of Locality 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 2nd December 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 Locality Plan outcomes	
To support a local population that is living healthier for longer and where healthy expectancy matches or exceeds the national average by 2025.	☒
To achieve a reduction in inequalities (including health inequality) in Bury, that is greater than the national rate of reduction.	☒
To deliver a local health and social care system that provides high quality services which are financially sustainable and clinically safe.	☒
To ensure that a greater proportion of local people are playing an active role in managing their own health and supporting those around them.	☒

Implications						
Are the risks already included on the Locality Risk Register?	Yes	☐	No	☒	N/A	☐
Are there any risks of 15 and above that need to be considered for escalation via an NHS GM Statutory Committee or Board in line with the Risk Escalation process ?	Yes	☐	No	☒	N/A	☐
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	☐

Implications						
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	☐

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	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	######	Y
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			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	Simkat Shore Holdings LTD	X			Direct	Director	z	Present	As per policy - see details above. (Y,Y,Y,Y,Y)	######	Y
	Kissock	Neil	Director of Finance/Section 151 Officer	None Declared					Nil Interest		Present		######	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 Present	As per policy - see details above (Y,Y,Y,Y,Y)		
	Fawcus	Joanna	Director of Operations, NCA	None Declared					Nil Interest		Present			
	Allan	Lorna	Chief Digital and Information Officer Digital Services, NCA	Trustee at St Leonard's Hospice in York			x	Direct	Trustee	Dec-23	Present			
	Stott	Jill	Declaration of Interest form awaited											
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, Pennine Care NHS Foundation Trust	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) & Francis House Hospice (Manchester) University Hospital of Wales 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 Junior Doctor Daughter is a medical student	2018 2018 2023 2024 2024 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	Kath	Member of the Locality Board	KWJ Coaching and Consulting Rools and Bones 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 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	02 December 2024	**Action**	Approve
Item No.	3	**Confidential**	No
Title	Minutes of the Previous Meeting held on 4th November 2024 and action log		
Presented By	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 November 2024 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;
- Ratify the decisions made at the Locality Board meeting on the 4th November 2024.
- Provide an update on the action listed in the log.

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 Locality Plan outcomes	
To support a local population that is living healthier for longer and where healthy expectancy matches or exceeds the national average by 2025.	☒
To achieve a reduction in inequalities (including health inequality) in Bury, that is greater than the national rate of reduction.	☒
To deliver a local health and social care system that provides high quality services which are financially sustainable and clinically safe.	☒

Links to Locality Plan outcomes	
To ensure that a greater proportion of local people are playing an active role in managing their own health and supporting those around them.	☒

Implications						
Are the risks already included on the Locality Risk Register?	Yes	☐	No	☒	N/A	☐
Are there any risks of 15 and above that need to be considered for escalation via an NHS GM Statutory Committee or Board in line with the Risk Escalation process ?	Yes	☐	No	☒	N/A	☐
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	☐

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

BURY
INTEGRATED CARE
PARTNERSHIP

Draft Minutes

Date: Locality Board, 4th November 2024

Time: 4.00 pm

Venue: Meeting in Public (via Teams)

Title	**Draft Minutes of the Locality Board**
Author	Emma Kennett
Version	0.1
Target Audience	Locality Board
Date Created	November 2024
Date of Issue	November 2024
To be Agreed	Monday, 2nd December 2024
Document Status (Draft/Final)	Draft
Description	Locality Board Minutes

Document History:

Date	Version	Author	Notes
November 2024	0.1	Emma Kennett	Draft Minutes produced
Approved:			
Signature:			..... **Add name of Committee/Chair**

Locality Board

MINUTES OF MEETING
Locality Board Meeting in Public (via Teams) 4th November 2024 4.00 pm until 6.00 pm **Chair – Dr Cathy Fines**

ATTENDANCE

Voting Members
Dr Cathy Fines, Senior Clinical Leader in the Borough (Chair) Cllr Eamonn O'Brien, Leader of Bury Council Cllr Tamoor Tariq, Executive Member of the Council for Adult Care and Health Cllr Lucy Smith, Executive Member of the Council for Children and Young People Mr Warren Heppolette, Chief Officer for Strategy and Innovation (GMIC) Ms Lynne Ridsdale, Place Based Lead Ms Catherine Jackson, Associate Director for Nursing, Quality and Safeguarding (Bury) Mr Simon O'Hare, Associate Director of Finance Dr Kiran Patel, Medical Director, IDCB Ms Joanna Fawcus, Director of Operations, NCA Ms Lorna Allan, Chief Digital and Information Officer, NCA Ms Sarah Preedy, Chief Operating Officer, Pennine Care Foundation Trust Ms Helen Tomlinson, Chief Officer, Bury VCFA (Voluntary, Community, Faith & Social Enterprise) Ms Jeannette Richards, Executive Director of Children and Young People, Bury Council Mr Jon Hobday, Director of Public Health Mr Will Blandamer, Deputy Place Based Lead, Executive Director of Health and Care Mr Adrian Crook, Director of Adult Social Services and Community Commissioning
Non-Voting Members
Ms Kath Wynne-Jones, Chief Officer, Bury IDC
Invited Members and Observers
Cllr Russell Bernstein, Conservative Opposition Party Cllr Mike Smith, Radcliffe First Opposition Party Ms Cari Kay, Legal Services, Bury Council Ms Wendy Young (Children's for item 17) Ms Amanda Rafferty, Head of Locality Engagement, NHS Greater Manchester (for item 6) Dr Daniel Cooke, GP (For item 8) Dr Victoria Moyle, GP (For Item 8 Ms Zoe Alderson, Head of Primary Care (For Item 8) Mr Mark Beesley Chief Officer, Bury GP Federation (For Item 8) Ms Clare Postlethwaite, Associate Programme Director (Bury Locality) For Item 14) Ms Chloe Ashworth, Democratic Services, Bury Council Mrs Emma Kennett Head of Locality Admin & Governance

BURY INTEGRATED CARE PARTNERSHIP

MEETING NARRATIVE & OUTCOMES

1	Welcome, Apologies and Quoracy
1.1	The Chair welcomed all to the meeting.
1.2	Apologies were received from Mr Neil Kissock and Ms Sophie Hargreaves.
1.3	The meeting was declared quorate and was noted that any decisions taken at today's Teams meeting would need to be ratified at the next face to face Locality Board meeting in December 2024. Members noted the information.

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 today's meeting 4th November 2024 and previous meeting on 7th October 2024.** No declarations to note.

ID	Type	The Locality Board	Owner
D/11/01	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 7th October 2024 were considered as a true and accurate reflection of the meeting.
3.2	All actions from the last meeting were noted as being completed and closed.

ID	Type	The Locality Board	Owner
D/11/02	Decision	Accepted the minutes from the previous meeting as a true and accurate reflection of the meeting and noted that all actions from the last meeting were completed and closed.	

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

ID	Type	The Locality Board	Owner
D/11/03	Decision	Received the update.	

5	Place Based Lead Update
5.1	Ms Ridsdale presented the latest Place Based Lead update to the Locality Board and outlined the key developments since the last meeting. It was reported that: - • One of the 6 areas for improvement following the CQC and Ofsted inspection of SEND partnership arrangements in Bury, one was about Preparing for Adulthood. A 6th monitoring inspection by Dfe on fcusing PfA has recently been undertaken with positive reflections of partnership working focusing on educational attainment, employment and housing. • On the 17th October 2024, the King's Fund published a new report called 'Population health in Greater Manchester: The journey so far'. The report provided a 'deep dive' into the work of three of the localities in Greater Manchester and Bury was recognised for the quality of partnership working, leadership commitment, and evidence of progress in relation to addressing population health and health inequalities. This was an extremely positive achievement for Bury which should be commended. • A Cost of Living Summit took place earlier today (4th November 2024) in Radcliffe with the aim of understanding progress on anti-poverty and how we work collectively to prevent poverty and help people out of it. • Work was ongoing in respect of the Aging Well work and the pathfinder site at Clarence Park in Walmersley. There were a number of videos available online which showed the positive work being undertaken within this area.
5.2	Mr Blandamer provided an update on the work being undertaken in relation to the Commissioning intentions for 2024/25. It was reported that: - • NHS Greater Manchester was working with partners to develop and refine high level commissioning intentions for 2024/25, and the latest version of these had been included with the Place Based Lead Report. • These were Greater Manchester wide intentions but there was scope for each locality to provide a local perspective which would need to link into the refresh of the Locality Plan. • Ms Wynne-Jones would be leading on this work for the locality via the programmes and Integrated Delivery Board. A system workshop was going to be arranged for December 2024/January 2025 time dependant on availability.
5.3	The following comments/questions/observations were made by Locality Board members: -

	• A query as to whether there was any work currently underway at Greater Manchester level to align the Commissioning intentions to the 5 Pillars of the Greater Manchester Sustainability plan. Mr Heppolette commented that he had not seen anything specific in this regard and there may be an opportunity for this to be shaped via the 4 Locality Partnership in the first instance. Ms Wynne-Jones highlighted that she had not wanted to progress a piece of work if there was something further due to be issued in the coming weeks hence create a duplication of work. It was noted that for Bury, Neighbourhoods, end of life and Adult Social Care were all areas that would need to be included within this area. • In terms of the Commissioning Intentions, there was a need to ensure that VCFE and the long term commitment to adult social care were addressed accordingly. • Greater Manchester remained one of the lowest investors in primary care, with Bury at the lower end comparatively in Greater Manchester. In relation to the commissioning intentions, there was still no strong commitment or timeline or investment commitment to develop 'Left Shift' across Greater Manchester. There was a need for more detail and commitment to assure primary care/general practice. A further discussion on Primary Care was scheduled for later within the Locality Board meeting. • The Cost of Living Summit that had taken place earlier today had suggested that there was a potential some disconnect between what was happening on the ground at grass roots level and the Public Sector Reform Agenda and was important to consider this as part of future plans and developments.

ID	Type	The Locality Board	Owner
D/11/04	Decision	Received the update.	

6	Engagement for Bury including Fit for the Future
6.1	Mr Blandamer presented a report to update the Locality Board on the NHS Greater Manchester Fit for the Future engagement and Bury's Locality Participation Group.
6.2	It was reported that following discussions between the Place Based Lead and engagement colleagues from NHS Greater Manchester, Healthwatch and the VCFE, it was agreed that the most effective method for engagement on the Fit for the Future programme was to utlise the powerful networks and relationships that currently exist within Bury locality to cascade information and encourage involvement of citizens and communities. This was as opposed to developing something new e.g. a public event and would ensure that discussions are taken to the community in spaces that are relevant to them. Ms Tomlinson emphasised that it was important to build on the existing networks rather than setting up new mechanisms.
6.3	In terms of the locality engagement model, a group of engagement practitioners would be established that would meet regularly and may include other members such as providers and partners with a remit for engagement. This would be an informal community of practice that would assist the locality delivery partnership to strengthen its understanding of local need through effective collaborative engagement activity and support engagement practitioners to share learning and best practice.
6.4	The following comments/observations were made by Locality Board members: - • There was a need to consider how to draw on the existing work of the GP Practice Patient Participation Groups and how they can be specifically linked into this work.

ID	Type	The Locality Board	Owner
D/11/05	Decision	Noted the progress on the Fit for Future engagement programme and supported the development of a Locality Participation Group to facilitate a coordinated approach to engagement utilising existing channels.	

7	PCFT Service strategy
7.1	Ms Preedy submitted a presentation in relation to the Pennine Care Foundation Trust Strategy. It was reported that: - • That this was a refresh of the existing strategy rather than the development of an entirely new one. • The strategic direction remained relevant with no change to the vision, mission and values. • As part of the refresh, Pennine Care have looked at what they have delivered, the current context, health needs and how they compare with others. • Engagement has commenced which included discussions at today's Locality Board meeting. There was also planned engagement with colleagues, members of the public including service users and carers, Governors, Locality systems, partners including VCSE and GMMH as well as a generic survey. • The plan was to take the refreshed strategy to the Pennine Care Board in December 2024 to support the planning process. • In the terms of the work so far, there was a need for simplification of big ambitions and clearer direction on priorities, a focus on workforce, a desire to expand involvement of those with lived experience, a need to ger the basics right and a need to address waiting lists, reduce variation and more integrated care. • The Strategy refresh would support the mitigation of strategic risks within the organisation. • The Key areas of focus for 2025-30 were: - - Delivery of the clinical model in terms of addressing unwarranted variation, expanding crisis and community services in support of a more efficient and therapeutic inpatient model. - Driving improved performance across all of our key domains to ensure an improved patient and colleague experience; - Expanding opportunities to engage and learn from stakeholders, particularly those with lived and living experience; - Focusing on our colleagues – culture, leadership, recruitment, retention, wellbeing, development and engagement; - Advancing digital maturity and make best use of the estate; - Continuing to develop Research, Innovation and Improvement capability; - Continuing to deliver our anchor institute and Green Plan commitments; - Enhancing system leadership e.g. Learning Disabilities; - Cementing and expanding our partnerships inc. the VCSE and housing. • There was an opportunity as part of the engagement for stakeholders including the Locality Board to give their views on the refreshed strategy with a QR code included within the presentation.
7.2	The following comments/observations were made by Locality Board members: - • That it would be helpful to see further physical health links to the strategy in terms of new models of care including MDTs and frequency of attendees at A&E and how these pathways can be further developed. • The need to consider how digital links can be formed with the NCA in the context of their current work including refreshing of the NCA green plans. • It was positive that the VCFA were already linked into this work but was still further work to do in this area.

	• It would be beneficial to see the neighbourhood elements of the strategy strengthened linked to the levelling up agenda in some areas. • A need to make sure that the strategy refresh aligns with the Bury and GM commissioning intentions discussed earlier on the agenda. • In regards to staff and colleagues health/retention, a question as to whether Pennine had signed up to the 'GM healthy workforce charter'? which was really useful in supporting a healthy workforce and the Council could support the sign up process if required. Ms Preedy agreed to pick up a further conversation with Mr Hobday about this offer of support. • A question as to how the Urgent Care Offer can be improved from a workforce perspective. • A need to link in the workforce pipeline in terms of the 4 localities including colleges etc to the plans. • Query as to whether there were any outcome measures that would help understand the breadth of the work, particularly given the worries around equitability of funding. Ms Preedy confirmed that there were metrics against the strategy that could measure and provide confidence about delivery and also linked to the service mapping work due to come to a future Locality Board meeting. • A need to strive towards an equitable service offer across the Pennine Care footprint given the broad nature of mental health diagnosis. • It would be helpful for a further discussion on the strategy refresh to take place via the Bury Mental Health Board.

ID	Type	The Locality Board	Owner
D/11/06	Decision	Considered and discussed the presentation	
A/11/01	Action	Ms Preedy to pick up a further conversation with Mr Hobday about the GM healthy workforce charter	Ms Preedy

8	Deep dive - GP services
8.1	Dr Fines commented that there were a number of Primary Care colleagues in attendance for this item in relation to General Practice and thanked them for their time.
8.2	Dr Patel discussed the current General Practice strategy and key metrics in relation to capacity and demand including the number of appointments on offer. The presentation also covered: - • The ways in which practices were Improving outcomes for patients by reducing inequity & variation in access & quality of care. • The need to strengthen the relationship between provider partners across the Bury system in terms of reducing bureaucracy to support care navigation. • Background information in relation to the GP industrial action being taken which had seen the GP leaders at the BMA formally entering a dispute with NHS England in April this year over changes to the GP contract. • It was noted that for the past five years, annual increases to core contract payments had fallen well below inflation in the wider economy. BMA leaders argue that industrial action is about safety, security and hope and stress that under-funding of GP services is detrimental to patients. At just 8.4% the proportion of total NHS funding spent on primary medical care is at a historic low.
8.3	Mr Beesley commented that he attended the Greater Manchester GP Board and there was clearly frustration amongst general practice colleagues in relation to these contractual and funding issues that could impact on motivation and future service delivery in primary care. A general discussion took place in relation to 'left shift' and what this meant from an investment policy perspective going forward. It was noted that the impact of the budget was massive and there were now significant National Insurance and real living wage impacts that would impact on the future running of practices.

8.4	The following comments/observations were made by Locality Board members: - • The full detail on how GP practices operate were not fully understood however appeared that the key issues related to there not being enough doctors and there not being enough funding for what needs to be delivered which had built up over a period of time. • There appeared to be a broad consensus for changes and providing more care in a primary and community care setting however the same behaviours around A&E attendance were seen year on year. • Concern that not all GP Practices would survive until 25/26 in the current economic climate with many GPs being left feeling undervalued. • It was noted that the NCA have had some good success in a predictor of who would be more likely to not attend appointments and it is changing some of its DNAs for patient appointments. Ms Allen would be happy to share this approach and model if needs be. • Tower Hamlets established a PBR type mechanism for pop health management in Primary care. that's run for 15 years and has reduced avoidable hospitalisation by 54% over that period which may be helpful to look at. • The IDC were having a focus on CVD at the Major Conditions Board on Wednesday, 6th November 2024. There was a challenge in terms of understanding at practice level the variance to drive improvement any advice from Mr Heppolette was welcomed. • There was a need to look at Consultant referrals and the impact as well as the impact any industrial action would have. • Further advice and guidance was needed in terms of how to fund and resource the elective Programme properly. • There still appeared to be some bureaucracy issues between Primary Care providers in relation to Pharmacy First which needed to be resolved. • A need to see a real shift in relation to secondary care clinicians working more in the community • The Darzi report was welcomed and there was a need for 'left shift' however further work was needed to realign investment in line with these changes. • There are a couple of targets in the performance plan which the locality primary care team didn't receive regular data for but were part of the operating plan measures and a question as to whether there any plans at Greater Manchester level to provide this. Mr Heppolette commented that there was a need for localities to be sent this information. • If there is a real commitment to 'left shift' then this needed to included as part of the Commissioning intentions • The need to be mindful that there may only be particular elements of the Primary Care agenda that can be managed locally and some decisions and actions may need to be taken at Greater Manchester and National level in this regard. • The recent Dermatology tender process was a good example of where Primary Care discussions and engagement would have been beneficial at an early stage.
8.5	Dr Patel invited support from the NCA, Pennine and MFT colleagues around a push on a addressing the frustrations of GPs around reducing unwarranted bureaucracy including stuff unnecessarily coming back to GPs for redirection in the system. It was suggested that it might be mutually beneficial for a meeting to be arranged between Ms Fawcus and Ms Allan in this regard including how we can start deploying NCA physicians in the community sooner rather than later.
8.6	Dr Fines thanked everybody for this contributions to this item and commented that it would be helpful for providers to acknowledge the Collective Action and understand how to manage this as a system going forward.

		The Locality Board	
D/11/07	Decision	Noted the current General Practice position and the need to reduce system bureaucracy going forward.	

A/11/02	Action	A meeting to be arranged between Dr Patel, Ms Fawcus and Ms Allan in this regard including how we can start deploying NCA physicians in the community sooner rather than later.	

9	Winter planning/urgent care update
9.1	Mr Blandamer submitted an update report in relation to Winter Planning and Urgent Care.
9.2	It was reported that each year the Bury UEC comes together to plan arrangements for winter. This process commenced in September 2024 and this paper provided an update on the actions of the Bury Winter Planning Sub-Group.
9.3	It was noted that the Respiratory Hubs were now up and running within the locality which would see an extra 600 GP appointments being offered a week as part of the winter planning process.
9.4	A further more detailed paper would be brought back to a future Locality Board meeting.

		The Locality Board	
D/11/08	Decision	Received the report.	
A/11/03	Action	A further more detailed paper would be brought back to a future Locality Board meeting.	Mr Blandamer

10	4 hour wait target update
10.1	Ms Fawcus submitted a report in relation to the current performance against the National 4 Hour A&E Target at Fairfield General Hospital. It was noted that whilst the target was currently not being achieved the paper detailed a range of on going actions which was believed would help to improve the current performance. It was reported that: - • There was a really good team working across Bury to support this area. • The Same Day Emergency Care service had moved to the old Ward 9 at the hospital • In term of 6 hour waits at A&E, Bury was currently 14th in the country.
10.2	The following comments/observations were made by Locality Board members: - • There was lots of good work being undertaken at the hospital in supporting older people and some of the metrics in place were really promising. It was noted that Mr Crook had identified some potential further resources for 2 exercise practitioners to support this area. • It was clear from the update that there was a collaborative approach being adopted within this area to support patients.

ID	Type	The Locality Board	Owner
D/11/09	Decision	Noted the update	All

11	Integrated Delivery Collaborative Update
11.1	Ms Wynne-Jones presented the latest Integrated Delivery Collaborative update to the Locality Board. It was reported that: - • A Workshop had been held to consider alignment between PCN's and neighbourhoods. The output of this would be an MOU to define the relationships between PCN's and neighbourhoods and the relationship between primary care and other providers to be considered by IDC Board members.

	• A Workshop was held to consider how to manage High Intensity Users of A&E to which approximately 50 people attended. All IDC partners were represented at the event, and it was agreed that we would use a collaborative approach to improve outcomes for this service user group. This would include a more streamlined approach to data sharing and implementing a specific test of change for Mental Health patients working with NWAS and FGH.

ID	Type	The Locality Board	Owner
D/11/10	Decision	Noted the update.	

12	Performance Report
12.1	Ms Wynne-Jones submitted the latest Performance Report to the Locality Board and welcomed any questions or comments.
12.2	There was a question raised as to whether hypertension statistics would feature in this report going forward. Mr Heppolette stated that this would be a core measure.

ID	Type	The Locality Board	Owner
D/11/11	Decision	Noted the update	

13.1	Strategic Finance Group Update
13.2	Mr O'Hare presented the latest Strategic Finance Group Update. It was reported that: - • The purpose of this report was to update the Locality Board on the financial position of all partners, with specific focus upon the budgets delegated to the locality board by NHS Greater Manchester (GM). The position of all partners continued to be very challenged in 2024/25 with NHS GM in undertakings with NHS England which brings additional scrutiny and rigour around finance, performance and quality. • At month 5, NHS GM had an actual deficit of £132.5m versus an expected deficit of £107m, giving an unplanned variance of £25.5m adverse to plan, an increase of only £1.3m from month 4, and was forecasting recovery of this position by 31st March 2024, to allow delivery of the agreed £175m deficit. Within this position the Bury locality budgets, for which this board was responsible for were forecasting a deficit of £7.1m versus an expected break even annual position. The Northern Care Alliance (NCA) have forecast a £75.7m deficit at month 5, which was on plan, and Pennine Care NHS Foundation Trust (PCFT) were reporting a break even financial position at month 5. • The council's medium term financial strategy (MTFS) had been reviewed and updated and was being considered at November Cabinet along with initial budget proposals for the setting of the 2025/26 revenue budget. A funding gap of £35m was forecast by 2027/28 which reduced to £22.3m when savings proposals identified to date are taken into account and for context the current year revenue budget is £224m. • As at Month 5 £151.9m of ICS CIP had been delivered against a plan of £150.1m, an over delivery of £1.8m. The forecast CIP position was £491.5m against a target of £490.3m, an overachievement of £1.2m which was broadly in line with the prior month. In terms of CIP delivery on the budgets delegated to the locality, at month 4 £2.39m has been delivered against a full year requirement of £5.15m and it is anticipated that the full £5.15m would be delivered in 2024/25.

ID	Type	The Locality Board	Owner
D/11/12	Decision	Noted the contents of this report and the financial challenges across the Bury system and NHS GM.	

D/11/13	Decision	Noted the reduction in the deficit on the budgets that the locality board is responsible for and the distance still to delivery a break even position recurrently.	

13	Bury Contract Oversight Group Commissioning Intentions for 2025/26
13.3	Mr O'Hare presented a report regarding the Bury Contract Oversight Commissioning intentions for 2025/26. It was reported that: - • NHS Greater Manchester required all localities to submit their commissioning and contracting intentions for 2025/2026. • Bury had primary commissioning responsibility for 19 contracts, where NHS Greater Manchester was the contracting organisation, and was an associate to 22 contracts, where again NHS GM is the contracting organisation. The locality does not have direct responsibility for determining the future commissioning intentions or enacting the intentions through procurement and contracting for those where the locality is an associate; this work will be undertaken elsewhere in NHS GM. • The Provider Selection Regime (PSR) came into force on 1 January 2024. The PSR was a set of rules for procuring health care services in England by organisations termed relevant authorities (NHS England, Integrated care boards, NHS trusts, NHS foundation trusts and Local authorities and combined authorities. • As part of PSR, there are three provider selection processes that relevant authorities can follow to award contracts for health care services namely Direct award processes, Most suitable provider process and Competitive processes**.** • In terms of the recommended Commissioning and Contracting Intentions being proposed as part of this report Table 2 shows the contracts for which Bury have responsibility as lead commissioner. It should be noted that a number of these contracts expired on 31/03/24, and providers are now working to an implied contract for the period 2024/25, with work ongoing between the locality and the NHS GM contracting function, to ensure contracts are put in place as soon as possible. • Commissioning and contracting intentions for 2024/25 were agreed through local governance and GM STAR finance approval gained. The relevant paperwork is now progressing through the GM PSR processes to inform the issuing of a NHS Standard Contact. • Where there is an implied contract for the current financial year the arrangements will expire on 31/03/2025. Where NHS Standard Contracts are in place for the period 2024/25 for 1 year, with no option to extend, these will also expire on 31/03/25 . • In terms of next steps, it was noted that Commissioners/locality leads would need to complete and submit the GM STAR and GM PSR process for approval, Commissioners would need to report outcomes of the GM approval processes to the Bury Contract Oversight Group and robust plans would need to be put in place via the Contracts Oversight group to prepare for work required to inform 25/26 commissioning and contracting intentions.
13.4	The following comments/observations were made by Locality Board members/attendees: - • Assurance that the locality was working within procurement law as part of these proposals. Mr O'Hare confirmed that these proposals were in line with procurement law. • A query in relation to quality assured spirometry and the impact that the current contract ending on the 31st March 2025 could have within the locality on patients. It was noted that there was no budget for this service identified at present and discussions with Greater Manchester were required in this regard. Mr Heppolette suggested a further discussion on this matter via the GM Primary Care Commissioning Committee.

ID	Type	The Locality Board	Owner
D/11/14	Decision	Noted the content of the paper.	
D/11/15	Decision	Endorsed the recommendations including the commissioning and contracting intentions as set out in table 2 of the report for submission to NHS GM for approval (this is subject to ratification at the next face to face Locality Board meeting in December 2024).	
D/11/16	Decision	Noted the risks and issues.	
D/11/17	Decision	Noted a regular update will be provided on contracts lead by Bury and those to which Bury is an associate as part of the finance report.	
A/11/04	Action	A further discussion regarding quality assured spirometry to take place via the Primary Care Board.	Mrs Alderson/Mr Blandamer

14	Locality Estates update
14.1	Mrs Postlethwaite was in attendance to provide an update in relation to Locality Estates development work over recent months and articulate the priority areas moving forward for the locality.
14.2	It was recognised that the ageing estate across many parts of the locality risks being an obstacle to service change and expansion. The ability of the estates solution to sufficiently respond to service need is particular challenging due to the economic and financial constraints that exist both within our locality and across Greater Manchester more widely.
14.3	It was noted that over recent months, significant work has been progressed to ensure that, despite financial and economic constraints, the locality estate plans are sufficiently developed to ensure that the local estates solution continues to be a key enabler to the delivery of service and place based change within the borough.
14.4	Recognising the current financial climate across all areas of public service, recent work has focused on the ability of innovate work at partnership level to ensure that focused estates solutions can still be found.
14.5	Within Bury, the two major priority schemes noted were the Uplands practice proposal (Whitefield) and the Prestwich community hub regeneration proposal. Dialogues to date with Greater Manchester colleagues have articulated the urgency of a solution in Whitefield due to the nature of the current building. The Prestwich scheme has been described as the key strategic service change proposal for Bury due to the aspirations to base local health teams and GP practices alongside council and community services in a single hub facility.
14.6	Whilst there remained significant work required in order to secure the scheme, work in relation to the Whitefield proposal over recent months has been positive. The scheme now has regional approval to proceed within a national decision awaited. The solution being proposed involves the ex-library site which removes the need for costly interim decanting of the GP practice during construction works and also removes some complex land assembly issues associated with the current site that have been an obstacle to previous proposals. Current plans for the scheme aim for site acquisitions and the majority of design finalisation work to be concluded by the end of March 2025.
14.7	Alongside specific estates proposals, it was recognised that the major housing developments proposed at Elton and Walshaw create pressures on GP provision relating to the housing growth being planned. Detailed discussions have been progressed with local planning colleagues with key advice provided by

	the NHS Property Services national planning advisory team. Work to date has enabled an appropriately drafted inclusion in the Strategic Planning Document (SPD) for both these housing proposals that accurately outlines the likely health impact and the requirement for the developer to respond appropriately to aid in delivering a solution
14.8	In order to afford change across the estate, all localities were required to review assets and classify as core, flex or tail – with clear plans then being required with regard to the related proposals to appropriately dispose of any tail estate. For Bury, this work included the classification of Sunnybank clinic as tail estate with work now being progressed to fully vacate the facility to allow the disposal of this site and related saving to health.
14.9	In terms of the risks associated with the paper, whilst the intended and strength of partnership across the borough continued to ensure innovate and forward-thinking estates solutions to be considered, it was recognised that there remains a risk that financial constraints at a local and also Greater Manchester level create a risk to the ability to deliver proposals as quickly as hoped.
14.10	The following comments/observations were made by Locality Board members: - • The plans around the future of Sunnybank Clinic did not appear to have been previously discussed from a political perspective and was not clear whether the ward councillor had been sighted on this matter. Mrs Postlethwaite commented that the Sunnybank site had not been fully utilised for many years and the facility had not been actively used by patients. There was currently one NCA Service (Stoma) operating from the building which would soon be relocating in line with their wishes which would leave the building vacant at that point. Mrs Postlethwaite agreed to pick this engagement element up separately outside the meeting with Cllr O'Brien, Cllr O'Brien and the ward councillor/s outside of the meeting.

ID	Type	The Locality Board	Owner
D/11/18	Decision	Supported the proposal to formally progress the vacating and related disposal of Sunnybank Clinic (NB - this decision would need to be formally ratified at the next face to face Locality Board meeting in December 2024)	
D/11/19	Decision	Noted the key priority schemes for Bury at Whitefield and Prestwich.	
A/11/05	Action	Mrs Postlethwaite agreed to pick this engagement element up separately outside the meeting with Cllr O'Brien, Cllr O'Brien and the ward councillor/s outside of the meeting.	Ms Postlethwaite

15	Population Health and Wellbeing update
15.1	Mr Hobday submitted the latest update report in relation to Population Health and Wellbeing.

ID	Type	The Locality Board	Owner
D/11/20	Decision	Noted the update.	

16	Clinical and Professional Senate update
16.1	Dr Patel submitted the latest update report in relation to the Clinical and Professional Senate.

ID	Type	The Locality Board	Owner
D/11/21	Decision	Noted the update.	

17	SEND Improvement and Assurance Board minutes DFE Visit on preparing for adulthood
17.1	Ms Young was in attendance to provide an update on the preparation work that had been undertaken ahead of a future CQC and Ofsted inspection
17.2	The latest version of the Send Improvement and Assurance Board minutes would be circulated to members on Email following todays meeting as they were not available at the time of papers being issued.
17.3	The following comments/observations were made by Locality Board members: - • It was suggested that the Chair of the Send Improvement and Assurance Board could be invited to a future Locality Board meeting. Dr Fines commented that this was a reasonable suggestion which could be picked up.

ID	Type	The Locality Board	Owner
D/11/22	Decision	Noted the update.	All
A/11/06	Action	Latest version of the Send Improvement and Assurance Board minutes to be circulated to members	Mrs Kennett
A/11/07	Action	Chair of the Send Improvement and Assurance Board could be invited to a future Locality Board meeting.	Dr Fines

18	Any other business
18.1	There were no items raised.

ID	Type	The Locality Board	Owner
D/11/23	Decision	Noted the information	

19	Date and time of next meeting
19.1	It was noted that the next Locality Board meeting would take place on Monday, 2nd December 2024, 4.00 - 6.00pm at Bury Town Hall.

BURY INTEGRATED CARE PARTNERSHIP

Locality Board Action Log – November 2024

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

Date	Reference	Action	Lead	Status	Due Date	Update
4th November 2024	A/11/01	Ms Preedy to pick up a further conversation with Mr Hobday about the GM healthy workforce charter	Ms Preedy		December 2024	
4th November 2024	A/11/02	A meeting to be arranged between Dr Patel, Ms Fawcus and Ms Allan in this regard including how we can start deploying NCA physicians in the community sooner rather than later	. Dr Patel		December 2024	
4th November 2024	A/11/03	A further detailed paper would be brought back to a future Locality Board meeting in relation to winter planning.	Mr Blandamer		January 2024	Added to Forward Plan for January 2025
4th November 2024	A/11/04	A further discussion regarding quality assured spirometry to take place via the Primary Care Board.	Mrs Alderson/Mr Blandamer		December 2024	PCCC discussed the matter of QAS at its Committee on the 25th November 2024. Whilst GM commissioning intentions indicate that this is a priority for 2025/26, no budget has been identified therefore the service will cease as planned on the 31st March 25.

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

Date	Reference	Action	Lead	Status	Due Date	Update
4th November 2024	A/11/05	Mrs Postlethwaite agreed to pick up the engagement element of the Sunnybank Site plans outside the meeting with Cllr O'Brien, Cllr Tariq and the relevant ward councillor/s.	Ms Postlethwaite		December 2024	Follow-up queries in relation to the disposal have now been progressed and responded to outside the Locality Board meeting with detailed work now being progressed to assess possibility of site for housing. Full update note will go out to ward councillors once final proposal for the site confirmed
4th November 2024	A/11/06	Latest version of the Send Improvement and Assurance Board minutes to be circulated to members	Mrs Kennett		November 2024	Circulated on the 5th November 2024
4th November 2024	A/11/07	Chair of the Send Improvement and Assurance Board could be invited to a future Locality Board meeting.	Dr Fines		TBC	

Meeting: **Locality Board**			
Meeting Date	02 December 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. Bury Hospice

I am delighted to confirm that Stuart Richardson has been appointed as the Chief Executive of Bury Hospice and commenced his role today. Stuart worked in Bury many years ago and rose to Chief Executive level in an NHS provider and therefore brings a wealth of health care delivery experience to the work of the hospice.

In welcoming Stuart, we pay tribute to the outstanding work of Helen Lockwood in her period as the Hospice Chair. Helen, working with the board, has bought stability, transparency, energy and transformational ambition to the work of the hospice and the wider Bury focus on end of life and palliative care. Helen has been the SRO for the Bury end of life and palliative care programme that has seen a number of important innovations and strengthened partnership working, including new models of out of hospice service delivery, and also in ensuring the hospice are part of our urgent care response arrangements. Helen will retain her support for the hospice by continuing as one of the trustees.

The work of Bury hospice is increasingly recognised locally and nationally. For example, in October 24 the hospice received a highly commended awarded in the national MCA Awards for the work with NECS that delivered night sitting, help line and outreach over 7 days. And locally the hospice received an honorary award from Bury College to recognise the Hospice's outstanding contributions to the local community that has had a significant positive impact on peoples' lives, and the role of the hospice in supporting students through the offer of work experience and live project opportunities.

I am pleased to say Stuart is committed to continuing that work as a wider system leader in our integrated delivery arrangements and I am sure all partners will welcome him and the continued leadership of the hspice in what will need to be recognised as a key priority for Bury given the expected considerable demand for end of life care in the coming years.

2. Locality Assurance Meeting – 28th November

NHS GM in Bury received its second quarterly assurance visit last week. The key elements of the visit were as follows:

2.1 To recognise multiple examples of the partnership work in Bury demonstrating improved outcomes for residents in the borough and compliant with the key strategic intent of the GM sustainability plan. Particularly recognition was given to:

- Historically low Days kept away from home numbers from FGH.
- No mental health out of area placements from Bury residents.
- The comprehensive role out of My happy mind to all primary care schools supporting emotionally health and wellbeing and creating resilience in young children.
- Highest number of LD Health checks in primary care
- 24000 more appointments in primary care April to Augst 2024 compared to same period in 2019.

2.2 To recognise key challenges in the health and care system in Bury and to work across the ICB and with partners to resolve them. The challenges have all been considered in the year 2024 by the locality board and included:

- The relatively under GPd position of Bury compared to other parts of Greater Manchester and the limitations imposed on Bury by having a significantly lower LCS

budget than elsewhere.

- The priorities associated with responding to the OFSTED/CQC judgement of widespread and systemic failure of the Bury SEND partnership arrangements, in particular:
    - Community paediatric waiting times
    - Neuro CAMHS waiting times.
    - The remaining need for a locally commissioned provider of adult ADHD services across Bury/Oldam and Rochdale
- The gaps in mental health provision in Bury relating to crisis response and early intervention services, manifesting in relatively high numbers of Days kept away from home, section 117 costs, and inappropriate attendance at ED and the need for a commissioned response focused less on OAPs and more on demand reduction through transformed community mental health provision.

2.3 Recognised sisgniicant challenges to the financial position of the NHS GM in Bury largely as a result of pressures on the CHC and complex care budget, and confirming the steps taken in Bury.

We will continue to work with ICB colleagues corporately to address these priorities and they will also be reflected in the prioritisation and commissioning intentions framework in development.

3. Let's Do It Refresh Workshop

I would like to thank colleagues from the Bury Integrated Care Partnership for attending a workshop on 26th November to support the work to refresh the Let's Do It Strategy. As the Board is aware the Let's Do It strategy is the strategy for the borough with ambitious objective to 2030 for economic growth and reducing deprivation. Its delivery, through the key lenses of Local, Enterprising, Together, and Strengths, is dependent on high quality partnership of business, the voluntary sector, public services, and the residents of the borough.

The refreshed strategy will be finalised in December and the consideration of the Locality board in January of the opportunity for the health and care system to play its fully part will be welcome.

4. Health Scrutiny

Colleagues from both Council and NHS GM Bury attended the Health Scrutiny meeting on 28th November and provided an update on 2 key items: - the operation of the Urgent Care System and preparedness for winter, and the work being done to support adult care providers in the borough with workforce development and support.

On the former particular reference was made to the efforts in Bury to secure more rapid improvement in the delivery of the 4 hour wait target in A&E and I would like to thank colleagues from FGH and the wider system for their positive contribution to the workshop held on 27th November to this end. FGH is currently the 4th best ED in GM, but we are working hard to improve further.

On the latter, the committee recognised outstanding work to provide solutions to adult care provider recruitment, retention and leadership development, and the work with Bury College to secure the workforce for the future. The committee particularly noted that since the establishment of the programme, supported by national Market Sustainability investment funding, Bury has No CQC rated inadequate care homes or care providers in Bury and over 90% of such providers rated as good or outstanding – the second-best performance of any locality in the Northwest.

I would like to extend my appreciation to Adult Care colleagues in supporting and valuing the adult care providers in the borough.

5. Childhood Obesity

The Health and Well Being board – as a sister to this Locality Board and operating as a standing committee on health inequality and population health - have received updates in recent years on all aspects of addressing obesity, including the development and delivery of the physical activity strategy for the borough, and the work on the borough on sustainable Food choices. I am therefore pleased to advise the locality board that the most recent national childhood obesity measurement programme results for 23/24 (compared to 22/23) showed a 0.75% reduction in the overweight and obesity category for reception age children and a statistically significant reduction of 3.89 % in the Year 6 cohort. These are statistically significant reductions and outperform the reduction across GM as a whole. This is hugely important progress, and thanks are expressed to all partners – schools, community organisations and the public health team.

6. Bury Healthwatch

I know a number of colleagues attended the opening of the new Healthwatch premises in Bury this month and are planning on attending the AGM on 4th December at 5pm in the mosses Centre. Healthwatch Bury are an invaluable partner – discharging their stator responsibility including 'enter and view' capability and also producing reports and recommendations for NHS and care services – but also providing a n invaluable source of advice and engagement – listening to communities and patients. I would like to recognise the large role that Adam Webb as Chief Officer of Bury Healthwatch has played, and his outstanding contribution to partnership in Bury, as I understand Adam is leaving us this month. We look forward to continuing to work constructively with Healthwatch in future years.

7. Christmas Period

As this is the last Locality board of 2024, I would like to place on record my thanks to all partners in the Bury health and care system for the quality of engagement and partnership in the Bury. I would particularly like to recognise the work of our front-line staff from all organisations over the festive period in maintaining services to our residents in what can be a busy and challenging period.

Lynne Ridsdale
Place Lead NHS GM (Bury)
Chief Executive Bury Council
2/12/24

Pennine Care NHS Foundation Trust

Maximising potential

Introduction

Pennine Care NHS Foundation Trust

PCFT are currently undertaking a refresh of the Service Mapping work in order to identify the level of variation in services across the PCFT footprint. This work will inform service and investment planning, with the aim to drive out unwarranted variation, improve outcomes, increase access, reduce waiting times and increase efficiency.

Variation is identified as where we are:

- Not compliant/fully compliant against a LTP/national standard
- Have significant variation against national benchmarks for services
- Have identified significant gaps in the demand and available capacity in services through local service planning

Service Variation - Bury

Pennine Care NHS Foundation Trust

Early indications of service variation in Bury are as below – (Please note this is not the final validated version)

Community Mental Health Teams	**Gap**
Inpatient Services	**Gap**
Memory Assessment Services	**Gap**
Crisis Resolution / Home Treatment Team	**Partial Gap**
Living Well	**Gap**
Talking Therapies	**Gap**
Step 3.5	**Gap**
Liaison	**Partial Gap**
Section 136	**Gap**
CAMHS	**Gap**
Parent and Infant Mental Health Services	**Partial Gap**

Next Steps - Governance Process

Pennine Care NHS Foundation Trust

The work is not yet finalised and will be validated by our internal governance process as outlined below –

- 2nd December 2024 – Finance review
- 9th December 2024 – Operational Performance and Oversight
- 11th December 2024 – Trust Management Board
- 12th December 2024 – Business Planning Summit
- January 2025 – Performance and Finance Committee

Northern Care Alliance
Bury Elective Waiting Times Update

21st November 2024

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GM Waiting Times

GM Locality - RTT Waiting List (September 24)

GM Locality	Total All	65+ Weeks	78+ Weeks
Greater Manchester Total	**451,381**	**796**	**39**
NHS MANCHESTER	91,852	106	1
NHS WIGAN BOROUGH	53,453	152	14
NHS STOCKPORT	49,605	64	2
NHS BOLTON	46,795	235	14
NHS SALFORD	46,154	70	3
NHS TRAFFORD	38,682	49	1
NHS OLDHAM	33,623	24	0
NHS HEYWOOD, MIDDLETON AND ROCHDALE	33,333	34	2
NHS BURY	29,386	38	1
NHS TAMESIDE	28,498	24	1

- **Total GM waiters - stabilised and reducing**, with the current position at **451,381** (Sep-24).
- **Bury waiters -** currently at **29,386 in September**, accounting for **6.5% of GM's total**.
- **65+ Week Waits** – **796 currently waiting in GM** and **38 in Bury.** Bury accounts for **4.8% of the GM total** 65+ Week Waits.
- **78+ Week Waits** – **decreasing in GM since May 2023** with **39 currently waiting**. **Bury** has been **decreasing since September 2023 with 1 currently waiting**, **2.5% of the GM total** 78+ Week Waits.

Bury Locality Waits: All Providers (September 24)

Bury Locality Waits by Provider (Sep-24)	Total All		65+ Weeks		78+ Weeks	
	Volume	% Bury Total	Volume	% Bury Total	Volume	% Bury Total
Bury Locality Total - All Providers	**29,386**	**100%**	**38**	**100%**	**1**	**100%**
NORTHERN CARE ALLIANCE NHS FOUNDATION TI	18,813	64%	12	32%	0	0%
MANCHESTER UNIVERSITY NHS FOUNDATION TR	7,055	24%	1	3%	0	0%
BOLTON NHS FOUNDATION TRUST	1,613	5%	19	50%	0	0%
Other GM NHS Trusts	524	2%	5	13%	0	0%
Other Providers	1,381	5%	1	3%	1	100%

RTT Performance: NCA and Bury Patients (Sep 24)

Northern Care Alliance NHS Foundation Trust

Total Waits

Specialty	Total
Total Waiting	**142,811**
Dermatology Service	17,933
Neurology Service	17,180
Trauma and Orthopaedic Service	14,463
Ear Nose and Throat Service	11,909
Gastroenterology Service	11,497
Gynaecology Service	8,633
Other - Surgical Services	8,295
Urology Service	8,017
Ophthalmology Service	6,851
Cardiology Service	6,774

In **September NCA** had a **total** of **142,811 waiters** – **Dermatology and Neurology** being the **top two specialties**.

Total **Bury** waiters **at NCA** is **18,813 - Dermatology and ENT** being the **top two specialties**.

Bury ENT waiters account for **18% of NCA waiters**.

17.9% of Dermatology waits and **14.3% of T&O** waits **at NCA are for Bury** registered patients.

65+ Week Waits

Specialty	65+ Weeks
Total 65+ Weeks	**120**
Gynaecology Service	24
Dermatology Service	23
Neurology Service	17
Trauma and Orthopaedic Service	16
Urology Service	13
General Surgery Service	6
Ophthalmology Service	5
Other - Surgical Services	4
Plastic Surgery Service	3
Neurosurgical Service	3

In **September NCA** had a **total of 120 65+ Week waiters** with **Gynaecology and Dermatology** being the **top two specialties**.

Total **Bury waiters** at **NCA** is **12**.

80% of Ophthalmology waits (4 out of 5 breaches) at **NCA** are for **Bury registered patients**.

Bury Gynaecology waiters account for **4% of NCA 65w breaches and Bury Dermatology waiters account for 9%.**

78+ Week Waits

Specialty	78+ Weeks
Total 78+ Weeks	**1**
Urology Service	1

In **September NCA** had a **total** of **1 78+ Week waiters** with **Urology** being the **specialty with a breach.**

There are zero Bury 78 week waiters at **NCA.**

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NCA RTT Performance: All Localities (September 24)

Specialty	Total All		65+ Weeks		78+ Weeks	
	Volume	% Total	Volume	% Total	Volume	% Total
Dermatology Service	17,933	13%	23	19%	0	0%
Neurology Service	17,180	12%	17	14%	0	0%
Trauma and Orthopaedic Service	14,463	10%	16	13%	0	0%
Ear Nose and Throat Service	11,909	8%	1	1%	0	0%
Gastroenterology Service	11,497	8%	1	1%	0	0%
Gynaecology Service	8,633	6%	24	20%	0	0%
Other - Surgical Services	8,295	6%	4	3%	0	0%
Urology Service	8,017	6%	13	11%	1	100%
Ophthalmology Service	6,851	5%	5	4%	0	0%
Cardiology Service	6,774	5%	2	2%	0	0%
Other - Paediatric Services	6,591	5%	1	1%	0	0%
Other - Medical Services	6,482	5%	1	1%	0	0%
Neurosurgical Service	5,043	4%	3	3%	0	0%
General Surgery Service	4,991	3%	6	5%	0	0%
Rheumatology Service	2,542	2%	0	0%	0	0%
Respiratory Medicine Service	2,432	2%	0	0%	0	0%
Oral Surgery Service	1,649	1%	0	0%	0	0%
Plastic Surgery Service	957	1%	3	3%	0	0%
Elderly Medicine Service	436	0%	0	0%	0	0%
Other - Other Services	68	0%	0	0%	0	0%
General Internal Medicine Service	66	0%	0	0%	0	0%
Cardiothoracic Surgery Service	2	0%	0	0%	0	0%
Total	**142,811**	**100%**	**120**	**100%**	**1**	**100%**

- The **main specialties driving current NCA RTT performance** are **Dermatology, Neurology, Spinal Surgery** (which is **counted under Trauma & Orthopaedics**), **and ENT**
- **Dermatology** has experienced a **large increase in seasonal urgent suspected cancer pathway demand** which has **reduced capacity to treat lower clinical urgency long waits** in addition to GM Service Closure
- **ENT** is a service that is **experiencing capacity constraints, and complex septorhinoplasty demand growth**
- **Urology and Spinal Surgery** services are subject to **capacity constraints**

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RTT Performance: MFT and Bury Patients (Sep 24)

Northern Care Alliance NHS Foundation Trust

Total Waits

Specialty	Total
Total Waiting	**195,516**
Other - Medical Services	24,704
Oral Surgery Service	20,405
Other - Paediatric Services	19,547
Gynaecology Service	19,281
Other - Surgical Services	16,071
Ophthalmology Service	12,041
Ear Nose and Throat Service	11,701
Gastroenterology Service	10,524
Cardiology Service	10,261
Respiratory Medicine Service	10,034

In **September MFT** had a **total** of **195,516 waiters** – **Other - Medical Services and Oral Surgery** being the **top two specialties**.

Total **Bury** waiters **at MFT** is **7,055 - Oral Surgery and Other-Medical Services** being the **top two specialties**.

8.1% of Oral Surgery waits, **4.9% of Other - Surgical and 4.4% of Other - Medical** waits **at MFT are for Bury** registered patients.

65+ Week Waits

Specialty	65+ Weeks
Total 65+ Weeks	**262**
Gynaecology Service	108
Trauma and Orthopaedic Service	62
Other - Surgical Services	40
Other - Medical Services	16
Ophthalmology Service	13
Cardiology Service	7
Other - Other Services	6
General Surgery Service	4
Other - Paediatric Services	2
Gastroenterology Service	2

In **September MFT** had a **total of 262 65+ Week waiters** with **Gynaecology and Trauma and Orthopaedics** being the **top two specialties**.

Total **Bury waiters** at **MFT** is **1**.

The **specialty** for **Bury's 65w breach** is **Gynaecology**.

1% of Gynaecology waits at **MFT** are for **Bury registered patients**.

78+ Week Waits

Specialty	78+ Weeks
Total 78+ Weeks	**14**
Gynaecology Service	4
Other - Surgical Services	4
Ophthalmology Service	4
Other - Medical Services	2

In **September MFT** had a **total** of **14 78+ Week waiters** with **Gynaecology, Other – Surgical Services, Ophthalmology and Other - Medical Services** being the **specialties with breaches.**

There are zero Bury 78 week waiters at **MFT.**

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NCA 62 Day Cancer Performance April-Nov 2024*

** Including Oct and Nov MTD as a pre-uploaded position*

NHS Northern Care Alliance NHS Foundation Trust

GP Suspected Cancer	Target: 85%					
Cancer Site	**Total Patients**	**Breach**	**Non Breach**	**NCA Compliance**	**Bury Locality Performance**	**Variance**
Brain	4	3.00	1.00	25.00%	25.00%	0.00%
Breast	15	0.50	5.00	90.91%	NA	NA
Colorectal	180	91.00	70.00	43.48%	38.56%	-4.92%
CUP	1	0.00	1.00	100.00%	NA	NA
Gynaecology	81	35.00	24.50	41.18%	33.33%	-7.84%
Haematology	68	25.50	36.50	58.87%	67.07%	8.20%
Head and Neck	77	40	21	34.43%	33.33%	-1.09%
Lung	171	41.00	74.50	64.50%	64.29%	-0.22%
Other	12	3.50	7.50	68.18%	NA	NA
Sarcoma	12	4.00	2.00	33.33%	0.00%	-33.33%
Skin	434	199.5	203.5	50.50%	50.06%	-0.43%
Upper GI	135	32.00	68.50	68.16%	69.72%	1.56%
Urology	503	124.5	300.5	70.71%	71.36%	0.65%
Total	**1693**	**599.50**	**815.50**	**57.63%**	57.26%	-0.37%

Breast & CUP incidental findings following a referral into another specialty. Large variance in Sarcoma, however small volume of treated patients.

National Screening	Target: 85%					
Cancer Site	**Total Patients**	**Breach**	**Non Breach**	**NCA Performance**	**Bury Locality Performance**	**Variance**
Colorectal	45	35.00	3.00	8%	0.00%	-7.89%
Gynaecology	6	1.00	3.00	75%	0.00%	-75.00%
Lung	61	15.00	16.00	52%	54.00%	2.39%
Total	**54**	**32.50**	**17.00**	34%	31.40%	-2.94%

Significant variance in Gynae, however based on 1 x breach patient.

Local Upgrade	Target: 85%					
Cancer Site	**Total Patients**	**Breach**	**Non Breach**	**NCA Performance**	**Bury Locality Performance**	**Variance**
Brain	97	2.00	84.00	97.67%	98.02%	0.35%
Breast	18	1.00	8.00	88.89%	NA	NA
Colorectal	129	22.50	92.00	80.35%	76.25%	-4.10%
CUP	27	0.00	24.50	100.00%	100.00%	0.00%
Gynaecology	49	12.50	22.00	63.77%	68.97%	5.20%
Haematology	91	12.50	72.00	85.21%	86.25%	1.04%
Head and Neck	57	14.5	26.5	64.63%	62.30%	-2.33%
Lung	353	48.00	195.50	80.29%	75.71%	-4.58%
Sarcoma	5	1.00	4.00	80.00%	NA	NA
Skin	106	25.5	72	73.85%	64.80%	-9.05%
Upper GI	122	18.50	75.00	80.21%	80.33%	0.12%
Urology	230	28	168	85.71%	84.88%	-0.83%
Total	**1284**	**186.00**	**843.50**	81.93%	79.14%	-2.79%

Minimal variance in performance between patients from the Bury locality in comparison with the NCA wide position

5% Improvement in GP 62 Day Performance

1% Improvement in Screening 62Day Performance

1.65% Deterioration in Local Upgrade 62Day Performance

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NCA 28 Day Cancer Performance April – Nov 2024*

** Including Oct and Nov MTD as a pre-uploaded position*

Northern Care Alliance NHS Foundation Trust

FDS All Communication Types, All Referral Routes:

All Referral Routes	Target: 77% (Skin 85%)				
Cancer Site	28 Breach	28 NonBreach	NCA Performance	Bury Locality Performance	Variance
Brain	282	970	77.5%	77.8%	0.3%
Breast	43	12	21.8%	18.8%	-3.0%
Colorectal	1,859	4,045	68.5%	64.8%	-3.7%
CUP	8	7	46.7%	50.0%	3.3%
Gynaecology	1,146	2,169	65.4%	70.5%	5.1%
Haematology	79	200	71.7%	69.0%	-2.7%
Head and Neck	916	2,184	70.5%	50.0%	-20.5%
Lung	209	1,430	87.2%	90.9%	3.7%
Other	400	1,580	79.8%	81.7%	1.9%
Paediatrics	10	33	76.7%	100.0%	23.3%
Sarcoma	73	217	74.8%	76.4%	1.6%
Skin	4,354	6,905	61.3%	59.0%	-2.3%
Upper GI	676	2,069	75.4%	71.7%	-3.7%
Urology	863	1,451	62.7%	58.5%	-4.2%
Totals	10,918	23,272	68.1%	71.4%	3.3%

There has been a 7.6% improvement from 22/23 to 24/25 period, despite the ongoing challenges within the Skin Pathway

Significant Variance in ENT performance for Bury Locality – audit of breaches to be undertaken and presented at a future NCACIC.

NCA focus to drive performance to 83% from April 2025 is to develop diagnostic pathways to increase Cancer Confirmed Performance from 47%* to 70%

CARE APPRECIATE INSPIRE

NCA 31 Day Cancer Performance April- Nov 24*

** Including Oct and Nov MTD as a pre-uploaded position*

All Referral Routes	Target: 96%					
Cancer Site	**Total Patients**	**Breach**	**Non Breach**	**NCA Performance**	**Bury Locality Performance**	**Variance**
Brain	142	7	149	95.3%	88.9%	-6.4%
Breast	9	0	9	100.0%	NA	NA
Colorectal	324	25	349	92.8%	94.6%	1.8%
CUP	36	0	36	100.0%	100.0%	0.0%
Gynaecology	58	3	61	95.1%	100.0%	4.9%
Haematology	269	0	269	100.0%	100.0%	0.0%
Head and Neck	51	11	62	82.3%	72.7%	-9.6%
Lung	227	0	227	100.0%	100.0%	0.0%
Sarcoma	9	0	9	100.0%	NA	NA
Skin	403	201	604	66.7%	66.3%	-0.4%
Upper GI	266	13	279	95.3%	100.0%	4.7%
Urology	743	12	755	98.4%	99.1%	0.7%
Total	**2,537**	**272**	**2,809**	90.3%	90.1%	-0.2%

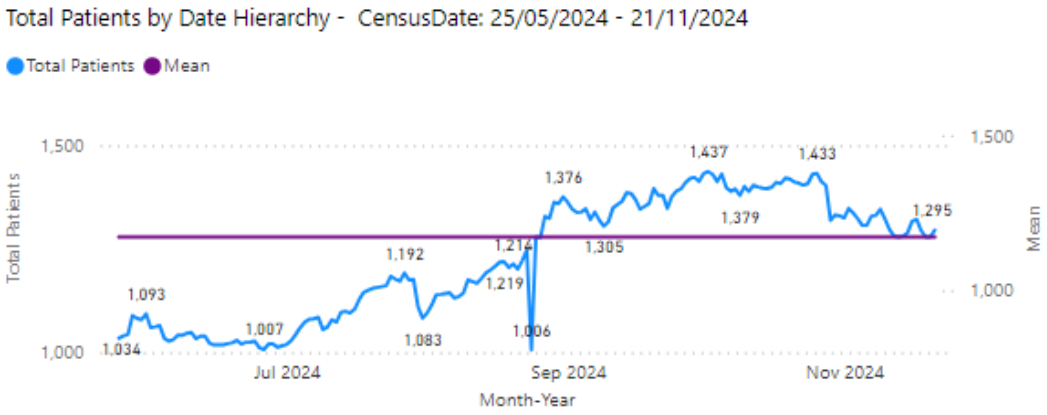
Minimal variance in performance between patients from the Bury locality in comparison with the NCA wide position

31 Day Performance has remained fairly static in the main. Some deterioration within Skin due to capacity vs demand challenges. Deterioration in Colorectal across Oldham due to complex patient work up , requiring development of the preoperative pathway for Cancer patients.

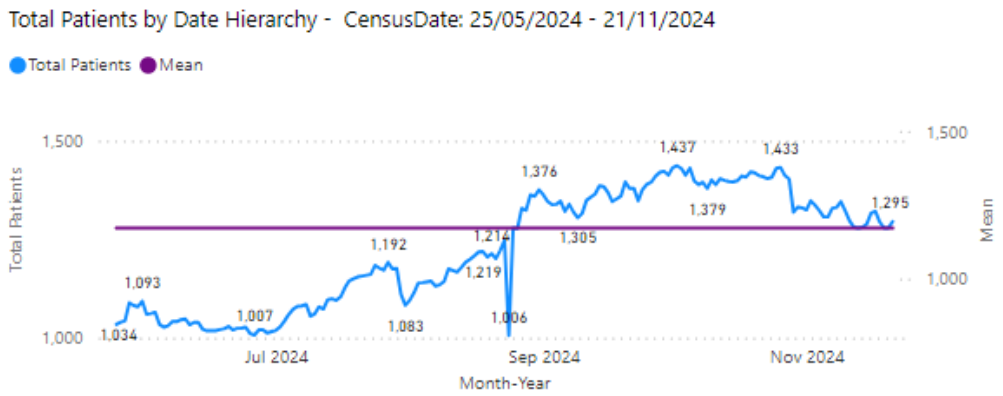
NCA 63+ Backlog – March-August 2024

Northern Care Alliance NHS Foundation Trust

NCA Position



Bury Locality Position



The trend between Bury locality patients and the NCA position is incredibly similar, no distinct variance.

The NCA Backlog has increased since the beginning of the financial year.

Key Drivers:

- Skin referral volumes, and continued closure of Tameside. Significant capacity gap between April – September, however the PTL has reduced by 1100 patients since September. The 63+ backlog has reduced by almost 500 patients.

- Endoscopy wait time increase from March-July, and remained at an average of 16.1 days. CDC Endoscopy unit to go live from 2/12, with impact to TAT and therefore FDS, Backlog and 62D position expected to be established from end of Jan 2025.

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NCA Cancer Performance 24/25

Northern Care Alliance NHS Foundation Trust

We have recently amalgamated all care org specialty cancer improvement plans into a single NCA Plan. Developing specific and measurable aims and actions associated with the required improvements across CWT Standards.

Key Focuses:

- Reducing variance between care organisation pathways

- Reducing variance in performance between NCA, GM and National Benchmarks

- Increasing FDS Performance to 83% by April 2025 via the reduction of days to Cancer Confirmed

- Establishing and resolving capacity and demand gaps to reduce non-compliance with BPTP

- Developing an NCA model to support reduction in preoperative wait times enabling 96% compliance with 31D Pathways

- Establishing opportunities for MDT reform to support both D38 and D62 pathway compliance enabling improvements within NCA and GMC Performance

- Pathway redesign with a focus upon developing NCA access and delivery for cancer diagnostics and treatments

CARE APPRECIATE INSPIRE

Summary

- RTT waits have stabilised and continue to reduce within NCA
- Cancer has seen a 5% improvement in GP 62 Day performance and a 1% improvement in screening 62 Day performance
- Key areas of focus identified to support further areas of improvement for RTT, diagnostics and cancer standards

Meeting: Locality Board			
Meeting Date	02 December 2024	**Action**	Receive
Item No.	8	**Confidential**	No
Title	Children's and Young Peoples Delivery Plan Update		
Presented By	Will Blandamer, Executive Director, Health and Adult Care - Bury Council and Deputy Place Lead - NHS GM (Bury)		
Author	Louise Rule, Associate Programme Director Children & Young People, NHS Greater Manchester Integrated Care		
Clinical Lead	Dr Cathy Fines, Associate Medical Director, GM Integrated Care Board		

Overview

The attached presentation provides an update in relation to the Joint Forward Delivery Plan for Children and Young People developed by the GM Integrated Care Partnership. It is for the consideration of each of the ten locality boards in GM.

The Bury Locality Board have prioritised children's services and children's health and wellbeing in the year 2024. There are many aspects of the GM Joint Forward Delivery plan that are recognisable to Bury, relate to key priorities in Bury, and have been the subject of consideration or update in the Bury Locality Board.

There are 6 key priorities and a high-level position is provided for each.

1) **Child Development in the Early Years.**
   This has been a priority in Bury and is co-ordinated by the Start Well Group chaired by the Director of Public Health. Key initiatives in Bury have included the investment in Health Visiting services, the mapping of the first 1000 days pathway, the connection to Bolton maternity services, and implementation of a model of family hub in Redvales and in Chesham.

   However further work in Bury is required to:
   - scale the roll out of family hub development as an inherent part of integrated neighbourhood team working,
   - strengthened performance reporting of HV services.
   - Further development via the Start Well group.
   - Oversight of maternity quality by place (Bury) rather than by maternity unit.

2) **SEND and School Age Well Being**
   The locality board is sighted on the priority of this in Bury following the February inspection and has been briefed on the progress of the SIAB.
   Key initiatives have been implementation of mental health in schools, the autism in schools

project, my happy mind in primary and secondary schools, padlets as a trusted source of advice, and multiple sources of guidance to young people. In addition, there is positive progress by NHS partners on addressing some waiting times – securing improvement in core CAMHS services and SLCN (including the roll out of 'can do', contributing fully to EHCP completion review and assurance, and working on transition and particularly preparing for adulthood. Work continues in partnership with Bury2gether on the implementation of the PINS model in schools in Bury.

However further work in Bury is required to:

- Ensure the recommendations on the neurodevelopment pathway are fully implemented in Bury.
- Strengthen the Bury Autism Board
- Address significant waiting time challenges in community paediatrics, adult ADHD and neuro CAMHS.

3) Long Term physical conditions

Some progress in Bury has been made, for example in securing for the first time access to dedicated epilepsy nurse capacity in the borough, and some important interventions around asthma care and response.

However further work in Bury is required to review all aspects of long-term conditions care for children and we will participate in GM wide benchmarking and stocktake reviews and development of transition pathways.

4) Mental Health

The locality board has received a detailed overview of a comprehensive model of emotional health and mental health and wellbeing services for children described by the I thrive model. A full workshop to review progress and next steps was held with practitioners from multiple organisations in Bury on 27th November and the outcomes of this workshop will inform next steps.

5) Risk and Complex Care

Bury Council through the DCS is fully connected to the potential of the skyline project in Bury and an update to Locality Board will be provided as required.

Further work in Bury is required around understanding palliative and end of life care for children in the context of the wider strategy and Bury will participate in the benchmarking review across GM.

6) Family Help

Bury is looking to accelerate its implementation of family hubs and is also leading in GM on implementation of the Family Safeguarding model.

Recommendations

The Locality Board is asked to discuss and provide comments in relation to the presentation.

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 Locality Plan outcomes	
To support a local population that is living healthier for longer and where healthy expectancy matches or exceeds the national average by 2025.	☒
To achieve a reduction in inequalities (including health inequality) in Bury, that is greater than the national rate of reduction.	☒
To deliver a local health and social care system that provides high quality services which are financially sustainable and clinically safe.	☒
To ensure that a greater proportion of local people are playing an active role in managing their own health and supporting those around them.	☒

Implications						
Are the risks already included on the Locality Risk Register?	Yes	☐	No	☐	N/A	☒
Are there any risks of 15 and above that need to be considered for escalation via an NHS GM Statutory Committee or Board in line with the Risk Escalation process ?	Yes	☐	No	☐	N/A	☒
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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	☒
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If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒

Implications						
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	☐

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

Joint Forward Delivery Plan for Children and Young People

Greater Manchester Integrated Care Partnership

"Giving every child and young person the best start in life".

Foreword

We want to ensure that children and young people across Greater Manchester have the best possible start in life and have their physical and mental health supported as they grow up to become young adults. We recognise that we have variation in the availability and quality of services across Greater Manchester and demand for services means longer waiting times for assessment and treatment for some of our children & young people. We must continue to work collectively to tackle these issues whilst also focussing on early intervention and prevention whilst ensuring that our children & young people and their families can access support when they need it.

Through this Joint Forward Delivery Plan, underpinned by our commitment to put the voice of children & young people at the heart of the way we design and deliver services, we have set out our activity that seeks to achieve this aim. The plan will be overseen by groups set up by partner organisations, that have a critical role in improving the health of our children & young people and collective responsibility for reducing the health inequalities in our city-region.

Ambition

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

‘Giving every child and young person the best start in life’

Vision

An integrated approach to improving outcomes for children and young people and tackling inequalities that puts the needs and experience of children, young people and families at the heart of our ambitions.

The vision for Greater Manchester is a city region where:

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

Challenges for Children and Young People in Greater Manchester

Children growing up in Greater Manchester are from diverse backgrounds and communities, and the degree of challenge they face varies significantly between the ten boroughs and neighbourhoods within them.

The Joint Forward Plan presents an opportunity for local authorities, NHS Greater Manchester and partners to build on improvements already made and continue to work together to ensure that all our children and young people get the best start in life.

Greater Manchester is home to **654,086** children and young people aged **0-17** (inclusive). The population of this age group **increased by 7.2%** between 2011 and 2021, compared to an increase of **3.9% in England overall.**

Infant mortality rate

▲ **4.7** per 1000

(compared to 3.9 in England[2])

Known smoker at the time of delivery

▲ **9.2%**

(compared to 8.8%[3])

2 year olds at or above expected level of development

▼ **77.5%**

(compared to 80.5% in England[4])

Predicted Speech, Language and Communication need

21-39%

across GM localities

(compared to UK prevalence rate 8-10% of all children, up to 50% for those growing up in low-income households)

Children and young people with an Education, Health and Care Plan

▲ **4.8%**

(compared to 4.3% in England)

Children and young people with a SEND Support Plan

▲ **13.2%**

(compared to 13% in England[5])

5 year olds with visibly obvious dental decay

▲ **33%**

(compared to 24% nationally[6])

0-5 year olds admitted to hospital due to dental cavities and decay

▲ **259** per 100,000

(compared to 179 in England[7])

Overweight

4-5 year olds

9.2%

(compared to 8.8% in England[8])

10-11 year olds

23.9%

(compared to 22.7% in England[9])

Rate of children and young people aged 8 to 25 in 2023 in England with a probable mental health condition

20.3%

(compared to 12.5% in 2017[10])

First time entrants to criminal justice system

196 per 100,000

(compared to 149 in England[15])

Children and young people admitted to hospital due to asthma

202 per 100,000

(compared to 122 in England[11])

0-24 years olds living in an area of deprivation

58.3%

(compared to 35% nationally[12])

Cared for 0-18 year olds

92.1 per 10,000

(compared to 70.5 in England[13])

0-18 year olds open to children's social care services

405 per 10,000

(compared to 339 in England[14])

Children and Young People Voice

The Children & Young People (CYP) System Group has set out a firm commitment to actively involve children and young people in its decision making. Building on the existing practice within localities and services, the CYP System Group will support young people to develop a young person's shadow panel. The shadow panel will work with the CYP System Group to embed the Lundy Model of participation and will amplify young people's voices within mental, physical and public health.

#BeeWell survey data[16]

Average life satisfaction and mental wellbeing scores of young people in GM are lower than those of young people in England (in studies using the same measures as #BeeWell).

In 2023,

83%

of Year 10 pupils in GM said that they have hope and feel optimistic for their future. This is an improvement from

72%

in 2020 and

81%

in 2022.

14%

of young people in GM report high levels of emotional difficulties.

This has improved from around 16% in both 2021 and 2022.

Young people in GM eligible for free school meals

reported eating healthy food **less often (47%)** than their peers (61%).

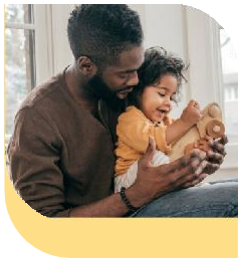
zzzzz!

44.1%

of Year 10 pupils in GM say they do **not** get enough **sleep**.

Our commitments

Shared Ambitions: Having a shared vision, shared principles and set of priorities for Greater Manchester children & young people.



Tackling inequalities: Understanding and responding to inequalities as part of our work to improve outcomes for children & young people.

Children and young people's voice: Incorporating the voice and rights of children & young people in decision-making that affects the support they receive in the community and acute settings.

Resourcing & Commissioning: Taking a partnership approach and longer-term view to resourcing our priorities through shared responsibility and transparency of available resources.

Early intervention & prevention: A central component of our strategy for improving outcomes for children & young people and tackling inequalities at both universal and targeted levels.

Shared leadership, governance, reporting and accountability: Development of appropriate governance with clear lines of accountability for shared priorities including a commitment to better understand and respond to variation across the city-region.

Work in partnership with VCSE sector and communities themselves: Recognising and valuing the work of the VCSE sector on improving health outcomes for children & young people.

Innovation & shared learning: sharing and adopting innovative practice and sharing learning in the field of children & young people's health and wellbeing.

Child Development in the Early Years

Taking an integrated approach to early years, recognising the importance of the first 1,001 critical days and responding to the detrimental impact of Covid-19 on the development of children aged 0-5 years old.

Includes:

- Embedding early years pathways through Family Hub infrastructure to ensure a consistent 'Start for Life' offer across GM localities that meets the 'go further' expectations of the national Family Hubs programme.
- Full implementation of the Saving Babies' Lives Care Bundle.

Outcomes:

- Clear, evidence-based offer to support early years child development across different tiers of need.
- Reduced variation across GM through shared standards embedded in local commissioning models and joint approaches to early years interventions and workforce support.
- Reduction in early neonatal deaths and stillbirth rates.
- Reduction in maternal mortality rates.
- Smoking at the time of delivery rate reduced to 4% or less by 2026.

SEND and School-Age Children Wellbeing

A commitment to addressing inconsistencies in the offer across Greater Manchester and improve the wellbeing of school-age children with special educational needs and disabilities (SEND), Learning Disabilities and Autism (LDA), and Speech, Language and Communication (SLC) needs.

Includes:

- Review and redesign of the GM neurodevelopmental pathway.
- Roll-out the Balanced System® approach to Speech, Language & Communication.

Outcomes:

- Fully integrated neurodevelopmental pathway in place.
- Neurodivergent young people will be better supported with their mental health and have access to support pre and post diagnosis.
- Improved school experience for neurodivergent CYP in GM.
- Whole system, redesigned Speech, Language and Communication pathway in place aligned to Balanced System® principles and outcomes.
- Reduced variation in access to SLC support across GM and increased consistency in support offered in schools, colleges and community settings

Long-Term Physical Conditions (CORE20PLUS5)

Supporting children and young people to live healthier lives and live well with long-term conditions through equitable, effective and efficient management of diagnosed health conditions.

Includes:

- Asthma
- Epilepsy
- Diabetes
- Oral health

Outcomes:

- Children will receive developmentally appropriate care as they transition from child to adult long term condition health care services.
- Children with asthma will be more confident to self-manage their condition and have appropriate adult and peer support around them, leading to improved wellbeing.
- More children with diabetes who are overweight will receive the support they need to manage their weight resulting in improved wellbeing and a reduction in complications from excess weight.
- CYP with epilepsy will receive equitable service provision regardless of where they live in GM.

Mental ill Health

Responding to the rise in the number of children & young people seeking support for mental ill health through a focus on earlier support and preventing escalation in the community, whilst also having the right pathways in place for those in crisis.

Includes:

- Mental Health Support Teams (MHST) in schools
- Child and Adolescent Mental Health Services (CAMHS)
- Crisis support
- Perinatal mental health provision

Outcomes:

- More schools with Mental Health Support Teams.
- Standardisation of the core CAMHS service available in the ten local areas in GM.
- Reduced variation in CYP community mental health services access, experience and outcomes.
- Increased availability of specialist perinatal mental health community care and support.

Risk and Complex Care

Understanding and responding to the specific health needs of children and young people who are vulnerable, at risk or have complex care needs, and those requiring palliative and end of life care.

Includes:

- Project Skyline
- Palliative and end of life care

Outcomes:

- 10 new children's homes opened under 'Project Skyline', ensuring that GM cared for children with complex need can remain in their local area.
- Fully integrated health offer to meet the needs of the children and young people living in Skyline homes.
- Babies, children and young people will have their palliative care needs identified earlier.
- A reduction of crisis hospital admissions at end of life which could be managed in the community.

Family help

Working towards a shared vision of family help – supporting families to get help when they need it from the right places and people in their communities.

Includes:

- Development of Family Hubs

Outcomes:

- Improved access to a joined-up family support offer for families within communities.
- Opportunities for earlier intervention for families that need help, leading to a reduction in demand for higher-cost, crisis level services.
- More integrated early years and health services available in communities.

Joint Forward Delivery Plan Milestones

2024

June

- Completion of Asthma Friendly Schools pilot scheme

2025

January

- Full implementation of the 'Saving Babies Lives Care Bundle' of evidence-based best practice to reduce perinatal mortality.

February

- Transition pathways in place ensuring that children with long term conditions (asthma, diabetes and epilepsy) receive developmentally appropriate care as they transition from children's to adult health care services.

March

- 40 primary schools across GM to be PINS (Partnership for Inclusion of Neurodiversity in Schools) trained, aiming to improve the school experience for pupils with SEND by empowering schools to support neurodiverse children.
- The first cared for children to be placed within a Greater Manchester owned and managed children's home under 'Project Skyline' – GM's new shared children's residential care service.
- Epilepsy Specialist Nurse provision levelled-up to a ratio of 1nurse to every 250 patients.
- Standardisation of the core CAMHS service available in the ten local areas in GM.

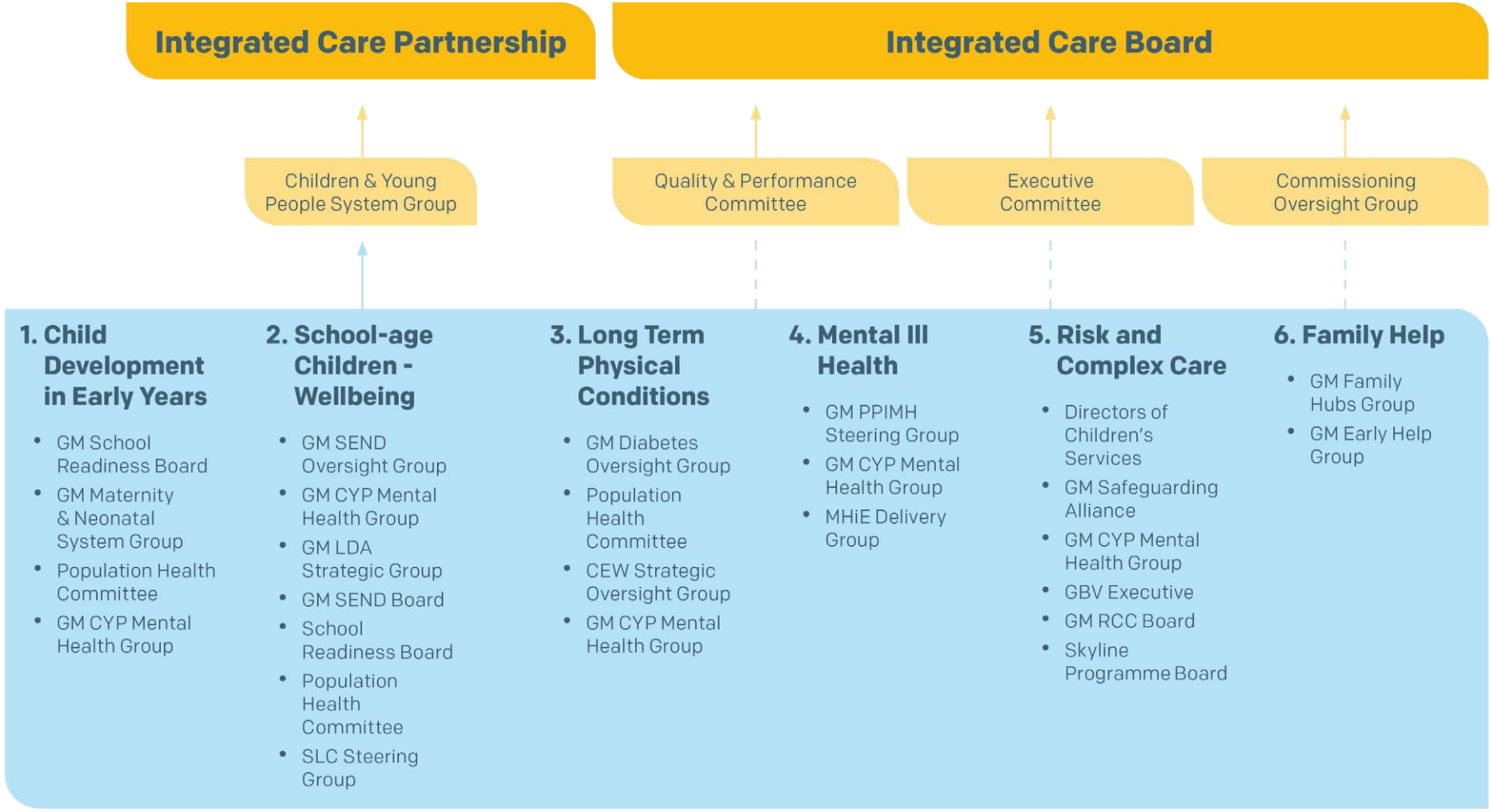
2026

March

- Redesigned Speech, Language and Communication pathway in place, aligned to the Balanced System® model, reducing variation across GM.
- Development of a sustainable, long-term neurodevelopmental pathway, which is needs-led and put intervention and support before diagnosis, supported by a unified pathway and multi-disciplinary team.

ICB governance

Joint Forward Delivery Plan Governance



Meeting: Locality Board			
Meeting Date	02 December 2024	**Action**	Receive
Item No.	9	**Confidential**	No
Title	Locality Plan/Sustainability Plan Update		
Presented By	Will Blandamer, Executive Director, Health and Adult Care - Bury Council and Deputy Place Lead - NHS GM (Bury)/ Kath Wynne-Jones, Chief Operating Officer – IDCB		
Author	Kath Wynne-Jones, Chief Operating Officer – IDCB		
Clinical Lead			

Executive Summary

This paper is intended to provide an update to the Board of the progress made with planning for 25/26 and beyond. The 3 papers attached include: -

1) The first draft of our Locality Plan for 25-26 for health and social care.
2) A summary of GM asks with regard to development of a 3-5 year sustainability plan. A local group set up by the IDC Chief Officer has been established to oversee this process.
3) The current draft version of the GM Sustainability Plan.

Recommendations

The Locality Board is asked to note the progress made to date.

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 Locality Plan outcomes	
To support a local population that is living healthier for longer and where healthy expectancy matches or exceeds the national average by 2025.	☒
To achieve a reduction in inequalities (including health inequality) in Bury, that is greater than	☒

Links to Locality Plan outcomes	
the national rate of reduction.	
To deliver a local health and social care system that provides high quality services which are financially sustainable and clinically safe.	☒
To ensure that a greater proportion of local people are playing an active role in managing their own health and supporting those around them.	☒

Implications						
Are the risks already included on the Locality Risk Register?	Yes	☐	No	☐	N/A	☒
Are there any risks of 15 and above that need to be considered for escalation via an NHS GM Statutory Committee or Board in line with the Risk Escalation process ?	Yes	☐	No	☐	N/A	☒
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Governance and Reporting		
Meeting	**Date**	**Outcome**
N/A		

Bury Integrated Care Partnership Planning 2025/2026

Part of Greater Manchester Integrated Care Partnership

Presentation by:

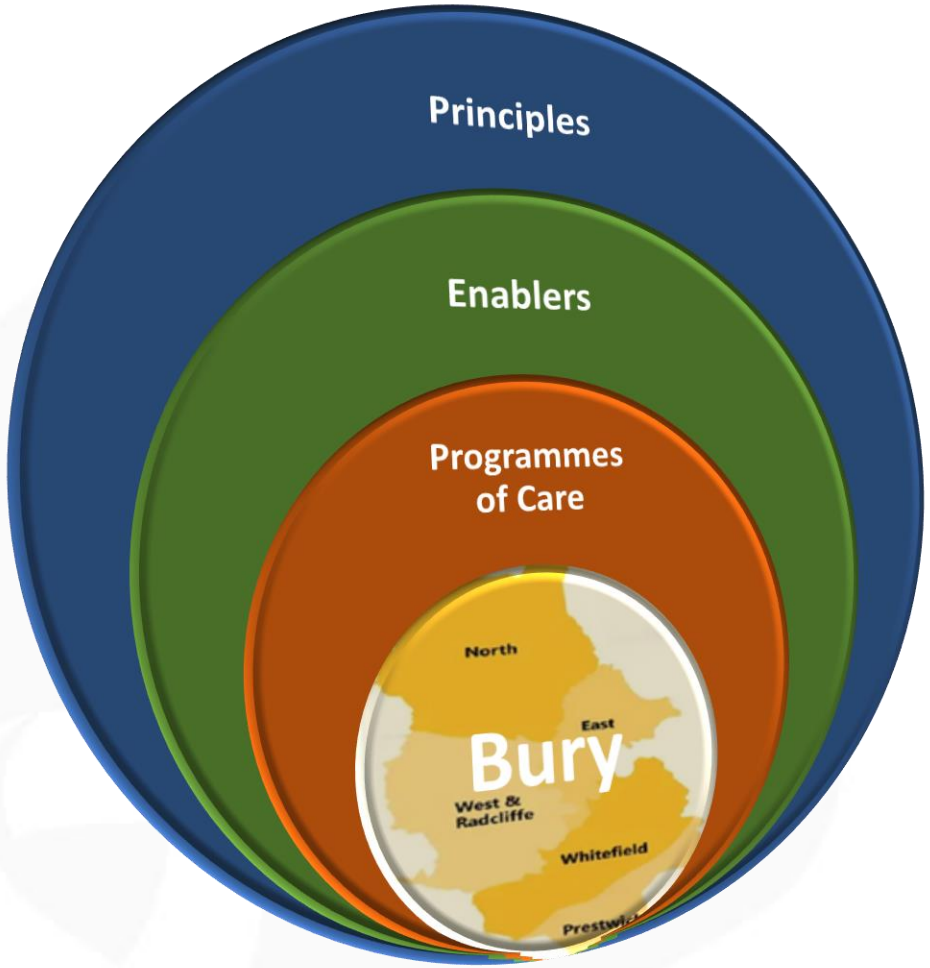
Kath Wynne-Jones

Our ambition

BURY INTEGRATED CARE PARTNERSHIP

We work together across health and care partners to :-	
1	**Improve population health and reduce health inequality of those in the most disadvantaged areas**
2	**Optimise Demand Reduction through primary intervention, secondary preventions and tertiary prevention**
3	**Fully realise the benefit of neighbourhood team working with a focus on the assets of residents and communities and providing proactive care**
4	**Reduce inefficiency and duplication in the pathways of care as major contribution to the financial recovery**
5	**Secure the right workforce in the right place with a shared ambition, supported by appropriate technology**
6	**Ensure delivery of high quality and financial sustainable services for our population**

Our approach



Programmes of Care

- Urgent and emergency Care
- Mental health
- Primary care
- Elective and community care,
- Major conditions,
- End of life,
- Adult social care,
- Learning disabilities,
- Children and young people

Enablers

- Workforce
- Estates
- Digital
- Clinical and professional leadership
- Communications and engagement
- Financial flows
- Partnership working and collaboration
- VCSE provision

Principles

- Focus on prevention and population health through neighbourhood working
- Residents in control of their own health and connected to their communities
- Residents in control of how services are organised around them and delivered closer to home where appropriate
- Timely and effective access to services where required
- Clinical, professional , managerial and political leads working together
- Adoption of strengths-based approaches
- Co-production

High level priorities for 25/26

BURY INTEGRATED CARE PARTNERSHIP

- Urgent and Emergency Care – demand management, service shaping and connectivity of out of hospital services
- Planned care, community services and major conditions – 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
- Enablers: finance, workforce , digital and estates

Planning approach : aligning our priorities

BURY INTEGRATED CARE PARTNERSHIP

GM sustainability plan

- Cost improvement (providers and locality)
- System sustainability (Locality and Multi – provider)
- Reducing prevalence (Locality including non-NHS providers)
- Proactive care (Localities including primary and community care)
- Optimising care (as delivered by a new model of care)

GM strategy and GM implementation or still in design phase

GM strategy and locality / multi-provider footprint implementation

Locality plan and locality implementation

Health and Social Care Locality Plan in the context of 'Let's Do It' – our place based plan to deliver faster economic growth and a reduction in health inequalities

Our priority programmes and measures of success

BURY INTEGRATED CARE PARTNERSHIP

Locality Board Programme	Deliverables	Metrics
Population Health	Locality: Live well, VCSE development, Workwell vanguard, Local Delivery of GM Moving, GM Make Smoking History and GM Alcohol reduction plan, Delivery of statutory public health duties, Reduction in HIV, viral hepatitis and TB, CVD and diabetes prevention plan	-annual physical activity for adults and children -smoking prevalence -alcohol consumption rates -HIV, viral hepatitis and TB rates -school readiness -childhood obesity -immunization rates
Primary care and neighbourhoods	Primary Care: Local implementation of blueprint, diagnostic provision, CVD and diabetes Neighbourhood working: integration, local priorities and PSR integration	-14 day access to a GP -Pharmacy first uptake - % diabetics receiving 8 processes of care - % of hypertension patients who are treated to target as per NICE guidance - % of patients identified as having 20% or greater 10 year risk of developing CVD are treated with statins - Neighbourhood indicators - No of people through ACM - Dementia diagnosis rates
Urgent and emergency care	Locality: Attendance and admission avoidance (including hospital at home GP in-reach and Consultant outreach, ICCC and new acuity tool) internal flow, discharge frontrunner GM: Service reconfiguration, out of hours procurement and transport procurements	-4 hour wait -DKAF -% reduction in attends and admissions -readmissions -H@H occupancy -GIRFT metrics -UCR times - Av LOS -% on pathways 0-3

Our priority programmes and measures of success

BURY INTEGRATED CARE PARTNERSHIP

Locality Board Programme	Deliverables	Metrics
Planned care, community services and major conditions	Elective: Advice and guidance/ OP transformation / Booking Management Service, ENT/T&O/Cardiology/Dermatology pathways & EUR / weight management services Community: alignment of funding and specifications to support neighbourhood working and out of hospital care Major conditions: CVD, respiratory integration Cancer: Targeted lung health checks, patient stratified follow up, prehab and behaviour change End of life: care planning, education and support, improving transfer from hospital to community GM: Strategic reviews	-Referral no's - Waiting times: OP/surgery / community / cancer -% people with more than 3 admissions in their last 90 days --Percentage of people dying in preferred place
Mental health (MH) and emotional wellbeing	Locality and GM: Suicide prevention, mental wellbeing – coping and thriving, children's and young people's (CYP) mental health, community provision, crisis response, ADHD/ASD, dementia, maintaining low levels of Out of Area placements, perinatal and parent MH.	-Reducing number of CYP in CAMHS services. -Out of area placements in mental health -12 hour waits in ED -CRFD numbers - Improving NHS Talking therapies recovery rate - Improving SMI health check uptake

Our priority programmes and measures of success

BURY INTEGRATED CARE PARTNERSHIP

Locality Board Programme	Deliverables	Metrics
Children's and young people	First 1000 days, Neurodiversity model, prevention of childhood obesity, long term condition management, SEND, school nursing	- immunisation rates -childhood obesity rates -Reduced waiting times for specialist health services for children (including neurodevelopmental pathways) -Health visiting 2-year checks
Adult Social Care (ASC)	ASC: Social work quality, social work workforce, finance, CQC readiness LD: Transformation, better homes, training and employment, better health	-Number of people leaving IMCs services and live independently -number of people accessing care and support information and advice that promotes people's wellbeing and independence -people with LD who have their own front door and employment -% people with LD having health checks
Enablers	Digital: baseline capability, online consultations, EPAACS and dementia plans Workforce: Growing and developing the workforce, workforce integration, good employment charter, equality and diversity, wellbeing Estates: Four LP programme	-% population with care plans
Finance	Complex care, medicines management, Better Care Fund review, contract reductions	-Financial position -% market share of spend by sector

Locality financial risks

BURY INTEGRATED CARE PARTNERSHIP

- Money to invest in left shift of services to support reduction in hospital infrastructure: we are under resourced for primary care and community services
- VCSE commitment on a longer term basis
- Staying well /live well decisions by PCN's
- Longer term funding for hospital at home
- Quality assured spirometry
- Asks of Mental Health services to support pressures being seen in all parts of the system, including A&E
- Advice and Guidance: GM priority and needs to be funded at GM level
- Asks regarding prevalence / proactive care and expectations on PC and community care funding which is already under pressure in the Borough, and may reduce potential investment in local neighbourhood priorities

It should be noted that this list of pressures excludes those budgets currently under pressure that are being actively managed as part of 24/25 CIP plans

Bury Locality Commissioning Intentions

- In addition to the GM Commissioning Intentions shared at the last Locality Board , the following locality priorities have been identified:
  - Elective care pathways: ENT / T&O / Cardiology (4LP)
  - Neighbourhood development (workforce integration, local neighbourhood priorities and PSR integration)
  - Children's : First 1000 days
  - Adult Social Care: Social work quality, social work workforce, finance, CQC readiness
  - LD: Transformation, better homes, training and employment, better health
  - End of life: care planning, education and support, improving transfer from hospital to community
  - Digital: baseline capability, online consultations, EPAACS and dementia plans
  - Workforce: Growing and developing the workforce, workforce integration, good employment charter, EDI, wellbeing
  - Estates: 4LP programme
  - Finance: Complex care, medicines management, BCF review, contract reductions

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The Sustainability Plan in Localities

1. Introduction

1.1. This note sets out the **key actions for localities** in developing the locality delivery contribution to the GM Sustainability Plan.

1.2. Its content has been developed through discussions with leads from the Four Locality Partnership covering the NCA footprint. The timeline for data by locality and the annual planning cycle have also been considered.

1.3. To support localities in this work we have developed a template to capture the local delivery contribution **(Appendix A).**

2. What is the role of localities in the Sustainability Plan?

2.1. Each element of the Sustainability Plan (i.e. the five pillars and their constituent programmes) has a GM (and/or trust) and/or locality focus.

2.2. Figure 1 shows that localities have a primary focus on delivery of **the Reducing Prevalence (RP) and Proactive Care (CP) pillars.** However, they also contribute to other pillars

- Each locality has a Cost Improvement Programme as part of the ICB's overall plan and, in turn, the CIP of the relevant local trust/s will need to be seen in the context of locality delivery plans.
- System Productivity and Performance (SPP) through system groups and the trusts providing services in their locality.
- Locality commissioning intentions will be part of the Optimising Care pillar, along with any locality implications of the work of the Health and Care Review.

Figure 1

	Cost Improvement	System Productivity and Performance	Reducing Prevalence	Proactive Care	Optimising Care
	Cost Improvement Plans (CIPs) leading to financial sustainability through Financial Sustainability Plans (FSPs)	Multi-provider/system activities to improve the use of our resources and our performance	Maintaining the population in good health, building up individuals' capabilities and positive assets and avoiding future costs through prevention	Catching ill health early, managing risk factors, and delivering evidence based, cost effective interventions to reduce the level of harm	Transforming the model of care through system actions
Focus of delivery	Trusts and the ICB (including locality CIP) but may impact locality delivery	Trusts (through System Groups) and other parts of the system as appropriate (e.g. primary care) broken down to place level	Localities (including partnership with non-NHS organisations and services)	Localities (including primary care and community services)	As determined by the focus of the new model of care – may be clinical (e.g. maternity) or sectoral (e.g. community services)

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3. The Content of the Locality Contribution

3.1. The content of the locality delivery plans will be produced in phases to align with data available and wider system planning.

3.2. Where localities share a common provider trust or have another reason for working closely together, they may choose to align some of their programmes and include reference to these across the templates for multiple localities.

Phase 1: Existing Programmes and Confirmed Plans

Localities to provide details of existing programmes and confirmed plans against the five pillars. The first phase relates to existing programmes and planned programmes for 2025/26. The narrative below provides a guide to some of the likely considerations for localities against each of the pillars. There may be other issues that localities wish to reflect in their responses.

a) Summarise the locality's cost improvement programmes – both as part of ICB's CIP and set out the key CIP programmes of the relevant, local trust/s. intended to support a sharing of financial positions and intentions between the trusts, local authority, VCFSE and ICB.
b) Summarise the programmes in localities that contribute to programmes in the System Productivity and Performance pillar, particularly through the work of the system groups. System groups to be asked to describe their expectation of the programmes localities need to have in place – and localities to describe their local arrangements. These programmes must ensure connection with the position of the local authority – particularly on adults and children's services. An indication of programmes and likely scope at this stage is sufficient. We anticipate that this will include confirmed plans to improve performance and access in key areas (i.e. discharge, OAPs etc.)
c) Provide details of their 2025/26 plans for programmes that fall within the Reducing Prevalence and Proactive Care pillars – indicating which pillar each programme relates to. Indicate the impact (quantified where possible) of these programmes and any related process measures. This may include programmes not currently listed in the Sustainability Plan - which only included programmes where evidence for ROI could be identified.
d) Describe the locality contribution to the Optimising Care Pillar with a focus on the Health and Care Service Review. This includes local commissioning intentions and how the locality is supporting the transformation of care pathways. Health and Care Service Review will be asked to describe what localities need to have in place.

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Greater Manchester

Phase 2: Future Focus and Requirements Following Data Analysis

The second phase is for localities to do the following in relation to future programmes – from 2026/27 onwards. It is recognised that localities will only be able to complete this once the relevant data is provided – see timetable in figure 2.

a) Utilise the data about their population through the health profiles to indicate where they would focus future programmes to reduce prevalence and enable proactive care. Where possible, this should include any requirements for investment.
b) Indicate the impact on the projected Non-Demographic Growth (NDG) of the programmes (Investment-ROI) using the methodology from the Sustainability Plan and any other impact (non-financial) that might result.

Plans for the future focus phase should take account of the Financial Sustainability Plans (FSPs) of the relevant local trusts.

The main data set to enable localities to do this is the **locality Health Profiles and data about Non-Demographic Growth (NDG).** The latter is a locality version of the data that supported the GM Sustainability Plan. The **Health Profiles** will be available to localities in the **first half of November** through Tableau**.**

Data on NDG will be available at the end of November (TBC) and will be supported in due course by analytical tools and data on national benchmarking and against other comparator areas. Work is ongoing to establish the precise methodology for this.

By the end of December we anticipate that localities will have the full, consolidated data This will enable the draft local contributions to the sustainability plan to be developed by the end of January.

The timelines for this data are summarised in Figure 2:

Figure 2

Timing	Data	Details
By Mon 11th Nov	Health Profiles dashboard	Information about the population: • Core demographics • Prevalence of long-term conditions (none/single/multiple) and smoking status • 111/999 calls • A&E attendances • Non-elective admissions • Day cases and elective admissions • Outpatient first and follow up appointments This information can be split for analysis by • Deprivation segment • CORE20PLUS5 segment • Neighbourhood (for some measures only – not all can be split down to neighbourhood level)
By the end of November	Population segmentation	Locality population analysis by the segments used in the Sustainability Plan • Good health – no/one lifestyle risk • Maternity • Single long-term condition (LTC) • Multiple LTCs • Mental health illness • Homelessness and substance misuse • Cancer • Frailty • Palliative Care Future NDG
By end of December	Population analysis tools	Tools to analyse data Other templates to indicate possible priorities for the locality based on benchmarking. Details TBC

4. The Timing of the Locality Contribution

Each locality will be asked to develop a draft plan of its contribution to the Sustainability Plan **by the end of January**. This is to align with the overall annual planning process for 2025-26 and to enable the local plans to be ready to commence delivery from month one in 2025-26. The overall timetable is below:

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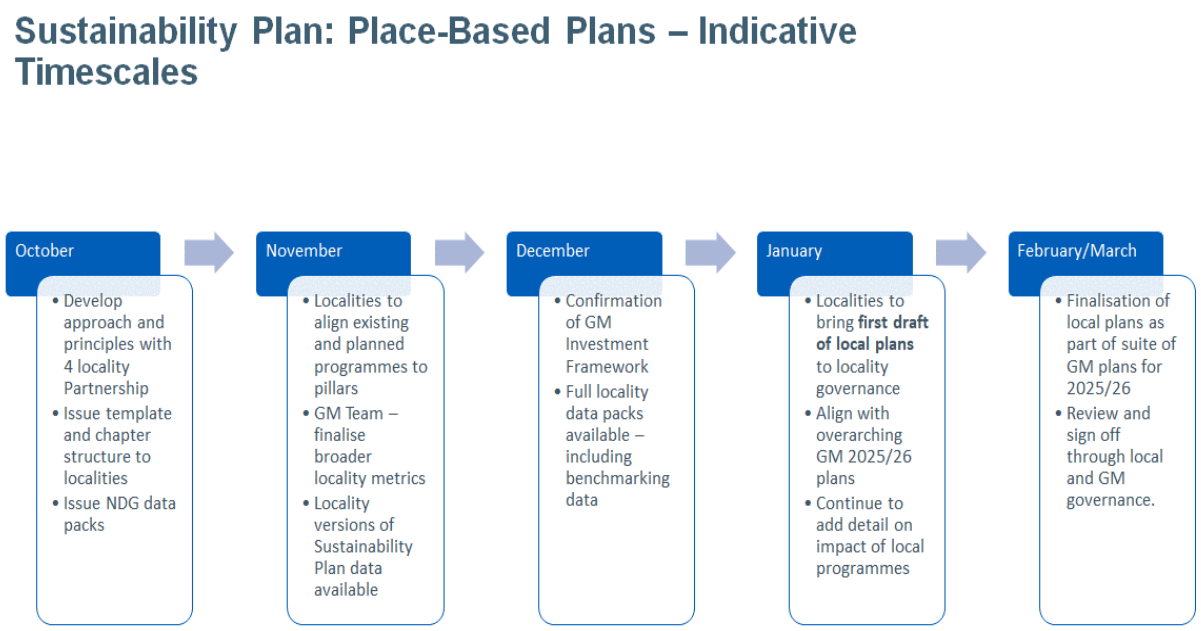
Greater Manchester

Figure 3



The development of a broader set of locality metrics (going further than existing NHSE operational measures) covering the locality role in addressing the social determinants of health - for example, on housing, school readiness, physical activity, community safety – is underway and is expected to be in place by the end of November.

Enc: Locality Template (Appendix A)

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GM Sustainability Plan

Notes

This document is an updated Word version of the Sustainability Plan as endorsed by NHS GM Board on 18 Sep 2024.

Some supplementary information and details which was not part of the Board pack but was used throughout the system to detail the plans is also included here and shown in blue in relevant subsections.

Any subsequent changes since 18th Sep are indicated in red with an explanatory footnote.

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Contents

Any subsequent changes are indicated in red with an explanatory footnote. Detail in the full version of the plan that was not included in the public board papers but was correct at the time, is shown in blue.

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1. Introduction and Context

1.1 This plan

- Greater Manchester (GM) Integrated Care System (ICS) provides healthcare for 3m people living in 10 places. As a system, GM has sought to improve population health through working with partners whilst at the same time improving the NHS financial position and health service performance.
- A population-based approach to developing this Sustainability Plan has set out the current and future pattern of demand and associated costs attributable to Non-Demographic Growth (NDG), quantified the opportunities to improve population health, set out the immediate priorities to inform phasing and sequencing of these opportunities over time and considered the financial and performance position of the 9 NHS providers.
- This shows how a deficit of £175m this year may be compounded by approximately £600m of additional demand but can be addressed over time through a combination of population health measures, system collaboration and provider efficiencies. This will require a mixture of targeted, evidenced-based improvement with additional innovation in key areas of priority
- The plan is based on the recognition that system sustainability rests on addressing the challenges we face across finance, performance and quality and population health - and the relationship between these
- This is a 'plan of plans' since it comprises plans from across the GM system, categorised under 5 'pillars' of sustainability.

1.2 The development and delivery of the plan

- Delivering this plan and moving to a sustainable health and care system will require us to be explicit about investment (revenue and capital). Investment in prevention, early diagnosis, primary and community care and mental health is inherent in this plan. Transparent identification and reporting against that investment will be established.
- Where plans for future years are less well developed, assumptions have been made (and described)
- Discussions with local authority Treasurers are underway to support the connection to financial health at a place level as part of local integrated planning and delivery
- The governance and monitoring of the plans has yet to be determined in detail but is indicated in this plan and will be confirmed swiftly.

1.3 Overview – what the plan shows

We need to show ***how*** the system:

- ***Both*** returns to financial balance through addressing the underlying deficit
- ***And*** secures a sustainable future through addressing future demand growth and implementing new models of care year on year

This plan shows that:

- The projected remaining deficit, after Cost Improvement Plan delivery, could be eliminated over three years through
    - Consistent and complete implementation of existing Cost Improvement Plans (CIPs)

Any subsequent changes are indicated in red with an explanatory footnote. Detail in the full version of the plan that was not included in the public board papers but was correct at the time, is shown in blue.

- Complete implementation of system wide plans already developed across GM along with assumptions about those not yet detailed
- Assumptions on reconfiguration of parts of the system which have not yet been planned in detail
- Assumptions on reducing the number and scope of procedures of limited clinical value (PLCV), although this is not yet detailed

- With additional investment, the impact of Non-Demographic Growth (NDG) could be mitigated through
  - Assumptions about the impact of reducing prevalence and enabling proactive care on the health of the population

1.4 Our vision and the outcomes we are seeking

"We want Greater Manchester to be a place where everyone can live a good life, growing up, getting on and growing old in a greener, fairer more prosperous city region"

1.5 Our missions

1.6 Our strategy and our plans

- Our Five-Year ICP Strategy (March 2023) sets out how we will work together to improve the health of our city-region's people. It is supported by our Five-Year Joint Forward Plan. We have described our plans for this financial year (2024-25) in our Operational Plan
- The relationship between these plans is illustrated in the next section. This includes the

importance of the Sustainability Plan in addressing the undertakings issued by NHS England

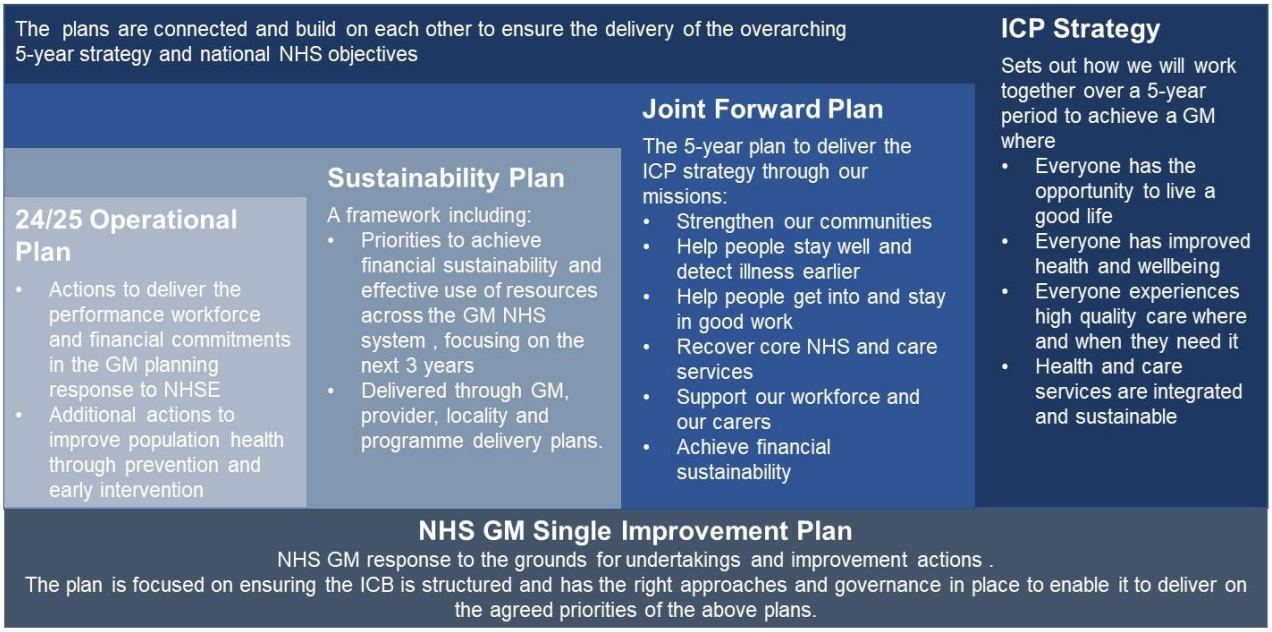
- This Sustainability Plan is needed because the challenges we face now are more complex and acute than we have ever experienced in Greater Manchester. These challenges cover finance, performance, quality and population health. We have a significant underlying financial deficit; we are not consistently meeting core NHS delivery standards; and the health of our population is getting worse
- Innovation is a priority for us as described in the five year Joint Forward Plan, and the recent Health Innovation Manchester strategic plan describes how innovation will contribute to the agenda.
- We know that we need to change what we do and how we do it. We must do this to deliver on our responsibility to improve the health of our population – and to do this within the resources available to us
- We know that this will take longer than a single year, so this plan covers three years initially

1.6.1 The changes we need to make

- We know that we must change our model of care for the system to be sustainable. We cannot solely rely on current cost improvement programmes within our NHS services as they are not sufficient to address the underlying deficit
- Equally, we know that the current model is running consistently in deficit; not achieving the required performance standards; has wide variation across organisations, places and communities; and is not geared up to meet projected demand and costs in the next five years and beyond.
- Meeting these challenges will require fundamental change in the system – we need a radical change from a current model characterised by crisis-based responses in hospital caused by exacerbation or deterioration in health: this is a highly expensive way to run a health system and is not delivering the best outcomes for our residents. There is therefore a need to act both on reducing the prevalence of poor health and to ensure we provide preventative, proactive care to stem further deterioration.
- This will require a change in how we allocate our financial resources and how and where care is delivered, and people are supported to live good lives

NHS Greater Manchester

1.7 NHS GM plan alignment



1.8 How the pillars of sustainability contribute to our missions

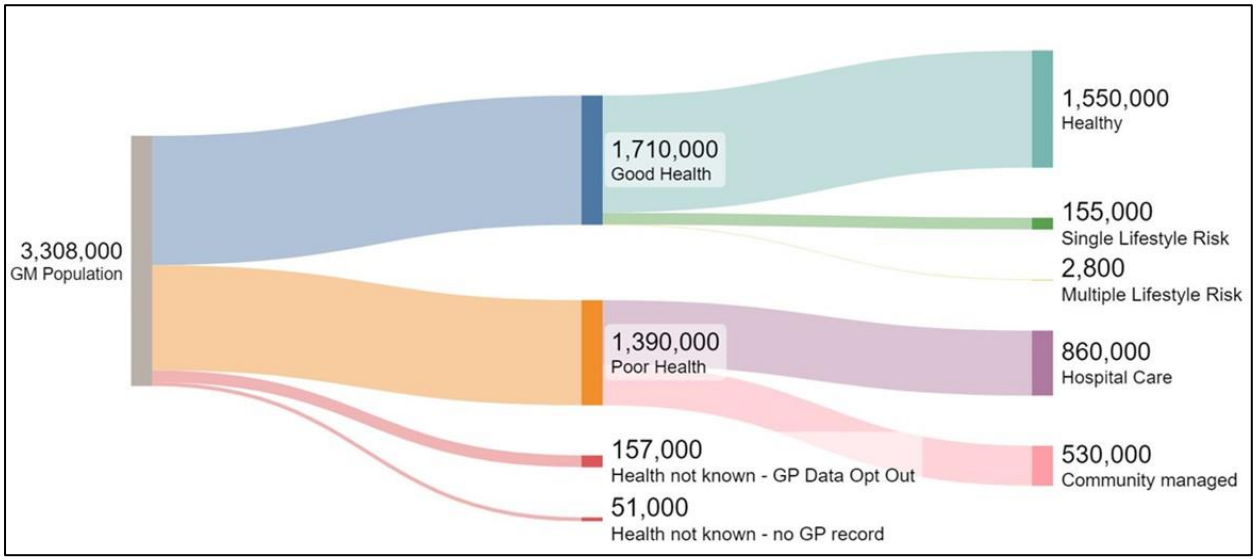
- The 'pillars' of sustainability cover the full range of our missions – from enabling people to live good lives – through to ensuring financial sustainability
- **Cost improvement** in both providers and the ICB and **system productivity** will enable the effective recovery of core NHS services and support our workforce, thus enabling financial sustainability
- **Reducing prevalence** – acting on the wider determinants of health – will be enabled through strengthening our communities and helping people to stay well and detecting illness earlier, as well as enabling people to get into and stay in good work
- **Proactive care** will also help people to stay well and detecting illness earlier, as well as enabling people to get into and stay in good work, and contributing to recovering NHS services and thus enabling financial sustainability
- **Optimising care** will enable the system to move towards the model of health described in our strategy and missions. It will also enable people to stay well and detect illness earlier, the effective recovery of core NHS services and support for our workforce, thus enabling financial sustainability

1.8.1 Table showing how the pillars of sustainability contribute to the missions

Pillar	Mission					
	Strengthen our communities	Help people stay well and detect illness earlier	Help people get into and stay in good work	Recover core NHS and care services	Support our workforce and our carers	Achieve financial sustainability
Cost Improvement				✓	✓	✓
System Productivity				✓	✓	✓
Reducing Prevalence	✓	✓	✓			(✓)
Proactive Care		✓	✓			(✓)
Optimising Care		✓		✓	✓	✓

1.9 The health of our population

- The strain our system is under reflects the poor health of much of our population. The newly available longitudinal record data which includes both primary and secondary care data shows that around half of the GM population presently have some formally identified poor health
- This is the primary driver of demand and cost in the system – and we know that the position will deteriorate further if we do not change our models of care and support



1.10 The Greater Manchester Model for Health

- In the ICP Strategy we set out our Model for Health (see below). The model aims to ensure that as many people as possible are supported to maintain good health at home and in their

communities –reducing demand on crisis-based and specialist care

- We know that we must do more, and rapidly, to make sure this model is delivered consistently across our conurbation. This needs to focus on:
  - Consistent, at scale, delivery of an integrated neighbourhood model – including same day GP access where clinically appropriate and a community services delivered to a core GM standard
  - The systematic use of Population Health Management approaches to identify at risk cohorts and intervene earlier, delivered through more resilient primary care connecting to community and intermediate tier services
  - Accelerated progress of our mental health model, particularly crisis and community developments including Living Well, in-patient transformation, and access to psychological therapies
  - Continued focus on early cancer diagnosis
  - Much greater support for people to take more control over their own health - including digital offers
  - Standardisation of care pathways with consistent offer across GM and reduced variation
  - Significantly expanded use of new care models – including more care delivered outside hospital

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2 The pillars of sustainability and the financial bridge

2.1 The pillars of sustainability

- These pillars are of course interdependent and cannot exist in isolation.
- For example, collective actions on provider productivity may enhance performance and optimise care as well as contribute to individual provider CIPs.
- Similarly, progress in proactive care delivery may also impact on other financial drivers, such as prescribing costs.
- These interdependencies need to be understood as we make key decisions in implementing this plan.

2.2 Estimating non-demographic growth impacts

- To understand the health needs of the population we have used the Analytics and Data Science Platform (ADSP) to access linked patient-level data on the GM population and developed a segmentation of the population. We have updated the methodology produced by Carnall Farrar in the SFF in Jan 2024, to use data that now includes primary care.
- In this analysis, we have observed what actually happened to the population's health between 2018 and 2024 and then used our understanding of this change to project forward to what the health of the population, and the resultant demand for services and their associated cost, might look like in 2030

We have identified the following population segments (each person can only be in one of these)

- Good health – no/one lifestyle risk
- Maternity
- Single long-term condition (LTC)
- Multiple LTCs
- Mental health illness
- Homelessness and substance misuse
- Cancer
- Frailty
- Palliative Care

- Our estimates show that the population will tend to move from better health and less costly segments to more complex and costly segments
- The consequence of these changes in terms of patient numbers is substantial:
  - the number of people in the Mental health illness segment being about 5 times larger in 2030 than it currently is
  - The number of people in the Frailty segment (the costliest) being 3 times larger than it currently is

2.2.1 Understanding the impact of non-demographic growth

- The GM registered population is constantly changing. Between 2018 and 2024 approximately 1.7m people were either born or moved into the GM health system. Over the same period around 300k people left the system.
- If these birth, death and migration patterns remained similar in proportion through to 2030, we estimate a similar number to enter the GM system but a much larger proportion leave (nearly 900k).
- The additional costs of any new entrants to the GM system over this period would be offset by both a demographic growth increase to our allocation and also the reduced system costs of those who have left
- However, we do need to factor in the consequences of health deterioration within the current population if we are to properly understand our financial position in 2028/9.
- The features of health deterioration or non-demographic growth are complex:
    - In a constrained system, non-demographic growth does not always manifest in healthcare activity that is easily quantified or observed. For example, in a system that is unable to increase bed or ward capacity, we may experience an increase in the severity or acuity of patients or in other healthcare environmental pressures such as trolley care. We may see impacts outside the hospital such as in mortality rates or primary, community, social care and VCFSE usage or just in the requirement for more complex multi-morbidity treatment.
    - Interventions that tackle health deterioration are generally not 'cost saving' because they address costs that the system is yet to incur.
    - An investment strategy is required because we need to ensure we invest resource and effort today, so the additional costs of tomorrow are averted.

2.3 The cost of non-demographic growth

- In the Strategic Financial Framework (presented to Board in January 2024) the estimated non-demographic growth costs stood at £539m. This was calculated by taking provider estimates of future activity demands and taking out what could be attributed to demographic growth
- Using this new population deterioration methodology, we estimate additional costs of non-demographic growth to be around £600m. This figure has been further validated by the Health Economics Unit who have been undertaking similar work in London
- The best way to reduce the cost impact of non-demographic growth, and an objective for our 'Investment Strategy', is to support people to stay in, or move into, a healthier segment.
    - For example, the projected additional costs from people moving from the 'good health' segment to the mental health illness' segment is around £85m so our interventions should be aimed at keeping people mentally well and in the good health segment.
- Similarly, the projected costs for the 120k people who move from multiple long-term conditions segment into the frailty segment is £222m.
    - Although there may be some benefits from reducing the high costs of healthcare to those in the frailty segment through service redesign and other model of care adjustments, the most sustainable and cost-effective solution is to stop people moving into the frailty segment at all – this could be through transformed models of care or targeted upstream investments such as in the Ageing Well programme

2.4 Leading action on non-demographic growth

- The actions to address the projected non-demographic growth must be place-led.
- This will require an understanding of local projections by population segment, age and deprivation. It will set a clear challenge and trajectory for localities to be measured against and to demonstrate their ability to maintain or improve the health of their population.
- The action required will need to have considered blend of improvement and innovation, underpinned by demanding targets and rigorous method.

- Locality level performance against a comprehensive and appropriate set of preventative measures will be developed with localities each locality. For example:

  - The effectiveness of primary care, especially performance against care processes for CVD, diabetes etc alongside health checks for SMI, LD etc
  - The effectiveness of social care – e.g. proportion of people still at home 91 days after discharge from hospital into reablement/ rehabilitation services, the proportion of service users reporting control over their daily life etc.
  - A&E attendance, admission and readmission by population
  - Falls prevention,
  - Reductions in violence-, alcohol- or drug-related admissions,
  - The proportion of the adult population economically active
  - Decent Homes standards and supported housing provision
  - Medicines optimisation,
  - School readiness,
  - Obesity reduction
  - Active Lives survey results

2.4.1 Taking action on non-demographic growth

- The actions to keep people physically and mentally well focus on:
  - considering the environments in which people live and work, and the experiences they have
  - delivering more consistent proactive care to support effective population health management
  - reducing disparities in care for people in deprived socioeconomic groups
- These are actions to address the social and behavioural determinants of health (income, work, reducing alcohol, tobacco and drug harms etc); coordinated and integrated secondary prevention through proactive primary care supported by integrated neighbourhood level teams providing holistic support; and citizen-led approaches to address the determinants of health in ways which are directly relevant to every community.
- These are supported through our framework for prevention and early intervention
- The action required will need to have considered blend of improvement and innovation, underpinned by demanding targets and rigorous method.
- The leadership, support and coordination of this range of activities is the reason we developed neighbourhood and place-based working as the foundation of our model in Greater Manchester.

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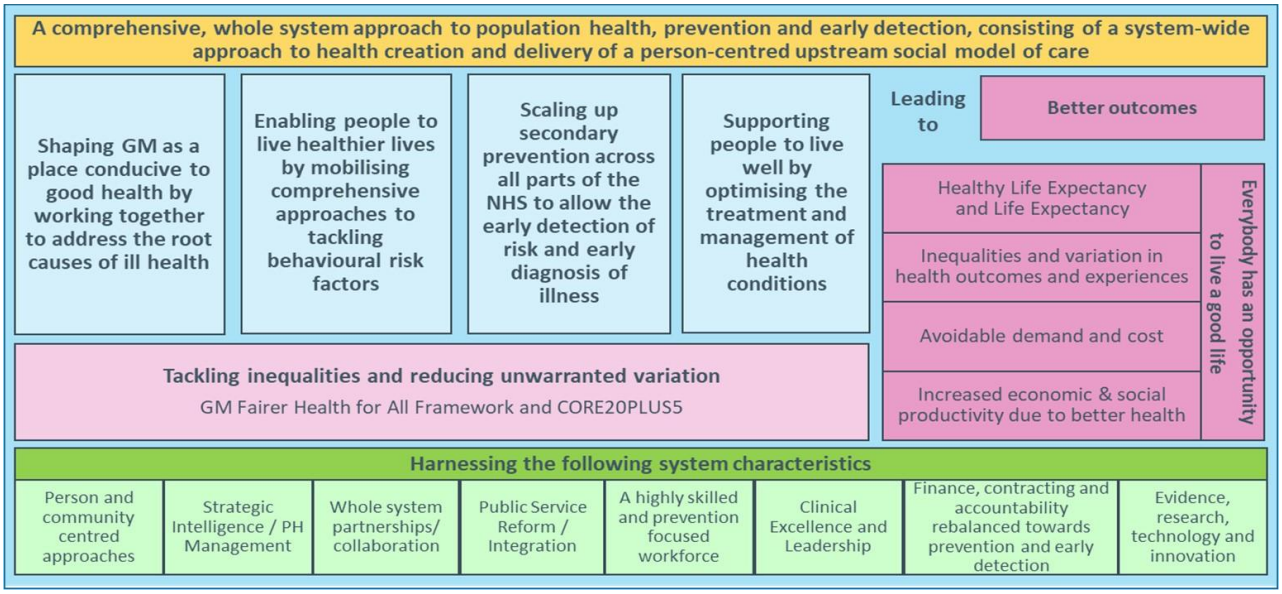
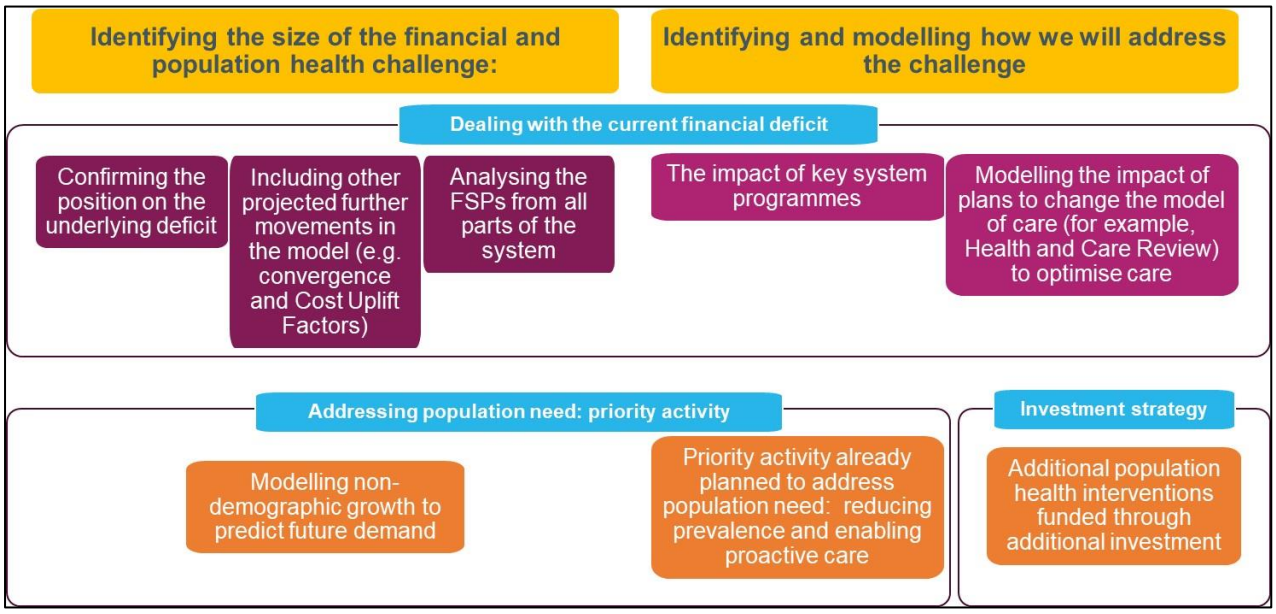
2.4.2 The GM Prevention and Early Intervention Framework

A comprehensive, whole system Population Health approach



2.5 Developing the financial bridge: the key activities



2.5.1 Key finance facts and figures

- NHS GM receives income of >£7bn per year
- It spends this through contracts including within GM:
  - 64% in current provider contracts (acute and mental health)
  - 12% in primary care for existing service provision
  - 5% in community services (acute block contracts)
  - 5% CHC and individual placements
  - 3% non-NHS contracts
  - 2% corporate costs

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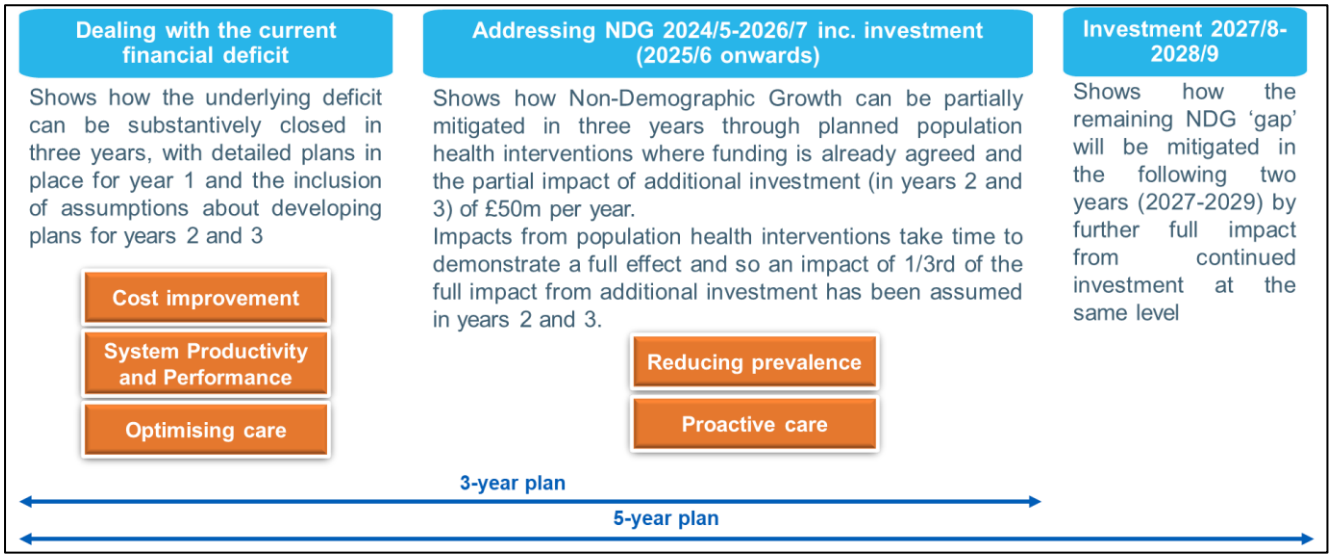
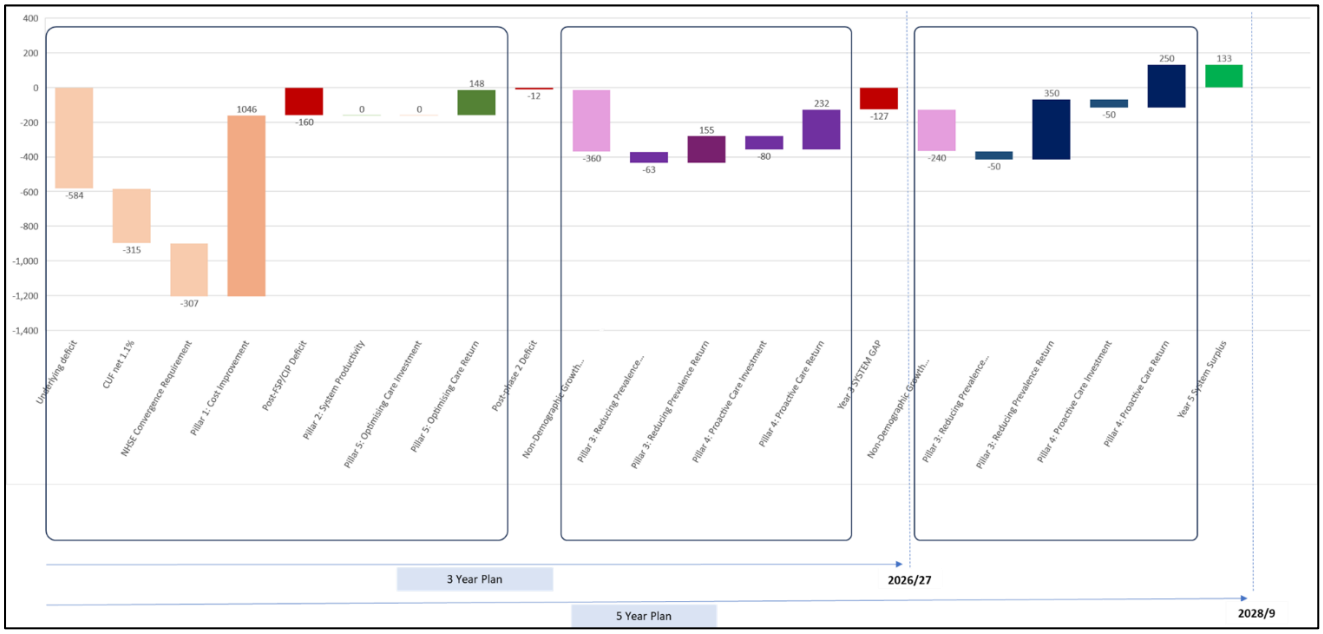
2.6 The financial bridge – what it shows

The bridge shows three 'blocks' with associated pillars



2.7 The financial bridge



2.7.1 The financial bridge – the contents

- The bridge shows three 'blocks' with associated pillars. The detailed financial information against each block is shown below.

Any subsequent changes are indicated in red with an explanatory footnote. Detail in the full version of the plan that was not included in the public board papers but was correct at the time, is shown in blue.

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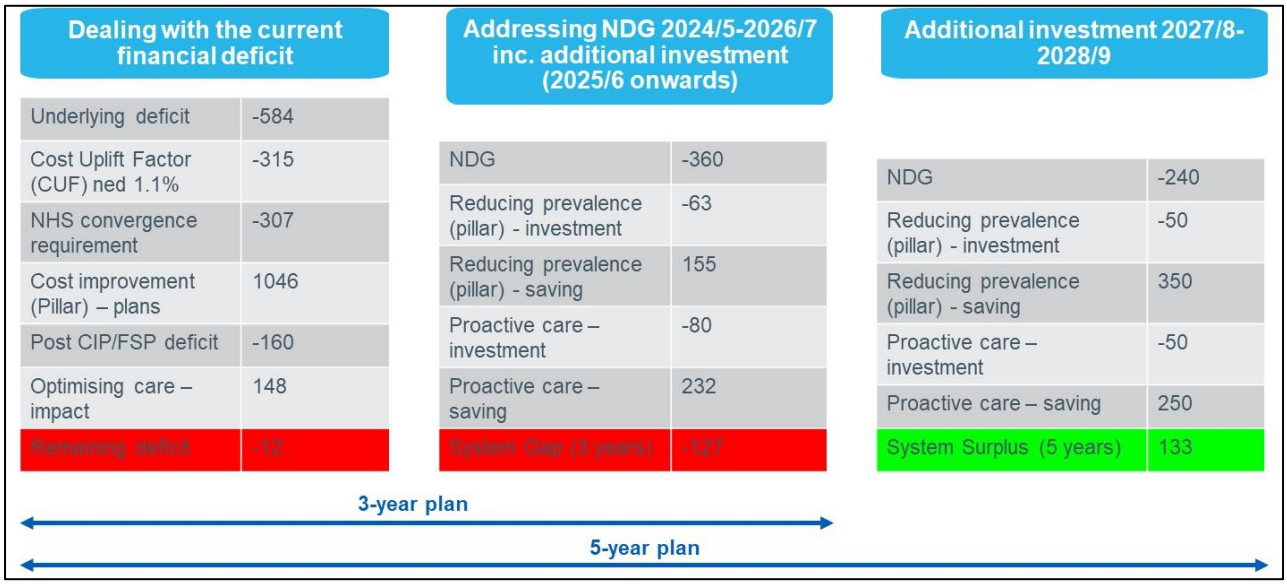
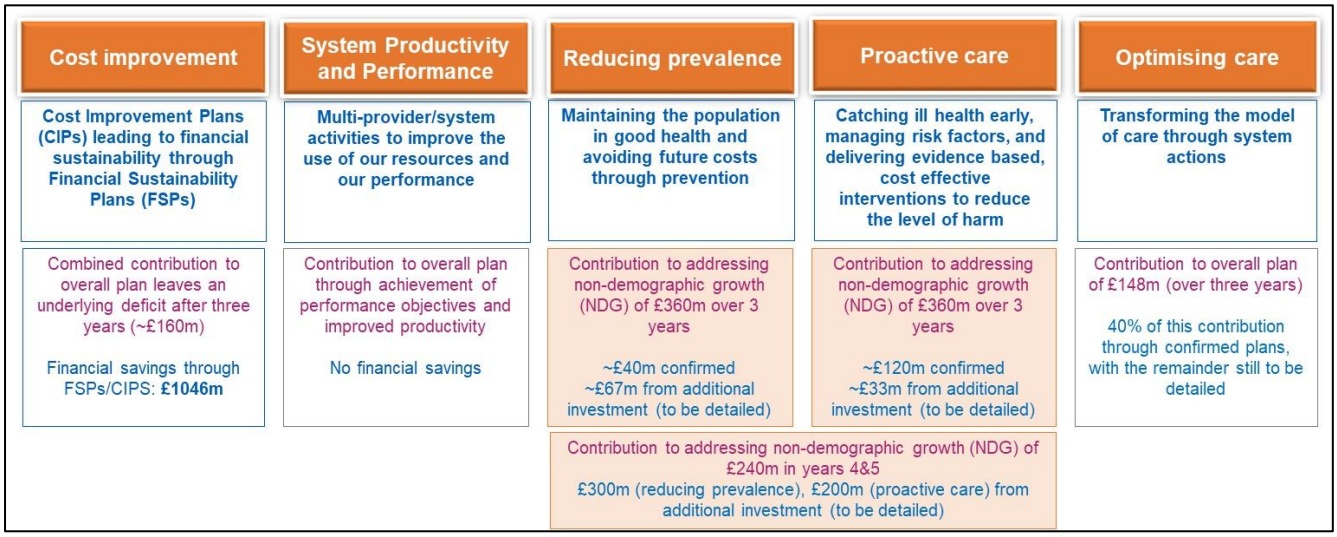


2.8 The pillars of sustainability and their contribution

From the analysis to develop the bridge, we identified five aspects of sustainability which we need to pursue: the 'pillars' of sustainability. Each of these contributes through finance and/or performance impacts. Details are in the following sections



2.9 Cost improvement – overview

Cost Improvement Programmes (CIPs) are a key driver of bridging the underlying gap, both for providers and the ICB.

- The focus of respective CIPs needs to be clear to ensure we avoid double counting elsewhere across the sustainability plan.
- ICB CIPs covers some system costs e.g. Contract Reconciliation. These are currently included here as cost improvement.
- We show here the key programmes included in CIP plans for the ICB and across the providers

Principles used in developing this plan

- Trust/provider improvement plans were checked to include only those things that are within their scope
- Assumptions within provider plans were checked against assumptions about allocations from the ICB and any associated growth
- GM-wide programmes will have financial implications for individual providers and these impacts were calculated/reported centrally to avoid double-counting

2.10 Cost improvements – Trust and ICB[1]

- As part of individual Trust Financial Sustainability Plans, there are ambitious levels of Cost Improvement Programmes (CIP) set out over the next 3 years to support working to run rate balance. Work is planned at different levels.
  1. At individual organisational level. A thematic framework for this is under development, to be completed by the end of September.
  2. At locality/ sector level
  3. At GM level – Trust Provider Collaborative (TPC) led commitments and schemes (listed under the System Productivity and Performance pillar in this plan)

Organisation (Trust)	Locality/ sector	ICB	
Key themes in Trust CIPs • Income • Corporate services transformation • Digital transformation • Estates and Premises transformation • Medicines efficiencies • Procurement • Service re-design • Pay	Examples include: • Four Localities Partnership • Mental Health Trust collaboration • Joint working Bolton FT & WWLFT	A wide range of programmes, including: • Continuing Health Care • Medicines Optimisation • Mental Health OAPs • Autism and LD • Better Care Fund • Community Services • Estates • Independent Sector	• Legal Services • Locality Individual Schemes • Non-Healthcare Contract Consolidation (NHCC)s • Optimal Organisational Structure • Translation and Interpretation • Virtual Wards • Workforce External Drivers

2.10.1 ICB cost improvements

Programme(s)	SRO	Financial Saving?
Continuing Health Care	Mandy Philbin	Yes – already included in ICB CIP
Medicines Optimisation	Manisha Kumar	
Mental Health OAPs	Manisha Kumar	
Autism and LD	Mandy Philbin	
Better Care Fund	Rob Bellingham	
Community Services	Rob Bellingham	
Estates	Kathy Roe	
Independent Sector – including diagnostics, orthopaedics, ophthalmology and use of Elective Recovery Fund	Rob Bellingham/Kathy Roe	
Legal Services	Mandy Philbin	
Locality Individual Schemes	Locality leads	
Non-Healthcare Contract Consolidation (NHCC)s	Rob Bellingham	
Optimal Organisational Structure	Janet Wilkinson	
Translation and Interpretation	Rob Bellingham	
Virtual Wards	Martyn Pritchard	
Workforce External Drivers	Janet Wilkinson	

[1] More detail can be found in the Appendices: section 4.1

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2.10.2 Cost improvement – oversight and governance

Programme	SRO (the relevant CEO)	Oversight and Governance
CIP/FSP Delivery - Bolton FT	Fiona Noden	Trust Boards ICB Provider Oversight Meetings
CIP/FSP Delivery - Christie	Roger Spencer	
CIP/FSP Delivery - MFT	Mark Cubbon	
CIP/FSP Delivery - NCA	Owen Williams	
CIP/FSP Delivery - Stockport FT	Karen James	
CIP/FSP Delivery - Tameside FT	Karen James	
CIP/FSP Delivery - WWL FT	Mary Fleming	
CIP/FSP Delivery - GMMH	Karen Howell	
CIP/FSP Delivery - Pennine Care	Anthony Hassall	
CIP/FSP Delivery - GM ICB	Mark Fisher	Integrated Care Board ICB Finance Committee

2.10.3 Financial Sustainability Plans (detail)

Organisation	23/24 outturn (£m)	24/25 plan (£m)	25/26 plan (£m)	26/27 plan (£m)
Output from the FSPs overall position				
Providers	-£141.7	-£175.0	-£128.6	-£46.9
ICB	-£38.1	£0.0	£0.0	£0.0
Optimum Bias	£0.0	£0.0	-£15.0	-£75.8
System Repayment	£0.0	£0.0	-£36.7	-£37.4
Overall	**-£179.8**	**-£175.0**	**-£180.3**	**-£160.0**
CIP Delivery (Including optimum bias)				
Recurrent	£161.4	£311.4	£257.3	£234.8
Non-Recurrent	£181.8	£178.8	£171.5	£97.0
Total	**£343.2**	**£490.2**	**£428.8**	**£331.8**
Recurrent	47%	64%	60%	71%
Non-Recurrent	53%	36%	40%	29%

- £160m
Gap from FSPs and system repayment by 26/27

60-70%
Of Future CIP Recurrent to land the system on a sustainable footprint.

- **Financial Sustainability Plans £160m gap 26/27–** All 10 parts of the system have developed an FSP, whilst at different stages of governance, the table illustrates the output of those documents.
- **Additional to the FSPs, there are two further adjustments:**
  - **System Repayment –** As a result of the deficit in 23/24 and the control total in 24/25, GM has to repay at 0.5% of our allocation c£35-£40m per year.

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- **Optimism Bias –** This is based on elements of the FSP having income assumptions from the ICB that are not agreed or included in ICB FSP. Also, recurrent level of CIP at Providers 14% more in 25/26, than planned in 24/25. Consequently, 25/26 recurrent levels reset to equate to 24/25.

- Financial Sustainability Plans (FSPs) covering the period up to and including 2026/7, from 7 of the 9 NHS providers in GM were analysed to identify the programmes within them (not the value of any savings). Two were not available at the time of analysis and one of the 7 focused entirely on financial data and so could not be included in the analysis.
- Most of the 6 FSPs analysed drew in some way on previous categorisation by PwC of cost and potential improvement opportunities into operational, strategic and system categories.
- The majority focused on operational issues such as
  - Provider productivity and efficiency
  - Workforce – especially the use of bank and agency staff, and sickness absence (in some organisations)
  - Corporate functions
- Strategic issues included:
  - Clinical staff (skill mix, staff numbers, productivity)
  - Flow – including LoS and NRTR
  - Underfunded services and/or services of low clinical value
  - Estates – including maintenance –a focus for some but not all
  - Streamlining operations between sites (for those with more than one site)
- These issues are mainly included in pillar 2 – System Productivity, as they link with GM-wide programmes in some way or in pillar 5 – Optimising care

2.11 System Productivity and Performance

- The national definition of NHS productivity is how well the NHS turns a volume of inputs into a volume of outputs. In the context of the GM Sustainability Plan it is about how we optimise and maximise the use of our assets and resources in order to produce the best outcomes for our population, which address the system's deficits in performance, population health and finance.
- It is closely associated with our aims for sustained performance improvement and collaborative schemes are in place/ planned, aimed to improve system productivity and performance. These will be integral to delivering financial plans, alongside returning to consistent delivery of all NHS core standards.
- The schemes will enable delivery of the individual Trust and ICB commitments in terms of CIPs and FSPs, as well as working to improve performance and quality – exploiting our opportunities as a system to work at scale, and to learn and adopt best practice.
- Whilst these programmes may not generate financial savings, they are a vital part of enabling and securing a sustainable system, improving the experience of patients in the system, and supporting the dedication and skills of our colleagues delivering and supporting care.
- Trusts will continue to work together across GM in terms of productivity, facilitated through the relevant system group, and building on various benchmarking exercises with regular updates available for consideration and action through GM governance

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2.12 System Productivity and Performance – the programmes[2]

Programme	Contribution to system sustainability
Programmes to drive performance improvement and quality of care through optimising models of care and implementing targeted new ones	
Elective care	• Reduced waiting times for patients • Reduce variation in access
Cancer	• Reduced waiting times and managing growth in demand. • Reduce variation in access and provide service resilience. • Cost avoidance – reduced LoS related to anticipated growth in demand, waiting list initiatives, in/outsourcing. • Reduced variation.
Diagnostics	• Wait list reduction. • Reduction in outsourcing • Reduced turnaround times for patients
Mental Health	• Savings from reduced OAPs can be reinvested in Mental Health services
Urgent and Emergency Care (UEC)	• Improved patient flow. • Achievement of 95% of patients seen within 4hrs in A&E by March 2027 • Sustain Cat 2 ambulance response times at or above national target
Transform corporate services through innovation and enhanced collaboration, to make them more efficient, resilient and cost-effective	
Scaling People Services Programme	• Enabler of realising CIPs; standardisation of systems/processes and automation will enable efficiencies
Corporate services	• Enabler of realising CIPs; improved workforce resilience
Other programmes	
Workforce	• Sickness absence - potential savings contribution to CIPs • Turnover - cost prevention • Reduced temporary staffing and improved capacity
Digital	• Requires significant capital investment • Will then deliver both financial efficiencies and productivity gains

2.12.1 System Productivity and Performance – oversight and governance

Programme	SRO	Programme Lead	Oversight/ Governance
Elective	Fiona Noden & John Patterson	Dan Gordon	GM Elective Care Board to TPC
Cancer	Roger Spencer	Claire O'Rourke	GM Cancer Board to TPC
Diagnostics	Roger Spencer	Chris Sleight	GM Diagnostics & Pharmacy Partnership Group to TPC
Mental Health	Manisha Kumar/ Anthony Hassall	Xanthe Townend	GM Mental Health Partnership Board
UEC	Steve Rumbelow	Gill Baker	GM UEC System Group to ICB Board

[2] More detail can be found in the Appendices: section 4.2

Any subsequent changes are indicated in red with an explanatory footnote. Detail in the full version of the plan that was not included in the public board papers but was correct at the time, is shown in blue.

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Programme	SRO	Programme Lead	Oversight/ Governance
Workforce	Karen James/ Janet Wilkinson	Rebecca Steer / Jane Seddon	HRDs to TPC Health & Care Group to People & Culture Committee
HR Scaling People Services Programme	Karen James/ Janet Wilkinson	Rebecca Steer	HRDs to TPC Health & Care Group to People & Culture Committee
Transforming corporate functions	TBC	TBC	TPC
Digital	Anthony Hassall/Alison McKenzie-Folan	Malcom Whitehouse/ Gareth Thomas	GM ICS Digital Transformation Group

2.13 Reducing prevalence

The opportunity to reduce the growth in prevalence is based on primary prevention
Primary prevention involves taking action to reduce the incidence of disease and health problems within the population. The purpose is to prevent disease or illness from ever occurring.
Primary prevention of poor health includes actions to:

- Supporting people to live healthier lives by improving the conditions in which they are born, work, live, grow, and age (including education, employment, income, social support, community safety, air and water quality, and housing).
- Supporting people to tackle behavioural risk factors (such as smoking alcohol, substance misuse, poor diet and inactivity)
- Prevent infectious disease (such as with immunisation)
- These can be delivered at a whole population level (universal measures) or targeting those at highest risk

Benefits

- This will reduce the number of individuals that move between segments, particularly those that may drift out of the good health segment without intervention
- Reducing the volume of individuals that become ill will allow for resource to be spent on those most in need and produce a saving to the system

2.14 Reducing prevalence: programmes and impact[3]

Programme	Investment already agreed 3 years (£m)	Savings 3 years (£m)
HIV	5.1	10.2
Making Smoking History	4.2	16.8
Physical Activity	2.1	16.2
Work and health	1.2	3.6
Home Improvement	0	5.5
Totals	**12.6**	**52.3**

[3] Figures for individual programmes were not presented to the Board – only the 'total' figures. More details can be found in the Appendices – section 4.3

In addition to the impact from investment already agreed, further impact could be gained from additional investment for the faster and wider implementation of programmes already underway

	Additional investment to be agreed - 3 years (£m)	Additional savings - 3 years (£m)
Other Population Health	**50**	**117**

- Overall Impact ~£40m (savings – investment)
- Impact from additional investment in three years: £67m (savings – investment)
- ROI from additional investment assumed to be 1/3rd of full impact because of the early stage of the programmes

2.14.1 Reducing prevalence – oversight and governance

Programme	SRO	GM Programme Lead	Oversight and Governance
HIV	PBLs	Jane Pilkington	Locality Board/Pop Health Committee
Making Smoking History	PBLs	Jane Pilkington	Locality Board/Pop Health Committee
Physical Activity	PBLs	Jane Pilkington	Locality Board/Pop Health Committee
Work and health	PBLs	Jane Pilkington	Locality Board/Pop Health Committee
Home improvement	PBLs	Helen Simpson	Locality Board/Pop Health Committee

2.15 Proactive Care

There are two streams of work in this pillar:

- The secondary prevention elements of the GM multi-year prevention plan
- A focus on reducing variation in the provision of services across GM

Secondary and tertiary prevention are key to providing more consistent, person centred and proactive care

- Secondary prevention focuses on early detection of a problem to support effective early treatment such as prescribing statins to reduce cholesterol and activities such as screening and health checks in non-symptomatic patients

Tertiary prevention is about supporting people to live well by optimising the treatment and management of chronic conditions to minimise further harm

Benefits

Providing care more efficiently will be driven by improvement in population health management and also reduce the financial costs to the system if people are seen/supported by the most appropriate teams

2.15.1 Proactive Care: GM multi-year prevention plan

- **Initial focus** on preventing CVD and Diabetes as a significant driver of morbidity, mortality, demand and cost
- Building on our existing evidence-based GM CVD Prevention strategy and GM Diabetes Strategy 2022-2027 and shifting the focus to scaled up delivery.
- Defined evidenced based, cost-effective preventative interventions for CVD and Diabetes

    - Evidenced based population health and secondary prevention interventions for CVD and Diabetes to prioritise for GM in 2024/25 have been identified. Secondary prevention interventions are predominantly clinical in nature and will occur during interactions with the health service. Primary prevention initiatives are described in the 'reducing prevalence' pillar.
- **Looking forward:** in 25/26 we will consolidate and continue to drive delivery of key outcomes re CVD and diabetes and also plan for future years, building an evidenced based approach to prevention priority identification and targeting of resources

2.15.2 Proactive Care; reducing variation across GM

- From the data we have available (for example, the Strategic Financial Framework p.37-59) we know that there is substantial variation between localities and providers across GM. Whilst some of the variation can be explained, in many cases it is likely to be unwarranted.
- In terms of localities, the Strategic Financial Framework examined the overall opportunity across seven segments of the population: 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.
- It calculated total per-capita cost for each of the ten localities across the seven areas and identified a 'most cost effective' place for each segment. It then set out the potential avoided cost if every place could deliver healthcare for their population (excluding the CORE20 segment) at the same cost per capita as the most cost-effective place.
- Across the seven areas, a potential cost avoidance opportunity of £1,025m was identified. This related to services provided by acute/community providers and did not include primary care costs. Over half the opportunity was in avoided A&E/non-elective costs.
- This showed that it might be possible to improve equity of provision, reduce costs and maintain quality in the areas of:
    - People with multiple long-term conditions (18 years and over)
    - Mental illness (children and adults under 65)
    - People who are homeless
    - People over 65 who are frail
- Even if only a proportion of this opportunity can be realised, it is still significant.
- This needs to be a focused programme of work driven through localities and is not currently part of GM plans

2.15.3 Proactive care: the role of commissioning

- To ensure we align locality and GM plans to deliver primary and secondary prevention (pillars 3 and 4) a strong commissioning perspective is needed.
- The commissioning process must:
    - understand the population need, current service provision and gaps in service offers
    - develop outcome-based service specifications (with co-design with lived experience)
    - procure/contract services
    - continuously evaluate of delivery of outcomes.
- This will involve both NHS and other providers, including the VCSFE

2.15.4 Improving care for the most disadvantaged communities

- The opportunity to improve health and address and reduce disparities in care related to access, experience and outcomes for the most disadvantaged communities will improve the general health of the population.
- For GM this relates to the 1.1m residents living in areas classified within the 20% most deprived socio-economic areas of the UK, people with specific characteristics (such as ethnicity), and socially excluded groups (such as people seeking asylum or experiencing homelessness).
- It will also ensure that all residents of GM are seen in the most appropriate care setting, reducing the need for acute services which will improve outcomes and reduce costs to the system.
- Fairer Health for All is our system-wide commitment and framework for reducing health inequalities in Greater Manchester and needs to be embedded across all the pillars. Hard-wiring health inequalities into the way the system works requires a deliberate design and a shift in expenditure patterns over the long term.
- This opportunity is also predicated on fully delivering a neighbourhood based integrated, preventative, person centred model of care and support across GM and empower people to be more active participants in their own health and wellbeing.

2.16 Proactive care: programmes and impact[4]

Programme	Investment already agreed 3 years (£m)	Savings 3 years (£m)
Alcohol Care Teams	2.1	5.4
CVD	9	65
Diabetes	3	3
Social Prescribing	3	10.5
Tobacco Treatment Teams	13.2	66
Totals	**30**	**150**

In addition to the impact from investment already agreed, further impact could be gained from additional investment for the faster and wider implementation of programmes already underway

	Additional investment to be agreed - 3 years (£m)	Additional savings - 3 years (£m)
Other Population Health	**50**	**83**

- **Overall Impact ~£120m (savings – investment)**
- **Impact from additional investment in three years: £33m (savings – investment)**
- ROI from additional investment assumed to be 1/3rd of full impact because of the early stage of the programmes

[4] Figures for individual programmes were not presented to the Board – only the 'total' figures. More details can be found in the Appendices – section 4.4

2.16.1 Proactive care – oversight and governance

Programme	SRO	GM Programme Lead	Oversight and Governance
Alcohol Care Teams	PBLs	Jane Pilkington	Locality Board/Pop Health Committee
CVD	PBLs/Manisha Kumar	Claire Lake/Jane Pilkington	Locality Board/Pop Health Committee
Diabetes	PBLs/Manisha Kumar	Claire Lake/Jane Pilkington	Locality Board/Pop Health Committee
Social Prescribing	PBLs	Jane Pilkington	Locality Board/Pop Health Committee
Tobacco Treatment Teams	PBLs	Jane Pilkington	Locality Board/Pop Health Committee

2.17 Optimising Care

- This pillar focuses on transforming the model of care through system actions.
- This will be driven through reviews of our health and care system and strategic commissioning,
- Commissioning (supported by robust contracts) of outcome-focused and evidence-based services and interventions will ensure we commission the right service at the right time by the right team in the most cost effective, efficient way.
- Further potential reconfiguration through the Health and Care review, as well as options such as hot and cold sites will require new models to be implemented.
- This will include commissioning new care models/services with a prevention focus (with outcome-based specifications) from other sectors – including primary and/or community care where acute based services are currently a less efficient/resilient option. This is in line with the GM Model for Health and will need to be supported by an investment strategy

2.17.1 Health and Care Service Review[5]

- This review will be an enabler of the transformation of the model of care which underpins this plan
- It is based on the following principles:
  - We will provide the highest quality care
  - We will streamline our services to align with service user needs
  - We will promote wellbeing and adopt a posture of prevention
  - We will reach service users where it's best
- The critical factors to underpin these principles are:
  - We will prepare our workforce for tomorrow
  - We will work as a team with our partners
  - We will leverage technology to its full potential
- The review process is already underway:
  - some of which are listed in this plan (dermatology, ophthalmology, neurorehabilitation)
  - others that will be developed further in the coming year (gynaecology, community services and maternity services)

[5] Further details including 25/6 priorities are detailed in the Appendices – section 4.5

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2.18 Optimising care: programmes and impact[6]

Programmes already identified	Savings 3 years (£m)
Pathology	10
Dermatology	19
Neurorehabilitation	10
Commissioning more effective processes – vasectomies	1.125
Adult ADHD	13.175
Referral Thresholds	5
PLCV - TES and spinal injections	1.25
TOTAL	**59.6**

	Additional savings 3 years (£m)
Programmes not yet detailed e.g. through Health and Care Review (assumed as 1/3rd of total three-year savings already identified)	19.9
Other PLCV (to be determined)	69
TOTAL	**88.9**

- Impact from programmes already detailed ~£60m
- Impact from additional savings to be detailed/determined: ~£89m
- Total savings: ~£149m

2.18.1 Other programmes to be considered: Procedures of Low Clinical Value

- Like other ICBs, NHS GM has a suite of commissioning statements, developed in line with the national evidence base, which apply stringent criteria for procedures of limited clinical value (PLCV) - a term applied to a range of elective surgical procedures that we no longer wish to fund or are not formally commissioned via NHS or IS providers.
- In the main they are procedures that have traditionally included complimentary or alternative treatments, aesthetic treatments, or treatments without NICE guidance of cost-effectiveness.
- Across NHS GM in 23/24 we spent a total of £139m, (an increase of £13m from 23/24) on PLCV. Of this spend, £23m (an increase of £3m since 23/24) is spent outside of the GM system.
- More intensive and faster consideration of PLCV than is currently supported through commissioning review has the potential to provide significant savings.
- If a three-year saving of ~£69m could be made (~50% of annual spend) then the £160m gap would be made up, combined with other savings. However, this requires more work and is not without potential challenges
- The issue of PLCV along with 'unfunded services' is in most provider FSPs, although without details of the actual procedures targeted

[6] Figures for individual programmes were not presented to the Board – only the 'total' figures. More details can be found in the Appendices – section 4.5

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2.18.2 Optimising care – oversight and governance

Programme	SRO	Programme Lead	Oversight and Governance
Pathology	Roger Spencer	Chris Sleight	TPC
Dermatology	Rob Bellingham	Jennie Gammack	Health and Care Review Group
PLCV - TES and spinal injections			
		Sara Roscoe	Commissioning Oversight Group
Commissioning more effective processes – vasectomies		Sara Roscoe	Commissioning Oversight Group
Adult ADHD		Sandy Bering/Xanthe Townend	Commissioning Oversight Group/Mental Health Board
Neurorehabilitation		Sara Roscoe	Commissioning Oversight Group
Referral Thresholds		Sara Roscoe	Commissioning Oversight Group

2.19 Governance – summary

- The governance and accountability for the elements in this plan can be summarised as follows:

Pillar	Governance and oversight through
Cost Improvement	Trust Boards, ICB Provider Oversight Meetings, ICB Board and Finance Committee
System Productivity	System Boards, TPC (currently under review)
Reducing Prevalence	Locality Boards, Population Health Committee
Proactive Care	Locality Boards, Population Health Committee
Optimising Care	Commissioning Oversight Group (COG), relevant System Boards, TPC (currently under review)

2.19.1 Governance – system groups

- A review of system groups is currently being undertaken. These groups include:
  - The GM Cancer Alliance, required and funded by NHS England.
  - Mental health services
  - Urgent and Emergency care services
  - Elective care
  - Diagnostics (with some elements of pharmacy)
  - Sustainable services (Health and Care Services Review)
  - Local Maternity and Neonatal services (LMNS)
  - Childrens and Young Peoples services (CYP)
- The review will make recommendations on:
  - The future role and function of system groups (including clarity about what they do not have responsibility for).
  - An assessment of the effectiveness of current system groups in delivery of agreed roles and functions.
  - Any proposed changes to leadership and reporting arrangements.

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3 How we will enable sustainability

3.1 Investment strategy

- Each year NHS GM receives growth funding as part of its national allocation from NHSE. Some of this is contractually allocated to various parts of the system, including providers. However, the remainder could be used (as is its intention) to fund growth in parts of the system determined by the strategy of NHS GM
- In 2024/5 the remainder was ~**£61m**. This varies year on year depending on changes to national contractual arrangements.
- To date NHS GM has not spent this funding on growth but has netted it off in their accounts against other costs – usually against convergence costs which are of a similar amount
- If the convergence costs can be covered by savings elsewhere in the system, this growth funding could be used for its original purpose. For the purposes of this analysis, we have assumed **£50m** a year might be available to fund growth (from year 2 – 2025/6).
- This proposal requires consideration by the GM system but must target allocative efficiency for the achievement of outcomes for the population.

3.2 The role of capital

- Capital is an important enabler to the delivery of the Sustainability Plan
- The Capital Resource and Allocation Group has been tasked with developing a long-term plan for deployment of system capital. This work is focusing on:
    - Clearly defining the parameters of what is meant by a sustainable capital plan.
    - The investment strategy if we must live within current capital constraints.
    - What the system could achieve if it had increases capital to deploy into several key areas (Estates, Digital, Equipment). Particularly linking this to known areas i.e. the £3.4bn of national capital to support productivity.
- This work is ongoing and focused on three phases, including a Y1 plan for no increases in capital income, with options for Y2-5 being developed to support strategic requirements

3.3 Continued grip and control

The strengthened NHS GM oversight arrangements will be pivotal in tracking delivery of the programmes set out in the Sustainability Plan. These include:

- Provider Oversight Meetings (POMS): building on and succeeding the PWC led finance and performance recovery meetings. The scope is broader to include finance, quality, performance and workforce
- Locality Assurance Meetings (LAMS): focus on delivery of delegated functions. These follow a consistent approach to the POMS
- System Group Meetings: focus on delivery of transformation programmes
- Performance Improvement Assurance Group (PIAG): focus on tracking actions and impact of the refreshed Performance Improvement Plans (PIPs)

3.4 Addressing the undertakings

The Sustainability Plan supports our system response to the four pillars in the Improvement Plan developed in response to the undertakings issued by NHS England:

- Leadership and governance
- Financial sustainability
    - Develop three-year plan to address underlying deficit position
    - Clarify system commissioning intentions and implement
- Performance and assurance
- Quality

3.5 Our workforce

This plan has a strong relationship to our People and Culture strategy. As illustrated below, our ability to deliver this plan rests on supporting our workforce and developing collaborative cultures as well as the appropriate controls to ensure that the size and composition of our workforce matches the financial resources available.

3.6 Assumptions on which the plan is based

The following assumptions are the basis of the Sustainability Plan:

a) Trust and ICB **cost improvement** will be delivered in full as planned, along with the achievement of all performance objectives.
b) Other financial savings will be achieved through **optimising care** through service review/commissioning, and consideration (specifically) of reducing Procedures of Limited Clinical Value (PLCV)
c) We will move to a model of care that supports people to maintain good health (**reducing prevalence** and **proactive care**) through changing how we allocate our financial resources

3.6.1 Key points for system consideration

If the remaining deficit is to be addressed:

- Confirmation of assumptions of savings from programmes not detailed in Optimising Care ~£20m over three years
- Confirmation of progressing the reduction of Procedures of Limited Clinical Value (PLCV) with savings to go against system costs – this will require difficult system choices if the savings are to be realised fully.
- Prioritisation of addressing any key gaps – for example system wide ambitions for digital transformation, mental health

If NDG is to be addressed:

- Confirmation of the investment proposal
- Establishment of a programme to reduce variation across localities through enabling more consistent Proactive Care

If this plan is to be delivered:

- Allocate clear responsibility to deliver against this plan to organisations, locality boards and system groups
- Development of a broader set of Locality Metrics that capture the effectiveness of places in improving health and reducing crisis-based demand
- Design a mechanism to attribute the share of delivery to places – to enable shared accountability between providers, local government, primary care and other partners

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4 Appendices

These were not presented to the Board but formed the basis of the summary tables which were endorsed.

4.1 Cost improvement

4.1.1 Value of CIP programmes

£m	2024/5 Target
NHS GM	103
Providers	387.3
TOTAL	490.3

4.1.2 Trust cost improvements

Provider	2024/5 FY plan (£m)
Bolton	24.3
GMMH	23.9
MFT	148.0
Pennine Care	14.5
NCA	85.6
Stockport	24.6
Tameside	17.6
Christie	21.4
WWL	27.3
TOTAL	**387.3**

4.1.3 ICB Cost improvements

Programme(s)	2024/5 FY plan (£m)
Continuing Health Care	13.0
Medicines Optimisation	33.0
Mental Health OAPs	10.0
Autism and LD	0.3
Better Care Fund	4.5
Community Services	5.0
Estates	5.0
Independent Sector	3.0
Legal Services	0.5
Locality Individual Schemes	12.1
Non-Healthcare Contract Consolidation (NHCC)s	1.2
Optimal Organisational Structure	8.5
Translation and Interpretation	0.5
Virtual Wards	5.0
Workforce External Drivers	1.5
TOTAL	**102.6**

4.2 Details of programme plans – System productivity and performance

Programme	3-year ambition	Key issues	Key interventions	Contribution to system sustainability
Programmes to drive performance improvement and quality of care through optimising models of care and implementing new ones in targeted areas				
Elective care	• Reducing waiting list size to c240,000 by March 2027 • Minimise patients waiting over 40 weeks	• Size of overall wait list: if linear trend was to continue the overall wait list would stagnate at around 500k. • Number of long waiters • Underlying demand and capacity	• Introduce GM referral gateway and specialist advice. • Increase capacity for Outpatient first appointments. • Maximise capacity and utilisation of theatres (inc. new TIF builds) • Embed Mutual Aid policies and processes across the system	• Reduced waiting times for patients • Reduce variation in access. • Additional revenue from paid for activity
Cancer	• Deliver sustainable improvements to achieve the NHSE standards for cancer consistently across GM. • Deliver the 2028 requirement of 75% of cancers diagnosed at early stage. • Deliver optimal pathways for high-risk tumour sites to improve patient outcomes. • Deliver personalised care and treatment. • Improve cancer care	• Managing Demand • Diagnostic Reporting Capacity • Treatment – capacity, volumes, variation • Based on current referral trajectories, we are projecting a potential 7% increase year on year in FDS activity.	• Create ‘step change’ in front end pathway delivery. • Full and active commitment to Single Queue Diagnostics expansion • Optimisation of surgical pathway capacity	• Reduced waiting times and managing growth in demand. Reduce variation in access and provide service resilience. • Cost avoidance – reduced length of stay and related to anticipated growth in demand, WLI, in/outsourcing. • Reduced variation.

Any subsequent changes are indicated in red with an explanatory footnote. Detail in the full version of the plan that was not included in the public board papers but was correct at the time, is shown in blue.

Programme	3-year ambition	Key issues	Key interventions	Contribution to system sustainability
	related health inequalities			
Diagnostics	• Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition. • Mature Imaging, Pathology, Endoscopy and Physiological Sciences Networks. • Develop digital infrastructure. • Continued rollout of CDC programme and system wide process to increase diagnostic capacity and reduce inequalities in access.	• Workforce sustainability • Growing demand and insufficient capacity • System variation • Modelling indicates a potential shortfall in capacity meeting demand.	• Diagnostics performance improvement initiatives • CDC expanded capacity for system increase capacity and mutual aid access. • Endoscopy system triage and audit • Operationalise Digital Pathology	• Activity revenue • Wait list reduction. • Reduction in outsourcing • Reduced turnaround times for patients
Programmes to drive performance improvement and quality of care through optimising models of care and implementing new ones in targeted areas				
Mental Health	• Elimination of Out of area placements (OAPs)	• For OAPs, a linear trend on growth could see a rise of 198% in March 2027	• Quality oversight of OAPs, improving patient flow, effective discharge planning, ensuring appropriate community capacity across all localities. Increased provision of alternatives to admission and onward care home/supported housing options	• Savings from reduced OAPs can be reinvested in Mental Health services

Any subsequent changes are indicated in red with an explanatory footnote. Detail in the full version of the plan that was not included in the public board papers but was correct at the time, is shown in blue.

Programme	3-year ambition	Key issues	Key interventions	Contribution to system sustainability
Urgent and Emergency Care (UEC)	• To recover urgent and emergency care performance across GM ensuring population of GM receive timely and appropriate care in right setting	• Increased demand and acuity, resulting in challenges with patient flow. • The 4hr A&E standard of care not being delivered to all patients. • Management of winter pressures. • Effectiveness of Capacity & Discharge funding.	• Improve efficiency and effectiveness of Hospital at Home Services. • Driving standardisation and performance improvement management. • Ongoing evaluation of schemes from Capacity and Discharge funding. • Management of winter pressures and system escalation via System Coordination Centre. • Development of 3-year UEC System Plan. • Sustain GM hospital handover operational improvement plan. • Development of consistent Care Coordination models across the ICS	• Improved patient flow. • Achievement of 95% of patients seen within 4hrs in A&E by March 2027 • Sustain Cat 2 ambulance response times at or above national target
Transform corporate services through innovation and enhanced collaboration, to make them more efficient, resilient and cost-effective				
Scaling People Services	Reduce corporate running costs with a focus on consolidation, standardisation, and automation to deliver services at scale	• Demands on HR teams are growing. • Expectations of the workforce are increasing	• Development of models and shared approaches around transactional People Services (Recruitment, HR Administration, Payroll); and Occupational Health	• Enabler of realising CIPs • Standardisation of systems/processes and automation will enable efficiencies
Transforming corporate functions	Implement work on transforming specific corporate functions and shared services	• Workforce resilience • Cost pressures	• Pursuing a single ledger across Trusts • Collaborative procurement e.g. legal services • Route map for system digital architecture	• Enabler of realising CIPs • Improved workforce resilience

Any subsequent changes are indicated in red with an explanatory footnote. Detail in the full version of the plan that was not included in the public board papers but was correct at the time, is shown in blue.

Programme	3-year ambition	Key issues	Key interventions	Contribution to system sustainability
Other programmes				
Workforce targets	Meet workforce targets on sickness absence, agency spend and turnover	• Retention • Workforce wellbeing • Reliance on bank and agency	• Workforce Efficiency programme • GM Temporary Staffing Strategy • Wellbeing benchmarking • Ongoing retention projects in providers, enabled by the NHS People Promise	• Sickness absence - potential savings contribution to CIPs • Turnover - cost prevention • Reduced temporary staffing and improved capacity
Digital	Rationalisation of systems & infrastructure, including: 1) EPR 2) Common Service Platforms 3) Infrastructure 4) Medicine Optimisation. 5) Digitalisation of Paper 6) Primary Care	Will require significant capital investment to enable the projects to be delivered	1) EPR – transition to 'Epic Connect' model which would enable sharing of capabilities across the system, including workforce mobility across Trusts – would mitigate the need for high levels of bank & agency staff 2) Common Service Platforms – Finance & HR; single financial ledger in GM needs to be explored as a priority 3) Infrastructure – rationalisation of Data Centres – 30+ Data Centres across GM and therefore we are vulnerable to market price increases 4) Medicine Optimisation – automation of prescribing generic drugs 5) Digitalisation of Paper - reduction in storage costs; pilot at NCA – potential opportunity to scale this up across GM 6) Primary Care - Digital strategy realisation – multiple opportunities on a PCN footprint including, Triage consulting, Pharmacy First, recruitment of patients for clinical trials etc.	• Will deliver both financial efficiencies and productivity gains

4.3 Details of programme plans – Reducing prevalence

Programme	Year 1 Investment	Year 1 Savings	Year 2 Investment	Year 2 Savings	Year 3 Investment	Year 3 Savings	Investment already agreed 3 years (£m)	Savings 3 years (£m)
HIV	1.7	3.4	1.7	3.4	1.7	3.4	5.1	10.2
Making Smoking History	1.4	2.8	1.4	5.6	1.4	8.4	4.2	16.8
Physical Activity	0.7	2.7	0.7	5.4	0.7	8.1	2.1	16.2
Work and health	0.4	0.6	0.4	1.2	0.4	1.8	1.2	3.6
Home Improvement	0	0	0	5.5	0	0	0	5.5
Totals							**12.6**	**52.3**

In addition to the impact from investment already agreed, further impact could be gained from additional investment for the faster and wider implementation of programmes already underway

	Additional investment to be agreed - 3 years (£m)	Additional savings - 3 years (£m)
Other Population Health	**50**	**117**

- Overall Impact ~£40m (savings – investment)
- Impact from additional investment in three years: £67m (savings – investment)
- ROI from additional investment assumed to be 1/3rd of full impact because of the early stage of the programmes

4.4 Details of programme plans – Proactive care

Programme	Year 1 Investment	Year 1 Savings	Year 2 Investment	Year 2 Savings	Year 3 Investment	Year 3 Savings	Investment already agreed 3 years (£m)	Savings 3 years (£m)
Alcohol Care Teams	0.7	0	0.7	2.7	0.7	2.7	2.1	5.4
CVD	3	21	3	21	3	23	9	65
Diabetes	3	1	0	1	0	1	3	3
Social Prescribing	1	3.5	1	3.5	1	3.5	3	10.5
Tobacco Treatment Teams	4.4	22	4.4	22	4.4	22	13.2	66
Totals							**30**	**150**

In addition to the impact from investment already agreed, further impact could be gained from additional investment for the faster and wider implementation of programmes already underway

	Additional investment to be agreed - 3 years (£m)	Additional savings - 3 years (£m)
Other Population Health	**50**	**83**

- **Overall Impact ~£120m (savings – investment)**
- **Impact from additional investment in three years: £33m (savings – investment)**
- ROI from additional investment assumed to be 1/3rd of full impact because of the early stage of the programmes

4.5 Details of programme plans – Optimising care

Service area	3-year ambition	Rationale for change	Contribution to system sustainability	Financial savings (total over three years)
Pathology	Development and implementation of a new operating model for pathology	Pathology services facing unprecedented challenges with workforce, greater demand and high expectations for quicker diagnostics. Opportunities to influence end to end diagnostic pathways with a greater ability to interface with other diagnostic services. New LIMS systems and Digital Pathology coming into GM provide an opportunity to standardise and ensure efficiency, and a single operating model would drive this at pace.	Reduction of outsourcing for reporting and incorporate costs of storage and digitization.	£10m
Dermatology	Implementation of the agreed model of care for dermatology, including the Single Point of Access and community model	Significant increase in suspected cancer referrals, impacting performance and wait times, and sustainability issues. Current trend suggests almost 36,000 additional dermatology suspected cancer referrals in 2026-27 than in 2022-23 with the elective waiting list increasing significantly	Improvement in both performance and in ensuring the patient is treated in the most appropriate setting for their condition.	£19m
Neurorehabilitation	Implement lead provider model	Significant increase in the use of the Independent Sector and a reduction in the NHS bed provision. Based on costs increasing for next the 3 years at same level as seen between 2022/23 to 2023/24 at around 18%. Impact is an increase in costs over the next 3 years of £13.09m.		£10m

Service area	3-year ambition	Rationale for change	Contribution to system sustainability	Financial savings (total over three years)
Vasectomies	Undertake a systematic assessment of services against an agreed set of outcome, efficiency, effectiveness and quality measures to ensure most effective use of resources across GM and reduce inequality of provision.	Vasectomies are a procedure which can safety be delivered in a community setting, under local anaesthetic. There is already community provision which works effectively, serving several GM localities however still several patients attending secondary care and other providers for procedures at national tariff. It is the intention to reprocure more cost-effective services in the community which will also free up capacity in secondary care	Reductions in unwarranted variation in cost and quality	£1.125m
Adult ADHD	A changed approach to the way the ICB responds to Adult ADHD – prioritising access to individuals on waiting lists in most clinical need through a triage assessment model to support GPs and patients in clinical need with wider psychosocial alternatives offer for those not eligible for NHS-funded assessments	Demand for adult ADHD assessments has risen at such speed that services are simply unable to keep up across the country and locally in Greater Manchester Increasing concerns raised by primary care, specialist services and Coroners about increased waiting times, joint working with respect to shared care protocols for medication and the quality of some private providers in delivering whole pathways of support (including under Right to Choose arrangements) Existing growing waiting list for Adult ADHD assessments of more than 20,000 adults (and a recognition that this is increasing by at least 1,500 each month above commissioned capacity and funding). This	• Improved utilisation of limited GM capacity and full pathway capacity and funding to deal with growing backlogs, longer waiting times and risks that are negatively affecting people's day-to-day lives • Reduced risk of uncapped rise in funding pressures from ADHD 'Right to Choose' requests	£13.175m

Service area	3-year ambition	Rationale for change	Contribution to system sustainability	Financial savings (total over three years)
		translates to a waiting list cost pressure of at least £15-20m using existing model	where no clinical rationale	
Referral Thresholds	In order to address referral variation and make optimum use of the capacity we have availably and utilise our finances well, the Clinical Reference Groups (CRG) are tasked with identifying appropriate referrals thresholds for high volume specialties thus allowing as a system for optimisation of our NHS provision with priority being given to Ophthalmology. Working with local and system partners including Getting it Right First Time (GIRFT) team to ensure that the changes we made lead to improved quality, deliver sustainable service provision and wider system efficiencies.	All NHS providers are reviewing their productivity as part of their internal cost improvement programmes, (CIP). There is a need to apply similar methodology across all providers delivering elective care, including reviewing first to follow up ratio's, adherence to service specification and clinical thresholds to manage demand and optimise the use of our available capacity.	Improvement in financial sustainability Improvement in productivity and performance	£5m
Already agreed: TES and spinal injections	Undertake a systematic assessment of services against an agreed set of outcome, efficiency, effectiveness and quality measures to ensure most effective use of resources across GM and reduce inequality of provision. To review commissioning statements	The ICB has seen an increase in activity and cost of providers undertaking procedures of limited clinical value (23/24 activity versus 2019/20 (pre covid)), and so there is a need to validate this activity to ensure that providers are only undertaking procedures to those patients who meet the stringent clinical criteria.	Reductions in unwarranted variation in cost and quality. Improvement in performance and productivity. Improvement in financial	£1.25m
Further areas to be pursued – at greater speed and wider scope than currently planned				£69m

Any subsequent changes are indicated in red with an explanatory footnote. Detail in the full version of the plan that was not included in the public board papers but was correct at the time, is shown in blue.

Service area	3-year ambition	Rationale for change	Contribution to system sustainability	Financial savings (total over three years)
	for the procedures of limited clinical value, nationally now referred to as the 'Evidence-based interventions programme', The EBI programme, is designed to reduce the number of medical or surgical interventions as well as some other tests and treatments which the evidence shows are inappropriate for some patients in some circumstances. The GM Procedures of Limited Clinical Value (PLCV) Steering group has a programme of clinical, evidence-based reviews of procedures which are of low/limited clinical value. The recommendations of the group are to decommission or implement clinical thresholds.		performance.	

4.5.1 Health and Care Review forward plans

In 2024/5 the focus of the programme was on provider sustainability issues:

- Dermatology – mobilisation plan being developed to deliver SPOA and community model for delivery – Q2 Go Live
- Ophthalmology - Development of a strategy for a sustained service provision, address service delivery issues – Elements to be delivered from Q3
- Neurorehabilitation – Sustainability partner for the "Devonshire Unit", moving to deliver a lead provider model, reducing impact on IS

placements – Implementation from Q2

- Gynaecology – "Think Tank" – June 2024 to understand challenges
- Community Services Review – Scoping and mapping resource requirements
- Maternity Services – Early engagement

The 2025/6 programmes of work are shown below:

Emergency Care	Community Services	Outpatient transformation/long term condition management	Women's and Childrens	Market Management
• Key deliverables: • Sustainability of Urgent Care Provision across Greater Manchester with consideration given to reconfiguration of ED departments/ UTC	• **Key deliverables:** • Create a vision for Community Services that aligns to the GM strategy, • Strengthen integration and partnership working at place and in neighbourhoods • Develop core standards to reduce unwarranted variation, drive efficiency, and resilience. • Develop the strategic commissioning approach2 • Improving our community data set • Support a workforce plan for community services	• Key deliverables: • Deliver alternatives to in hospital care as part of any pathway design • Implementation of services to ensure that patients with a long-term condition are proactively managed with priority being given to CVD, Diabetes, Respiratory and frailty. • Ensure that people living with a long-term condition receive personalised, more anticipatory integrated Care	• Key deliverables: • Deliver a sustainable model of care for Gynaecology • Deliver the objectives set out in the Women's Health strategy including the development of the provision of Women's Health Hubs • **Children's – Deliver JFP** ➢ Child Development in the Early Years ➢ SEND and School-Age Children Wellbeing ➢ Long-Term Physical Conditions (CORE20PLUS5) ➢ Mental ill Health ➢ Vulnerability, Risk and Complex Care ➢ Family help • Maternity Services – Deliver the recommendations from the Maternity Services Review	• Key deliverables: • Development of a strategy to manage the market in order to ensure that we retain our CORE NHS provision., describing the adequacy of service provision across specialities in scope ensuring clear commissioning and contractual approaches. • Through pathway redesign/ services change consider opportunities for lead/ collaborative provider models.

Any subsequent changes are indicated in red with an explanatory footnote. Detail in the full version of the plan that was not included in the public board papers but was correct at the time, is shown in blue.

Meeting: Bury Locality Board			
Meeting Date	02 December 2024	**Action**	Receive
Item No.	10	**Confidential**	No
Title	Chief Officers Report		
Presented By	Kath Wynne-Jones		
Author	Kath Wynne-Jones		
Clinical Lead	Kiran Patel		

Executive Summary
This paper is intended to provide an update to the Board of progress with the work of the IDC, and progress with the delivery of programmes across the Borough
Recommendations
The Board are asked to note the progress of the strategic developments, and progress of the programmes

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 Locality Plan outcomes	
To support a local population that is living healthier for longer and where healthy expectancy matches or exceeds the national average by 2025.	☒
To achieve a reduction in inequalities (including health inequality) in Bury, that is greater than the national rate of reduction.	☒
To deliver a local health and social care system that provides high quality services which are financially sustainable and clinically safe.	☒
To ensure that a greater proportion of local people are playing an active role in managing their own health and supporting those around them.	☒

Implications						
Are the risks already included on the Locality Risk Register?	Yes	☒	No	☐	N/A	☐
Are there any risks of 15 and above that need to be considered for escalation via an NHS GM Statutory Committee or Board in line with the Risk Escalation process ?	Yes	☒	No	☐	N/A	☐
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	☐

Governance and Reporting		
Meeting	**Date**	**Outcome**

Bury Integrated Delivery Collaborative Update

1. Context

This report is intended to outline to the Board progress which has been made with the key programmes of work within the IDC.

2. Key strategic developments

- Through November we have been building our locality contribution to GM planning processes. There are 2 key asks:
    - The first relating Commissioning Intentions / Plans for 25/26 . Appendix 1 provides our first draft of our Locality Plan for 25/26 building on the GM Commissioning Intentions received last month by Locality Board
    - The second relates to the GM system sustainability plan, the first draft of which needs to be completed by the end of January. A local group set up by the IDC Chief Officer has been established to oversee this process. Appendix 2 outlines this in more detail.

- Over the past month we have been facing severe pressure across Mental Health Services with the number mental health patients in ED , the number of patients who are clinically ready for discharge, and are managed under section 117 arrangements. All of these pressures are limiting required access for patients in community. Bury is recognizably under resourced in terms of a range of crisis response, community based and early intervention prevention services. We recognise that we need a shared and consistent narrative on the requirements from future GM held Mental Health Investment Funding to secure a commissioning response addressing gaps in our portfolio of services. The mental health programme board in Bury has a considered this and a summary position has been developed which will be compared through the Mental Health Board to the outcome of the service plan work PCFT colleagues are due to bring to the locality board on 2/12 to enable an agreed prioritization and that can be supported by all partners. Locally we do not agree with the GM commissioning intentions prioritization of OAPs as in Bury we have been on zero for months, however the service gaps that are driving failure demand are.

- Workshop held to consider how we can provide better care for patients in care homes. The output of this workshop was to:
    - Focus on providing an increased level of proactive care by Physical and Mental Health Teams
    - Focus on providing education and support to care homes for end of life patients
    - Alongside this, a piece of work has commenced to ensure we make best use of our MSK/falls related services

- Following the workshop between the VCSE and IDC members an MOU focusing on financial sustainability, governance, partnerships, and workforce has been drafted. This will considered by IDC Board in the new year.

- Following the workshop between the PCN and neighbourhood CD members an MOU to support more collaborative ways of working is in development

- We have putting a significant amount of focus through NCA Group Executives on how we gain more traction on the primary / secondary care interface principles, which is very closely linked

to the actions that GP's are taking under collective action. We have engaged with the Manchester Locality to understand how they have gained traction with MFT to implement, and are sharing this learning through various forums with the NCA.

- An approach to transforming Community Services across the 4 Localities Partenrship is under development

- Dementia workshop held on the 12th November with agreement to scope the potential for a Bury dementia hub building on the good work currently underway including the discharge frontrunner programme.

- Contributing to NCA Clinical Leadership Model discussions for the place based workstream

- Workshops being planned for November/December
    - System sustainability workshop with all IDC and Locality Board members in replacement of the the next IDC Board: 27th November. As part of this workshop we will determine our priorities for investing non recurrent monies available to us next year, including how we would align any new monies to support reducing prevalence of disease and supporting proactive management of care
    - Major Conditions Board to map all work currently happening across each of the domains for each Major Condition: 6th December
    - A 6-month review of our urgent care plan: successes and current challenges linked to our performance improvement plan: 28th December
    - Understanding of prevention services across the locality and opportunities for closer integration

3. October IDC Programme Highlights:

Elective Care, Cancer and Community Health*:*

- GM Community Health Services Baseline Template for Bury submitted.
- GM MSK Baseline Provision Template completed and submitted for Bury.
- Bury representation at the GM Specialist Advice Steering Group – initial scoping template completed and submitted.
- Major Conditions Board – COPD, CVD/Diabetes and Cancer scoping completed and submitted.
- 25/26 Contract and Commissioning Intentions paper completed for Locality Board.

Mental Health:

- Bury has consistently had among the lowest OAPs in GM with most weeks seeing 0 OAPs.
- The numbers of bed days occupied by people who are clinically ready for discharge remains above trajectory and there is some evidence of increased 12+ hour waits in ED.
- We are on track to deliver the actions in phase 1 of the OAPs and Clinically Ready for Discharge improvement plan.
- There continues to be good progress with the community mental health transformation with all VCSE Living Well staff now in post and work progressing well on integrated CMHT redesign.
- A test of change has been initiated to try and better support patients with high numbers of A&E attendances and reduce avoidable hospital attendance.
- There was a well attended Bury system workshop to self-assess in relation to the new Greater Manchester Dementia United Quality Standards. This assessment with inform the Bury Dementia Strategy and work plan.

- There continues to be good progress in delivering the CAMHS expansion and improved early help offer for CYP.

Neighbourhoods:
- INTs were represented at a community 'market place' event at FHG promoting ACM.
- An education and engagement event for GPs on COPD has been planned for 3rd December linked to the respiratory priority for the East and West Neighbourhoods.
- INT and GP Leads have been engaging with practices including practice managers around the Neighbourhood priorities and LCS targets.

Palliative and EoLC:
- The latest data shows that Bury continues to have the highest proportion of people dying in their usual place of residence in GM.
- There has been a decision by system finance leads that it is not viable to progress the bid to the MacMillian Social Impact Fund at this stage because of the risk associated with the potential requirement for any future return on investment to be repaid. This is very unfortunate as it was an opportunity to bring much needed additional resources into palliative care provision in Bury using an innovative funding model.
- Bury Hospice are working with the FGH high intensity service user lead to identify patients suitable for the involvement of the Hospice Outreach/Liaison team in their support package to improve community support and prevent avoidable A&E attendances.
- A rapid discharge QI project has commenced at FGH to support more timely discharge of patients at the end of life.

Workforce
- strengths based awareness training is now available to all partners to roll out
- partners engaged well to develop a proposal for a care leavers health and care careers event planned for early 2025
- a good provider event held for care providers following which a closer partnership is being developed with Bury College to provide a more co-ordinated approach to supporting college placements - this is linked to the Mayor's ambition to level up technical education in Manchester.

LD & Autism:
- "Together Towards Independence" programme: 45 staff trained in strengths-based "Progression" model; systems being set up to record number of people who live more independently as a result.
- New Commissioning manager for Complex Cases now in post: to work across NHS and ASC – high-cost case review process developed.

Pilot project: involving people with Learning Disabilities in quality assessment of care providers – completed (work by Matt Logan)

Complex Care:
- Q1 2024-25 - >80%
- Q2 2024-25 - >80%
- Currently running at 100% for September and October
- ADAM data system cleanse complete.
- Management of finance side of database under control.
- Transfer of CCP jointly funded cases payments to LA with recharge in place.
- Recovery plan in plan for financial recovery.

Adult Social Care:

- the CQC has now published 12 assessment reports with 55 councils now undergoing the local authority assessment process (Local authority assessment reports - Care Quality Commission) as it works towards assessments of all 153 councils over two years. No local authorities in Greater Manchester had been contacted at the time of writing. Local authorities in Lancashire have begun to be contacted in recent weeks.

Primary Care:

Prog.1 - Alternative at Scale Solutions

- Women's Health Hub – First two clinics have taken place with 7F2F and 13 Tel appointments in total. Staffing Sunday Clinics is proving difficult with only two in every four likely to have a local GP as intended. The provider is therefore looking at alternative days before needing to consider out of area GPs.
- QAS – Risk regarding lack of funding escalated at locality board and in GM
- Paediatric Phlebotomy - Revised entry criteria drafted and shared for comments/inclusion in 25/26 contract.
- Winter Pressures – Respiratory and Surge Clinics – in place as of 5th November offering an additional 206 surge/ 600 respiratory appointments. Eligibility criteria for Surge includes the requirement for practices to complete our local sit rep to ensure capacity is allocated to those who need it most.

Prog.5 – Current and Future Estate

- Awaiting further details on estates funding (if any) following budgetary announcement.
- Several rents/rates discussions with practices and property companies being supported

Prog.6 – Integration (Wider PC/Neighbourhoods/PSR)

- Schedule 7 – Face to Face session held with PCN CDs, Neighbourhood CDs and system leaders
- North neighbourhood prescribing project ongoing – Tower live, dates agreed for Garden city, Woodbank and Ramsbottom

Prog.7 – Quality and Assurance

- PCN Assurance:
  - Q1 Assurance returns due – Prestwich & Bury returns remain outstanding. Prestwich cited GPCA as reason for non-response.
  - Q2 requests sent out – due back end of Nov
- PCQV – All remaining visits bar 3 booked. Themes and best practice are being collated will be presented to GPLC/PCCC in January.
- Modern General Practice – Horizon confirmation received and now awaiting funding. Outstanding PCNs sent reminders. (Katie looking into in a bit more detail due to online consultations query)
- MOT continue to focus on savings plans set out by GM although at 50% capacity due to recent GM reorganisation.
- MOT GP LCS
  - several practices have not submitted Q1 & Q2 documents despite reminders. Two Peer to peer review meetings completed, remaining meetings scheduled to take place within next 2 weeks.
  - Q2 data for AMS & Sustainability data sent to practices and on sharepoint.
- FFT has now started flowing again – no breaches

Prog. 8 – System Leadership

- GP Collective Action - weekly returns to GM and system in place. Providers have been asked to outline supportive actions they are taking to resolve pathway issues which have previously been highlighted as part of the bureaucracy and primary care/secondary principles work and which now form part of GPCA – Responses to this request remain outstanding.
- Commissioning intentions are now in the process of being formed

Prog.9 – Workforce (recruitment/development and retention)

- ARRS Recruitment Bury PCN - 22/23 & 23/24 - all claims now resolved
- ARRS Recruitment plans for 24/25 – All now received
- ARRS claims received up to month 5 for HPW - Bury 24/25 claims still only up to April
- Workforce strategy final sessions taking place on GP webinars and feedback will inform strategy and delivery plan

Urgent and Emergency Care

- BCO Collaborative
  Work underway across all 5 workstreams to improve A&E performance in line with the waterfall plan to improve performance
  System event planned for the 28th November to review successes so far and to provide a final check on change plans in place over the winter period

- Winter Planning
  Winter Planning continues to progress, with a winter Planning subgroup meeting every two weeks, and winter sheme monitoring in place

- GP Out of Hours Commissioning
  Prepared a GP Out of Hours Commissioning Brief for PCCC approval

4. Performance – October 2024

- A&E 4-Hour Performance - in October 24 was 67.3%, an increae on the previous month's performance of 64.5%, which is higher than October 23 which was 64.7%.

- A&E Attendances – there were 7129 A&E attendances from Bury registered patients in October 2024, higher than October 23 (7070). Bury currently had 33.7 attendances per 1000 population and has the 5th lowest attendance rate for localities within GM.

- No Reason/no criteria to reside (NCTR) - percentage for Bury in October 24 was 15.3% which is a decrease on September 24 which was 18.7%. Bury had higher than the GM percentage of 13.2% - the 8th highest percentage of the GM localities.

- Specific Acute non-elective spells - there were 1797 specific acute non-elective spells from Bury registered patients in October 24, lower than October 23 (2007). Bury currently has 7.7 specific acute non elective spells per 1000 population and has the 5th lowest rate for 1000 for localities within GM.

- LD Health checks 14+ - the percentage of patients aged 14+ having received an LD health check in September 24 was 32.7%, which is an increase on September 23 which was 22.0%. Bury is

lower than the GM percentage of 35.9% and has the 8th highest percentage of the GM localities. Bury and GM have not met the national target of 75%.

- Access to Children and Young People MH Services - there were 3565 accesses to Children and Young Peoples Mental Health Services for Bury registered patients in September 24, higher than September 23 (3305).

- Dementia: Diagnosis Rate (aged 65+) -the percentage of patients aged 65+ having received a dementia diagnosis as of September 24 is 76.1%, which is lower than September 23 which was 77.2%. Bury currently has a higher diagnosis rate than GM which has a rate of 74.4% and Bury has the 4th highest dementia diagnosis rate of the GM localities. Bury and GM are both above the national target of 66.7%.

- Length of stay adults: Mental Health Patients - the proportion of discharges with a long LOS in September 24 was 42.9%, a decrease on September 23 which was 50.0%. Bury currently has a lower proportion with a long LOS than GM at 52.5% and Bury had the 2nd lowest proportion of the GM localities.

- MH Patients with no criteria to reside / clinically ready for discharge - the percentage of mental health patients with NCTR as of October 24 was 13.0%, a decrease from September 24 at 17.6%. Bury has a higher percentage than GM which is 11.2% and Bury has the 2nd highest percentage of GM localities.

- MH Patients with no criteria to reside - the percentage of mental health patients with NCTR as of October 24 is 13 which I slower than the figure for September 24 which was 18. Bury has 0.06 mental health patients with NCTR per 1000 population and has the joint 2nd highest rate alongside Tameside locality within GM.

- Access to community MH services - there were 1615 people who received two or more contacts from mental health services for adults with severe mental illness for Bury registered patients in September 24, higher than August 24 (1565) and September 23 (1545). Bury currently has 9.7 contacts per 1000 population and has the 4th lowest rate per 1000 for localities within GM.

- Talking Therapies Access Rate – there were 295 accesses to Talking Therapies for Bury registered patients in September 24, lowerr than September 23 (400) Bury currently has 1.4 accesses per 1000 population - the 7th lowest rate per 1000 for localities within GM.

- Women Accessing Specialist Community Perinatal MH Services – There were 180 women accessing to Perinatal MH Services for Bury registered patients for the rolling 12 months to September 24, higher than September 23 (145). Bury currently has 1.70 accesses per 1000 population - the 5th lowest rate per 1000 for localities within GM.

- 2-hour UCR referrals - the percentage of UCR referrals that received a 2-hour response standard for Bury registered patients in September 24 was 96.8% - an increase on September 23 at 66.7%. Bury currently has the 4th highest percentage in the GM localities and above the national target of 70%. Local Authority reporting shows that 99% of Bury residents received a 2-hour response in October 2024 with 1 missing target.

- GP Appointments within 14 days - the percentage of GP appointments taking place within 14 days of booking in September 24 for the Bury population was 79.0%, which is a slight decrease on September 23 which was 78.5%. Bury is currently lower than GM which is 82.7% and has the lowedt percentage in GM localities.

- E. Coli Blood Stream Infections - there were 162 counts of E. coli blood stream infections in the rolling 12 months to August 24 which is higher than August 2023 (134). Bury has 0.77 counts per 1000 population and has the 2nd highest rate for GM localities.

- Antimicrobial resistance: total prescribing of antibiotics in Primary Care - the percentage of total prescribing of antibiotics in primary care in August 24 for the Bury populations was 85.8% which is lower than August 23 which was 99.3%. Bury currently has the lowest percentage of the GM localities.

- Antimicrobial reistant proportion of broad spectrum antibiotic prescribing in Primary Care – in August 204 for Bury population ws 5.9% whichi s a decrease on August 2023 which was 6.1%. Bury currently has the 4th lowest percentage of the GM localities.

- Diagnostics Waiting 6 weeks + - September 24 performance of 15.8% of patients waiting more than six weeks, this is a decrease on the September 23 figures (24.0%). Bury's performance is worse than GMs performance of 16.9% in September 24 and is the 5th highest in GM.

- RTT Incomplete 65+ weeks – published August 24 data shows a decrease in 65+ week waits from August 24 with 162 pathways to 38 pathways in September (-124). There was a decrease in pathways in September 24 with 38 pathways, compared to September 23 when there were 752 pathways (-714 pathways).

  In September, Dermatology shows the highest decrease of pathways with 2 pathways compared to August 24 when there were 20 pathways a decrease of 18 pathways.

  Bury locality currently has the 4th lowest number of 65+ weeks wait out of all GM localities.

- 28-day wait from referral to faster diagnosis (all patients) - the percentage of patients told of a cancer diagnosis outcome within 28 days of the 2WW referral in September 24 for the Bury population was 64.0% - a decrease on September 23 which was 69.1%. Bury is currently not meeting the target of >75% and has the lowest performance out of all GM localities.

5. Recommendations

The Board are asked to note the progress and risks outlined within this paper.

Kath Wynne-Jones
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November 2024

BURY INTEGRATED CARE PARTNERSHIP

Locality Performance Report November 2024

Part of Greater Manchester Integrated Care Partnership

Presentation by:

Bury - Oversight Metrics

Show Definitions

Domain	Code	Measure	Frequency	Date	Latest	Previous	Change	Target/Median	Numerator	Denominator	Quartile
Urgent Care	N/A	A&E 4 hour performance	Monthly	Oct 24	67.3%	64.5%	↗	76.0%	4,798	7,129	N/A
	N/A	A&E Attendances	Monthly	Oct 24	7,129	6,897	↗	N/A	N/A	N/A	N/A
	S123a	Adult general & acute bed occupancy adjusted for void beds (Type 1 Only) (NCA)	Monthly	Mar 24	87.2%	88.5%	↘	92.0%	1,335	1,531	Upper
	N/A	No Reason/Criteria To Reside patients (NCTR) as % of occupied beds	Monthly	Oct 24	15.3%	18.7%	↘	N/A	1,616	10,566	N/A
	EM11	Total number of specific acute non-elective spells	Monthly	Oct 24	1,797	1,826	↘	N/A	N/A	N/A	Lower
	EM30a	Average number of adult G&A overnight beds available (NCA)	Monthly	Oct 24	91.3%	90.0%	↗	N/A	1,402	1,536	Upper
Elective Care	EM07a	GP Referrals Made (General and Acute)	Monthly	Mar 24	2,869	2,919	↘	5,744	N/A	N/A	Lower
	EM07	Total Referrals Made (General and Acute)	Monthly	Mar 24	5,369	5,443	↘	10,411	N/A	N/A	Lower
Cancer	N/A	Cancers Diagnosed At Early Stage using Full Registration Data	Annual	Dec 21	53.7%	51.7%	↗	75.0%	514	957	Inter
Mental Health & Learning Disabilities	S030a	% of patients aged 14+ with a completed LD health check	Monthly	Sep 24	32.7%	26.9%	↗	75.%	384	1,175	Inter
	EH09	Access to Children and Young Peoples Mental Health Services	Monthly	Sep 24	3,565	3,520	↗	5,343	N/A	N/A	Inter
	EAS01	Dementia: Diagnosis Rate (Aged 65+)	Monthly	Sep 24	76.1%	75.9%	↗	66.7%	1,845	2,425	Upper
	S086a	Inappropriate adult acute mental health Out of Area Placement (OAP) bed days	Monthly	Mar 24	635	685	↘	0	N/A	N/A	Inter
	N/A	Number of MH patients with no criteria to reside (NCTR)	Monthly	Oct 24	13	18	↘	N/A	N/A	N/A	Lower
	N/A	Percentage of MH patients with no criteria to reside (NCTR)	Monthly	Oct 24	13.0%	17.6%	↘	N/A	13	100	Lower
	S110a	Overall Access to Community MH Services for Adults and Older Adults with Severe Mental Illnesses	Monthly	Sep 24	1,615	1,565	↗	3,728	N/A	N/A	Lower
	S081a	Talking Therapies: Access Rate	Monthly	Sep 24	295	350	↘	N/A	N/A	N/A	Lower
	S131a	Women Accessing Specialist Community Perinatal Mental Health Services	Quarterly	Sep 24	180	170	↗	N/A	N/A	N/A	Lower
	S125a	Long length of stay for adults (60+ days)	Monthly	Sep 24	42.9%	50.0%	↘	0.%	15	35	Inter
Community	N/A	% 2-hour Urgent Community Response (UCR) first care contacts	Monthly	Sep 24	96.8%	96.1%	↗	N/A	179	185	N/A
Primary Care	S053b	% of hypertension patients who are treated to target as per NICE guidance	Annual	Mar 23	66.6%	54.7%	↗	77.%	19,957	29,979	Lower
	S053c	% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins	Quarterly	Jun 24	63.3%	63.1%	↗	62.1%	6,660	10,525	Inter
	S129a	GP appointments - percentage of regular appointments within 14 days	Monthly	Sep 24	79.0%	81.7%	↘	81.2%	62,309	78,846	Lower
Quality	S042a	E. coli blood stream infections	Monthly	Aug 23	134	128	↗	N/A	N/A	N/A	Upper
	S044a	Antimicrobial resistance: total prescribing of antibiotics in primary care	Monthly	Aug 24	85.8%	87.2%	↘	87.1%	N/A	N/A	Upper
	S044b	Antimicrobial resistance: proportion of broad-spectrum antibiotic prescribing in primary care	Monthly	Aug 24	5.9%	6.0%	↘	10.%	6,720	113,840	Upper

Bury - Oversight Metrics

The below metrics are currently missing from the report due to lack of locality level reporting or the measure is currently being built.

Theme	Indicator	
Urgent and Emergency Care	Reduce adult general and acute bed occupancy below 92%	Currently available in the scorecard at trust level but not locality
Primary Care and Community Services	Proportion of Urgent Community Response referrals reached within two hours	Currently available in the scorecard at trust level but not locality
	% patients describing their overall experience of making a GP appointment as good	Build in progress
	Proportion of virtual ward beds occupied	Currently unavailable at locality level due to inaccurate reporting

Bury

A&E 4 hour performance
Number of attendances at A&E departments, and of these, the number of attendances where the patient spent less than 4 hours from time of arrival to time of admission, or discharge, or transfer.

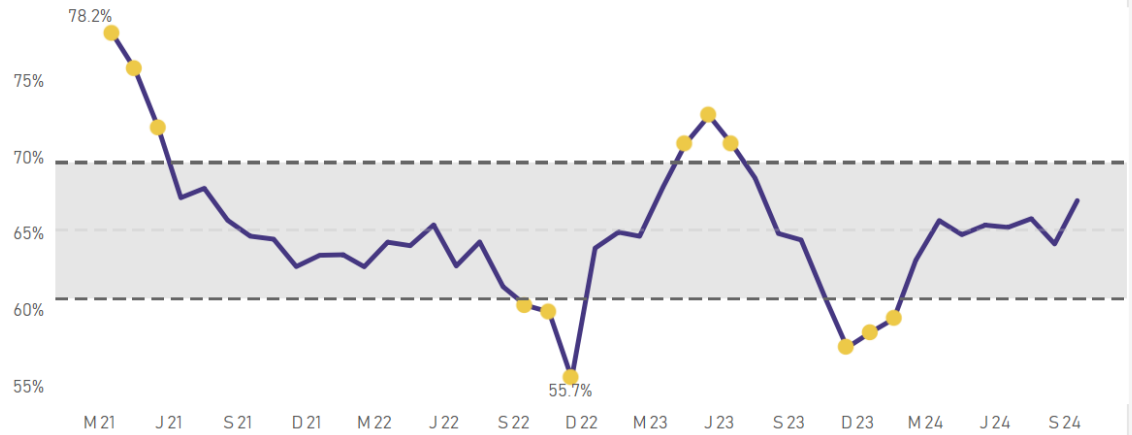
Source: Emergency Care Dataset (ECDS) (Monthly)

67.3%
October 2024

64.5%
September 2024

76.0%
National Target

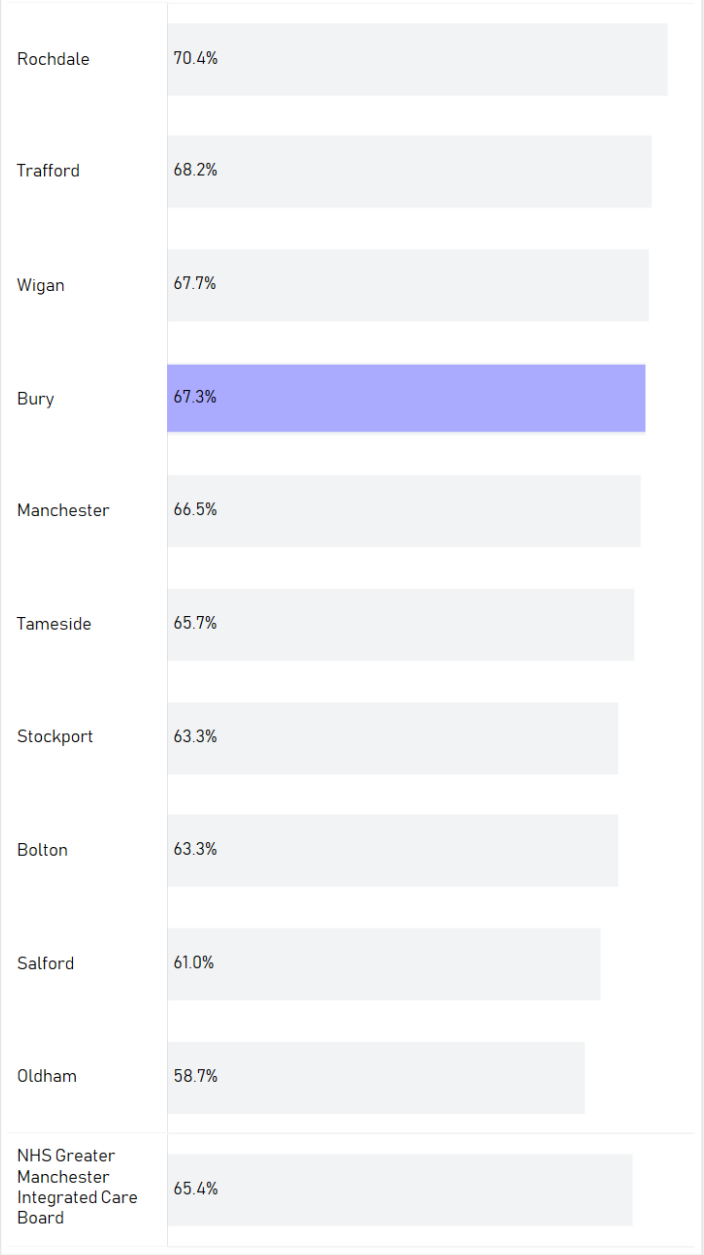
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	78.2%	75.9%	72.1%	67.5%	68.1%	66.0%	65.0%	64.8%	63.0%	63.7%	63.8%	63.0%
2022-23	64.6%	64.4%	65.7%	63.0%	64.6%	61.7%	60.5%	60.0%	55.7%	64.2%	65.2%	65.0%
2023-24	68.2%	71.0%	72.9%	71.0%	68.8%	65.2%	64.7%	61.1%	57.7%	58.7%	59.6%	63.4%
2024-25	66.0%	65.1%	65.7%	65.6%	66.1%	64.5%	67.3%					

Selected measure at October 2024 has continuously increased for 1 period(s) of time

Latest Value GM Benchmarking



Narrative

- This metric is subject to daily review.
- 4-hour performance in Oct was 67.3%, an increase on the previous month's performance of 64.5%.
- Oct 24 performance is 67.3% which is higher than Oct 23 which was 64.7%.
- Bury performance is currently above the overall GM performance of 65.4% and is the 4th best performing locality in GM.

Bury

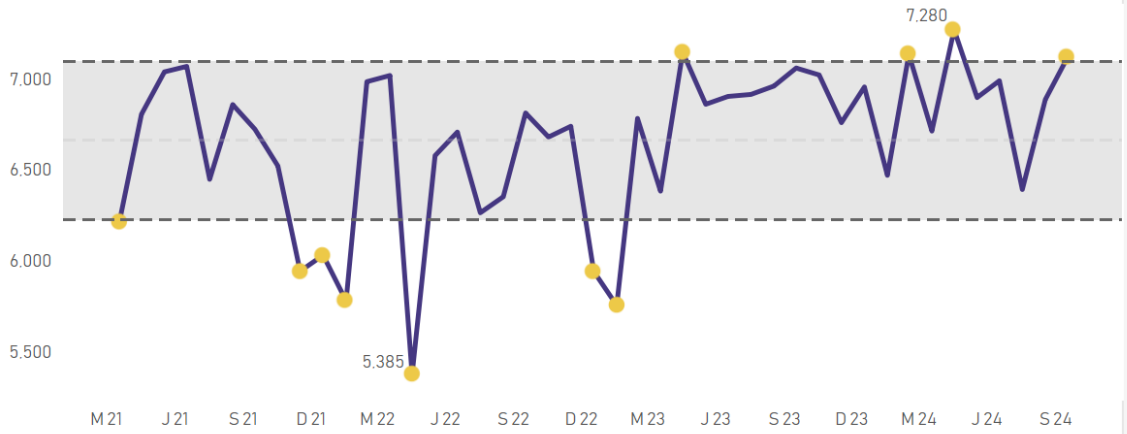
A&E Attendances
Number of attendances at A&E departments

Source: Emergency Care Dataset (ECDS) (Monthly)

7,129
October 2024

6,897
September 2024

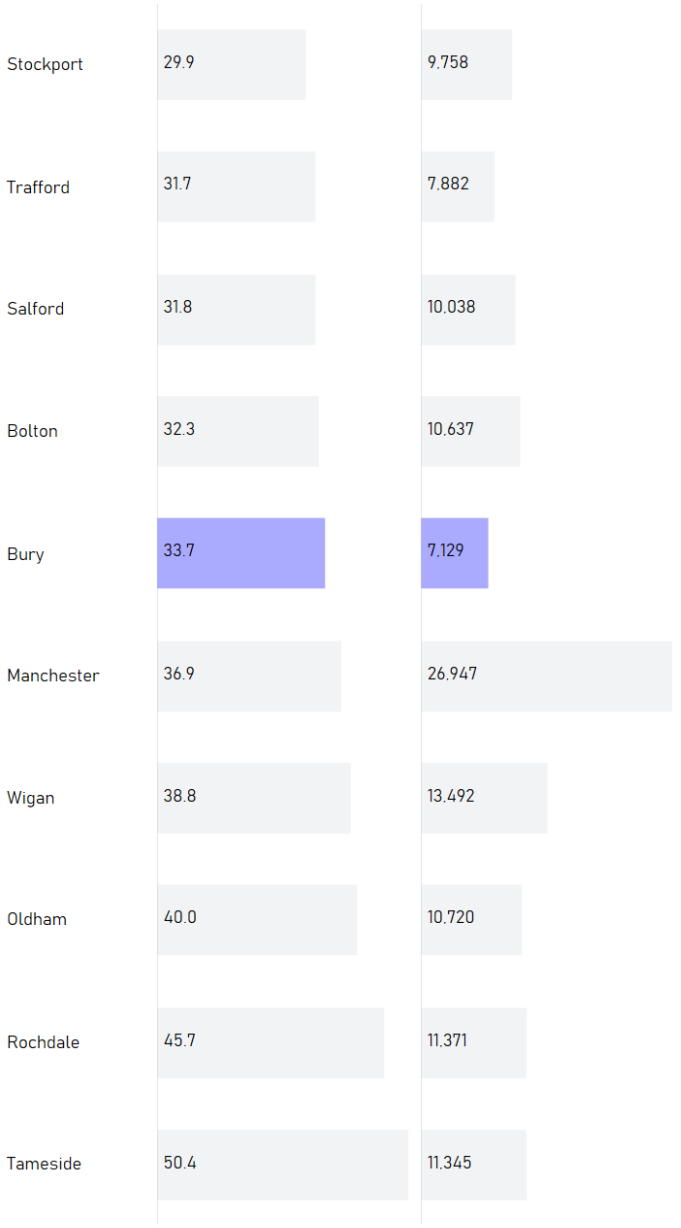
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	6.220	6.816	7.049	7.079	6.459	6.869	6.734	6.532	5.954	6.042	5.791	6.995
2022-23	7.029	5.385	6.589	6.718	6.275	6.363	6.823	6.691	6.750	5.953	5.766	6.793
2023-24	6.394	7.156	6.871	6.914	6.925	6.971	7.070	7.032	6.770	6.966	6.481	7.145
2024-25	6.724	7.280	6.908	7.000	6.403	6.897	7.129					

Selected measure at October 2024 has continuously increased for 1 period(s) of time

Latest Value GM Benchmarking
Attendances Rate per 1000 population & Count



Narrative

- There were 7129 A&E attendances from Bury registered patients in Oct 24, higher than Oct 23 (7070).
- Bury currently has 33.7 attendances per 1000 population and has the 5th lowest attendance rate for localities within GM.

Bury

No Reason/Criteria To Reside patients (NCTR) as % of occupied beds
Total occupied beds, and of these, the number of patients who are fit for discharge and have no need to reside in a hospital bed

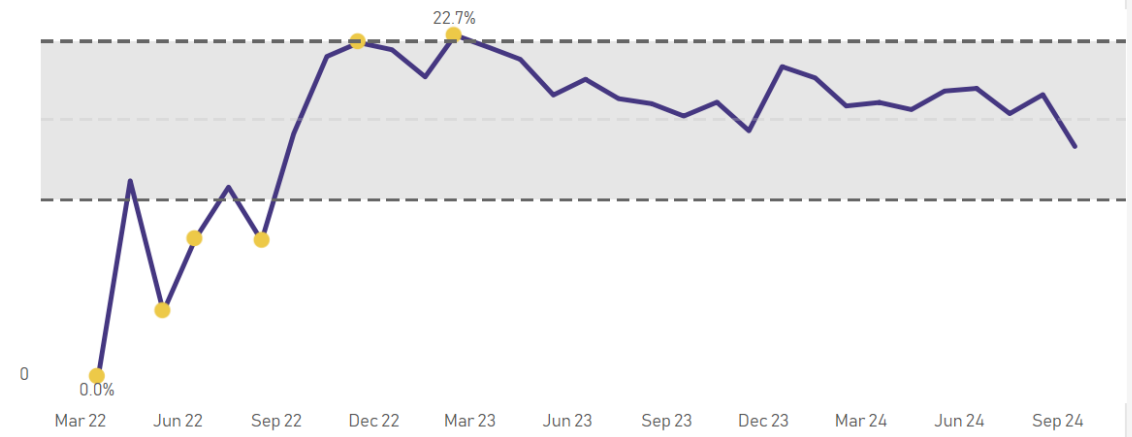
Source: GM Admissions - Local (Monthly)

15.3%
October 2024

18.7%
September 2024

No Target

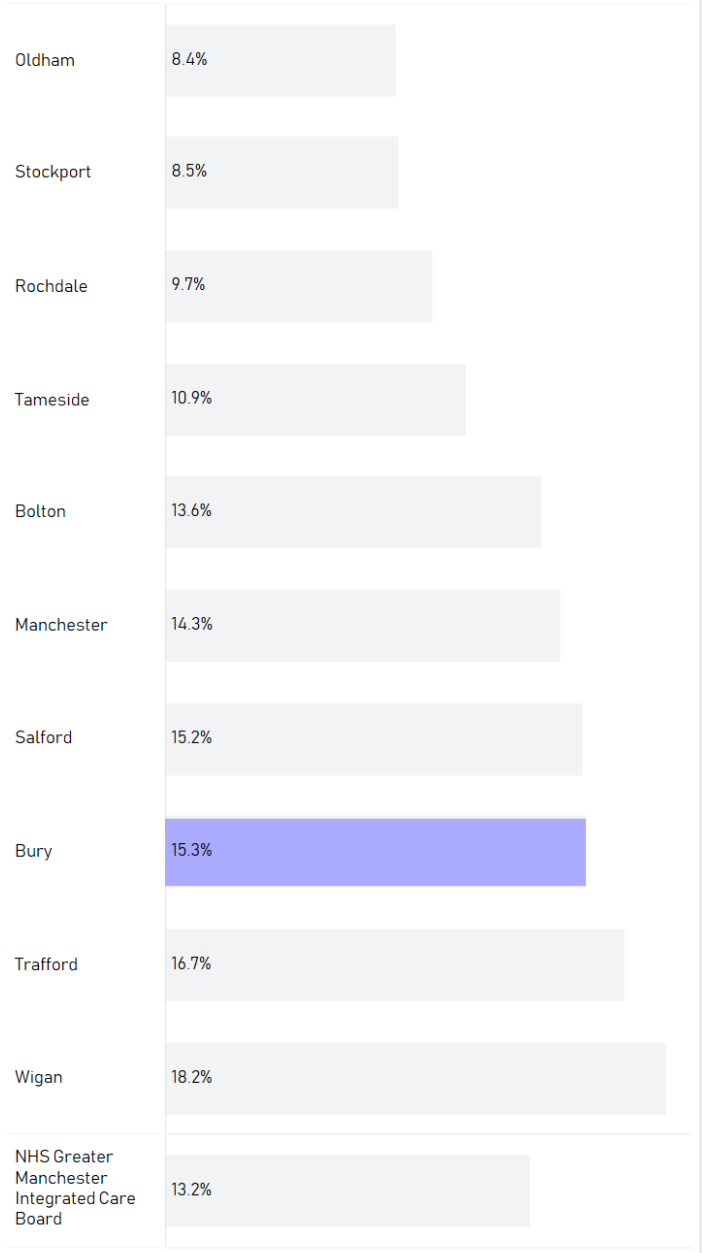
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	0.0%	13.0%	4.3%	9.2%	12.6%	9.0%	16.1%	21.3%	22.2%	21.7%	19.9%	22.7%
2023-24	21.9%	21.1%	18.7%	19.7%	18.5%	18.1%	17.3%	18.2%	16.3%	20.6%	19.8%	18.0%
2024-25	18.2%	17.7%	19.0%	19.1%	17.5%	18.7%	15.3%					

Selected measure at October 2024 has continuously decreased for 1 period(s) of time

Latest Value GM Benchmarking



Narrative

- This metric is subject to daily review.
- NCTR percentage for Bury in Oct 24 is 15.3% which is a decrease on Sept 24 which was 18.7%
- Bury is currently higher than the GM percentage of 13.2% and has the 8th highest percentage of the GM localities.

Bury

Total number of specific acute non-elective spells
Number of specific acute non-elective spells in the period (auto-calculated sum of E.M.11a and E.M.11b)

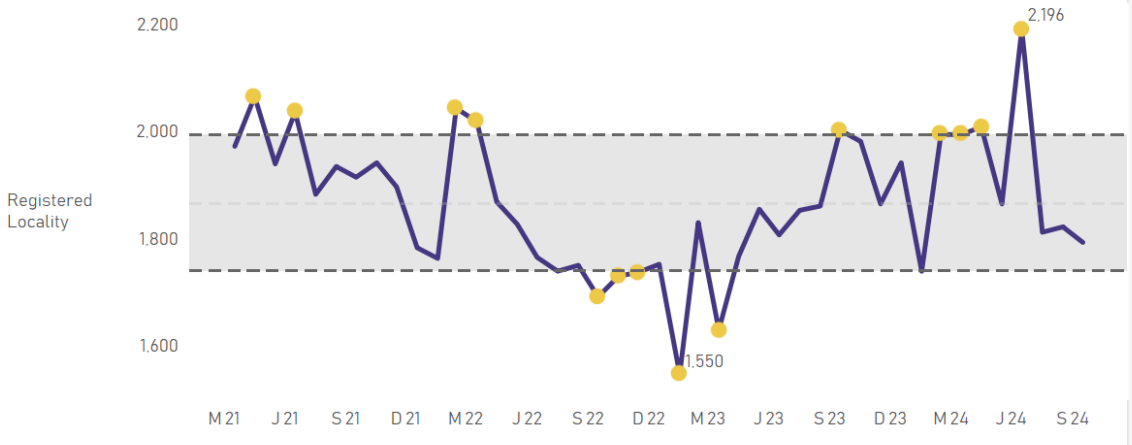
Source: National Flows APC (Monthly)

1,797
October 2024

1,826
September 2024

83/91
National Rank
Lower Quartile

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	1,977	2,070	1,944	2,041	1,887	1,939	1,919	1,946	1,901	1,787	1,767	2,048
2022-23	2,023	1,873	1,831	1,769	1,743	1,754	1,695	1,734	1,741	1,756	1,550	1,834
2023-24	1,633	1,771	1,859	1,811	1,857	1,865	2,007	1,986	1,869	1,946	1,743	1,999
2024-25	1,999	2,013	1,869	2,196	1,816	1,826	1,797					

Selected measure at October 2024 has continuously decreased for 1 period(s) of time

Latest Value GM Benchmarking
Count & Rate Per 1000 Population

Narrative

- There were 1797 specific acute non-elective spells from Bury registered patients in Oct 24, Lower than oct 23 (2007)
- Bury currently has 8.5 specific acute non-elective spells per 1000 population and has the 5th lowest rate per 1000 for localities within GM.

NCA

Trust level - not locality

Average number of adult G&A overnight beds available

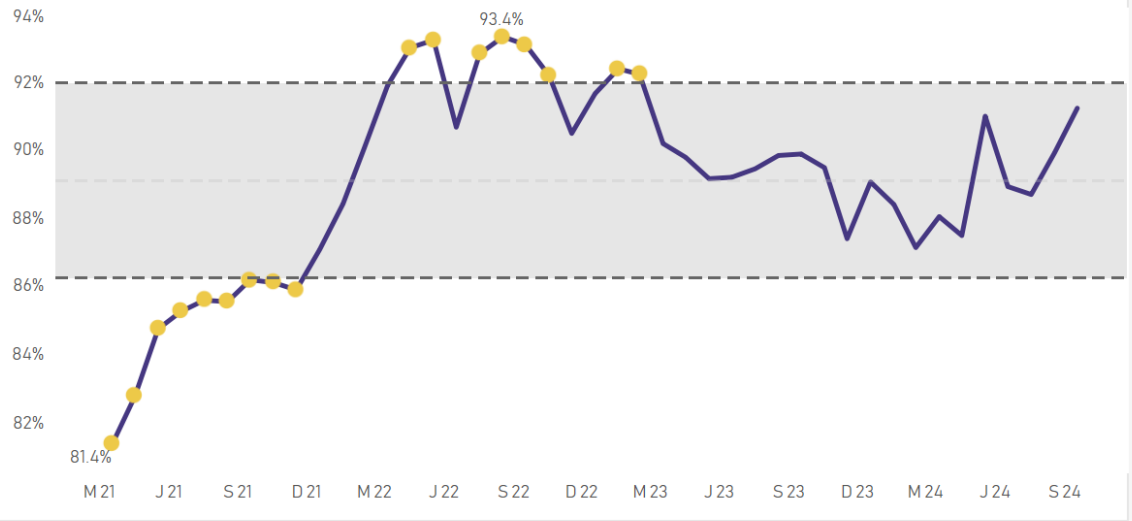
The percentage of adult general and acute (G&A) overnight beds that are occupied, as an average over a monthly period. This uses the UEC daily sitrep definition of a general and acute bed open/occupied as at 8am each day. They exclude maternity and mental health beds.

Source: UEC Daily Sitrep (Monthly)

91.3%
October 2024

90.0%
September 2024

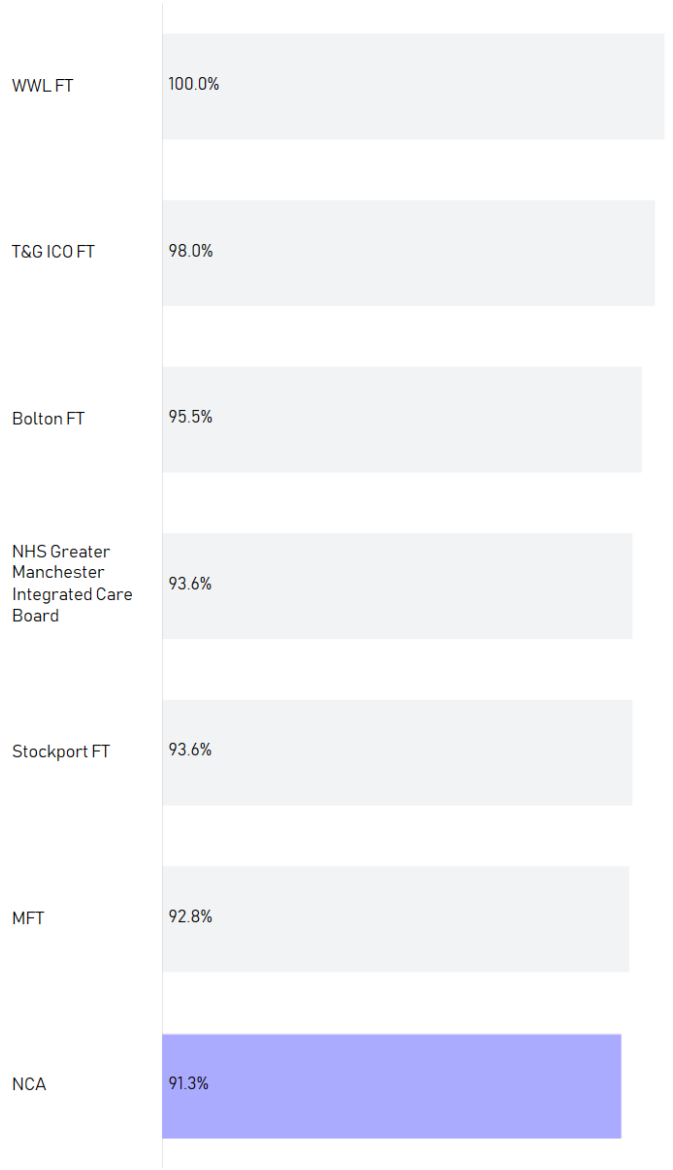
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	91.9%	93.0%	93.3%	90.7%	92.9%	93.4%	93.1%	92.2%	90.5%	91.7%	92.4%	92.3%
2023-24	90.2%	89.8%	89.2%	89.2%	89.5%	89.9%	89.9%	89.5%	87.4%	89.1%	88.4%	87.2%
2024-25	88.1%	87.5%	91.0%	89.0%	88.7%	90.0%	91.3%					

Latest Value GM Benchmarking

National Rank against other localities



Narrative

- NCA had an adult and acute beds occupancy rate of 91.3% in Oct 24. The lowest of the GM Trusts.
- This data shows NCA position across all NCA sites, not just FGH.
- Bury patients will also attend MFT.
- GM occupancy rate is 93.6% for Oct 24.

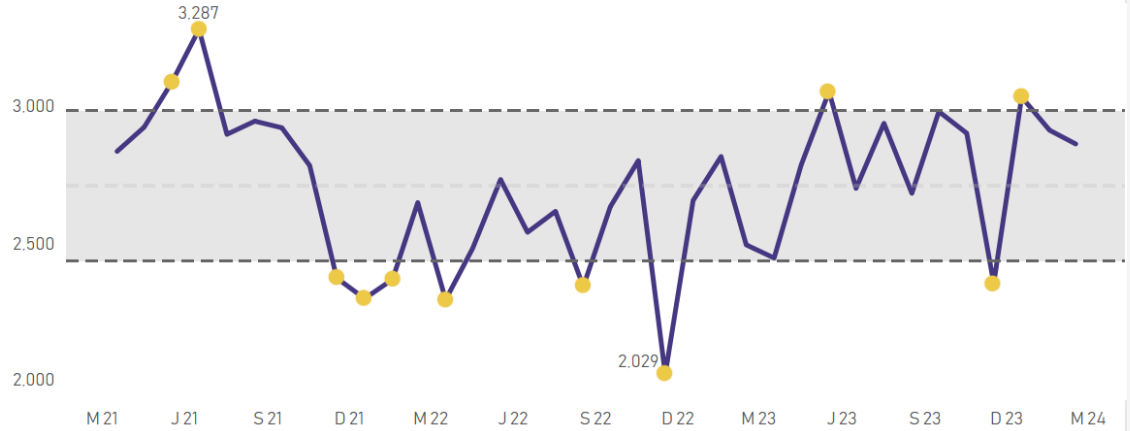
Bury

GP Referrals Made (General and Acute)
Total GP Referrals made for 1st Consultant led OP appointments in specific acute treatment functions

Source: Monthly Referral Return (MRR) (Monthly)

2,869	2,919	94/107	5,744
March 2024	February 2024	National Rank Lower Quartile	National Median

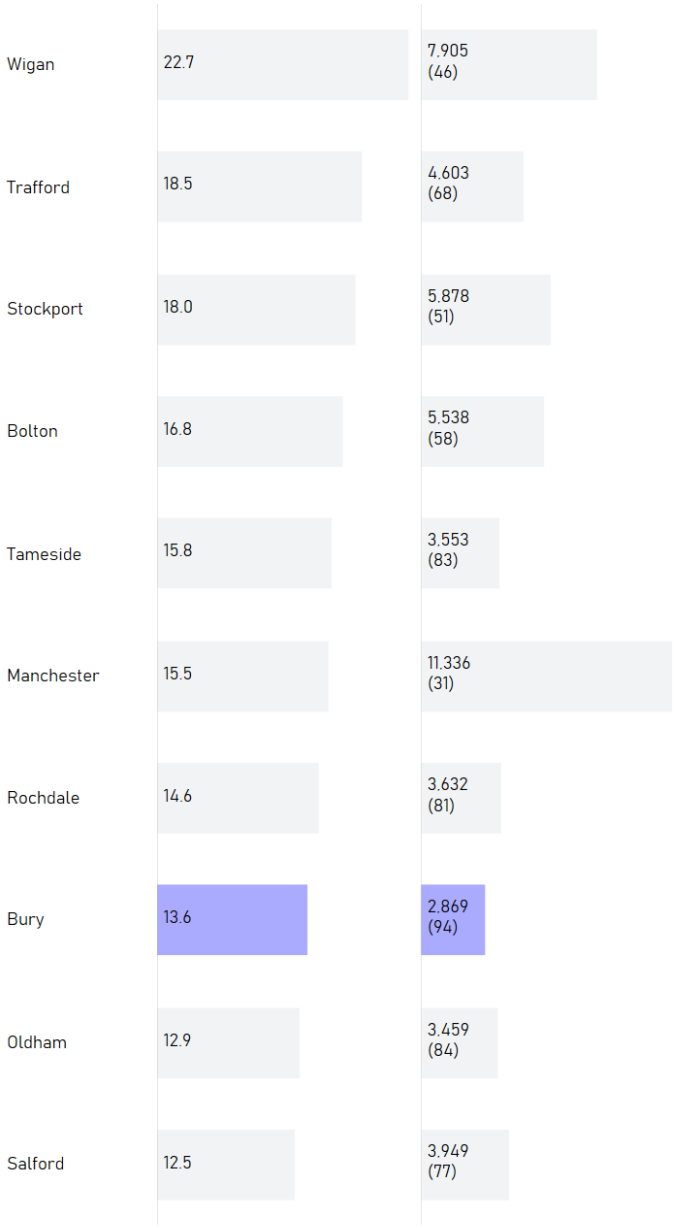
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	2.842	2.930	3.095	3.287	2.904	2.952	2.928	2.790	2.380	2.305	2.375	2.655
2022-23	2.301	2.488	2.739	2.547	2.623	2.349	2.640	2.808	2.029	2.663	2.823	2.501
2023-24	2.453	2.792	3.060	2.707	2.944	2.689	2.987	2.908	2.360	3.040	2.919	2.869

Selected measure at March 2024 has continuously decreased for 2 period(s) of time

Latest Value GM Benchmarking
Rate per 1000 / Count (National Rank based on count)



Narrative

- There were 2869 GP referrals made for Bury registered patients in March 24, higher than March 23 (2501).
- Bury currently has 13.6 GP referrals made per 1000 population and has the 3rd lowest rate per 1000 for localities within GM.

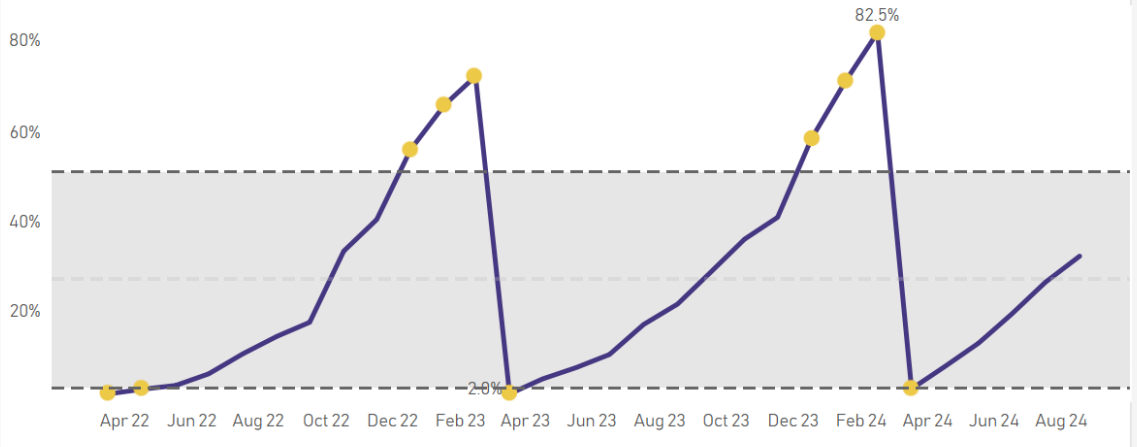
Bury

% of patients aged 14+ with a completed LD health check
The % of people on the QOF Learning Disability Register who received an annual health check between the start of the financial year and the end of the reporting period

Source: Learning Disabilities Health Check Scheme (Monthly)

32.7%	26.9%	34/106	75.%
September 2024	August 2024	National Rank Inter Quartile	National Target

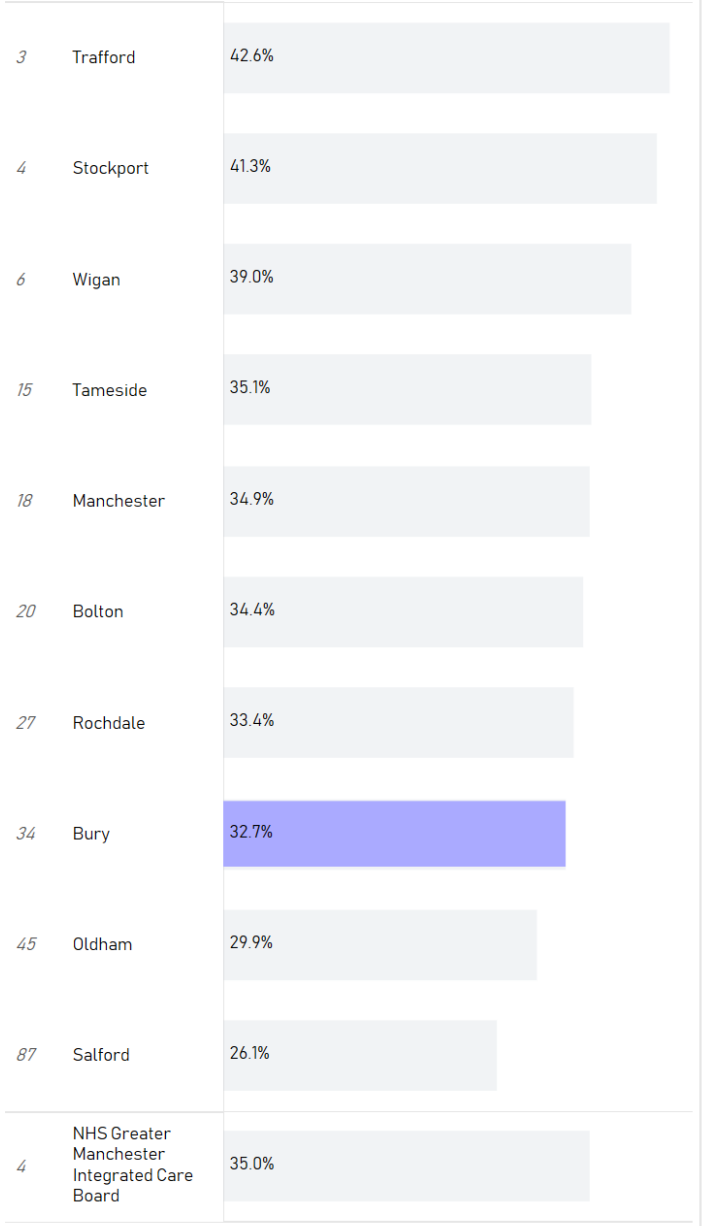
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	2.0%	3.1%	3.9%	6.5%	10.9%	14.8%	18.0%	33.8%	40.8%	56.4%	66.4%	72.7%
2023-24	2.0%	5.4%	7.9%	10.8%	17.5%	22.0%	29.1%	36.5%	41.3%	58.9%	71.7%	82.5%
2024-25	3.2%	8.1%	13.3%	19.8%	26.9%	32.7%						

Selected measure at September 2024 has continuously increased for 5 period(s) of time

Latest Value GM Benchmarking
National Rank against other localities



Narrative

- The percentage of patients aged 14+ having received an LD health check in Sept 24 is 32.7%, which is an increase on Sept 23 which was 22.0%.
- Bury is currently lower than the GM percentage of 35.9% and has the 8th highest percentage of the GM localities.
- For the last 2 years Bury has delivered the majority of annul checks in the months Jan to March
- Bury and GM have not met the national target

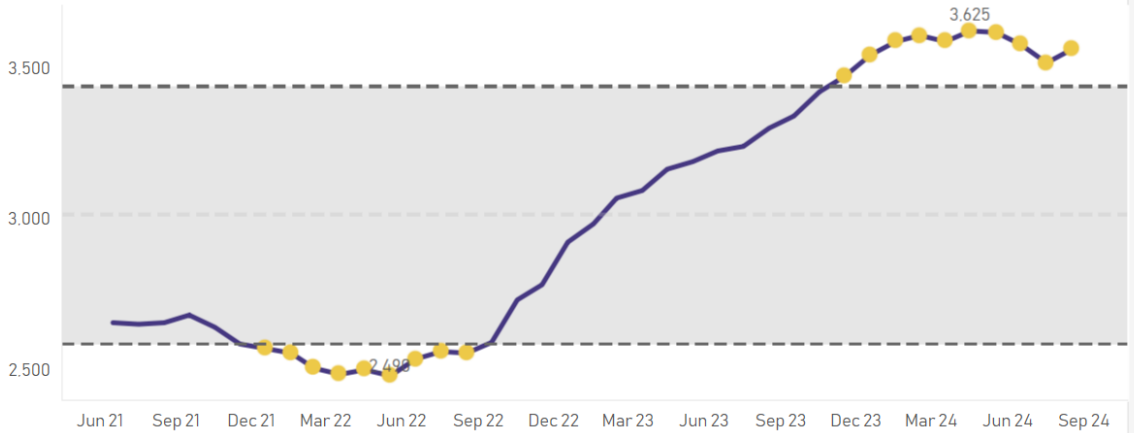
Bury

Access to Children and Young Peoples Mental Health Services
Access to Children and Young Peoples Mental Health Services

Source: Published MHSDS (Monthly)

3,565	3,520	78/106	5,343
September 2024	August 2024	National Rank Inter Quartile	National Median

Outliers more than 1 standard deviation from the mean

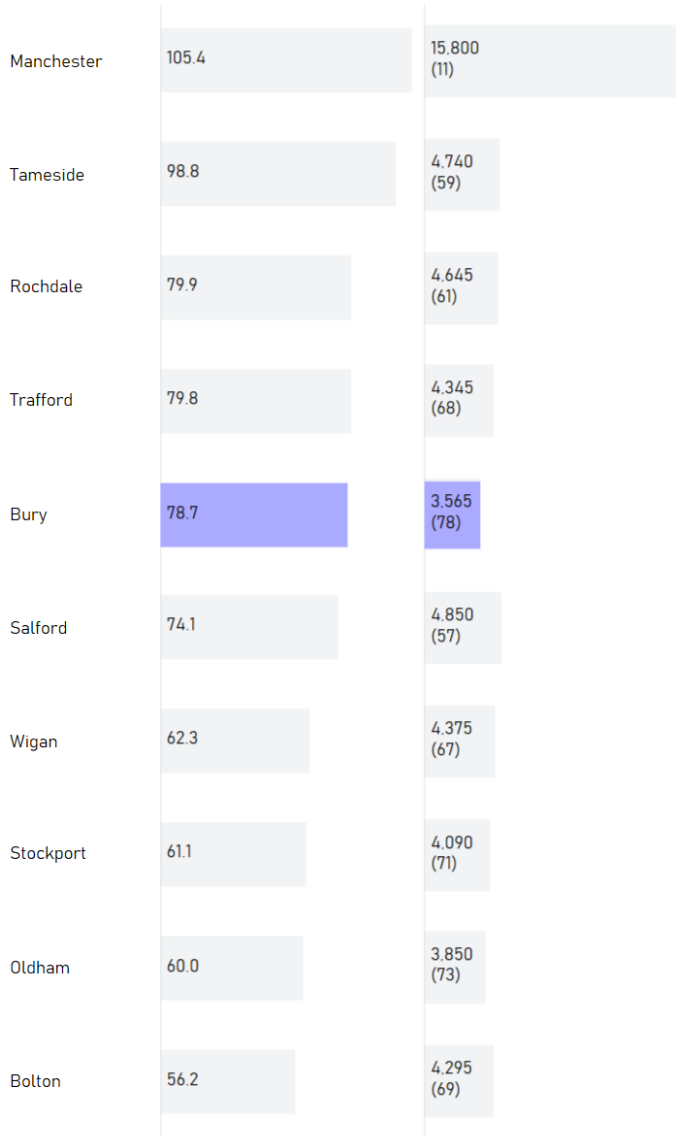


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22				2.665	2.660	2.665	2.690	2.650	2.595	2.580	2.565	2.515
2022-23	2.495	2.510	2.490	2.545	2.570	2.565	2.600	2.740	2.790	2.930	2.990	3.075
2023-24	3.100	3.170	3.195	3.230	3.245	3.305	3.345	3.425	3.475	3.545	3.590	3.610
2024-25	3.590	3.625	3.620	3.580	3.520	3.565						

Selected measure at September 2024 has continuously increased for 1 period(s) of time

Latest Value GM Benchmarking

Rate per 1000 | Count (National Rank based on count)



The rate is calculated using the 0-17 population figure for each locality | Bury: 45,310

Narrative

- There were 3565 accesses to Children and Young Peoples Mental Health Services for Bury registered patients in Sept 24, higher than Sept 23 (3305).
- Bury currently has 78.7 accesses made per 1000 population and has the 5th highest rate per 1000 for localities within GM, but is on course against the usual annual trajectory in Bury.

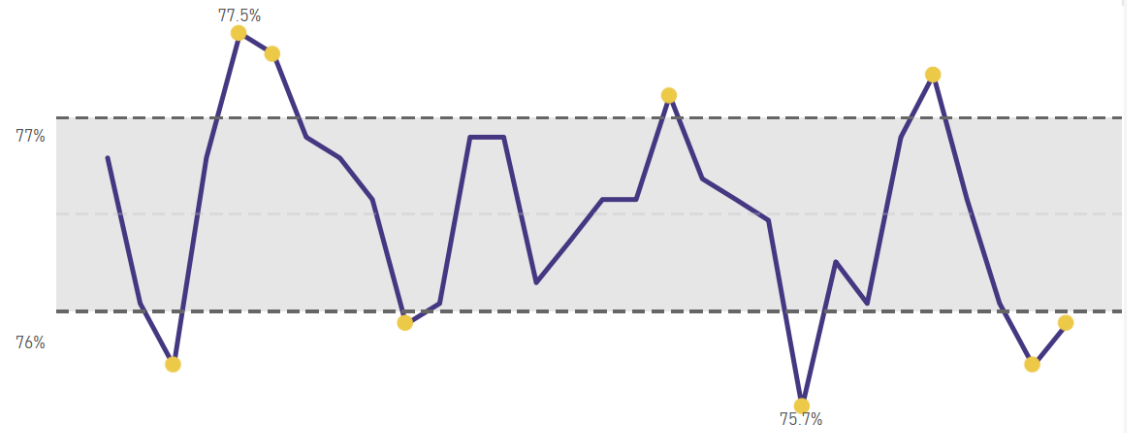
Bury

Dementia: Diagnosis Rate (Aged 65+)
Diagnosis rate for people aged 65 and over, with a diagnosis of dementia recorded in primary care, expressed as a percentage of the estimated prevalence based on GP registered populations.

Source: Primary Care Dementia Data (Monthly)

76.1%	75.9%	10/106	66.7%
September 2024	August 2024	National Rank Upper Quartile	National Target

Outliers more than 1 standard deviation from the mean

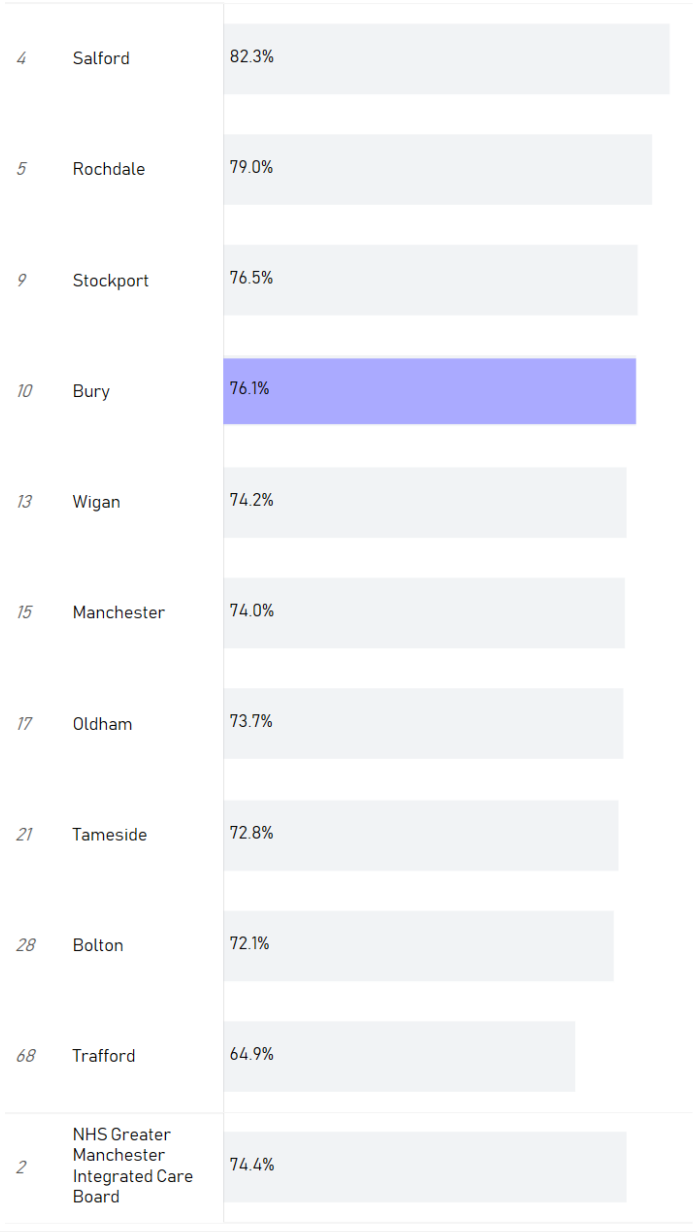


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	76.9%	76.2%	75.9%	76.9%	77.5%	77.4%	77.0%	76.9%	76.7%	76.1%	76.2%	77.0%
2023-24	77.0%	76.3%	76.5%	76.7%	76.7%	77.2%	76.8%	76.7%	76.6%	75.7%	76.4%	76.2%
2024-25	77.0%	77.3%	76.7%	76.2%	75.9%	76.1%						

Selected measure at September 2024 has continuously increased for 1 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities



Narrative

- The percentage of patients aged 65+ having received a dementia diagnosis as of Sept 24 is 76.1%, which is Lower than Sept 23 which was 77.2%
- Bury currently has a higher diagnosis rate than GM which has a rate of 74.4%. Bury has the 4th highest dementia diagnosis rate of the GM localities.
- Bury and GM are both above the national target of 66.7%.

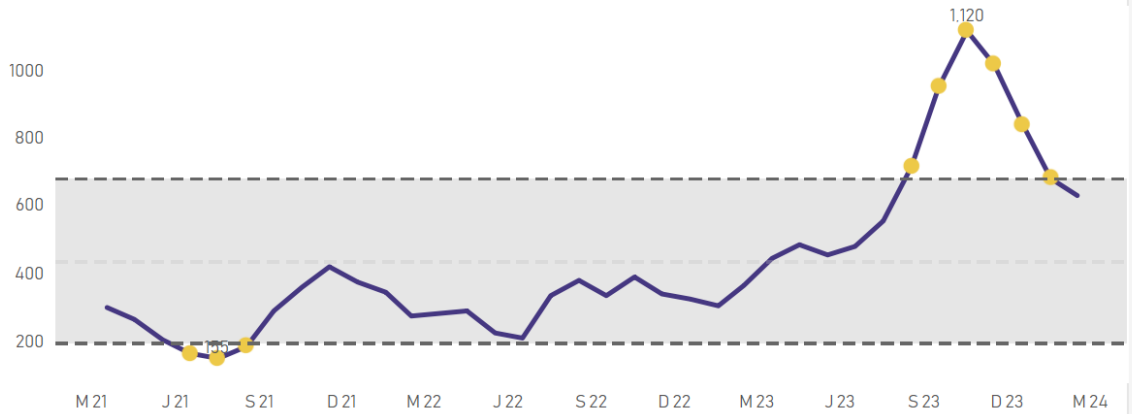
Bury

Inappropriate adult acute mental health Out of Area Placement (OAP) bed days
Number of inappropriate OAP bed days for adults that are either 'internal' or 'external' to the sending provider

Source: Out of Area Placements in Mental Health Services Official Statistics (Monthly)

635	685	79/107	0
March 2024	February 2024	National Rank Inter Quartile	National Target

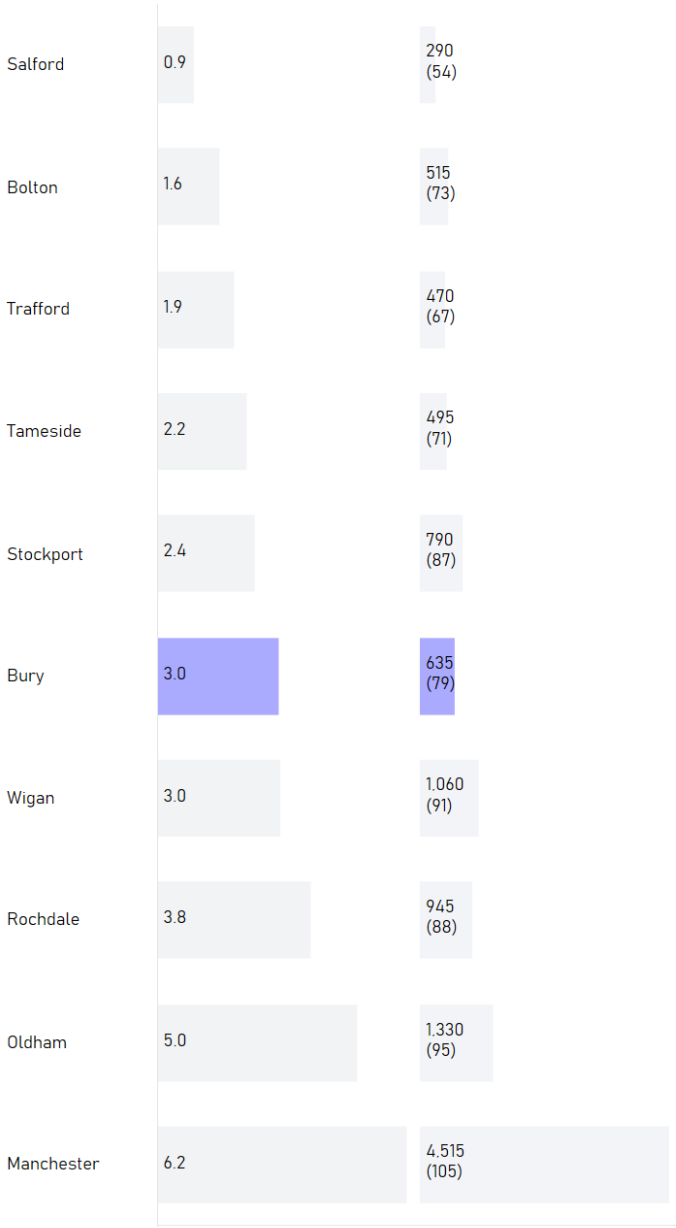
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	305	270	210	170	155	190	295	365	425	380	350	280
2022-23		295	230	215	340	385	340	395	345	330	310	370
2023-24	450	490	460	485	560	720	955	1,120	1,020	845	685	635

Selected measure at March 2024 has continuously decreased for 4 period(s) of time

Latest Value GM Benchmarking
Rate per 1000 / Count (National rank)



Narrative

- Latest data confirms OAP is zero in Bury and has been either 1 or 0 for the last month.
- There were 635 inappropriate OAP bed days for Bury registered patients in March 24, higher than March 23 (370).
- These are subject to real time daily and weekly monitoring by multi-agency teams and there is a slight lag in the formally reported data.
- Bury currently has 3.0 OAP bed days per 1000 population and has the joint 6th highest rate with Wigan per 1000 for localities within GM.

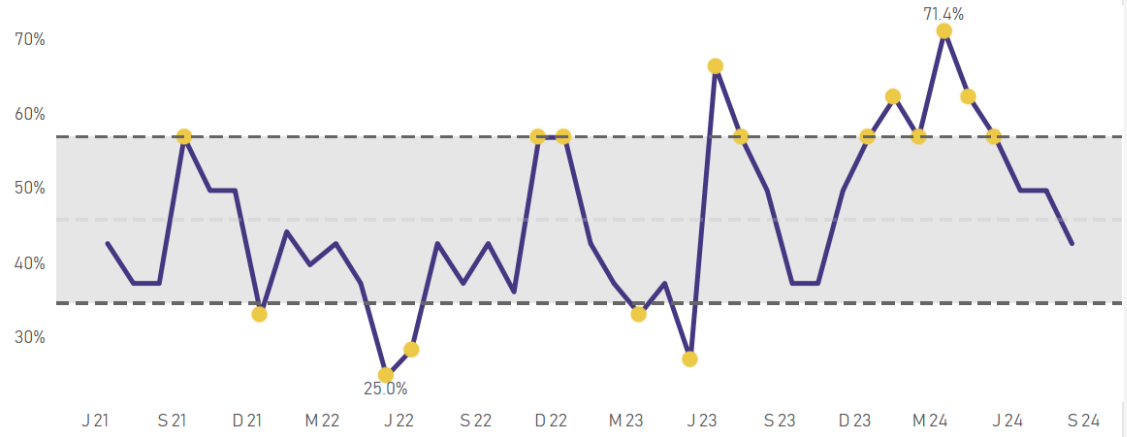
Bury

Long length of stay for adults (60+ days) - Mental Health Patients
Proportion of all discharges from adult acute and older adult acute beds, with a length of stay of over 60 days

Source: Published MHSDS (Monthly)

42.9%	50.0%	53/95	0.%
September 2024	August 2024	National Rank Inter Quartile	National Target

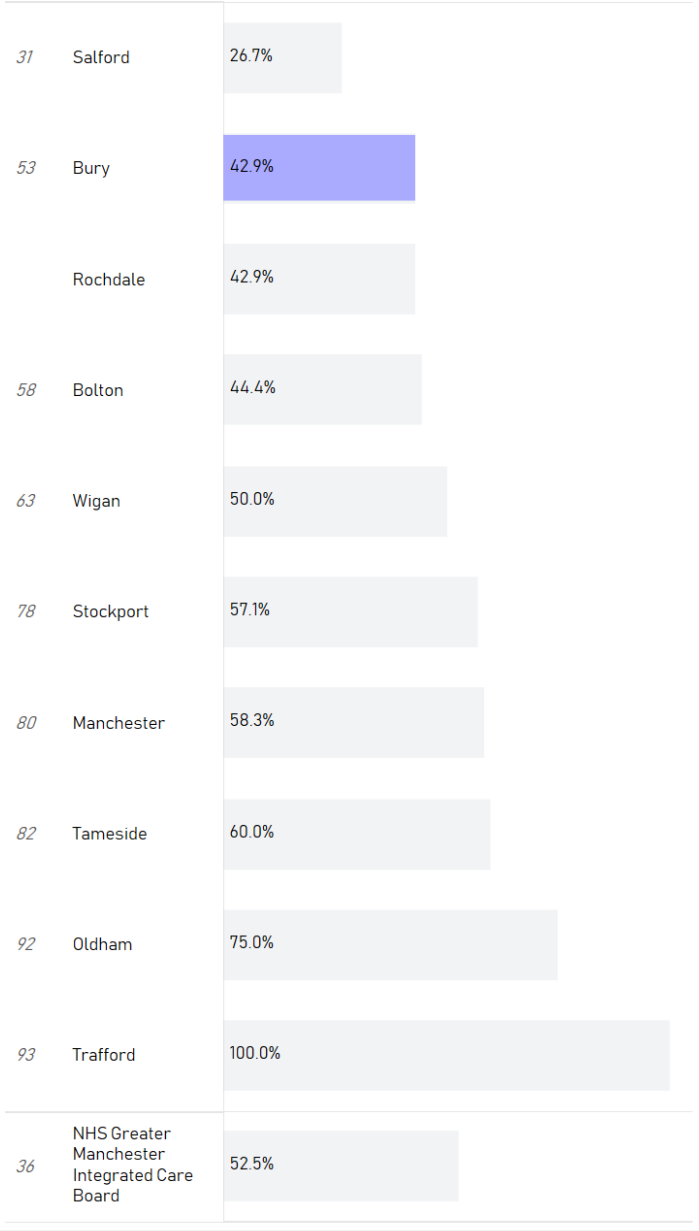
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22				42.9%	37.5%	37.5%	57.1%	50.0%	50.0%	33.3%	44.4%	40.0%
2022-23	42.9%	37.5%	25.0%	28.6%	42.9%	37.5%	42.9%	36.4%	57.1%	57.1%	42.9%	37.5%
2023-24	33.3%	37.5%	27.3%	66.7%	57.1%	50.0%	37.5%	37.5%	50.0%	57.1%	62.5%	57.1%
2024-25	71.4%	62.5%	57.1%	50.0%	50.0%	42.9%						

Selected measure at September 2024 has continuously decreased for 1 period(s) of time

Latest Value GM Benchmarking
National Rank against other localities



Narrative

- The proportion of discharges with a long LOS in Sept 24 is 42.9%, which is a decrease on Sept 23 which was 50.0%.
- Bury currently has a lower proportion with a long LOS than GM which has a proportion of 52.5% and Bury has the 2nd lowest proportion of the GM localities.
- Bury and GM are above the national target of 0%.

Bury

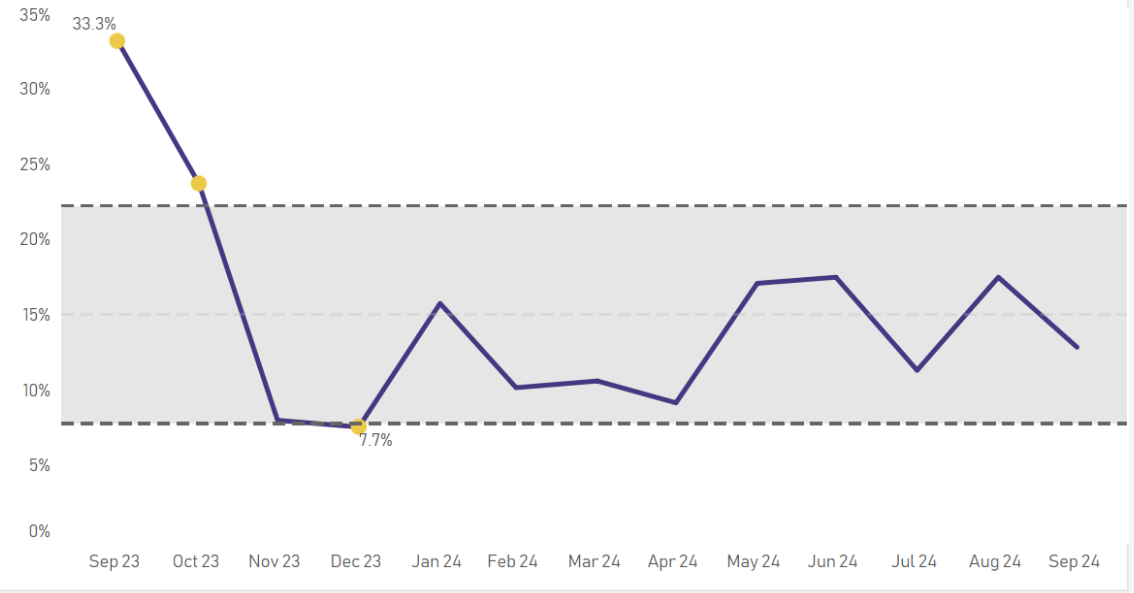
Percentage of MH patients with no criteria to reside (NCTR)
Percentage of beds occupied by MH patients who are ready to be discharged

Source: GM Admissions - Local (Monthly)

13.0%
October 2024

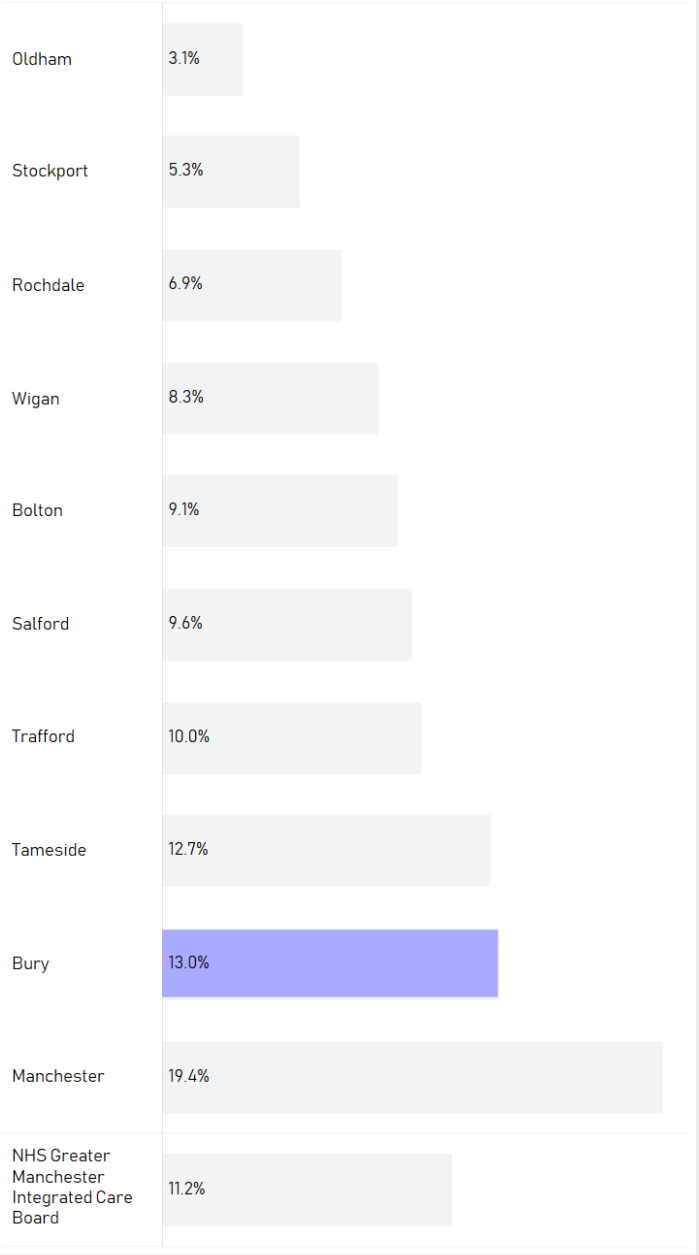
17.6%
September 2024

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023-24							33.3%	23.9%	8.1%	7.7%	15.9%	10.3%
2024-25	10.8%	9.3%	17.2%	17.6%	11.5%	17.6%	13.0%					

Latest Value GM Benchmarking



Narrative

- The percentage of mental health patients with NCTR as of Oct 24 is 13.0%, which is a decrease from Sept 24 which was 17.6%
- Bury currently has a higher percentage than GM which is 11.2%.
- Bury has the 2nd highest percentage Rate of the GM localities.

Bury

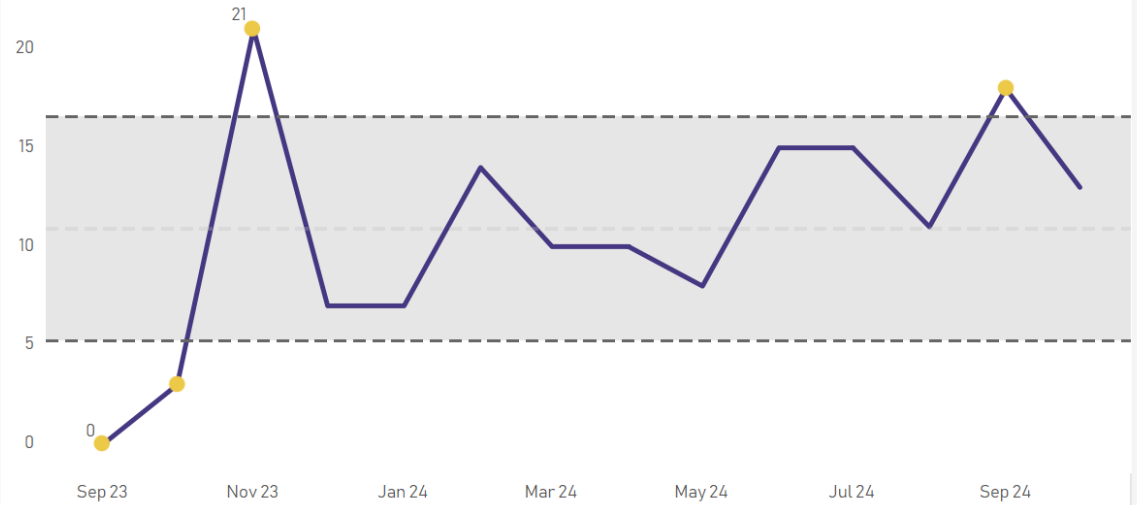
Number of MH patients with no criteria to reside (NCTR)
Number of beds occupied by MH patients who are ready to be discharged

Source: GM Admissions - Local (Monthly)

13
October 2024

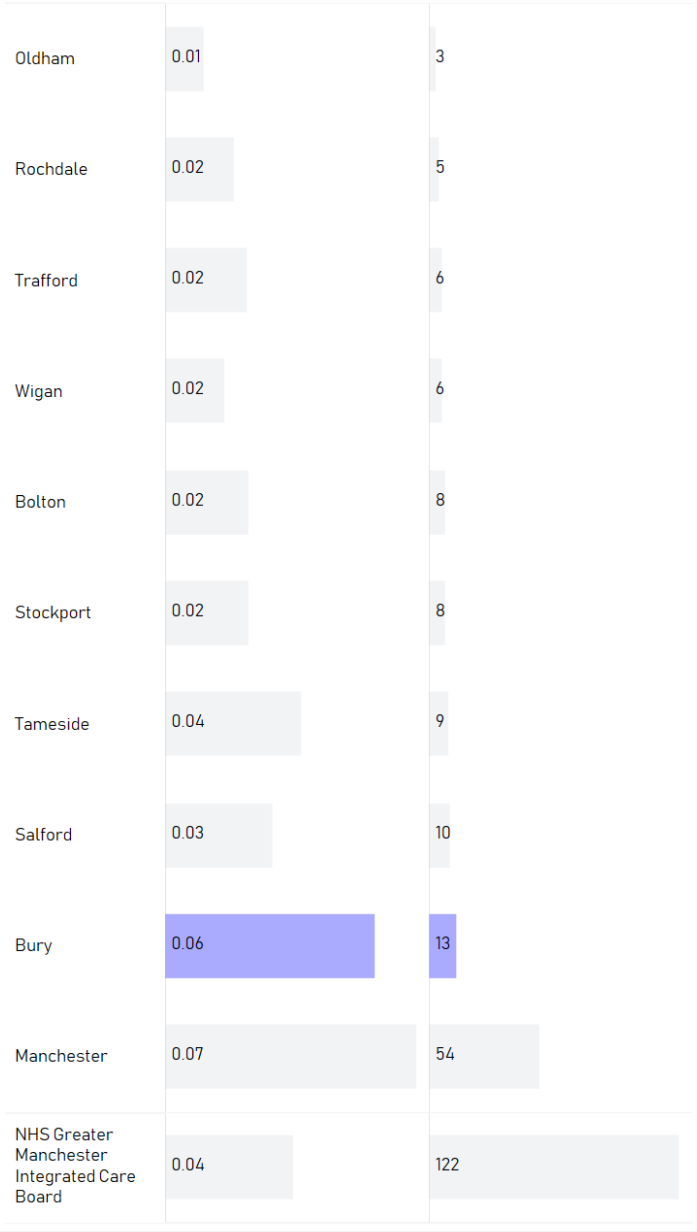
18
September 2024

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023-24						0	3	21	7	7	14	10
2024-25	10	8	15	15	11	18	13					

Latest Value GM Benchmarking
Rate per 1000 / Count



Narrative

- This metric is subject to daily review.
- The number of mental health patients with NCTR as of Oct 24 is 13, which is Lower than the figure for Sept 24 which was 18
- Bury currently has 0.06 mental health patients with NCTR per 1000 population and has the 2nd highest rate in locality within GM.

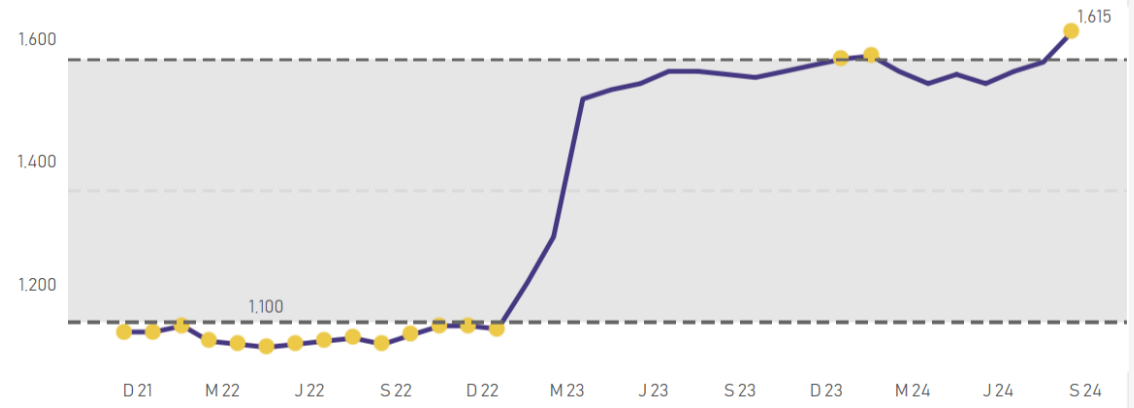
Bury

Overall Access to Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses
Number of people who receive two or more contacts from NHS or NHS commissioned community mental health services (in transformed and non-transformed PCNs) for adults and older adults with severe mental illnesses, in a rolling 12 month period

Source: Published MHSDS (Monthly)

1,615	1,565	86/106	3,728
September 2024	August 2024	National Rank Lower Quartile	National Median

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22									1.125	1.125	1.135	1.110
2022-23	1.105	1.100	1.105	1.110	1.115	1.105	1.120	1.135	1.135	1.130	1.205	1.280
2023-24	1.505	1.520	1.530	1.550	1.550	1.545	1.540	1.550	1.560	1.570	1.575	1.550
2024-25	1.530	1.545	1.530	1.550	1.565	1.615						

Selected measure at September 2024 has continuously increased for 3 period(s) of time

Latest Value GM Benchmarking
Rate per 1000 | Count (National Rank)

The rate is calculated using the 18+ population figure for each locality | Bury: 166,400

Narrative

- There were 1615 people who received two or more contacts from mental health services for adults with severe mental illness for Bury registered patients in Sept 24, higher than both Aug 24 (1565) and Sept 23 (1545).
- Bury currently has 9.7 contacts per 1000 population and has the 4th lowest rate per 1000 for localities within GM.

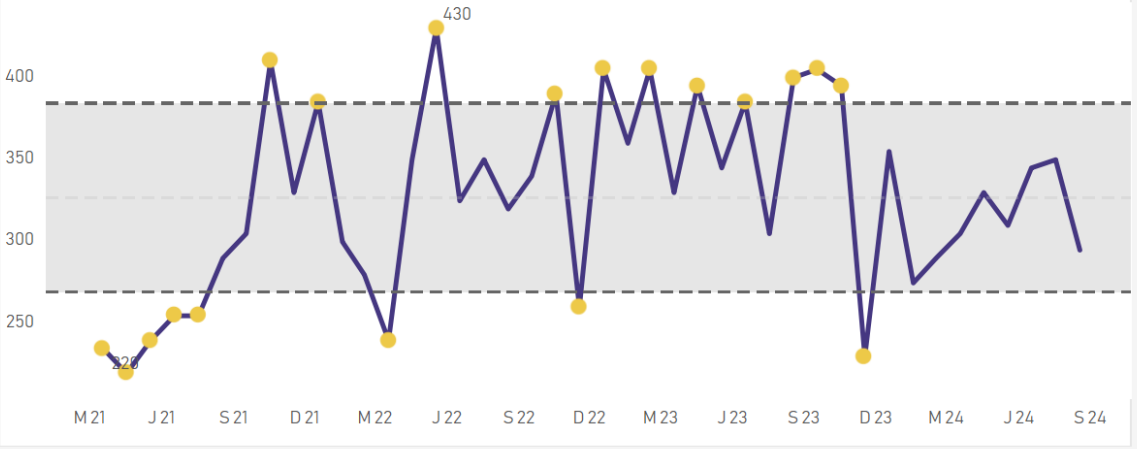
Bury

Talking Therapies: Access Rate
This indicator tracks our ambition to expand Improving Access to Psychological Therapies (IAPT) services, also known as NHS Talking Therapies. The primary purpose of this indicator is to measure improvements in access to psychological therapy (via IAPT) for people with depression and/or anxiety disorders.

Source: Improving Access to Psychological Therapies Data Set (Monthly)

295	350	92/110	No Target
September 2024	August 2024	National Rank Lower Quartile	

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	235	220	240	255	255	290	305	410	330	385	300	280
2022-23	240	350	430	325	350	320	340	390	260	405	360	405
2023-24	330	395	345	385	305	400	405	395	230	355	275	290
2024-25	305	330	310	345	350	295						

Selected measure at September 2024 has continuously decreased for 1 period(s) of time

Latest Value GM Benchmarking
Rate per 1000 / Count (National rank)

Narrative

- There were 295 accesses to Talking Therapies for Bury registered patients in Sept 24, lower than Sept 23 (400)
- Bury currently has 1.4 accesses per 1000 population and has the 7th lowest rate per 1000 for localities within GM.

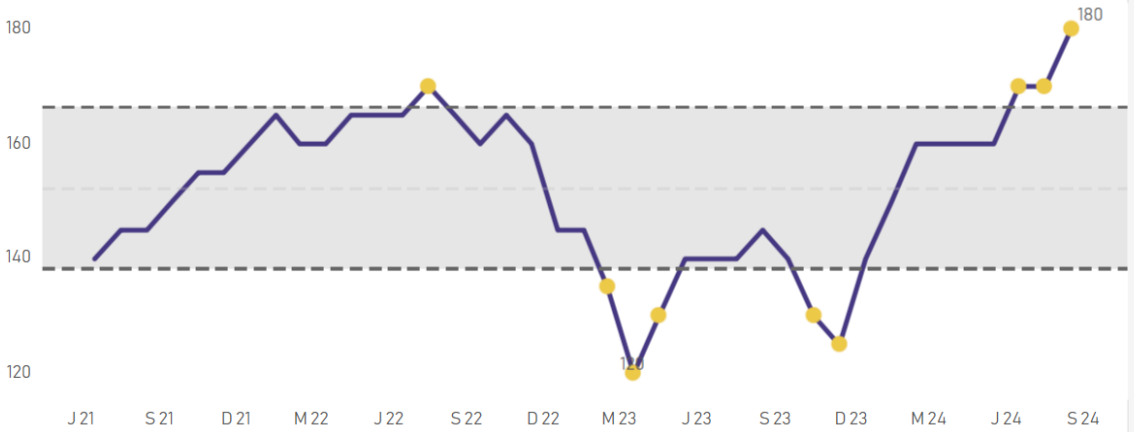
Bury

Women Accessing Specialist Community Perinatal Mental Health Services
Women Accessing Specialist Community Perinatal Mental Health Services (Rolling 12 mths)

Source: Published MHSDS (Quarterly)

180	170	91/107	No Target
September 2024	August 2024	National Rank Lower Quartile	

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22				140	145	145	150	155	155	160	165	160
2022-23	160	165	165	165	170	165	160	165	160	145	145	135
2023-24	120	130	140	140	140	145	140	130	125	140	150	160
2024-25	160	160	160	170	170	180						

Selected measure at September 2024 has continuously increased for 1 period(s) of time

Latest Value GM Benchmarking
Rate per 1000 | Count (National Rank)

The rate is calculated using the female population figure for each locality | Bury: 105,754

Narrative

- There were 180 women accessing Perinatal Mental Health Services for Bury registered patients for the rolling 12 months to Sept 24, higher than Sept 23 (145).
- Bury currently has 1.70 accesses per 1000 population and has the 6th lowest rate per 1000 for localities within GM.

Bury

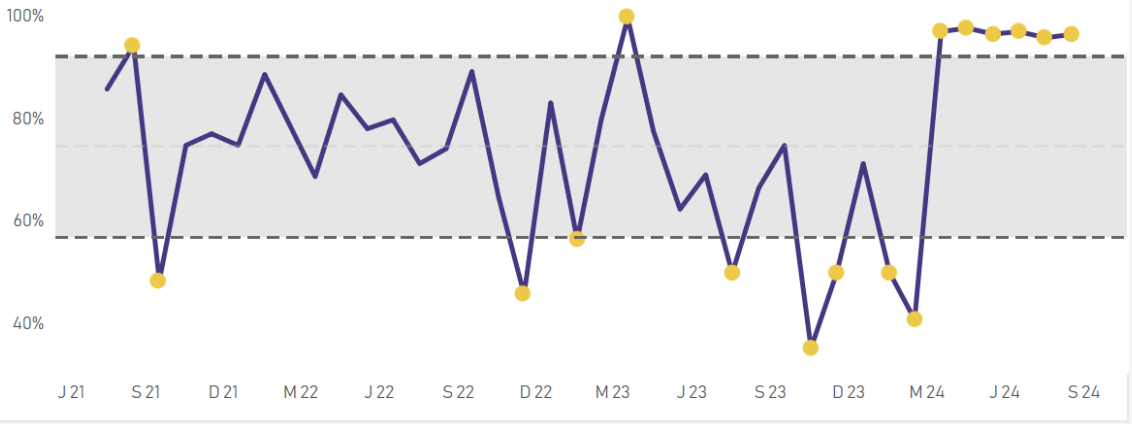
% 2-hour Urgent Community Response (UCR) first care contacts

Percentage of 2-hour UCR referrals subject to the 2-hour response standard (as specified in the UCR technical guidance), with an RTT end date in reporting month, that achieved the 2-hour response standards

Source: Community Services Data Set (CSDS) (Monthly)

96.8%	96.1%	70%
September 2024	August 2024	National Target

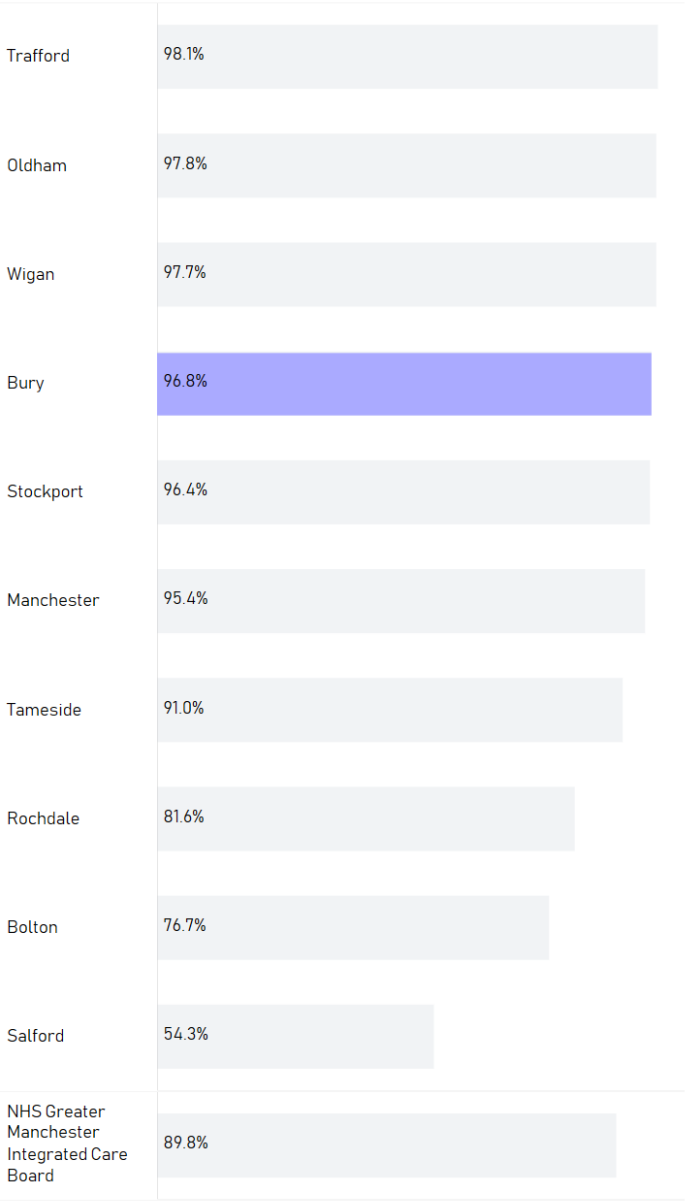
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22					86.0%	94.5%	48.5%	75.0%	77.3%	75.0%	88.9%	79.4%
2022-23	68.9%	84.9%	78.3%	80.0%	71.4%	74.4%	89.5%	65.0%	45.8%	83.3%	56.5%	80.0%
2023-24	100.0%	77.8%	62.5%	69.2%	50.0%	66.7%	75.0%	35.3%	50.0%	71.4%	50.0%	40.9%
2024-25	97.3%	98.0%	96.8%	97.3%	96.1%	96.8%						

Selected measure at September 2024 has continuously increased for 1 period(s) of time

Latest Value GM Benchmarking



Narrative

- The percentage of UCR referrals that received a 2-hour response standard for Bury registered patients in Sept 24 was 96.8%, which is an increase on Sept 23 which was 66.7%.
- Bury currently has the 4th highest percentage in the GM localities and is currently above the National Target of 70%.
- Local authority reporting shows that 99% of Bury residents received a 2-hour response in Oct 24 with only 1 missing target.

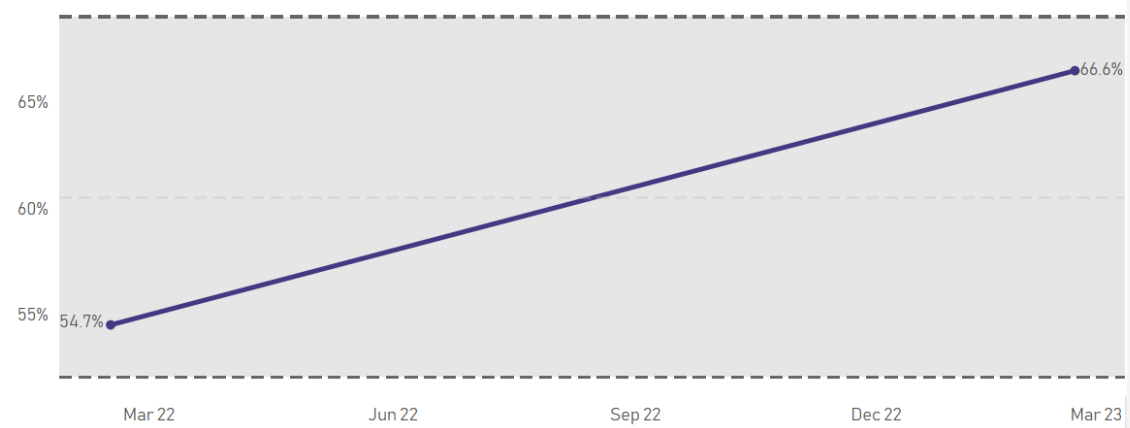
Bury

% of hypertension patients who are treated to target as per NICE guidance
% of hypertension patients who are treated to target as per NICE guidance

Source: NHS Quality Outcome Framework (Annual)

66.6%	54.7%	82/106	77.%
March 2023	March 2022	National Rank Lower Quartile	National Target

Outliers more than 1 standard deviation from the mean



	Mar
2021-22	54.7%
2022-23	66.6%

Selected measure at March 2023 has continuously increased for 2 period(s) of time

Latest Value GM Benchmarking
National Rank against other localities

5	Stockport	73.3%
11	Salford	72.3%
19	Wigan	71.6%
48	Bolton	69.4%
58	Rochdale	68.5%
62	Oldham	68.3%
63	Trafford	68.3%
82	Bury	66.6%
87	Tameside	65.9%
91	Manchester	65.4%
18	NHS Greater Manchester Integrated Care Board	69.0%

Narrative

- The percentage of hypertension patients treated to target as of March 23 is 66.6%, which is an increase on March 22 which was 54.7%.
- Bury currently has a lower percentage than GM which is 69.0% and Bury has the 3rd lowest percentage of the GM localities.
- Bury and GM are not currently meeting the national target of 77%.

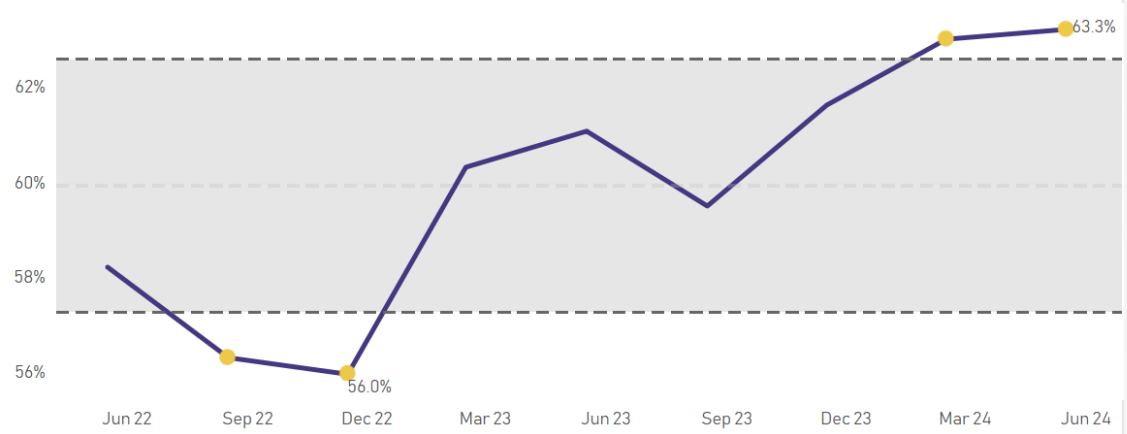
Bury

% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins
% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins

Source: CVD Prevent (Quarterly)

63.3%	63.1%	38/106	62.1%
June 2024	March 2024	National Rank Inter Quartile	National Median

Outliers more than 1 standard deviation from the mean



	Jun	Sep	Dec	Mar
2022-23	58.3%	56.3%	56.0%	60.4%
2023-24	61.1%	59.5%	61.7%	63.1%
2024-25	63.3%			

Selected measure at June 2024 has continuously increased for 3 period(s) of time

Latest Value GM Benchmarking
National Rank against other localities

2	Oldham	70.3%
4	Tameside	69.4%
8	Manchester	68.8%
13	Rochdale	66.9%
16	Trafford	66.9%
25	Salford	65.9%
37	Stockport	63.6%
38	Bury	63.3%
47	Wigan	62.8%
57	Bolton	61.8%
6	NHS Greater Manchester Integrated Care Board	65.9%

Narrative

- The percentage of patients identified as having 20% or greater 10-year risk of developing CVD as of June 24 is 63.3%, which is an increase on June 23 which was 61.1%

- Bury currently has a lower percentage than GM which is 65.9% and Bury has the 3rd lowest percentage of the GM localities.

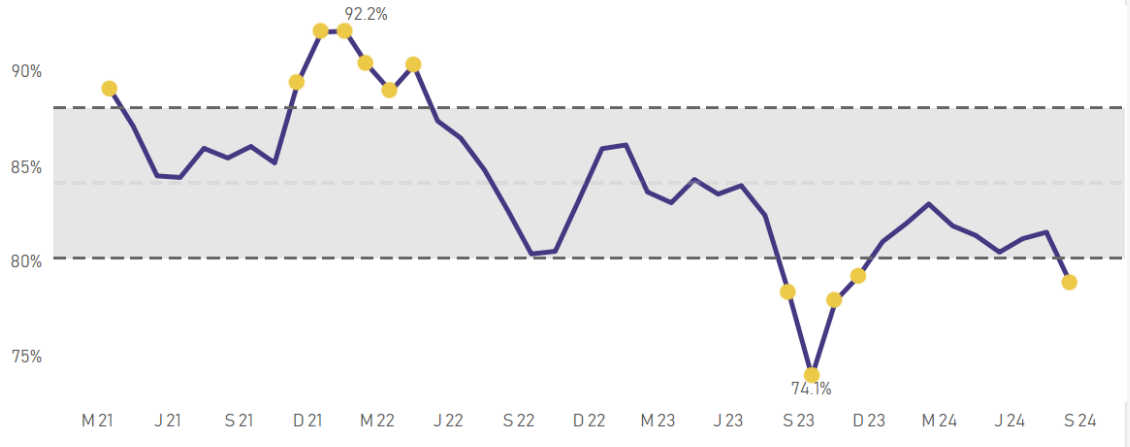
Bury

GP appointments - percentage of regular appointments within 14 days
Percentage of appointments where the time between booking and appointment was 'Same day', '1 day', '2 to 7 days' or '8 to 14 days'

Source: Appointments in General Practice (Monthly)

79.0%	81.7%	83/106	81.2%
September 2024	August 2024	National Rank Lower Quartile	National Median

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	89.2%	87.2%	84.6%	84.6%	86.1%	85.6%	86.2%	85.3%	89.5%	92.2%	92.2%	90.5%
2022-23	89.1%	90.5%	87.5%	86.6%	85.0%	82.8%	80.5%	80.7%	83.3%	86.1%	86.3%	83.8%
2023-24	83.2%	84.4%	83.7%	84.1%	82.6%	78.5%	74.1%	78.1%	79.4%	81.2%	82.1%	83.2%
2024-25	82.0%	81.5%	80.6%	81.3%	81.7%	79.0%						

Selected measure at September 2024 has continuously decreased for 1 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities

Narrative

- The percentage of GP appointments taking place within 14 days of booking in Sept 24 for the Bury population was 79.0%, which is a slight increase on Sept 23 which was 78.5%.
- Bury is currently lower than GM which is 82.7% and has the lowest percentage of the GM localities.

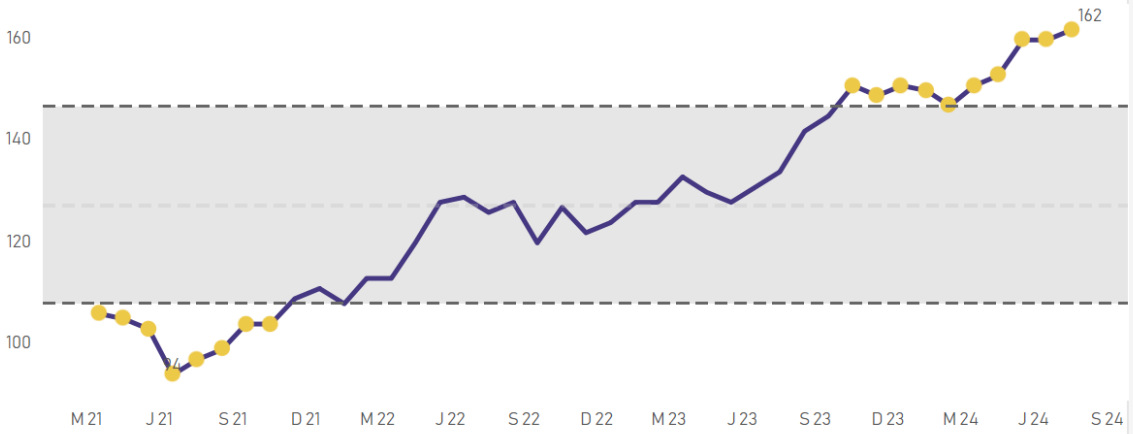
Bury

E. coli blood stream infections
12-month rolling counts of E. coli blood stream infections

Source: National Statistics: E. coli bacteraemia: monthly data by location of onset (Monthly)

162	160	22/107	No Target
August 2024	July 2024	National Rank Upper Quartile	

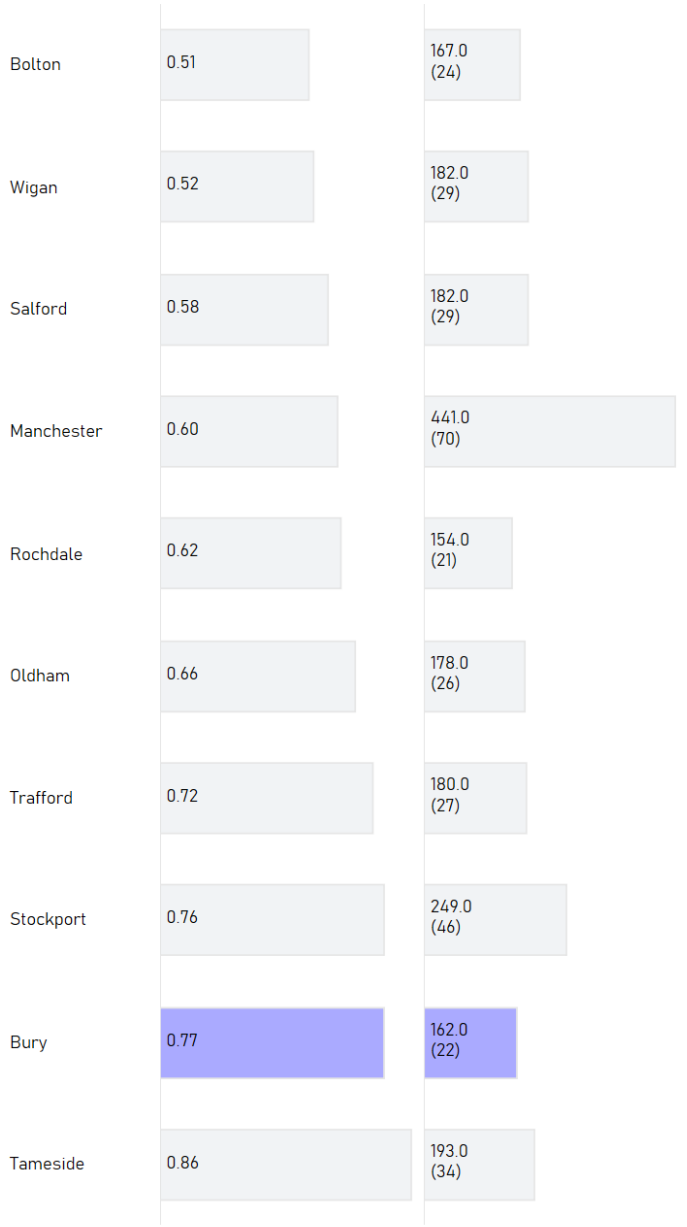
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	106	105	103	94	97	99	104	104	109	111	108	113
2022-23	113	120	128	129	126	128	120	127	122	124	128	128
2023-24	133	130	128		134	142	145	151	149	151	150	147
2024-25	151	153	160	160	162							

Selected measure at August 2024 has continuously **increased** for **1** period(s) of time

Latest Value GM Benchmarking
Rate per 1000 / Count (National Rank)



Narrative

- There were 162 counts of E. Coli blood stream infections in the rolling 12 months to Aug 24, which is higher than Aug 23 (134).
- Bury currently has 0.77 counts per 1000 population and has the 2nd highest rate per 1000 for localities within GM.

Bury

Antimicrobial resistance: total prescribing of antibiotics in primary care
The number of antibiotic (antibacterial) items prescribed in primary care, divided by the item-based Specific Therapeutic group Age-Sex related Prescribing Unit STAR-PU

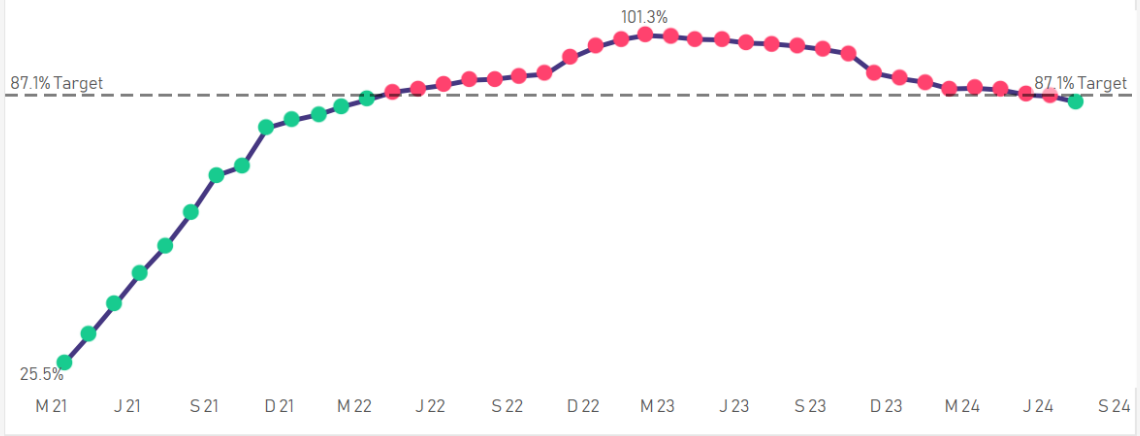
Source: EPACT Prescribing Data (Monthly)

85.8%
August 2024

87.2%
July 2024

87.1%
National Target

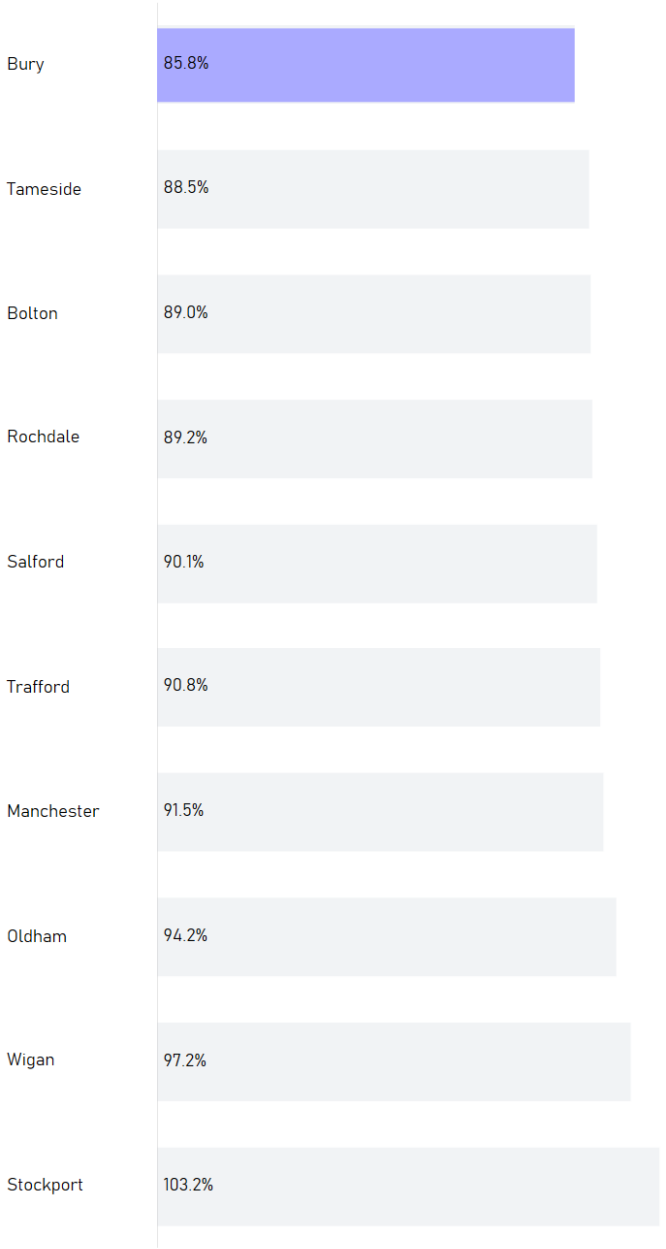
Performance Against National Target of 87.1%



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	25.5%	31.9%	39.0%	46.1%	52.5%	60.2%	68.8%	70.9%	79.9%	81.6%	83.0%	84.8%
2022-23	86.4%	88.1%	88.9%	89.7%	90.9%	91.1%	91.8%	92.3%	96.0%	98.6%	100.3%	101.3%
2023-24	100.9%	100.4%	100.2%	99.5%	99.3%	98.8%	98.0%	97.0%	92.5%	91.3%	90.4%	88.9%
2024-25	89.0%	88.7%	87.5%	87.2%	85.8%							

Selected measure at August 2024 has continuously decreased for 4 period(s) of time

Latest Value GM Benchmarking



Narrative

- The percentage of total prescribing of antibiotics in primary care in Aug 24 for the Bury population was 85.8%, which is lower than Aug 23 which was 99.3%.
- Bury currently has a lowest percentage of the GM localities.

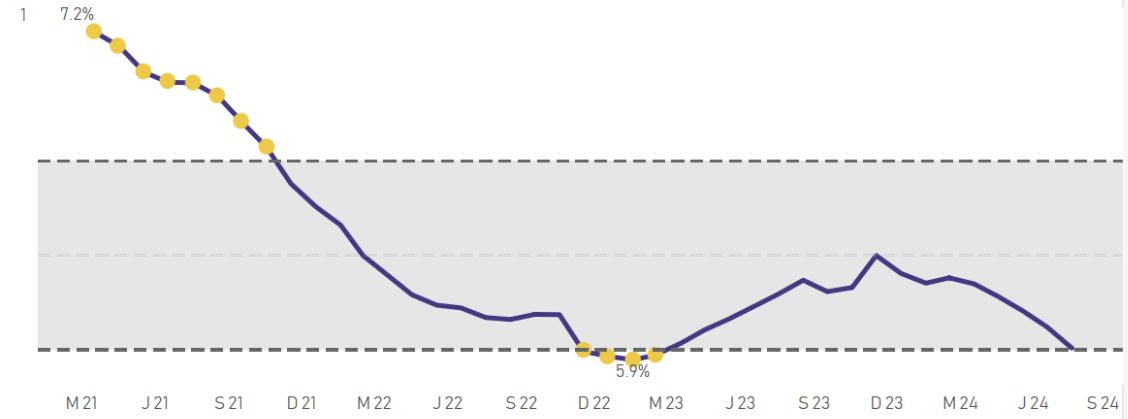
Bury

Antimicrobial resistance: proportion of broad-spectrum antibiotic prescribing in primary care
The number of broad-spectrum antibiotic (antibacterials) items from co-amoxiclav, cephalosporin class and fluoroquinolone class drugs as a percentage of the total number of antibacterial items prescribed in primary care.

Source: EPACT Prescribing Data (Monthly)

5.9%	6.0%	26/112	10.%
August 2024	July 2024	National Rank Upper Quartile	National Target

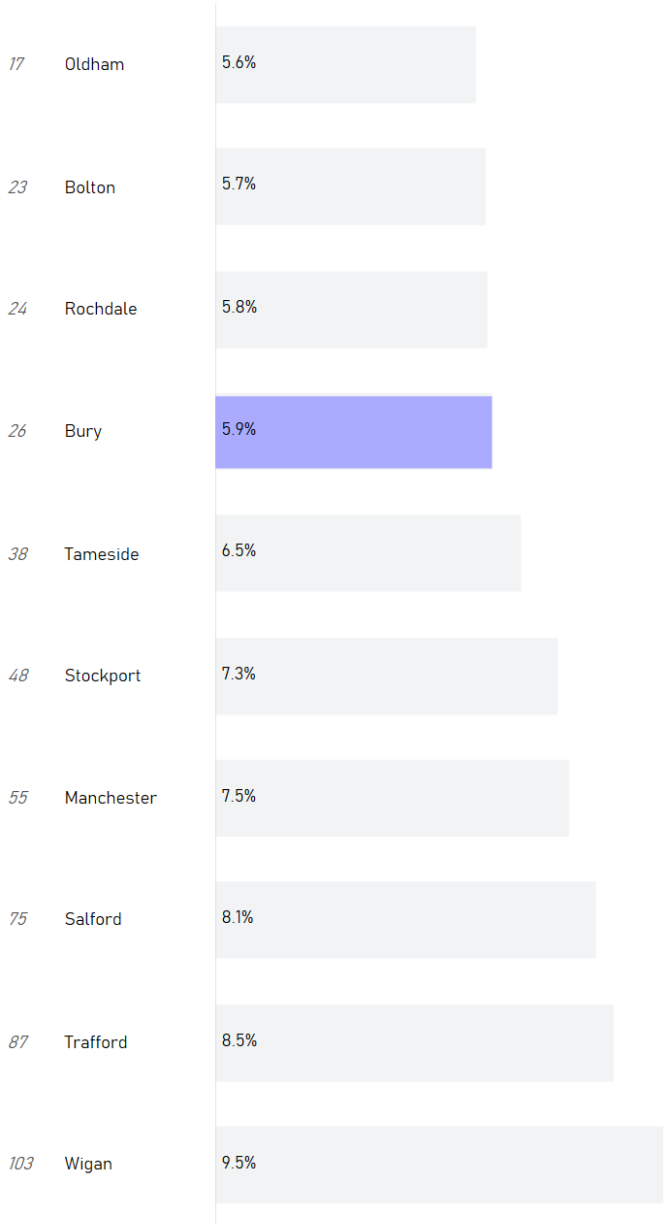
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	7.2%	7.1%	7.0%	7.0%	7.0%	6.9%	6.8%	6.7%	6.6%	6.5%	6.4%	6.3%
2022-23	6.2%	6.1%	6.1%	6.1%	6.0%	6.0%	6.0%	6.0%	5.9%	5.9%	5.9%	5.9%
2023-24	5.9%	6.0%	6.0%	6.1%	6.1%	6.2%	6.1%	6.2%	6.3%	6.2%	6.2%	6.2%
2024-25	6.2%	6.1%	6.1%	6.0%	5.9%							

Selected measure at August 2024 has continuously decreased for 5 period(s) of time

Latest Value GM Benchmarking
National Rank against other localities



Narrative

- The proportion of broad-spectrum antibiotic prescribing in primary care in Aug 24 for the Bury population was 5.9%, which is a decrease on Aug 23 which was 6.1%.
- Bury currently has the 4th lowest percentage of the GM localities.
- Bury is within the less than 10% target.

Bury - Sight Metrics

Domain	Code	Measure	Frequency	Date	Latest	Previous	Change	Target/Median	Numerator	Denominator	
Elective Care	EB28	Diagnostic 6ww: All	Monthly	Sep 24	15.8%	20.2%	↘	1.%	742	4,688	Inter
	EB20	RTT incomplete: 65+ week waits	Monthly	Sep 24	38.00	162.0	↘	0.	38	N/A	Inter
Cancer	S012a	28 Day Wait from Referral to Faster Diagnosis: All Patients	Monthly	Sep 24	64.0%	70.8%	↘	75.%	565	883	Lower
Maternity	S104a	Number of neonatal deaths per 1,000 total live births	Annual	Dec 22	0.0	1.9	↘	1.5	0	2,014	Upper
	S022a	Number of stillbirths per 1,000 total births	Annual	Dec 22	4.0	3.8	↗	3.2	8	2,014	Lower
Screening and Immunisations	S049a	Breast screening coverage, females aged 53-70, screened in last 36 months	Annual	Dec 23	69.2%	70.0%	↘	N/A	15,249	22,036	Inter
	S046a	COVER immunisation: MMR2 Uptake at 5 years old	Quarterly	Jun 24	83.4%	85.8%	↘	95.%	461	553	Lower
	S050a	Females, 25-64, attending cervical screening within target period (3.5 or 5.5 year coverage, %)	Quarterly	Mar 24	70.6%	70.4%	↗	80.%	38,155	54,020	Inter
	S047A	Seasonal Flu Vaccine Uptake: 65 years and over	Monthly	Feb 24	77.5%	77.3%	↗	85.%	29,492	38,042	Inter

Bury - Sight Metrics

The below metrics are currently missing from the report due to lack of locality level reporting or the measure is currently being built.

Theme	Indicator	
Cancer	Total patients waiting over 62 days to begin cancer treatment vs target	Build in progress
LD and Autism	Inpatients with a learning disability and/or autism per million head of population	Build in progress
Primary Care and Community Services	Units of Dental Activity delivered as a proportion of all Units of Dental Activity contracted	Build in progress
Screening and immunisation	Bowel screening, aged 60-74, screened in the last 30 months	DQ issues

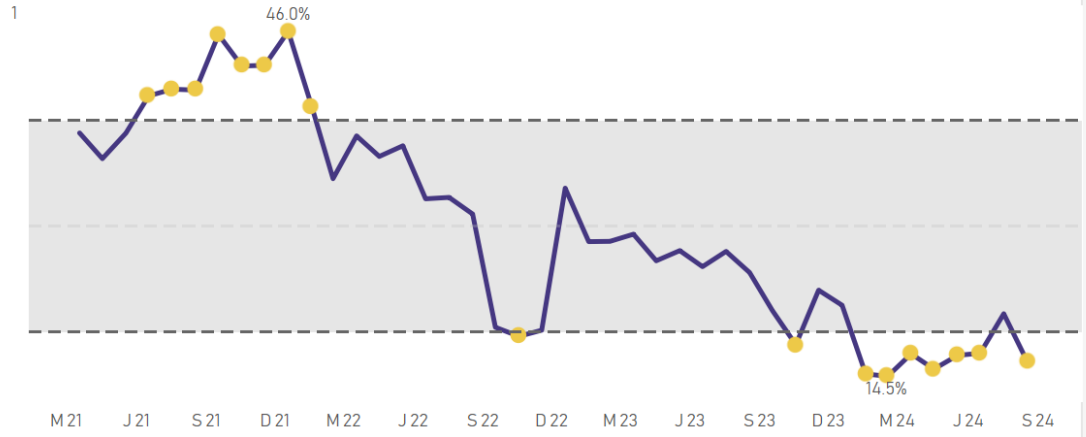
Bury

Diagnostic 6ww: All
% of Patients waiting over 6 weeks for a diagnostic test or procedure

Source: Monthly Diagnostics Waiting Times and Activity Return - DM01 (Monthly)

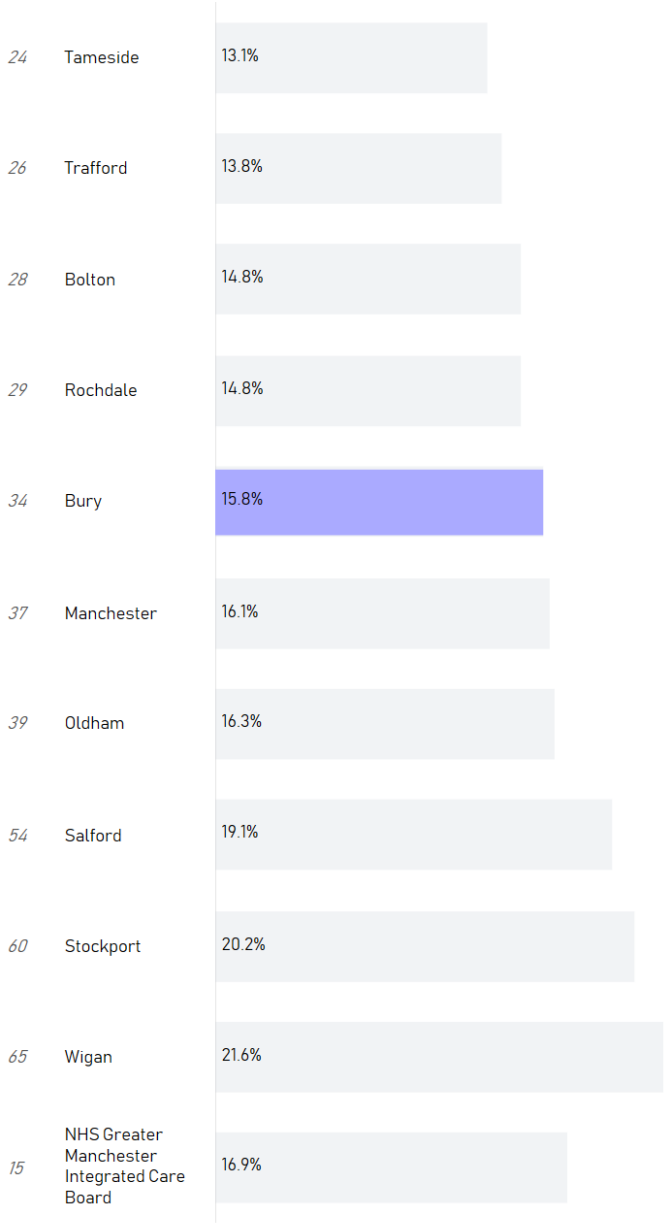
15.8%	20.2%	34/107	1.%
September 2024	August 2024	National Rank Inter Quartile	National Target

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	36.7%	34.4%	36.7%	40.1%	40.7%	40.6%	45.7%	42.8%	42.9%	46.0%	39.1%	32.5%
2022-23	36.4%	34.6%	35.5%	30.7%	30.8%	29.3%	19.0%	18.1%	18.7%	31.7%	26.8%	26.8%
2023-24	27.5%	25.0%	26.0%	24.5%	25.9%	24.0%	20.5%	17.4%	22.3%	21.0%	14.7%	14.5%
2024-25	16.5%	15.1%	16.4%	16.6%	20.2%	15.8%						

Latest Value GM Benchmarking
National Rank against other localities



Narrative

- Sept 24 performance of 15.8% of patients waiting more than six weeks, this is a decrease on the Sept 23 figures (24.0%).
- Burys performance is slightly Better than GM's performance of 16.9% in Sept 24.
- Bury performance is the 5th highest percentage of the GM localities.
- Bury and GM are both above the less than 1% target.

Bury

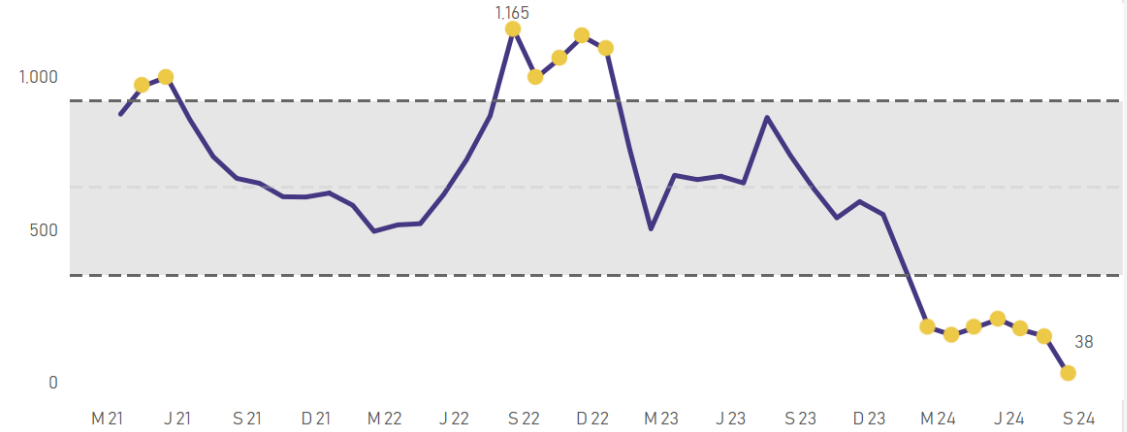
RTT incomplete: 65+ week waits

"The number of 65+ week incomplete RTT pathways based on data provided by NHS and independent sector organisations and reviewed by NHS commissioners via SDCS.
The definitions that apply for RTT waiting times, as well as guidance on recording and reporting RTT data, can be found on the NHS England and NHS Improvement Consultant-led referral to treatment waiting times rules and guidance webpage."

Source: Consultant-led RTT Waiting Times data collection (National Statistics). (Monthly)

38.00	162	24/121	0.
September 2024	August 2024	National Rank Inter Quartile	National Target

Outliers more than 1 standard deviation from the mean

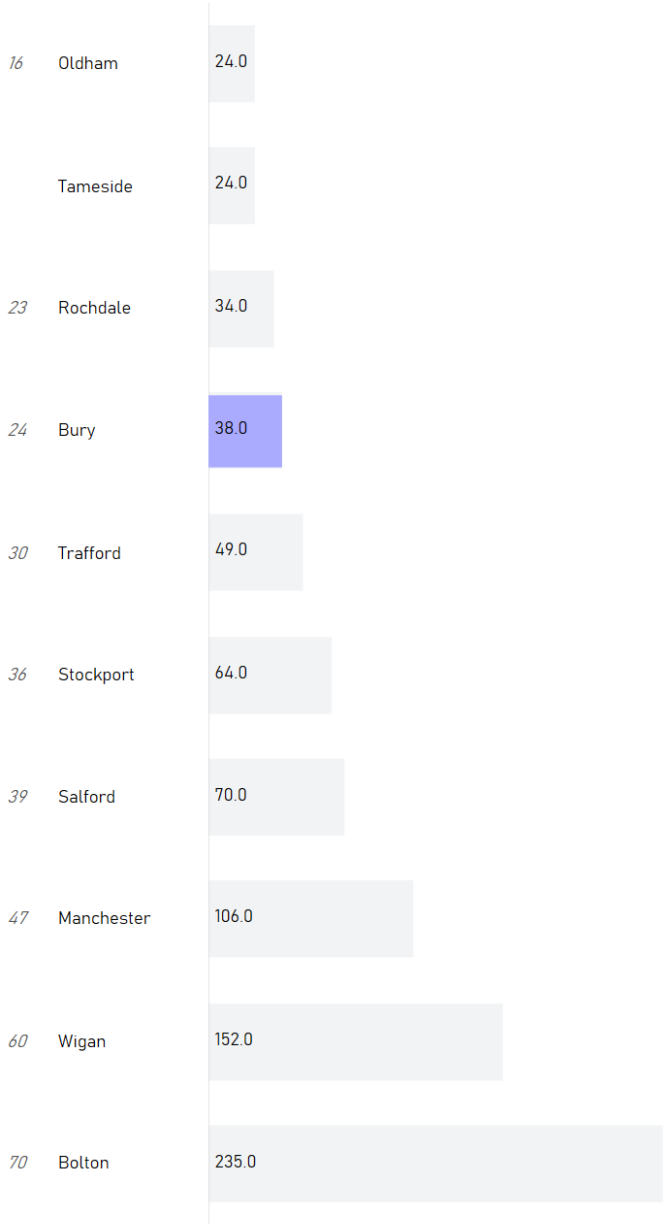


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	888	980	1,009	871	749	678	662	618	617	630	590	505
2022-23	526	530	626	739	882	1,165	1,007	1,070	1,142	1,099	773	513
2023-24	688	674	685	663	877	752	646	549	602	560	371	191
2024-25	166	190	218	184	162	38						

Selected measure at September 2024 has continuously decreased for 3 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities



Narrative

- Published Sept 24 data shows a decrease in 65+ Week Waits from Aug 24 with 162 pathways to 38 pathways in Sept (-124). There was a also a huge decrease in pathways in Sept 24 with 38 Pathways, Compared to Sept 23 when there were 752 pathways (-714 Pathways)
- In Sept 24, Dermatology shows the highest decrease of pathways with 2 pathways compared to Aug 24 when there were 20 pathways a decrease of 18 pathways
- In Sept 24 there were no specialties that showed an increase in pathways, all specialties saw a reduction.
- Bury locality currently has the 4th lowest number of 65+ Week waits out of all the GM localities.

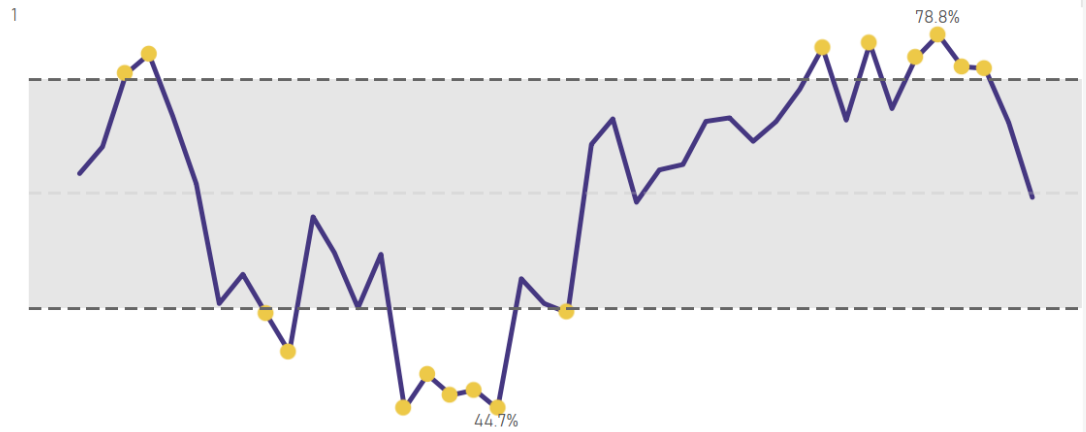
Bury

28 Day Wait from Referral to Faster Diagnosis: All Patients
Proportion of patients told cancer diagnosis outcome within 28 days of their TWW referral for suspected cancer, TWW referral for exhibited breast symptoms, or urgent screening referral

Source: National Cancer Waiting Times Monitoring Data Set (CWT) (Monthly)

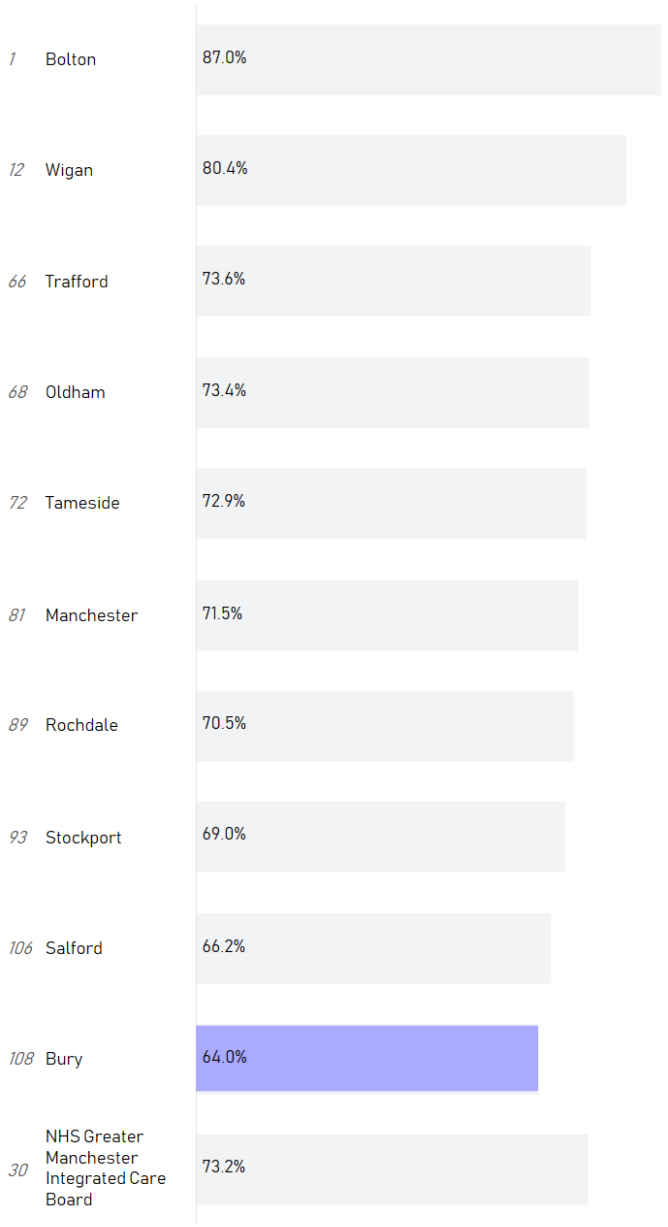
64.0%	70.8%	108/114	75.%
September 2024	August 2024	National Rank Lower Quartile	National Target

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	66.2%	68.6%	75.2%	77.0%	71.4%	65.2%	54.3%	57.0%	53.4%	49.9%	62.2%	58.9%
2022-23	53.9%	58.8%	44.7%	47.8%	46.0%	46.4%	44.7%	56.6%	54.3%	53.5%	68.8%	71.1%
2023-24	63.5%	66.5%	67.0%	70.9%	71.2%	69.1%	70.9%	73.8%	77.6%	71.0%	78.0%	72.1%
2024-25	76.6%	78.8%	75.9%	75.7%	70.8%	64.0%						

Latest Value GM Benchmarking
National Rank against other localities



Narrative

- The percentage of patients told of a cancer diagnosis outcome within 28 days of the 2WW referral in Sept 24 for the Bury population was 64.0%, which is a decrease on Sept 23 which was 69.1%.
- Bury locality currently has the lowest performance out of all the GM localities.
- GM performance is currently 73.2%
- Bury is currently not meeting the target of 75% or greater.

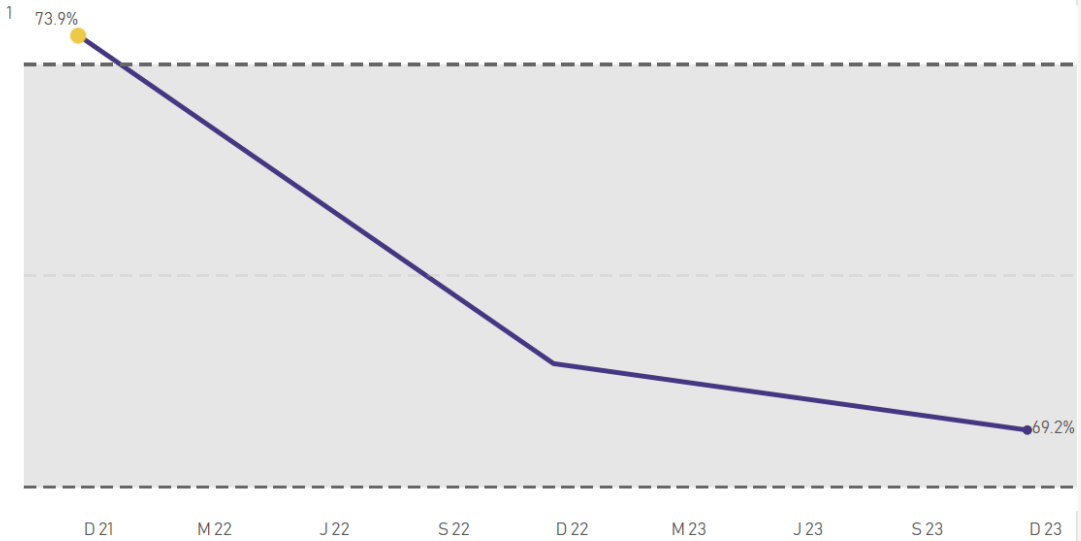
Bury

Breast screening coverage, females aged 53-70, screened in last 36 months
3-year screening coverage %: The number of females registered to the practice screened adequately in previous 36 months divided by the number of eligible females on last day of the review period

Source: Fingertips, Public Health Data, Public Health Outcomes Framework (Annual)

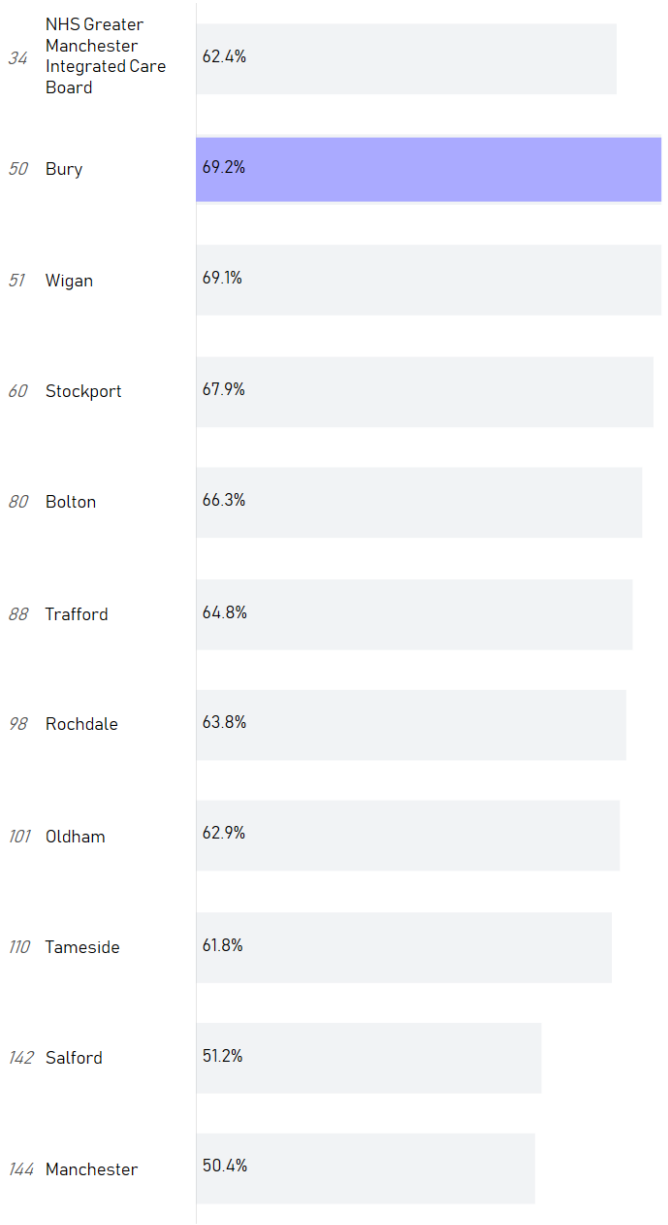
69.2%	70.0%	60%
December 2023	December 2022	No Target

Outliers more than 1 standard deviation from the mean



	Dec
2021-22	73.9%
2022-23	70.0%
2023-24	69.2%

Latest Value GM Benchmarking
National Rank against other localities



Narrative

- The 3-year breast screening coverage to December 23 for the Bury population was 69.2% for eligible females.
- Bury locality currently has the highest percentage out of all the GM localities and is higher than the GM percentage of 62.4%.

Bury

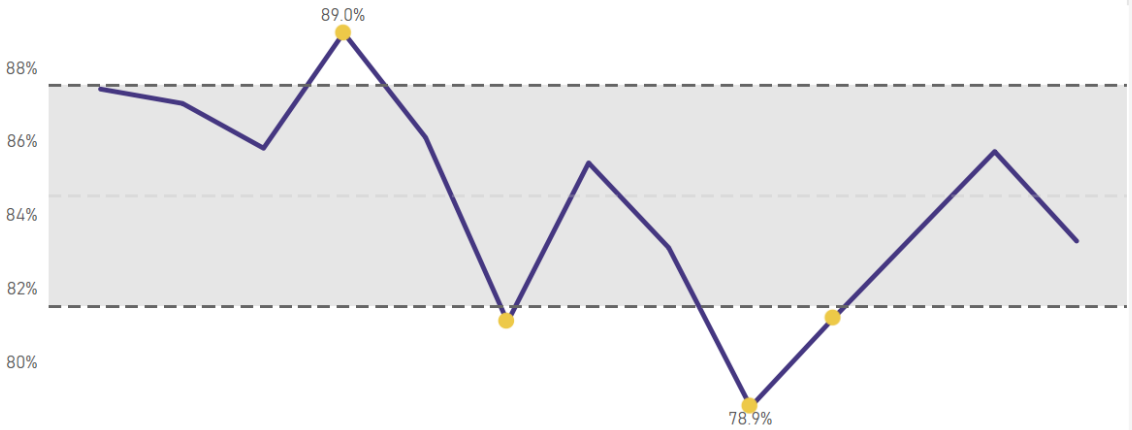
COVER immunisation: MMR2 Uptake at 5 years old
Population vaccination coverage – MMR for two doses (5 years old)

Source: Cover of vaccination evaluated rapidly (COVER) programme (Quarterly)

83.4%
June 2024

95.%
National Target

Outliers more than 1 standard deviation from the mean



	Jun	Sep	Dec	Mar
2021-22	87.5%	87.1%	85.9%	89.0%
2022-23	86.2%	81.2%	85.5%	83.2%
2023-24	78.9%	81.3%		85.8%
2024-25	83.4%			

Latest Value GM Benchmarking
National Rank against other localities

11	Stockport	92.4%
12	Trafford	92.4%
24	Wigan	90.8%
49	Bolton	88.5%
84	Rochdale	83.7%
85	Tameside	83.6%
86	Bury	83.4%
93	Salford	80.7%
99	Oldham	77.5%
104	Manchester	72.1%
34	NHS Greater Manchester Integrated Care Board	83.0%

Narrative

- The percentage of MMR2 uptake at 5 years old as of June 24 is 83.4%, which is an increase on June 23 which was 78.9%
- Bury currently has a higher percentage than GM which is 83.0% and Bury has the 7th lowest percentage of the GM localities.
- Bury and GM are not meeting the national target of 95%.

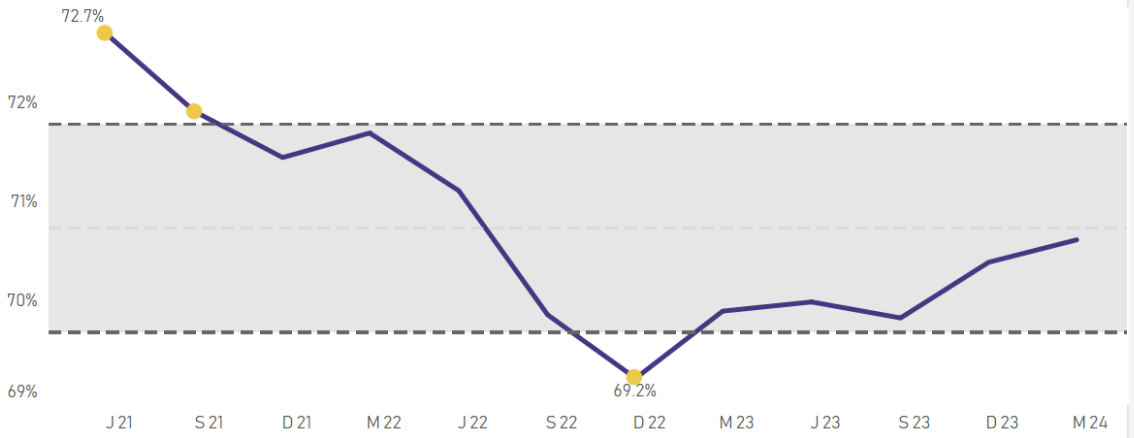
Bury

Females, 25-64, attending cervical screening within target period (3.5 or 5.5 year coverage, %)
The overall cervical screening coverage: the number of women screened adequately in the previous 42 months (if aged 24-49) or 66 months (if aged 50-64) divided by the number of eligible women on last day of review period.

Source: Cervical Screening Programme - Coverage Statistics [Management Information] (Quarterly)

70.6%	70.4%	69/106	80.%
March 2024	December 2023	National Rank Inter Quartile	National Target

Outliers more than 1 standard deviation from the mean



	Jun	Sep	Dec	Mar
2021-22	72.7%	71.9%	71.5%	71.7%
2022-23	71.1%	69.9%	69.2%	69.9%
2023-24	70.0%	69.8%	70.4%	70.6%

Selected measure at March 2024 has continuously increased for 2 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities

3	Stockport	77.3%
6	Trafford	76.1%
39	Wigan	73.7%
66	Rochdale	70.8%
69	Bury	70.6%
73	Tameside	70.2%
75	Oldham	69.8%
93	Bolton	67.6%
98	Salford	64.7%
104	Manchester	60.2%
32	NHS Greater Manchester Integrated Care Board	68.7%

Narrative

- The cervical screening coverage to March 24 for the Bury population was 70.6% for eligible females.
- Bury locality currently has the 5th highest percentage out of all the GM localities and is higher than the GM percentage of 68.7%.
- Bury and GM are not meeting the national target of 80%.

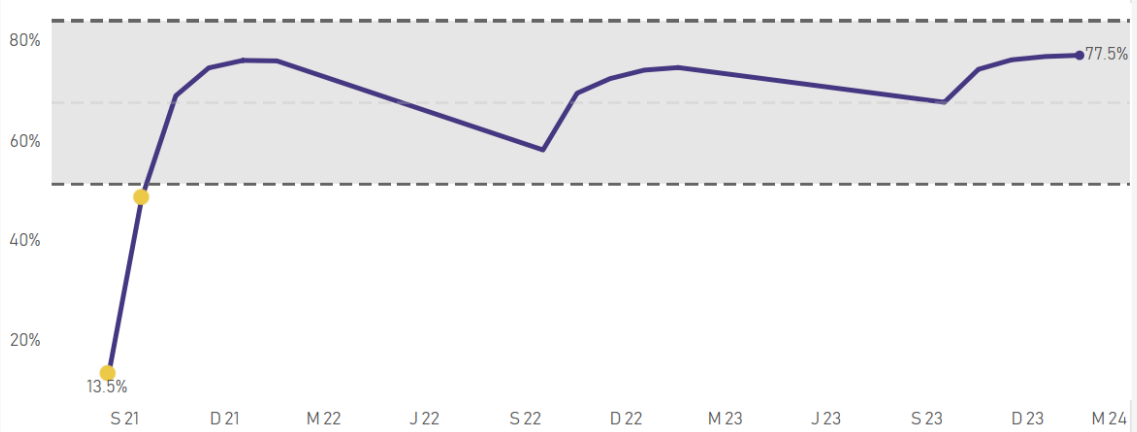
Bury

Seasonal Flu Vaccine Uptake: 65 years and over
The uptake of seasonal influenza vaccination among those aged 65 and over

Source: Seasonal influenza vaccine uptake in GP patients: monthly data, 2022 to 2023 (Monthly)

77.5%	77.3%	71/106	85.%
February 2024	January 2024	National Rank Inter Quartile	National Target

Outliers more than 1 standard deviation from the mean



	Sep	Oct	Nov	Dec	Jan	Feb
2021-22	13.5%	48.8%	69.4%	75.0%	76.5%	76.4%
2022-23		58.5%	69.9%	72.8%	74.6%	75.1%
2023-24		68.1%	74.7%	76.6%	77.3%	77.5%

Selected measure at February 2024 has continuously increased for 4 period(s) of time

Latest Value GM Benchmarking
National Rank against other localities

4	Stockport	83.2%
49	Trafford	79.3%
62	Wigan	78.5%
71	Bury	77.5%
77	Oldham	76.9%
79	Rochdale	76.1%
80	Bolton	76.1%
89	Tameside	73.4%
90	Salford	73.3%
102	Manchester	67.8%
34	NHS Greater Manchester Integrated Care Board	76.2%

Narrative

- The seasonal influenza vaccination uptake to February 24 for the Bury population was 77.5% for those aged 65+.
- Bury locality currently has the 7th lowest uptake out of all the GM localities and is higher than the GM percentage of 76.2%.
- Bury and GM are not meeting the national target of 85%.

Oversight Metrics Glossary

Domain	Code	Measure	Description	Data Source	Frequency	Latest	Updated	RAG rated against	Desired Direc
Urgent Care	EM30a	Average number of adult G&A overnight beds available	The percentage of adult general and acute (G&A) overnight beds that are occupied, as an average over a monthly period.	UEC Daily Sitrep	Monthly	Oct 24	1st	No Target	Decrease
	S123a	Adult general & acute bed occupancy adjusted for void beds (Type 1 Only)	Percentage of general and acute (G&A) day beds occupied (adjusted for covid void beds).	UEC Daily Sitrep	Monthly	Mar 24	1st	National Median	Decrease
	EM11	Total number of specific acute non-elective spells	Count of spells	National Flows APC	Monthly	Oct 24	1st	National Median	Decrease
	N/A	A&E Attendances	Number of attendances at A&E	Emergency Care Dataset (ECDS)	Monthly	Oct 24	1st	No Target	Decrease
	N/A	A&E 4 hour performance	A&E attendances seen within 4hrs	Emergency Care Dataset (ECDS)	Monthly	Oct 24	1st	No Target	Increase
	N/A	No Reason/Criteria To Reside patients (NCTR) as % of occupied beds	Null	GM Admissions - Local	Monthly	Oct 24	1st	No Target	Decrease
Elective Care	EM07	Total Referrals Made (General and Acute)	Total GP & Other Referrals made for 1st Consultant led OP appointments in specific acute treatment functions	Monthly Referral Return (MRR)	Monthly	Mar 24	2nd Thursday	National Median	Increase
	EM07a	GP Referrals Made (General and Acute)	Total GP Referrals made for 1st Consultant led OP appointments in specific acute treatment functions	Monthly Referral Return (MRR)	Monthly	Mar 24	2nd Thursday	National Median	Increase
Cancer	N/A	Cancers Diagnosed At Early Stage using Full Registration Data	Count of cancers diagnosed at stages 1 and 2 divided by count of cancers diagnosed at stages 1, 2, 3, and 4	Cancer Early Staging Data Statistics via The National Disease Registration Servi..	Annual	Dec 21	2nd Thursday	National Median	Increase
Mental Health & Learning Disabiliti..	S086a	Inappropriate adult acute mental health Out of Area Placement (OAP) bed days	Inappropriate Out of Area Placements	Out of Area Placements in Mental Health Services Official Statistics	Monthly	Mar 24	2nd Thursday	National Target	Decrease
	S081a	Talking Therapies: Access Rate	Number of people accessing first treatment	Improving Access to Psychological Therapies Data Set	Monthly	Sep 24	2nd Thursday	No Target	Increase
	EA0S1	Dementia: Diagnosis Rate (Aged 65+)	Dementia: Diagnosis Rate (Aged 65+)	Primary Care Dementia Data	Monthly	Sep 24	2nd Thursday	National Target	Increase
	EAS01	Dementia: Diagnosis Rate (Aged 65+)	Dementia: Diagnosis Rate (Aged 65+)	Primary Care Dementia Data	Monthly	Sep 24	2nd Thursday	National Target	Increase
	S030a	% of patients aged 14+ with a completed LD health check	% of patients aged 14+ with a completed LD health check	Learning Disabilities Health Check Scheme	Monthly	Sep 24	2nd Thursday	National Target	Increase
	S110a	Overall Access to Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses	Number of people who receive two or more contacts from NHS or NHS commissioned community mental health services (in transformed and non-transformed PCNs) for adults and older adults with severe mental illnesses, in ..	Published MHSDS	Monthly	Sep 24	2nd Thursday	National Median	Increase
	S125a	Long length of stay for adults (60+ days)	Number of people for a given CCG discharged from an adult acute inpatient bed with a hospital spell over 60 days (calculated from the point of admission to the point of discharge)	Published MHSDS	Monthly	Sep 24	2nd Thursday	National Target	Decrease
	EH09	Access to Children and Young Peoples Mental Health Services	Number of CYP aged 0-17 supported through NHS funded mental health services receiving at least one contact.	Published MHSDS	Monthly	Sep 24	2nd Thursday	National Median	Increase
	S131a	Women Accessing Specialist Community Perinatal Mental Health Services	Number of women accessing specialist community PMH and MMHS services in the reporting period	Published MHSDS	Quarterly	Sep 24	2nd Thursday	No Target	Increase
	N/A	Number of MH patients with no criteria to reside (NCTR)	Number of MH patients with no criteria to reside	GM Admissions - Local	Monthly	Oct 24	1st	No Target	Decrease
	N/A	Percentage of MH patients with no criteria to reside (NCTR)	Percentage of MH patients with no criteria to reside	GM Admissions - Local	Monthly	Oct 24	1st	No Target	Decrease
Commun..	N/A	% 2-hour Urgent Community Response (UCR) first care contacts	Percentage of 2-hour Urgent Community Response referrals subject to the 2-hour standard where care was provided within two hours	Community Services Data Set (CSDS)	Monthly	Sep 24	2nd Thursday	National Target	Increase
Primary Care	S053b	% of hypertension patients who are treated to target as per NICE guidance		NHS Quality Outcome Framework	Annual	Mar 23	2nd Thursday	National Target	Increase
	S129a	GP appointments - percentage of regular appointments within 14 days	Percentage of appointments where the time between booking and appointment was 'Same day', '1 day', '2 to 7 days' or '8 to 14 days'	Appointments in General Practice	Monthly	Sep 24	Last Thursday	National Median	Increase
	S053c	% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins	% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins	CVD Prevent	Quarterly	Jun 24	2nd Thursday	National Median	Increase
Quality	S042a	E. coli blood stream infections	12-month rolling counts of E. coli	National Statistics: E. coli bacteraemia: monthly data by location of onset	Monthly	Aug 23	1st Wednesday	No Target	Decrease
	S044b	Antimicrobial resistance: proportion of broad-spectrum antibiotic prescribing in primary care	The proportion of broad-spectrum antibiotic prescribing in primary care	EPACT Prescribing Data	Monthly	Aug 24	2nd Thursday	National Target	Decrease
	S044a	Antimicrobial resistance: total prescribing of antibiotics in primary care	The proportion of antibiotic prescribing in primary care	EPACT Prescribing Data	Monthly	Aug 24	2nd Thursday	National Target	Decrease

Sight Metrics Glossary

Domain	Code		Measure	Description	Data Source	Frequency	Latest	RAG rated against	Target/National
Elective Care	2	EB20	RTT incomplete: 65+ week waits		Consultant-led RTT Waiting Times data collection (National Statistics).	Monthly	Sep 24	National Target	0
	146	EB28	Diagnostic 6ww: All	% of Patients waiting over 6 weeks for a diagnostic test or procedure	Monthly Diagnostics Waiting Times and Activity Return - DM01	Monthly	Sep 24	National Target	1.%
Cancer	62	S012a	28 Day Wait from Referral to Faster Diagnosis: All Patients	Count of patients told cancer diagnosis outcome within 28 days divided by total count of patients told cancer diagnosis outcome following their TWW referral for suspected cancer, TWW referral for exhibited breast symptoms, or urgent screening referral	National Cancer Waiting Times Monitoring Data Set (CWT)	Monthly	Sep 24	National Target	75.%
Maternity	230	S022a	Number of stillbirths per 1,000 total births	Count of cancers diagnosed at stages 1 and 2 divided by count of cancers diagnosed at stages 1, 2, 3, and 4	MBRRACE-UK - Perinatal Mortality Surveillance Report	Annual	Dec 22	National Median	3
	460	S104a	Number of neonatal deaths per 1,000 total live births	Number of neonatal deaths per 1,000 total live births	MBRRACE-UK - Perinatal Mortality Surveillance Report	Annual	Dec 22	National Median	1
Screening and Immunisations	150	S047A	Seasonal Flu Vaccine Uptake: 65 years and over	number of people over 65 who received the seasonal influenza vaccination divided by the number of eligible people who are aged 65 and over	Seasonal influenza vaccine uptake in GP patients: monthly data, 2022 to 2023	Monthly	Feb 24	National Target	85.%
	468	S046a	COVER immunisation: MMR2 Uptake at 5 years old	% children whose fifth birthday falls within the time period who have received two doses of MMR vaccination	Cover of vaccination evaluated rapidly (COVER) programme	Quarterly	Jun 24	National Target	95.%
	473	S050a	Females, 25-64, attending cervical screening within target period (3.5 or 5.5 year coverage, %)	% of females, age 25-64 yrs, attending cervical screening within target period (3.5 yrs if aged 24-49 or 5.5 yrs if aged 50-64)	Cervical Screening Programme - Coverage Statistics [Management Information]	Quarterly	Mar 24	National Target	80.%
	499	S048a	Bowel screening coverage, aged 60-74, screened in last 30 months	% of eligible men and women, age 60-74 yrs, with an adequate screening result in previous 30 mths	NHS population screening programmes: KPI reports	Quarterly	Dec 23	National Target	60.%
	514	S049a	Breast screening coverage, females aged 53-70, screened in last 36 months	% women eligible for screening who have had a test with a recorded result at least once in the previous 36 months	Fingertips, Public Health Data, Public Health Outcomes Framework	Annual	Dec 23	No Target	

PIA Locality Report

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BURY INTEGRATED CARE PARTNERSHIP

Meeting:			
Meeting Date	02 December 2024	**Action**	Receive
Item No.	12	**Confidential**	No
Title	Bury ICP Strategic Risk Report (Risks above 15)		
Presented By	Catherine Jackson, Associate Director for Nursing, Quality and Safeguarding (Bury)		
Author	Catherine Jackson, Carolyn Trembath, Kath Wynne-Jones		
Clinical Lead	Catherine Jackson, Associate Director for Nursing, Quality and Safeguarding (Bury)		

Executive Summary

This report details the locality strategic and programme risks set by the Risk, Performance and Scrutiny Group as scored above 15 using the strategic risk descriptors detailed in section 3 of the report. The risks are described in summary and high-level mitigating actions are included. Further detailed information on the risk mitigations is discussed and actioned through the Transformation/Programme Boards and workstreams.

A further quality risk register is available and scrutinised at the System Assurance Committee.

Recommendations

The Board is asked to discuss and consider the risks and make recommendations to the Risk Performance and Scrutiny Group to ensure robust transparency, oversight and mitigation of locality strategic and performance risks.

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

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

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

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

Bury ICP Strategic Risk Report

1. Introduction

1.1. This report updates the Locality Board on the key strategic risks to the delivery of the Locality Plan and Board priorities.

1.2. This report updates the Locality Board on the risks considered 15 or greater by the workstreams of the IDCB.

1.3. Risks are managed by the relevant IDCB workstream and this report providers an overview to inform Locality Board members of high risks but does not contain those judged to be under 15 or all the actions that are ongoing in mitigation.

1.4 There is a Risk, Performance and Scrutiny Group who consider all the borough level risks, seeks assurance from the Transformation/Programme Boards and workstreams to advise on the elements of managing, scoring and escalation processes.

1.5 There is currently no electronic system for risk management for the borough whilst an agreement is made across the GM ICP and no locality risk manager.

2. Risk Descriptors

			Likelihood				
			1	2	3	4	5
			Rare	Unlikely	Possible	Likely	Almost certain
Consequence	5	Catastrophic	5	10	15	20	25
	4	Major	4	8	12	16	20
	3	Moderate	3	6	9	12	15
	2	Minor	2	4	6	8	10
	1	Negligible	1	2	3	4	5

KEY

	Theme	Risk description	Initial score / Q1	Q2	Q3	Q4	Risk movement	Risk target	Assurance
1	Strategy and transformational change	BECAUSE of the partnership-wide, organisational and GM ICP breadth of transformational ambition, THEN there is a risk that there is insufficient finance, capacity and focus to deliver health and care strategic change locally.	16	16			↔	8	Local governance structures reflects ICB governance. Generic Communications and Engagement Strategy which supports the public messages and campaigns. Finalised locality budget annually. Locality Board operation agreed by GM March 2023 with relevant delegated authority. The Operational Planning Guidance for 2024/25 was released on 27th March for local review. Bury 2030 'Let's Do It' strategy embedded and refreshed in Q1 2024. Scrutiny on delivery in place at Strategic Finance Committee, System Assurance Committee, IDCB and Locality Board. Relevant prioritised workstreams with programme leadership.
2	Finance: System Finance Position	BECAUSE of the risk that the financial position of all partners, THEN there is a risk that this challenges the model of	16	16			↔	8	Finance and Scrutiny committee oversight. Saving planning meetings. QIPP management and oversight. Improvement work carried out

		partnership working in the Bury Integrated Care Partnership by inducing actions that effectively cost shunt within the system.							since last quarter means that there is vastly improved clarity on budgets. PwC support across range budgets.
3a	Finance: Locality Healthcare budgets *24/25 only*	BECAUSE the locality is currently overspent by approx. £6.8m vs a budget of £71m and the locality does not have many options to reduce spend other than mental health, individualised commissioning (including CHC and children), Better Care Fund and charities; and additionally must find 5% CIP, and the overall NHS GM position and that of statutory partners in Bury is also very challenged THEN there is a high risk that financial balance will not be achieved.	16	16			↔	8	1.Bury System Finance Group. 2.PWC input. 3.Monthly Locality assurance meetings with NHS GM. 4.Weekly finance and complex care meetings. 5. 7 Projects to drive down costs. 6.Saving planning meetings. 7.QIPP management and oversight. 8.Programme leads in place, monthly formal scrutiny. 9.Programme leads active management CIP targets.
3b	Finance: Locality Healthcare budgets *Recurrent position*	BECAUSE the locality is currently overspent by approx. £6.8m vs a budget of £71m and the locality does not have many options to reduce spend other than mental health, individualised commissioning (including							1.Bury System Finance Group. 2.System wide workshops being set up. 3.Monthly Locality assurance meetings with NHS GM. 4.Weekly finance and complex care meetings. 5. 7 Projects to drive down costs. 6. Saving planning meetings.

		CHC and children), Better Care Fund and charities; and additionally must find 5% CIP, and the overall NHS GM position and that of statutory partners in Bury is also very challenged THEN there is a high risk that recurrent financial balance will not be achieved.							7. QIPP management and oversight. 8. Programme leads in place, monthly formal scrutiny. 9. Programme leads active management CIP targets.
4	Finance: Locality Operating costs budgets	The locality currently has a budget of £3.4m and is forecasting to break even in 2024/25. This is primarily due to £0.13m of non-recurrent funding and a significant number of vacancies that are not being recruited to BECAUSE there is a difference between the budget and the planned establishment, THEN there is a risk to delivering transformation projects and staff well being.	16	16			↔	8	Finance and scrutiny committee oversight. Saving planning meetings. QIPP management and oversight. Work to reconcile the RBMS function and costs.

5	Data and insight	BECAUSE of a loss of locality analytics and data sharing solutions since the formation of the ICB, THEN there is a risk that data and insights are not adequately shared and used across all partners and sectors, resulting in a lack of ability to make real time and longer-term changes and improvements for the benefit of our communities.	16	16			↔	4	Working with GM ICB analytics team on some projects to gain insights. Using data from Tableau and other sources where available. Local data sharing work rounds in place between NCA and ICB. Datasets now more readily available and shared informing programmes of accurate timely data.
6	Urgent and Emergency Care	BECAUSE of limited flow of patients out of the ED and hospital, the number of patients in ED is greater than the staff's capacity to safely manage, THEN there is a risk that this could lead to a compromised quality of care given to patients. Also, IF the number of patients on the Days Kept Away from Home (DKAFH) list do not reduce, THEN patients will be kept in hospital unnecessarily leading to potential increased harm for those patients (e.g. increased risk of infection, deconditioning)	16	16			↔	8	Extended criteria for UTC introduced. Pre-ED streaming to direct patients to alternative services as required. BCO easing the pressure rapid improvement plan and NWAS improvement group. 08:30 to midnight daily once all new staff are in post (LF) (Peoples Committee) from Sept 2022. Daily review at bronze meeting. Regular DKAFH meetings, walk rounds and Pathway 2 reviews. BCO Patient Flow and Discharge Collaborative. Staff recruitment and IDT redesign. Work on discharge app to improve accuracy of information and figures. Work with Discharge Front Runner

		and for other patients attending the emergency department and requiring admission to an acute bed (e.g. reduced ED capacity, trolley waits in ED).							Programme nationally recognised. Partnership work on discharge pathways for ASC funded and CHC funded people. Programme of work with PCFT to improve MH delays.
7	End of Life Risk included to show progress. To be removed in Q3 reporting.	BECAUSE additional investment cannot be secured to fund palliative care services then key elements of the GM Commitments, National Ambitions for palliative and EoLC, THEN there is a risk that an agreed Bury model cannot be implemented	16	8			↔	8	Palliative Care Consultant now in post to provide leadership. Active workstream. Progressing options for key service developments, including Hospice at Night, 7-day Hospice Outreach and weekend medical cover at the Hospice. Attention with partners to securing funding for end-of-life care in the locality.
8	Elective Care and Community Care	BECAUSE of the waiting times created by the pandemic and on-going staffing challenges, including junior doctors industrial action, THEN there is a risk that patients have delayed treatment, are at risk of harm and have a poor experience which could affect their health and wellbeing.	16	16			↔	4	GM ICB programme boards. Bury Elective Care and Cancer Recovery and Reform Board in place. Waiting list target tracked by provider. Waiting well in some specialties. Waiting list quality surveillance in place at divisional level for NCA. Community Services transformation programme led by ICB under 5 work pillars.

9	Services for Children, including SEND	BECAUSE the Bury system is not delivering in-line with the SEND national framework expectations, THEN there is a risk that the children, young people, families, and carers do not get the right support from health services, Children's Social Care and Education to ensure they reach as good outcomes as all children.	16	16			↑	8	Children's Improvement Board in place. Work continues on an improvement journey to strengthen the support for children, young people. and families in the borough. External support from national team. Independently chairing a SEND improvement board. Refreshed action plan underway. Committed £300k investment in the HV service from NCA. Investment into Early Years team. Neuro-development pathway development and reduction in waiting lists. Pathway mapping of the first 1001 days, and the potential roll-out of family hubs. Launch parenting strategy and early years proposition with oversight by the Childrens Strategic Partnership Board.
10	Sustainable General Practice	BECAUSE the apportionment of delegated monies into Primary Care is not equitable to that across GM THEN there is a risk that the whole of PC will be limited as to what they can support/deliver which could lead to the local general	16	16			↔	8	Benchmarking of spend/outcomes and discussions both locally and at GM (has revealed investment is significantly lower). Ongoing discussions to raise risk in GM and need for equitable/sufficient funding moving forward. System partners fully engaged in difficult decisions which may need

		practice strategy and GM PC Blueprint not being delivered in full and ultimately poorer outcomes for the patients of Bury.							to be taken as a result. Left shift of services and funding needed.
11	The delivery of the Uplands practice estate solution	BEAUSE an affordable scheme cannot be achieved to enable move of Uplands practice from current premises, THEN there is a risk that patients will have a poor experience of healthcare due to the condition of the estates.	16	16			↔	8	Work continues to achieve a redevelopment in this area due to the state and limited remaining life of the current Uplands Health Centre site. A preferred option has been agreed subject to financial and contractual agreements being reached with all parties. Greater Manchester ICB and regional approval for the proposed scheme has now been confirmed, national approval is awaited. If national approval confirmed, the current aim is to achieve the majority of development costs for this as a capital funded schemes prior to the end of March 2025.
12	Implementation of Working Together to Safeguard Children guidance (2023). Included to show progress, to be removed from Q3 reporting	The 2023 revision to the guidance focuses on strengthening multi-agency working across the whole system of help, support and protection for children and their families, keeping a child-centred approach while bringing a whole-family focus, and embedding strong,	16	8			↓	4	Partnership arrangements in place through the Bury Children's Safeguarding Partnership. Arrangement in draft awaiting approval by Partnership groups. Draft submitted to GMICB.

		effective, and consistent multi-agency child protection systems. BECAUSE there are significant changes within the guidance which require all safeguarding partners to work through locally to ensure ready for implementation from September and publication of arrangements by December 2024, THEN there is the risk that the locality will not be compliant by the set deadlines.							
13	GP collective action	Risk: There is a risk that GP Collective action Cause: in response to the BMA ballot outcome will Impact: withdrawal from supporting non-contractual services that support requests from the hospitals as well as community services.	12	16			↑	4	Sit rep reporting taking place weekly. Local working group established. Providers/commissioners asked to consider required changes in process/pathways in support of our practices.
14	Mental Health Programme	If the number of inappropriate Out of Area Placements is not significantly reduced this will result in continued risk	16	12			↓	8	GM, PFT and locality level improvement plan in place. Weekly locality and GM MADE meetings to support flow in MH

		of poor experience of care for some patients and financial pressure on the locality budget.							wards. GM crisis programme to increase / improve community based crisis provision and pathways. Actively monitored through Bury MH Programme Board.
15	Mental health programme	If patient flow is not improved in MH inpatient wards this will lead to delayed discharge of patients to more appropriate placements, drive demand for inappropriate Out of Area Placements and increase the risk of 12-hour breaches in ED	16	16			↔	8	GM, PFT and locality level improvement plan in place. Weekly locality and GM MADE meetings to support flow in MH wards. GM crisis programme to increase / improve community based crisis provision and pathways. Actively monitored through Bury MH Programme Board.
16	Mental health programme	If Bury (and the other NES localities) are unable to commission a provider of adult ASD assessment and ADHD assessment and treatment there will be complete reliance on the right to choose pathway resulting in: • inability to implement a managed pathways of care. • reliance on right to	16	16			↔	8	Right to choose pathway is in place for patients requiring assessment & GPs have previously been provided with information. Panel meets to look at any individual patients flagged by GPs or other H&SC professionals. Contract is in place with a provider for share care of existing ADHD patients with ADHD for 2024.25.

		choose with the associated inequality in access and cost pressures. ongoing reputational impact.							GM programme of work with aim of redesigning adult ADHD pathway. Risk has been formally escalated to GM exec and NES localities in active discussion with GM leads to identify commissioning options for 2025.26. Actively monitored through Bury MH Programme Board.
17	Mental health programme	If the number of referrals for adult neurodevelopmental assessments via the right to choose pathways continues to increase this will lead to potentially inequitable provision and significant financial pressures on the locality budget.	16	16			↔	8	Active monitoring of eligibility of RTC referrals and spend. GM programme of work with aim of redesigning adult ADHD pathway. Risk has been formally escalated to GM exec and NES localities in active discussion with GM leads to identify commissioning options for 2025.26. Actively monitored through Bury MH Programme Board.
18	Mental health programme	If demand and waiting times for CYP neurodevelopmental assessments are not reduced this will lead to continued delays in diagnosis and follow up treatment and support for children and families, and risk of further poor	16	16			↔	8	Progress monitored as part of the SEND inspection improvement plan. GM triage / prioritisation criteria implemented. PCFT waiting list initiatives planned.

		OFSTED / CQC inspection outcomes.							Waiting list reviews/check ins for those who are waiting the longest Tailored support for those who are waiting Development of an ND early help offer for families across GM.

4 Recommendations

4.1 None.

5 Actions Required

5.1 The Locality Board is asked to note the contents of the report and to raise any issues for the IDCB and Risk, Performance and Scrutiny Group.

Meeting:			
Meeting Date	02 December 2024	**Action**	Receive
Item No.	13	**Confidential**	No
Title	System Finance Group Update – November 2024		
Presented By	Simon O'Hare - Locality Finance Lead – NHS GM (Bury and HMR Localities)		
Author	Simon O'Hare - Locality Finance Lead – NHS GM (Bury and HMR Localities)		
Clinical Lead			

Executive Summary

The purpose of this report is to update the locality board on the financial position of all partners, with specific focus upon the budgets delegated to the locality board by NHS Greater Manchester (GM). The position of all partners continues to be very challenged in 2024/25.

At month 6 NHS GM has received an allocation of £175m, which is now reflected in the revised balanced annual plan for the system, with monies having flowed to providers and being allocated to NHS GM functions to reflect the opening plan. The month 6 NHS GM position is showing a deficit of £49.2m versus an expected deficit of £18.5m, giving an unplanned variance of £30.7m adverse to plan, an increase of £5.2m from month 6, and is forecasting recovery of this position by 31st March 2025, to allow delivery of the agreed £175m deficit. Within this position the Bury locality budgets, for which this board is responsible for are forecasting a deficit of £6.8m versus an expected break even annual position. The Northern Care Alliance (NCA) are £1.4m overspent at month 6 versus a plan of £0.8m abd have forecast to achieve their agreed deficit of £4.4m. Pennine Care NHS Foundation Trust (PCFT) are reporting a break even financial position at month 6 and a very slight surplus at year end, both in line with plan

The council's medium term financial strategy (MTFS) has been reviewed and updated and is being considered at November Cabinet along with initial budget proposals for the setting of the 2025/26 revenue budget. A funding gap of £35m is forecast by 2027/28 which reduces to £22.3m when savings proposals identified to date are taken into account and for context the current year revenue budget is £224m.

As at Month 6 £187.3m of CIP has been delivered by NHS GM against a plan of £187.6m, a slight under delivery of £0.3m. The forecast CIP position is £491.6m against a target of £490.3m, an overachievement of £1.3m which is broadly in line with the prior month. In terms of CIP delivery on the budgets delegated to the locality, at month 6 £2.79m has been delivered against a month 6 plan of £3.08m, with shortfalls against plan in Medicines Optimisation and Complex Care, this therefore puts signifianct risk on the full delivery of 2024/25 CIP.

Recommendations

Locality board members are asked to:

- Note the contents of this report and the financial challenges across the Bury system and NHS GM.
- Note the reduction in the defict on the budgets that the locality board is responsible for and the distance still to delivery a break even position recurrently

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

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

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

System Finance Group Update – October 2024

1. Introduction

1.1. The purpose of this report is to update members of the locality board on the financial position of the 4 statutory bodies who primarily serve the population of Bury, along with that of NHS Greater Manchester Integrated Care (NHS GM).

2. Background

2.1 The position of all partners continues to be very challenged in 2024/25 with NHS GM in undertakings with NHS England which brings additional scrutiny and rigour around finance, performance and quality.

3. Bury Council

3.1.1 The council's medium term financial strategy (MTFS) has been reviewed and updated and is being considered at November Cabinet along with initial budget proposals for the setting of the 2025/26 revenue budget. A funding gap of £35m is forecast by 2027/28 which reduces to £22.3m when savings proposals identified to date are taken into account and for context the current year revenue budget is £224m.

3.1.2 The majority of the forecast funding gap relates to 2025/26 (£19.5m) and work is continuing to identify further savings proposals in advance of the budget-setting council meeting in february as reserve levels are insufficient to support the setting of a budget over the full 3 year period covered by the MTFS.

3.2 NHS Greater Manchester

3.2.1 NHS Greater Manchester (GM) remains in undertakings with NHS England, and this brings additional scrutiny and rigour around finance, performance and quality.

3.2.2 At month 6 NHS GM has received an allocation of £175m, which is now reflected in the revised balanced annual plan for the system, with monies having flowed to providers and being allocated to NHS GM functions to reflect the opening plan. The month 6 NHS GM position is showing a deficit of £49.2m versus an expected deficit of £18.5m, giving an unplanned variance of £30.7m adverse to plan, an increase of £5.2m from month 6, and is forecasting recovery of this position by 31st March 2025, to allow delivery of the agreed £175m deficit. This position is shown below in table 1

Table 1

Month 6 2024/25 (£m)	YTD Plan	YTD Actual	YTD Variance	Full Year Plan	Full Year Forecast	Full Year Variance
GM NHS Providers	-£18.5	-£44.0	-£25.5	£0.0	£0.0	£0.0
NHS GM	£0.0	-£5.3	-£5.3	£0.0	£0.0	£0.0
ICS Total	**-£18.5**	**-£49.2**	**-£30.7**	**£0.0**	**£0.0**	**£0.0**

3.2.5 As at Month 6 £187.3m of CIP has been delivered by NHS GM against a plan of £187.6m, a slight under delivery of £0.3m. The forecast CIP position is £491.6m against a target of £490.3m, an overachievement of £1.3m which is broadly in line with the prior month.

3.3 NHS GM – Bury Locality

3.3.1 At month 6, the Bury locality, on the budgets delegated from NHS GM, is forecasting a year end deficit of £6.8m, against an anticipated break even position. This deficit has reduced from £7.1m at month 5 and is shown overleaf in table 2.

Table 2

Bury Locality Month 6 Finance Position						
Directorate	YTD Budget	YTD Actual	YTD Variance	Annual Budget	Forecast Outturn	Forecast Variance
Acute	£1,087,632	£1,087,449	-£183	£2,175,584	£2,175,584	£0
CHC	£10,175,918	£13,231,447	£3,055,529	£20,195,649	£23,178,689	£2,983,040
Community	£8,897,012	£8,974,171	£77,159	£17,482,380	£17,564,771	£82,391
Mental Health	£8,114,728	£10,827,732	£2,713,004	£16,182,512	£19,898,068	£3,715,556
Other	£1,367,181	£1,433,736	£66,555	£2,804,534	£2,990,474	£185,940
Primary Care	£2,388,581	£2,213,535	-£175,046	£5,354,868	£5,229,555	-£125,313
Grand Total	£32,031,052	£37,768,071	£5,737,019	£64,195,527	£71,037,141	£6,841,614

3.3.2 As can be seen the primary causes of this deficit position are in Complex Care (CHC and Mental Health) and the main drivers of the deficit are:

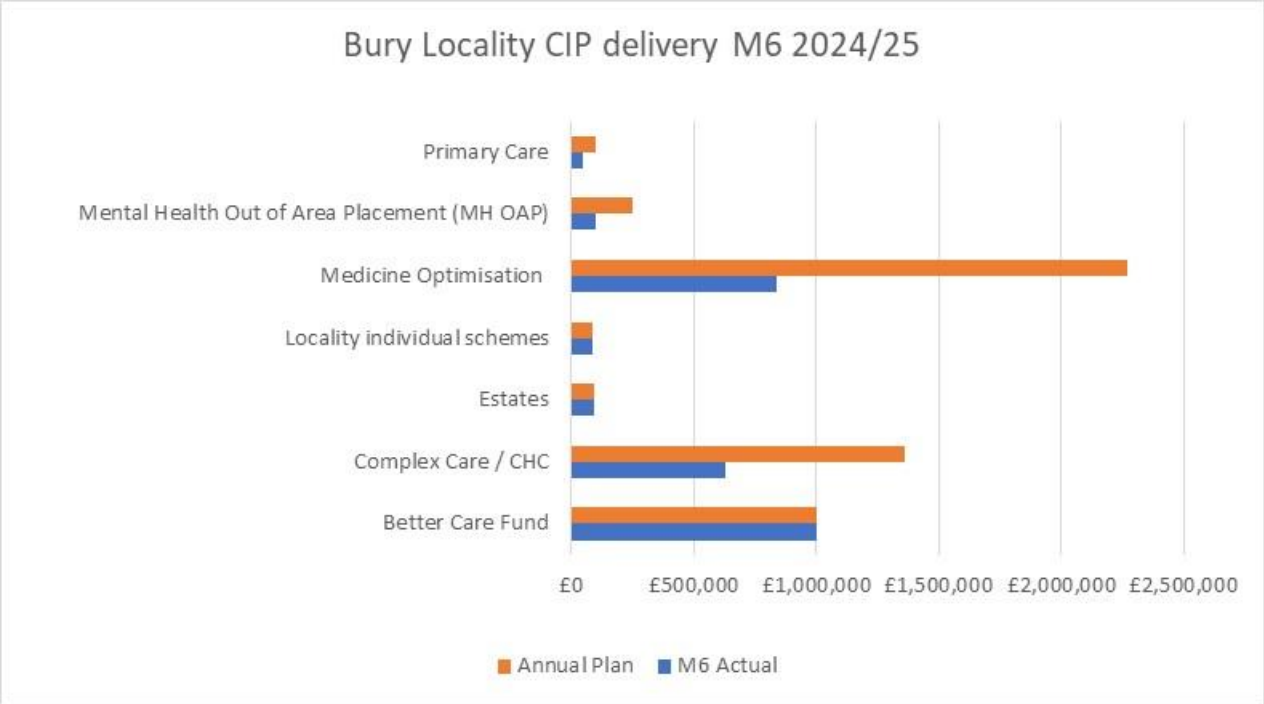
- Increases in the cost and number of Complex Case packages, shared 50:50 with the council
- Increases in the costs and number of Complex Case packages solely funded by the NHS
- Prior year pressures brought forward
- The impact of changes to the discharge pathway from acute hospital which has caused greater costs to the locality
- High performance with regard to discharges of residents of the borough with a learning disability or autism, from hospital settings into the community.

The locality is focussed upon delivery of an action plan, is receiving support from Price Waterhouse Cooper and is the subject of monthly intervention meetings from NHS GM Executive colleagues to address and reduce this deficit in Complex Care. This has been successful in driving out £2m from the forecast since month 4.

3.3.3 Alongside these very significant pressures there are also smaller pressures with regard ADHD / ASD assessments (£0.2m) and estates (£0.2m). The former is particularly volatile as more providers are being approved nationallyto delivered services.

3.3.4 With regard to CIP achievement at month 5, the locality has achieved £2.79m of CIP delivery which is 54% of the annual target, but delivery is behind plan in terms of Medicines Optimisation and CHC / Complex Care. There are risks associated with full delivery of the Medicines Optimisation target due to staffing pressures and also with CHC / Complex Care due to demand and inflationary pressure. It should also be noted that alongside the £400k costs reduction savings the Complex Care / CHC team have also delivered £1.54m of savings that have avoided increased costs. CIP delivery and annual plan values are shown overleaf in graph 1.

Graph 1



5.0 Conclusion

5.1 Locality board members are asked to:

- Note the contents of this report and the financial challenges across the Bury system and NHS GM.
- Note the reduction in the defict on the budgets that the locality board is responsible for and the distance still to delivery a break even position recurrently

Simon O'Hare
Locality Finance Lead – NHS GM (Bury and HMR Localities)
s.ohare@nhs.net
November 2024

Meeting:			
Meeting Date	02 December 2024	**Action**	Receive
Item No.	14	**Confidential**	No
Title	Population Health update		
Presented By	Jon Hobday – Director of Public Health		
Author	Jon Hobday – Director of Public Health		
Clinical Lead	N/A		

Executive Summary
An overview of the work discussed and planned in key population health/public health meetings.
Recommendations
To note the work being discussed.

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 Locality Plan outcomes	
To support a local population that is living healthier for longer and where healthy expectancy matches or exceeds the national average by 2025.	☒
To achieve a reduction in inequalities (including health inequality) in Bury, that is greater than the national rate of reduction.	☒
To deliver a local health and social care system that provides high quality services which are financially sustainable and clinically safe.	☐
To ensure that a greater proportion of local people are playing an active role in managing their own health and supporting those around them.	☒

Implications						
Are the risks already included on the Locality Risk Register?	Yes	☐	No	☐	N/A	☒
Are there any risks of 15 and above that need to be considered for escalation via an NHS GM Statutory Committee or Board in line with the Risk Escalation process ?	Yes	☐	No	☐	N/A	☒
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	☒

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

BURY INTEGRATED CARE PARTNERSHIP

Population Health and Wellbeing update

1. Introduction

1.1. This paper sets out recent population health updates and discussions from key meetings locally and in Greater Manchester (GM).

2. GM Population Health Committee

3.1 No GM population health committee has taken place since the update at the last Locality Board Meeting.

4 Bury Health and Wellbeing Board

4.1 The last Health and Wellbeing Board took place on 12th November. There were 4 substantive items for discussion, the anti-poverty evaluation, drug and alcohol related harm plans, national smoking legislation and tobacco control updates and the work of the Bury homelessness partnership.

4.2 The anti-poverty strategy evaluation item looked at the quality, process and outcomes of the strategy. It reviewed the work going on throughout the 9 key areas of the strategy including - tackling food poverty, wellbeing and poverty, finance and debt, adult poverty and education, work and wages, child poverty and education, fuel poverty, community engagement and reducing stigma and digital inclusion. The evaluation concluded that the strategy and approach has demonstrated strong leadership and effective coordination addressing immediate, medium- and long-term poverty challenges. It also made a series of recommendations to refine the approach going forward which included developing a local cost of living dashboard and further strengthening partnerships.

4.3 The drug and alcohol harm related item focused on the current provision and pathways in place and the outcomes for our residents. The item highlighted that we had just under 1200 people in service between July 23 and June 24, and that 46% of those in treatment have shown 'treatment progress' (in line with national levels). The data from the item also highlighted how on a positive note Bury has lower rates of alcohol related admissions when compared to national levels.

4.4 The national smoking legislation and tobacco control updates highlighted the tobacco and vape legislation that is currently going through parliament. Specifically, if passed through how it will:

4.4.1 create a smoke-free generation, gradually ending the sale of tobacco products across the country and breaking the cycle of addiction and disadvantage.

4.4.2 strengthen the existing ban on smoking in public places to reduce the harms of passive smoking, particularly around children and vulnerable people.

4.4.3 ban vapes and nicotine products from being deliberately branded, promoted, and advertised to children to stop the next generation from becoming hooked on nicotine.

4.4.4 provide powers to introduce a licensing scheme for the retail sale of tobacco, vapes and nicotine products in England, Wales, and Northern Ireland, and expand the retailer registration scheme in Scotland.

4.4.5 strengthen enforcement activity to support the implementation of the above measures.

4.4.6 The item also outlined all the work going on locally to support Bury residents to quit smoking including targeted provision for high-risk groups including routine and manual workers, those with mental health conditions and those in the LGBTQI+ community. It also outlined the swop to stop support we have in place providing free vapes and starter kits to those wanting to quit.

4.5 The homelessness and housing item provided an overview of local and regional approach to tackle homelessness. It highlighted some key statistics for Bury including 1082 homelessness cases in the last 12 months, 183 cases in temporary accommodation, 2865 housing register applications and 24 rough sleepers. It highlighted the key reasons for the increase in homelessness are cost of living, lack of social housing, expensive housing market in Bury and GM, breakdowns in relationships, increase in complex needs, increased numbers of non-priority customers and migration pressures.

4.5.1 The item also outlined the work of the Bury Homelessness Partnership and the positive interventions in place which aim to try and address the issue including hospital discharge protocols, prison pathways, transition pathways, A Bed Every Night (ABEN) and migration pathways.

4.5.2 The item also covered the work both in progress and planned to try and address this issue further including, introducing neighbourhood housing support services, bringing Six Town housing back into the council, increasing the temporary stock accommodation and reviewing the current commissioned services.

Jon Hobday
Director of Public Health
j.hobday@bury.gov.uk
November 2024

Meeting: Locality Board			
Meeting Date	02 December 2024	**Action**	Receive
Item No.	15	**Confidential**	No
Title	Primary Care Commissioning Committee update		
Presented By	Adrian Crook, Director of Adult Social Services and Community Commissioning		
Author	Faith Farnworth-Collinge, Governance Support Officer		
Clinical Lead			

Executive Summary
The Primary Care Commissioning update is provided as a highlight report from the meeting held on the 25th November 2024.
Recommendations
The Locality Board is asked to note the highlight report from the last Primary Care Commissioning Committee.

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 Locality Plan outcomes	
To support a local population that is living healthier for longer and where healthy expectancy matches or exceeds the national average by 2025.	☒
To achieve a reduction in inequalities (including health inequality) in Bury, that is greater than the national rate of reduction.	☒
To deliver a local health and social care system that provides high quality services which are financially sustainable and clinically safe.	☒
To ensure that a greater proportion of local people are playing an active role in managing their own health and supporting those around them.	☒

Implications						
Are the risks already included on the Locality Risk Register?	Yes	☐	No	☒	N/A	☐
Are there any risks of 15 and above that need to be considered for escalation via an NHS GM Statutory Committee or Board in line with the Risk Escalation process ?	Yes	☐	No	☒	N/A	☐
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	☐

Governance and Reporting		
Meeting	**Date**	**Outcome**
Primary Care Commissioning Committee	25/11/2024	Highlight report attached.

Bury Primary Care Commissioning Committee (PCCC) Highlight Report

Chair: Adrian Crook
Reporting period: November 2024
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:

Out Of Hours (OOH) commissioning intentions - due to time constraints, it was requested that a virtual decision be made regarding Out Of Hours (OOH) commissioning intentions. An email was sent to all Placed Based PCCC members on 6 November 2024. The Chair summarised the outcome that the majority of the vote was in support and was received with 5 votes (out of 6) in support received. The Terms of Reference for PCCC state that the decision will be met by the majority vote and as such confirmation of the outcome has been provided to the Programme Manager.

Quarter 2 Contracting Report - a comprehensive overview of all contracts as at Q2 was received by the committee. Concerns remain regarding the lack of business intelligence support to aid performance monitoring/management of PC contracts, which has been raised previously. It was also noted that General Practice is currently unable to access MoCA Training free of charge and this inequity needed support from central GM colleagues to resolved.

Commissioning Intentions/CIP 2025/2026 – The committee received GM/local commissioning intentions for 2025/26 which took into account the required 5% CIP. It was the view of committee members that whilst cognisant of the financial position across GM, it could not support a 5% CIP on all Primary Care Enhanced Services due in the context of Bury being the third lowest funded locality in GM, this does not however mean that efficiencies and reinvestment cannot be considered. PCCC also could not support the continuation of QAS as a funding stream has not been identified.

In addition, PCCC were presented with updates regarding:

- The Primary Care Programme as a whole (highlight and risk report)
- Finance

Priority actions in coming period:

GP Collective Action: Ongoing provider service improvements to mitigate around collective action impact

General Practice Leadership Collaborative - Development Plan

BeCCoR – Discussion around next years contract in order to consider local commissioning arrangements

Enhanced Services - Recommissioning of various contracts for 2025/26 as agreed by the committee

Primary Care Quality – Progress report on Primary Care Quality Visits and update from GM workshop

Decisions made:

Out Of Hours (OOH) commissioning intentions – The PCCC supported the recommendation of a Direct Award C 1+1 year for GP out of hours contractual arrangements.

Commissioning Intentions/CIP 2025/2026 – Value for money contractual alterations to be considered but no blanket 5% CIP to be applied to PC delegated budget.

Quality Assured Spirometry – Will cease 31/03/25 unless a funding stream can be identified

Top 3 risks & mitigation:	RAG rating
Investment into General Practice – Impacting our commissioning options e.g. LCS and Spirometry etc. Discussions are ongoing via BeCCoR	
MOT CIP Delivery – Priorities have been reviewed and non-essential work stood down	
GPCA – Impact of collective action on wider system	

Any other information:

Key escalations for NHS Greater Manchester PCCC:

Funding with regards to QAS provision at locality level beyond 31st March 25 remains a concern.
Localities need a better understanding of the BI function supporting PC both in terms of existing and future dashboards and how they might meet ongoing requirements of localities
MOCA – support needed to secure training FOC for 25/26
CIP – Bury cannot support a 5% CIP against the PC Delegated Budget

Meeting: Locality Board			
Meeting Date	02 December 2024	**Action**	Receive
Item No.	16	**Confidential**	No
Title	Bury Integrated Care Partnership System Assurance Committee Summary Report		
Presented By	Catherine Jackson, Associate Director for Nursing, Quality and Safeguarding		
Author	Catherine Jackson,Associate Director for Nursing, Quality and Safeguarding		
Clinical Lead	Cathy Fines, Associate Medical Director		

Executive Summary
This report provides the Locality Board with a summary from the Bury Integrated Care Partnership System Assurance Committee meeting that took place in November 2024.
Recommendations
The Locality Board is asked to receive the report and share any feedback to the System Assurance Committee for action.

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

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☐	N/A	☒
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☐	N/A	☒
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☐	N/A	☒
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☐	N/A	☒

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

Governance and Reporting		
Meeting	**Date**	**Outcome**
System Assurance Committee	11/11/2024	Summary to be provided to Locality Board

System Assurance Committee Highlight Report – September 2024

1. Introduction

1.1. This report provides the Locality Board with a summary from the Bury Integrated Care Partnership System Assurance Committee (SAC) meeting that took place in November 2024.

2. Background

2.1. This report is a summary of the System Assurance Committee held on 11th November 2024. Since May 2024, it has been agreed that the SAC will now be held bi-monthly.

3. Headlines from the System Assurance Committee

3.1 Community Safety Partnership

Chris Woodhouse provided a presentation outlining the work of the Community Safety Partnership (CSP) and the ongoing engagement of the refresh/current plan. Chris highlighted the following key points.

Community cohesion

There was significant national disorder over the summer, whilst Bury avoided any direct public disorder, there were residents from Bury who were charged with disorder, including in Newton Heath and in Manchester. A motion was accepted by all parties at all Councils in September which is a series of recommendations to strengthen communication.

The CSP is interested to understand the changing patterns of communities and in particular some of the influencers including informal community leads within those communities that can help communicate messages wider.

There are informal networks of community leads, who may not be part of any formal team Bury structure, but that might be able to quash any rumours and help manage community concern. This is an area of particular interest going forward.

Increased work around tackling serious youth violence

This piece of work is linked to a spate of violent incidents in the Town Centre and Whitefield earlier in the year. This has led to a district priority in terms of tasking some work particularly around Whitefield, to understand the kind of vulnerabilities at play in that neighbourhood and do some targeted work on known offenders in the area to help build capacity and resilience within that neighbourhood. There are multi-disciplinary meetings being set up to look at how this is strategically managed. If any committee members are interested in becoming involved in that, their details can be forwarded to Chris.

Bury's nighttime economy

This relates particularly to the run up to Christmas. There has been some additional policing resource secured to cover the early hours of the morning; particularly the period from 3:00am to 5:00am where previously the policing shift pattern would have finished.

All the above areas of work are being picked up through conversations via the CSP in relation to the refresh. These will then feed into what the priorities need to look like going forward in

the context of Let's Do It.

There is currently a priority around domestic abuse, which the CSP is looking to shape based on the conversations to date to explicitly link activity with the work around substance misuse and mental health. Some Committee members have been involved in safeguarding reviews and domestic homicide reviews; work now needs to be undertaken around how that is included into the new plan. Engagement on this activity is continuing and within the slides there is a QR code and link to information. Views are welcomed to help further shape the strategy; also one of the principles within the plan is around how to increase dialogue with communities around safety to ensure continued awareness across organisations and networks which this Committees members represent.

Chris reported that at a recent circles of influence session with young people there was a significant request for more police presence in an informal capacity in schools. The CSP is now looking at the opportunity to do some work around building confidence and trust.

3.2 GMICB Prevention Future Deaths Annual Report

Catherine Jackson provided the first GMICB 2023/2024 Annual Report on Prevention of Future Deaths (PFDs). The report provides a comprehensive overview of the insights gained from national reviews of PFDs which are published and in the public domain.

A PDF is a issued by the coroner to an organisation/s when the coroner feels that there needs to be a change in policy or practice or there is wider learning to be embedded to prevent the potential of the same thing happening to another person.

The report also outlines the governance structures and processes that NHS Greater Manchester has implemented to effectively respond to and learn from these reviews and that the lessons learned are systematically integrated into practice, thereby enhancing patient safety, and preventing future incidents.

The purpose of bringing the report to System Assurance Committee was to provide assurance that PFD reports are discussed locally and that there is a mechanism as an ICB to capture learning and to share this learning with localities.

NHS Bury had two PFDs in the two-year period; one in the last year was related to accessing phlebotomy services, Bury has to respond to the PFD with a timely letter to the coroner to explain how the issue has been addressed. This then has to be reviewed a period of time later to ensure what was put in place is being undertaken and to give assurance Bury has made changes.

The second PFD related to a person with an eating disorder which was issued to a wide range of services across GM; hospital setting, mental health service, community and specialist eating disorders services. Again Bury had to respond to say what would be done differently and what has been put in place. This will also require a review to ensure that any improvements have been embedded and maintained.

3.3 Patient Services Update

Mark Pameria presented a report based on data from quarter 2 (July – September of 2024/25). The report outlines Patient Services activity for Bury locality, based on enquiries, complaints

and MP letters managed by NHS Greater Manchester (NHS GM) Patient Services team.

The report is a first iteration of a report to provide information about the patient services team and the inquiries it deals with.

The report highlighted a backlog of primary care complaints. The team manages primary care complaints in line with the NHS complaints and the complaints relation regulations under delegated responsibility from NHS England.

Complaints about primary care go directly to the practice and many do receive good resolution through the practice. There is an option under the NHS complaints resolution to refer to the Commissioner and thus directed through to the patient services team.

The backlog of primary care complaints is being managed under the recovery directory with some dedicated resource; there are currently around 100 complaints. The team is working with the quality leads through primary care to speed up and get those responses back. There is an intense piece of work taking place with the backlog that is reported through the NHS GM Quality and Performance Committee which the team has also been part of. The team is now back to its agreed recovery trajectory in that area with NHS England.

The team is undertaking a piece of work with the Datix system to establish some dashboards which may be more useful as cases can be drilled down into to find particular information which will provide more granular information for Bury.

3.4 Bury Council Quality Assurance and Improvement Framework and Levels of Support Framework

Quarter 1 and 2 state of the market update

Matt Logan presented the state of market report highlighting the key headlines. The report included an update on both quarter one and quarter two due to the Quality Assurance and Improvement Framework only becoming live in Quarter 2.

The Committee will receive a report every quarter which will outline the quality assurance reviews that have been carried out and the results and themes coming out of those including; the complaints and concerns that have been dealt with and managed as a commissioning team; an update on the latest CQC inspections and ratings within Bury for adult social care providers and any next steps and future plans produced as a commissioning team around quality assurance.

Looking forward into quarter three, there will be a larger data set of quality assurance results post completion of the improvement plan. Work is ongoing with providers on the improvement plans on actions that have been identified.

Bury is second in Greater Manchester for a percentage of care home beds within good and outstanding care homes and is also second highest in the Northwest. Bury is also substantially above the England average. In the report it states Community services, self-care at home and supported living has two ‘care at home’ providers rated inadequate or requires improvement; this is no longer the case after reinspection.

Community services no longer has any 'requires improvement' or 'inadequate' care at home providers. Bury is currently fourth in GM but from a commissioning point of view it is a much more positive position.

Provider Development Plan
Matt reported that at the end of each cycle, there will be assurance assurance (QA) reviews; the aim is to have a Provider Development Plan to address any issues identified and will support providers to improve.

There has been a provider workforce event to look at how best to support providers with staff recruitment, retention and development. Work is also being undertaken around what that excellence programme might look like.

3.5 New and Emerging issues
New and emerging concerns are raised as part of the Quality Report presented by Catherine Jackson. Issues and mitigating actions are discussed from a partnership perspective to explore how the system can resolve issues. All emerging issues and risks are reported to GMICB System Qualty Group (SQG) through the Locality Flash Reports.

4 Associated Risks

4.1 None.

5 Recommendations

5.1 None

6 Actions Required

6.1 The Locality Board is asked to note the contents of the report and to raise any issues for the System Assurance Committee to address.