AGENDA FOR

LOCALITY BOARD

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

Dear Member/Colleague

Locality Board

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

Date:	Monday, 3 March 2025
Place:	Microsoft Teams
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

1 **AGENDA PACK** *(Pages 3 - 160)*

Agenda

Locality Board – Meeting in Public (on Teams)

Date: 03rd March 2025

Time: 4.00 pm – 6.00 pm

Venue: Microsoft Teams

Chair: Cllr O'Brien

Full agenda pack begins on next page.

Date and time of next meeting
Monday, 07th April 2025 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 26th February 2025 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 (on Teams)

Date: 3rd March 2025

Time: 4.00 pm – 6.00 pm

Venue: Microsoft Teams

Chair: Cllr O'Brien

Item No.	Time	Duration	Subject	Paper Verbal	For Approval Discussion Information	By Whom
1.0	4.00 – 4.10	10 mins	Welcome, apologies and quoracy	Verbal	Information	Chair
2.0			Declarations of Interest	Paper	Information	Chair
3.0			Minutes of previous meeting held on 3rd February 2025 and action log • Family Hubs linked to Neighbourhood working	Paper Paper	Approval Information	Chair Stephen Holden
4.0			Public questions	Verbal	Discussion	Chair
Place Based Lead Update						
5.0	4.10 – 4.20	10 mins	Key Issues in Bury	Paper	Discussion	Lynne Ridsdale
Locality Board Priorities						
6.0	4.20-4.30	10 mins	Elective Care/Waiting time position including Pathway Redesign and Paediatric ENT Update	Presentation	Discussion	Jo Fawcus /Sanjay Kotegaonkar
7.0	4.30-4.40	10 mins	Whitefield Scheme Paper	Paper	Discussion	Clare Postlethwaite
8.0	4.40-4.50	10 mins	Overview of Children's National Policy changes including Children's Priorities	Paper	Discussion	Robert Arrowsmith
9.0	4.50-5.00	10 mins	Pennine Care Service Mapping	Verbal	Discussion	Sarah Preedy
10.1 10.2	5.00-5.10	10 mins	Lets Do it strategy for borough Locality Plan	Verbal Verbal	Discussion Discussion	Lynne Ridsdale Will Blandamer

Integrated Delivery Collaborative Update						
11.0	5.10-5.15	5 mins	Integrated Delivery Board Update	Paper	Discussion	Kath Wynne-Jones
12.0	5.15-5.20	5 mins	Performance Report	Paper	Discussion	Kath Wynne-Jones
13.0	5.20-5.30	10 mins	Risk Report	Paper	Information	Catherine Jackson
Updates						
14.0	5.30-5.35	5 mins	Strategic Finance Group Update	Paper	Discussion	Simon O'Hare
15.0	5.35-5.40	5 mins	Population Health and Wellbeing update	Paper	Information	Jon Hobday
Committee/Meeting updates						
16.0	5.40-5.45	5 mins	Clinical and Professional Senate update	Paper	Information	Kiran Patel
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, 7 April 2025, 4.00 - 6.00pm in Committee Rooms A and B, Bury Town Hall**		_____	

Meeting: Locality Board			
Meeting Date	03 March 2025	**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 3 March 2025 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	☐
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	☐

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	X			Direct	Councillor		Present	As per policy - see details above		
				Young Christian Workers - Training & Development	X			Direct	Development Team		Present			
				Labour Party		X		Direct	Member		Present			
				Prestwich Arts College		X		Direct	Governor		Present			
				Bury Corporate Parenting Board		X		Direct	Member		Present			
				No Barriers Foundation		X		Direct	Trustee		Present			
				CAFOD Salford		X		Direct	Member		Present			
				Prestwich Methodist Youth		X		Direct	Trustee		Present			
				Unite the Union		X		Direct	Member		Present			
Cllr	Tariq	Tamoor	Executive Member of the Council Adult Care and Health	Bury Council - Councillor	X			Direct	Councillor	May-10	Present	As per policy - see details above		
				Health Watch Oldham	X			Direct	Manager	Aug-20	Present			
				Pretty Little Thing				Indirect			Present			
				Action Together CIC	X			Direct	Employed		Present			
				The Derby High School			X	Direct	Governor	Apr-18	Present			
				St Lukes Primary School		X		Direct	Member		Present			
				Unite the Union		X		Direct	Community Member	May-12	Present			
				Labour Party		X		Direct	Member	Jun-07	Present			
Cllr	Smith	Lucy	Executive Member of the Council for Children and Young People	Bury Council	X			Direct	Councillor		Present	As per policy - see details above		
				Business in the Community	X			Direct		July 2023	Sep-23			
				The Christie NHS Foundation Trust				Indirect	Related to Spouse	Jul-23	Present			
				Labour Party				Direct	Member		Present			
				Community in the Union				Direct	Member		Present			
				Socialist Health Association				Direct	Member		Present			
				Catholics for Labour				Direct	Member		Present			
				GMB Union				Direct	Member		Present		######	Y
Dr	Fines	Cathy	Associate Medical Director and Named GP	GP Federation	X			Direct	Practice is a member	2013	Present	Declaration of interest as per policy as detailed above (Y,Y,Y,Y,Y)		
				Tower Family Health Care	X			Direct	Partner in a member practice in Bury Locality	2017	Present			
				Horizon Clinical Network	X			Direct	Practice is a member	2019	Present			
				Greater Manchester Foundation Trust				Indirect	Husband is employed		Present		######	Y
	Jackson	Catherine	Associate Director of Nursing, Quality & Safeguarding	Northern Care Alliance				Indirect	Partner is a Director at the Northern Care Alliance	2019	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	Locality Finance Lead	Simkat Shore Holdings LTD	X			Direct	Director	Apr-19	Present	As per policy - see details above. (Y,Y,Y,Y,Y)		
	Kissock	Neil	Director of Finance/Section 151 Officer	None Declared					Nil Interest	Aug-24	Present			
	Heppolette	Warren	Chief Officer for Strategy & Innovation	Greater Sport			X	Direct	Trustee	2018	Present	As per policy - see details above (Y,Y,Y,Y,Y)		
				FC United			X	Direct	Director	2021	Present			
Voting Members (Aligned & Non-Pooled Budget)														
Dr	Howarth	Vicki	Medical Director – Bury Care Organisation, NCA	Unilabs Ltd - Private Histopathology Service	X			Direct	Providing services as Consultant Histopathologist to the	2011	Present	As per policy - see details above (Y,Y,Y,Y,Y)		
				Tameside and Glossop Integrated Care NHS Foundation Trust	X			Direct	Bank Consultant Histopathologist performing Coronial Post-	2015	Present			
	Fawcus	Joanna	Director of Operations, NCA	None Declared					Nil Interest	Nov 23	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			
Dr	Patel	Kiran	Member of the Locality Board	Tower Family Health Care - Primary Care General Practice	X			Direct	GP Partner	Jul-18	Present	As per policy - see details above (Y,Y,Y,Y,Y)		
				Bury GP Federation - Enhanced Primary Care Services	X			Direct	Medical Director	Apr-18	Present			
				Laserase Bolton - Provider of a range of cosmetic laser and injectable	X			Direct	Medical Director	1994	Present			
				Laserase Bolton - Provider of a range of cosmetic laser and injectable				Indirect	Spouse is a Shareholder	2012	Present			
				Tower Family Health Care - Primary Care General Practice				Indirect	Spouse is a Director	Jul-18	Present			
	Preedy	Sarah	Chief Operating Officer, Pennine Care NHS Foundation Trust	None Declared					Nil Interest	Nov 23	Present			
	Hargreaves	Sophie	Chief Officer, Manchester Foundation Trust	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	Chief Officer, Bury VCFA	Bury VCFA (Voluntary, Community, Faith & Social Enterprise)	X			Direct	Chief Officer in organisation which may seek to do business with health or social care organisations	Nov-21	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			X	Direct	Chairman	2024	Present	As per policy - see details above (Y,Y,Y,Y,Y)		
				Manchester Football Association			X	Direct	Non Exec Director (Board Champion for Safeguarding)	2018	Present			
				Francis House Hospice (Manchester)				Indirect	Spouse is a Registered Nurse	2024	Present			
				University Hospital of Wales				Indirect	Daughter is a Foundation Year 1 Doctor	2024	Present			
				Leeds University				Indirect	Daughter is a medical student	2019	Present			
	Richards	Jeanette	Executive Director of Children and Young People, Bury	None Declared					Nil Interest	Nov 23	Present			
	Hobday	Jon	Director of Public Health	None Declared					Nil Interest		Present	As per policy - see details above		
	Bulman	Richard	Director of Nursing, Bury Care Organisation	None Declared					Nil Interest	2025	Present		######	
	Crook	Adrian	Director of Adult Social Care and Community Services	Bolton Hospice			X	Direct	Trustee	Jul-05	Present	As per policy - see details above (Y,Y,Y,Y,Y)		
Non-Voting Members														
	Wynne-Jones	Kath	Chief Officer, Bury Integrated Delivery Collabrative	KWJ Coaching and Consulting	X			Direct	Owner	July 21	Present	As per policy - see details above (Y,Y,Y,Y,Y)		
				Roots and Branches CIC	X			Direct	Director	Nov 23	Present			
				The University of Manchester - Elizabeth Garrett Anderson programme	X			Direct	Tutor	Oct-22	Present			
Invited Members														
Cllr	Bernstein	Russell	Cllr Bury Council, Conservative Leader	Bury Council	X			Direct	Councillor	May-21	Present	As per policy - see details above (Y,Y,Y,Y,Y)		
				Philips High School			X	Direct		Sep-19	Present			
				Bury and Whitefield Jewish Primary			X	Direct		Sep-19	Present			
				Conservative Party		X		Direct	Councillor	Jul-19	Present			
Cllr	Smith	Mike	Attendee of the Locality Board as Leader of Radcliffe First	Angles and Arches	X			Direct	Director	16/1/2009	Present	As per policy - see details above (Y,Y,Y,Y,Y)		
				Anodising Colour		X		Indirect	Spouse is a lab technician	2017	Present			
				Radcliffe First		X		Direct	Leader	2019	Present			
				Radcliffe Litter Pickers		X		Direct	Member	2019	Present			
				Growing Older Together		X		Direct	Member	2019	Present			

Meeting: Locality Board			
Meeting Date	03 March 2025	**Action**	Approve
Item No.	3	**Confidential**	No
Title	Minutes of the Previous Meeting held on 3rd February 2025 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 3rd February 2025 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 3rd February 2025.
- 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		

Draft Minutes

Date: Locality Board, 3rd February 2025

Time: 4.00 pm

Venue: Committee Rooms A&B, Bury Town Hall

Title	**Draft Minutes of the Locality Board**
Author	Emma Kennett
Version	0.1
Target Audience	Locality Board
Date Created	February 2025
Date of Issue	February 2025
To be Agreed	Monday, 3rd March 2025.
Document Status (Draft/Final)	Draft
Description	Locality Board Minutes

Document History:

Date	Version	Author	Notes
February 2025	0.1	Emma Kennett	Draft Minutes produced
Approved:			
Signature:			..... **Add name of Committee/Chair**

Locality Board

MINUTES OF MEETING
Locality Board Meeting in Public 3rd February 2025 4.00 pm until 6.00 pm **Chair – Cllr Eamonn O'Brien**

ATTENDANCE

Voting Members
Cllr Eamonn O'Brien, Leader of Bury Council (Chair) Cllr Lucy Smith, Executive Member of the Council for Children and Young People Cllr Tamoor Tariq, Executive Member of the Council for Adult Care and Health Mr Warren Heppolette, Chief Officer for Strategy and Innovation (GMIC) Ms Lynne Ridsdale, Place Based Lead Mr Simon O'Hare, Associate Director of Finance Ms Lorna Allan, Chief Digital and Information Officer, NCA Ms Joanna Fawcus, Director of Operations, 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 Dr Kiran Patel, Medica Director, IDCB 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 Mr Stephen Holden, Interim Director of Education and Skills (deputising for Ms Richards)
Non-Voting Members
None in attendance.
Invited Members and Observers
Cllr Bernstein, Conservative Opposition Party Ceri Kay, Legal Services, Bury Council Fin McCaul, Lead, Long Term Conditions, NHS Greater Manchester (Bury) Katy Alcock, Senior Directorate Manager – Integrated Care, Bury Care Organisation Ms Chloe Ashworth, Democratic Services, Bury Council Mrs Emma Kennett Head of Locality Admin & Governance, NHS Greater Manchester (Bury)

BURY INTEGRATED CARE PARTNERSHIP

MEETING NARRATIVE & OUTCOMES

1	Welcome, Apologies and Quoracy
1.1	The Chair welcomed all to the meeting.
1.2	Apologies were received from Dr Cathy Fines, Ms Catherine Jackson, Mr Neil Kissock, Dr Vicky Howarth, Ms Sophie Hargreaves Ms Kath Wynne-Jones and Cllr Mike Smith,
1.3	The meeting was declared quorate.

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 3rd February 2025 and previous meeting 6th January 2025.**

ID	Type	The Locality Board	Owner
D/02/01	Decision	Received the declaration of interest register.	

3	Minutes Of the Last Meeting and Action Log
3.1	The minutes from the Locality Board meeting held on 6th January 2025 were considered as a true and accurate reflection of the meeting. The status in relation to existing actions was documented as part of the Action Log

3.2	It was reported that there was a need for the Locality Board to ratify the decision made at the last meeting in relation to Single Point of Access as the meeting was held on Teams and decisions can only be taken when meetings are in person in line with existing governance arrangements.
3.3	Mr Blandamer commented that a copy of a letter from NHS England and the Department for Education in relation to the 6 monthly Bury SEND Stocktake review Meeting had been circulated to Locality Board members as part of the meeting papers for information. It was reported that there was still a considerable amount of work to complete within this area however progress to date had been positive in terms of the outcomes for children and young people.

ID	Type	The Locality Board	Owner
D/02/02	Decision	Accepted the minutes from the previous meeting as a true and accurate reflection of the meeting and noted the updates in respect of the actions from the last meeting.	
D/02/03	Decision	Ratified the decision made at the January Locality Board meeting in relation to Single Point of Access	
D/02/04	Decision	Noted the letter in relation to the 6 monthly SEND Stocktake review Meeting.	

4	Public Questions
4.1	There were no public questions received.

ID	Type	The Locality Board	Owner
D/02/05	Decision	Received the update.	

5	Terms of Reference Review
5.1	Mr Blandamer presented a report in relation to the Locality Board Terms of Reference.
5.2	It was reported that the Terms of Reference have been reviewed and a minor change had been proposed on page 9 in respect of the attendees/non voting membership and a representative from Bury Hospice being invited to attend future meetings.
5.3	The following comments/observations were made by Locality Board members: - • It was highlighted that leadership representation from the Hospice would be welcomed at future meetings given that the projected increased demand for palliative care over the next few years and the associated impact this could have on parts of the Health and Social care System. • That this membership proposal would further build on the strong working relationship in place with the Hospice. • There was potential for Hospice UK to be linked into some of the future work within this area in terms of some of the emerging trends and proactive steps that can be taken to manage demand. • There were a number of Hospices across the Country who were struggling from a financial perspective which could lead to closures. • There was a Network of Hospice Leaders Meeting that already met in Greater Manchester which was useful in terms of benchmarking data and sharing experiences. • It was suggested that an update on End of Life Care/Hospices be submitted to a future Locality Board meeting.
5.4	It is envisaged that there will be some further changes required to these Terms of Reference in the coming months once the Greater Manchester Governance Team review has been concluded

ID	Type	The Locality Board	Owner
D/02/06	Decision	Recommended the revised Terms of Reference for approval via the respective ICB and Council Governance	
A/02/01	Action	An update on End of Life Care/Hospices be submitted to a future Locality Board meeting.	Mr Richardson

6	Place Based Lead Update
6.1	Ms Ridsdale presented the latest Place Based Lead update to the Locality Board.
6.2	It was reported that: - • A Locality Plan Workshop had taken place on the 29th January 2025 and colleagues that attended were thanked for their input. The outcome of the workshop would be to refine and further develop the Locality plan, with its focus on population health improvement, on delivering the model of neighbourhood working in the borough at greater pace and scale, and in collectively articulated key characteristics of transformed service delivery. It was noted that the Locality had received a draft of the locality plan today, but it had not yet been amended to reflect the outcome of the workshop or indeed the national planning guidance received on the following day. The work to refine and develop would continue into February 2025. • The January Health and Well Being Board considered the Bury anti-poverty strategy and programme delivery and received the update report on the Better Care Fund. Of particular note was a progress report on the implementation of working well – an ICB funded programme in all 10 parts of Greater Manchester supporting improved pathways for those close to the workplace but unable to access due to issues of health. This work will form a cornerstone of the implementation of "live well" and in the operation of the trailblazer programme for worklessness and the prevention demonstrator site. • The SEND improvement and Assurance Board met in January 2025 and recognised there was a real focus required for the next 6 months in terms of recognisable improved services and outcomes for children and families. For the NHS there was particular challenges in relation to waiting times for a number of services in terms of CAMHS ND pathways and some NCA services, and the need for Adults ADHD commissioned service. • The 2025/2026 NHS planning guidance was issued on 30th January 2025, it was noted that there were fewer national priorities included as part of the guidance and that the strong neighbourhood focus reflected a lot of the work already underway within Bury. • A copy of the newly published guidelines to help integrated care boards, local authorities and health and care providers develop neighbourhood health services in 2025/26 was included as an Appendix to this paper. • The Lets Do it Strategy was still being refreshed and a further iteration would be available in due course.
6.3	The following comments/observations were made by Locality Board members: - • The 'working well' discussions at the Health and Wellbeing Board had been extremely positive with a strong impact seen in this area. • A Locality Plan Workshop had been well received and there would now need to be a greater connection to health inequalities as part of the next phase. • The national planning guidance was a good starting point in terms of the minimum requirements for areas such as Mental Health and Primary Care however the locality should be striving to achieve over and above these requirements.

ID	Type	The Locality Board	Owner
D/02/07	Decision	Received the update.	

7.	Virtual Wards
7.1	Ms Alcock was in attendance to present a report in relation to Virtual Wards with provided background information about the National and Greater Manchester picture, and about the development of the service within the Bury locality.
7.2	It was reported that: - • The Bury Hospital at Home (Virtual Ward) service was set up in October 2022. • The achievements of the service and the risks of not continuing the service for Bury residents and the wider Bury system were described. • Delivering acute hospital level care in the patient's own home provides the system with significant opportunity to narrow the gap between demand and capacity for secondary care beds. As demand continues to rise the Hospital at Home services have worked to mature and provide a real alternative to hospital admission and support the early discharge of admitted patients from hospital care, thus reducing length of stay. • The beneficial outcomes for patients receiving care in their own home or familiar residence are; reducing the risks known to be associated with hospitalisation (including deconditioning, falls, nosocomial infections), enabling patients to recover faster from acute illness and, by maintaining connection to their regular support systems and community, reducing the likelihood of patients becoming reliant on longer term care options. • Not all localities had implemented Hospital at Home in the same integrated way as Bury had achieved. • There were regular discussions at the Bronze meeting in relation to days kept away from home with partners appropriately held to account for this.
7.3	The following comments/observations were made by Locality Board members: - • This model of work had been fundamental in shifting the delivery of care and Ms Alcock should be commended in this regard. • The use of terminology was important as the term 'Virtual ward' may not be as recognised as 'Hospital at home'. • This was an inherent part of the cultural shift needed within the health and care sector. • It may be beneficial for the locality to share their experiences of the Hospital at Home implementation with a wider audience. Mr Blandamer agreed to pick this action up and look to formally record this excellent work. • The work of the VCFA was fundamental within this area. • Ms Alcock's contribution to the Urgent & Emergency Care Bronze meeting particularly in relation to the work of the integrated discharge team as well as her work on virtual wards was commended.

ID	Type	The Locality Board	Owner
D/02/08	Decision	That agreement is reached across the Bury system to work towards the continuation of the Hospital at Home service beyond March 2025 and commitment from the Locality Board to support collaborative working to facilitate the continuation of the service.	
A/02/02	Action	Mr Blandamer to formally record the excellent work being undertaken in relation to Bury Hospital at Home (Virtual Ward).	Mr Blandamer

8.	Pharmacy First and patient led ordering
8.1	Mr McCaul was in attendance to present a report in relation to Pharmacy First.
8.2	It was reported that: - • The new Pharmacy First service launched on the 31 January 2024. • The services added to the existing consultation service to enable community pharmacies to complete episodes of care for 7 common conditions following defined clinical pathways • The slides provided an update on the Pharmacy First Programme across Greater Manchester including Bury. • There had been 499 Pharmacy First referrals in December 2024 for Bury. • Pharmacy First was scheduled to continue until the 31st March 2025 at present and had been no formal communication around its continuation beyond that point at present.
8.3	The following comments/observations were made by Locality Board members: - • A query as to where these pharmacies in Bury were based linked to health inequalities and a query whether there were any gaps in service provision. Mr McCaul stated that all pharmacies in Bury were offering this service however there were some issues being encountered around the payment arrangements for 'walk in' patients. • In Whitefield, there an area where there was only one pharmacy that patients could access. • There was need to ensure that pharmacies are given appropriate levels of support to enable them to be successful in the delivery of this scheme. • An example given of where the Pharmacy First service had been accessed and some confusion around pathways and eligibility for access. Mr McCaul stated that some of the national adverts in this area hadn't been particularly helpful as could be interpreted that adults are able to access Pharmacy First for ear acne when that is not the case. • There was a clear synergy between the Pharmacy First Scheme and the localities prevention/'left shift' agenda.
8.4	Mr McCaul agreed to provide some further detailed Bury specific Pharmacy First data to the Locality Board in due course.

ID	Type	The Locality Board	Owner
D/02/09	Decision	Noted the update	
A/02/03	Action	Mr McCaul agreed to provide some further detailed Bury specific Pharmacy First data to the Locality Board in due course.	Mr McCaul

9.	System response - Collective Action
9.1	Dr Patel provided a verbal update on the latest developments surrounding the system response to the GP collective action which followed on from previous discussions at the Locality Board.
9.2	It was reported that: - • There had been a number of system meetings and discussions to mitigate the risks within this area and minimise any impact on patient care. It was felt that the system was responding well to the issues raised. • There been engagement with the Local Medical Committee (LMC) and Greater Manchester colleagues in this regard. • There was a need to strike a balance between action for future change within general practice and patient care.

	• This programme of work would need to be linked into the planning process. • That the issues in this area were not restricted to funding and also needed to see a shift in service deliver and staffing to ensure that resources are deployed effectively.
9.3	The following comments/observations were made by Locality Board members: - • The need to make a robust case for additional NHS funding to support Primary Care to support medium and long term sustainability. The historic funding issues had previously been described at the Locality Board in addition to the levelling up conversations that had taken place. • This programme of work had started in the guise of an emergency planning type response however had now become more of a business as usual type approach. • Bury didn't have a diagnostic hub at present which would be beneficial in terms of a 'shift' and this requirement had been captured as part of the Locality Plan refresh.

		The Locality Board
D/02/10	Decision	Noted the update.

10	Locality/Sustainability Plan Sign Off
10.1	Mr Blandamer submitted the latest draft version of the Bury Integrated Care Partnership Locality Plan to the Locality Board. It was reported that: - • There were some further changes required to the draft plan in the context of the recent Locality Board workshop and the new planning guidance issued. • The changes would include further detail in relation to Population Health management, prioritisation and next steps. • There would be a need to provide a specific return within this area as part of the Greater Manchester Integrated Care Planning and Governance requirements however the final draft plan would be brought back to the Locality Board in March 2025 for final sign off.
10.2	The following comments/observations were made by Locality Board members: - • In terms of the neighbourhoods requirements contained within the Planning Guidance, the Locality had been developing these integrated teams for a number of years and was therefore well placed within this regard. • The positive impact of Adult Social Care in the borough should be commended including low unit cost associated with service delivery. • Further clarity was required within the plan in relation to the all age mental health requirements.

		The Locality Board	
D/02/11	Decision	Noted the update.	
A/02/04	Action	Final draft of the Locality Plan to be brought back to the Locality Board meeting in March 2025.	Mr Blandamer

11	Service Mapping – PCFT
11.1	Ms Preedy informed members that the Pennine Care Service Mapping work was currently under development and had been considered at the Trust Management Board meeting last week.
11.2	A copy of the Service mapping paper would be shared with the Locality Board once available at its meeting in either March or April 2025.

ID	Type	The Locality Board	Owner
D/02/12	Decision	Noted the update.	

A/02/05	Action	A copy of the Service mapping paper would be shared with the Locality Board once available at its meeting in either March or April 2025.	Ms Preedy

12	Integrated Delivery Collaborative Update		
12.1	Mr Blandamer presented the latest Integrated Delivery report to the Locality Board which provided an update to the Board of progress with the work of the IDC, and progress with the delivery of programmes across the Borough.		
ID	**Type**	**The Locality Board**	**Owner**
D/02/13	Decision	Noted the update	

13	Performance Report		
13.1	Mr Blandamer presented the latest Performance Report to the Locality Board. It was reported that: - • In terms of A&E 4-Hour Performance - in November 24 was 63.7%, a decrease on the previous month's performance of 67.3%, which is higher than November 23 which was 61.1%. • A&E Attendances – there were 6921 A&E attendances from Bury registered patients in November 2024, lower than November 23 (7032). Bury currently had 32.8 attendances per 1000 population and has the 5th lowest attendance rate for localities within GM. • Further work was ongoing to strengthen the content of the Performance report which would be submitted to future Locality Board meeting.		
ID	**Type**	**The Locality Board**	**Owner**
D/02/14	Decision	Noted the Performance report.	

14	Strategic Finance Group Update
14.1	Mr O'Hare submitted the latest Strategic Finance Group update to the Locality Board.
14.2	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. • The month 8 NHS GM position was showing a deficit of £72.6m versus an expected deficit of £7m, giving an unplanned variance of £65.6m adverse to plan, and remained forecasting recovery of this position by 31st March 2025 to break even, to allow delivery of the agreed £175m deficit. Within this position the Bury locality budgets, for which this board was responsible for are forecasting a deficit of £6.8m versus an expected break even annual position. • It should be noted that this Bury position had improved at month 9. The Northern Care Alliance (NCA) were £3.4m overspent at month 8 versus a plan of £1.9m and have forecasted to achieve their agreed deficit of £4.4m. Pennine Care NHS Foundation Trust (PCFT) were reporting a £1.3m deficit at month 8 versus a break even plan, but continued to forecast a very slight surplus at year end. • The council was progressing sign off, of the 2025/26 financial plan through it's own governance route and an update would be brought on this to the next locality board. • As at Month 8 £285m of CIP had been delivered by NHS GM against a plan of £281.5m, a slight over delivery of £3.5m. The forecast CIP position was delivery of £495.2m against a target of £490.3m, again a slight overachievement of £1.3m but this does have £79m of risk attached. In terms of CIP delivery on the budgets delegated to the locality, at month 8 £2.81m had been

	delivered against a month 8 plan of £3.43m, with shortfalls against plan in Medicines Optimisation and Complex Care, this therefore put a risk of £1.4m on the full delivery of 2024/25 CIP. • 2025/26 NHS planning guidance and financial allocations were now being worked through and would be included as part of the next finance report to the Locality Board. • The primary causes of this deficit position within Bury were the areas of Complex Care (CHC and Mental Health) and the main drivers of this deficit were discussed with members which included: - ▪ 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 was focussed upon delivery of an action plan and had received support from Price Waterhouse Cooper and was 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. • In terms of the CHC budget, assumptions had been made when setting the budget within this area which needed to be revisited given the aging population of the borough/demand on services.
14.3	The following comments/observations were made by Locality Board members: - • The need to review the CHC Budget position in terms of whether this is realistic expectation based on local demographics and benchmarking to other Greater Manchester authorities. It was noted that Mr O'Hare was holding discussions in this regard to further review the data/budgets within this area. • Previously some of the overspend within the CHC/Complex Care area had been mitigated through other budgets however this option was no longer positive under the new NHS Greater Manchester delegated arrangements.

ID	Type	The Locality Board	Owner
D/02/15	Decision	Noted the contents of this report and the financial challenges across the Bury system and NHS GM	
D/02/16	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	
D/02/17	Decision	Note the further delay in the 2025/26 NHS planning guidance	

14	Population Health and Wellbeing update
14.1	Mr Hobday presented the latest Population Health and Wellbeing update.
14.2	It was reported that: - • There had been no Population Health meeting since the last Locality Board meeting.

	• There had been a number of key discussions held at the last Health & Wellbeing Board with some of the updates already touched on as part of other agenda items at today's meeting. The three substantive items were included an update on the anti-poverty work in Bury, an update on the usage of the Better Care Fund (BCF) and a discussion on Bury's local work well vanguard and the recent submission as to what we would do if we had funding to become a an economic inactivity trailblazer area.

ID	Type	The Locality Board	Owner
D/02/18	Decision	Noted the update.	

15	Clinical and Professional Senate update
15.1	Dr Patel submitted the latest update in respect of the Clinical and Professional Senate meeting held in January 2025. It was reported that: - • A presentation had been shared presentation around clinical leadership in the ICB, which highlighted the importance of the Clinical and Professional Senates in each of the localities. It also ties the Bury Clinical and Professional Senate to a governance architecture across the ICB, in terms of clinical leadership. The presentation also highlighted that the Clinical and Professional Senate will have an increasingly important role around some devolved accountability, responsibility and even budget.

ID	Type	The Locality Board	Owner
D/02/19	Decision	Noted the information	

16	Family Hub Governance update
16.1	Mr Holden presented a paper that set out the emerging governance arrangements for the Family Hubs programme of work within Bury. It was reported that: - • the Family Hub Delivery Board had met once to consider the Terms of Reference, the remit of the family hub offer in Bury, the current landscape and potential areas for future focus.
16.2	The following comments/observations were made by Locality Board members: - • There was no explicit reference to neighbourhood working as part of these governance arrangements and was important that this was addressed as part of a further iteration of these governance arrangements in terms of the work of the Integrated Neighbourhood Teams • In terms of the additional representation being sought from the Voluntary, Community and Social Enterprises (VCSE), it was noted that Mr Holden would pick this point up directly with Ms Tomlinson outside of the meeting. • The need to be mindful of how health in communities is funded in the future from a general perspective.

ID	Type	The Locality Board	Owner
D/02/20	Decision	Noted the information	
A/02/06	Action	A revised version of the Family Hub Governance including neighbourhood to be shared with the Locality Board.	Mr Holden

17	Primary Care Commissioning Committee update
17.1	Mr Crook presented the latest highlight report from the Primary Care Commissioning Committee meeting held in January 2025. • There had been a discussion around a particular practice potentially wishing to consolidate premises with some engaging having already commenced with patients in this regard.

	• In terms of GP Resilience, the PCCC was provided with an update regarding the number of single handed GP contract holders in place across Bury. Whilst the committee was aware that this was solely a partners decision there were concerns around the impact this potentially has for patients and therefore discussions with the practices concerned were needed. •		
ID	**Type**	**The Locality Board**	**Owner**
D/02/21	Decision	Noted the report	

18	**Send Improvement and Assurance Board minutes**		
18.1 18.2	Members received copies of the minutes from the Send Improvement and Assurance Board meeting held in November 2024 for information. It was noted that a copy of the draft January meeting would be circulated to Locality Board members following today's meeting.		
ID	**Type**	**The Locality Board**	**Owner**
D/02/22	Decision	Noted the minutes.	
A/02/07	Action	A copy of the Send Improvement and Assurance Board minutes from January 2025 to be circulated to members.	Mrs Kennett

19	**Any Other Business**		
19.1	There were no items raised.		
ID	**Type**	**The Locality Board**	**Owner**
D/02/23	Decision	Noted the information	

20.	**Date and time of next meeting**
19.1	It was noted that the next Locality Board meeting would take place on **Monday, 3rd March 4.00 - 6.00pm via Microsoft Teams**

Locality Board Action Log – January 2025

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

Date	Reference	Action	Lead	Status	Due Date	Update
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	It was noted that Mr Blandamer had mentioned to the Chair of the Send Improvement and Assurance Board and this would be picked up in due course.
2nd December 2024/3rd February 2025	A/12/01/ A/02/05	A further detailed paper in relation to Service Mapping would take place on the Locality Board meeting in January 2025.	Ms Preedy		March 2025	Update schedule for March Locality Board meeting.
2nd December 2024	A/12/02	A further version of the Locality plan would be brought back to the Locality Board meeting in February 2025.	Ms Wynne-Jones		February 2025	Final plan scheduled to be submitted to the Locality Board in March 2025
2nd December 2024	A/12/03	Further headlines in relation to the 2025/26 Planning Guidance/funding would be provided at the Locality Board meeting in January 2025 if the information is available.	Mr O'Hare		February 2025	February 2025 – verbal update on key headlines provided however more detail would be included in the next finance report. .
2nd December 2024	A/12/04	Further prioritisation to be undertaken in respect of the Bury priorities linked to the Joint Forward Delivery Plan for Children and Young People	Mrs Richards		March 2025	Update included on agenda.

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

Date	Reference	Action	Lead	Status	Due Date	Update
		developed by the Greater Manchester Integrated Care Partnership.				
6th January 2025	A/01/01	Message of thanks to be shared with staff/colleagues in the health and care system working through this busy and challenging winter period.	Will Blandamer		January 2025	Message of thanks passed on at the Integrated delivery board and also at the Bronze UEC meeting.
6th January 2025	A/01/02	Formal letter in relation to the DfE 6 monthly stocktake was awaited which would be shared with Locality Board members once available.	Ms Richards		TBC	Shared as part of papers for February Locality Board meeting.
6th January 2025	A/01/03	Overview of the Childrens national policy changes to be brought back to the Locality Board in the coming months.	Ms Richards		March 2025	Included on agenda
6th January 2025	A/01/05	Elective Care update to cover Pathway Redesign & Paediatric ENT to be added to the Locality Board Forward Plan	Mrs Kennett		March 2025	Update included
3rd February 2025	A/02/01	An update on End of Life Care/Hospices be submitted to a future Locality Board meeting.	Mr Richardson		TBC	

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

Date	Reference	Action	Lead	Status	Due Date	Update
3rd February 2025	A/02/02	Mr Blandamer to formally record the excellent work being undertaken in relation to Bury Hospital at Home (Virtual Ward).	Mr Blandamer		TBC	
3rd February 2025	A/02/03	Mr McCaul agreed to provide some further detailed Bury specific Pharmacy First data to the Locality Board in due course.	Mr McCaul		TBC	
3rd February 2025	A/02/04	Final draft of the Locality Plan to be brought back to the Locality Board meeting in March 2025.	Mr Blandamer		March 2025	Included on agenda
3rd February 2025	A/02/06	A revised version of the Family Hub Governance including neighbourhood to be shared with the Locality Board.	Mr Holden		March 2025	Revised Paper included under Matters Arising.

Meeting: Locality Board			
Meeting Date	03 March 2025	**Action**	Receive
Item No.	3	**Confidential**	No
Title	Family Hub Governance Update - AMENDED		
Presented By	Stephen Holden		
Author	Stephen Holden		
Clinical Lead	Jeanette Richards		

Executive Summary

This paper sets out the emerging governance arrangements for the Family Hubs programme of work within Bury. The Family Hub Delivery Board has met once to consider the Terms of Reference, the remit of the family hub offer in Bury, the current landscape and potential areas for future focus. This paper aims to update the board on the governance arrangements, the areas discussed in this first meeting of the board and the links between the Family Hubs programme and wider neighbourhood work.

Recommendations

The Locality Board is asked to consider this information and support collaborative working to continue to help shape the strategic aims of the Family Hub Delivery Board.

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.	☒
	☒

Links to Locality Plan outcomes	
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		

Family Hubs Governance Update - Amended

1. Introduction

1.1 This paper sets out the emerging governance arrangements for the Family Hubs programme of work within Bury.

2. Background

2.1 Family hubs are a way to deliver integrated early help to local communities. They provide an opportunity to offer a strengthened and more connected universal and targeted offer for families. This ensures that the identification of early need is more systematic so that families get the support they need as early as possible. By doing this, family hubs support health and educational outcomes for all children but crucially play a part in closing the gap in poorer outcomes related to deprivation. Family hubs are grounded in local communities, responding to their specific needs and working with the strengths of each community. As such, they have a key role in building connections and capacity within communities.

2.2 The Department for Education, in its Family Hubs and Start for Life programme guide, states that family hubs are a place-based way of joining up locally in the planning and delivery of family services. Family hubs bring services together to improve access, improve the connections between families, professionals, services and providers, and put relationships at the heart of family support. Family hubs offer support to families from conception, and to those with children of all ages (0–19, or up to 25 for those with special educational needs and disabilities [SEND], with a great Start for Life offer at their core.

2.3 Annex F of the Family Hubs and Start for Life programme guide lists the core services to be delivered through Family Hubs and sets out minimum expectations of the services which are not receiving additional investment through this programme. The delivery expectations of the funded services are included in the main programme guide. The core services do not represent a exhaustive list and you local areas choose to deliver other services outside of these, according to local need. Annex F

2.4 Family Hubs are an integral part of neighbourhood working in Bury. Public services, including Family Hubs, work more effectively together and with the community when they are geographically aligned - where front line staff from different agencies know each other, have a shared understand of strengths and risks in communities, and work differently together and with the voluntary sector.

2.5 Neighbourhood located Family Hubs will be integral to the proposed multi-agency teams working on geographical footprints of 30-50k population. These multi agency teams are presumed to also include representatives from the Council, DWP, Voluntary Services, GMP, GMFRS, Housing providers and others. In addition, it includes the operation (on the same footprint) of integrated health and care teams including primary care, community care, adult and children's care, mental health services, and aspects of secondary care delivered in neighbourhoods.

3. The Family Hub Delivery Board

3.1 The newly formed Family Hub Delivery Board is a subgroup of the Bury Children's Strategic Partnership Board

3.2 The Children's Strategic Partnership Board (CSPB) take on responsibility for the integrated governance of health, care and education commissioning for children and young people in Bury so that they get the best start in life.

3.3 The Children's Strategic Partnership Board sets the principles and high level strategic direction of children's health, care and education.

3.4 The Family Hub Delivery Board is responsible to the CSPB for children and young people's Health and Wellbeing ages 0-19, incorporating Early Years, Family Help and Prevention.

3.5 The board has representation from: Bury Council Children's Services, Public Health, a Bury Council Councillor, NHS GM Integrated Care, Northern Care Alliance, bury Early Attachment Service, Housing and Neighbourhood Services, Bury Council Wellness Services, Health Watch, Bury Council Business Growth and Infrastructure, Associate Programme Director (Bury Locality) for the NHS, Midwifery (Bolton Foundation Trust) and the Department for Work and Pensions.

3.6 Additional representation is sought from the Voluntary, Community and Social Enterprises (VCSE) and the Parent Carer Forum (Bury2Gether) in readiness for the next meeting.

3.7 The Board will meet every 6 weeks initially and move to every quarter once work streams have been established.

3.8 The board will establish task and finish groups to develop specific areas of work once agreed by the board.

3.9 The East Bury Family Hub which has been operational since October 2023 and partners have started to deliver services locally to the community from the building. There is an established East Bury Leadership team, steering the operational development which will, going forward, report to this board. This will be the model implemented as further Family Hubs become operational.

4. The Role of the Family Hub Board

4.1 To set clear outcomes for the health and wellbeing of children and young people

4.2 To deliver on the Let's Do It Strategy that has neighbourhood working at its heart

4.3 To bring together data and the expertise of professionals and families to set priorities to improve outcomes and to plan and organise services accordingly

4.4 To establish a clear and consistent family offer across the borough, understood by all and responsive to the different needs of families

4.5 To work with communities to increase self-help and early help within communities, build resilience and reduce over-reliance on services

4.6 To develop accessible and well-understood pathways, ensuring that 'no door is the wrong door' for children, young people and families

4.7 To establish an integrated workforce development and training programme for staff and volunteers

4.8 To establish an outcome-based performance monitoring framework

4.9 To provide regular progress updates and exception reports to CSPB

4.10 To ensure work is aligned with that of other partnerships/groups and workstreams in order to avoid duplication and ensure best use of resources

5. Terms of Reference and Governance

5.1 Attached for information is the draft terms of reference for the FHDB. These Terms of Reference were discussed as an agenda item in the first FHDB meeting and are now subject to change following this discussion.

5.2 Included in the Terms of Reference is the governance framework for the Children's Strategic Partnership. This will need updating once the terms of reference and governance architecture have been agreed.

5.3 As the remit of the FHDB becomes clearer, additional governance arrangements may be necessary, including potential reporting lines to the Public Service Reform Board and Bury's Integrated Care Partnership Board. This will be discussed at future board meetings.

6. Work Plan and Future Focus

6.1 During the first meeting of the FHDB, the following areas of focus were identified:

- Buildings for delivery. This will be a key focus for the board and a likely separate task and finish group. This work builds on the information in the briefing brough to Locality Board in August 2024.
- Budget for delivery
- Key stakeholder engagement with children, young people and families
- IT infrastructure within family hub buildings to ensure that all partners have access to the necessary systems
- Data sharing agreements between partners.
- Workforce
- Communications
- Protocols for integrated working
- Responding to the learning from the Family Hub Pilot in East Bury
- Reviews of operational delivery
- Reviews of governance and reporting to appropriate linked boards.

6.2 These areas of focus will now be built into a work plan that will drive the work of the delivery board.

6.3 In addition to the above, the board is also reacting to changes in children's social care. Building on from the McAlister report (2023) Stable Homes, Built on Love, the Government released a policy statement on 18.11.24 titled 'Keeping Children Safe, Helping Families Thrive', which outlines the vision for the future of the children's social care system and core legislative proposals. The overarching aim is to ensure that children and families are supported at the right time by the right service and are offered intervention and preventative services at the earliest opportunity. We have already started our first stages of implementation with our planned re-launch of our 'Family Help' service which will provide us with a good basis for introducing the reforms over the next 12 months. We are meeting with the DfE on 26.02.25 to discuss how we, locally can start to develop our plans to move toward embedding the changes across our family help and social care directorate.

7. Conclusion

7.1 The first meeting of the FHDB was successful in setting a joint understanding of the expectations of family hubs delivery, the current Bury offer and the key areas for future activity of the board.

7.2 Following the board, the following activity is now in train

- Redrafting of the Terms of Reference
- Extending representations on the board to further cover all stakeholders
- A redesign of the CSPB governance framework to involve the FHDB
- The creation of a work plan to sequence the activity and oversight of the board

8 Recommendations

8.1 The Locality Board is asked to consider this information and support collaborative working to continue to help shape the strategic aims of the Family Hub Delivery Board.

Stephen Holden
Director of Education and Skills
s.holden@bury.gov.uk
January 2025

Meeting: Locality Board			
Meeting Date	03 March 2025	**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. Locality Plan

We continue to work on the refresh of the Locality Plan following the workshop in January and the presentation in the February Locality Board. The key learning was to ensure a sharper articulation of locality plan priorities within which our individual programmes of work (e.g urgent care, mental health, Adult Care transformation etc) sit. We are working to re-present the priorities according to 4 key themes, themselves reflective of the GM strategy.

- Population health management
- Prevention, reducing prevalence, and proactive active care
- Transforming Community Care in Neighbourhoods
- Optimising Care

The next iteration will be brought to the April Locality Board.

2. GIRFT (Getting it Right First Time) review – Virtual Wards

Following the very positively received presentation at the February Locality Board on the work on hospital at home/virtual wards, the work was subject to the review by the national GIRFT time. A broad-based multi-agency team met with the GIRFT review team to reflect on progress and next steps. A commentary report has received confirming much good practice in Bury, including the focus on step up, a personalised approach, and the integrated nature of the service in relation to other key elements of the UEC landscape including SDEC. A number of areas for suggested improvement were also identified, including strengthening some data capture processes, and the connection to diagnostic capacity/point of care testing.

In addition, following the Locality Board meeting representatives of the Locality have strongly advocated to the GM UEC programme board on the value of the programme in Bury and the relatively very high performance of the Bury initiative, for consideration as part of the GM prioritisation of UEC spend.

3. Dementia Care Programme Delivery Group

I am pleased to advise the first meeting of the Bury Dementia Care Programme Delivery Group was held on 25th February and was well attended by public sector and VCSE colleagues. The group reflected on the outcome of the workshop previously held (as part of a GM Dementia United programme of workshops in all 10 localities), and as also the draft dementia strategy considered by the Bury Integrated Delivery Board. In the context of the broad based strategy (which will come to the Locality Board in April for consideration) work will continue to develop and refine a programme of work – but the meeting recognised that this would be building on good progress – e.g the complex dementia discharge work, and the utilisation of GM Care Record for dementia planning in Ramsbottom.

4. LGA Visit

As part of the ongoing preparation for the impending CQC assessment of Adult Care Services at the Council, the Local Government Association were invited to visit for 3 days to undertake a 'mock inspection'. The 7-person team met staff, users, carers and partners to obtain a comprehensive view of the service.

We are awaiting the formal feedback from the visit, but the informal feedback received at the end of the visit was very positive. The reviewers recognised the enthusiasm, commitment and professional of the care staff, recognised high quality leadership, and commended the clarity of the transformation strategy and its alignment to improved delivery.

The reviewers were also very complementary about the extent of integration between Adult Care and NHS services both at a strategic and also operational level (though intermediate care and the model of integrated neighbourhood team working).
Adult Services will receive he report and use any recommendations to continue the improvement journey, and the formal report will be shared at the next Locality Board.

5. NHS planning Guidance – Childrens MDT

At the last Locality Board there was particular recognition of the NHS planning guidance pertaining to integrated neighbourhood delivery. The meeting considered that our model of INT working in Bury, aligned to the work of the GP Strategy and future opportunity of strengthening community diagnostic capability. Since the last Locality Board further guidance proposing that model of neighbourhood working on populations of 30-50,000 should also be the default setting for integrated multi-disciplinary team working on childrens services. The guidance indicates that;

- Neighbourhood MDTs for children and young people will provide integrated care that provides timely access to specialist advice, including paediatric and mental health expertise, through primary care-led team working. This will deliver care closer to home and improve the outcomes and experience for children and young people, as well as their families and carers.
- Greater benefits are realised when neighbourhood MDTs are integrated with wider local services, especially education, social care, voluntary sector, and community and social enterprise (VCSE) partners to provide holistic, targeted needs-led planning and support.
- This approach will enhance the current primary care offer for children and young people who might otherwise require referrals to secondary care, community services or other health and social care support. It also increases the opportunities for early intervention and prevention support, especially for children in their early years.

I suggest that the Locality Board invites the Integrated Delivery Board to convene a workshop to discuss this next stage of our neighbourhood model of working and invite all key partners to positively contribute an input into the meeting describing how they would align services accordingly.

6. GM Collective Action

Locality Board members will note the national agreement on the GP Collective Action and recognise the intent to provide a firmer foundation for GP services as a core component of the left shift transformation proposed. In Bury all partners – GPs, NHS GM, NCA, Pennine Care and others have worked effectively to understand and address issues of unnecessary duplication, miscommunication, and bureaucracy related to the primary /secondary care interface – and Locality Board will recognise this is work as responding to a commitment in our GP strategy. While the collective action may conclude, I would strongly suggest we continue in partnership to strengthen the primary/secondary care interface work and build on some of the insights and solutions that have been made during this period, and for a further updated on the GP strategy progress including this issue to come to a future locality board.

Lynne Ridsdale
Place Lead NHS GM (Bury)
Chief Executive Bury Council
342/25

NCA Diagnostic (DM01) & Cancer diagnosis (FDS) waiting times for Bury locality patients

Fig1: DM01 Waiting Times; Dec-24

	NCA performance: Bury patients		GM / NHS Benchmarks	
	Bury-based patients awaiting test at NCA	% waiting less than 6wks for test	% of GM pts waiting less than 6wks for test	% of NHS pts waiting less than 6wks for test
MRI	899	99%	86%	81%
Non Obstetric Ultrasound	500	92%	89%	80%
Echocardiography	269	78%	77%	70%
Audiology Assessments	235	90%	67%	54%
CT	204	100%	87%	90%
Colonoscopy	142	77%	85%	72%
Gastroscopy	104	87%	89%	75%
Dexa Scan	87	100%	90%	79%
Sleep Studies	83	71%	53%	65%
Cystoscopy	45	91%	82%	72%
Flexi Sigmoidoscopy	43	72%	85%	72%
Peripheral Neurophys	26	96%	90%	66%
Urodynamics	11	55%	58%	57%
Grand Total	**2,648**	**91%**	**84%**	**77%**

Fig2: Cancer FDS Waiting Times; Dec-24

	NCA performance: Bury patients		GM / NHS benchmarks	
	No. of patients diagnosed	% diagnosed within 28 days	% of GM patients diagnosed within 28 days	% of NHS patients diagnosed within 28 days
Suspected skin cancer	146	84.2%	90.0%	86.5%
Suspected lower gastrointestinal cancer	127	76.4%	72.6%	66.6%
Suspected upper gastrointestinal cancer	78	75.6%	77.1%	78.1%
Suspected gynaecological cancer	70	70.0%	71.8%	68.5%
Suspected head & neck cancer	67	67.2%	68.0%	75.1%
Suspected urological malignancies	54	61.1%	65.5%	63.7%
Suspected lung cancer	38	92.1%	90.6%	84.4%
Suspected brain / CNS tumours	8	87.5%	76.8%	83.2%
Suspected haematological malignancies	8	87.5%	77.7%	62.2%

NCA narrative / actions:
Diagnostic times largely in line with rest of GM / wider NHS benchmark.

Suspected skin cancer resilience being reviewed through GM transformation programme.

Key:	NCA performance equal or better than benchmark	NCA performance 0%<>3% worse than benchmark	NCA performance >3% worse than benchmark

Source: Statistics » Monthly Diagnostics Data 2024-25
Statistics » 2024-25 Monthly Cancer Waiting Times Statistics

Referral to treatment (RTT) waiting times for Bury locality patients

Fig3: RTT waiting times; Dec-24

	NCA performance: Bury patients		GM / NHS Benchmarks	
	Bury-based patients for treatment at NCA	% waiting less than 18wks for treatment	% of GM pts waiting less than 18wks for treatment	% of NHS pts waiting less than 18wks for treatment
Dermatology Service	2,901	43%	47%	58%
Trauma and Orthopaedic Service	2,241	47%	54%	57%
Ear Nose and Throat Service	2,090	48%	47%	49%
Gastroenterology Service	1,906	61%	57%	63%
Ophthalmology Service	1,496	46%	63%	67%
Cardiology Service	1,470	51%	51%	60%
Other Surgical Services	1,352	66%	57%	60%
Urology Service	1,238	50%	53%	59%
Neurology Service	942	53%	56%	54%
Gynaecology Service	905	53%	47%	55%
Rheumatology Service	682	51%	62%	65%
General Surgery Service	584	49%	51%	58%
Other - Paediatric Services	548	31%	51%	59%
Respiratory Medicine Service	349	58%	65%	62%
Neurosurgical Service	275	61%	64%	61%
Plastic Surgery Service	143	67%	45%	54%
Elderly Medicine Service	64	94%	73%	82%
Oral Surgery Service	54	52%	42%	50%
Grand Total	**19,857**	**51%**	**54%**	**59%**

NCA narrative / actions:
Specialties have been asked to develop productivity plans to improve waiting times. Plans include tackling DNA rates (i.e. use of text reminder services) / theatre & clinic utilisation / PIFU etc

Most challenged specialties will likely require additionality to meet the elective recovery targets for 25/26

ENT reduced demand has been seen in Bury locality, expected other localities will replicate and similar outcomes expected

OP Excellence Programme in place

Key:	NCA performance equal or better than benchmark	NCA performance 0%<>3% worse than benchmark	NCA performance >3% worse than benchmark

Source: Statistics » Consultant-led Referral to Treatment Waiting Times Data 2024-25

Bury RTT Patients at MFT – Dec 24

Treatment Function Name	Total All	Total within 18 weeks	Total 18-51weeks	Total 52 plus weeks	Total 65 plus weeks	Total 78 plus weeks
General Surgery Service	222	115	100	7	0	0
Urology Service	271	114	141	16	0	0
Trauma and Orthopaedic Service	162	64	81	17	0	0
Ear Nose and Throat Service	276	145	122	9	0	0
Ophthalmology Service	261	143	101	17	0	0
Oral Surgery Service	1648	652	906	90	0	0
Plastic Surgery Service	75	34	31	10	0	0
Cardiothoracic Surgery Service	18	12	6	0	0	0
General Internal Medicine Service	14	11	2	1	0	0
Gastroenterology Service	352	165	179	8	0	0
Cardiology Service	201	117	80	4	0	0
Respiratory Medicine Service	113	64	49	0	0	0
Neurology Service	8	1	7	0	0	0
Rheumatology Service	67	28	39	0	0	0
Elderly Medicine Service	4	2	2	0	0	0
Gynaecology Service	844	319	467	55	3	0
Other - Medical Services	1121	582	528	11	0	0
Other - Mental Health Services	1	0	1	0	0	0
Other - Paediatric Services	759	343	392	24	0	0
Other - Surgical Services	742	394	327	21	0	0
Other - Other Services	81	41	37	3	0	0
Total	7240	3346	3598	293	3	0

Meeting:	Bury Locality Board		
Meeting Date	03 March 2025	**Action**	Consider
Item No.	7	**Confidential**	No
Title	Whitefield Health Centre Redevelopment Proposals - Update		
Presented By	Clare Postlethwaite		
Author	Clare Postlethwaite		
Clinical Lead	Dr. Cathy Fines		

Executive Summary

Whitefield Health Centre is a facility that is becoming increasingly difficult to maintain to a sufficient standard for clinical service delivery and for a number of years, attempts have been made to find a solution for the Uplands Medical Practice who deliver services from that site.

Significant partnership working between all local partners has enabled the development of a proposal involving the redevelopment of the former library site.

This report provides an overview of the current position on this important project and also outlines the work now required to secure this scheme.

Recommendations

To note the progress to date on this project and to support progression to project completion, noting the associated 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 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.	☒

Links to Locality Plan outcomes	
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:						
Ongoing dialogue with ICB team to advise on level of assessment and consultation that is required in relation to this proposal.						
Are there any associated risks including Conflicts of Interest?	Yes	☒	No	☐	N/A	☐

Governance and Reporting		
Meeting	**Date**	**Outcome**
Bury Locality Board Meeting	03/03/2025	

BURY INTEGRATED CARE PARTNERSHIP

Whitefield Health Centre Redevelopment Proposals - Update

1. Introduction

1.1. The current Whitefield Medical Centre is the base for Uplands Medical Practice with the current premises being in poor condition with ongoing and increasing difficulties to NHS Property Services in being able to maintain the facility to an acceptable standard. The out-dated nature of the current premises is already impacting on both patient experience and staff retention at the practice.

1.2. The Whitefield Medical Centre site has been the focus of NHS redevelopment plans for over fifteen years with numerous failed attempts over the years to secure a solution for the practice.

1.3. Due to the increasing costs of the existing facility alongside the complexity of developing the existing site, it has recently been agreed that it would be more beneficial to use the former library building, on Pinfold Lane, as the permanent relocation solution.

1.4. This report outlines progress to date and next steps planned to secure this important scheme.

2. Background

2.1. Whitefield library closed in 2017 and was subsequently used as a Covid vaccination centre from October 2020 to September 2022.

2.2. Due to the challenges of developing the current health centre site, collaboration across system partners recently agreed that the use of the former library building on Pinfold Lane would offer a more achievable solution for the practice.

2.3. The redevelopment for health purposes of the former library site is contained in the town centre development plans for Whitefield, with the assumption that once vacated the Uplands site will be sold on the open market – the majority of this site being owed by NHS Property Services with a small portion within Bury Council ownership. Once vacated, there is agreement to market the Uplands site as a single entity to attempt to release best value to both NHS Property Services and Bury Council for the site.

2.4. At the Bury Council Cabinet held on 12th February the proposal to sell the former library site to NHS Property Services was approved with the related draft heads of terms already agreed.

2.5. Work is now being progressed to gain GP practice agreement to the related agreement to lease documentation that will then enable funds to be drawn down in order to complete this sale. Current target is to achieve completion on this sale by early March 2025 at the latest.

2.6. The current proposal will allow the practice to remain operating from their current premises up until the point the new facility is completed hence, reducing costs and disruption in relation to any temporary relocation requirement.

3. Proposed New Facility

3.1 The internal designs for the proposed scheme are now in the final stages of development with practice colleagues and their patient participation group both supportive and enthused about the scheme being proposed.

3.2 To ensure time and cost efficiency, the proposal assumes a refurbishment of the existing former library facility hence, only a single storey facility is proposed.

3.3 Whilst the proposed scheme only allows circa two additional consultation rooms, the reality is that various areas within the current premises are no longer functional hence, in real terms the proposal moves the practice into a fit for purpose building with significantly more usable space available for clinical service delivery.

3.4 The scheme proposed centres around an existing courtyard with discussions with the patient participation group and practice colleagues already considering innovative ways in which this space may be utilised by the wider community. Discussions to date have also considered how best to allow community groups to access the meeting room space planned within the new facility.

3.5 The distance between the current Whitefield health centre site is circa 0.2miles from the proposed former library building therefore, does not require a full public consultation. That said, detailed discussions have been progressed with the patient participation group to understand the travel implications and a full traffic impact assessment will form part of the scheme development process in the usual way.

3.6 In order to reduce the revenue implications of the scheme, it has been recognised as a 'trigger scheme' at Greater Manchester level with NHS England capital being secured on this basis – the draw down of this capital with be phased over 2024/25 and 2025/26 in line with scheme development.

3.7 The securing of NHS England capital for the scheme also ensures that no ongoing capital revenue charge will apply to the funds applied to deliver the project.

3.8 Current project plans target a start on site around summer 2025 with a new facility forecast to be operational around summer 2026.

4 Associated Risks

4.1 With the support of all system partners, significant progress on this priority scheme has been made over recent months however, there remains significant work to do to secure this scheme and allow construction to start on site.

4.2 In order to drawdown the national funds allocated to the scheme, there is a requirement to first ensure that the GP practice have agreed and signed the related agreement to lease document. Whilst the practice is supportive of the scheme and work is progressing to reach this agreement, this remains a risk until a final agreed and signed document is achieved,

4.3 The current funds allocated to the scheme were based on budgeted estimates for the construction works proposed and this remains the target for the scheme however, until the scheme is presented to the market for tender there remains a risk that scheme costs will be in excess of budget set. This is a usual risk of schemes of this type at project initiation stage and the Greater Manchester ICB estates team continues to work with locality team colleagues to assess the likely actual budget requirements.

4.4 Whilst initial views from planners have been sought, the scheme will need to follow the usual planning process and hence, this should be noted as a risk until a full planning permission is secured.

5 Recommendations

5.1 To note the progress to date on this project and to support progression to project completion, noting the associated risks.

6 Actions Required

6.1 The Locality Board is required to:

- Approve progression of the scheme to completion as described.

Clare Postlethwaite
Associate Programme Director
clare.postlethwaite2@nhs.net
February 2025

Meeting: Locality Board			
Meeting Date	03 March 2025	**Action**	Receive
Item No.	8	**Confidential**	No
Title	Overview of Children's National Policy changes including Children's Priorities		
Presented By	Robert Arrowsmith		
Author	Robert Arrowsmith		
Clinical Lead	N/A		

Executive Summary
To provide an overview of the Childrens national policy changes and priorities.
Recommendations
The Locality Board are asked to provide any comments and note the update provided.

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

Links to 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		

Children's Wellbeing and Schools Bill

Children's social care measures

- **Kinship and family networks** – Require LAs to offer FGDM before care proceedings, define kinship care in law, LAs to publish local offer, extend the role of VSHs to cover CiN and children living in kinship arrangements
- **Child protection** – Education to be included in MASAs, multi-agency child protection teams, introduce a single unique identifier for children
- **Care leavers** – LAs to offer 'Staying Close' and publish a local offer
- **Care –** RCCs, new 'DoLs in the community' framework, Ofsted oversight of provider groups and a new financial oversight scheme, fines for unregistered children's homes, backstop SoS power to ban profiteering
- **Workforce** – Allow new regulations on use of agency workers, extend legislation on wilful neglect in certain care and detention settings.

Children's Wellbeing and Schools Bill

Education measures

- **CME –** LA to consent to withdrawal of certain children from school, LAs to maintain a register of children not in school, a duty on parents to cooperate with the LA on EHE and use of SAOs
- **Independent education –** Expanded regulation, new Ofsted powers on illegal schools
- **Academies –** Require all teachers to have QTS, all schools to teach to national curriculum, SoS powers of direction, end academy order in response to failings, parity on teacher pay and conditions
- **Admissions –** Require all schools to work with LA on admissions, give LAs the power to direct academy admissions, new powers for the Schools Adjudicator re max PAN
- **New schools –** Remove requirement for all schools to be academies, allow LAs and others to propose opening new maintained schools and PRUs
- **Other measures –** Free breakfast clubs in primaries, curbs on branded school uniforms, broaden teacher misconduct regime, single set of rules on employment of children.

Relevant reforms 2025 and beyond

DfE

- Children's Wellbeing and Schools Bill
  - CSC pilots, pathfinders, trailblazers
  - Education reforms
- Curriculum and assessment review
- SEND reforms
- Childcare and early years
- Child poverty taskforce (joint with DWP)

DHSC

- Darzi Review / new long term strategy
- Mental Health Bill

DCMS

- New youth strategy

MHCLG

- Devolution
- Local government reorganisation
- Local government funding review.

Home Office

- Development of Young Futures:
  - Prevention partnerships
  - YF hubs (NB now led by DfE)
- Review of group-based CSE / Casey Review
- Response to IICSA recommendations
- Policing review
- Knife crime reduction plan
- Reducing violence against women and girls
- Prevent (part of wider radicalisation review)

Ofsted

- Review of all frameworks post-Big Listen
- Development of new frameworks / regulation linked to CWS Bill
- Scorecard judgements
- Annual safeguarding checks for schools

CQC

- Response to the Dash Review

Meeting: Locality Board			
Meeting Date	03 March 2025	**Action**	Receive
Item No.	11	**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	☐

Implications						
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 January and February, we have continued to develop our locality contribution to GM planning processes. Following the system workshop in January, the refreshed locality plan was received by the Locality Board in February, with detailed portfolio planning continuing throughout February and March. The latest version of the locality plan is attached.

- Planning guidance has been published since the last IDC Board. The publications are included within the papers. The neighbourhood delivery model is a welcome publication for us to support the direction of travel with neighbourhood working and to inform the review of neighbourhood working we are due to commence in April.
- We continue to focus on the operational issues raised by GP Collective Action collectively across Bury and HMR with the LMC and our local providers.
- We are establishing governance from April with the NCA to progress implementation of the primary / secondary care interface principles, which is very closely linked to the actions that GPs are taking under collective action.
- Major conditions board workshop held which identified next steps to scope programmes for CVD and diabetes, respiratory, MSK, dementia and cancer. Further prioritisation will take place in March, including determination of how we use out £50k allocated spend from GM for CVD and diabetes.
- Draft MOU to support joint working between the PCN's and neighbourhoods has been developed. This will be considered at the first meeting of the neighbourhood/PCN Board in April.
- First meeting of the 4LP Programme Board held to ensure delivery of this programme is rooted in localities.
- Work has continued supported by place partners to design the place element of the NCA CLM. This is due to be presented to the Programme Board in March/April.

Workshops being planned: -

- Understanding of prevention services across the locality and opportunities for closer integration: 27th February 2025.

3. IDC Programme Highlights:

<u>Workforce:</u>

System partners from Persona, Bardoc, NCA and NHS GM collaborated to deliver a health and care careers event designed for care leavers. The event introduced young care leavers to the many roles and employers that make up the health and care sector and allowed them to get insights into some of work of the sector and the careers on offer. Attendees also had the opportunity to get careers advice and go out to workplaces to get a sense of the workplace and the team. The event was a great success and a great demonstration of partners working together proactively on a key workforce issue - attracting young people to the sector.

<u>Adult Social Care</u>

Bury Adult Social Care Peer Challenge

A Local Government Association (LGA) Peer Challenge Team spent three days talking to over 150 people from adult social care and partners in Bury between the 11th and 13th February to support our preparations for CQC Assessment. Here are a few of the things they told us as part of their feedback presentation:

"The workforce here in Bury are spectacular"
"We have travelled the length and breadth of the country and never seen the depth of integration we have seen here in Bury, it's outstanding"
"Collaboration is evident at every level and in every area"
"You should all be very proud of what you are achieving"

The LGA will be providing a formal report in around 4 weeks.

Complex Care

Performance good >80% for past 12 months.
Q1 2024-25 - 79%
Q2 2024-25 - >80%
Q3 2024-25 - >80%
No long waits.

ADAM data system cleanse complete and management of finance side of database under control.

Transfer of CCP jointly funded cases payments to LA with recharge in place. Prior year reconciliation complete.

Recovery plan in plan for financial recovery in place, challenged due to increasing costs of packages and patient numbers.

Mental Health:

- PCFT Focus Week took place week beginning 20th Jan with a focus on reducing delayed discharged from mental health wards. Good partnership working across the week. One of the key themes emerging for Bury is the limited provision for temporary accommodation options for patients who are homeless.
- The opening of the new mental health supported living scheme at Saxon House, The Rock has unfortunately been delayed due to incomplete building works. Revised date for patients moving in is now 3rd March.
- The tender for a support provider for the new supported housing scheme, Topping Mill, has been launched – closes to bids on 12th March.

Neighbourhoods:

- In all Neighbourhoods there has been active engagement and planning with practices to support delivery of the 2024.25 Neighbourhood targets (respiratory & frailty) within the Locally Commissioned Services[LCS] contract.
- Planning and engagement work has continued to determine the Neighbourhood priorities and indicators that will form part of the Locally Commissioned Services contract with GPs for 2025/26.
- Horizon PCN have identified clinical leads to act as links with the 3 Neighbourhoods they operate across strengthening the connection between the PCN and these Neighbourhoods.
- An MOU between PCNs and Neighbourhoods has been drafted and is currently out for engagement and feedback. Part of the purpose is to facilitate better integrated working around common objectives.
- East: The Horizon PCN Social Prescribing Service is now offering weekly drop-ins at Clarence Park for those with learning disabilities – the Live Well team are supporting with physical activities.

- Prestwich: planning to engage with NMGH in relation to high intensity service users and promote referrals for Active Case Management.

Palliative and EoLC:

- A number of quality improvement projects are underway or about to commence. These include verification of death training to enable some community nurses to verify.
- The Community Specialist Palliative Care team has been stepped down from 7 days to 5 days [weekday] operations as there is insufficient capacity to consistently sustain 7-day working. A business case is in development to make the case for increased capacity.

Integrated Community and Elective

The second meeting of the ICEPS Board took place in February. The ToR for the group has been finalised and a meeting is scheduled with MFT to discuss their input into the Board and locality programme. The board is still awaiting confirmation of the transfer of the Community Health Services Contract and the expectations of the locality. The board welcomed an update on the Community Health Services Reviews being conducted by the NCA through the Four Locality Partnership.

Primary Care

- GPCA: Good collaborative discussions are taking place with providers, enabling swift solutions to be put in place for most escalated issues.

- Bury Locally Commissioned Service Contract: Work is taking place to finalise the content of next year's contract; this includes items of additionality which may be possible if levelling up monies are agreed.

- Alternative at Scale Solutions: The landscape has changed following the intention to commission a GM gynae spec, this would duplicate what was intended through the WHH and therefore they have been stood down in favour of this model. We have yet to see the final service specification for this procurement, but our ambitions remain as those outlined in the Women's health strategy.

- Risk: Quality Assured Spirometry will cease on the 31/03/25 due to a lack of funding. GM is fully aware, and practices have been informed

- Online Consultation Platforms: work continues by General Practice to scope the options available to them with regards to online consultation platforms. The shortlist consists of 6 providers, demonstrations from each can be arranged to assess suitability if needed whilst practices can seek peer review of platforms currently successfully in use at practice as part of the options review ensuring a decision is reached.

LD & Autism

- NHS High cost case review has begun: desktop review of cases completed with draft list for sign off; project group invites sent out, CHC nurses attended training on Care Cubed (tool which supports payment to providers at market rates)
- Contribution to Local Government Association Peer review exercise for ASC.

4. Performance –

- LD Health checks 14+ - the percentage of patients aged 14+ having received an LD health check in December 24 was 52.1%, which is an increase on December 23 which was 41.3%. Bury is lower than the GM percentage of 58.8% and has the lowest percentage of the GM localities. For the last two years Bury has delivered the majority of annual checks in months January to March.

- Access to Children and Young People MH Services - there were 3525 accesses to Children and Young Peoples Mental Health Services for Bury registered patients in December 24, higher than December 23 (3475). Bury currently has 77.5 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.

- Dementia: Diagnosis Rate (aged 65+) -the percentage of patients aged 65+ having received a dementia diagnosis as of December 24 is 75.4%, which is the lowest in this financial year. Bury currently has a higher diagnosis rate than GM which has a rate of 74.6% 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%.

- No Reason/no criteria to reside (NCTR) mental health - percentage of Mental Health patients with NCTR as of January 25 is 16.5%, which is an increase from January 24 which was 7.7%. Bury currently has a higher percentage than GM which is 15%. Bury has the 3rd highest percentage rate of the GM localities.

- Number of MH Patients with no criteria to reside - the number of mental health patients with NCTR as of January 25 is 14 which is higher than the figure for January 24 which was 7. Bury currently has 0.066 mental health patients with NCTR per 1000 population and has the 4th highest rate in locality within GM.

- Access to community MH services - there were 1770 people who received two or more contacts from mental health services for adults with severe mental illness for Bury registered patients in December 24, higher than December 23 (1560). Bury currently has 10.6 contacts per 1000 population and has the 5h lowest rate per 1000 for localities within GM.

- Talking Therapies Access Rate – there were 190 accesses to Talking Therapies for Bury registered patients in December 24, lower than December 23 (395) Bury currently has 0.9 accesses per 1000 population - the 2nd lowest rate per 1000 for localities within GM.

- Women Accessing Specialist Community Perinatal MH Services – There were 200 women accessing to Perinatal MH Services for Bury registered patients for the rolling 12 months to December 24, higher than December 23 (125). Bury currently has 4.9 accesses per 1000 population – the 2nd highest rate per 1000 for localities within GM.

- Length of stay adults: Mental Health Patients - the proportion of discharges with a long LOS in December 24 was 50.0%, which matches December 23 which was 50.0%. Bury currently has a lower proportion with a long LOS than GM at 58.3% and Bury had the 4th lowest proportion of the GM localities.

- Percentage of Hypertension patients who are treated to target as per NICE Guidance – according to the GM CVDPREVENT Dashboard – CVDP007HYP Bury is currently performing at 66.7% in January 2025. Bury is currently ranked 5th out of the 10 GM localities. GM are performing at 67%.

  CVD P003CHO for Bury is currently performing at 63.7% in January 2025. Bury is currently ranked 2nd out of 10 GM localities with GM performing at 66.7%.

- E. Coli Blood Stream Infections - there were 150 counts of E. coli blood stream infections in the rolling 12 months to December 24 which is higher than December 2023 (149). Bury has 0.71 counts per 1000 population and has the 4th 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 November 24 for the Bury populations was 81.7% which is lower than November 23 which was 97%%. Bury currently has the lowest percentage of the GM localities.

- Antimicrobial resistant proportion of broad-spectrum antibiotic prescribing in Primary Care – in November 2024 for Bury population was 5.8% which is a decrease in November 2023 which was 6.2%. Bury currently has the 3rd lowest percentage of the GM localities. Bury is within the 10% target.

- A&E 4-Hour Performance - in January 25 was 64.1%, an increase on the previous month's performance of 61.3%, which is higher than January 24 which was 58.7%.

- A&E Attendances – there were 6732 A&E attendances from Bury registered patients in January 25, lower than January 24 (6966). Bury currently had 31.7 attendances per 1000 population and has the 2nd lowest attendance rate for localities within GM.

- Percentage of Patients with no criteria to reside as % of occupied beds - the percentage of patients with NCTR as of January 25 was 14%, a decrease from January 24 at 20.6%. Bury has a higher percentage than GM which is 13.5% and Bury has the 5th lowest percentage of GM localities.

- Specific Acute non-elective spells - there were 2067 specific acute non-elective spells from Bury registered patients in January 25, higher than January 24 (1946). Bury currently has 9.7 specific acute non elective spells per 1000 population and has the 5^{8h} lowest rate for 1000 for localities within GM.

- Diagnostics Waiting 6 weeks + - December 24 performance of 12.6% of patients waiting more than six weeks, this is a decrease on the December 23 figures (22.3%). Burys performance is better than GMs performance of 16.2% in December 24 and is the 2nd lowest in GM. Bury and GM are both above the less than 1% target.

- RTT Incomplete 65+ weeks – published December 24 data shows a decrease in 65+ week waits from with 22 pathways down from 34 pathways in November 24. There was a significant decrease in pathways in December 24 with 22 pathways, compared to December 23 when there were 602pathways (-580 pathways).

  In December 24, ENT services show the largest decrease in pathways with 0 compared to 4 in November 2024.

  Bury locality currently has the 4th lowest number of 65+ week waits 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 December 24 for the Bury population was 80.1% - an increase on November 24 which was 78.6%. Bury locality currently has the 5th lowest performance out of all the GM localities. GM performance is currently 79.5%. Bury is above the target of 75% or greater.

- Breast Screening coverage females 53-70 screened in last 36 months – the 3-year screening coverage to December 24 for Bury populations was 73.3% for eligible females. Bury locality currently has the 2nd highest percentage out of all the GM localities and is higher than the GM percentage of 68.1%.

- 2-hour UCR referrals - the percentage of UCR referrals that received a 2-hour response standard for Bury registered patients in December 24 was 98% - an increase on December 23 which was 50%%. Bury currently has the highest percentage in the GM localities and above the national target of 70%. Local Authority reporting shows that 96% of Bury residents received a 2-hour response in January 2025 with 4 patients missing target.

5. Recommendations

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

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January 2025

NHS England

2025/26 priorities and operational planning guidance

Publication reference: PRN01625

Foreword from the NHS Chief Executive

Our 76-year history is one of progress and transformation – as society, technology and medicine have changed, so has our health service. But the NHS currently faces twin challenges, managing today's very real pressures – a legacy of the historic context set out by the Darzi Review – while continuing to build momentum towards long-term solutions.

While headline performance is far from what any of us want to see, our staff have continued to deliver improvements in the services patients most value. You have done this in the face of rising costs and demand, unprecedented industrial action, and long-term underinvestment in capacity and productivity-improving technology. Thank you – I do not underestimate the effort this has taken from colleagues at all levels across the NHS.

NHS productivity also continues to improve, enabling us to deliver more care for patients. Over 2023/24, NHS providers delivered around 5% more activity year-on-year, for 0.12% more income. In the first 7 months of this year the acute sector improved productivity by over 2% – double the improvement rate pre-pandemic. The NHS is on track this year to surpass the £7 billion of efficiencies delivered in 2023/24 – achieved through innovation and reform, continuous improvement, investment in technology, data and new capacity, and better workforce retention. These steps provide the springboard for us to reimagine services as part of the 10 Year Health Plan.

But the timeliness and experience of care is still not good enough. While more people are completing treatment in A&E within 4 hours, a growing number are facing waits of 12 hours or more. In elective care – and in primary, community and mental health services – despite record activity, continued high demand means improvements are not yet nearly enough to allow everyone to access services in a timely or convenient way. And this impacts staff when they can't provide the quality and experience of care they, and their patients, want.

In 2025/26, we are giving systems greater financial flexibility to manage constrained budgets. The government has made difficult choices to provide additional funding. While this provides effective real-terms growth in the NHS budget, it must cover final pay settlements for 2025/26, increased employer national insurance contributions, faster improvement on the elective waiting list and new treatments mandated by NICE. Overall, this means NHS organisations will need to reduce their cost base by at least 1% and achieve 4% improvement in productivity, in order to deal with demand growth. NHS England will transfer

a higher proportion of funding than ever before directly to local systems and minimise ringfencing, allowing local leaders maximum flexibility to plan better and more efficient services. And, to be clear, all parts of the NHS must now live within their means.

Reflecting the Mandate from government and our evolving ways of working, we have also honed national priorities to increase local autonomy. This year's planning guidance is more focused – setting out a small set of headline ambitions and the key enablers to support organisations to deliver them, alongside local priorities. This reflects the direction of travel towards earned autonomy for systems, with support, oversight and intervention from NHS England based on their specific needs and performance. 2025/26 is a reset moment, and it starts with the planning process – with more autonomy and flexibility comes greater responsibility and accountability.

Difficult decisions will be needed, and we must meet this collective challenge together. To balance operational priorities with the funding available, while continuing to lay foundations for future reforms, the NHS will need to reduce or stop spending on some services and functions and achieve unprecedented productivity growth in others. Open and ongoing conversations will be needed with staff, the public and stakeholders at organisation, place and system level about what it's going to take to improve productivity, reduce waste and tackle unwarranted variation. We will back local leaders to take tough decisions, where they are clearly rooted in the needs of their populations and best use of available staff, and where all reasonable steps have been taken to maximise resources available for clinical services. Equally, we will challenge organisations who are not able to demonstrate a robust approach to prioritising patient care by bearing down on duplication and waste.

We are asking integrated care boards (ICBs) and providers to take a forensic look at their workforce and what they spend money on; NHS England is doing the same. Changes at NHS England have already generated nearly £500 million of savings to support frontline services, and an organisation almost 35% smaller than its predecessors. ICBs are similarly working to cut duplication, alongside reducing their running costs. We anticipate that both ICBs and providers will need to review their spend on non-frontline staff again for 2025/26 to prioritise frontline care. NHS England will do the same and, in line with the NHS Operating Model, will again become a smaller organisation this year, further reducing our headcount and reprioritising spend to allocate more funding to systems.

We will also change how we work; that will start with the planning process. We are streamlining the process to reduce the number of submissions from systems so that local focus can be on developing high quality submissions, underpinned by robust and realistic

delivery plans that are assured and approved by ICB and provider boards. Alongside a simpler process, we will continue to engage with you to evolve our operating model, and we will agree a 'compact' with each system, setting out how we will work together and what each organisation is committing to deliver, including how NHS England will support you.

The 10 Year Health Plan gives us reason to hope for a better future, but it doesn't give us licence to pause for breath. We have a rare opportunity to set out a bold vision for the future and chart an ambitious course for the coming years. But a relentless focus on improvement is needed now more than ever – to deliver services for patients who need them today, and to continue to lay the foundations on which a better future can be built.

NHS staff at all levels have shown we can be ambitious, and deliver, through challenge. They will, as always, be key to success this year. Taking the opportunities and rising to the challenges of this coming year will require exceptional leadership – something we have in spades across the NHS. As Lord Darzi said, there are effective solutions to the challenges we face already being delivered somewhere every day by our talented and committed staff.

We will support boards and other leaders to learn from each other, to share what works, to adopt and adapt for local circumstances and to continue to innovate and deliver for patients. We will also continue to ask and support you to make the NHS a better, fairer place to work for all our colleagues, and to give them the tools and permission they need to improve care.

And I end, as always, with genuine thanks for your continued efforts on behalf of our patients, our staff and taxpayers.

Amanda Pritchard

Introduction

The investigation by Lord Darzi makes clear that, despite the efforts of our dedicated staff, the NHS is facing major challenges in meeting the growing needs of an ageing population. Individuals are spending an increasing proportion of their lives in ill-health and too many patients cannot access timely care. To address these challenges and make the NHS sustainable now and for future generations, systems need to agree and deliver plans within the resources allocated that maximise productivity and start to implement the reforms needed to improve services for patients, shifting the system from hospital to community, analogue to digital, and sickness to prevention. At the same time, we will work with government to create the 10 Year Health Plan to transform the model of care.

The government mandate has reduced the number of essential objectives for the NHS. Consistent with these objectives, NHS England has reduced the number of national priorities for 2025/26, giving local systems greater control and flexibility over how local funding is deployed to best meet the needs of their local population. Systems are encouraged to shift their focus from inputs to outcomes for patients and local communities, supported by changes to the financial framework. We will continue to work with systems to deliver on the fundamentals of good care, maintaining our collective focus on the overall quality and safety of our services. By helping people to spend more years in good health, the NHS will also enable more people to stay in and return to work, supporting economic growth.

The government's investment in the NHS in October's Budget was welcome; however, 2025/26 will be a challenging year and we must all live within our means. It has never been more important that we continue to ensure taxpayers' money is spent wisely. This will require a relentless focus on operational performance, recovering productivity, tackling unwarranted variation, and reducing delays and waste. In many places radical reform and reprioritisation will be the right answer. We and government will stand behind local leaders to make the best choices to meet the needs of their local populations, including where this means reducing or stopping lower-value activity.

As the system leaders, integrated care boards (ICBs) will lead the process of planning and arranging services to deliver the expectations set out in this guidance, including ensuring the reforms are put in place to secure a sustainable health system in the future. In their role as strategic commissioners, they will drive more integrated care through the development of neighbourhood health services, as well as planning the arrangement of acute services to maximise productivity and value.

Boards of providers are responsible for maximising value and delivering against the priorities set out in this guidance within the allocated financial envelope. Boards of providers and ICBs should use the Insightful Board series to drive better outcomes, productivity and decisions. Collaboration between NHS organisations will form part of NHS England's assessment of providers and ICBs.

Beginning in 2025/26 we will move to a more devolved system where ICBs and trusts can earn greater freedom and flexibility and patients have more choice and control. In mature, highly performing systems, it is expected that providers will be able to take on more responsibility for leading the planning and transformation of local services within a strategic framework set by ICBs. Excellent leadership and management are key to delivering these changes. NHS England will support local systems with a programme to transform NHS leadership and management over the next 2 years. This includes co-producing a development programme for strategic commissioning with NHS leaders.

NHS England will have a direct relationship with both ICBs and providers to ensure they deliver on their respective roles. In support of the updated Operating Model, we will publish a new NHS Improvement and Assessment Framework that will set out how NHS England will assess the performance and capability of providers (NHS trusts and foundation trusts) and ICBs. A new performance, regulatory and improvement framework will link with the NHS Improvement and Assessment Framework and set out NHS England's approach to supporting delivery. We will make best practice available to all to support local decisions and provide targeted direct support where it is needed. Where there is clear evidence of what works, we will adopt a stronger 'comply or explain' approach for the key actions that will help deliver the smaller number of national priorities. These are clearly set out in the boxes in this guidance.

Our national priorities for 2025/26

The national priorities to improve patient outcomes in 2025/26 are:

- **reduce the time people wait for elective care**, improving the percentage of patients waiting no longer than 18 weeks for elective treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement. Systems are expected to continue to improve performance against the cancer 62-

day and 28-day Faster Diagnosis Standard (FDS) to 75% and 80% respectively by March 2026

- **improve A&E waiting times and ambulance response times** compared to 2024/25, with a minimum of 78% of patients seen within 4 hours in March 2026. Category 2 ambulance response times should average no more than 30 minutes across 2025/26
- **improve patients' access to general practice,** improving patient experience, **and improve access to urgent dental care,** providing 700,000 additional urgent dental appointments
- **improve patient flow through mental health crisis and acute pathways,** reducing average length of stay in adult acute beds, **and improve access to children and young people's (CYP) mental health services**, to achieve the national ambition for 345,000 additional CYP aged 0 to 25 compared to 2019

In delivering on these priorities for patients and service users, ICBs and providers must work together, with support from NHS England, to:

- **drive the reform that will support delivery of our immediate priorities and ensure the NHS is fit for the future**. For 2025/26 we ask ICBs and providers to focus on:
  - reducing demand through developing Neighbourhood Health Service models with an immediate focus on preventing long and costly admissions to hospital and improving timely access to urgent and emergency care
  - making full use of digital tools to drive the shift from analogue to digital
  - addressing inequalities and shift towards secondary prevention
- **live within the budget allocated, reducing waste and improving productivity**. ICBs, trusts and primary care providers must work together to plan and deliver a balanced net system financial position in collaboration with other integrated care system (ICS) partners. This will require prioritisation of resources and stopping lower-value activity
- **maintain our collective focus on the overall quality and safety of our services**, paying particular attention to challenged and fragile services including maternity and

neonatal services, delivering the key actions of the ‘Three year delivery plan’, and continue to address variation in access, experience and outcomes

Local prioritisation and planning

2025/26 needs to mark a financial reset. Systems must develop plans that are affordable within the allocations set, exhausting all the opportunities to improve productivity and tackle waste (see below), and take decisions on how to prioritise resources to best meet the health needs of their local population. To help systems meet the focused set of national priorities we are increasing the freedoms systems have to allocate their resources by releasing most funding ring fences. Service Development Funding (SDF), which is already deployed to frontline service providers, is rolled into core allocations. Further detail is set out in the Revenue finance and contracting guidance. We will also consult on changes to the national and local quality requirements in the NHS Standard Contract to align with this approach.

To deliver the goals set out above and live within budget, providers will need to reduce their cost base by at least 1% and achieve 4% overall improvement in productivity before taking account of any new local pressures or dealing with non-recurrent savings from 2024/25. This represents a step change across all services. ICBs and providers must demonstrate that all productivity and efficiency opportunities have been exhausted before considering where it is necessary to reduce or stop services, taking account of each organisation’s own legal duties. Given the more focused set of national priorities, the Department of Health and Social Care (DHSC) and NHS England will reduce in size and reprioritise resources to support frontline services and improvements in productivity.

In deciding how to prioritise resources to best meet the health needs of their local population, ICB and provider boards are expected to explicitly consider both the in-year and medium-term quality, financial and population health impacts of different options (see Annex: Principles for local prioritisation). Plans should reflect the needs of all age groups and explicitly children and young people (CYP).

Delivering our national priorities

Reduce the time people wait for elective care

NHS England has published an elective reform plan to meet the NHS constitutional elective care standards for adults and CYP by the end of the Parliament. The plan specifies the actions we expect systems and providers to take in 2025/26 on the journey towards the 18-week standard. They include delivering activity levels consistent with the national value weighted activity target of 118%, effective demand management, driving pathway reform, maximising utilisation of existing capacity (including in the independent sector), and giving patients choice and control over their care. All systems must:

- optimise referral management including through use of high quality specialist advice and guidance, triage, patient initiated follow-up (PIFU) and straight-to-test pathway approaches
- provide patients with more choice and control by making at least 70% of elective care appointments (across specialties) available for citizens to view and manage via the NHS App
- validate patients on a referral to treatment (RTT) waiting list after 12 weeks and then every 12 weeks in line with good practice and published guidance, maximising the use of digital tools for both patient contact and data quality
- minimise unwarranted diagnostic referrals to create capacity for appointments and tests that truly benefit patient outcomes.
- implement the Further Faster methodology to drive optimisation of outpatient clinic processes and clinic utilisation
- improve the experience and reduce the inequalities of care for patients receiving elective care. As part of the development of an NHS Quality Strategy we will set out plans on how the NHS will increase its focus on listening to, learning from and working with patients, carers and communities to drive improvements in the experience of all people using our services

The contract default between ICBs and providers for most planned elective care will continue to pay unit prices for activity delivered in line with funded levels. Further detail is set out in the Revenue finance and contracting guidance.

Working with Cancer Alliances, systems are also expected to continue to focus on performance against the cancer waiting time standards, driving further improvement by:

- maximising care for low-risk patients in non-cancer settings, including maintaining the faecal immunochemical test (FIT) in lower GI pathways, low-risk pathways for post-HRT bleeding, and breast pain only pathways
- improving the productivity in cancer pathways including teledermatology in urgent suspected skin cancer and nurse or allied health professional (AHP)-led local anaesthetic biopsy in the prostate cancer pathway

Improve A&E waiting times and ambulance response times

Urgent and emergency care (UEC) performance remains a long way from a resilient or acceptable position. NHS England will work with systems to improve levels of performance across the UEC pathway, including through embedding and expanding neighbourhood health services. The immediate task for 2025/26 is to apply the learning from our best performing systems in 4 key areas:

1. **Reduce avoidable ambulance dispatches and conveyances, and reduce handover delays by:**
   - working towards delivering hospital handovers within 15 minutes, with joint working arrangements that ensure that no handover takes longer than 45 minutes
   - improving access to urgent care services at home or in the community including urgent community response (UCR) and virtual ward (also known as hospital at home) services
   - improving 'hear and treat' rates, increasing the proportion of Category 2 calls, and ensuring all 3 and 4 calls[1] are clinically navigated, validated and where appropriate triaged in ambulance control centres, or in single points of access in line with existing guidance
2. **Improve and standardise urgent care at the front door of the hospital by:**

[1] other than nationally agreed exclusions

- increasing the proportion of patients seen, treated and discharged in 1 day or less using the principles of same day emergency care (SDEC)
- optimising the urgent care offer to meet the needs of their local population, including the use of urgent treatment centres (UTCs)

3. **Reduce length of stay in hospital and ensure that patients are cared for in the most appropriate setting by:**

- increasing the percentage of patients discharged by or on day 7 of their admission in line with existing guidance
- working across the NHS and local authority partners to reduce average length of discharge delay in line with the Better Care Fund (BCF) policy framework. ICBs should review BCF commitments to ensure they represent the best use of resources, and plan sufficient intermediate care capacity to meet demand, including through surge periods across the year

To support this NHS England will:

- publish guidance to support ICBs in their commissioning of ambulance services in 2025/26, and publish a new ambulance commissioning specification in 2025/26 to enhance decision-making capacity and capability across all ambulance services, and drive consistency across the country. This will support ICBs in their commissioning of ambulance services in 2026/27
- make new capital available to increase the number of co-located urgent treatment centres (UTCs) in 2025/26 (working towards having a collocated UTC with every Type 1 ED) and support the expansion of SDEC capacity. Systems need to set out their approach to improvement, where they think capacity is required, and the first set of investments they propose to start in 2025

More detail on the expectations in relation to the BCF, and the support available to local teams, is available for the NHS and local authorities in the BCF planning requirements.

4. **Set the foundations of the neighbourhood health model** by continuing to embed, standardise and scale core components of existing practice. This includes taking a consistent, system-wide population health management approach to patient

segmentation and risk stratification. NHS England has published guidelines to support this.

Improve patients' access to general practice and improve access to urgent dental care

ICBs are expected to continue to support general practice to enable patients to access appointments in a more timely way and improve patient experience. ICBs should ensure that all GP practices inform patients, on the day they first make contact, how their request will be handled, as stipulated in the GP contract. All ICBs are expected to:

- put in place action plans by June 2025 to improve contract oversight, commissioning and transformation for general practice, and tackle unwarranted variation
- continue to support the delivery of modern general practice and target support to practices based on their ability to provide access and a good overall experience for patients
- improve access to dental care by commissioning additional urgent appointments to deliver their share of the government's manifesto commitment to an additional 700,000 appointments

NHS England will support this by providing general practice teams and primary care commissioners with national guidance, evidence-based content and support tools and consulting on reforms to the dental contract to deliver longer-term improvements in dental access. We will also support trusts to work with primary care to streamline the patient pathway, improving the interface between primary and secondary care, with clear recommendations through the 'Red Tape Challenge'. This is due to report to the Secretary of State and NHS England Chief Executive in early 2025.

Improve patient flow through mental health crisis and acute pathways and access to CYP mental health services

To support the national mental health objectives for 2025/26, we expect ICBs to meet the Mental Health Investment Standard (MHIS) and work with providers to:

- deliver the 10 high impact actions for mental health discharges and ensure that system discharge plans include mental health acute pathways to reduce average lengths of stay in the adult acute mental health pathway, improve local bed availability and reduce the need for inappropriate out of area placements
- reduce waits longer than 12 hours in A&E through:
  - maximising the use of crisis alternatives, including 111 mental health option, crisis resolution and home treatment teams, and community mental health services to keep people well at home
  - robust system oversight, implementation of the mental health OPEL framework and use of the mental health UEC action cards
- improve productivity by reducing unwarranted variation in the numbers of CYP accessing services and the number of contacts per whole time equivalent hours worked
- reduce unwarranted variation in the numbers of CYP accessing services by improving productivity and increasing the number of direct and indirect contacts per whole time equivalent hours worked
- reduce local inequalities in access to CYP mental health services, between disadvantaged groups and the wider CYP population
- expand mental health support teams consistent with the government's aim of reaching 100% coverage by 2029/30

Ring-fenced funding is available to support the delivery of effective courses of treatment within NHS Talking Therapies and reduce ill-health related inactivity, through access to individual placement support (IPS).

To continue to reform and improve mental health services and improve value for money in the NHS, all mental health providers will be asked to submit, implement and report against a plan to improve productivity during 2025/26.

In line with the proposed Mental Health Act reform, ICBs should work with local system colleagues to ensure that there is high quality and accessible community infrastructure in place for people with a learning disability and autistic people. They should also ensure that

admissions to a mental health hospital are for assessment and treatment that can only be delivered in an inpatient setting.

Address inequalities and shift towards prevention

It remains critical that ICSs explicitly agree local ambitions and delivery plans for vaccination and screening services and services aimed at addressing the leading causes of morbidity and mortality such as cardiovascular disease and diabetes. ICBs and provider trusts are expected to work together to reduce inequalities in line with the Core20PLUS5 approach and ensure plans reflect the needs of all age groups, including CYP.

NHS England intends to continue to prioritise prevention and proactive care as part of effective population health management through the GP contract, including increasing the focus on the prevention of cardiovascular events by supporting GPs to treat more people to target levels of blood pressure and lipid control.

Making the shift from analogue to digital

In addition to continuing to improve digital maturity, systems are asked to prioritise actions that support the delivery of our priorities to improve patient outcomes or have been shown to reduce costs or release staff time to deliver patient care. We expect that:

- all providers proactively offer NHS App-first communications to patients (with due regard to digital inclusion), by default through the NHS Notify service
- all GP practices have enabled all core NHS App capabilities. These include health record access, online consultations, appointment management, prescriptions management, online registration, and patient messaging
- all systems adhere to the ‘Federated Data Platform (FDP) First’ policy, connecting their own digital and data infrastructure to the FDP. NHS England will support adoption of the FDP to 85% of all secondary care trusts by March 2026
- all providers shift to the national collaboration service NHS.Net Connect where feasible

- all systems complete planned electronic patient record (EPR) system procurements and upgrades, and all trusts without an EPR continue to work to procure and implement one as quickly as is safely possible
- all providers deploy the Electronic Prescription Service wherever possible
- all providers integrate systems with the NHS e-Referral Service
- all providers achieve and maintain compliance with the NHS Multi-Factor Authentication Policy and act to strengthen their cyber security
- all systems mitigate against digital exclusion, including by implementing the framework for NHS action on digital inclusion

Live within our means, reducing waste and maximising productivity

As set out above, 2025/26 needs to mark a financial reset, in particular in systems and providers that have not lived within planned allocations. While NHS productivity has increased at around twice the historical rate since 2021/22, there remains scope for a further step change. Across the NHS we are seeing around 14% more patient contacts than pre-pandemic, but we also have 19% more staff. As part of reducing unwarranted variation and exhausting all possible realistic in-year productivity and efficiency opportunities, ICBs and providers must:

1. **Reduce spend on temporary staffing and support functions by:**

   - achieving close to 100% delivery of planned core capacity before accessing premium capacity, including the use of agency and premium bank rates, waiting list initiatives, and insourcing arrangements, managing to tariff prices as a guide
   - reducing agency expenditure, as far as possible as part of optimising cost and productivity. As a minimum all systems are expected to deliver a 30% reduction based on current spending, with further reductions over the Parliament
   - reducing bank use, with all systems expected to deliver a minimum 10% reduction. Bank rates should be optimised as far as possible with collaborative arrangements in place across and between systems
   - conducting a robust review of establishment growth and reduce spend on support functions to April 2022 levels

2. **Improve procurement, contract management and prescribing by:**

   - working to accepted operating models and commercial standards, making full use of the consolidated supplier frameworks agreed through NHS Supply Chain
   - optimising medicines value and improving the adoption of and compliance with best value frameworks in medicine and procurement
   - reducing unwarranted variation in prescribing, implementing the guidance on 'Low value prescribing' and ensure that patients are prescribed the best value biological medicine where a biosimilar medicine is available.
   - reducing unwarranted variation in all age continuing care spend and placement pricing through standardised complex care specification(s), improved sharing of placement data and integrated 'at scale' commissioning practices
   - optimising energy value. Trusts are expected to procure energy through the new national contract developed with Crown Commercial Services (CCS) and use green plans to identify and achieve savings from sustainable energy funding

NHS England will work with individual systems to identify support to realise these savings.

3. **Drive improvements in operational and clinical productivity. Providers are expected to:**

   - develop plans that address the activity per WTE gap against the pre-Covid level
   - avoid duplication and low-value activity, including a renewed focus on minimising inappropriate spend against evidence-based intervention (EBI) procedures. Commissioners are expected to work with providers to ensure that payment depends on meeting the relevant criteria
   - systematically implement all elements of the People Promise to improve the working lives of all staff and increase staff retention and attendance and implement the 6 high impact actions to improve equality, diversity and inclusion. The evidence is clear that engaged, motivated staff improve productivity and patient outcomes

A full list of resources to support benchmarking and to identify the areas for local improvement can be found on the Productivity and Efficiency Improvement Hub. NHS IMPACT will continue to help develop the leadership and organisational capacity, capability and infrastructure to create the conditions for improvement. As part of this, NHS England's

Clinical and Operational Excellence Programme will support organisations to deliver the priorities in this guidance.

Next steps and plan submission

We ask ICBs, in their role as strategic commissioners, to work with their partner trusts and wider system partners to develop plans by the end of March to meet the national objectives set out in this guidance and the local priorities agreed by ICSs. Plans should be calibrated against the quality objectives laid out in this document and triangulated across activity, workforce and finance. Plans must be fully owned and signed off by ICB and partner NHS trust and foundation trust boards. NHS England will separately set out guidelines and supporting materials for plan development, submission and review. Boards will be asked to confirm how these have been used to inform the development and assurance of plans.

ICBs and their partner trusts have a duty to prepare a plan setting out how they propose to exercise their functions in the next 5 years [the 'Joint Forward Plan' (JFP)]. We expect that ICBs and trusts will wish to perform a limited refresh of existing plans before the beginning of the new financial year given the anticipated publication of the 10 Year Health Plan in the spring of 2025 and a multi-year financial settlement for the public sector as part of the Spending Review 2025. We will work with systems to develop a shared set of expectations and timetable for a subsequent more extensive revision of JFPs aligned to wider reform of nationally co-ordinated NHS planning processes. This will include a shift from single to multi-year operational and financial planning.

National priorities and success measures for 2025/26

Priority	Success measure
Reduce the time people wait for elective care	Improve the percentage of patients waiting no longer than 18 weeks for treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement[2]
	Improve the percentage of patients waiting no longer than 18 weeks for a first appointment to 72% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement[2]
	Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026
	Improve performance against the headline 62-day cancer standard to 75% by March 2026
	Improve performance against the 28-day cancer Faster Diagnosis Standard to 80% by March 2026
Improve A&E waiting times and ambulance response times	Improve A&E waiting times, with a minimum of 78% of patients admitted, discharged and transferred from ED within 4 hours in March 2026 and a higher proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26 compared to 2024/25
	Improve Category 2 ambulance response times to an average of 30 minutes across 2025/26
Improve access to general practice and urgent dental care	Improve patient experience of access to general practice as measured by the ONS Health Insights Survey
	Increase the number of urgent dental appointments in line with the national ambition to provide 700,000 more
Improve mental health and learning disability care	Reduce average length of stay in adult acute mental health beds
	Increase the number of CYP accessing services to achieve the national ambition for 345,000 additional CYP aged 0–25 compared to 2019
	Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, delivering a minimum 10% reduction
Live within the budget allocated, reducing waste and improving productivity	Deliver a balanced net system financial position for 2025/26
	Reduce agency expenditure as far as possible, with a minimum 30% reduction on current spending across all systems
	Close the activity/ WTE gap against pre-Covid levels (adjusted for case mix)
Maintain our collective focus on the overall quality and safety of our services	Improve safety in maternity and neonatal services, delivering the key actions of the of the 'Three year delivery plan'
Address inequalities and shift towards prevention	Reduce inequalities in line with the Core20PLUS5 approach for adults and children and young people
	Increase the % of patients with hypertension treated according to NICE guidance, and the % of patients with GP recorded CVD, who have their cholesterol levels managed to NICE guidance

[2]Against the November 2024 baseline, with all providers required to increase their RTT performance to a minimum of 60% and performance on wait for first appointment to a minimum of 67%

Annex: Principles for local prioritisation

Systems will need to take difficult decisions about how to prioritise their resources. All organisations must review their existing governance and reporting frameworks to proactively manage quality, and mitigate, manage and escalate risks and concerns. ICBs and providers must work together to:

- put in place a robust clinically led process to support local prioritisation decisions, taking account of the 6 key principles for delivering quality care set out in 'A Shared Commitment to Quality'
- produce impact assessments and test all changes with boards as well as consider what changes require involvement, whether by consultation or otherwise, with the public, patients, staff groups and local authorities

Provider and ICB boards must:

- embed a robust quality and equality impact assessment (QEIA) process as part of financial and operational decision-making (including cost improvement plans)

In addition to considering matters required by applicable legal duties, we ask that boards consider the following principles when making local prioritisation decisions:

- safeguard the quality and safety of services, paying particular attention to challenged and fragile services
- protect access to essential services, prioritising urgent and emergency care, and those patients with the greatest clinical need
- wherever possible take actions that are consistent with narrowing existing health inequalities including inequalities in access
- take account of the medium-term quality, financial and population health impacts alongside in-year impacts

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Neighbourhood health guidelines 2025/26

Publication (/publication)

Content

Why a new approach is needed

1. There is an urgent need to transform the health and care system. We need to move to a neighbourhood health service that will deliver more care at home or closer to home, improve people's access, experience and outcomes, and ensure the sustainability of health and social care delivery. More people are living with multiple and more complex problems, and as highlighted by Lord Darzi (https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england), the absolute and relative proportion of our lives spent in ill-health has increased.

2. Addressing these issues requires an integrated response from all parts of the health and care system. Currently, too many people experience fragmentation, poor communication and siloed working, resulting in delays, duplication, waste and suboptimal care. It is also frustrating for people working in health and social care.

3. Neighbourhood health reinforces a new way of working for the NHS, local government, social care and their partners, where integrated working is the norm and not the exception. Some places have already made progress in developing

an integrated local approach to NHS and social care delivery. The full vision for the health system will be set out in the 10 Year Health Plan (https://www.gov.uk/government/publications/change-nhs-help-build-a-health-service-fit-for-the-future), including proposals to help make this emerging vision for neighbourhood health a reality, informed by existing work and public, staff and stakeholder engagement.

4. This document sets out guidelines to help integrated care boards (ICBs), local authorities and health and care providers continue to progress neighbourhood health in 2025/26 in advance of the publication of the 10 Year Health Plan. The appendix provides more specificity around the initial 6 components of neighbourhood health to create a common understanding of what lies at its core, but the guidelines are deliberately short and permissive about how neighbourhood health should be implemented, setting out a framework for action that can be tailored to local needs.

5. Neighbourhood health aims to create healthier communities, helping people of all ages live healthy, active and independent lives for as long as possible while improving their experience of health and social care, and increasing their agency in managing their own care. This will be achieved by better connecting and optimising health and care resource through 3 key shifts at the core of the government's health mission:

- **from hospital to community –** providing better care close to or in people's own homes, helping them to maintain their independence for as long as possible, only using hospitals when it is clinically necessary for their care
- **from treatment to prevention –** promoting health literacy, supporting early intervention and reducing health deterioration or avoidable exacerbations of ill health
- **from analogue to digital** – greater use of digital infrastructure and solutions to improve care

The plan to reform elective care (https://www.england.nhs.uk/publication/reforming-elective-care-for-patients/) is an example of this commitment in action, improving experience and convenience by providing more direct access to tests, scans and surgery in dedicated local centres and empowering people with more choice over when and where they will be treated, including through the NHS app.

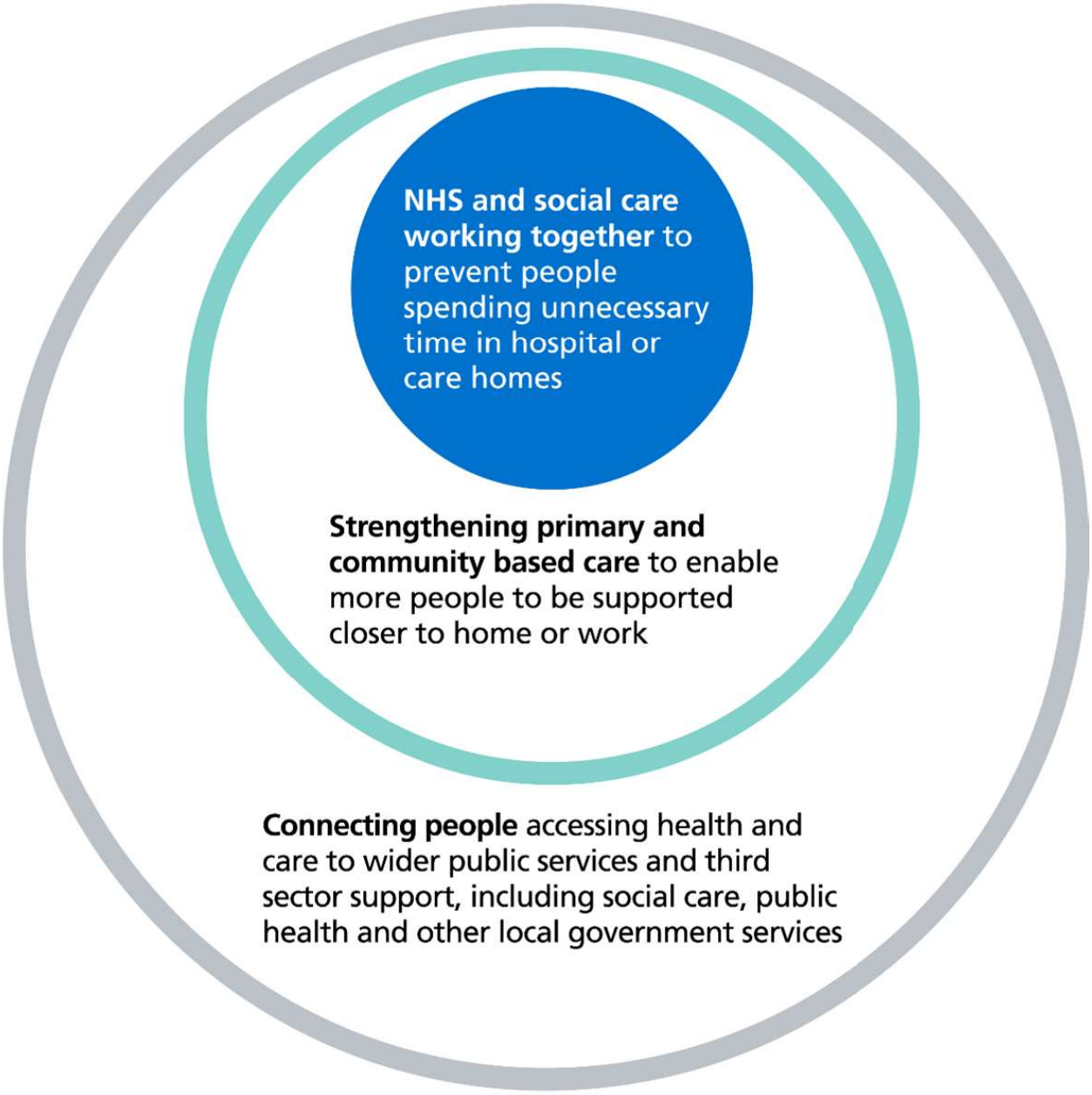
6. All parts of the health and care system – primary care, social care, community health, mental health, acute, and wider system partners – will need to work closely together to support people's needs more systematically, building on existing cross-team working, such as primary care networks, provider collaboratives and collaboration with the voluntary, community, faith and social

enterprise (VCFSE) sector. In some parts of the country this is already happening, and much can be learned from these experiences. System* leaders will need to work with partners across local communities, together creating a collaborative high-support, high-challenge culture, to develop a shared vision and outcomes, define population boundaries for neighbourhood health and introduce joint accountability arrangements.

* Use of the term “system” in this publication refers to integrated care system.

7. In the coming months, drawing on learnings from existing work, the focus will be on creating the national and local conditions for different ways of working. The diagram below shows the aims for all neighbourhoods over the next 5 to 10 years. For 2025/26, through the standardisation and scaling of the initial 6 components, we are asking systems to focus on the innermost circle to prevent people spending unnecessary time in hospital and care homes. As core relationships between the local partners grow stronger, we expect systems to focus increasingly on the outer circles. This will involve exploring their own ways of building or reinforcing links with wider public services, the third sector and local communities to fully transform the delivery of health and social care according to local needs:

Diagram showing the aims for all neighbourhoods over the next 5 to 10 years



(https://www.england.nhs.uk/wp-content/uploads/2025/01/Diagram-showing-the-aims-for-all-neighbourhoods-over-the-next-5-to-10-years.png)

Image text:

- NHS and social care working together to prevent people spending unnecessary time in hospital or care homes.
- Strengthening primary and community based care to enable more people to be supported closer to home or work.
- Connecting people accessing health and care to wider public services and third sector support, including social care, public health and other local government services.

Neighbourhood health is an important part of wider public sector reform. Previous estimates suggest around 1 in 5 GP appointments are taken up for non-medical reasons, such as loneliness or to seek advice on housing or debts. A less complex and simpler connection between health and wider local public services, as depicted in the outer circle of the diagram, has the potential to improve outcomes for people and wider public sector productivity, and to reduce pressure on GP surgeries, emergency departments, acute hospital services and providers of long-term social care. It is an opportunity to enhance the partnership between councils, local public agencies like job centres, the third sector and NHS partners, and to design much clearer pathways for non-medical support from the local public and third sectors.

> 8. NHS England regional teams, working with local government partners and informed by the evidence generated from existing work in systems, should work with systems to agree locally what specific impacts they will seek to achieve during 2025/26. We expect these to include, as a minimum, **improving timely access** to general practice and urgent and emergency care, **preventing long and costly admissions** to hospital and **preventing avoidable long-term admissions** to residential or nursing care homes.

9. This document provides further guidelines on neighbourhood health. These draw together key points from earlier guidance and build on existing local best practice. It should be read alongside the 2025/26 NHS operational planning guidance (https://www.england.nhs.uk/publication/2025-26-priorities-and-operational-planning-guidance/) and 2025 to 2026 Better Care Fund policy framework (https://www.gov.uk/government/publications/better-care-fund-policy-framework-2025-to-2026), so systems can make progress against the above aims in advance of the publication of the 10 Year Health Plan.

Making a start on delivery

10. Many local organisations across England have collaborated over the past few years to develop great examples of one or more of the individual components that make up an effective neighbourhood health service. Many of these best practice examples have informed the development of national policy or guidance, including the Fuller Stocktake (https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/) and Intermediate care framework (https://www.england.nhs.uk/publication/intermediate-care-framework-

for-rehabilitation-reablement-and-recovery-following-hospital-discharge/). The priority now is to connect those components and implement them system-wide, starting with frontline services for people with the most complex health and care needs.

11. While 2025/26 will be a challenging financial year for the NHS, local government and social care, the coming months offer a significant opportunity to build on current momentum for a neighbourhood health approach in order to ensure the ongoing sustainability of health and social care delivery. Systems are asked to do this by:

- **standardising 6 core components of existing practice** to achieve greater consistency of approach
- **bringing together the different components into an integrated service offer** to improve coordination and quality of care, with a focus on people with the most complex needs
- **scaling up** to enable more widespread adoption
- **rigorously evaluating** the impact of these actions, ways of working and enablers both in terms of outcomes for local people and effective use of public money

This will set the foundations for scaling and expanding the neighbourhood approach over the coming years.

12. The focus in 2025/26 should be supporting adults, children and young people with complex health and social care needs who require support from multiple services and organisations. This cohort has been estimated at around 7% of the population and associated with around 46% of hospital costs, according to NHS England analysis from adapted Bridges to Health data. It is likely that systems will initially prioritise specific groups within this cohort where there is the greatest potential to improve levels of independence and reduce reliance on hospital care and long-term residential or nursing home care, both improving outcomes and freeing up resources so systems can go further on prevention and early intervention. This approach is likely to focus on around 2% to 4% of the population. Examples of population cohorts with complex needs include:

- adults with moderate or severe frailty (physical frailty or cognitive frailty, for example, dementia)
- people of all ages with palliative care or end of life care needs
- adults with complex physical disabilities or multiple long-term health conditions
- children and young people who need wider input, including specialist paediatric expertise into their physical and mental health and wellbeing
- people of all ages with high intensity use of emergency departments

13. Increasing coordination, consistency and scale in delivering health and social care to specific sub-cohorts should result in the following benefits over time:

- avoiding or slowing health deterioration, preventing complications and the onset of additional conditions, and maximising recovery whenever possible to increase healthy years of life
- streamlining access to the right care at the right time, including continued focus on access to general practice and more responsive and accessible follow-up care enabled through remote monitoring and digital support for patient-initiated follow-up
- maximising the use of community services so that better care is provided close to or in people's own homes
- reducing emergency department attendances and hospital admissions, and where a hospital stay is needed, reducing the amount of time spent away from home and the likelihood of being readmitted to hospital
- reducing avoidable long-term admissions to residential or nursing care homes
- reducing health inequalities, supporting equity of access and consistency of service provision
- improving people's experience of care, including through increased agency to manage and improve their own health and wellbeing
- improving staff experience
- connecting communities and making optimal use of wider public services, including those provided by the VCFSE sector

14. Evidence from services and research (https://www.prucomm.ac.uk/assets/uploads/files/commissioning-for-integrated-service-delivery-at-place-initial-report-final-2.pdf) has identified elements of partnership working that are critical for effective implementation of neighbourhood health:

- **a mechanism for joint senior leadership**, such as a joint neighbourhood health taskforce, **in each place** to drive integrated working, comprising senior leaders from the constituent organisations across health and care, including the acute hospital
- **a collaborative high-support, high-challenge culture,** which fosters strong relationships between all system partners, including the NHS, local government, social care providers and the VCFSE sector. This culture is supported by **shared values, outcomes, clear lines of accountability and definitions** for how services are organised at place and neighbourhood level (https://www.england.nhs.uk/publication/designing-integrated-care-systems-icss-in-england/) (aligning service delivery across organisations to agreed populations at these levels)

- **visible clinical and professional leadership and management**, at both system and place level, supported through the effective clinical and care professional leadership framework (https://www.england.nhs.uk/publication/integrated-care-systems-guidance/#heading-13). This includes **working in partnership with communities** (https://www.england.nhs.uk/publication/integrated-care-systems-guidance/#heading-12) (including people and carers* with lived experience and local third sector organisations) to co-develop neighbourhood health locally, and to mobilise change
- **effective processes** (including communication channels, IT systems and information governance processes) and **training and workforce development** to enable collaborative working
- **making best use of all funding arrangements**, including those that are formally pooled, to facilitate partnership working

* Wherever “carer” is used in this publication, it refers to both paid and unpaid carers.

15. Learning from work in 2025/26, alongside emerging research and innovation, will inform the future development of the neighbourhood health and care model as it extends to other population cohorts. This learning will also shape support offers to systems, and a more formal evaluation framework for the future delivery of neighbourhood health systems will be developed. We now ask systems to:

- consider how they will evaluate the impact of the changes they make in a systematic, consistent and scalable way to build the case for future expansion and link to the triple aim of improving population health outcomes, people’s experience of health and care services and value for money
- embrace the government’s “test and learn” approach (https://www.gov.uk/government/speeches/reform-of-the-state-has-to-deliver-for-the-people) to enable continuous improvement in real-time and build on existing good practice such as the NHS IMPACT Improving Patient Care Together framework (https://www.england.nhs.uk/nhsimpact/)

Summary of requirements for 2025/26

16. Building on the foundations laid by the Fuller Stocktake (https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/), approaches to tackle health inequalities, such as Core20PLUS5 (https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/) and Core20PLUS5 for children and young people

(https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/core20plus5-cyp/), outreach work and using data and local insights, systems should work with partner organisations to:

- **apply a consistent, system-wide population health management approach** which draws on quantitative data and qualitative insights to understand needs and risks for different population cohorts
- **use this information to design and deliver the most appropriate care for each population cohort** and to inform best-value commissioning decisions that empower frontline staff to provide more person-centred care, enabling people to live independently for longer
- **continue to embed, standardise and scale the 6 initial core components of a neighbourhood health service** (detailed in appendix 1) and ensure capacity and structures across providers are aligned to best meet demand

17. Best practice also suggests systems should consider:

- improving coordination, personalisation and continuity of care for people with complex needs, including increased agency in managing their own care, supported by:
    - a single electronic health and care record that is actively used in real-time by frontline health and social care staff
    - a care coordination function between the person or their carer and the wider multi-professional team supporting them if needed, working across organisational boundaries
- applying learnings from existing or emerging neighbourhood health models, such as enhanced health in care homes (https://www.england.nhs.uk/community-health-services/ehch/), the 24/7 neighbourhood mental health centres (https://www.england.nhs.uk/mental-health/mental-health-learning-disability-and-autism-inpatient-quality-transformation-programme/localising-and-realigning-inpatient-services/), women's health hubs (https://www.england.nhs.uk/publication/womens-health-hubs/), family hubs (https://www.gov.uk/government/collections/family-hubs-and-start-for-life-programme) and the Health and Growth Accelerators (https://www.england.nhs.uk/2024/12/world-leading-nhs-trial-to-boost-health-and-support-people-in-work/), ensuring that services are delivered at an efficient and effective scale

18. Systems should also tackle health inequalities (https://www.england.nhs.uk/long-read/publication-of-nhs-englands-statement-on-information-on-health-inequalities/) when developing their neighbourhood health

service. This will include:

- getting the basics right (such as ensuring services are accessible to people with disabilities and implementing reasonable adjustments as needed)
- engaging with local communities and working with them as equals to design and deliver services, working particularly closely with specific communities that have been historically underserved
- analysing outcomes by population demographics, deprivation, age, ethnicity, disability (supported by the reasonable adjustment digital flag (https://digital.nhs.uk/services/reasonable-adjustment-flag)) and inclusion health groups (https://www.england.nhs.uk/long-read/a-national-framework-for-nhs-action-on-inclusion-health/)

Next steps

19. ICBs and local authorities are asked to jointly plan a neighbourhood health and care model for their local populations that consistently delivers and connects the initial core components at scale, with an initial focus on people with the most complex health and care needs. More mature systems will be working to develop an integrated neighbourhood delivery plan across the 6 initial core components, published as part of Joint Forward Plans and informed by engagement with local communities, that includes:

- improving collaboration and enabling effective ways of working
- agreeing commissioning models, new funding flows and contractual mechanisms between the NHS and local authorities
- workforce planning and development
- evaluation
- exploring the use of neighbourhood buildings across all partners, including local government, following on from recent ICB-led estates strategy work

20. We will provide further details of a national implementation programme over the coming months, designed for all parts of the health and social care system involved in delivering neighbourhood health. The initial phase of this programme will aim to work with at least one place in every system. These places will already be demonstrating a more developed approach to delivery at local level, with clear leadership across the ICB, local NHS and local authority. System partners in these places will be provided with facilitation support, as well as support to ensure robust evaluation and monitoring of progress. This test and learn approach will help to identify what is working most effectively and the conditions that are required to deliver a set of target outcomes. The national implementation

programme will sit alongside a very small number of learning and evidence sites, which will test the model at scale, including its impact on flows in and out of an acute hospital.

21. We will also shortly share case studies of existing good practice. NHS England regional teams, working with local government partners, will continue to have a key role in sharing and spreading emerging best practice and learning with systems.

22. We will continue to work with systems to co-develop the vision for neighbourhood health, focusing on removing barriers and creating the conditions for success. These guidelines will be kept under review as further learning emerges.

Appendix 1

The foundations of a neighbourhood health service are already in place in many areas across the country. This appendix describes 6 core components (A to F) associated with an effective neighbourhood service, as identified from the current evidence.

Initial 6 core components

Local systems will need to consider each component within the context of the needs of their local population and the current configuration of services. They will also need to evaluate how effectively individual interventions link together to improve the way services are delivered for their local population and the outcomes people achieve.

Given local projections of future need and demand, systems will want to consider how to have the greatest impact on health and wellbeing outcomes for the local population as well as benefits for the system when prioritising resource allocation, strategic leadership and quality improvement efforts.

A. Population health management

- Ensure there is a person-level, longitudinal, linked dataset encompassing:
  - general practice and wider primary care
  - community health services
  - mental health
  - acute care
  - social care
  - public health

Over time, this dataset should be broadened to include other data held by local or central government, including employment, education and safeguarding. It should be supported by appropriate data sharing and processing agreements. This should enable analysis of population health outcomes, biopsychosocial risk drivers and health and care system resource use. NHS England will continue to work with the National Data Guardian to support integrated care boards (ICBs) to navigate the necessary information governance requirements, but partners should already share existing data wherever possible.

- Apply a single, consistent system-wide population health management method to ICB analytics platforms to segment and risk stratify populations, based on complexity and forecasted resource use. Where systems do not already have an existing tool, they must work with the NHS Federated Data Platform team to select one which is compatible. In 2025/26, NHS England will work with ICBs to review the impact and evidence behind effective risk stratification to enable further signposting to validated tools.
- A population health management approach should be supported by a system-wide intelligence function (https://www.england.nhs.uk/long-read/building-an-ics-intelligence-function/) used to:
    - inform strategic commissioning and resource allocation
    - enable providers to work together to best organise their workforce to deliver health and care

Systems should ensure they complement these analytical approaches with wider quantitative and qualitative insight into groups that might be under-represented in NHS datasets, for example, people with severe mental illness or learning disability or autistic people. Implementation of the Reasonable Adjustment digital flag information standard (https://www.england.nhs.uk/long-read/the-reasonable-adjustment-digital-flag-action-checklist-what-you-need-to-do-to-achieve-compliance/) will also help analyse data for some of these population groups.

- Clinical data systems should have complementary functionality, including compatibility and integration between GP systems, digital social care records and other provider systems. This will support effective case finding, care navigation and risk-based prioritisation of proactive, planned, responsive and urgent care. This will also inform the design and work of neighbourhood multidisciplinary teams.
- Further guidance on using data to segment and risk stratify populations will follow in 2025, to complement existing resources (https://www.e-lfh.org.uk/programmes/population-health-management/) and the Population Health Academy (https://future.nhs.uk/connect.ti/populationhealth?sm_newemail=).

B. Modern general practice

- ICBs are asked to continue to support general practices with the delivery of the modern general practice model (https://www.england.nhs.uk/gp/national-general-practice-improvement-programme/modern-general-practice-model/), to deliver improvements in access, continuity and overall experience for people and their carers. This is a response to increasing demand and a foundational step to enable practices to move from a model of reactive to more proactive care.
- ICBs are expected to streamline the end-to-end access journey for people, carers and staff, making it quicker and easier to connect with the right healthcare professional, team or service, including community pharmacy, use of Pharmacy First (https://www.england.nhs.uk/primary-care/pharmacy/pharmacy-services/pharmacy-first/) and digital self-service options such as repeat prescription ordering via the NHS app. This approach will accommodate the needs of different groups and patients and support continuity of care.
- People and their carers should have the ability to access services equitably (https://www.england.nhs.uk/long-read/inclusive-digital-healthcare-a-framework-for-nhs-action-on-digital-inclusion/) in different ways (online, telephone and in person) with highly usable and accessible online systems (the NHS app, practice websites, online consultation tools) and telephone systems. There should also be structured information gathering at the point of contact (regardless of contact channel) and clear navigation and triage based on risk and complexity of needs.
- Staff should have access to structured information about the complexity of the presenting complaint and need. This information should be organised alongside population segmentation (including by age) and risk stratification information into a single workflow. This approach will support staff in efficiently navigating and triaging needs safely and fairly, including enabling risk-based prioritisation of continuity of care and optimising use of the general practice and wider multi-professional team.

C. Standardising community health services

- Many community health services will play a key role in delivering neighbourhood health and care, and many of these services should be commissioned as part of an integrated neighbourhood health offer.
- When designing, commissioning and delivering neighbourhood health, ICBs and providers should be using the Standardising community health services publication (https://www.england.nhs.uk/publication/standardising-community-health-services/) (covering NHS-funded specialist support for

people with physical health needs and neurodevelopmental services for children and young people). This will ensure funding is used to best meet local needs and priorities.

- Some people will have both physical and mental health needs, or drug and alcohol dependency. It is essential that care is planned to meet all health and social care needs and that service boundaries do not prevent seamless, joined-up care. Systems should continue to make use of the mental health Additional Roles Reimbursement Scheme (https://www.england.nhs.uk/mental-health/working-in-mental-health/mental-health-practitioners/), which is jointly funded with primary care, to improve primary care mental health and access to community-based mental health services for people of all ages, as well as through services such as NHS Talking Therapies for anxiety and depression (https://www.england.nhs.uk/mental-health/adults/nhs-talking-therapies/). For children and young people, it's also critical to join up with mental health services (https://www.england.nhs.uk/mental-health/cyp/) and mental health support teams (https://www.england.nhs.uk/mental-health/cyp/trailblazers/#_Mental_Health_Support) in schools and further education. For people with co-occurring drug and alcohol dependency, services should engage with local authority commissioned substance misuse services. It will also be important to link in with VCFSE sector support for adults, children and young people around mental health, social isolation and substance misuse.

D. Neighbourhood multidisciplinary teams (MDTs)

- The approach to establishing integrated neighbourhood teams has been well defined in the Fuller Stocktake (https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/). Such teams bring a wider range of expertise together, from across health, social care, VCFSE and wider partners to benefit a shared population. As part of this approach, there will need to be multidisciplinary coordination of care for population cohorts with complex health and care or social needs who require support from multiple services and organisations. They are expected to deliver proactive (https://www.england.nhs.uk/long-read/proactive-care-providing-care-and-support-for-people-living-at-home-with-moderate-or-severe-frailty/), planned and responsive care, and prioritise care based on individual people's needs and the opportunity for greatest impact. Footprints should be designed to optimise neighbourhood working and partnership with local authorities. Detailed guidance on neighbourhood MDTs for children and young people will be published in early 2025.

- Functions include overseeing or delivering holistic joint assessments, case reviews and deployment of coordinated provision, medication reviews, care planning for long-term conditions and personalised care and support planning (https://www.england.nhs.uk/personalisedcare/pcsp/), including social prescribing (https://www.england.nhs.uk/personalisedcare/social-prescribing/), comprehensive geriatric assessments and advanced care plans. For people with co-occurring severe mental illness, we would expect these functions to remain within core community mental health services. However, we would expect a joined-up approach to planning care for people with significant mental and physical health needs across teams.
- In best practice models, a core team is assigned for complex case management, with links to an extended team that enables access to additional specialist resource as needed. The composition of teams may vary depending on the population being served by the MDT and local prioritisation of clinical need. Teams could include GPs, specialist nurses or consultants (such as, specialist dementia nurses and secondary care clinicians, including paediatricians and geriatricians), district nurses, GP nurses, acute hospital consultants, allied health professionals, health visitors, mental health professionals, social prescribing link workers and social workers, home care staff, residential care home and nursing home staff, as well as wider system and community partners (such as from public health and the VCFSE sector).
- It is best practice to assign a care coordinator to every person or their carer in the population cohort as a clear point of contact to improve both their experience and continuity of care. The role could be undertaken by any member of the core team and will link into clinical triage and onward referrals as required. It will also set expectations with the person or their carer as part of the care plan process, so that all parties understand their part in improving outcomes.

E. Integrated intermediate care with a ‘Home First’ approach

- Systems are asked to deliver short-term rehabilitation, reablement and recovery services (integrated intermediate care) taking a therapy-led approach (rehab or reablement care overseen by a registered therapist) working in integrated ways across health and social care and other sectors.
- Ensure referrals can be made directly from the community (step-up) or as part of hospital discharge planning (step-down (https://www.england.nhs.uk/publication/intermediate-care-framework-for-rehabilitation-reablement-and-recovery-following-hospital-discharge/)), applying a ‘Home First’ approach (https://www.england.nhs.uk/publication/a-community-rehabilitation-and-reablement-model/), with assessments and

interventions delivered at home where possible and working closely with urgent neighbourhood services.
- Implement good operational case management systems and measure outcomes (with reference to the objectives and metrics set out in the Better Care Fund policy framework for 2025 to 2026 (https://www.gov.uk/government/publications/better-care-fund-policy-framework-2025-to-2026)) to ensure best use of resources.

F. Urgent neighbourhood services

- Standardise and scale urgent neighbourhood services for people with an escalating or acute health need. This means ensuring urgent community response (https://www.england.nhs.uk/community-health-services/urgent-community-response-services/) and hospital at home (virtual ward) (https://www.england.nhs.uk/long-read/virtual-wards-operational-framework/) services are aligned to local demand and work together (with access increasingly through a single point of access (https://www.england.nhs.uk/long-read/single-point-of-access-spoa/)) to deliver a co-ordinated service. These urgent neighbourhood services should align with services at the front door of the hospital, such as urgent treatment centres (https://www.england.nhs.uk/publication/urgent-treatment-centres-principles-and-standards/) and same day emergency care (https://www.england.nhs.uk/urgent-emergency-care/same-day-emergency-care/), which are also increasingly accessed through a single point of access.
- As part of ambulance service improvement of See and Treat and Hear and Treat pathways, senior clinical decision makers in a single point of access should provide advice and referral to appropriate services either before ambulance dispatch or as part of a “call before convey” approach. Single points of access should also provide clinical advice to other healthcare professionals and care home workers, so staff avoid calling 999.
- As outlined in the integrated intermediate care section above, ensure step-up pathways (to prevent avoidable admissions) and step-down pathways (to support timely and effective discharge) use resources efficiently and effectively. Service footprints should be determined locally, balancing scale of delivery with building on local relationships to ensure smooth referral pathways into urgent and planned care services. Where footprints span multiple neighbourhoods, services should still operate in a way that feels like a seamless service for people and carers.

Secondary care contribution to neighbourhood health

Local acute services can provide significant contribution to the development of a neighbourhood health service. Home First and person-centred approaches need to be embedded throughout the health and care system so that appropriate risk-based decisions are always made, and hospital care only used when clinically necessary. In this way, every part of the system works collaboratively to reduce the risks associated with a hospital admission and a lengthy hospital stay if admission is unavoidable.

Clinicians in hospitals can continue to work collaboratively with community-based teams to ensure that their patients benefit from a neighbourhood health service by:

- supporting continuity of care in the community for people under the care of a specialist hospital team such as respiratory, diabetes, stroke or cardiology. This might include providing specialist input to neighbourhood MDTs such as through clinics delivered jointly in primary or community settings, using digital technology and infrastructure, or by establishing pathways into the hospital which avoid the emergency department, for example, by using urgent treatment centres, same day emergency care pathways or outpatient clinics.
- supporting the development of hospital at home (virtual ward) (https://www.england.nhs.uk/long-read/virtual-wards-operational-framework/), single point of access (https://www.england.nhs.uk/long-read/single-point-of-access-spoa/) and community diagnostic centres (https://www.england.nhs.uk/long-read/community-diagnostic-centres/)*, including providing clinical advice and oversight as required.
- ensuring that frailty services are joined up in all settings, whilst maximising the delivery of these services within community settings. This will include the development of frailty-attuned hospital services (https://www.england.nhs.uk/urgent-emergency-care/same-day-emergency-care/acute-frailty/), ensuring they connect with community frailty provision to support integrated end-to-end frailty pathways, and support for care transfer hubs (https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-discharge-and-community-support-guidance), which arrange support services to assist discharge from hospital for those with the most complex needs.

By delivering proactive, planned, responsive and urgent care close to or in people’s own homes, effective local neighbourhood services will relieve pressure on acute services.

* Community diagnostic centres are likely to be considered anchor sites between primary, community and secondary care, enabling direct referral for diagnostic tests from a range of providers and optimising onward referrals to a range of health care settings for adults and children. 170 community diagnostic centres will be open by March 2025, with more than one in each ICB. The development of neighbourhood health services should include close working with associated community diagnostics centres to ensure that pathways are streamlined.

Planning for a flexible workforce

A flexible workforce working within and for local communities will be crucial for delivering neighbourhood health services.

To prepare for the move towards neighbourhood health, ICBs and local authorities are encouraged to connect as broadly as possible across their local communities to agree how best to use their collective local resources.

- Building on partnerships developed through the Better Care Fund, continue to develop **joint demand and capacity assessment, modelling and planning across health and social care.** This will provide a clear understanding of the capacity available to serve the local population across all providers and commissioners. This should include joint bottom-up mapping of existing workforce capacity, skills and capabilities across all partners and providers (including hospitals and mental health services) to optimise staff deployed across pathways, irrespective of organisational boundaries. This co-ordinated approach will help staff be deployed more flexibly where needed most, enable continuity of care, and create opportunities for streamlined joint recruitment, training and staff rotation across services.
- Take a user-centred approach to the design of teams, including job planning across different settings. This may include upskilling teams within the MDTs to **cover multiple functions that traditionally may have been delivered separately** so they are safely able to work in a more agile way and increase continuity for people and carers.
- **Ensure staff are aware of, and are involved in building, the local neighbourhood service model** to optimise the use of all services, including wider primary care, general practice, mental health, community health services, neighbourhood MDTs, social care services and “self-access” options where appropriate, supported by shared digital tools.
- Identify barriers and opportunities to **better enable productive integrated working** so that staff have the skills and tools to safely work across organisational boundaries and serve their local populations, ensuring best use of funding to meet local need, and improving workforce interactions and

experience. This should include ensuring care workers can deliver delegated healthcare activities such as blood pressure checks and other healthcare interventions. The government has recently published new guidance on safe delegation to care staff (https://www.skillsforcare.org.uk/Support-for-leaders-and-managers/Managing-a-service/Delegated-healthcare-activities/Delegated-healthcare-activities.aspx).

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BURY INTEGRATED CARE PARTNERSHIP

Locality Performance Report February 2025

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
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	Dec 24	52.1%	45.8%	↗	75.%	611	1,173	Inter
	EH09	Access to Children and Young Peoples Mental Health Services	Monthly	Dec 24	3,525	3,560	↘	5,433	N/A	N/A	Lower
	EAS01	Dementia: Diagnosis Rate (Aged 65+) (monthly performance)	Monthly	Dec 24	75.4%	76.1%	↘	66.7%	1,833	2,431	Upper
	S086a	Inappropriate adult acute mental health Out of Area Placement (OAP) bed days (rolling 3 month total)	Monthly	Mar 24	635	685	↘	0	N/A	N/A	Inter
	N/A	Number of MH patients with no criteria to reside - number of beds occupied by mental health patients who are ready to be discharged	Monthly	Jan 25	14	13	↗	N/A	N/A	N/A	Lower
	N/A	Percentage of MH patients with no criteria to reside (NCTR)	Monthly	Jan 25	16.5%	14.8%	↗	N/A	14	85	Lower
	S110a	Overall Access to Community MH Services for Adults and Older Adults with Severe Mental Illnesses	Monthly	Dec 24	1,770	1,695	↗	3,740	N/A	N/A	Lower
	S081a	Talking Therapies: Access Rate	Monthly	Dec 24	190	275	↘	N/A	N/A	N/A	Lower
	S131a	Women Accessing Specialist Community Perinatal Mental Health Services	Quarterly	Dec 24	200	195	↗	N/A	N/A	N/A	Lower
	S125a	Long length of stay for adults (60+ days)	Monthly	Dec 24	50.0%	60.0%	↘	0.%	20	40	Inter
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	Sep 24	63.1%	63.3%	↘	62.2%	6,745	10,685	Inter
	S129a	GP appointments - percentage of regular appointments within 14 days	Monthly	Dec 24	77.5%	74.8%	↗	82.3%	56,413	72,795	Lower
Quality	S042a	E. coli blood stream infections	Monthly	Dec 24	150	154	↘	N/A	N/A	N/A	Upper
	S044a	Antimicrobial resistance: total prescribing of antibiotics in primary care	Monthly	Nov 24	81.7%	83.8%	↘	87.1%	N/A	N/A	Upper
	S044b	Antimicrobial resistance: proportion of broad-spectrum antibiotic prescribing in primary care	Monthly	Nov 24	5.8%	5.8%	↘	10.%	6,341	109,110	Upper
	S037A	% of patients describing their overall experience of making a GP appointment as good	Annual	Mar 23	71.4%		→	73.9%	N/A	N/A	N/A

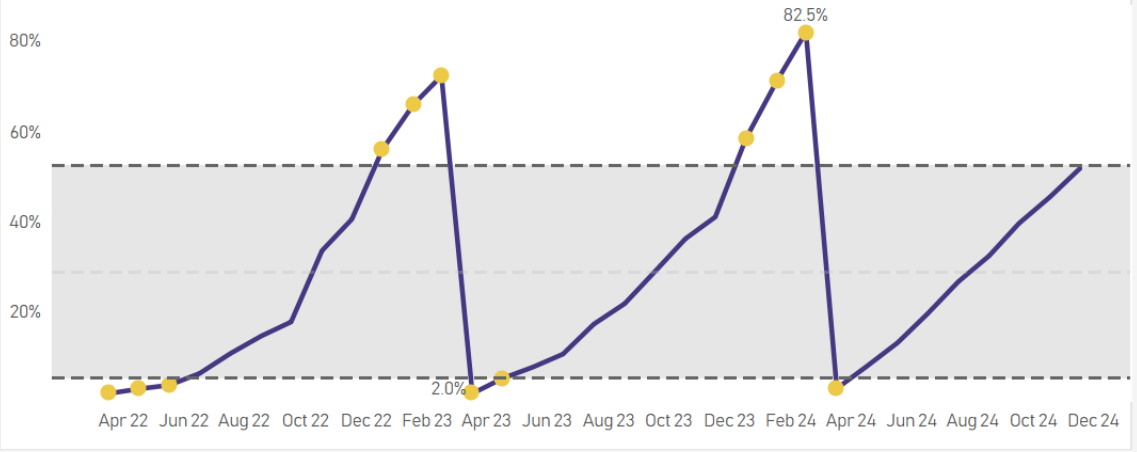
Bury

% 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)

52.1%	45.8%	43/106	75.%
December 2024	November 2024	National Rank Inter Quartile	National Target

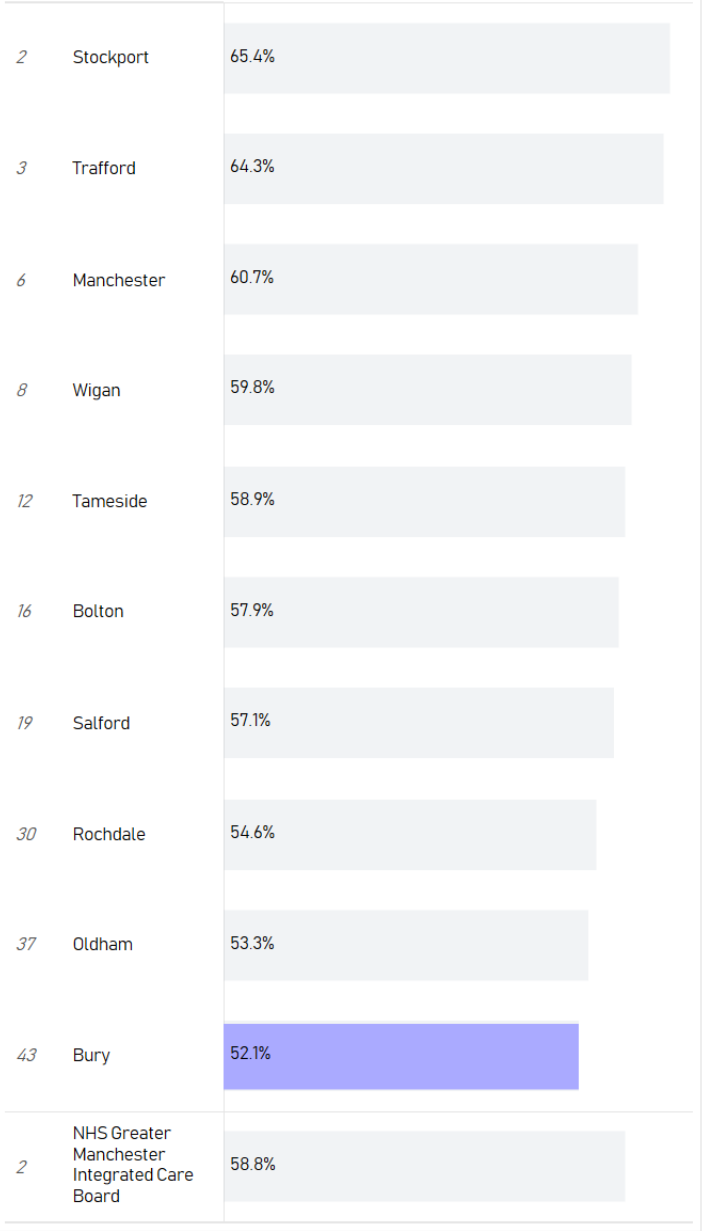
Outliers more than 1 standard deviation from the mean



	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%	39.9%	45.8%	52.1%			

Selected measure at December 2024 has continuously increased for 8 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 Dec 24 is 52.1%, which is an increase on Dec 23 which was 41.3%.
- Bury is currently reporting lower than the GM percentage of 58.8% and currently has the lowest percentage of the GM localities.
- However, for the last 2 years Bury has delivered the majority of annual checks in the months Jan to March and our relative performance is expected to improve.

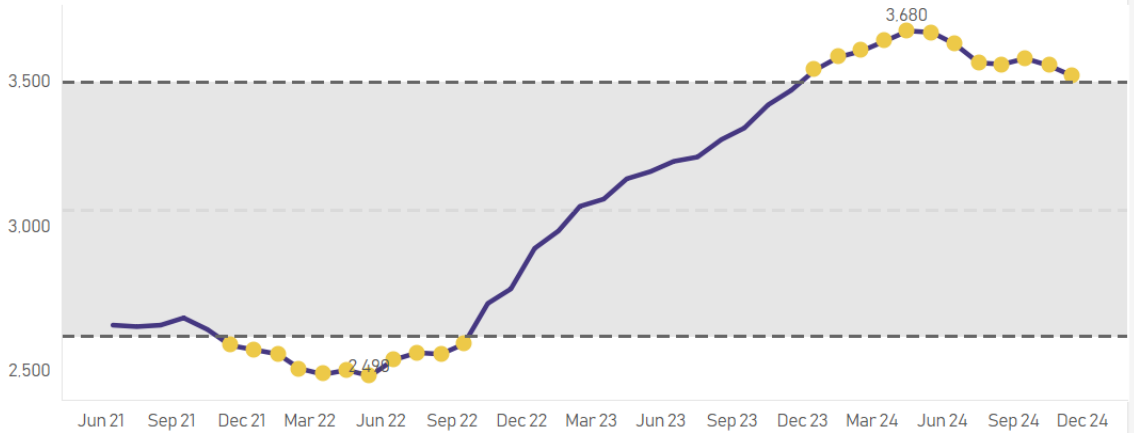
Bury

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

Source: Published MHSDS (Monthly)

3,525	3,560	83/106	5,433
December 2024	November 2024	National Rank Lower Quartile	National Median

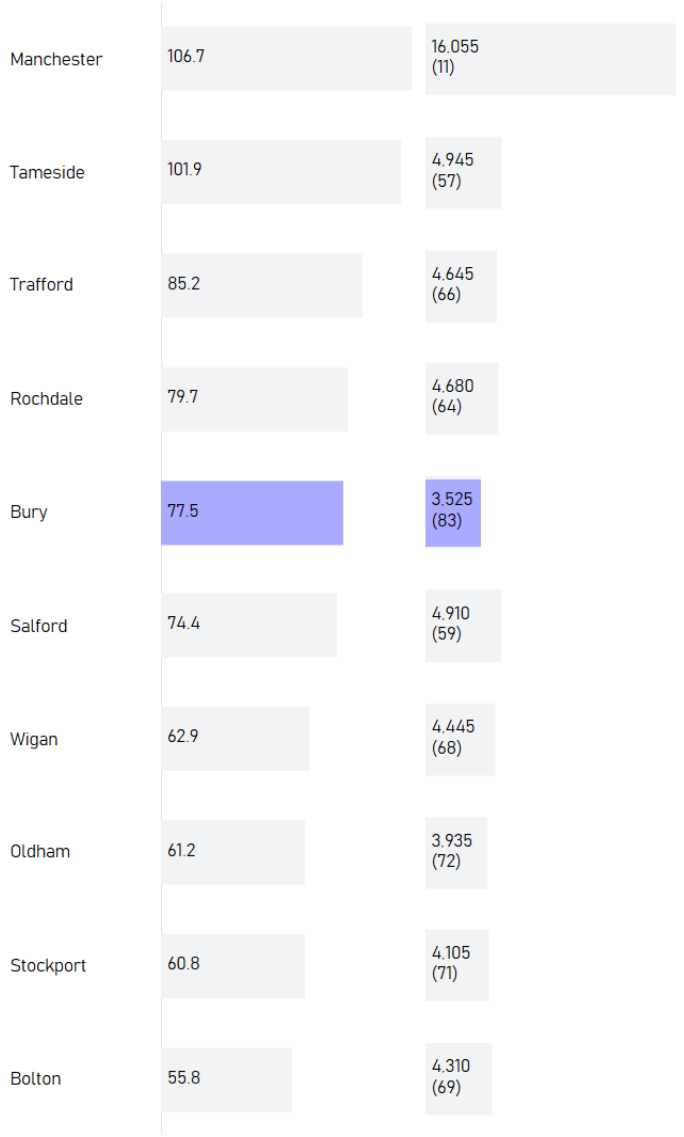
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22				2,665	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	3,645	3,680	3,675	3,635	3,570	3,565	3,585	3,560	3,525			

Selected measure at December 2024 has continuously decreased for 2 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 registered population figure for each locality | Bury: 45,310

Narrative

- There were 3525 accesses to Children and Young Peoples Mental Health Services for Bury registered patients in Dec 24, higher than Dec 23 (3475).
- Bury currently has 77.5 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.

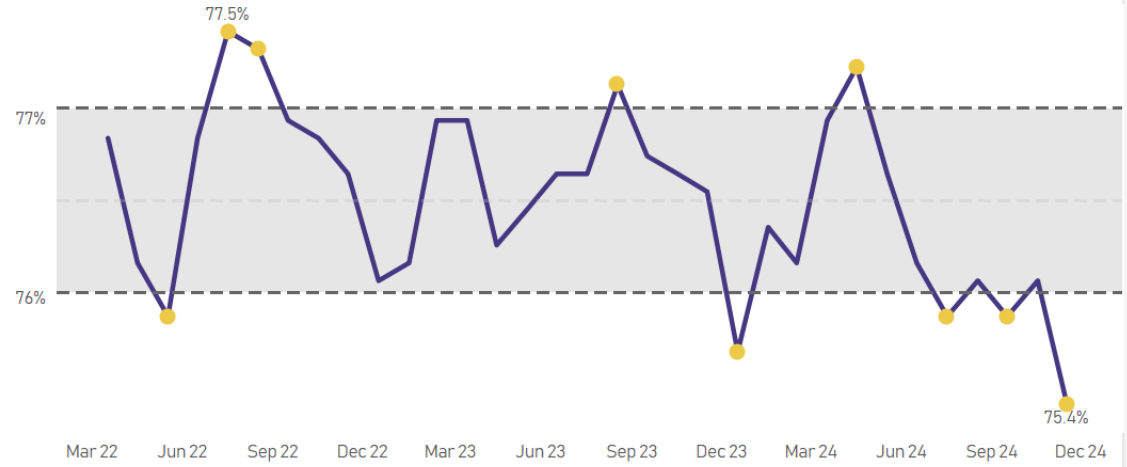
Bury

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)

75.4%	76.1%	11/106	66.7%
December 2024	November 2024	National Rank Upper Quartile	National Target

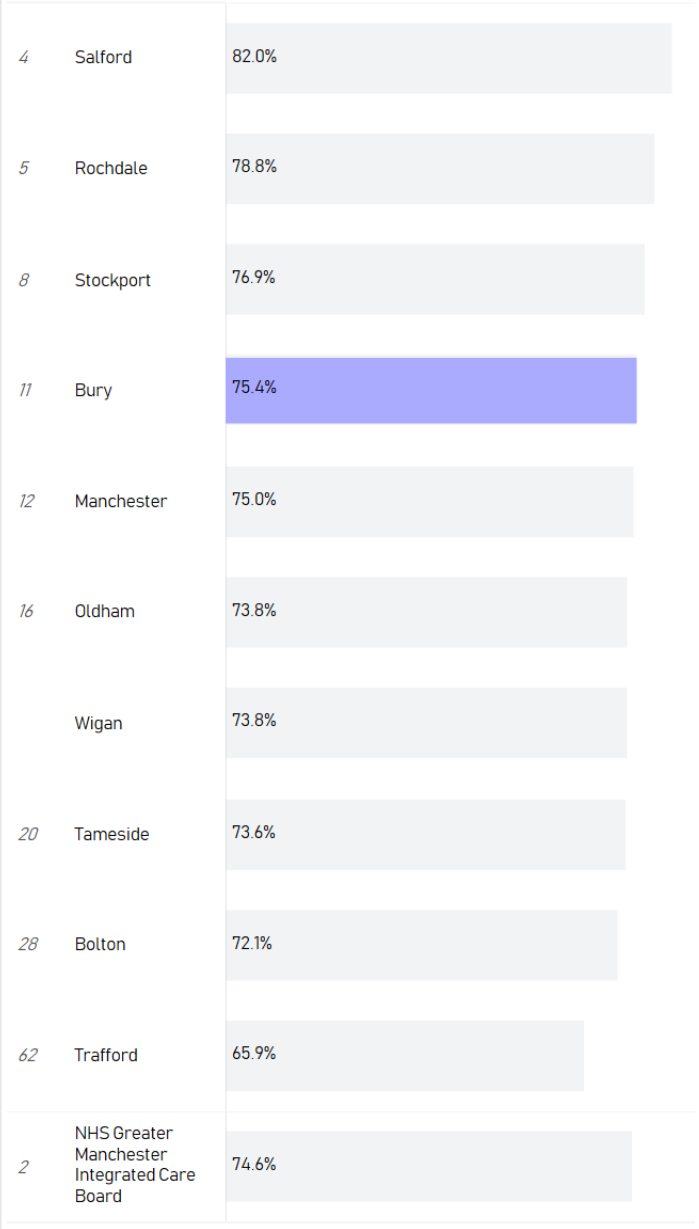
Outliers more than 1 standard deviation from the mean



	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%	75.9%	76.1%	75.4%			

Selected measure at December 2024 has continuously decreased 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 Dec 24 is 75.4%, which is the lowest it has been this financial year.
- In Dec 24 Bury has a higher diagnosis rate than GM which has a rate of 74.6%. Bury has the 4th highest dementia diagnosis rate of the GM localities.
- Bury and GM are both above the national target of 66.7%.

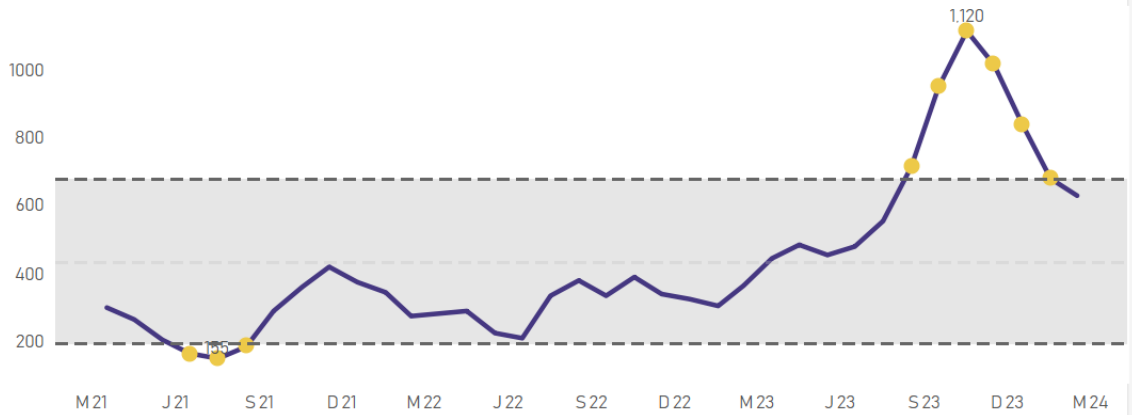
Bury

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)

The rate is calculated using the registered population figure for each locality | Bury: 212,363

Narrative

- There were 635 inappropriate OAP bed days for Bury registered patients in March 24, higher than March 23 (370).
- However this indicator is subject to real time daily and weekly monitoring by multi-agency teams and there is a significant lag in the formally reported data.
- For the past 3 months to w/c 24/2/25 OAP has been either 1 or 0

Bury

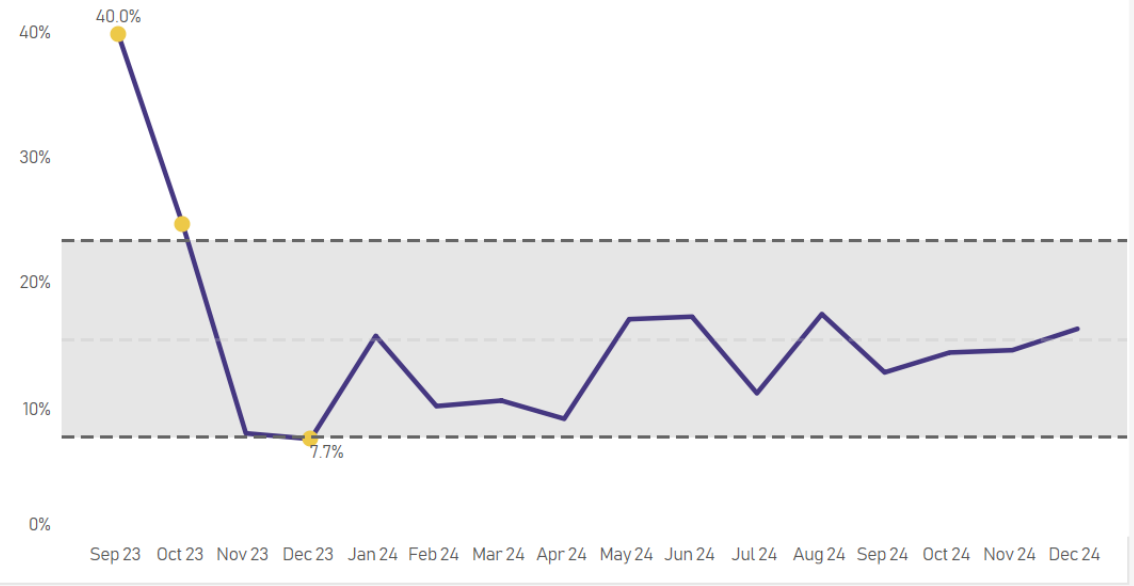
Percentage of MH patients with no criteria to reside (NCTR)
Percentage of beds occupied by MH patients who are ready to be discharged

Source: GM Admissions - Local (Monthly)

16.5%
January 2025

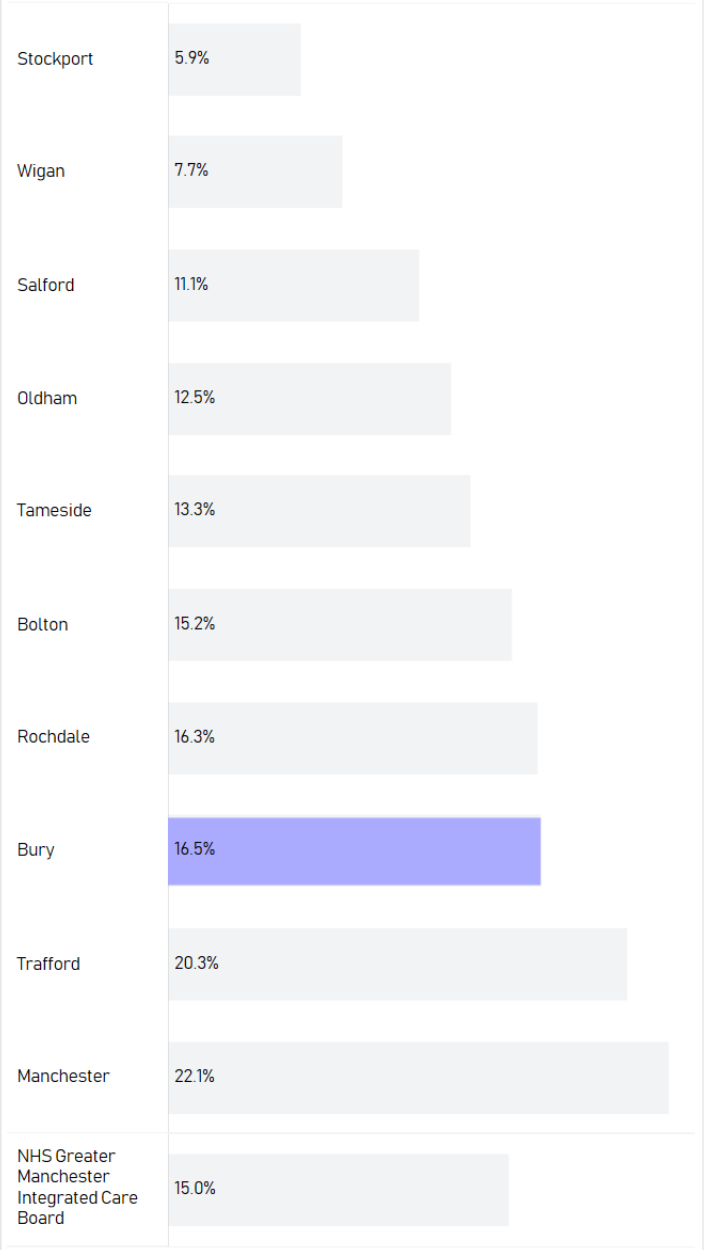
14.8%
December 2024

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023-24							40.0%	24.7%	8.1%	7.7%	15.9%	10.3%
2024-25	10.8%	9.3%	17.2%	17.4%	11.3%	17.6%	13.0%	14.6%	14.8%	16.5%		

Latest Value GM Benchmarking



Narrative

- The percentage of mental health patients with NCTR as of Jan 25 is 16.5%, which is an increase from Jan 24 which was 7.7%
- Bury currently has a higher percentage than GM which is 15.0%.
- Bury has the 3rd highest percentage rate of the GM localities.

Bury

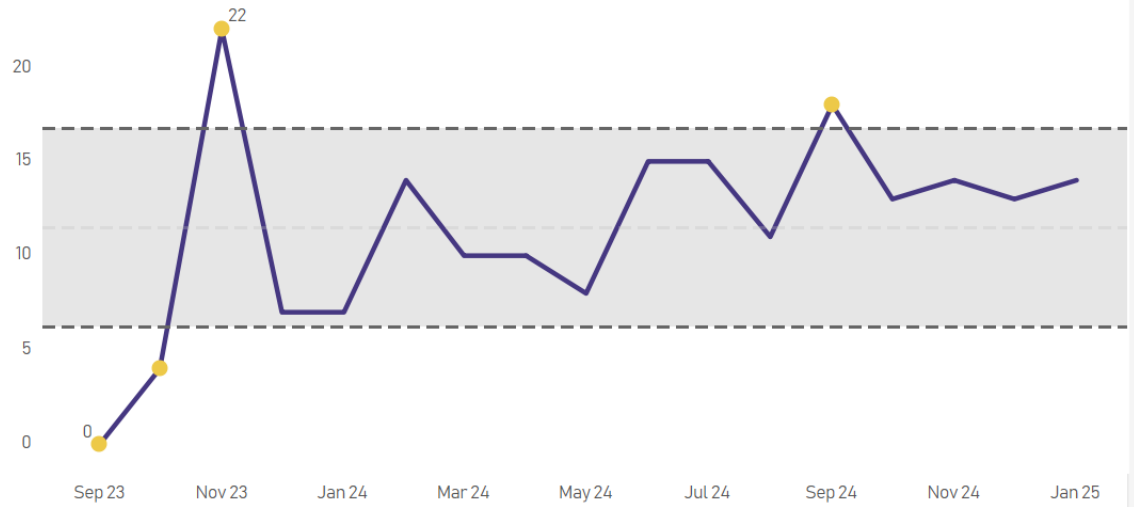
Number of MH patients with no criteria to reside (NCTR)
Number of beds occupied by MH patients who are ready to be discharged

Source: GM Admissions - Local (Monthly)

14
January 2025

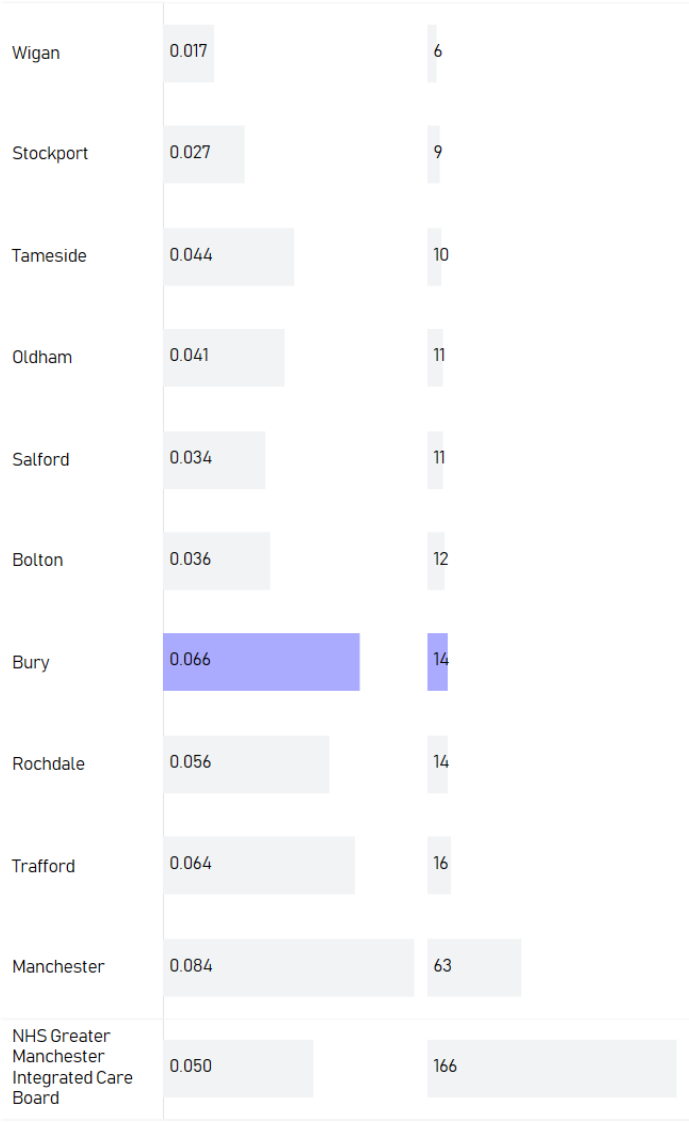
13
December 2024

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023-24						0	4	22	7	7	14	10
2024-25	10	8	15	15	11	18	13	14	13	14		

Latest Value GM Benchmarking
Rate per 1000 | Count



The rate is calculated using the registered population figure for each locality | Bury: 212,363

Narrative

- This metric is subject to daily review.
- The number of mental health patients with NCTR as of Jan 25 is 14, which is higher than the figure for Jan 24 which was 7
- Bury currently has 0.066 mental health patients with NCTR per 1000 population and has the 4th highest rate in locality within GM.

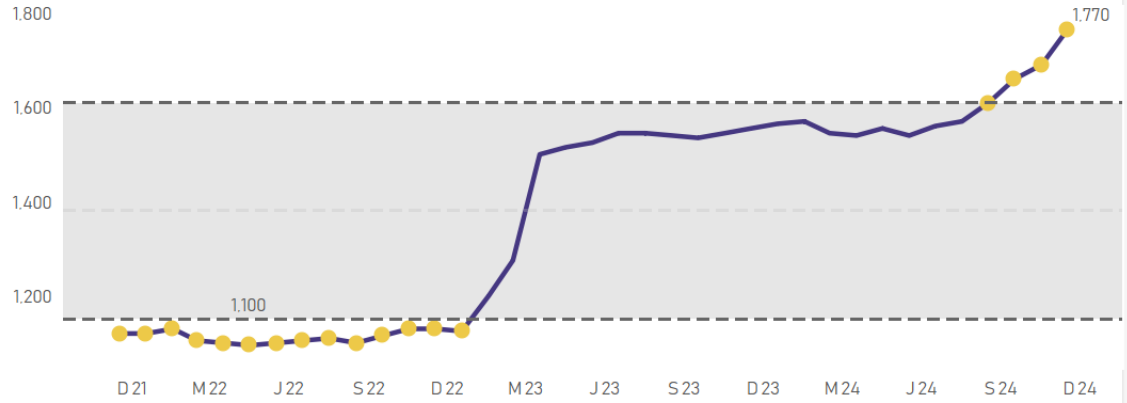
Bury

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)

1,770	1,695	85/106	3,740
December 2024	November 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	1,545	1,560	1,545	1,565	1,575	1,615	1,665	1,695	1,770			

Selected measure at December 2024 has continuously increased for 6 period(s) of time

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

The rate is calculated using the 18+ registered population figure for each locality | Bury: 166,508

Narrative

- There were 1770 people who received two or more contacts from mental health services for adults with severe mental illness for Bury registered patients in Dec 24, higher than Dec 23 (1560).
- Bury currently has 10.6 contacts per 1000 population and has the 5th lowest rate per 1000 for localities within GM.

Bury

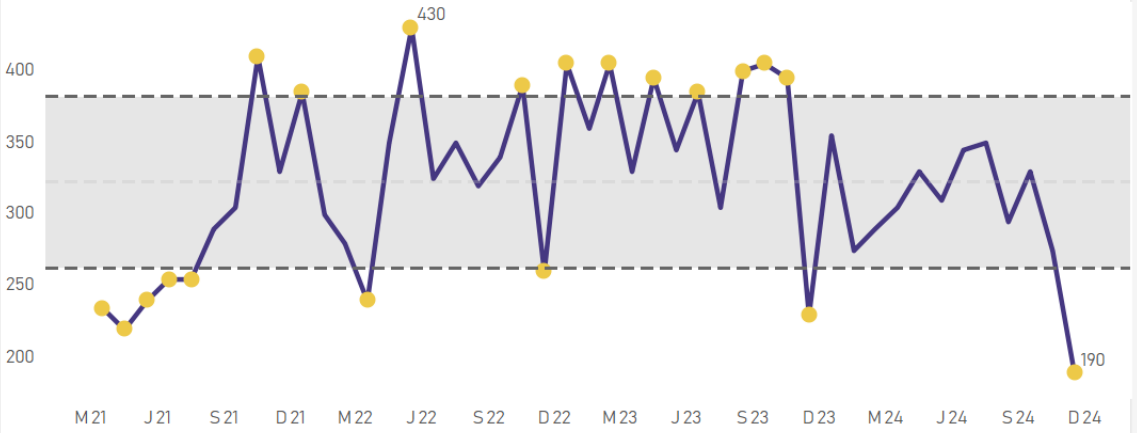
Talking Therapies: Access Rate

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)

190	275	106/109	No Target
December 2024	November 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	330	275	190			

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

Latest Value GM Benchmarking

Rate per 1000 | Count (National rank)

1	Manchester	2.3	1,745 (14)
2	Salford	2.2	710 (42)
3	Stockport	1.5	485 (59)
4	Bolton	1.4	470 (60)
5	Wigan	1.4	495 (56)
6	Tameside	1.4	320 (85)
7	Oldham	1.3	360 (76)
8	Trafford	1.2	305 (87)
9	Bury	0.9	190 (106)
10	Rochdale	0.9	225 (98)

The rate is calculated using the registered population figure for each locality | Bury: 212,363

Narrative

- There were 190 accesses to Talking Therapies for Bury registered patients in Dec 24, lower than Dec 23 (230)
- Bury currently has 0.9 accesses per 1000 population and has the 2nd lowest rate per 1000 for localities within GM.

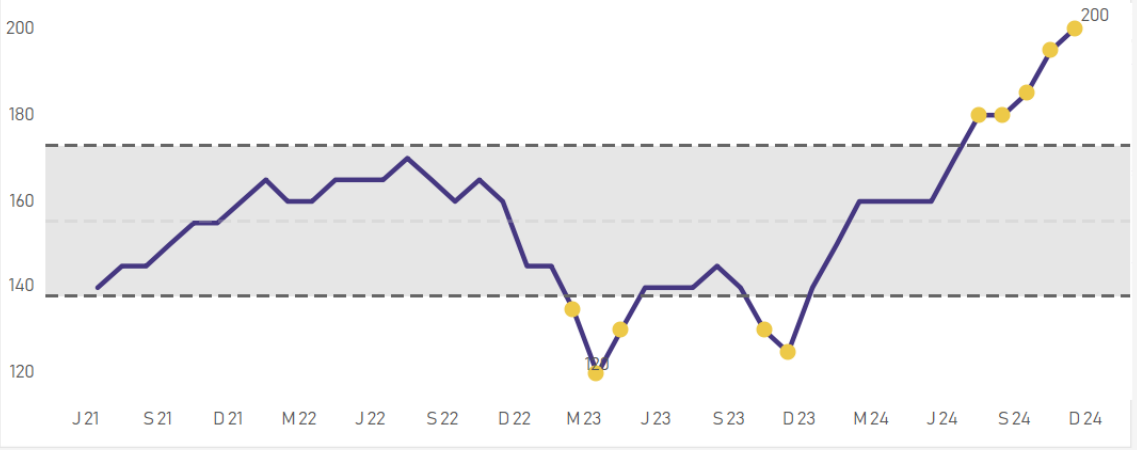
Bury

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

Source: Published MHSDS (Quarterly)

200	195	90/107	No Target
December 2024	November 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	180	180	185	195	200			

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

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

1	Stockport	5.1	315 (64)
2	Bury	4.9	200 (90)
3	Tameside	4.9	220 (85)
4	Trafford	4.9	230 (84)
5	Wigan	4.9	320 (62)
6	Oldham	4.6	255 (79)
7	Bolton	4.4	290 (68)
8	Rochdale	4.4	220 (85)
9	Salford	3.4	265 (72)
10	Manchester	2.8	540 (40)

The rate is calculated using the 15-44 female population figure for each locality | Bury 40,914

Narrative

- There were 200 women accessing Perinatal Mental Health Services for Bury registered patients for the rolling 12 months to Dec 24, higher than Dec 23 (125).
- Bury currently has 4.9 accesses per 1000 population and has the 2nd highest rate per 1000 for localities within GM.

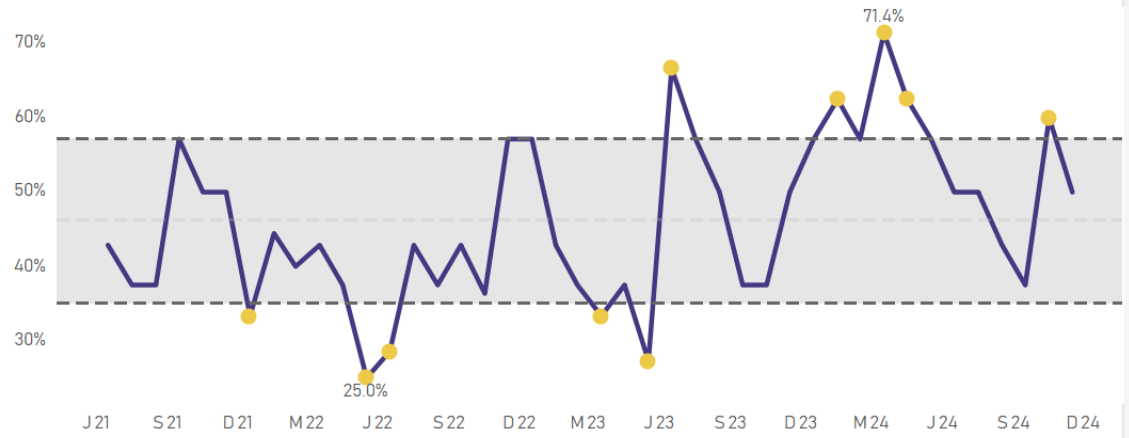
Bury

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)

50.0%	60.0%	59/100	0.%
December 2024	November 2024	National Rank Inter Quartile	National Target

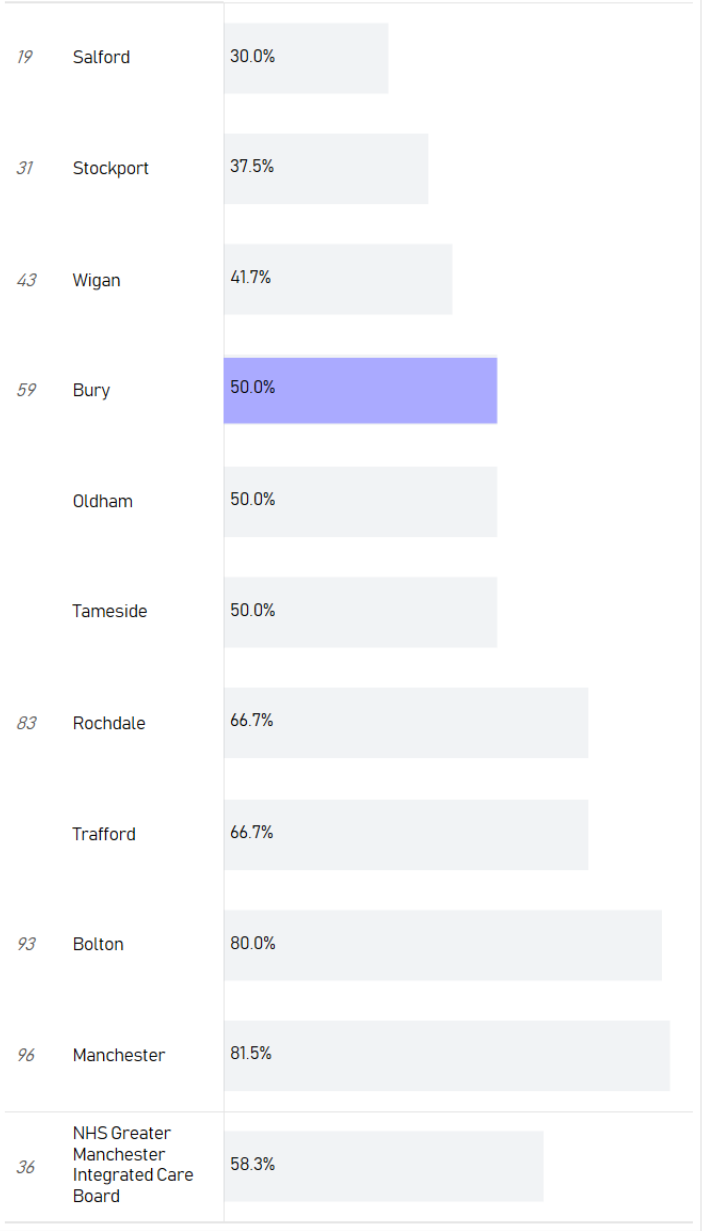
Outliers more than 1 standard deviation from the mean



	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%	37.5%	60.0%	50.0%			

Selected measure at December 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 Dec 24 is 50.0% which matches Dec 23 which was also 50.0%.
- Bury currently has a lower proportion with a long LOS than GM which has a proportion of 58.3%. Bury has the 4th lowest proportion of the GM localities alongside Stockport.
- Bury and GM are above the national target of 0%.

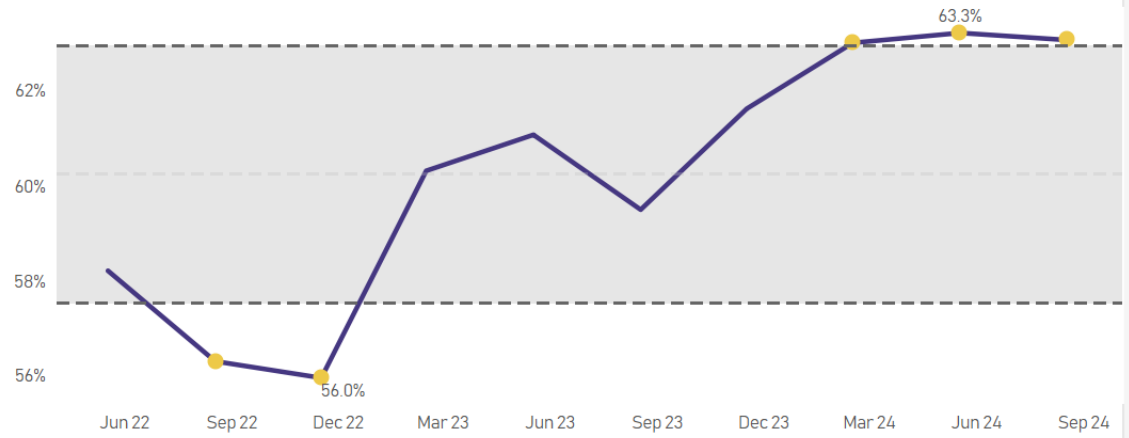
Bury

% 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)

63.1%	63.3%	42/106	62.2%
September 2024	June 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%	63.1%		

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

Latest Value GM Benchmarking
National Rank against other localities

3	Oldham	70.3%
5	Tameside	69.2%
7	Manchester	68.8%
16	Rochdale	67.0%
18	Trafford	66.8%
27	Salford	65.7%
38	Stockport	63.5%
42	Bury	63.1%
46	Wigan	62.8%
60	Bolton	61.8%
6	NHS Greater Manchester Integrated Care Board	65.8%

Narrative

- The percentage of patients identified as having 20% or greater 10-year risk of developing CVD as of Sept 24 is 63.1%, which is an increase on Sept 23 which was 59.5%

- Bury currently has a lower percentage than GM which is 65.8% and Bury has the 3rd lowest percentage of the GM localities.

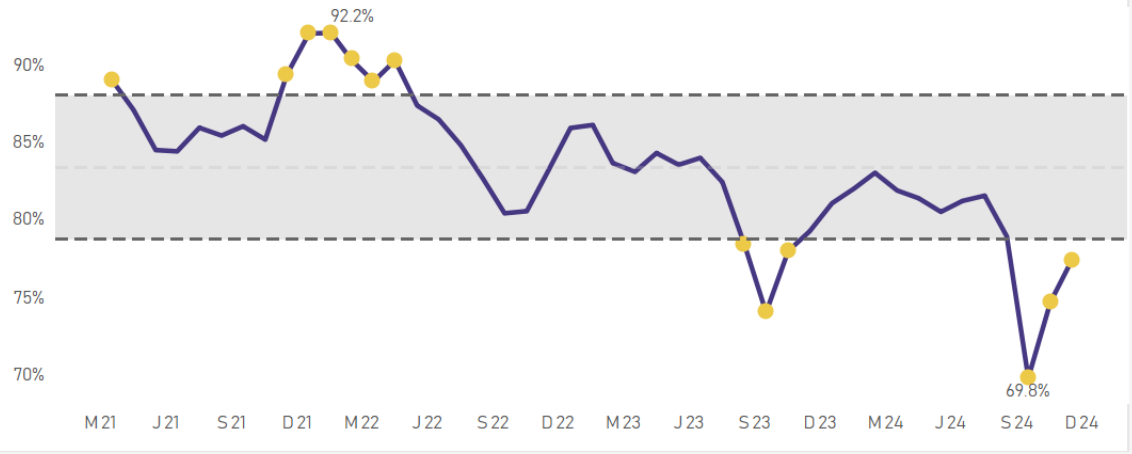
Bury

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)

77.5%	74.8%	95/106	82.3%
December 2024	November 2024	National Rank Lower Quartile	National Median

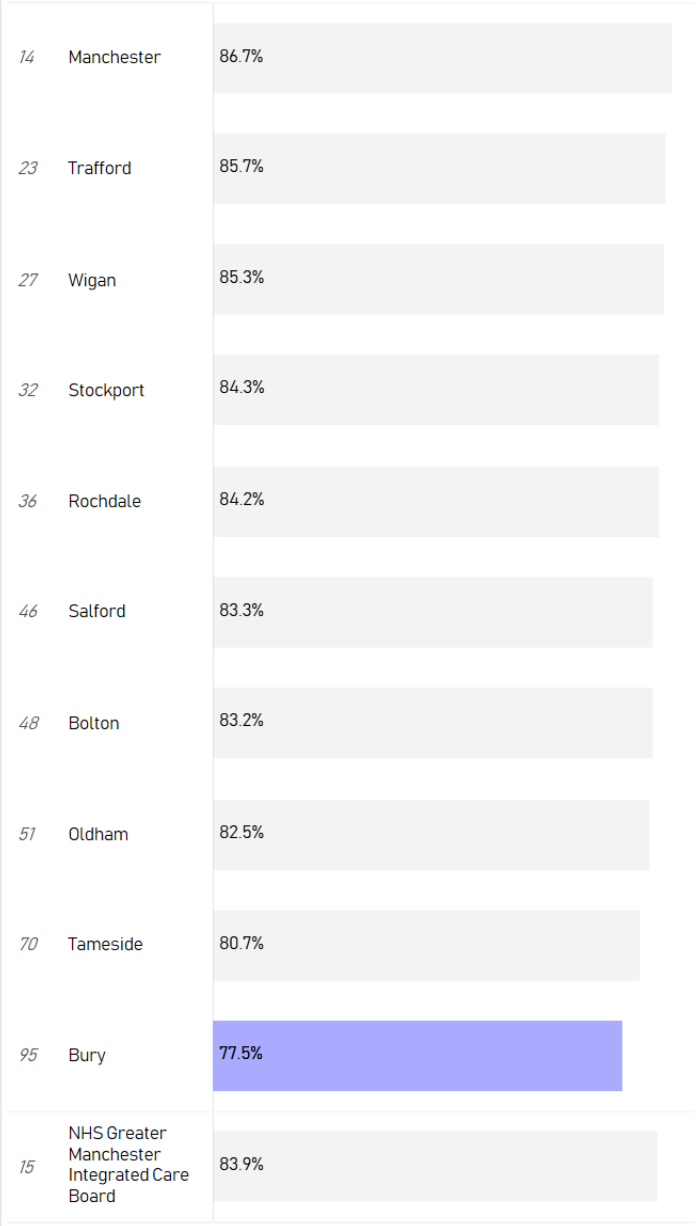
Outliers more than 1 standard deviation from the mean



	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%	69.8%	74.8%	77.5%			

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

Latest Value GM Benchmarking
National Rank against other localities



Narrative

- This data is currently under query with GM as figures dating back to Apr 21, now differ to those previously provided and presented to board.
- This new data suggests that Bury is 77.5% in comparison with 83.9% for GM.
- Board should note that this includes 'all' appointments, including those that can be pre booked in advance such as annual reviews, smears etc. When filtering this data to just those not typically scheduled in advance 98% of Burys Patients are seen within 14 days in comparison with a GM 87%

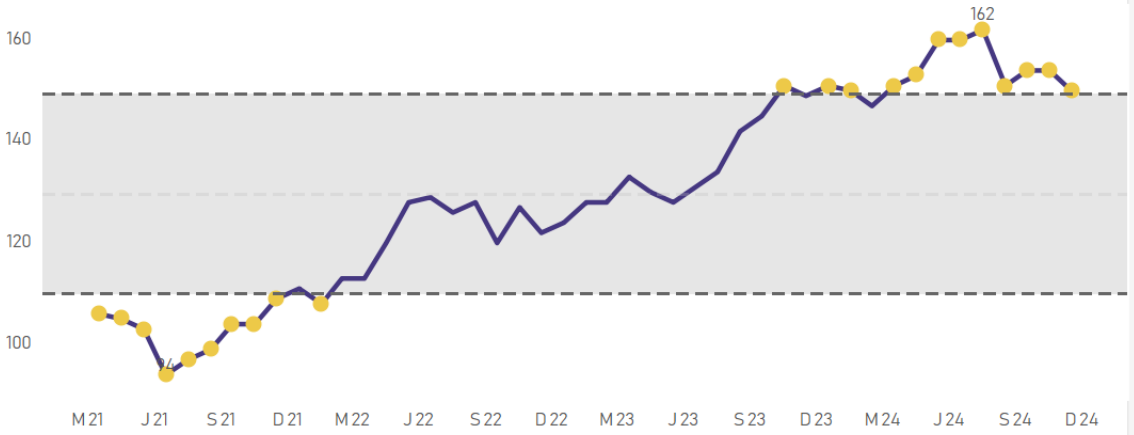
Bury

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)

150	154	19/107	No Target
December 2024	November 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	151	154	154	150			

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

The rate is calculated using the registered population figure for each locality | Bury: 212,363

Narrative

- There were 150 counts of E. Coli blood stream infections in the rolling 12 months to Dec 24, which is higher than Dec 23 (149).
- Bury currently has 0.71 counts per 1000 population and has the 4th highest rate per 1000 for localities within GM.

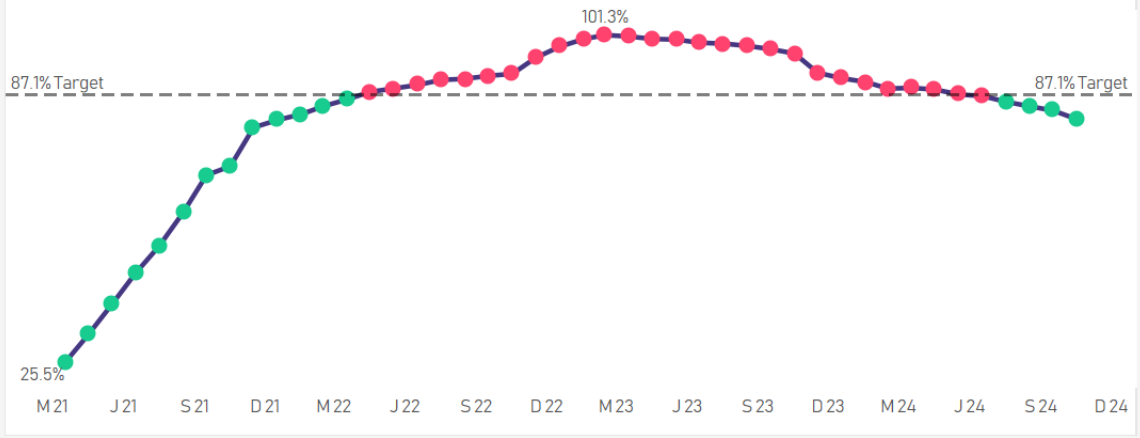
Bury

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)

81.7%	83.8%	87.1%
November 2024	October 2024	National Target

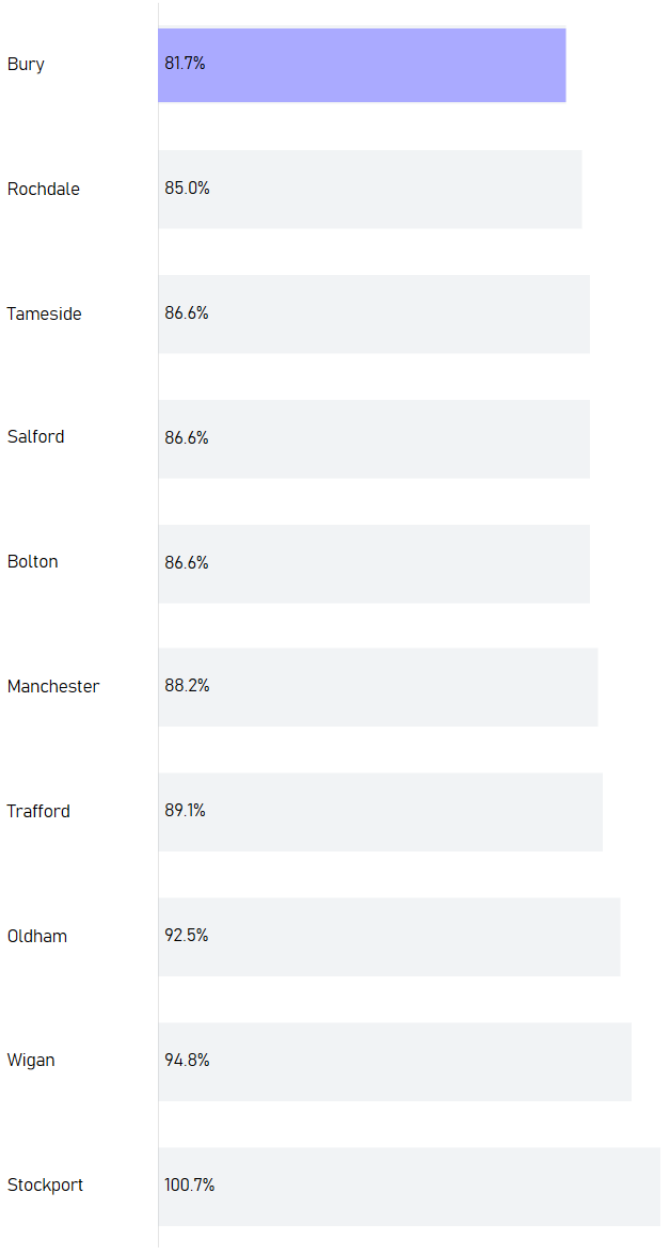
Performance Against National Target of 87.1%



	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%	84.7%	83.8%	81.7%				

Selected measure at November 2024 has continuously decreased for 7 period(s) of time

Latest Value GM Benchmarking



Narrative

- The percentage of total prescribing of antibiotics in primary care in Nov 24 for the Bury population was 81.7%, which is lower than Nov 23 which was 97.0%.
- Bury currently has a lowest percentage of the GM localities.

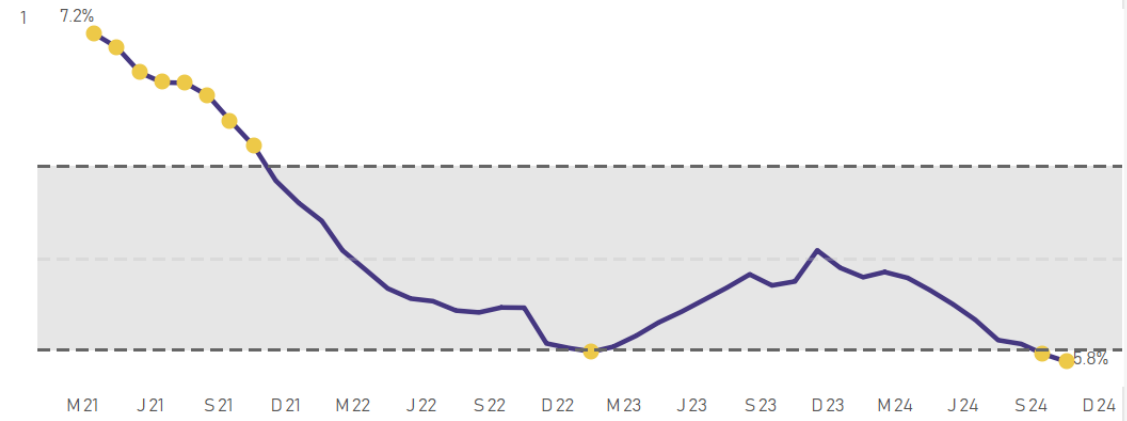
Bury

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)

5.8%	5.8%	21/111	10.%
November 2024	October 2024	National Rank Upper Quartile	National Target

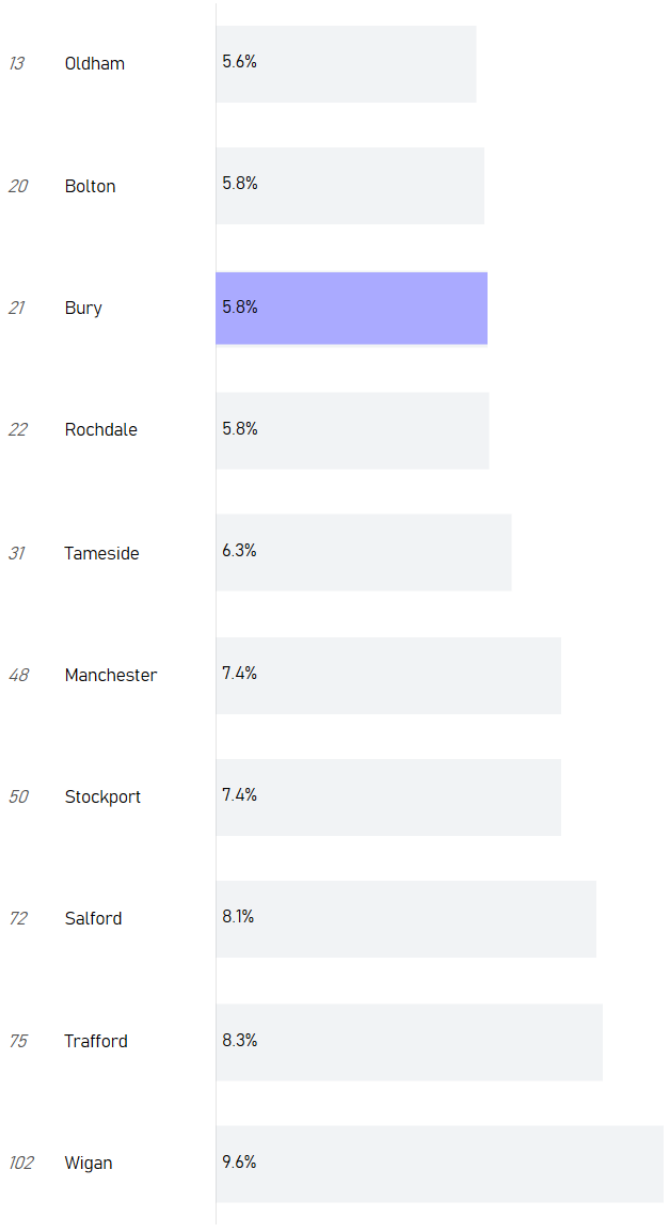
Outliers more than 1 standard deviation from the mean



	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%	5.9%	5.8%	5.8%				

Selected measure at November 2024 has continuously decreased for 8 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 Nov 24 for the Bury population was 5.8%, which is a decrease on Nov 23 which was 6.2%.
- Bury currently has the 3rd lowest percentage of the GM localities.
- Bury is within the less than 10% target.

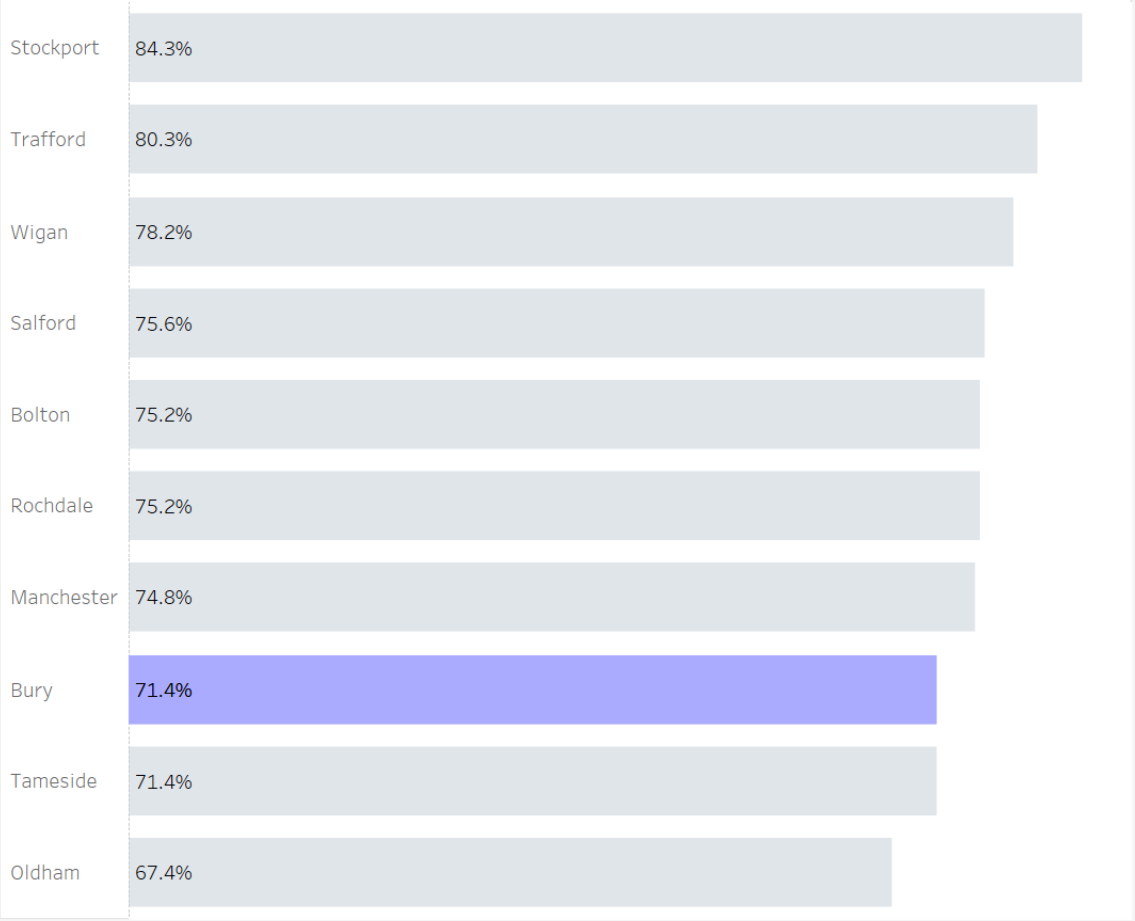
Bury

% of patients describing their overall experience of making a GP appointment as good

The weighted percentage of people who report through the GP Patient Survey their overall experience of their GP practice as 'very good' or 'fairly good'

Source: GP Patient Survey (Annual)

Please note: The publication of the 2024 survey results is the start of a new time series for GPPS. This means that trend data for previous years of the survey is not presented alongside the 2024 results as it would normally be. The 2024 results are not comparable with previous years because of two significant changes which have been made to the survey in 2024



Narrative

- Bury currently has the 8th lowest percentage of the GM localities with 71.4% of patients describing their overall experience of making a GP Appointment as good.

Bury - Sight Metrics

Domain	Code	Measure	Frequency	Date	Latest	Previous	Change	Target/Median	Numerator	Denominator	
Urgent Care	N/A	A&E 4 hour performance	Monthly	Jan 25	64.1%	61.3%	↗	78.0%	4,313	6,732	N/A
	N/A	A&E Attendances	Monthly	Jan 25	6,732.0	7,033.0	↘	N/A	6,732	N/A	N/A
	N/A	No Reason/Criteria To Reside patients (NCTR) as % of occupied beds	Monthly	Jan 25	14.0%	13.5%	↗	N/A	1,560	11,140	N/A
	EM11	Total number of specific acute non-elective spells	Monthly	Jan 25	2,067.0	2,104.0	↘	N/A	2,067	N/A	Lower
Elective Care	EB28	Diagnostic 6ww: All	Monthly	Dec 24	12.6%	11.3%	↗	1%	566	4,507	Upper
	EB20	RTT incomplete: 65+ week waits	Monthly	Dec 24	22.00	34.0	↘	0.	22	N/A	Upper
Cancer	S012a	28 Day Wait from Referral to Faster Diagnosis: All Patients	Monthly	Dec 24	80.1%	78.6%	↗	75%	734	916	Inter
Maternity	S104a	Number of neonatal deaths per 1,000 total live births	Annual	Dec 23	1.5	0.0	↗	1.4	3	2,049	Inter
	S022a	Number of stillbirths per 1,000 total births	Annual	Dec 23	5.4	4.0	↗	3.1	11	2,049	Lower
Screening and Immunisations	S049a	Breast screening coverage, females aged 53-70, screened in last 36 months	Annual	Dec 24	73.3%	69.2%	↗	N/A	16,305	22,244	Inter
	S046a	COVER immunisation: MMR2 Uptake at 5 years old	Quarterly	Sep 24	88.1%	83.4%	↗	95%	554	629	Inter
	S050a	Females, 25-64, attending cervical screening within target period (3.5 or 5.5 year coverage, %)	Quarterly	Jun 24	70.3%	70.6%	↘	80%	37,935	53,940	Inter
	S047A	Seasonal Flu Vaccine Uptake: 65 years and over	Monthly	Feb 24	77.5%	77.3%	↗	85%	29,492	38,042	Inter
Community	N/A	% 2-hour Urgent Community Response (UCR) first care contacts	Monthly	Dec 24	98.0%	97.1%	↗	N/A	288	294	N/A

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	Proportion of Urgent Community Response referrals reached within two hours	Currently available in the scorecard at trust level but not locality
	Proportion of virtual ward beds occupied	Currently unavailable at locality level due to inaccurate reporting
	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
Urgent and Emergency Care	Reduce adult general and acute bed occupancy below 92%	Currently available in the scorecard at trust level but not locality

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.

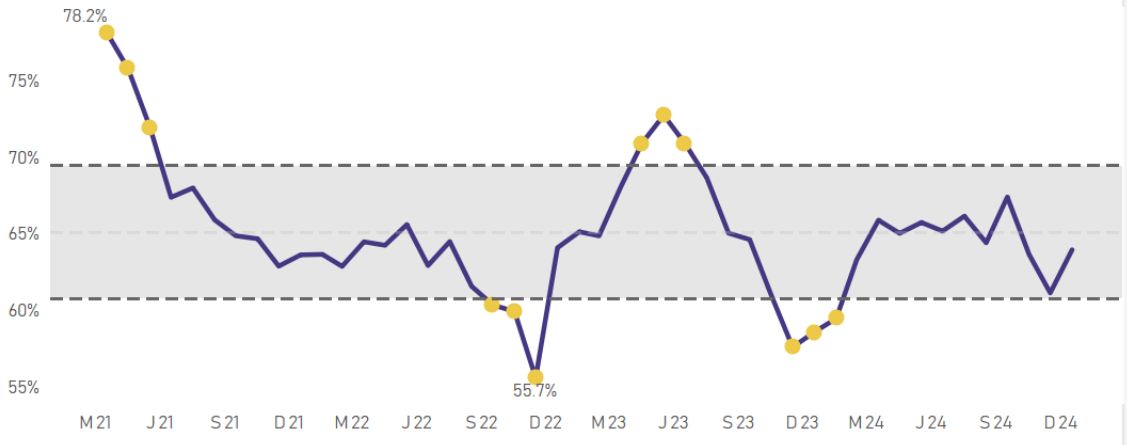
Source: Emergency Care Dataset (ECDS) (Monthly)

64.1%
January 2025

61.3%
December 2024

78.0%
National Target

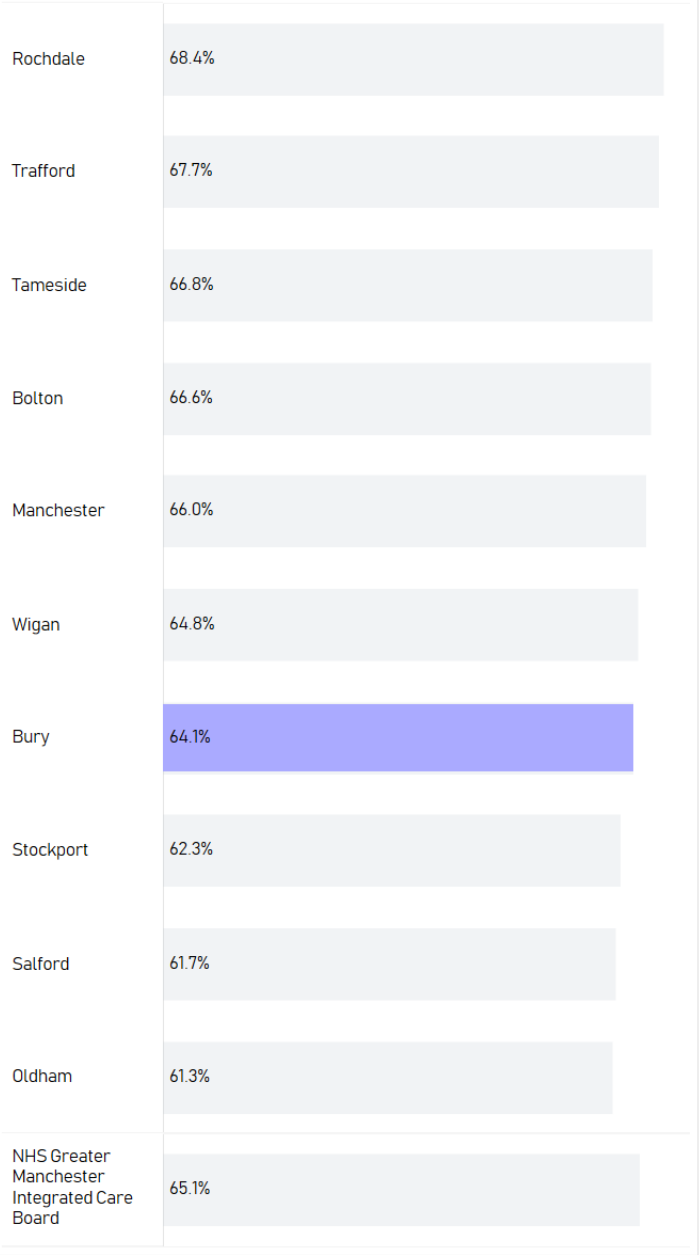
Outliers more than 1 standard deviation from the mean



	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%	65.9%	65.3%	66.3%	64.5%	67.5%	63.8%	61.3%	64.1%		

Selected measure at January 2025 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 Jan 25 was 64.1%, an increase on the previous month's performance of 61.3%.
- Jan 25 performance is 64.1% which is higher than Jan 24 which was 58.7%.
- Bury performance is currently below the overall GM performance of 65.1% and is the 7th best performing locality in GM.

Bury

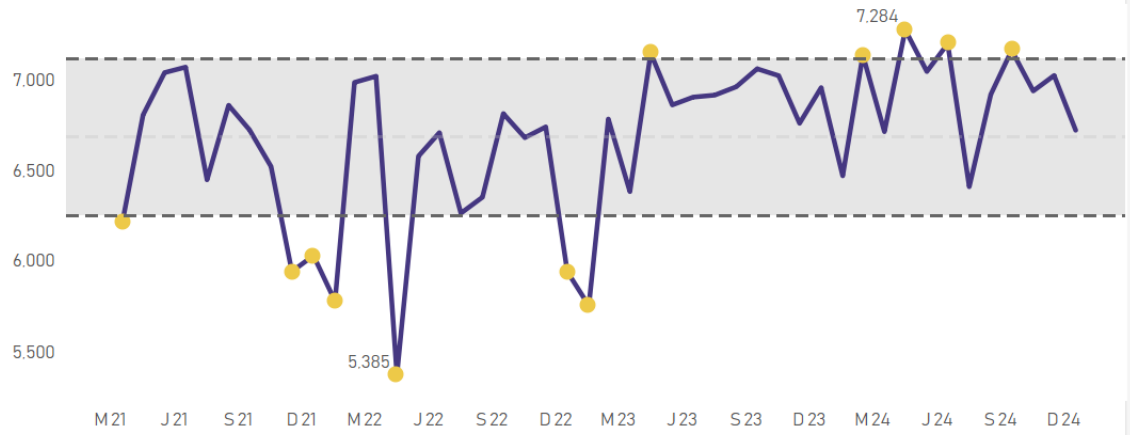
A&E Attendances
Number of attendances at A&E departments

Source: Emergency Care Dataset (ECDS) (Monthly)

6,732
January 2025

7,033
December 2024

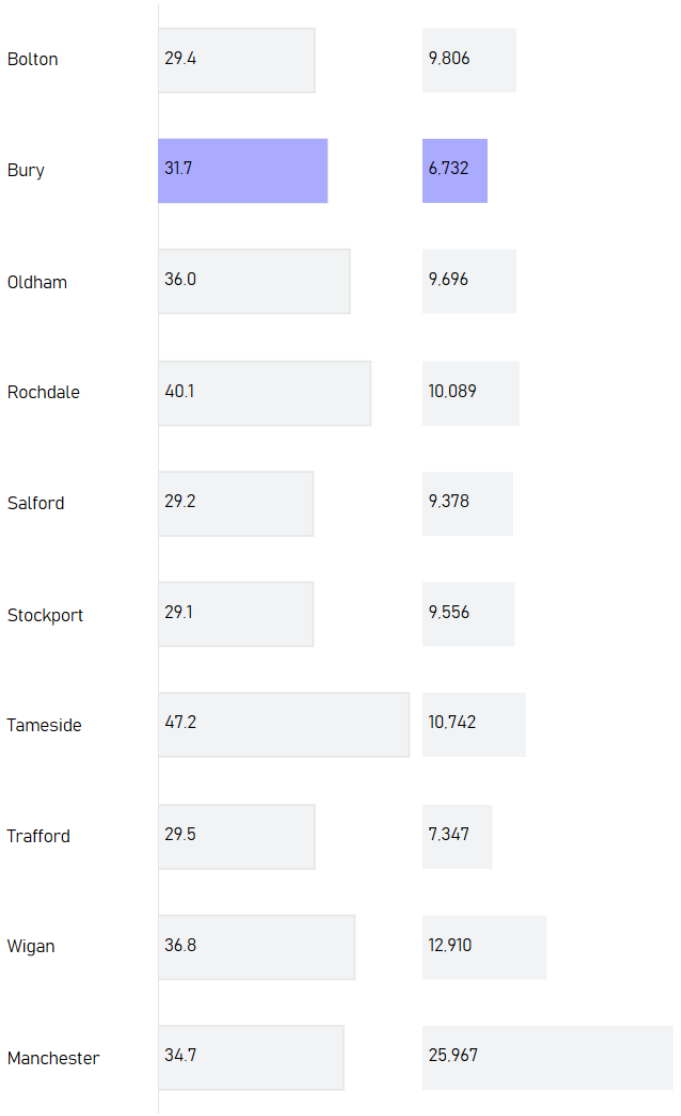
Outliers more than 1 standard deviation from the mean



	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	7.284	7.055	7.208	6.421	6.929	7.172	6.948	7.033	6.732		

Selected measure at January 2025 has continuously decreased for 1 period(s) of time

Latest Value GM Benchmarking
Attendances Rate per 1000 population & Count



The rate is calculated using the registered population figure for each locality | Bury: 212,363

Narrative

- There were 6732 A&E attendances from Bury registered patients in Jan 25, Lower than Jan 24 (6966).
- Bury currently has 31.7 attendances per 1000 population and has the 2nd lowest attendance rate for localities within GM.

Bury

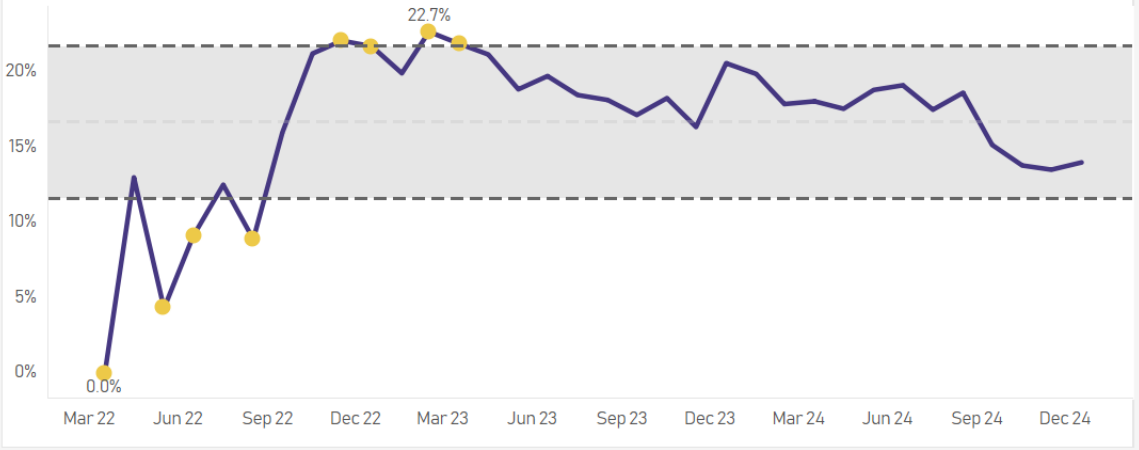
No Reason/Criteria To Reside patients (NCTR) as % of occupied beds
Total occupied beds, and of these, the number of patients who are fit for discharge and have no need to reside in a hospital bed

Source: GM Admissions - Local (Monthly)

14.0%
January 2025

13.5%
December 2024

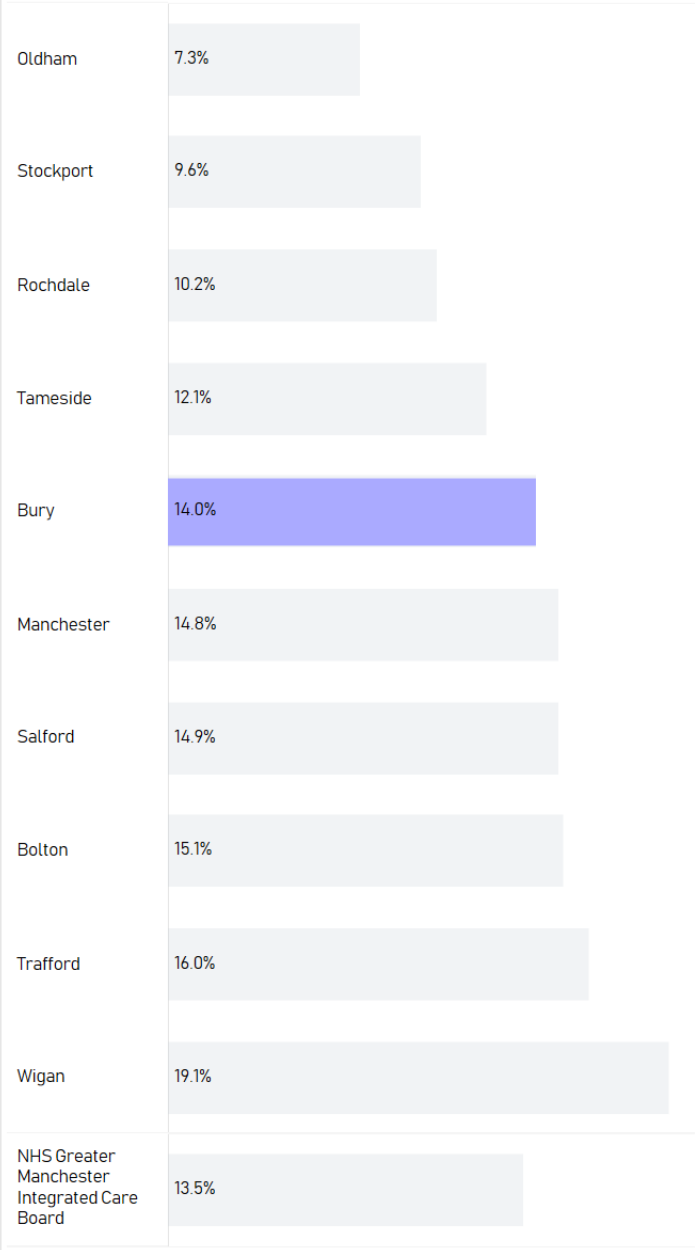
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	0.0%	13.0%	4.3%	9.1%	12.5%	8.9%	16.0%	21.2%	22.1%	21.7%	19.9%	22.7%
2023-24	21.9%	21.2%	18.9%	19.7%	18.5%	18.1%	17.2%	18.3%	16.4%	20.6%	19.9%	17.9%
2024-25	18.1%	17.6%	18.8%	19.1%	17.5%	18.6%	15.2%	13.8%	13.5%	14.0%		

Selected measure at January 2025 has continuously increased for 1 period(s) of time

Latest Value GM Benchmarking



Narrative

- This metric is subject to daily review.
- NCTR percentage for Bury in Jan 25 is 14.0% which is a decrease on Jan 24 which was 20.6%.
- Bury is currently higher than the GM percentage of 13.5% and has the 5th lowest 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)

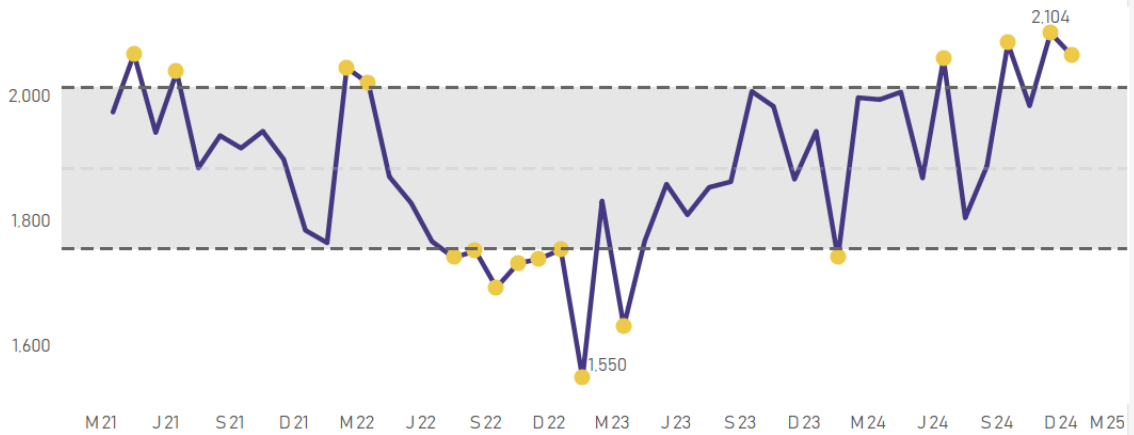
Source: National Flows APC (Monthly)

2,067
January 2025

2,104
December 2024

87/94
National Rank
Lower Quartile

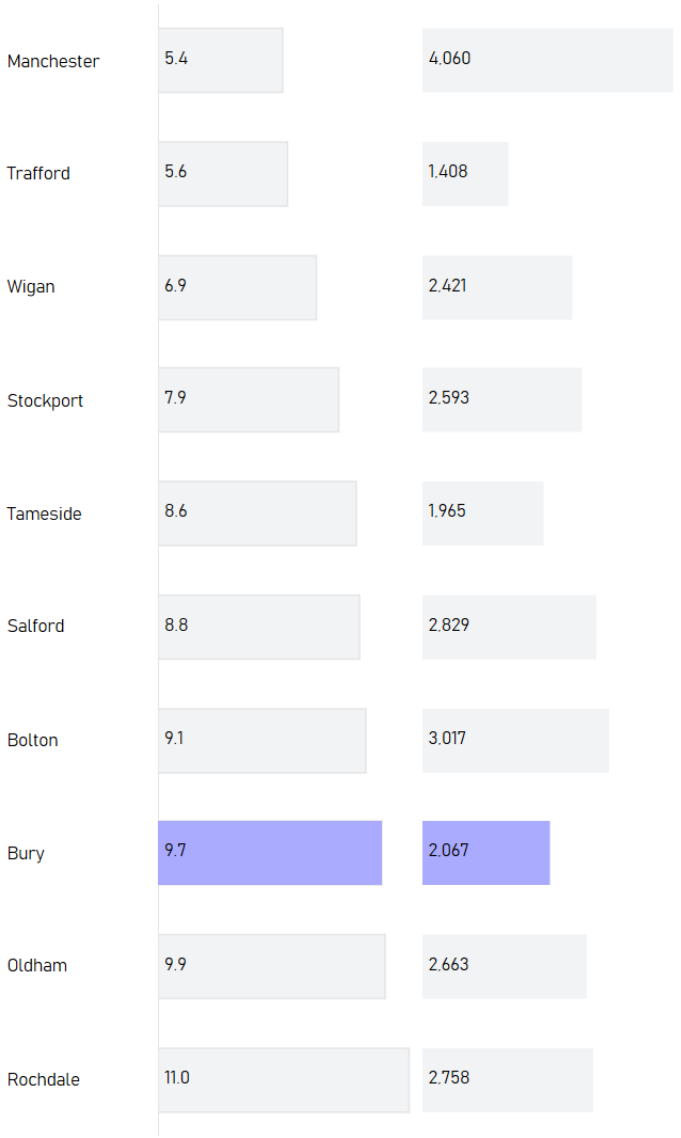
Outliers more than 1 standard deviation from the mean



	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	1,770	1,861	1,812	1,856	1,865	2,010	1,986	1,869	1,946	1,743	2,000
2024-25	1,997	2,009	1,871	2,062	1,807	1,890	2,087	1,987	2,104	2,067		

Selected measure at January 2025 has continuously decreased for 1 period(s) of time

Latest Value GM Benchmarking
Count & Rate Per 1000 Population



The rate is calculated using the registered population figure for each locality | Bury: 212,363

Narrative

- There were 2067 specific acute non-elective spells from Bury registered patients in Jan 25, Higher than Jan 24(1946)
- Bury currently has 9.7 specific acute non-elective spells per 1000 population and has the 8th lowest rate per 1000 for localities within GM.

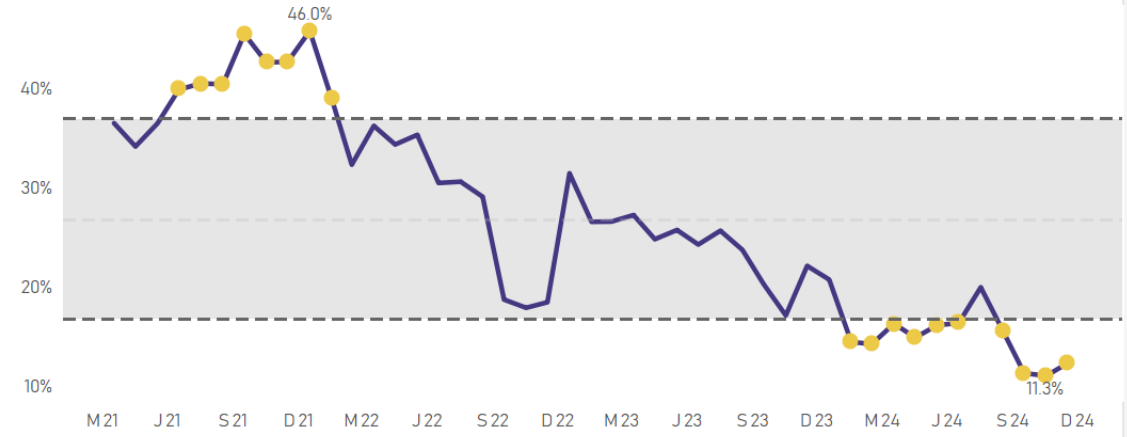
Bury

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)

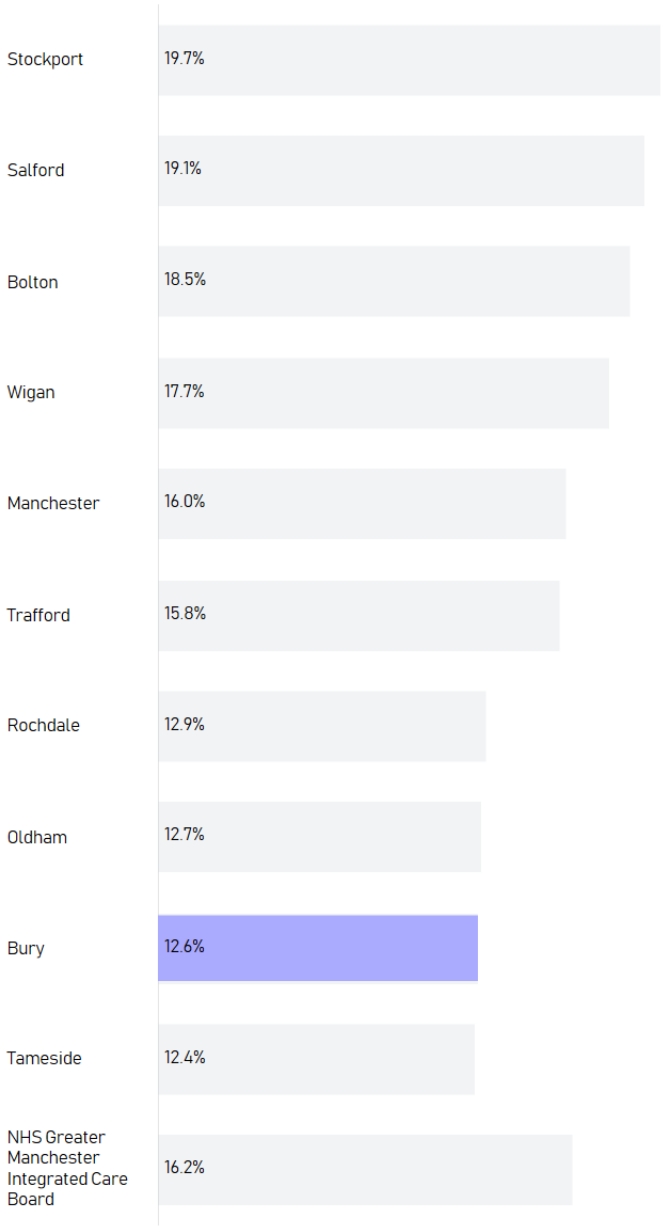
12.6%	11.3%	23/107	1.%
December 2024	November 2024	National Rank Upper Quartile	National Target

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	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%	11.6%	11.3%	12.6%			

Latest Value GM Benchmarking
National Rank against other localities



Narrative

- Dec 24 performance of 12.6% of patients waiting more than six weeks, this is a decrease on the Dec 23 figures (22.3%).
- Burys performance is better than GM's performance of 16.2% in Dec 24.
- Bury performance is the 2nd lowest percentage of the GM localities.
- Bury and GM are both above the less than 1% target.

Bury

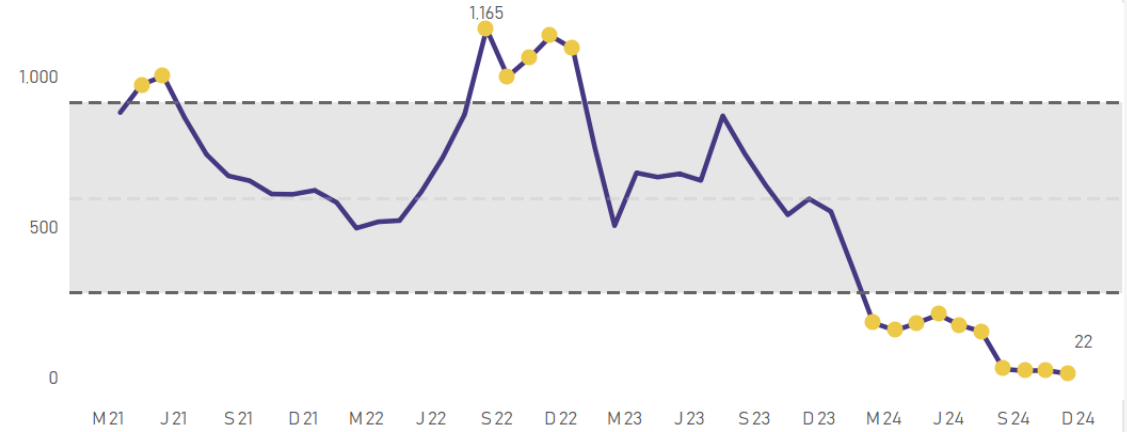
RTT incomplete: 65+ week waits

"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)

22.00	34	17/121	0.
December 2024	November 2024	National Rank Upper Quartile	National Target

Outliers more than 1 standard deviation from the mean

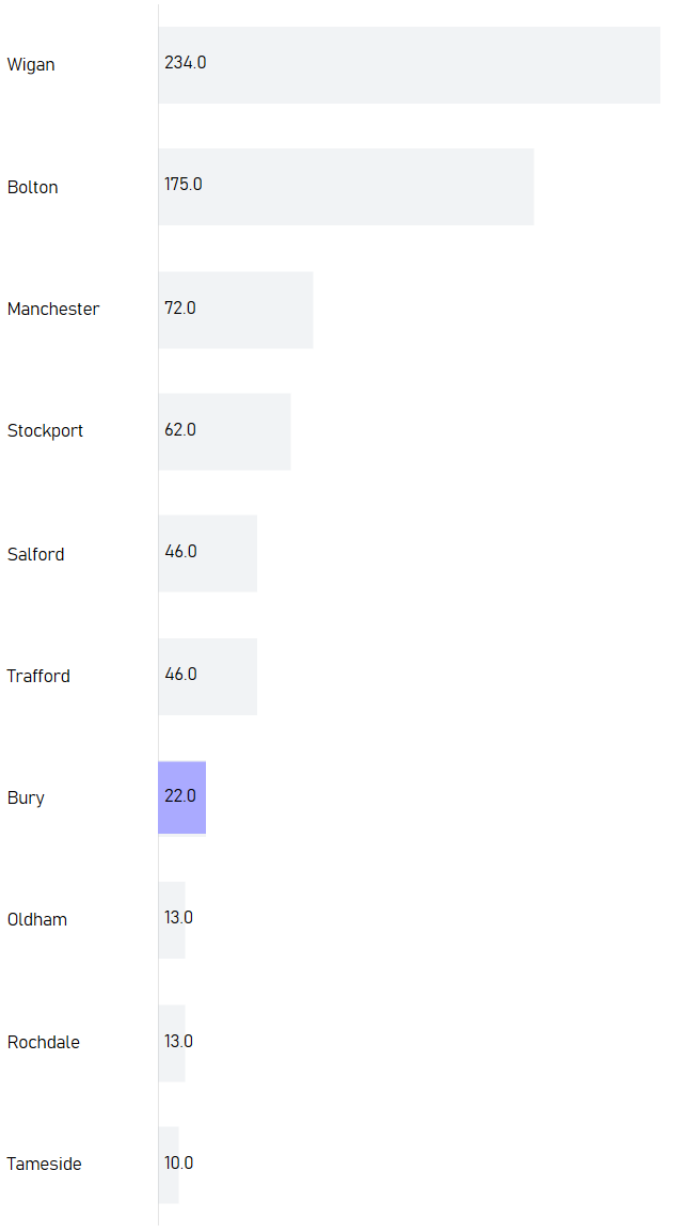


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	888	980	1,009	871	749	678	662	618	617	630	590	505
2022-23	526	530	626	739	882	1,165	1,007	1,070	1,142	1,099	773	513
2023-24	688	674	685	663	877	752	646	549	602	560	371	191
2024-25	166	190	218	184	162	38	32	34	22			

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

Latest Value GM Benchmarking

National Rank against other localities



Narrative

- Dec 24 data shows a decrease in 65+ Week Waits with 22 pathways down from 34 pathways in Nov 24.
- There was a significant decrease in pathways in Dec 24 with 22 Pathways, Compared to Dec 23 when there were 602 pathways (- 580 Pathways)
- In Dec 24, ENT Services shows the largest decrease in pathways with 0 pathways compared to 4 in Nov 24
- Bury locality currently has the 4th lowest number of 65+ Week waits out of all the GM localities.

Bury

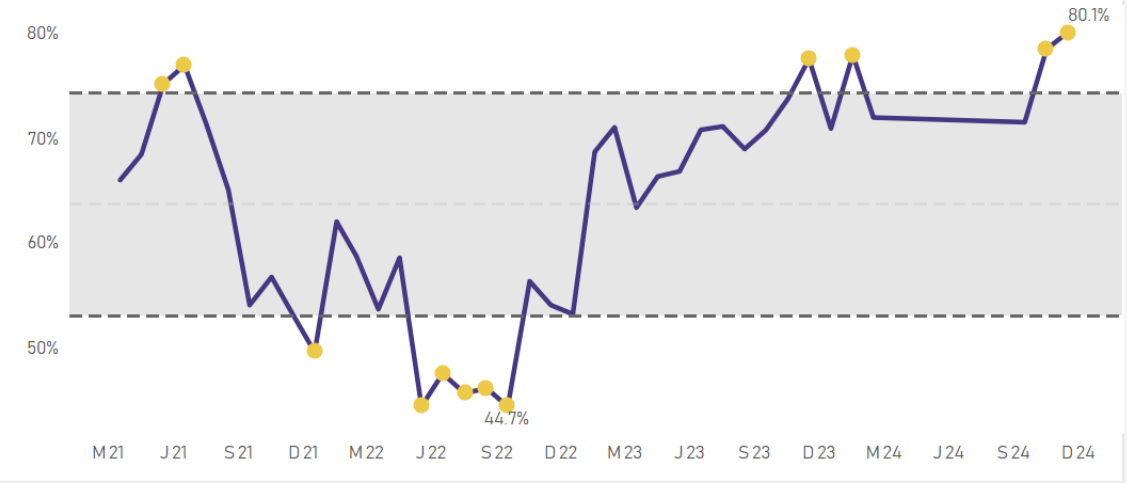
28 Day Wait from Referral to Faster Diagnosis: All Patients

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)

80.1%	78.6%	36/114	75.%
December 2024	November 2024	National Rank Inter Quartile	National Target

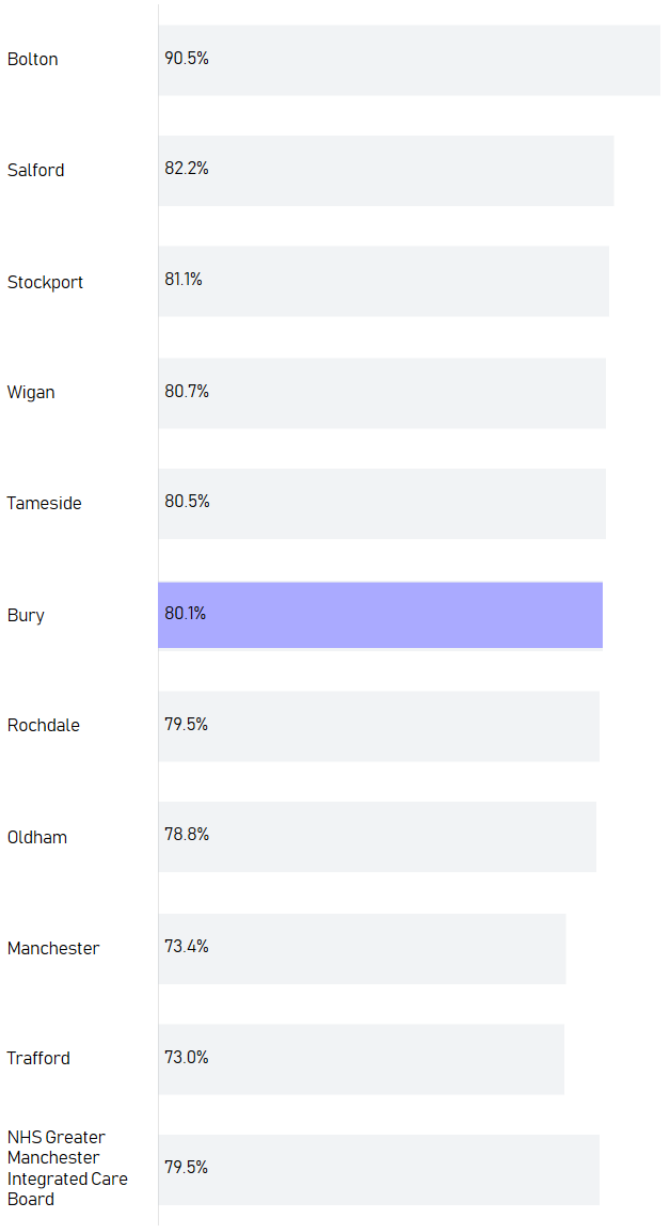
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	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							71.6%	78.6%	80.1%			

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 Dec 24 for the Bury population was 80.1%, which is an increase on Nov 24 which was 78.6%.
- Bury locality is currently the 5th lowest performance out of all the GM localities.
- GM performance is currently 79.5%
- Bury is above the target of 75% or greater.

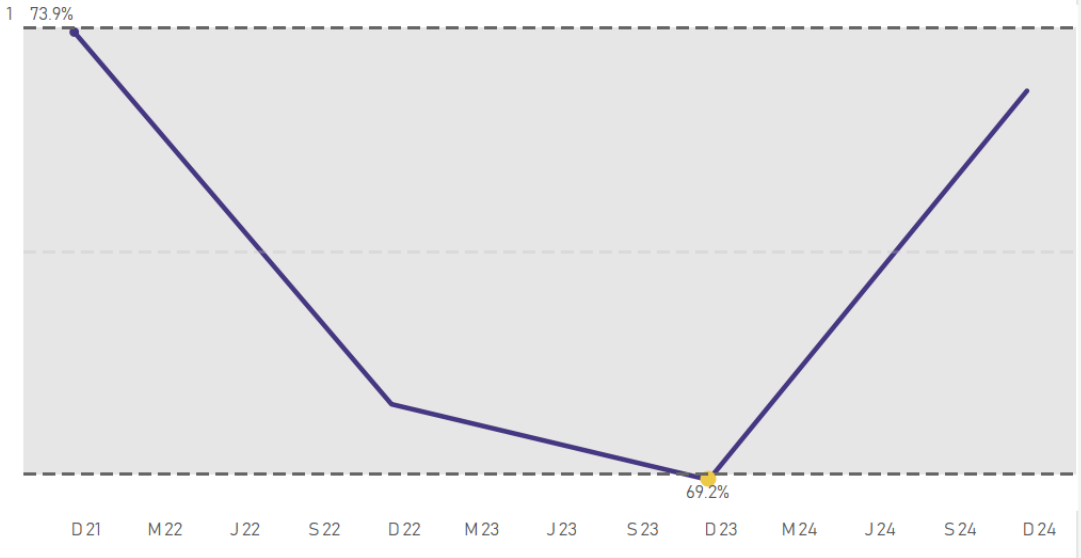
Bury

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)

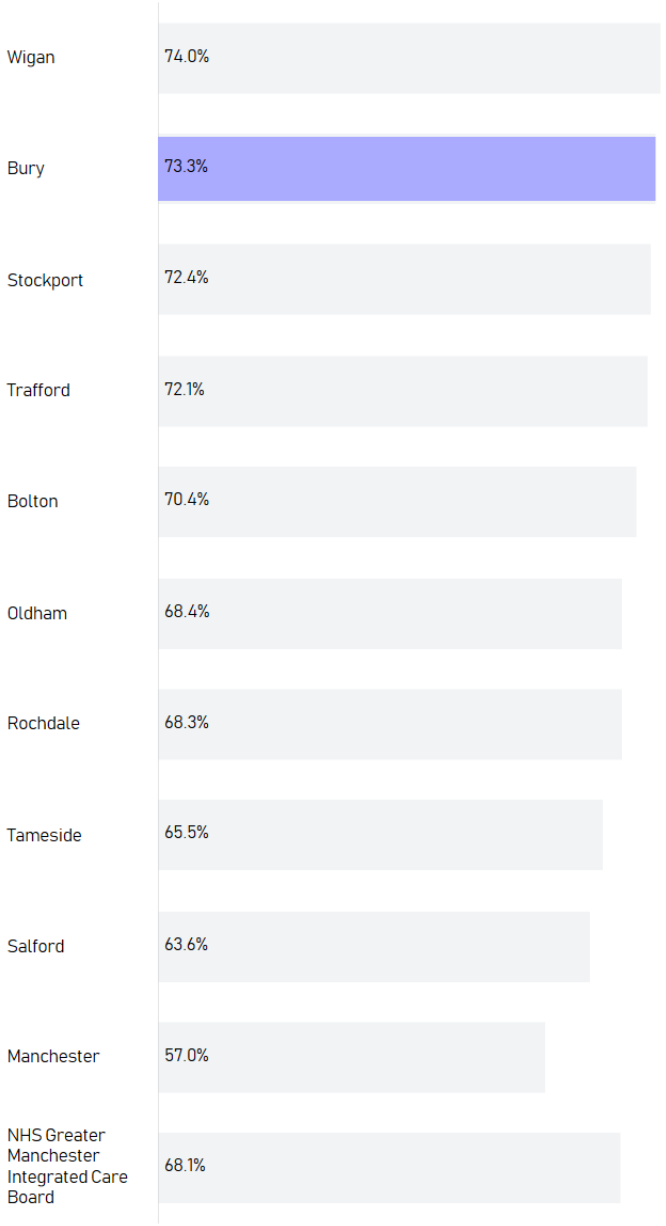
73.3%	69.2%	60%
December 2024	December 2022	No Target

Outliers more than 1 standard deviation from the mean



	Dec
2021-22	73.9%
2022-23	70.0%
2023-24	69.2%
2024-25	73.3%

Latest Value GM Benchmarking
National Rank against other localities



Narrative

- The 3-year breast screening coverage to December 24 for the Bury population was 73.3% for eligible females.

- Bury locality currently has the 2nd highest percentage out of all the GM localities and is higher than the GM percentage of 68.1%.

Bury

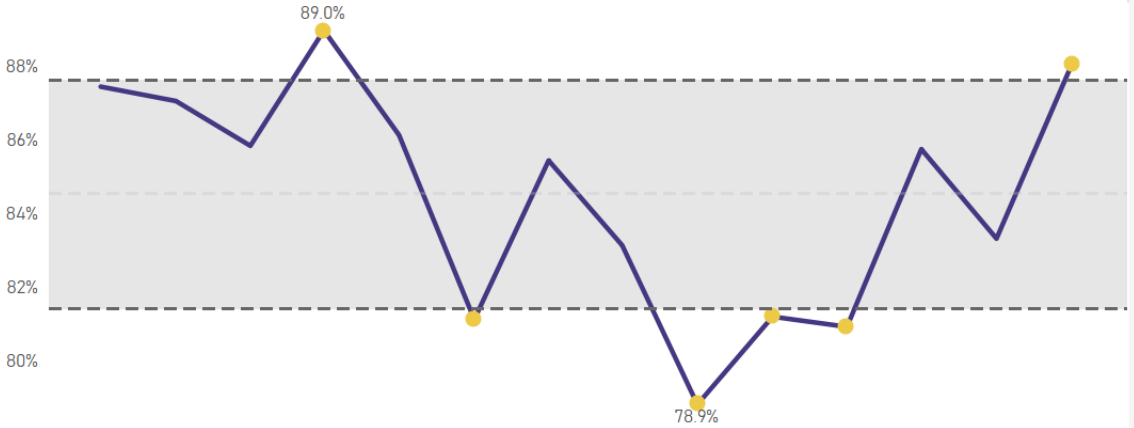
COVER immunisation: MMR2 Uptake at 5 years old
Population vaccination coverage – MMR for two doses (5 years old)

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

88.1%
September 2024

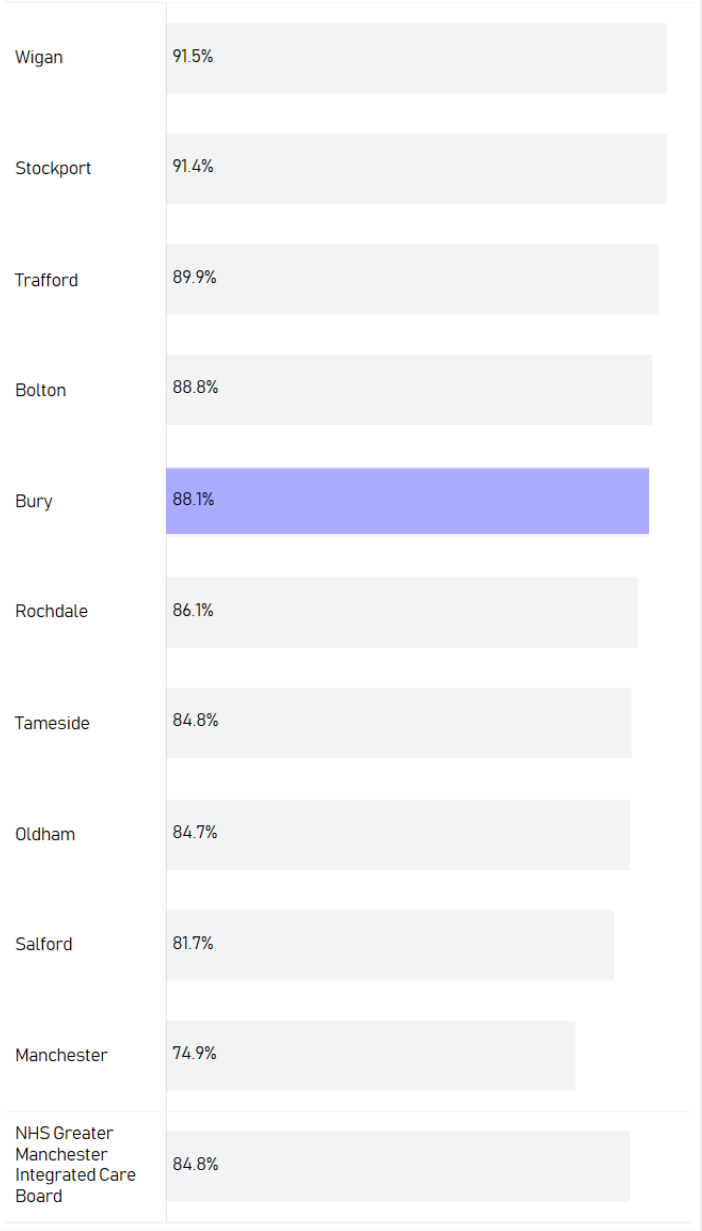
95.%
National Target

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%	81.0%	85.8%
2024-25	83.4%	88.1%		

Latest Value GM Benchmarking
National Rank against other localities



Narrative

- The percentage of MMR2 uptake at 5 years old as of Sept 24 is 88.1%, which is an increase on Sept 23 which was 81.3%
- Bury currently has a higher percentage than GM which is 84.8%
- Bury has the 4th best rate of uptake of the GM localities.
- Bury and GM are not meeting the national target of 95%.

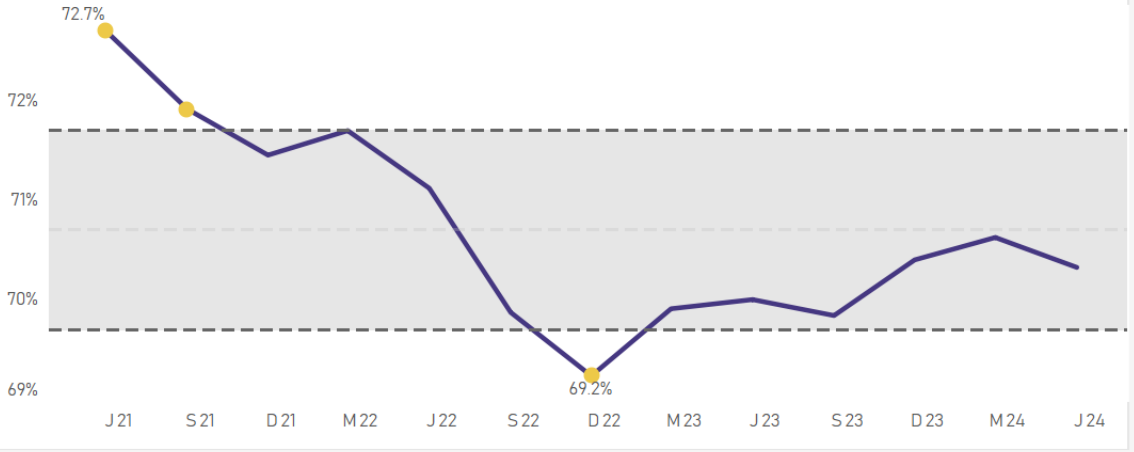
Bury

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)

70.3%	70.6%	68/106	80.%
June 2024	March 2024	National Rank Inter Quartile	National Target

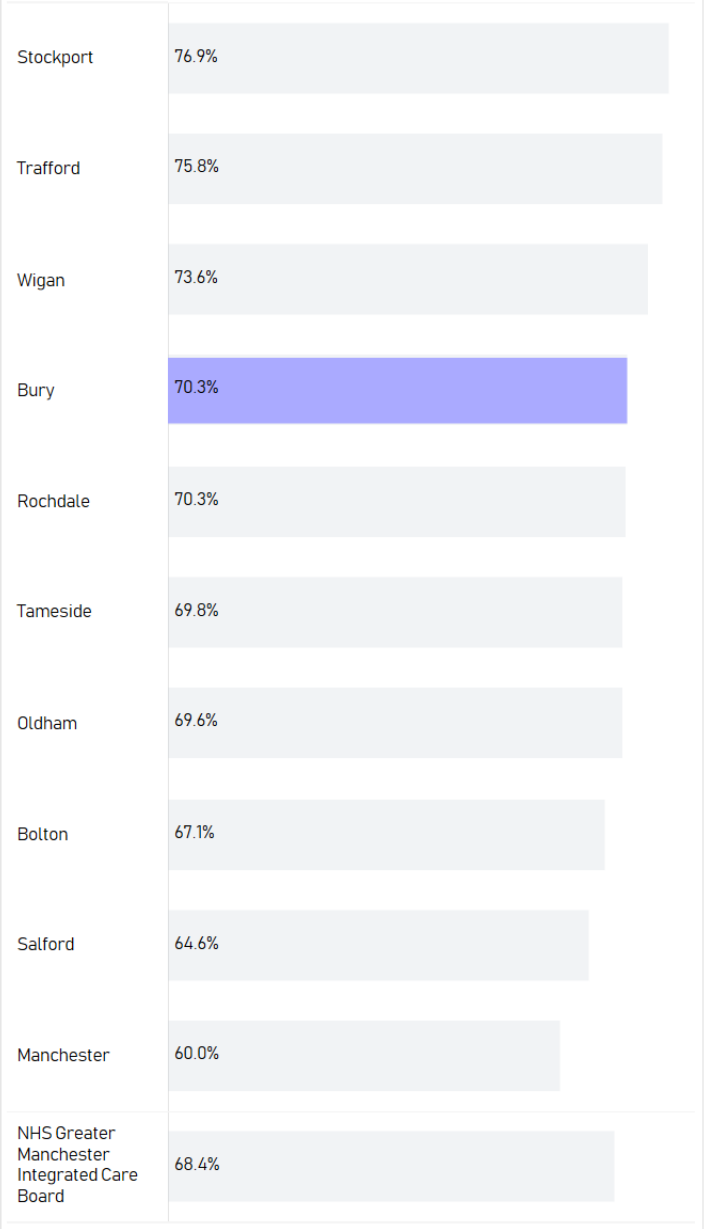
Outliers more than 1 standard deviation from the mean



	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%
2024-25	70.3%			

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

Latest Value GM Benchmarking
National Rank against other localities



Narrative

- The cervical screening coverage to June 24 for the Bury population was 70.3% for eligible females.
- Bury locality currently has the 4th highest percentage out of all the GM localities and is higher than the GM percentage of 68.4%.
- Bury and GM are not meeting the national target of 80%.

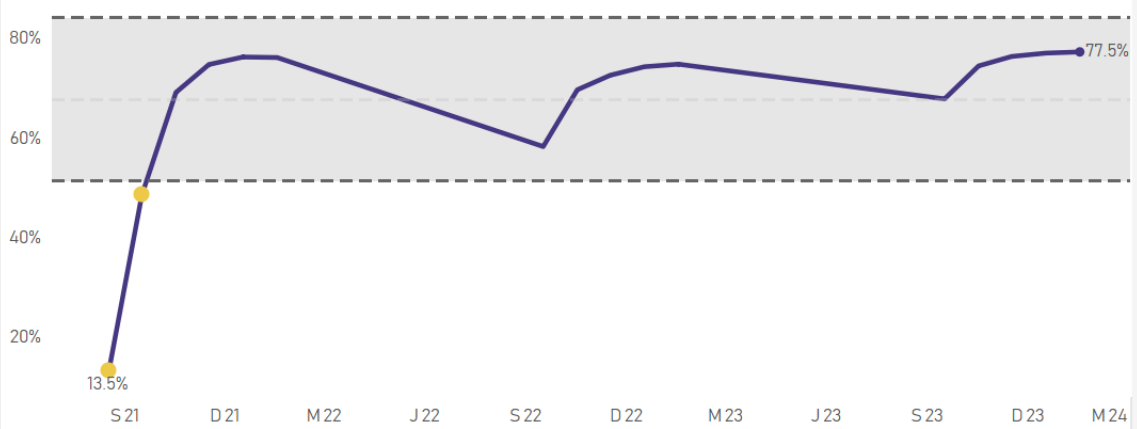
Bury

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

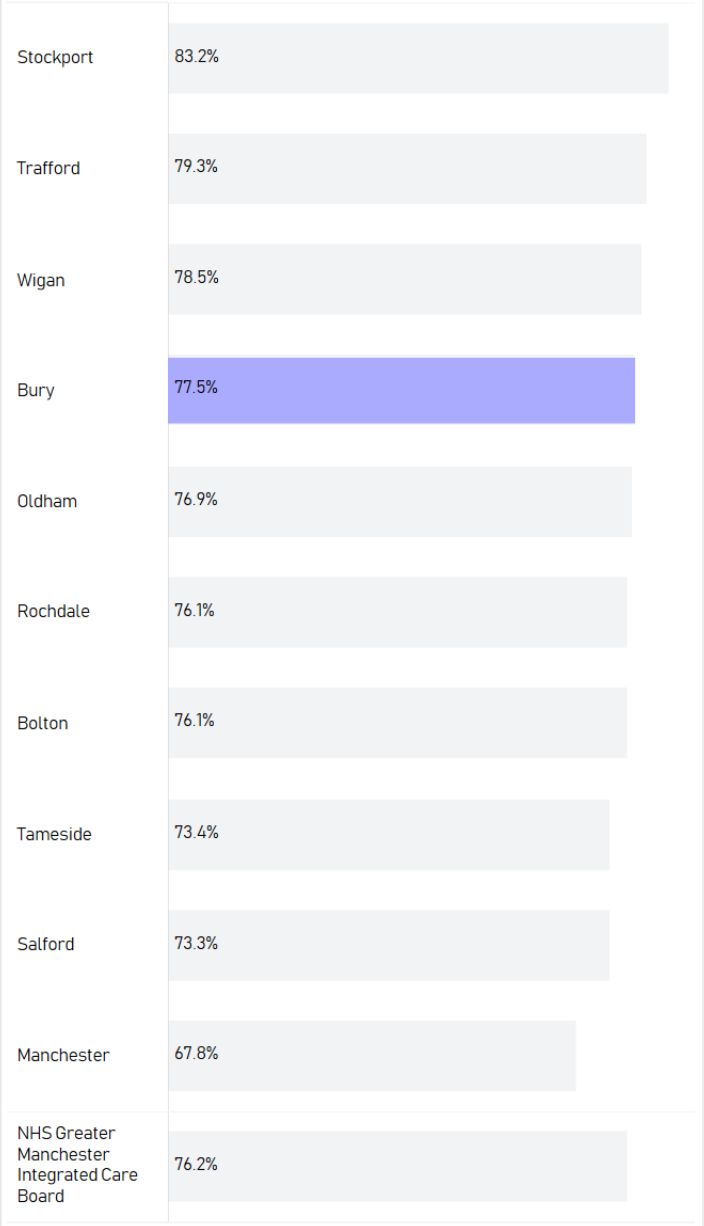
Outliers more than 1 standard deviation from the mean



	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



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 4th best 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%.

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

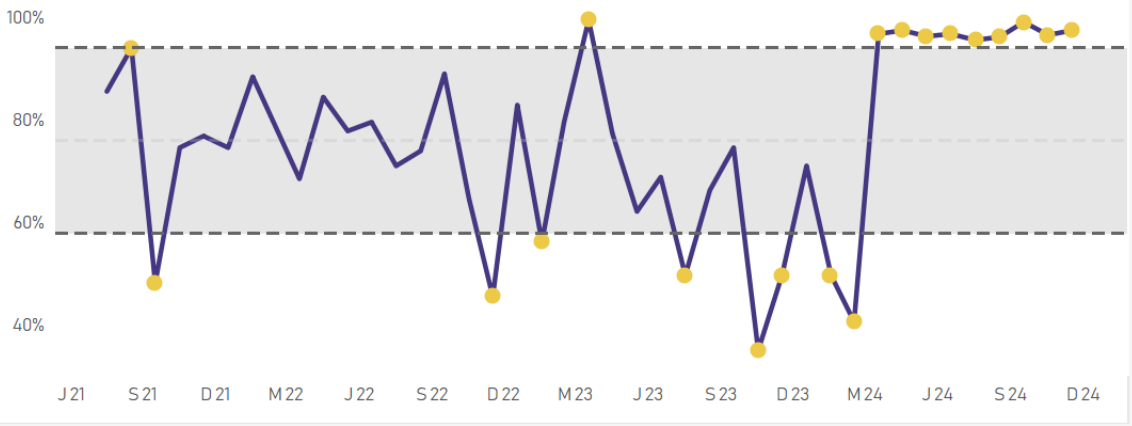
Source: Community Services Data Set (CSDS) (Monthly)

98.0%
December 2024

97.1%
November 2024

70%
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%	96.7%	99.6%	97.1%	98.0%			

Selected measure at December 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 Dec 24 was 98.0%, which is an increase on Dec 23 which was 50.0%.
- Bury currently has the highest percentage in the GM localities and is currently above the National Target of 70%.
- Local authority reporting shows that 96% of Bury residents received a 2-hour response in Jan 25 with 4 patients missing target.

Oversight Metrics Glossary

Domain	Code	Measure	Description	Data Source	Frequency	Latest	Updated	RAG rated against	Desired Direc
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 Service (NDRS)	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	Dec 24	2nd Thursday	No Target	Increase
	EAS01	Dementia: Diagnosis Rate (Aged 65+)	Dementia: Diagnosis Rate (Aged 65+)	Primary Care Dementia Data	Monthly	Dec 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	Dec 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 a rolling 12 month period	Published MHSDS	Monthly	Dec 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	Dec 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	Dec 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	Dec 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	Jan 25	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	Jan 25	1st	No Target	Decrease
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	Dec 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	Sep 24	2nd Thursday	National Median	Increase
Quality	S037A	% of patients describing their overall experience of making a GP appointment as good	The weighted percentage of people who report through the GP Patient Survey their overall experience of their GP practice as 'very good' or 'fairly good'	GP Patient Survey	Annual	Mar 23	2nd Thursday	National Median	Increase
	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	Dec 24	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	Nov 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	Nov 24	2nd Thursday	National Target	Decrease

Sight Metrics Glossary

Domain	Code	Measure	Description	Data Source	Frequency	Latest	RAG rated against	Target/National
Urgent Care	EM11	Total number of specific acute non-elective spells	Count of spells	National Flows APC	Monthly	Jan 25	National Median	
Elective Care	EB20	RTT incomplete: 65+ week waits		Consultant-led RTT Waiting Times data collection (National Statistics).	Monthly	Dec 24	National Target	0.
	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	Dec 24	National Target	1.%
Cancer	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	Dec 24	National Target	75.%
Maternity	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 23	National Median	3
	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 23	National Median	1
Screening and Immunisations	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.%
	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	Sep 24	National Target	95.%
	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	Jun 24	National Target	80.%
	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 24	No Target	
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	Dec 24	National Target	

PIA Locality Report

File created on: 2/14/2025 8:28:33 AM

Meeting: Locality Board			
Meeting Date	03 March 2025	**Action**	Receive
Item No.	13	**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, Associate Director for Nursing, Quality and Safeguarding (Bury) Kath Wynne Jones, Chief Officer, Bury Integrated Delivery Collabrative		
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 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 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.	☒

Links to Locality Plan outcomes	
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 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 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. Recommendations

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

3 Actions Required

3.1 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.

Catherine Jackson
Associate Director for Nursing, Quality and Safeguarding (Bury)
catherine.jackson2@nhs.net
February 2025

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	16		↔	8	Local governance structures reflect 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. Operational planning guidance received in February for 2025-26. Bury 2030 'Let's Do It' strategy embedded and refreshed regularly. Scrutiny on delivery in place at Strategic Finance Committee, System Assurance Committee, IDCB and Locality Board. Relevant prioritised workstreams with programme leadership in place.
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 partnership working in the	16	16	16		↔	8	Commissioning oversight through Commissioning Oversight Group (COP). Commissioning intentions developed for GMICB for 2025-26. Locality Finance and Scrutiny

		Bury Integrated Care Partnership by inducing actions that effectively cost shunt within the system.							committee oversight. Saving planning meetings in place. QIPP management and oversight. Improvement work carried out 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	15		↓	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. 10. Finance Locality Assurance Meetings (LAMs) monthly.
3b	Finance: Locality Healthcare budgets	BECAUSE the locality is currently overspent by approx. £6.8m vs a budget of £71m and the locality	16	16	16		↔	8	1.Bury System Finance Group. 2.System wide workshops being set up. 3.Monthly Locality assurance

	Recurrent position	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 recurrent financial balance will not be achieved.							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. 10. Finance Locality Assurance Meetings (LAMs) monthly.
4	Finance: Locality Operating costs budgets	The locality currently has a budget of £3.4m and is forecasting to be £0.1m overspent in 2024/25. This is primarily due to £0.13m of non-recurrent funding for RBMS but costs being £0.27m offset by 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	16	16	16		↔	8	Finance and scrutiny committee oversight. Saving planning meetings. QIPP management and oversight. Work to reconcile the RBMS function and costs.

		delivering transformation projects and staff well-being.							
5	Data, insight and intelligence (DII)	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	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. Futures platform developing.
6	Urgent and Emergency Care	BECAUSE of limited flow of patients out of the ED and hospital, the number of patients in ED can be greater than the staff's capacity to manage within targets, 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,	16	16	16		↔	8	FGH remained below OPEL 4. A&E attendances from Bury patients have reduced. A&E Streaming and Acuity Tool in place. A&E recruitment plan implemented MC, RR and Virtual ward all assisting to improve flow. Walk round assurance gained at visits to department.

		THEN patients will be kept in hospital unnecessarily leading to potential increased harm for those patients (e.g. increased risk of infection, deconditioning) and for other patients attending the emergency department and requiring admission to an acute bed (e.g. reduced ED capacity, trolley waits in ED).							
7	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	16		↔	4	GM ICB programme boards in place. Bury Elective Care and Cancer Recovery and Reform Board in place. 2025-26 operational planning guidance sets out waiting list reduction expectations.
8	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	16	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.

		health services, Children's Social Care and Education to ensure they reach as good outcomes as all children.							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. February 2025 – feedback following monitoring visit, positive improvements evidenced.
9	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 practice strategy and GM PC Blueprint not being delivered in full and ultimately poorer outcomes	16	16	16		↔	8	Discussions currently taking place with GM regarding additional investment through the LCS contract. This is not guaranteed but is a positive step forward.

		for the patients of Bury.							
10	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	16		↔	8	Work continues to secure a variable alternative Health Centre. Financial and contractual discussions are progressing well with all parties.
11	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	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. NCA reporting increase in activity across urgent care sites.
12	Mental health programme	If patient flow is not improved in MH inpatient wards this will lead to delayed discharge of patients to more	16	16	16		↔	8	GM, PFT and locality level improvement plan in place. Weekly locality and GM MADE meetings to support flow in MH

		appropriate placements, drive demand for inappropriate Out of Area Placements and increase the risk of 12-hour breaches in ED							wards. GM crisis programme to increase / improve community-based crisis provision and pathways. Actively monitored through Bury MH Programme Board. Bury continues to be over target for bed days occupied by patients who are CRFD
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 choose with the associated inequality in access and cost pressures. ongoing reputational impact.	16	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. 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. Approval is being sought through NHS GM to commission some ADHD and ASD assessment capacity from Optimise for 2025.26. There has been a small reduction in expenditure on right to choose referrals in the last 2 reported months.
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	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. Approval is being sought through NHS GM to commission some ADHD and ASD assessment capacity from Optimise for 2025.26.

									There has been a small reduction in expenditure on right to choose referrals in the last 2 reported months.
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 OFSTED / CQC inspection outcomes.	16	16	16		↔	8	Progress monitored as part of the SEND inspection improvement plan. GM triage / prioritisation criteria implemented. PCFT waiting list initiatives planned. 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. There continues to be very high demand and resulting waiting times.

Meeting:			
Meeting Date	03 March 2025	**Action**	Receive
Item No.	14	**Confidential**	No
Title	System Finance Group Update – February 2025		
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.

The month 9 NHS GM position is showing a deficit of £79.5m versus an expected deficit of £7.8m, giving an unplanned variance of £71.7m adverse to plan, and remains forecasting recovery of this position by 31st March 2025 to break even, 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 £6.16m versus an expected break even annual position.

The Northern Care Alliance (NCA) are £3.4m overspent at month 8 versus a plan of £1.9m and have forecast to achieve their agreed deficit of £4.4m. Pennine Care NHS Foundation Trust (PCFT) are reporting a £1.3m deficit at month 8 versus a break even plan, but continue to forecast a very slight surplus at year end.

The council is progressing sign off, of the 2025/26 financial plan through it's own governance route and an update will be brought on this to the next locality board.

As at Month 9 £339m of CIP has been delivered by NHS GM against a plan of £331m, a slight over delivery of £8m. The forecast CIP position is delivery of £495.2m against a target of £490.3m, again a slight overachievement of £1.3m but this delivery does have a level of risk attached. In terms of CIP delivery on the budgets delegated to the locality, at month 9 £3.08m has been delivered against a month 9 plan of £3.86m, with shortfalls against plan in Medicines Optimisation and Complex Care, this therefore puts a risk of £1.47m on the full delivery of 2024/25 CIP.

2025/26 NHS planning guidance and financial allocations were received in late January and the impacts of this upon NHS GM are being understood, with conversations with NHS England ongoing and a final agreed plan to be submitted in March. The impacts of the guidance upon the budgets that this board is responsible are not yet known but this is anticipated in March and an update will be brought to the April meeting. The overall inflationary uplift for NHS services is 2.15%, after the application of a 2% saving, but the uplift is differential across budget lines. The Better Care Fund is receiving a 1.7% inflationary uplift, all of which is mandated to be passed to the Local Authority, with a headline uplift of 3.9% nationally but the local impact of this will be different depending upon the make up of the services within the BCF.

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 deficit on the budgets that the locality board is responsible for and the distance still to delivery a break even position recurrently. • Note the high level impact of the 2025/26 planning guidance and anticipate further locality specific information in the April meeting.

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 – February 2025

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.

3.1 Bury Council

3.1.1 The council at the end of quarter 3 is forecasting an overspend of £2.66m against the £224.48m net budget which was set originally with a structural funding gap of £13.15m being met from reserves. The overspend primarily relates to social care and the cost of overnight accommodation for the homeless which are issues common to councils nationally and not unique to Bury.

3.1.2 The council has agreed it's revenue budget and related 4.99% council tax increase for 2025/26 which requires a £5.858m contribution from reserves to meet the funding gap which is significantly less than the c£19.5m gap previously reported in November. The improvement is primarily the result of a better than anticipated finance settlement (c£6m) and additional savings agreed for 2025/26 of £8.3m.

3.1.3 Significant uncertainty remains with regard to future funding levels but a forecast structural funding deficit of c£10m remains in 2026/27 with work being undertaken over the spring and summer to develop proposals which will significantly reduce the reliance on reserves in future years.

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 The month 9 NHS GM position is showing a deficit of £79.5m versus an expected deficit of £7.8m, giving an unplanned variance of £71.7m adverse to plan, and remains forecasting recovery of this position by 31st March 2025 to break even, to allow delivery of the agreed £175m deficit. This position is shown below in table 1

Table 1

Month 9 2024/25 (£m)	YTD Plan	YTD Actual	YTD Variance	Full Year Plan	Full Year Forecast	Full Year Variance
GM NHS Providers	-£7.8	-£47.6	-£39.8	£0.0	£0.0	£0.0
NHS GM	£0.0	-£31.9	-£31.9	£0.0	£0.0	£0.0
ICS total	-£7.8	-£79.5	-£71.7	£0.0	£0.0	£0.0

3.2.5 As at Month 9 £339m of CIP has been delivered by NHS GM against a plan of £331m, a slight over delivery of £8m. The forecast CIP position is delivery of £495.2m against a target of £490.3m, again a slight overachievement of £1.3m but this delivery does have a level of risk attached.

3.3 NHS GM – Bury Locality

3.3.1 At month 9, the Bury locality, on the budgets delegated from NHS GM, is forecasting a year end deficit of £6.16m, against an anticipated break even position. This position is an improvement from month 9 and is shown overleaf in table 2. The improvement had been primarily in the CHC directorate, with a smaller improvement in the Mental Health directorate.

Table 2

Month 9 Bury Locality Position						
Directorate	**YTD Budget**	**YTD Actual**	**YTD Variance**	**Annual Budget**	**Forecast Outturn**	**Forecast Variance**
Acute	£1,631,645	£1,630,852	-£793	£2,178,486	£2,175,584	-£2,902
CHC	£15,165,038	£18,460,841	£3,295,803	£20,195,649	£22,723,763	£2,528,114
Community	£13,318,740	£13,473,409	£154,669	£17,515,634	£17,706,416	£190,782
Mental Health	£12,321,564	£14,987,308	£2,665,744	£16,506,190	£19,964,362	£3,458,172
Other	£2,128,750	£2,199,422	£70,672	£2,933,174	£3,040,459	£107,285
Primary Care	£4,040,784	£3,897,516	-£143,268	£5,379,276	£5,262,417	-£116,859
Grand Total	**£48,606,521**	**£54,649,348**	**£6,042,827**	**£64,708,409**	**£70,873,001**	**£6,164,591**

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:

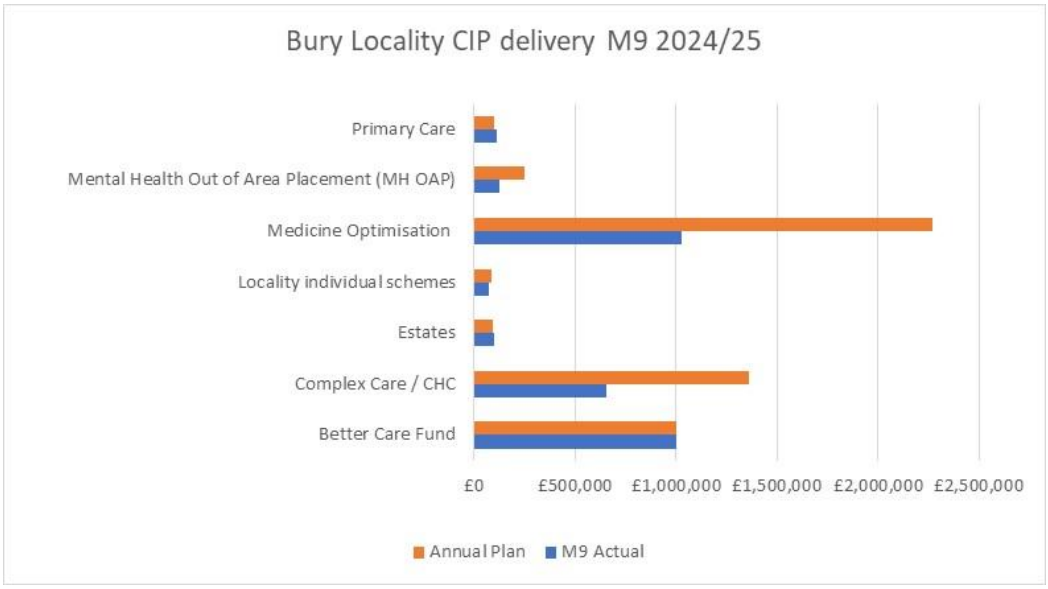
- Increases in the cost and number of Complex Case packages, shared 50:50 with the council
- Increases in the costs and number of Complex Case packages solely funded by the NHS
- Prior year pressures brought forward
- The impact of changes to the discharge pathway from acute hospital which has caused 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, has received 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 (£0.6m), with this being particularly volatile as more providers are being approved nationally to delivered services.

3.3.4 With regard to CIP achievement at month 9, the locality has achieved £3.08m of CIP delivery which is 60% of the annual target but there is only 25% of the year remaining and 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 historic excellent performance by this team, meaning the opportunity for savings is less than in other localities. There are £1.47m of risks associated with CHC / Complex Care delivery 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



4.0 2025/26

4.1 All partners are working on budget setting and plans for 2025/26, with the council the most advanced, having formally signed off a balanced budget in late February, due to the regulatory requirements and the release of draft financial settlements before Christmas.

4.2 2025/26 NHS planning guidance and financial allocations were received in late January and the impacts of this upon NHS GM are being understood, with conversations with NHS England ongoing and a final agreed plan to be submitted in March.

4.3 The overall inflationary uplift for NHS services is 2.15%, after the application of a 2% saving, but the uplift is differential across budget lines. The Better Care Fund is receiving a 1.7% inflationary uplift, all of which is mandated to be passed to the Local Authority, with a headline uplift for Local Authorities of 3.9% nationally but the local impact of this will be different depending upon the make up of the services within the BCF. This does leave a gap for NHS services funded from the Better Care Fund and clarification is being sought from NHS England on this specifically.

4.4 The impacts of the guidance upon the budgets that this board is responsible are not yet known but this is anticipated in March and an update will be brought to the April meeting.

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.
- Note the high level impact of the 2025/26 planning guidance and anticipate further locality specific information in the April meeting.

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February 2025

Meeting:			
Meeting Date	03 March 2025	**Action**	Receive
Item No.	15	**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 A GM Population Health Committee meeting was held on 18th February. Key items discussed included shaping healthy places - which included an overview of the sustainability agenda and the NHS green plan, population heath and prevention ambitions linked to the NHS annual planning and investment, and the health innovation Manchester work programme.

3.2 The Key point highlighted from the discussions were;-

3.3 **GM Live Well Platform**: Aims to scale prevention efforts and support locality work to reduce health, social, and economic inequalities.

3.4 **Sustainability Plan**: Emphasizes the need to shift from reactive care to prevention to avoid additional costs. Aligns with the Darzi report and the new 10-year health plan.

3.5 **Financial Flows**: Essential to lock in financial flows to support care closer to home, especially for long-term conditions.

3.6 **Right-Drift in NHS Expenditure**: Despite intentions to shift care to the community, hospital spending has increased, highlighting the need for investment in prevention.

3.7 **Social Factors**: Demand and costs are driven by social factors, necessitating a comprehensive approach to prevention across all public services.

3.8 **Neighbourhood Model**: Key mechanism for embedding prevention and proactive care, with a focus on making it available to all residents by 2025-26.

3.9 **Investment and Financial Challenges**: Significant investment is required to implement the plan, with a focus on long-term funding agreements and innovative payment mechanisms.

3.10 **Phased, Multi-Year Investment**: Necessary to start from 2025-26 to support prevention plans and achieve overall aims.

3.11 **Operational Practice**: Ensuring the right conditions for delivering benefits from investment, including protecting and targeting existing prevention budgets.

3.12 **Proposed Investment Programmes**: Include the GM Live Well Neighbourhood Model, scaling up CURE, and other key programmes.

3.13 **Financial Impact**: Investment in prevention is expected to drive cost savings and improve health outcomes, with a focus on evidence-based, scalable plans.

3.14 **GM Live Well Neighbourhood Model**: Focus on integrated neighbourhood and prevention work, with milestones for implementation and expected impact on population health.

3.15 **GM Prevention Demonstrator**: Aims to unlock a shift towards prevention delivered within communities, with key metrics and milestones.

3.16 **NHS GM Annual Plan**: Outlines commitments for 2025-26, including high-impact interventions and a focus on reducing prevalence and proactive care.

3.17 **Scaling Up CURE**: Tobacco dependency treatment programme with significant health and economic benefits.

3.18 **Primary Care Transformation (BeCCoR Programme)**: Aims to deliver evidence-based outcomes through a consistent GM scheme/contract with General Practice.

4 Bury Health and Wellbeing Board

4.1 No Health and Wellbeing Board meetings have taken place since the update at the last Locality Board.

Jon Hobday
Director of Public Health
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February 2025

BURY INTEGRATED CARE PARTNERSHIP

Meeting: Locality Board			
Meeting Date	03 March 2025	**Action**	Receive
Item No.	16	**Confidential**	No
Title	Clinical & Professional Senate Update		
Presented By	Dr Kiran Patel		
Author	Dr Kiran Patel		
Clinical Lead	Dr Kiran Patel		

Executive Summary
This report provides the Locality Board with a summary from the Clinical and Professional Senate meeting that took place in February 2025.
Recommendations
The Locality Board is asked to receive the report and share any feedback to the Clinical and Professional Senate for action.

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

Links to Locality Plan outcomes	
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Implications						
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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		

Clinical and Professional Senate Highlight Report – February 2025

1. Introduction

This report provides the Locality Board with a summary from the Clinical and Professional Senate meeting that took place on 26 February 2025.

2. Headlines from the Clinical and Professional Senate

2a. NHS Operating Plan – Kath Wynne-Jones

- Kath Wynne-Jones delivered a presentation relating to the NHS Operating Plan.
- Kath talked through the 2025/2026 NHS planning priorities and the key actions for delivery.
- A discussion took place regarding how these are implemented when for a number of them, they are dependent on external factors and decisions.
- Digital transformation was discussed as being a weakness for Bury and the need for the Bury Digital Board to be reinstated was also discussed.

2b. Clinical Leadership Update – Fin McCaul

- Deferred to a future meeting.

2c. Partner Update

- NCA – Vicki Howarth
    - Vicki Howarth was not in attendance and so there was no formal update from the NCA.
    - Richard Bulman was in attendance and provided a brief update on the continuous flow model which the NCA are using.

- Pennine Care - Ankur Khanna
    - No update provided from PCFT, no attendees from PCFT were present at the meeting.

- Emma Massey Principal Social Worker – Bury Council
    - Emma introduced herself as the new Principal Social Worker for Bury Council and discussed her priorities for the next 12-18 months, which include: strength-based practice, workforce and quality assurance.

- GP Update – Kath Wynne-Jones
    - Kath Wynne-Jones explained that there is now a regular weekly meeting in place to understand the issues across Bury and HMR. Kath explained that there are some issues which are being raised at this meeting, these theme into consistent areas, including:

        1. Referrals going back to GP's
        2. Issues with prescribing
        3. Gestational diabetes and issues with preventive vitamins and supplements
        4. Issues around referrals from private providers to into NHS organisations
        5. Issues with Shared Care

    - Collective Action feels very well managed and there is a good process of engaging with the NCA and Pennine Care.

2d. Paediatric Phlebotomy Referral Criteria – Rachele Schofield

- Rachele Schofield advised that a change has been made to the pediatric phlebotomy referral criteria. This is a borough wide service which is delivered by Rock Healthcare. Currently, until the end of March 2025, for all pediatric bloods for patients aged 2-18. The service accepts referrals directly from General Practice.
- There has been an increase in activity and following conversations with clinical leads, it is felt that some of the bloods that are being carried out are inappropriate and not always clinically necessary.
- Amendments have therefore been made to the referral criteria, from 1st April 2025 this service will only be for patients aged 5-12 years, and it will only be testing for conditions that can be managed within Primary Care, such as suspected menorrhagia, anaemia or celiac disease. Any bloods required for these conditions, for patients aged 12 years and over will be done in at the GP practice. Any children outside of these conditions (of any age), will go through Paediatric Advice & Guidance first to determine if/why the bloods are needed. Any patient under 5 will be referred to secondary care Paediatrics and not dealt with in Primary Care, following consultation with Advice & Guidance.

2e. AMD Update – Sanjay Kotegaonkar

- **CEG Update**

- Sanjay Kotegaonkar attended the last CEG meeting in Cathy Fines' absence and provided feedback to the senate. This included papers on GMMMG decision making in relation to various medication, papers from the Clinical Policy Audit and Standards Group including recommendations for approval on decisions surrounding commissioning on spinal injections, epidurals, radio frequency denervation, and policies regarding ICD deactivation.
- There were some medication recommendations for approval for example to approve Modafinil for MS.
- There was a presentation on the recent Hepatitis B Emergency Department National Testing programme
- There was also a paper and presentation on the GM prevention programme, this looked at how we take the intent and ambition and start to deliver on a footprint.

2f. Commissioning Oversight Group Feedback – Kiran Patel

- The minutes from the Commissioning Oversight Group were circulated to members within the Clinical & Professional Senate meeting paper pack.

2g. GMMMG Update - Salina Callighan

- No drug safety notices this month
- 2 Medical Supply Notices will likely impact Bury general practice, these were Quetiapine shortage and Hydrocortisone Injection shortages.
- Shared Care of Medicine (SCOM) update – there is a forerunner scheme proposal for 2026/2027. Zoe Alderson expanded on the forerunner programme and advised that this is being discussed as part of the Beyond Core Contract Review (BeCCoR) work. To level up four localities to a £16 per head investment. One scheme that is being suggested to be rolled out from 2025/2026 is the shared care medications programme. Bury is looking to implement this from the next financial year, pending funding approval.
- Promazine commissioning statement was presented jointly by GMMH & Pennie Care. Promazine is an old antipsychotic that is very toxic in overdose. There is an approved commissioning statement to not to start any new patients on Promazine and begin active deprescribing.
- Primary & Secondary care interface – A concern has been raised, around community pharmacy, the NCA, in particular the NCA pharmacy service and how it is ensures that the patient's medication history is requested, ensuring the use of the GM Care Record. Salina

advised that she has discussed this with NCA colleagues, and they are picking this up with appropriate colleagues.

2h. AOB

- Salina Callighan discussed that following a review on the Medicines Optimisation function across GM, the function has moved forward with a new operating model both at a pan GM level and a locality level. This does significantly impact locality teams.

3.The Locality Board is asked to receive the report and share any feedback to the Clinical and Professional Senate for action.

Kiran Patel
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February 2025