Agenda

Locality Board – Meeting in Public

Date: 8th April 2024

Time: 4.00 pm – 6.00 pm

Venue: Microsoft Teams Meeting

Chair: Cllr E O'Brien

Full agenda pack begins on next page.

Date and time of next meeting in public
Monday, 3rd June 2024, 4.00-6.00pm in Town Hall

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

If you would like to ask a question of the Bury Locality Board, please submit it by **email to** gmicb-bu.corporateoffice@nhs.net **no later than 3rd April 2024 at 5.00pm.** Questions received after this time will be taken to the following meeting.

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

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Agenda Item 1

BURY INTEGRATED CARE PARTNERSHIP

Agenda

Locality Board – Meeting in Public

Date: 8th April 2024

Time: 4.00 pm – 6.00 pm

Venue: Microsoft Teams Meeting

Chair: Cllr E O'Brien

Item No.	Time	Duration	Subject	Paper Verbal	For Approval Discussion Information	By Whom
1.	4.00 – 4.05	5 mins	Welcome, apologies and quoracy	Verbal	Information	Chair
2.			Declarations of Interest	Paper	Information	Chair
3.			Minutes of previous meeting held on 4 March 2024 including action log	Paper	Approval	Chair
4.			Public Questions	Verbal	Discussion	Chair
Place Based Lead Update						
5.	4.05 – 4.15	10 mins	Key Issues in Bury	Paper	Discussion	Lynne Ridsdale
Locality Board Priorities						
6.	4.15-4.30	15 mins	Planning process update • Draft Operational Plan - 2024/25	Paper	Discussion	Will Blandamer /Kath Wynne-Jones

Integrated Delivery Collaborative Update						
7.	4.30-4.45	15mins	Integrated Delivery Collaborative Update	Paper	Discussion	Kath Wynne-Jones
8.	4.45 – 5.00	15 mins	Update from Strategic Estates Group	Paper	Discussion	Will Blandamer
9.	5.00-5.10	10 mins	ADHD/ASD Update	Paper	Discussion	Will Blandamer
'Quadruple Aims' Updates						
10.	5.10-5.20	10 mins	Health and Wellbeing/inequalities outcome framework	Presentation	Information	Jon Hobday
11.	5.20-5.30	10 mins	Strategic Finance Group Update	Verbal	Information	Simon O'Hare
12.	5.30-5.40	10 mins	Performance Report	Presentation	Information	Will Blandamer
13.	5.40-5.45	5 mins	Clinical & Professional Senate Update	Paper	Information	Kiran Patel
14.	5.45-5.50	5 mins	System Assurance Committee update	Paper	Information	Catherine Jackson
15.	5.50-5.55	5 mins	Primary Care Commissioning Committee Update	Paper	Information	Adrian Crook
Closing Items						
16.	5.55 – 6.00	5 mins	Any Other Business	Verbal	Information	All
17.	_____	_____	**Date and time of next meeting in public Monday, 3rd June 2024, 4.00-6.00pm in the Council Chamber**	_____	_____	All

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 **4th April 2024 at 5.00pm.**
Questions received after this time will be taken to the following meeting.

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

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

Executive Summary

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

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

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

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

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

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

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

Recommendations

It is recommended that the Locality Board:-

- Receive the latest Declarations of interest Register;
- Consider whether there are any interests that may impact on the business to be transacted at the meeting on 8th April 2024 and
- Provide any further updates to existing Declarations of Interest within the Register.

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

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

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

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

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

Committees and Sub-Committees

Locality Board

Declaration of interest as
- Declare in meetings whe
- Not to be sent papers wh
- Not to be involved in any
- Remaining present at the
- Remaining present at the
- Being asked to leave the

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	
					Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests			From	To
Voting Members (Pooled Budget & Aligned & Non-Pooled Budget)											
Cllr	Eamonn	O'Brien	Leader of Bury Council & Joint Chair of the Locality Board	Bury Council - Councillor Young Christian Workers - Training & Development Labour Party Prestwich Arts College Bury Corporate Parenting Board No Barriers Foundation CAFOD Salford Prestwich Methodist Youth Unite the Union	X X	 X X X X X X X		Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct	Councillor Development Team Member Governor Member Trustee Member Trustee Member		
Cllr	Boroda	Nathan	Executive Member of the Council for health and Adult Care	Bury Council - Councillor Labour Party GM Overview and Scrutiny Committee Six Town Housing Board University of Greater Manchester General Assembly Unsworth Academy The Mellor Fund Manchester Jewish Rep Council Board of Deputies of British Jews Unite the Union Jewish Labour Movement North west Labour Regional Executive Committee	x	 x x x x x x x x x x x		Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct	Councillor Member Member Member Member Governor Board Member Management Board Deputy Member Member Member Member		
Cllr	Smith	Lucy	Locality Board Member	Bury Council Business in the Community The Christie NHS Foundation Trust Labour Party Community in the Union Socialist Health Association Catholics for Labour GMB Union	X X			Direct Direct Indirect Direct Direct Direct Direct Direct	Councillor Related to spouse Member Member Member Member Member	July 2023 July 2023	Sept 2023 Present
Dr	Fines	Cathy	Associate Medical Director and Named GP	GP Federation Tower Family Health Care Horizon Clinical Network Greater Manchester Foundation Trust	X X X			Direct Direct Direct Indirect	Practice is a member Partner in a member practice in Bury Locality Practice is a member Husband is employed	2013 2017 2019	Present
	Jackson	Catherine	Executive Nurse	NCA				Indirect	Partner is the Director of Patient Safety & Professional Standards at the NCA.	25/10/2021	Present
	Ridsdale	Lynne	Chief Executive for Bury Council	Bury Council		X		Direct	Chief Executive	Mar-23	Present
	O'Hare	Simon	Associate Director of Finance – Bury Interim Associate Director of Finance – HMR	Simkat Shore Holdings LTD	X			Direct	Director	z	Present
	Heppolette	Warren	Chief Officer for Strategy & Innovation	Greater Sport FC United			X X	Direct Direct	Trustee Director	2018 2021	Present Present
Voting Members (Aligned & Non-Pooled Budget)											
Dr	Howarth	Vicki	Member of the Locality Board	Unilabs Ltd - Private Histopathology Service Tameside and Glossop Integrated Care NHS Foundation Trust	X X			Direct Direct	Providing services as Consultant Histopathologist to the Alexandra Hospital, Cheadle. Bank Consultant Histopathologist performing Coronial Post-Mortems for Manchester South Coroner	2011 2015	Present Present
	Fawcus	Joanna	Director of Operations, NCA	None Declared					Nil Interest		Present
	Allan	Lorna	Chief Digital and Information Officer Digital Services, NCA	Form awaited							
	Stott	Jill	Declaration of Interest form awaited								
Dr	Patel	Kiran	Member of the Locality Board	Tower Family Health Care - Primary Care General Practice Bury GP Federation - Enhanced Primary Care Services Laserase Bolton - Provider of a range of cosmetic laser and injectable treatments Laserase Bolton - Provider of a range of cosmetic laser and injectable treatments Tower Family Health Care - Primary Care General Practice	X X X			Direct Direct Direct Indirect indirect	GP Partner Medical Director Medical Director Spouse is a Shareholder Spouse is a Director	July 2018 April 2018 1994 2012 July 2018	Present Present Present Present Present
	Preedy	Sarah	Chief Operating Officer, Pennine Care NHS Foundation Trust	None Declared					Nil Interest		Present
	Hargreaves	Sophie	Member of the Locality Board	Manchester & Trafford LCO				indirect	Spouse works as Transformation Manager	Sep-18	Present
	Tomlinson	Helen	Member of the Locality Board	H Tomlinson is Chief Officer in organisation which may seek to do business with health or social care organisations Bury One Commissioning Organisation	X			 Indirect	H Tomlinson is Chief Officer in organisation which may seek to do business with health or social care organisations Close family member is an employee at Bury One Commissioning Organisation	01/11/2021 Nov 2021	Present
	Blandamer	Will	Deputy Place Based Lead & Executive Director Health and Adult Care	Ashton on Mersey Football Club Trafford Manchester Football Association Ashton on Mersey Rugby Club Trafford Manchester Foundation Trust (Trafford) & St Anne's Hospice (Cheadle) Liverpool Univesity Leeds University			X X X	Direct Direct Direct Indirect Indirect Indirect	Chairman Board Champion for Safeguarding Director Spouse is a Community Nurse & Qualified Nurse Daughter is a medical student Daughter is a medical student	2018 2018 2023 2022 2017 2019	Present Present Present Present Present Present
	Richards	Jeanette	Executive Director of Children and Young People, Bury Council	None Declared					Nil Interest		Present
	Hobday	Jon	Director of Public Health	None Declared					Nil Interest		present
	Crook	Adrian	Director of Adult Social Care and Community Services Member of the Locality Board	Bolton Hospice			X		Trustee	Jul-05	Present

Non-Voting Members											
	Wynne-Jones	Wynne	Member of the Locality Board	KWJ Coaching and Consulting Roots and Branches CIC The University of Manchester - Elizabeth Garrett Anderson programme	X X X			Direct Direct Direct	Owner Director Tutor	July 2021 Nov 2023 Oct 2022	Present Present Present
	Passman	Ruth	Chair of Bury Healthwatch	None Declared					Nil Interest		
	Wilkinson	Catherine	Member of the Locality Board	Bury Provider Age UK Lancs	X		X	Direct	Director of Finance Trustee and Treasurer	November 2020 May 2018	Present
Invited Members											
Cllr	Bernstein	Russell	Cllr Bury Council, Conservative Leader	Bury Council Philips High School Bury and Whitefield Jewish Primary Conservative Party	X	 X	 X X 	Direct Direct Direct Direct	Councillor Councillor	May 2021 September 2019 September 2019 July 2019	Present Present Present Present
Cllr	Smith	Mike	Attendee of the Locality Board as Leader of Radcliffe First	Angles and Arches Anodising Colour Radcliffe First Radcliffe Litter Pickers Growing Older Together	X	 X X X		Direct Indirect Direct Direct Direct	Director Spouse is a lab technician Leader Member Member	16/1/2009 2017 2019 2019 2019	Present Present Present Present Present

s per policy:
re relevant
were conflicted
decision making where conflicted (which may then also involve the following action to be taken at a meeting)
s meeting but withdrawing from the discussion and voting capacity
s meeting and participating in the discussion but not involved in any voting capacity
meeting

Comments		
As per policy - see details above		
As per policy - see details above		
As per policy - see details above (Y,Y,Y,Y,Y)		
Declaration of interest as per policy as detailed above (Y,Y,Y,Y,Y)		
As per policy - see details above		
As per policy - see details above (Y,Y,Y,Y,Y)		
As per policy - see details above. (Y,Y,Y,Y,Y)	######	Y
As per policy - see details above (Y,Y,Y,Y,Y)		
As per policy - see details above (Y,Y,Y,Y,Y)		
As per policy - see details above (Y,Y,Y,Y,Y)		
As per policy - see details above (Y,N,N,N,N)		
As per policy - see details above (Y,Y,Y,Y,Y)		
As per policy - see details above (Y,Y,Y,Y,Y)		
As per policy - see details above		
As per policy - see details above (Y,Y,Y,Y,Y)		

As per policy - see details above (Y,Y,Y,Y,Y)
As per policy - see details above
As per policy - see details above (Y,Y,Y,Y,Y)
As per policy - see details above (Y,Y,Y,Y,Y)
As per policy - see details above (Y,Y,Y,Y,Y)

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

Executive Summary

The minutes of the Locality Board meeting held on 4th March 2024 are presented as an accurate reflection of the previous meeting, reflecting the discussion, decision and actions agreed.

Recommendations

It is recommended that the Locality Board:-

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

Links to Strategic Objectives

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

Implications

Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☐	N/A	☒
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☐	N/A	☒
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☐	N/A	☒

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

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

Draft Minutes

Date: Locality Board, 4th March 2024

Time: 4.00 pm

Venue: Committee Rooms A &B, Bury Town Hall, Knowsley Street, Bury

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

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

Locality Board

MINUTES OF MEETING
Locality Board Meeting in Public 4th March 2024 4.00 pm until 6.00 pm **Chair – Dr Cathy Fines**

ATTENDANCE

Voting Members
Dr Cathy Fines, Senior Clinical Leader in the Borough **(Chair)** Cllr Eamonn O'Brien, Leader of Bury Council Cllr Lucy Smith, Executive Member of the Council for Children and Young People Ms Lynne Ridsdale, Place Based Lead Mr Simon O'Hare, Deputy Locality Finance Lead Mr Warren Heppolette, Chief Officer for Strategy and Innovation (GMIC) Dr Kiran Patel, Medical Director, IDCB Kath Wynne-Jones, Chief Officer Bury, IDC (Deputising as Care Organisation representative for the meeting) Ms Heather Caudle, Group Chief Nursing Officer, NCA (for part) Mr Anthony Hassall, Chief Executive, Pennine Care NHS Foundation Trust Ms Helen Tomlinson, Chief Officer, Bury VCFA (Voluntary, Community, Faith & Social Enterprise) Mr Will Blandamer, Deputy Place Based Lead, Executive Director of Health and Care Mr Jon Hobday, Director of Public Health Ms Jeanette Richards, Executive Director of Children & Young People Mr Adrian Crook, Director of Adult Social Services and Community Commissioning
Non-Voting Members
Ruth Whittingham, Head of Legal Services, Bury Council Ruth Passman, Chair, Healthwatch (via Smartscreen link)
Invited Members
Cllr Russell Bernstein, Conservative Opposition Party Mr Fin McCaul, Clinical Lead Mr Jacob Botham, Programme Manager, Greater Manchester Combined Authority Ms Jane Case, Programme Manager, Bury Mr Adam Webb, Chief Officer, Healthwatch, Bury Ms Alexia Mitton, Assistant Director of Engagement, NHS Greater Manchester Mrs Emma Kennett, Head of Locality Admin & Governance, NHS Greater Manchester (Bury locality) Ms Philippa Braithwaite, Democratic Services, Bury Council Mr Chris Woodhouse, Strategic Partnerships Manager, Bury Council (for item 9)
Observers
Mr Robin Ward, NCA Public Governor
Ms Lorna Allan, Chief Digital and Information Officer, NCA
Ms Ruth Whittingham, Head of Legal Services, Deputy Monitoring Officer, Bury Council

MEETING NARRATIVE & OUTCOMES

1	Welcome, Apologies and Quoracy
1.1	The Chair welcomed all to the meeting.
1.2	Apologies were received from Mr Paul McKevitt, Dr Vicky Howarth, Cllr Nathan Boroda, Ms Catherine Jackson, Ms Joanna Fawcus,Ms Sarah Preedy, Ms Jill Stott, Ms Sophie Hargreaves and Cllr Mike Smith.
1.3	The meeting was declared quorate and commenced.

2	Declarations Of Interest
2.1	NHS GM has responsibilities in relation to declarations of interest as part of their governance arrangements (details of which can be found outlined in the NHS Greater Manchester Integrated Care Conflict of Interest Policy version 1.2).
2.2	NHS GM (Bury Locality) therefore, has a requirement to keep, maintain and make available a register of declarations of interest for all employees and for a number of boards and committees.
2.3	The Local Authority has statutory responsibilities detailed as part of Sections 29 to 31 of the Localism Act 2011 and the Relevant Authorities (Disclosable Pecuniary Interests) Regulations 2012. For other partners and providers, we understand that conflicts of interest are recorded locally and processed within their respective (employing) NHS and other organisations as part of their own governance and statutory arrangements too.
2.4	Taking into consideration the above, a register of Interests has been included detailing Declaration of Interests for the Locality Board.
2.5	In terms of agreed protocol, the Locality Board members should ensure that they declare any relevant interests as part of the Declaration of Interest Standing item on the meeting agenda or as soon as a potential conflict becomes apparent as part of meeting discussions.
2.6	The specific management action required as a result of a conflict of interest being declared will be determined by the Chair of the Locality Board with an accurate record of the action being taken captured as part of the meeting minutes.
2.7	There is a need for the Locality Board members to ensure that any changes to their existing conflicts of interest are notified to NHS GM (Bury Locality) Corporate Office within 28 days of a change occurring to ensure that the Declarations of Interest register can be updated.
2.8	**Declarations of interest from last meeting held on 5th February 2024** No declarations to note.
2.9	**Declarations of interest from today's meeting 4th March 2024** None to declare other than what was detailed on the Declarations of Interest register submitted within the meeting pack.

ID	Type	The Locality Board	Owner
D/03/01	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 5th February 2024 were considered as a true and accurate reflection of the meeting. Updates on actions were noted with specific reference made to the following ones: - • **A/02/01** - *Revised Terms of Reference to be submitted via respective NHS and Council governance arrangements*. It was noted that the Terms of Reference had been submitted via Council governance arrangements and were due to be submitted to the NHS GM Board meeting at the end of March 2024. • **A/02/02** - *Childrens waiting time information to be included as part of Performance Report for March Locality Board meeting.* Mr Blandamer commented that the Childrens Performance information was under review at the moment and there was a need to obtain a consistent set of metrics from Greater Manchester in this regard. Further information would be included as part of a future Performance report once available.

ID	Type	The Locality Board	Owner
D/03/02	Decision	Accepted the minutes and actions from the previous meeting as a true and accurate reflection of the meeting.	

4	Public Questions
4.1	There were no public questions received.

ID	Type	The Locality Board	Owner
D/03/03	Decision	Noted that there had been no public questions received..	

5.0	Place Based Lead Update
5.1	Ms Ridsdale introduced her item which provided an update on the key issues of the Bury Integrated Care Partnership.
5.2	It was reported that: - • The Local Area SEND inspection took place in February 2024 which looked at how the local area was working together to improve outcomes for children with SEND and their families. This included a focus on EHC plans, partnership strategies including communication, pathways, transitions, waiting times and alternative provision. The SEND report would be published on the Ofsted/CQC website in early April 2024 but until then any draft reports and findings were strictly embargoed as part of this process. A final copy of the final report would be shared once published and also discussed at key partnership meetings to ensure partnership plans continued to focus on making a different to children, young people and families in Bury. Colleagues across the heath and care partnership were thanked for all their contributions as part of the inspection. • In terms of measles, there was continuing concern about the number of measles cases nationally and in Greater Manchester. Fortunately, in Bury there have been no cases associated with the recent outbreak, but advice is that it is only a matter of time. The Vaccination Steering Group in Bury (chaired by Mr Jon Hobday) is working to step up delivery of MMR in all residents and targeting cohorts of particularly low uptake. • At a Greater Manchester wide level, work continued via the planning hub to plan to address the triple deficit of finance, performance, and population health gain. Work was focused on financial recovery, assurance, CIPs, the NHSE high level template submission of 28th February 2024 on key performance, finance and workforce requirements, and the timeline towards a final submission date of 2nd May 2024. In Bury, following approval at the last Locality Board the proposed locality priorities for 24/25 have been submitted to the GM for comparison and moderation with both the submissions from other localities and against the key GM wide priorities. Work continued to refine and shape local priorities and be clear in the Bury system where the focus for monitoring and delivery lies. A key focus at the locality level was the opportunity for prevention/early intervention and a number of local colleagues were attending a GM workshop on this on the 6th March 2024 with a particular focus on the twin priorities of CVD and diabetes. • It was highlighted that one element of the preventative programme GM wide was the inclusion of a number of standardised commitments in each of the 10 locally commissioned services for GP services. In Bury, this caused a particular difficulty as incorporating these GM requirements would be challenging given the current financial benchmarking position

	compared to other localities. There was a risk to the continued provision of a couple of services from primary care in order to accommodate the investment required. Those services had the potential to be of necessity addressed by secondary care providers which was both costly and the wrong strategic direction. This item has been discussed in detail at the Integrated Delivery Board and work was underway in an attempt to find a solution. The latest position will be reported to the GP 'membership' event on 13th March 2024 and the decision is a matter for the Bury Primary Care Commissioning Committee the following week. • In relation to Urgent Care Performance, good partnership work continued focusing on days kept away from home, the additional primary care capacity in surge and respiratory hubs, and out of area placements in mental health. A particular focus has been on achievement of the 4 hour wait target in A&E which is 76% by end of March 2024. The Bury system had historically performed relatively well on this indicator compared to the rest of GM but performance has been lower than hoped in recent months. Trajectories for improvement had been agreed and in particular in Bury getting the pre-ED streaming model fully operational after recent building work at FGH is crucial to the delivery of the target. The daily bronze meeting reviewed performance which is also subject to routines weekly monitoring from NHS GM to providers, and to the Deputy place lead.
5.3	The following comments/observations were made by Locality Board members: - • In terms of the locally commissioned GP services (LCS) within Bury, Dr Patel highlighted that the current service offer/funding arrangements within this area did not align with the new standard process being proposed across Greater Manchester. There was a need for a greater understanding of the timelines associated with these proposals in order to fully assess the impact locally. Mr Heppolette reported that it would be helpful to understand in more detail some of the local concerns and ascertain from the GM Team the exact implementation timescales. Mr Blandamer emphasised that there was a need to avoid the risk of local GPs being paid less, patients receiving a substandard service or increased demand being placed upon secondary care as part of these proposals. It was agreed that a meeting should be arranged between Mr Heppolette, Dr Patel and Mr Blandamer to discuss to work through these issues.

ID	Type	The Locality Board	Owner
D/03/04	Decision	Received the update.	
A/03/01	Action	Meeting to be arranged between Mr Heppolette, Dr Patel and Mr Blandamer to discuss the LCS issues further.	Mr Blandamer
A/03/02	Action	A further update on the LCS would be provided to the next Locality Board meeting in April 2024.	Mr Blandamer

6.1	Joint Forward Plan – Children & Young People Delivery Plan
6.1	Mr J Botham, Programme Manager, Greater Manchester Combined Authority was in attendance to present a report in relation to the Children & Young People Delivery Plan.
6.2	It was highlighted that the report included a copy of a previous paper for context purposes namely '*An Integrated Approach to delivering our Ambition for Children and Young People in Greater Manchester'* which was presented to the Greater Manchester Integrated Care Partnership and Greater Manchester Combined Authority in February 2024. This report acknowledged that the priorities for children & young people spanned across the ambitions of the Greater Manchester Strategy and the Integrated Care System but that there was also the requirement for shared accountability and even greater integration in the ambitions to improve outcomes for GM children & young people.
6.3	Following on from this, work was now underway to develop a Joint Integrated Forward Plan to take forward the development of a delivery plan outlining system programmes of work as part of the 'giving every child and young person the best start in life' priority. This delivery plan would outline what the key Children & Young People transformation pieces of work would be for 2024-2026, pulling together what was going to done together across the Integrated Care Partnership to improve the lives of some of the most vulnerable Children & Young People.
6.4	As part of this, there was a need to ensure that the draft priorities (Child Development in the Early Years, School-Age Children Wellbeing, Long-Term Physical Conditions, Mental ill Health, Vulnerability, Risk and Complex Care and Family help) contained at 2.8 of the report were fully aligned to the wider

	commissioning strategies and strategic financial planning for next year and this process was still emerging but in the meantime focused discussions were taking place with every Locality over the coming few months to see how local priorities for children and young people could be reflected within the Greater Manchester plans and to discuss how this could be supported through local integration with neighbourhood and prevention programmes.
6.5	The following comments/observations were made by Locality Board members: - • The paper was extremely positive and it was useful to see a piece of priorities work specific to Children and Young people. There was a need to look at priorities from a short, medium and long term perspective (prioritising the priorities) linked to levels of risk and was a need to ensure mental health was given immediate attention. • The need to ensure that neuro assessments and speech and language therapy priorities are included and aligned with local work. • Reference made to the Circles of Influence Event that had taken place last week and the interesting discussions that had taken place around diagnosis and accessing services and support. • The need to develop shared outcome measures to ensure that the correct services are being commissioned with positive outcomes for Bury. Mr Botham commented that performance metrics should not be the primary focus of service delivery however a much wider set of measures from both a quantitative and qualitative perspective was required. The challenges associated with prioritising this work into a performance framework were discussed. • The importance for effectively engaging with the workforce when developing such outcome measures was outlined. There was also a need to further strengthen the role/reference made to the workforce as part of this overall work programme. • It was suggested that a further discussion on these priorities take place at the Childrens Strategic Partnership Board.
6.6	Thanked members for their contributions and reported that a further version of the Children & Young People Delivery Plan would be submitted to a future Locality Board meeting.

ft	Type	The Locality Board	Owner
D/03/05	Decision	Supported the ambition to adopt a whole system wide approach to the delivery of the 'Giving every child and young person the best start in life' part of the GM Integrated Care Partnership Joint Forward Plan in line with the Strategic Financial Framework.	
D/03/06	Decision	Considered and commented on the priorities as outlined in para 2.8 and how they align with Bury's locality priorities for Children & Young People	
D/03/07	Decision	Considered how Bury can support and adopt the development of a single system approach to the Children & Young People Joint Forward Plan in line with local, regional and national priorities for Children & Young People.	
A/03/03	Action	Further discussion on the priorities to take place at the Childrens Strategic Partnership Board.	Ms Richards
A/03/04	Action	Children & Young People Delivery Plan to be added as pending item to the Locality Board Forward Plan.	Mrs Kennett

6.	Overview of Thrive Journey & Children and Young People NHS Community Pathways Waiting times
6.10	Ms Case, Programme Manager, Bury was in attendance and submitted a presentation in relation to the Thrive Journey Children and Young peoples NHS Community Pathways waiting times.
6.11	The presentation provided further details in relation to: -

	• The Thrive journey to date. • The myHappymind action taken in Bury • The Thriving in Bury Digital App and Campaign including work in relation to 'padlets' • Pathways • Progress made with the CAMHS service • Workforce • The Co – production undertaken with Children and Young People and Families • Waiting times with progress made in reducing waiting times in some areas through transformed service and additional capacity • Next steps including discussions via the Strategic Partnership Board.
6.12	The following comments/amendments were made by Locality Board members: - • Query as to why the 'Drop in Session' approach was being repeated. Ms Case confirmed that this approach was part of the new model and there was data available to validate this neighbourhood approach. It was noted that there was also an option to refer into the CAMHS service in addition to the 'Drop in' element. There would be a 6 month review of the service. • A question raised as to how children and young peoples support operated in terms of targeting children who may have issues with school attendance. Ms Case explained how this worked in terms of engagement with the local schools. • The need to seek further clarity on the timescales associated with the ADHD service developments at GM ICB level and assess how this will impact locally in terms of the service offer, resources and funding. Ms Case updated on the early adopter work being undertaken in Bury in respect of the Portsmouth Model which was being discussed further via the Mental Health Programme Board.

ID	Type	The Locality Board	Owner
D/03/08	Decision	Noted the presentation and comments made.	

7.	Integrated Delivery Collaborative Update
7.1	Ms Wynne-Jones presented the latest Integrated Delivery Collaborative Update to the Locality Board. It was reported that: - • Work continued in developing the 25 priorities for the IDC for 24/25 with further details included within Section 2 of the report. • A benchmarking exercise of offers across the PCN's and neighbourhoods had been undertaken and discussions had commenced to describe and align the neighbourhood development programme • A process had commenced in conjunction with the Associate Medical Director to align the 11 available clinical sessions to the programmes of work detailed within the report in addition to clinical capacity also available from providers, the PCN's and GP neighbourhood leads. • Specific focus had been given to the elective programme and how it focused on the system architecture to support effective demand management, and the implementation of the national and GM clinical interface guidance . This work was progressing across the NCA footprint due to the construct of elective services through the 4LP. • Preparation for the VCSE and IDC workshop in April 2024 was underway. • The team was supporting system wide discussions to enable a shared understanding and risk management approach of proposed changes to the Primary Care Locally Commissioned Services Contract.
7.2	The following comments/amendments were made by Locality Board members: - • A question raised in relation to Cambeck close and whether this was being prioritised. Mrs Wynne-Jones commented that this was not included as part of this particular set of priorities however was being considered as part of the Learning Disabilities work programme. • A query as to how these priorities linked with the wider Health and Care priorities. Mrs Wynne-Jones explained that this work had focused on the priorities of the Neighbourhood teams however these would need to connect to the Public Service Leadership priorities.

ID	Type	The Locality Board	Owner
D/03/10	Decision	Note the progress of the strategic developments and progress of the programmes	

8.	ICP People and Communities Strategy
8.8	Ms Mitton, Ms Tomlinson and Mr Webb submitted and discussed a report with members in relation to the ICP People and Communities Participation Strategy.
8.2	The paper set out: - • the draft People and Communities Participation Strategy for discussion and feedback seeking an understanding of how it should be implemented in Bury and any wider context. • proposed actions to further strengthen joint delivery with the local VCSE and faith based organisations as equal partners aligned to the commitments of the GM Accord and GM Fair Funding Protocol.
8.3	It was highlighted that the People and Communities Participation Strategy set out a new vision and ways of working with local residents and communities and focused on building a long-term systematic model for participation in health and care. It described how work would be carried out with partners and individuals to understand what matters to them; find the solutions to the challenges; and better enable participation in discussions and decisions about health and services.
8.4	Ms Mitton commented that Children and families had not been fully recognised within the initial draft of this strategy and this was now being addressed following feedback from other localities as part of similar Board discussions.
8.5	Mr Webb emphasised that this strategy and partnership approach was welcomed and would be key in tackling health inequalities within the borough.
8.6	Ms Tomlinson provided a voluntary sector perspective on the strategy and highlighted the need to meet local commitments to the GM Accord including commitment in relation to the formation of a pooled investment pot which recognises the role of the VCSE sector and empowers VCSE sector organisations to build on and create new solutions to support the lives of local residents. It was reported that Bury would be holding the next Accord forum meeting following previous meetings in Tameside and Salford. There would be an opportunity as part of this meeting to showcase some of the anti poverty work undertaken locally.
8.7	The following comments/observations were made by Locality Board members: - • Mrs Ridsdale expressed concern that the paper presented did not fully reflect the local progress being made including the good work around Marmott, the Community Strategy and the Elephants Trail which was underpinned by the Lets Do it Strategy. There was a need to ensure that local momentum was not lost as part of this proposed approach. Mr Blandamer commented that the joint presentation of the report was intended to demonstrate some of the good work being undertaken locality although acknowledged that the paper had not explicitly covered all areas of work. Ms Mitton stated that the strategy was intended to support localities and was not intended to unpick any of the good work being undertaken within localities. • The idea of 'sharing power' was positive and would be interesting to hear more on this following the first decision that is taken. • Mr Heppolette highlighted that part of the challenge of being a new organisation was making that initial offer back into localities setting out some general principles whilst acknowledging the different approaches and priorities across the localities. Proper translation and mobilisation is therefore required. • It would be helpful to have a more detailed discussion on this strategy at the next Health and Wellbeing Board.

ID	Type	The Locality Board	Owner
D/03/11	Decision	Discussed and commented on the strategy.	

A/03/05	Action	A more detailed discussion on this strategy to take place at the next Health and Wellbeing Board meeting.	Mr Hobday/Ms Mitton

9.	Bury Serious Violence Duty – Delivery Plan 2024/25
9.1	Mr Woodhouse, Strategic Partnerships Manager, Bury Council was in attendance to support the presentation of the paper in relation to the Bury Serious Violence Duty – Delivery Plan 2024/25.
9.2	It was reported that the Serious Violence Duty required statutory local services to work together to share information and target interventions to prevent and reduce serious violence. The Duty required local areas to develop a Joint Strategic Needs Assessment and subsequent delivery plan to set out how specified authorities, including local health partnerships, would work with local communities on tackling serious violence locally.
9.3	It was noted that Bury Community Safety Partnership had been actively involved with regional colleagues to share a regional Strategic Needs Assessment and the 'Greater than Violence' Greater Manchester Serious Violence strategy, from which work has taken place to develop a localised version of the needs assessment and a draft delivery plan for 2024/2025 which was presented within this report.
9.4	The health ecosystem was recognised as a key partner in the identification, prevention and targeted response to serous violence, and colleagues were asked to ensure system awareness of, and leadership on, activities to prevent violence and mitigate impacts where and when it occurs.
9.5	The following comments/amendments were made by Locality Board members: - • A question as to what co-production had taken place in developing this plan. Mr Woodhouse outlined the approaches that had been taken in developing this plan including links to the circles of influence within the safety agenda, work with schools (targeting both children in and out of school) and continuing work beyond 18 years old. • An offer of support from Ms Caudle from an NCA perspective and how the trust can feed into this work. Mr Woodhouse agreed to link in with Ms Caudle directly in relation to this offer.

ID	Type	The Locality Board	Owner
D/03/12	Decision	Reviewed the draft delivery plan in context of the Bury Serious Violence Strategic Needs Assessment	
D/03/13	Decision	Confirmed leadership commitment to addressing the priorities set out in the Plan	
D/03/14	Decision	outlined further prevention and early intervention activities from a health and care system perspective to contribute to the desired outcomes	
D/03/15	Decision	supported increased participation and membership through the Bury Serious Violence Steering Group	
A/03/06	Action	Mr Woodhouse to link in with Ms Caudle regarding NCA input into the Bury Serious Violence Duty – Delivery Plan 2024/25.	Mr Woodhouse

10.	Health & Wellbeing Board update – Population Health & Wellbeing
10.1	Mr Hobday provided a verbal update in relation to Population Health & Wellbeing agenda and recent discussions at the Health and Wellbeing Board.
10.2	It was reported that a paper in relation to the Outcomes framework for the health inequalities, and for the children's strategic partnership board would be submitted to the Locality Board meeting in April 2024. Further details should be available at this point following the budget announcements as to whether the Household Support fund would continue as this was risk for the locality and equated to around £3M in terms of support given to the most vulnerable.

ID	Type	The Locality Board	Owner
D/03/16	Decision	Noted the update.	

11.	Strategic Finance Group Update
11.1	Mr O'Hare presented the latest report to update members on the financial position of the 3 statutory bodies who primarily serve the population of Bury, along with that of NHS Greater Manchester Integrated Care (NHS GM).
11.2	It was reported that there was an improved position across all providers with the position having stabilised however financial challenges remained. Bury Council were anticipating delivery of a break even position at 31st March and Pennine Care a surplus, with Northern Care Alliance, NHS GM and the Bury locality within NHS all forecasting a deficit position. NHS GM has agreed a deficit year end position of £180m with NHS England of £180m, which would need to be repaid starting from 2025/26.
11.3	Financial plans for 2024/25 were currently being developed with each of the statutory organisations at different stages due to the regulatory frameworks that apply to them, with the Budget Council having approved the council financial plan for 2024/25 and all NHS organisations working to national planning deadlines which budgets not yet known which made decision making difficult.

ID	Type	The Locality Board	Owner
D/03/16	Decision	Noted the contents of this report, the challenging financial positions in all partner organisations in 2023/24, and the agreed council budget for 2024/25 and the continued challenging outlook for 2024/25.	

12.	Performance
12.1	Mr Blandamer presented the latest Performance Framework to the Locality Board and welcomed any questions from members. No questions on the report were received.
12.2	It was reported that the format of this report had remained the same despite a standard Greater Manchester format having been developed. It was noted that further work on this report would be required prior to the report being adopted locally in Bury.

ID	Type	The Locality Board	Owner
D/03/17	Decision	Noted the latest Performance report	

13.	Pharmacy First
13.1	Mr MCCaul was in attendance to provide an overview of the Pharmacy First Scheme.
13.2	It was reported that: - • Last year, the Government and NHS had promised a £645m investment in community pharmacies over the next two years to support a pharmacy common conditions services along with the NHS Pharmacy Contraception and NHS Hypertension Case-Finding services • There was a requirement for a Launch of Pharmacy First to take place by the 31st January 2024 as part of which community pharmacies could supply prescription-only medicines for seven common conditions. It was noted that his together with Pharmacy oral contraception and Blood Pressure expansion could save 10 million appointments in general practice a year once scaled, subject to consultation. • In Bury, a 'soft launch' had been implemented whilst all of the pathways were being worked through and tested. At present, access to the scheme was through GP referral however would be a move towards a walk in service once all issues had been worked through. • NHS England had released some early figures in relation to use of the Scheme which had seen an increase in pharmacy contacts (650) for February 2024 in respect of referrals for common ailments. • An Operational plan was in place to coordinate communications, stakeholder engagement, contractor support , training events, GP/CP drop-in sessions, data analysis, reporting /clinical assurance. • There were some national viability issues in the Pharmacy sector linked to historic funding/capacity issues with some of the larger pharmacies having pulled out of the market/closed shops in recent times.

13.3	The following comments/observations were made by Locality Board members: - • A question as to whether all pharmacies within the locality had signed up to the scheme. It was reported that all pharmacies with the exception of one had signed up to the scheme within Bury. • A Task and Finish Group had been set up under the GP Collaborative to support the Repeat Prescribing/workforce efficiencies elements of the scheme. • Clarification requested as to whether the scheme was likely to bring overall benefits to the Locality in the medium to long term. It was reported that the 'soft phase' would be key in terms of ensuring that all pathways were correct ahead of any wider launch. It was noted that collaboration with Neighbourhood Boards and GP Practices would be crucial in supporting the schemes success. • This felt like an overall positive step in the right direction from a preventative perspective in terms of reducing unnecessary GP appointments/hospital admissions however the current financial climate and challenges in respect of premises, IT and Workforce could make this difficult to achieve. There was a need to keep this scheme under review and monitor activity and funding flows. • Whether this model could increase health inequalities in light of the potential for more health literature people benefiting from this scheme. It noted that unfortunately localities had no control over the model as this had been agreed nationally with localities tasked with rolling the scheme out.. • It would be helpful to view the Asset maps from a pharmacy perspective as previously discussed at the *Lets Do it Challenge.* Mr Hobday commented that this linked to the Pharmacy Needs Assessment and would share this map with Locality Board members in due course. • There was a need to think about the pharmacy messaging required from a provider perspective should people present at the Urgent Care Treatment Centre. It was agreed that Mr MCCaul should link in with Ms Allen at the NCA to address this matter. Ms Wynne-Jones stated that there was an ED strand on one of Task & Finish Groups and would be able to confirm whether this specific element was being picked up if required.

ID	Type	The Locality Board	Owner
D/02/12	Decision	Received the updates.	
A/03/07	Action	Asset maps including pharmacy to be shared with Locality Board members.	Mr Jon Hobday
A/03/08	Action	Mr MCCaul to link in with Ms Allen at the NCA to address this matter in terms of pharmacy messaging from a provider perspective should people present at the Urgent Care Treatment Centre. Ms Wynne-Jones would also be able to confirm whether this specific element was being picked by one of the existing Task & Finish Groups.	Mr McCaul/L Allen/K Wynne Jones

14.	System Assurance Committee update
14.1	Mr Blandamer submitted the latest System Assurance Committee update from the January 2024 meeting. It was reported that: - • Three was ongoing work in relation to further developing Locality Risk Management process in the context of the new system. There was a meeting in relation to Corporate/Operational Risks at the end of January 2023 to review these risks to ensure that there was no duplication across workstreams/Transformation Programmes. The IDC had reviewed the risks to ensure they were aligned to programmes with the aim to have a further discussion the next Risk Performance and Scrutiny Group to ensure that this is comprehensive and reviews/updates are consistent going forward.

ID	Type	The Locality Board	Owner
D/02/13	Decision	Received the update.	

	15.	Closing Items
		• Any Other Business NCA Executive Representative – Locality Board

15.1	Ms Caudle informed members that there has been some internal executive changes at the NCA therefore Ms L Allan would be the NCA representative at the Locality Board from April 2024. Members noted this information.

ID	Type	The Locality Board	Owner
D/02/16	Decision	Noted the information and the meeting in public was closed at 5.55pm.	

Locality Board

Action Log – March 2024

Status Rating: In Progress | Completed | Not Yet Due | Overdue

Date	Reference	Action	Lead	Status	Due Date	Update
5th February 2024	A/02/01	Revised Terms of Reference to be submitted via respective NHS and Council governance arrangements.	Mrs Kennett/Ms Braithwaite	✓	March 2024	Changes approved via Council Governance. Changes approved at the GM Board meeting on the 20th March 2024..
4th March 2024	A/03/01	Meeting to be arranged between Mr Heppolette, Dr Patel and Mr Blandamer to discuss the LCS issues further.	Mr Blandamer	▶	March 2024	8/3/24 - Mr Blandamer Emailed K Patel and W Heppolette regarding need for a meeting. Mr Blandamer to update on latest position at meeting.
4th March 2024	A/03/02	A further update on the LCS would be provided to the next Locality Board meeting in April 2024.	Mr Blandamer	✓	April 2024	Included on the draft April agenda.
4th March 2024	A/03/03	Further discussion on the Childrens priorities as outlined in the GM report to take place at the Childrens Strategic Partnership Board.	Ms Richards	▶	May2024	
4th March 2024	A/03/04	Children & Young People Delivery Plan to be added as pending item to the Locality Board Forward Plan.	Mrs Kennett	✓	March 2024	Added to Forward Plan

Status Rating: In Progress | Completed | Not Yet Due | Overdue

Date	Reference	Action	Lead	Status	Due Date	Update
4th March 2024	A/03/05	A more detailed discussion on the ICP People and Communities Participation Strategy to take place at the next Health and Wellbeing Board meeting.	Mr Hobday		June 2024	
4th March 2024	A/03/06	Mr Woodhouse to link in with Ms Caudle regarding NCA input into the Bury Serious Violence Duty – Delivery Plan 2024/25.	Mr Chris Woodhouse		March 2024	
4th March 2024	A/03/07	Asset maps including pharmacy to be shared with Locality Board members.	Mr Jon Hobday		April 2024	
4th March 2024	A/03/08	Mr MCCaul to link in with Ms Allen at the NCA to address this matter. Ms Wynne-Jones would also be able to confirm whether this specific element was being picked by one of the existing Task & Finish Groups.	Mr Fin McCaul		March 2024	

Meeting: Locality Board			
Meeting Date	08 April 2024	**Action**	Receive
Item No.	5	**Confidential**	No
Title	Place Based Lead Update - Key Issues in Bury		
Presented By	Lynne Ridsdale, Place Based Lead		
Clinical Lead	Dr Cathy Fines		

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

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

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

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

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

1. Ofsted/CQC inspection of SEND arrangements.

We continue to wait for the formal publication of the Ofsted and CQC inspection from February. In the meantime, work continues on an improvement journey to strengthen the support for children, young people and families in the borough. Deborah Glassbrook will be independently chairing a SEND improvement board and we will ensure all partners in the health and care system have an opportunity contribute to its work. Regardless of the formal publication of the report, areas of potential improvement identified in the inspection period itself have been identified and are being addressed.

2. HV investment

The Locality Board will recall the prioritisation of childrens services in the year 23/24 and the receipt of a proposal identifying the need for investment in the Health Visiting Service in the borough – which has benchmarked with statistical neighbourhoods relatively poorly in terms of capacity. I am pleased to advice the Council meeting in March endorsed the budget for 24/25 and has committed £300k investment in the HV service from NCA. This is less than identified in the original case but is nevertheless welcomed and work is progressing between Council and NCA colleagues, and with others, to ensure it is used most effectively.

This investment, alongside work on the pathway mapping of the first 1001 days, and the potential roll our of family hubs in the borough, and the parenting strategy, form the component parts of a more comprehensive early years proposition for Bury and the start well sub group of the Childrens Strategic Partnership Board will be re-launched to provide oversight.

3. Locality assurance

NHS GM have developed a proposal for the assurance of delivery of functions delegated to localities. This will be a quarterly place-based assurance process will enable the ICB to gain assurance of locality delivery against delegated responsibilities and appropriate mitigation and oversight against emerging risks. It forms part of the overall system oversight system for Greater Manchester. It is proposed that the model will operate consistently with the recently established GM Provider Oversight process.

There is further work required to understand how this will work in practice – it is important that a place assurance process for example that relates to some aspect of the oversight of provider performance in a locality does not duplicate ICB provider assurance arrangements. There is also work to do to ensure the GM ICB assurance of localities is undertaken in accordance with the values of collaboration the ICB is committed to.

In Bury we will look to take a pragmatic approach to assurance process, avoiding unnecessary duplication. The Locality board will be updated accordingly.

4. **NHS planning.**

The Operational Planning Guidance for 2024/25 was released on 27th March. The table overleaf sets out the national objectives for 2024/25. These will be the basis for how NHS England will assess the performance of the NHS alongside the local priorities agreed by ICSs. Work is being undertaken to compare the GM submission with the new planning guidance to summarise key areas of concern.

In Bury we reviewed an operational planning priorities submission at the March locality board, and in this meeting, we will review the draft operational plan for 24/25 for NHS GM (developed in advance of the national planning guidance being received).

BURY INTEGRATED CARE PARTNERSHIP

5. Urgent Care System Performance

The urgent care system in Bury has performed relatively well in the post Xmas period and throughout the Easter bank holidays, and the daily system calls continue to be an important point of multi-agency working. I would like to thank all partners for their contribution.

The target of 76% waiting less that 4 hours in A&E has been missed at FGH as well across NCA and across GM as a whole. As always, the Bury system recognises this as a system responsibility not just at NCA responsibility. A number of steps are being taken around strengthened deflection work, A&E staffing, a model of continuous flow within the hospital, the full roll out of the National Front runner discharge programme, additional mental health provision in the hospital (crisis response), and improved discharge arrangements. The Bury system will continue to strive to improve the operation of the whole urgent care system, as a partnership team, including the A&E access targets.

6. Locally Commissioned GP Services.

Further to conversation at the March Locality Board, the Board can be advised that the Primary Care Commissioning Committee finalised the LCS arrangements for 24/25 without removing two important primary care-based services – dementia assessments and ring pessary services. This was achieved in a number of technical adjustments to the standards and payment arrangements, and notably through the support of NHS GM in recognising the two services as best practice in terms of 'left shift' to a primary care led system.

It will be noted that the Bury primary care commissioning committee formally operates as a subcommittee of the GM Primary Care Commissioning Committee, and the report of the Bury meeting to GM PCCC makes the following points:

1) Bury support a degree of standardization of LCS terms in pursuit of GM strategic intent. However, there must be due regard to differential levels of funding available, and there must be progress towards consistent funding availability.
2) That difficult decisions are being forced on poorly funded localities including potentially reduction of service provision where such primary care-based service provision is exactly reflective of the 'left shift' intent of the ICB, and work needs to be undertaken to explore every opportunity to invest in primary care provision and away from secondary care-based services where it is financially and clinically appropriate.
3) That we recognise that the proposal constitutes a year 1 implementation and support for the model from the Bury Primary Care Commissioning Committee for year 2 will be contingent on significant progress being made on the two points above.

7. GM Devolution Evaluation

Locality Board may be aware that last week a unique study evaluating the changes in Greater Manchester from 2016 to 2020 compared to the rest of England, was published in the journal of Social Science & Medicine. The study led by the University of Manchester builds on previous evidence by investigating how changes in the health system may have led to increases in life expectancy in Greater Manchester over this period, analysing 98 measures of performance. It was funded by The Health Foundation and supported

by the National Institute for Health and Care Research (NIHR) Applied Research Collaboration Greater Manchester (ARC-GM).

The potential of locally driven integration and collaboration is clear in this report. The Greater Manchester Integrated Care Partnership (GM ICP) and other integrated care systems across the country will learn from these findings. Overall, the evaluation confirms that real progress was made in the following areas:

• Improvements in population health - life expectancy, healthy life expectancy, and self-reported wellbeing all improved from April 2016 to the start of the COVID pandemic in February 2020. Those improvements in life expectancy were larger in localities with high levels of deprivation and low baseline outcomes.

• measures associated with social determinants of health improved, including reductions in alcohol related admissions, reductions in crime, higher levels of school attainment, and higher employment rates

• Cancer screening rates also increased towards the national average despite limited changes in public health spending and other measures of public health performance

• There was also evidence of improvements in adult social care effectiveness and satisfaction, despite decreases in expenditure and staff, and improvements in primary care access and patient centeredness

According to the study, there were.

- 11.1% fewer alcohol related hospital admissions,
- 11.6% fewer first-time offenders,
- 14.4% fewer hospital admissions for violence,
- and 3.1% fewer half school days missed from 2016 to 2020.

Same day GP appointments increased by 1.8% and unplanned A&E re-attendances were 2.7% lower, in line with increases in the GP and hospital workforce. Cancer screening rates also improved.
Adult social care effectiveness and overall satisfaction also improved by 17.6%, despite decreases in expenditure and staff.

However, adult obesity increased by 7.6% and median wait times for A&E treatment worsened by 12.2%. There were also mixed impacts of devolution on outpatient, mental health, maternity, and dental services.

The positive changes, argue the researchers, are likely to have been a result of different aspects of the Greater Manchester devolution deals. This study has important implications for integrated care systems however there are key differences between the setup of the GM Partnership and the organisation of Integrated Care Systems which are acknowledged. The University of Manchester has issued a media release about the evaluation, which will be published here.

Lynne Ridsdale
Place Based Lead
April 2024

BURY INTEGRATED CARE PARTNERSHIP

Appendix 1 – NHS Operating Standards 24/25

Area	Objective
Quality and patient safety	• Implement the Patient Safety Incident Response Framework (PSIRF)
Urgent and emergency care	• Improve A&E waiting times, compared to 2023/24, with a minimum of 78% of patients seen within 4 hours in March 2025
	• Improve Category 2 ambulance response times to an average of 30 minutes across 2024/25
Primary and community services	• Improve community services waiting times, with a focus on reducing long waits
	• Continue to improve the experience of access to primary care, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within 2 weeks and those who contact their practice urgently are assessed the same or next day according to clinical need
	• Increase dental activity by implementing the plan to recover and reform NHS dentistry, improving units of dental activity (UDAs) towards pre-pandemic levels
Elective care	• Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest (except where patients choose to wait longer or in specific specialties)
	• Deliver (or exceed) the system specific activity targets, consistent with the national value weighted activity target of 107%
	• Increase the proportion of all outpatient attendances that are for first appointments or follow-up appointments attracting a procedure tariff to 46% across 2024/25
	• Improve patients' experience of choice at point of referral
Cancer	• Improve performance against the headline 62-day standard to 70% by March 2025
	• Improve performance against the 28 day Faster Diagnosis Standard to 77% by March 2025 towards the 80% ambition by March 2026
	• Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028
Diagnostics	• Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%
Maternity, neonatal and women's health	• Continue to implement the Three-year delivery plan for maternity and neonatal services, including making progress towards the national safety ambition and increasing fill rates against funded establishment
	• Establish and develop at least one women's health hub in every ICB by December 2024, working in partnership with local authorities
Mental health	• Improve patient flow and work towards eliminating inappropriate out of area placements
	• Increase the number of people accessing transformed models of adult community mental health (to 400,000), perinatal mental health (to 66,000) and children and young people services (345,000 additional CYP aged 0–25 compared to 2019)
	• Increase the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies to 700,000, with at least 67% achieving reliable improvement and 48% reliable recovery
	• Reduce inequalities by working towards 75% of people with severe mental illness receiving a full annual physical health check, with at least 60% receiving one by March 2025
	• Improve quality of life, effectiveness of treatment, and care for people with dementia by increasing the dementia diagnosis rate to 66.7% by March 2025
People with a learning disability and autistic people	• Ensure 75% of people aged 14 and over on GP learning disability registers receive an annual health check in the year to 31 March 2025
	• Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, to the target of no more than 30 adults or 12–15 under 18s for every 1 million population
Prevention and health inequalities	• Increase the % of patients with hypertension treated according to NICE guidance to 80% by March 2025
	• Increase the percentage of patients aged 25–84 years with a CVD risk score greater than 20% on lipid lowering therapies to 65% by March 2025
	• Increase vaccination uptake for children and young people year on year towards WHO recommended levels
	• Continue to address health inequalities and deliver on the Core20PLUS5 approach, for adults and children and young people
Workforce	• Improve the working lives of all staff and increase staff retention and attendance through systematic implementation of all elements of the People Promise retention interventions
	• Improve the working lives of doctors in training by increasing choice and flexibility in rotas, and reducing duplicative inductions and payroll errors
	• Provide sufficient clinical placements and apprenticeship pathways to meet the requirements of the NHS Long Term Workforce Plan
Use of resources	• Deliver a balanced net system financial position for 2024/25
	• Reduce agency spending across the NHS, to a maximum of 3.2% of the total pay bill across 2024/25

Meeting: Locality Board			
Meeting Date	8th April 2024	**Action**	Consider
Item No.	6	**Confidential**	No
Title	Draft Operational Plan - 2024/25		
Presenter	Will Blandamer/Kath Wynne-Jones		
Author	Warren Heppolette/Paul Lynch /Ruth Boaden /Zulfi Jiva		
Clinical Lead	N/A		

Executive Summary

The latest draft of the Operational Plan for 2024/25 is attached which describes the activities that NHS GM will undertake in 2024/5, including the information required by NHS England (NHSE) to describe how we will meet the national NHS objectives (including detail of finance, activity, performance, and workforce), within the context of the GM Integrated Care Partnership (ICP) Strategy1. It also describes activity that is being undertaken which will have impact in future years and ensure the long-term sustainability of the NHS within GM – this will be set out in more detail in our Sustainability Plan, covering a three-year period.

Recommendations

It is recommended that the Locality Board note the latest draft version of the Operational Plan for 2024/25.

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

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

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☒	N/A	☐

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

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

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

NHS Greater Manchester

NHS Greater Manchester

Operational Plan - Draft

2024-2025

Part of Greater Manchester Integrated Care Partnership

NHS Greater Manchester

NHS Greater Manchester

DOCUMENT TITLE	NHS GM Operational Plan 2024-5
DATE	20/03/2024
FILE CLASSIFICATION:	Draft
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AUTHOR/S:	Warren Heppolette Paul Lynch Ruth Boaden Zulfi Jiva

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CONTENTS

NHS Greater Manchester

1 Introduction

1.1 Purpose of Plan

This plan describes the activities that NHS GM will undertake in 2024/5, including the information required by NHS England (NHSE) to describe how we will meet the national NHS objectives (including detail of finance, activity, performance, and workforce), within the context of the GM Integrated Care Partnership (ICP) Strategy[1].

It also describes activity that is being undertaken which will have impact in future years and ensure the long-term sustainability of the NHS within GM – this will be set out in more detail in our Sustainability Plan, covering a three-year period.

1.2 Context

2024/25 will be the second full year of operation of Greater Manchester's Integrated Care System (ICS). The ICS was established in July 2022, building on the health and social care devolution arrangements in place in Greater Manchester since 2016.

Our ICP Strategy sets out how all partners will work together to improve the health of our city-region's people and outlines our missions, which are to:

- Strengthen our communities
- Help people get into – and stay in – good work
- Recover core NHS and care services
- Help people stay well and detect illness earlier
- Support our workforce and our carers
- Achieve financial sustainability

This plan described the actions we will take to address these priorities. However, we enter 2024/25 needing to address the most complex set of challenges that the health and social care system in Greater Manchester has faced. We must respond to an interconnected triple deficit:

- A growing population health deficit
- A performance and quality deficit
- An underlying financial deficit

To address this triple deficit, we are clear that we need to change what we do and how we do it. This means that our plan for 2024/25 must set out the steps we will take to improve population health, recover performance and quality standards and secure financial sustainability. We must make substantial and lasting progress in all three areas of the deficit in 2024/25.

[1] https://gmintegratedcare.org.uk/greatermanchester-icp/icp-strategy/

Whilst we plan to reduce the triple deficit significantly in 2024/25, we know that we cannot address it entirely within one year. This means that, in addition to this Operational Plan for 2024/25, we will develop a Sustainability Plan that charts our path to addressing all parts of the deficit, including returning the system to financial balance, over a three-year period.

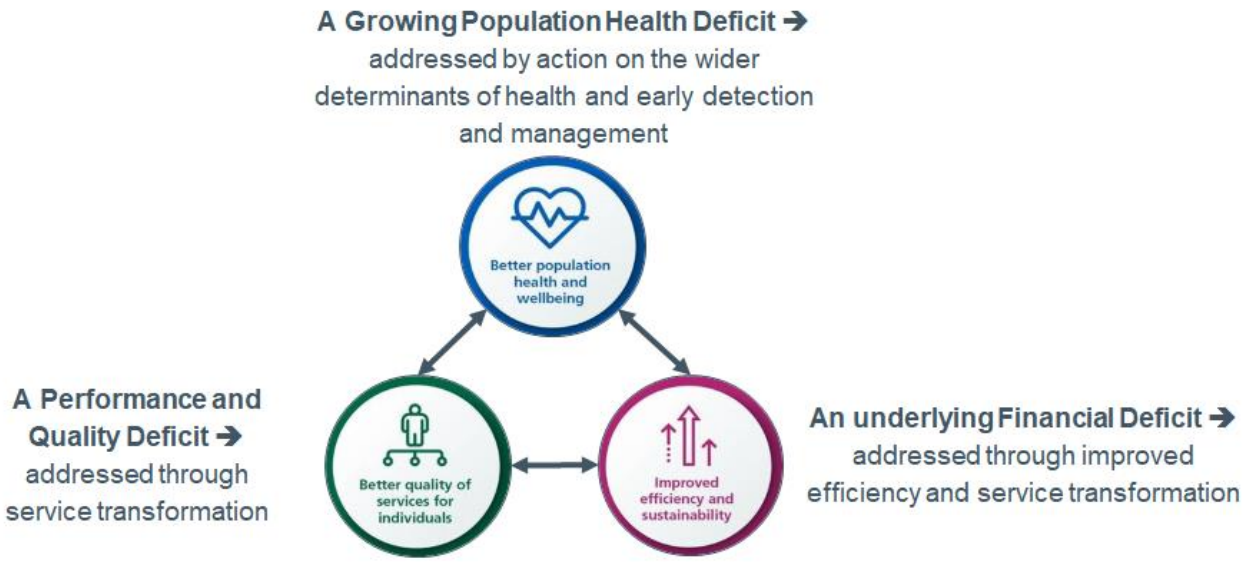
These plans are set in the context of our five-year Integrated Care Partnership Strategy and Joint Forward Plan – this Operational Plan represents the 2024/25 update of our Joint Forward Plan. Through our short, medium and long-term plans we must avoid escalating future costs through a system endeavour to improve population health, reducing demand on services as well as addressing current costs.

2 The Scale of the Challenge

2.1 The Triple Deficit

The challenge we face is that of an interconnected triple deficit (Figure 1). This relates to the NHS Triple Aim – a core objective for ICS – as illustrated below:

Figure 1



The scale of the deficit is significant – and it relates to both NHS GM as an organisation and the broader system.

The **population health deficit** includes:

- A projected 10% reduction in the proportion of the population on good health over the next 5 years, based on a 'do nothing' scenario.
- A projected doubling of the population with multiple long-term conditions over the next 5 years
- The continuing impact on health of the cost of living crisis and poverty

- The Greater Manchester Strategic Financial Framework[2], projects that the health of the population in Greater Manchester is likely to get worse in the next five years leading to an additional £1.9bn cost pressure for NHS services over and above our expected allocation. However, this can be addressed through a combination of population health measures and provider efficiencies.

The **performance and quality deficit** includes:

- Significant improvement needed in core national objectives across planned and emergency care
- Improvement needed in access to core mental health services and ending placements outside GM
- The challenges of recovering the 62-day cancer pathway
- Ongoing severe pressure on both adult and children's services
- Increasing demand on Primary Care

We face significant backlogs for care and support across a range of services – covering physical, mental and social health and well-being. We have a responsibility to our residents and patients to ensure that these backlogs, and the waiting times linked to them, are substantially reduced.

The **financial deficit** includes:

- An underlying financial deficit as we enter 2024/5
- Flexibility used in 2023/4 not available recurrently
- Huge challenges for local authorities to balance their books – within the national context of Section 114 notices[3]
- The continued financial pressure on the VCFSE sector (Voluntary, Community, Faith and Social Enterprise)

NHS GM has agreed with NHS England that it will carry a financial deficit of £180m in 2024/25 – we know that this must be paid back.

The three parts of the deficit are interrelated: decisions we make on a single element of the deficit will impact on the other two. This means that each decision we take must weigh up the impact on all three parts of the deficit.

All parts of the ICS will need to contribute to addressing the deficit. The principal role of each of the three main parts of the system is:

- Localities - driving population health improvement and prevention at scale.
- Providers - delivering core standards and planning for activity, workforce, and finance to improve productivity.
- NHS GM – overseeing the process and deploying our role as system commissioner to drive the changes needed.

[2] NHS GM Integrated Care Board Papers - February 2024
[3] https://commonslibrary.parliament.uk/what-happens-if-a-council-goes-bankrupt/

2.2 Our Approach to Addressing the Deficit

Working as a statutory ICS gives us the capabilities to act at scale to tackle all parts of the deficit. This includes:

- Accountability and Control – the range of statutory responsibilities we hold, and their attendant functions, to drive up performance and quality (see section 7)
- Collaboration, mutual aid, shared resource – based on the recognition that no one organisation or single part of the system is equipped to address the scale and complexity of the challenges we face. This approach is delivered through our operating model (see section 7.3)
- Place-Based, preventative care delivered at scale in neighbourhoods – driven through a single Locality Board and Place-Based Lead in each locality

This is underpinned by a system-wide approach to planning that aims to ensure that we produce a robust, aligned set of plans that maximise our available resources and are subject to detailed scrutiny and assurance (see section 7.2).

NHS Greater Manchester

3 Our plan for delivery: Summary

3.1 The Scope

Greater Manchester is one of only two ICSs in the country that are coterminous with a Mayoral Combined Authority. Mayoral Combined Authorities have a significant influence on the things that make us healthy - including jobs, skills, planning, housing, transport and air pollution – as set out in the Greater Manchester Strategy[4]. This means that we can use our collective resources to improve health across Greater Manchester and to focus on the social determinants of health. This is illustrated in our Model for Health (Appendix 2)

This Operational Plan contains details of how we will achieve the national NHS objectives (Appendix 1) as well as acting on the wider influences on health. These objectives cover the following areas:

- Urgent and emergency care
- Community health services
- Primary care
- Elective care
- Cancer
- Diagnostics
- Maternity
- Mental health
- People with a learning disability and autistic people
- Prevention and health inequalities
- Finance
- Workforce

Whilst it is vital that we ensure consistent delivery against these objectives, as an Integrated Care Partnership we must also seek to improve the health of the population through working in partnership with all parts of the system that contribute to good health – extending beyond the NHS. This means that this Operational Plan includes, for example, sections on Adult Social Care, Children and Young People as well as including how we will address the social determinants of health.

3.2 Population health

There are fewer national NHS objectives related to population health than the provision of NHS services, although it is a vital part of our approach to long-term system sustainability and the health and wellbeing of our population. We plan to meet the key NHS national objectives related to population health within the context of the approach described in section 4. The NHS objectives are one element of a wider approach to preventing ill health and supporting early intervention including partnership working to address the social determinants of health which is a core element of our strategy and our plans.

3.3 Performance

We is planning to meet the key performance requirements defined by NHSE in 2024/25 (as shown in Table 1, with details of all the objectives in Appendix 1), with the exception of the diagnostic waiting time requirements (see section 5.8).

[4] https://aboutgreatermanchester.com/the-greater-manchester-strategy-2021-2031/

NHS Greater Manchester

Table 1: GM Performance Plan for high level objectives 2024/25[5]

Performance	GM Plan
All department A&E performance Mar-25 (%)	77.0%
Elective 65w waits (Sep-24 waits)	0
Value Weighted Activity - including diverted pathways 2024/25 full year (% of 2019/20 baseline)	103.0%
62 day performance Mar-25 (%)	72.0%
Available G&A Beds Annual mean	6062

3.4 Workforce

A crucial part of both achieving our performance and finance objectives is our workforce. Our plans for meeting the national workforce requirements are shown in Table 2:

Table 2: GM Workforce Plans 2024-25[6]

Workforce	Plan FTE	Increase/ (decrease) in FTE
Expected Total Workforce Plan at Mar-25 FTE	88,674	(1,037)
Expected Substantive Staff in Post Plan at Mar-25 FTE	82,362	300
Expected Bank and Agency Plan at Mar-25 FTE5	6,312	(1,337)

3.5 Finance[7]

Our financial position at the end of 2024/5 is planned to be as shown in Table 3

Table 3

Finance	£m
2024/25 Plan Surplus/(Deficit) £m	(298.0)
Considerations:	
2024/5 Financial Efficiencies £m	434.8

[5] Data submitted to NHSE as part of high-level return on 29 Feb 2024
[6] Data submitted to NHSE as part of high-level return on 29 Feb 2024
[7] Data included in ICB Board paper for 20.3.24 meeting

4 Achieving System Sustainability through Prevention and Early Intervention

4.1 The Current Position

The health of the population of GM remains poor and is projected to deteriorate over the next five years. As well as negatively impacting the wellbeing and health outcomes of people living in GM, this deterioration in good health will further exacerbate current financial, operational and performance pressures.

Financial modelling suggests that a population health approach, focussed on 3 core preventive opportunities can make the biggest contribution to achieving financial and operational sustainability in GM over the medium term (3-5 years). Therefore, population health and prevention is an essential part of the solution now to achieve longer term financial and performance sustainability for GM.

NHS GM has a track record on delivering high impact population health and prevention activity. However, this renewed focus represents the opportunity to scale and spread this comprehensive approach, working as one across our system.

We are putting in place a **GM Multi-Year Prevention Plan** to maximise the population health and prevention opportunities with key deliverables agreed at system level. This will incorporate the work on the social determinants of health

We have worked with system partners to agree the actions we plan to undertake in year 1 (2024/25) where our focus will be on prevention of Cardiovascular Disease (CVD) and Diabetes. The evidence for prevention of CVD and Diabetes is clear and there is opportunity for us to act at scale

Our task at hand is not to duplicate efforts, but instead is to scale, systematise and work collectively to achieve the maximal preventative benefit whilst targeting and reducing unwarranted variation across the system.

The role of **place-based partnerships in our 10 localities** is integral to our endeavour to improve population health. The ICS Operating Model (see section 7.3) confirms the core role of localities in driving population health improvement and delivering preventative, proactive integrated models of neighbourhood care. This approach to neighbourhood working aligns with the broader Greater Manchester Public Service Reform agenda based on the recognition that all partners in the system need to contribute for us to turn the dial on the social determinants of health and well-being.

4.2 National NHS objectives

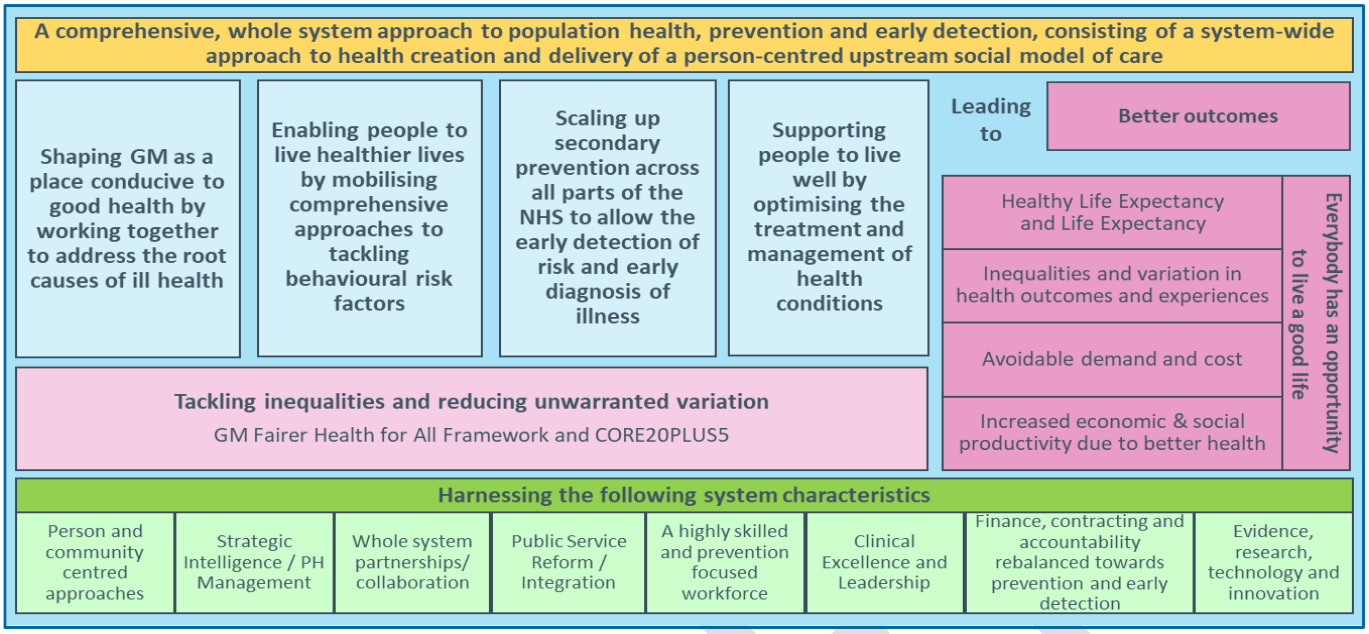
- Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2025
- Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%
- Continue to address health inequalities and deliver on the Core20PLUS5 approach

4.3 Our Prevention and Early Intervention Framework

The **GM Prevention and Early Intervention Framework** describes the comprehensive and whole system approach to prevention that is required to generate a step change in population level health outcomes. The Framework is outlined in Figure 2:

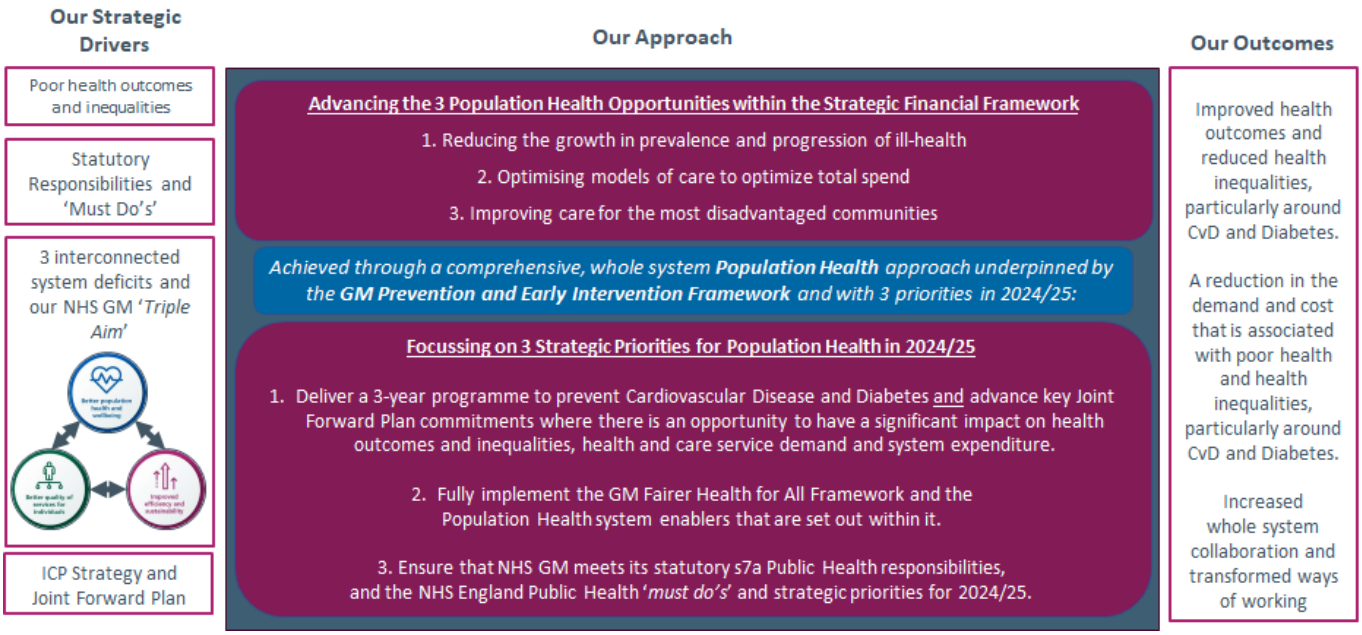
NHS Greater Manchester

Figure 2



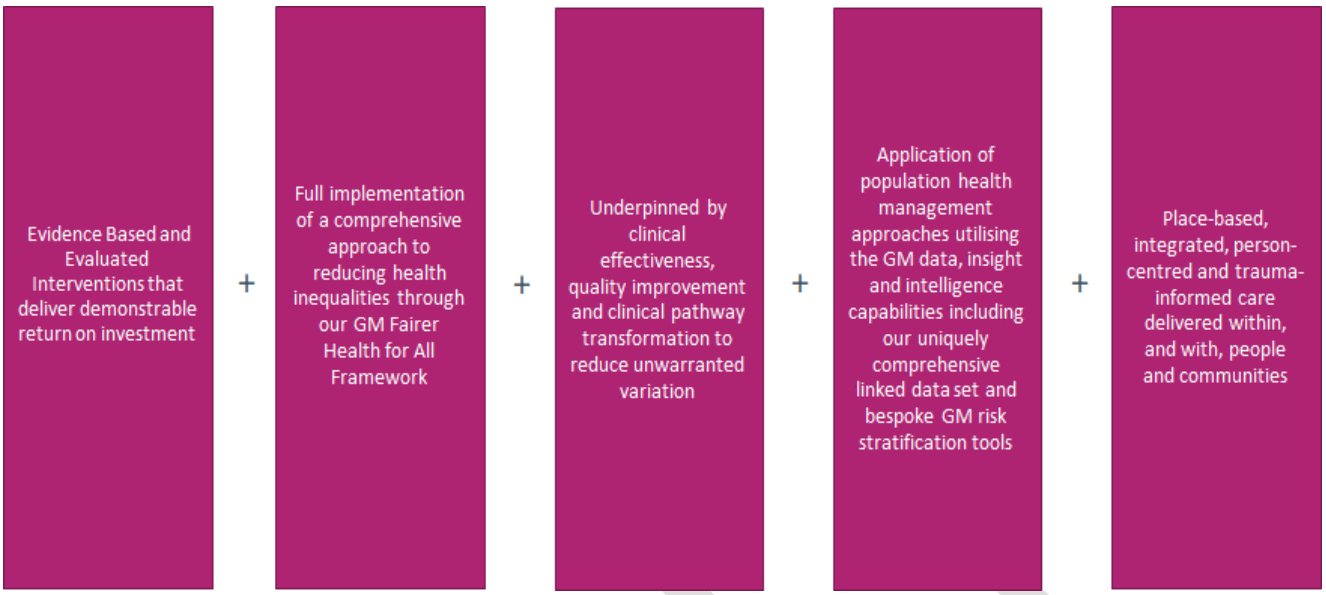
Our priorities for population health in the coming year will be delivered through a comprehensive, whole system approach underpinned by the GM Prevention and Early Intervention Framework. This is illustrated in Figure 3:

Figure 3



We know that **to deliver at scale** we need to focus on the five components shown in Figure 4

Figure 4



4.4 Key Actions for 2024/25 – What we will do once in GM

a) Create the system architecture required to drive the population health and prevention programme, which will underpin and enable system collaboration and learning; oversee delivery; and monitor and evaluate the impact of the system focus on population health and prevention.

b) Establish a population health management data programme to drive the intelligence required for full adoption of a population health management approach; to monitor and reduce unwarranted variation in outcomes; to identify and tackle where health inequalities lie in relation to CVD and diabetes to enable risk stratification of those at highest risk of poor outcomes.

c) Produce and embed digital tools to support the scaling of the prevention focus on CVD/diabetes.

d) Unlock collaboration and innovation at scale by partnering with Health Innovation Manchester (HInM).

e) Draw on skills from across the GM landscape to embed health economics within the multi-year population health and prevention programme.

f) Drive up quality of care and improve efficiencies with regards to population health and CVD and diabetes prevention through the creation of bespoke co-produced and tailored tools for health care professionals, supported by development of workforce competencies and associated educational programmes; as well as developing and implementing GM standards to monitor and improve quality of care.

g) Work with acute provider colleagues to describe the role of acute providers in the GM multi-year prevention plan – recognising that with current pressures a phased approach may be taken

h) Develop evidence-based and high impact public and patient communication and engagement campaigns to support the delivery of the prevention programme.

We will draw on the digital and innovation capabilities of Health Innovation Manchester, as a key partner, to deliver on this agenda. The main areas of focus, drawn from the Health Innovation Manchester priorities for 2024-27 are to:

- Address high priority system challenges and drivers of ill health, by deploying proven innovations in primary and secondary prevention in cardiometabolic and respirator
- Optimise digital products and services to support a shift towards prevention, secondary prevention and development of new models of care

4.5 Key Actions for 2024/25 – What we will do in Localities

a) Implement a population health management approach, delivered through integrated neighbourhood working, to deliver the evidenced based CVD and diabetes prevention interventions, focusing most on those most at risk and on those experiencing the most significant health inequalities in line with proportionate universalism.

b) Harness the capabilities of the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector in the implementation of this population health management approach within neighbourhoods.

c) Work with primary care to recover long term condition management for CVD and diabetes, with a focus on CVD and diabetes, for example through 2024/25 GP Quality Scheme LCS' and Primary Care Blueprint

d) Maximise prevention opportunities via integration across care interfaces at neighbourhood and locality levels and within primary, social, community, mental health and acute care settings to deliver the evidenced based CVD and diabetes prevention interventions.

e) Continue to work collaboratively at a local level, particularly with Local Government colleagues to tackle the key determinants of health and to shape the prevalence of modifiable risk behaviours.

All 10 localities have Locality Plans for health and social care in place – each reflecting the distinctive features of the locality. They are part of a suite of local plans – including place plans; local authority corporate plans; and health and well-being board plans. The plans share many consistent features, and all set out how partners, acting at place level – the only part of the system where we can bring together NHS and local authority spend – can operate at scale to focus on the social determinants and reduce demand on statutory services.

Each locality has outlined its priorities for 2024/25 – aligned to broader Greater Manchester strategy and plans. These priorities – combined with locality delivery of the system priorities of CVD and Diabetes, and local delivery of GM commissioning plans – form a Locality Delivery Portfolio for 2024/25.

4.6 The Expected Impact

A prioritised focus on CVD/diabetes prevention and early intervention at scale will lead to:

- An improvement in the health, and health outcomes, of our population.
- A reduction in health inequalities aligned to CORE20+5.
- High quality, personalised care delivered at, or close to home.
- A reduction in unwarranted variation

- A reduction in acute episodes of care, supporting the recovery of our performance.
- Financial savings realised over the medium term (three years)

In year 1, a focus on the prevention of CVD and diabetes will lead to a change in prescribing patterns and potentially impact on prescribing costs as the uptake of antihypertensives, anticoagulants, statins, diabetes medications and obesity drugs increase. These changes to prescribing patterns will not always mean new costs – for example, the cost-effective intervention may be prescribing the same drug but at a higher dose to yield better blood pressure or cholesterol control.

For example, every 1mmol/L of lower LDL cholesterol is 23% relative risk reduction in strokes[8]. Lowering blood pressure by 5 mmHg diastolic reduces the risk of stroke by an estimated 34% and ischaemic heart disease by 21%[9]. Further analysis of impact on health and service utilisation is ongoing using the Advanced Data Science Platform (ADSP) and will be available during the coming year.

Potential savings from optimisation of blood pressure and lipid management are shown in Figure 5:

Figure 5

Blood Pressure Optimisation	**Current Prevalence**	**Improvement to 70%**	**Improvement to 74%**	**Improvement to 77%**	**Improvement to 80%**
Potential **Heart attacks prevented** in 3 years	**Current GM position: 67.6%** of adult >18yrs with hypertension treated to target **Current England position: 66.7%**	80	155	228	301
Estimated savings (£)		Up to £0.6m	Up to £1.2m	Up to £1.2m	Up to £2.2m
Potential **strokes prevented** in 3yrs		119	232	341	44964
Estimated savings		Up to £1.7m	Up to £3.2m	Up to £4.7m	Up to £6.3m
Potential **deaths prevented**		64	124	183	241

Lipid Optimisation	**Current Prevalence**	**Improvement to 86%**	**Improvement to 90%**	**Improvement to 95%**
Potential **Heart attacks/stokes prevented** in 3 years	**Current GM position: 84.1%** of adult >18yrs with high cholesterol treated to target **Current England position: 82.3%**	162	497	915
Potential **deaths prevented**		20	60	110
Estimated savings (£)		100 strokes = £1.4m cost to NHS 100 heart attacks - £0.7m cost to NHS 100 strokes = £0.95m to social care		

This shift to upstream preventative care is far offset against the reduction in associated costs in acute health care settings, as well the personal costs to the individual and societal costs (due to economic inactivity for example). It is vital that the GM Multi-Year Prevention Plan is closely connected to commissioning intention workstreams to achieve the phase shift in investment.

Early in 2024/25, we will identify the prevention priorities for 2025/26 – early discussions have focused on respiratory and multimorbidity.

[8] Lowering blood pressure to prevent myocardial infarction and stroke: a new preventive strategy - NIHR Health Technology Assessment programme: Executive Summaries - NCBI Bookshelf
[9] Low-density lipoproteins cause atherosclerotic cardiovascular disease. 1. Evidence from genetic, epidemiologic, and clinical studies. A consensus statement from the European Atherosclerosis Society Consensus Panel - PubMed (nih.gov)

Through the GM Multi-Year Prevention Plan, we aim to undertake a phased approach to investment: starting with re-focusing areas of current spend towards prevention and transitioning, over time, to phased increase in upstream investment.

The primary budgets underpinning this work will, in year 1, include SCN SDF allocations, population health budget and allocations and a proportion of locality locally commissioned services for general practice being refocused on CVD and Diabetes.

4.7 Our plans to deliver the key actions

Our plans for population health and prevention are structured under three headings:

- Deliver a 3-year programme to prevent Cardiovascular Disease and Diabetes and advance key Joint Forward Plan commitments (particularly Missions 1 to 3) where there is an opportunity to have a significant impact on health outcomes and inequalities, health and care service demand and system expenditure.
- Fully implement our GM Fairer Health for All Framework and the Population Health System enablers that are set out within it, to meet the national objective of reducing health inequalities.
- Ensure that NHS GM meets its statutory s7a Public Health responsibilities, and the NHS England Public Health 'must do's' and strategic priorities for 2024/25

They are summarised in the following sections.

4.8 Prevention of CVD and diabetes

Full details of the activities to fulfil these plans are given in Appendix 3, Table 12.

4.8.1 Working with partners to tackle the Wider, Social and Commercial Determinants of Ill Health:

Health outcomes are largely shaped by the conditions in which people live and their experiences throughout their life. In relation to CVD and Diabetes, a whole system response requires a focus on mitigating the impact of poverty, increasing access to good employment and good housing, and reducing the impact of commercial activity, such as the advertising of junk food on transport and public sector advertising space. Examples of activities within the programmes include:

- Work and Health - establishing a GM Joint Inclusive Employment Unit (JIEU) which will be a joint unit consisting of GMCA, NHS GM, DWP and others with a remit to develop a joined up approach to reducing health related unemployment and improve rates of good employment. We are currently co-designing it and the plan is to begin to mobilise it in Q2 2024/25 culminating in a joint inclusive employment strategy by the end of 2024/25, shaping the work and skills elements of the GM Devolution Trailblazer deal. We will also be leading the planning and implementation of the GM WorkWell partnership vanguard.
- Tackling Poverty - Co-ordinate a GM approach to 'poverty proofing' health and care pathways
- Housing and Health - Develop integrated health and housing pathways
- Best Start / Children & Young People – see section 5.10
- Commercial Determinants - Support the development, and co-ordinate the implementation of,

proposals to implement Junk Food Advertising Restrictions

4.8.2 Tackling the top modifiable behavioural risk factors for disease:

There are a small number of behavioural risk factors which shape health outcomes and that these can be shaped and affected through multi-systemic interventions. In relation to CVD and Diabetes, this requires a specific focus on smoking, alcohol consumption, physical activity, and food and healthy weight. Examples of activities within the programmes include:

- Tobacco Treatment Services - support roll out of inpatient, maternity and mental health Tobacco Dependence Treatment Services
- Making Smoking History - publish a refreshed GM MSH 2030 Strategic Delivery Framework to ensure achievement of a smoke-free city region where less than 5% of people smoke by 2030
- Tackling Alcohol Harm - co-ordinate the development of a co-produced and evidenced based GM Alcohol Plan, ensure local alcohol harm services are integrated and provide end to end support to individuals with high levels of risk or need
- Increasing Physical Activity - oversee the 3-year (2024/25-2026/27) NHS GM contribution to the GM Moving Strategy
- Food and Healthy Weight - co-ordinate the development of a whole system 5-year Strategic Delivery Framework for Food and Healthy Weight (with a focus on Childhood Obesity),
- Improving Mental Wellbeing - lead the development and implementation of a co-designed delivery plan for the mental wellbeing strategic objectives of the GM Mental Health and Wellbeing Strategy.
- Ageing Well - Contribute to the implementation of the new GM Age Friendly Region Strategy.

4.8.3 Scaling up early detection and effective treatment with a specific focus on preventing CVD and Diabetes:

- We will prioritise evidenced based secondary prevention interventions for CVD and Diabetes in 2024/25. These are interventions that are predominantly clinical in nature and will occur during interactions with the health service. For example, these actions may range from focusing GP Quality schemes for 24/25 to deliver these key interventions, targeting NHS health checks using risk stratification tools such as QDiabetes or working with neighbourhood teams and VCSE and faith sector to overcome barriers to early diagnosis and treatment of certain communities.
- Enable real time access to health care records to facilitate proactive care driven by risk stratification and roll out the GM Cardiovascular Need Tool.
- Increase screening and early identification of at-risk populations to detect obesity, hypertension, high cholesterol, Atrial Fibrillation (AF) and Non-Diabetic Hyperglycaemia and Diabetes sooner
- Improve uptake, coverage and impact of NHS Health Checks and NHS Diabetes Prevention Programme (NDPP)/Healthier You and weight management programmes
- A summary of the secondary prevention interventions we will use is given in Table 4:

NHS Greater Manchester

Table 4

	Systematic Detection	Optimising Treatment
CVD	**Intervention = Systematic detection of the CVD 'ABCs'** A) **AF** – target 85% of the expected prevalence detected by 2029 B) **High Blood Pressure** – target 80% of the expected number of people with high BP are diagnosed by 2029 C) **High Cholesterol** – 75% people between 40-74 have received a cholesterol reading and CV assessment (QRISK) by 2029 Note: 2029 is the National Long Term Plan Target – our ambition is to achieve this sooner in GM	**Intervention = Optimising preventative treatment** A) **AF** – 95% people with known AF appropriately anticoagulated to prevent stroke by end of 2024/25 (Currently 90.68%) B) **High Blood Pressure** – target 77% of people with known high blood pressure treated to target by end 2024/25 (Currently 63.47%). C) **High Cholesterol** **Primary prevention:** • 70% of 40-74yr olds with QRISK >20% treated with a statin by end 2024/25 (Currently 67.26%) **Secondary Prevention:** • 90% of those with established CVD treated with a lipid lowering therapy by end of 2024/25 (Currently 83.65%) **Familial Hypercholesterolemia:** • 25% of those with familial hypertension treated with a statin by end of 2024/25
Diabetes	**Intervention = Healthier You (NDPP)** A) Achieve 150% of the profiled *referrals* to NDPP (14,900 places currently profiled per year for GM in national contract, current referrals are at 108%, there is capacity for up to 200%). B) 150% of the profiled 'milestone 1s' (7,450 programme *starts* profiled for GM per annum)	**Intervention = Structured Diabetes Education (SDE) Programmes** A) 10 % of people diagnosed with T1D in *attendance* at structured education for T1 diabetes within 12 months of diagnosis (2023 England average is 6.3% and current GM level is 3.1%) B) 15% of people diagnosed with T2D *attend* SDE within 12 months of diagnosis (2023 England average is 8.6% and current GM level is 4.5%)
	Intervention = NHS Health Checks A) Embed QDiabetes and a proportion of those with score >5.6 have HbA1c measured within 12m.	**Intervention = Scale up self-management through proactive digital support** A) >20% of the GM diabetes population registered on MyWay Diabetes[10] where they can access personal GP diabetes data and track care processes & treatment targets B) 100% of 18-39 yrs. T2D GM patients (7,000+) offered additional care reviews in line with the nationally funded T2DAY[11] programme.

[10] www.diabetesmyway.nhs.uk
[11] NHS England » NHS rolls out world-first programme to transform diabetes care for under 40s

4.8.4 Optimise the treatment and medical management of CVD and Diabetes

- Ensure the optimisation and management of known risk factors and established illness by implementing standardised equitable patient centred pathways and service specifications for Hypertension, Diabetes, Lipids, Chronic Kidney Disease (CKD) and Atrial Fibrillation.
- Optimise treatment to meet Hypertension, Cholesterol and HBA1c (a marker of diabetes control) targets and completion of all Diabetic 8 Care Processes

This will enable achievement of the two related NHS national objectives (Section 4.2):

- Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2025
- Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%

4.9 Implementation of the GM Fairer Health for All Framework

Full details of the activities to fulfil these plans are given in Appendix 3, Table 13.

Our GM approach to health inequalities involves the following:

- Fully implement our GM Fairer Health for All framework[12] that sets out our collaborative approach and priority action across the city-region to reduce health inequalities and ensure people have the best possible health and wellbeing, no matter who they are or where they live. It outlines key principles, alongside tools and resources for how we can collaborate, share, and learn across the system, and monitor progress through system wide outcome and assurance targets and metrics. The framework has been co-produced through extensive locality and community participation and engagement, and prioritises coordinated action to deliver against the six strategy missions and a roadmap for how we will:
  - Work together to fulfil statutory NHS responsibilities such as unlocking social and economic potential and delivering against Core20PLUS5 inequalities targets.
  - Enhance and embed prevention, equality, and sustainability into everything we do as a health and care system.
  - Tackle the discrimination, injustice and prejudice that lead to health and care inequalities.
  - Create more opportunities for people to lead healthy lives wherever they live, work and play in our city-region.
- Priorities in 24/25 are to develop the Fairer Health for All tools and resources and to scale investment in prevention and Health Inequality programmes enabling Fairer Health for All in action across neighbourhoods and localities. In 2024/25 we will:
- Implement the workforce development, leadership, intelligence, and governance tools that enable the system-wide implementation of the Fairer Health for All approach through the Fairer Health for All Academy, GM Health and Care Intelligence Hub and Fairer Health for All Assurance process.

[12] https://fairerhealthacademy.gmtableau.nhs.uk/file/fhfa-delivery-framework

- The Fairer Health for All Academy hosts a range of stories of change, examples of Fairer Health for All in Action and signposts to relevant training, shared learning and good practice across our neighbourhoods. Priorities in 2024 will be to develop inclusion health, poverty and leadership toolkits and to capture actionable insights from our neighbourhoods, localities and system groups by understanding the 'journeys of change'.
- The Fairer Health for All Fellowship programme[13] brings together representatives from across a diverse range of organisations to develop their knowledge and skills in population health, equality and sustainability, and put their learning into practice. Cohort 1 (16 Fellows) started in February 2024 for a 1 year programme (1 day per week), and a further cohort of 35 Fellows will be recruited in September 2024 (focusing on CVD and diabetes prevention).
- Hosting a range of web-based intelligence tools, the **Health and Care Intelligence hub** has been co-designed to powerfully consolidate data and insights from public and VCFSE sector partners across the city region into a single portal, enabling people and partners the opportunity to:
    - Bring data to life, understanding how health inequalities and variations in care change throughout a person's life
    - Focus on 'names not numbers' by capturing the insight and stories of change from different communities
    - Share wisdom and learning about which interventions work and why
    - Deepen understanding which communities have fewer opportunities to live healthily and are more likely to develop poor health by exploring the interactions between individual, family, and community factors
    - Ensure resources are targeted where needed, so policies and programmes can super-serve prioritised communities
    - Proactively work with communities to offer more opportunities to stay well and find and treat illnesses early
    - Measure progress, evaluate outcome indicators for different communities across various clinical pathways, and combine service data with community insights to understand reasons for poor access, unmet needs, and hidden harm
    - Model the anticipated impact of policies/interventions on different communities, protected characteristics, and environmental sustainability as well as costs vs benefits
- Continue to scale up and systematize Trauma Responsive and Person and Community-Centred Approaches including Social Prescribing, Live Well, Personalised Care, Creative Health
- Scale up and systematize the role of the VCFSE sector as a strategic partner and a provider of services
- Contribute to the implementation of the Primary Care Blueprint, particularly in relation to the Prevention and Population Health ambitions.

4.10 Ensure that NHS GM meets its statutory s7a Public Health responsibilities

Full details of the activities to fulfil these plans are given in Appendix 3, Table 14.

[13] https://fairerhealthacademy.gmtableau.nhs.uk/fellowships

- Improve uptake and access to cancer screening and childhood and winter vaccinations - commissioning and assurance of the 33 statutory NHS S7A Public Health programmes (12 screening, 18 immunisations and 3 other services including the child health information service), co-ordinating, commissioning and implementing the appropriate pan GM recommendations from the screening and immunisation insight report, for cancer screening/winter vaccinations/childhood immunisations.
- Improve the uptake of the MMR vaccination in population groups that have the highest risk of infection and outbreaks - continue to lead, co-ordinate and commission pan-GM activity, ensuring implementation of the GM MMR elimination strategy action plan
- Implement the national immunisation strategy and prepare the delegation of immunisations to the ICB.
- Co-ordinate and oversee the delivery of the current NHS GM Green Plan
- Ending New Cases of HIV by 2030 - oversee the commissioning and delivery of a 3-year plan to continue the prevention, intensive support, and effective treatment components within the wider programme to end all new cases of HIV in GM by 2030 as an international HIV Fast Track City
- Preventing Violence - co-ordinate the delivery and assurance of the statutory NHS GM requirements relating to Health and Justice including Liaison and Diversion, Reconnect and the Voluntary Attendance Pathfinder pilot, co-ordinate the delivery and assurance of the statutory NHS GM requirements and GM commitments relating to Gender-based Violence.

5 Achieving System Sustainability through Optimising Care

5.1 Optimising Care

This means providing care as effectively as possible (meeting the required NHS objectives) – with a focus on performance and quality improvement. Optimising care and the achievement of agreed performance objectives, and levels of activity, must be linked with the financial resources available, and the workforce, equipment and estates needed to provide those services.

We consider the provision of healthcare using the categories set out by NHSE in the objectives for the NHS, adding others as necessary to cover all aspects of healthcare provision. Where appropriate, details of our related Commissioning and QIPP (Quality, Improvement, Productivity and Prevention) programmes (see sections 5.13.1 and 6.2.2) are included here.

5.2 Urgent and Emergency Care

5.2.1 National Objectives

- Greater Manchester is **planning to deliver the national objective of 77%** of patients seen within 4 hours for all department A&E performance by March 2025.
- We also **plan to reduce adults general and acute (G&A) bed occupancy to 92%** or below by March 2025

5.2.2 Our Delivery Plans

- Further evaluation of virtual wards for 24/25 is planned, with a view to increase standardisation and identification of development opportunities, through our commissioning process. This may result in some alternatives to current pathways and service delivery. However, the aim is to maintain and improve community capacity.
- Locality driven schemes to focus on respiratory infections and extra capacity through UEC Capacity and Discharge funds, including ensuring that each locality supports further primary care provision.
- Continued monitoring of delayed transfer of care through the System Co-ordination Centre
- Work with NHS GM CYP networks to understand the opportunities for further improvement.
- National Tier 1 support to GM is focusing on flow and discharge improving pathways and processes in order to maintain good flow throughout the hospital. This will contribute to our ability to reduce G&A bed occupancy to 92% or below.

Our QIPP programme (see section 6.2.2) includes:

- Our plan to reduce **No Reason to Reside (NRTR)** to the national average. This will involve a reduction of approx. 500 beds occupied/day with a status of NRTR. Initial scoping work is looking at the opportunities and impact on the 4 hour target, the elective recovery work, the removal of escalation beds and increased utilisation of the virtual wards. Improve flow will lead to increased elective activity, reduced backlogs, and potential for increased Elective Recovery Fund (ERF).
- Review of **Step up Step Down (SUSD**) provision, with the potential for radical transformation under the community services review (see section 5.3). A primary/community care based model could be

established in localities with Primary Care Networks (PCNs), same day emergency care (SDEC) and their discharge to assess (D2A) services.

5.3 Community Health Services

5.3.1 National Objectives

- GM is **planning to consistently meet or exceed the 70% 2-hour urgent community response** (UCR) standard
- We will reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals

5.3.2 Our Delivery Plans

- All GM localities have full geographical coverage 8am-8pm 7 days per week with some exceeding this, with a plan to increase referrals into 2hr **UCR** provision from all sources including Primary Care and Care Homes, with a particular focus on 111 and 999.
- We will increase the use of **SDEC (Same Day Emergency Care)** and direct referral to the service, along with more consistent 24/25 reporting from July 24. This will show a positive impact on ED attendances and will support NWAS.
- We have ongoing work programmes to **enhance and improve the interfaces between General Practice and secondary care, community pharmacy** and supporting (non-GP) primary care delivery through our primary care blueprint
- Many localities already have services in place to streamline direct access – for example using Community Pharmacy and the Minor Ailments Scheme, Urgent Eyecare services supporting patients to contact opticians directly, signposting from GP practices, direct access to Paediatric Nurse Practitioners booked by the GP practice
- Work is underway with localities to **review community services** to develop and implement a minimum community data set; agree GM wide core standards; ensure community services delivery is fully integrated with wider system partners to enable more care in the community focussing on early intervention; and develop plans to create a skilled, resilient and sustainable community workforce.
- One element of this review is to develop a core GM set of service standards for a set of priority services including UCR which will include clear interface guidance to wider community / neighbourhood services. This will enable consistency across all localities whilst retaining the ability to provide services appropriate to the needs of the population.
- This project needs to identify whether it would be beneficial to include virtual wards with the view to move some outpatient activity into the community in 2025/26. When this is understood, work will need to be completed with primary care to ensure impacts and opportunities on the services across all the primary care disciplines.
- Community services are managed via the acute trusts. Due to various changes to the system, there has been a reduced ability to conduct formal contractual management arrangements, as well as a reduced ability (in some localities no visibility) to see performance, financial and impact data. We have a plan for clarity of both financial and activity/performance information from Q1 2024/25.

- This is a noncash releasing QIPP scheme that will release productivity benefit in 2024/5. On completion of year 1, when services are realigned and sustainably transformed, year 2 intentions will be to de-commission outpatient clinics from secondary care and build into community and primary care services allowing for estate rationalisation and improved flow. This will release productivity benefit with opportunity for 2025/26 financial benefit for Provider Trust Cost Improvement Plans (CIP).

5.4 Adult Social Care

We cannot achieve our objective of a preventative, neighbourhood model without a sustainable adult social care sector. Our aim is to support people to live well at home, as independently as possible, making sure that the care and support people experience is built on their own strengths and is of the best quality. There are several areas where there is a particularly close link with NHS national objectives.

We have agreed a set of transformation commitments that will guide our work in 2024/25. These are:

- Continue to improve and support transformation to ensure people live well at home
- Design and implement a social care workforce academy and integrated training hub both locally and at GM with a focus on retaining, growing, developing and attracting an appropriately skilled workforce. It will have a strong focus on values, community wealth and person-centred care and support
- Implementation of the social care workforce strategy key priorities
- Design and implement the GM Quality strategy for adult social care and the Quality Improvement and Assurance Framework and support localities towards achieving excellence
- Implement the complex needs strategy (see sections 5.11 and 5.12). Deliver the LD and MH complex needs projects, supporting people with a learning disability and/or autism out of hospital and ensuring people with complex mental health get the right care and support in the right place
- Deliver the Adult Social Care Mental Health social work strategy, alongside oversight of practice and assurance and the integration arrangements with trusts (see section 5.11
- Support localities with implementation of the social care reforms and other White paper proposals
- Support localities through Winter planning, including securing the best possible funding settlement for GM ASC from the £500m announced in September
- Further develop and roll out data and insight tools, to support informed decision making and assurance reporting locally, and to inform future priorities for the Living Well at Home transformation programme
- Deliver the funded ASC digital projects
- Continue to secure investment for ASC transformation; with a focus on the national DHSC housing transformation fund and the opportunity to consider supporting children into adult services
- Continue to work collaboratively with NW ADASS to ensure alignment of priorities and deliverables and the most effective use of resources
- Champion and influence the sector through representation in GM forums, and through engagement locally with key leaders/stakeholders and continue to develop relationships and collaboration with partners
- Continue to improve and support transformation to ensure people live well at home

5.5 Primary care

5.5.1 National Objectives

- We will make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need
- We plan to continue on the trajectory to deliver more appointments in general practice
- We will continue to grow Primary Care Workforce
- We will recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels

5.5.2 Our Delivery Plans

2024/25 will be the first full year of delivery of our Greater Manchester Primary Care Blueprint[14] which includes our commitments to improving primary care access through the NHSE Delivery Plan for recovering access to primary care[15] .

- National contract developments to review digital telephone data are expected to provide better understanding of **demand** in 2024/5.
- PCNs are still to determine their response to national contract announcements (24/25) around flexibility of ARRS (Additional Roles Reimbursement Scheme) skill mix and recruitment
- Q1 review and evaluation of local winter pressures funding into primary care, which will inform **capacity** delivery and impact considerations and opportunity

Key areas of focus in 2024/5 are:

- Ongoing work programmes to enhance and improve the **interfaces** between General Practice and secondary care, community pharmacy and supporting (non-GP) primary care delivery, in accordance with NHS GM Primary Care Blueprint aspirations
- **Pharmacy First.** NHS GM has increased the number of Community Pharmacies delivering Pharmacy First (98%) compared to CPCS (Community Pharmacy Consultation Service) sign-up (92%). Initial month's delivery of PF indicates higher service levels than compared to CPCS previously. This should impact demand on general practice in due course and also contributes to the achievement of the objectives for Community Health Services (section 5.3.1)
- **Consolidation of Out of Hours (OOH) support** (through commissioning), building on the successful Macro Single Electronic Patient Record and Clinical Function of the Greater Manchester Clinical Assessment Service by offering a single solution for Out of Hours triage (and some cross bordering/boundary appointment booking and visiting). This will deliver a 5-10 year economic model to benefit GM - with efficiencies year on year, as well as a common contracting, finance, spokesperson, Business Intelligence and EPR function. This will enable further consolidation of best practice and common subsystems, whilst retaining a local feel to the service and avoiding the unpicking of contracts already agreed.

[14] https://gmintegratedcare.org.uk/wp-content/uploads/2023/10/greater-manchester-primary-care-blueprint-october-2023.pdf
[15] https://www.england.nhs.uk/long-read/delivery-plan-for-recovering-access-to-primary-care-2/

- There will be continued strong engagement and collaborative working between NHS GM dental commissioners and GM Dental Provider Board, reviewing performance and delivery as well as quality and sustainability developments. We will build on the success of the GM Dental Patient Access Quality Scheme (2023/24) to encourage practices to see new patients and deliver access for urgent dental care. The national announcements by the DHSC and NHSE regarding Dental Recovery Plan presents additional UDA credits for new patients, which will increase UDA delivery during 2024/25 for those practice engaging with these national arrangements.

5.6 Elective care

5.6.1 National Objectives

- Greater Manchester is **planning to eliminate 65-week elective waits** by September 2024
- Greater Manchester is planning to **deliver the Elective Value Weighted Activity Target** for 2024/25

5.6.2 Our Delivery Plans

Demand

- We will increase the use of **referral streaming** (such as using Single Points of access and utilisation of Advice and Guidance) to ensure that the most appropriate route for accessing specialist advice is utilised supported by development of clinically led response libraries, faster response times and responsive education and training provision for both Primary and Secondary Care
- Through **the review/transformation of referral pathways** across GM we will have a particular focus on addressing unwarranted variation through system Pathway prioritisation/redesign
- 'What makes a good referral' guidance has been shared with GPs aimed at improving referral quality. **Improved referral management** in primary care is expected to release some secondary care capacity which will eventually lead to some capacity being released. Additionally, a series of Skin Lesion Recognition sessions is underway which aim to improve the competence of primary care clinicians in recognising skin lesions, thus improving referral quality.
- Development of a **dynamic referral template** for suspected cancer referrals is underway. This includes links to nationally published guidance to support GPs in managing patients within primary care, where appropriate to do so. This enhanced tool is expected to go-live in early 2024-25 and will be followed by similar development for general dermatology referrals.
- Several **teledermatology pilots** are underway in GM. Early analysis of data shows a reduction in the waiting time for treatment and, in some cases, allows a patient to be stepped down or discharged (as appropriate) without the need for a face-to-face contact

Capacity

- Deliver an appropriate **reduction in outpatient follow-up** (OPFU) in line with national ambitions utilising PIFU (Patient Initiated Follow Ups) in order to deliver around 30% more elective activity by 2024/25 than pre pandemic.
- Optimising the use of digital and face to face attendances by supporting patient travel and optimising the use of Digital initiatives such as remote attendances, Patient Engagement Portals and patient validation

- We will further develop our **collaborative working for Mutual Aid** across all trusts and Independent Sector organisations and track weekly our demand and capacity pressures. Surgical Hub utilisation at the point of referral or decision to admit to free capacity within acute trusts for mor complex procedures and long waiters.
- Improving missed appointments across all settings though better use of Patient Engagement Portals, waiting list validation and APOM (Anaesthesia and Peri-Operative Medicine) processes for Day case and inpatient procedures
- Develop 3 year forward modelling of TIF build investment to target our most pressured waiting lists, with mutual aid and pathway streaming to maximise its impact

Delivery Plans

- Greater Manchester is developing a clinically led **Clinical Services Strategy** (see section 5.13.2) aligned to the 3-year Sustainability plan. The strategy in Year 1 will focus on specialties which have been identified as having sustainability issues which include Dermatology, Gynaecology and Ophthalmology
- **Single Point of Access (SPOA**): There is an intention to introduce a SPOA for dermatology referrals initially then other specialties in succession. This will enable consistency across GM, clinical triage and advice & guidance to be provided by qualified staff and, where required, redirection to appropriate service, e.g., community or secondary care
- As gynaecology is one of GM's most pressured specialties, we will make optimum use of theatre capacity, developing and agree a productivity improvement trajectory with Trusts for several measures. Benchmarking against other Integrated Care Systems in relation to Gynaecology to understand whether we are an outlier or if there is any learning from other areas.
- The development of a Greater Manchester Service specification for implementation into all Independent Sector providers' contracts for delivery in 2024/25. This will include revised clinical pathways including thresholds for treatment, management of post-surgery complications, Key Performance Indicators (KPI's) and robust exit strategies

Productivity

- **Increase Theatre and Clinic** capacity by meeting the 85% day case and theatre utilisation expectations, using GIRFT and moving procedures to appropriate settings. This will be dependent on further Industrial Action and the optimisation of Surgical Hubs and Mutual Aid across GM
- **Improve missed appointment rates** by using the GIRFT Further Faster handbooks, waiting list validation and better use of patient engagement portals to improve patient communication and booking processes.
- We will establish an APOM network to identify key workstreams in order to move to an improved pre operative pathway across all specialties and to create pools of patients fit for surgery in order to ensure theatre lists are fully optimised.
- We will focus on theatre productivity metrics such as cases per list, theatre utilisation and inter-case downtime to ensure greater productivity of surgical lists
- We will run regular perfect weeks and super lists and share learning in order to build this into business as usual processes.

5.7 Cancer Care

5.7.1 National Objectives

- Greater Manchester **is planning to meet the 62-day waiting time cancer objective** of 70% of patients by March 2025
- We will meet the **Faster Diagnosis Standard (FDS)** for 77% of people to wait no more than 28 days from urgent referral to receiving a communication of diagnosis for cancer or a ruling out of cancer

5.7.2 Our Delivery Plans

Greater Manchester Cancer Alliance, on behalf of the ICB will lead a wide-reaching programme of work designed to support the GM system in delivering optimal care and outcomes for patients, reducing variation, addressing health inequalities and working to deliver the constitutional standards and interim targets. This includes the operational response to the delivery of the FDS standard

Collective provider plans **confirm planned delivery of the interim 70% waiting time target by March 2025, and the achievement of the FDS**. Counterfactual trajectories outline the requirement for transformation to deliver this target in a sustainable manner and is underpinned by a programme of work led by the GM Cancer Alliance.

Demand

- Demand from increased referrals is expected to convert to an increase in 62-day demand (diagnostics and treatment) by 3.4%.
- Referral growth is expected in line with drive to increase early diagnosis. Trend lines over time suggest 7% growth in year. Key initiatives led by GM Cancer Alliance Early Diagnosis Programme Board include primary care education, public and patient awareness/presentation, referral management between primary and secondary care, case finding (including targeted lung health checks), optimisation of filter function tests, and the active monitoring of conversion rates to maximise the diagnosis of cancer.
- The expansion of breast mastalgia pathways, along with new HRT and IDA pathways are expected to support the management of demand

Capacity

- Optimisation of specialist diagnostic pathways and system capacity will be supported by the Cancer Alliance single queue diagnostic programme which is designed to share capacity to optimise capacity
- Surgical treatment pathway optimisation will be supported by a dedicated improvement workstream with the Cancer Alliance
- Diagnostic capacity expansion (see also section 5.8) is expected through the CDC programme, digital pathology and PACs reporting initiatives are expected to support the increased demand from suspected cancer pathways

Assumptions

- Planning assumes that there will be no changes to NICE NG12 referral criteria or genomic pathways, with updated referral forms already uploaded onto all GP systems in GM.

- Plans for delivery assume sufficient allocation of outpatient, diagnostic and treatment capacity pointed to cancer pathways from the overall activity plan
- Planning is supported by target treatment volumes modelled by GM Cancer Alliance and assumes proactive approach to management of capacity
- Our plan assumes organisational productivity targets are delivered in provider organisations, that the FDS is delivered and the over 62 day backlog does not increase
- Delivery will be dependent on sufficient diagnostic test and reporting, and specialist workforce availability

Delivery plans

- The Cancer Alliance will lead delivery on pathway improvement and optimisation to deliver the 62 day standard, including roll out of one stop treatment clinic (saves mean wait of 15 days per pathway for high risk lung patients) with current roll out to Obstetrics and Gynaecology.
- We will ensure optimisation of pathway developments – e.g., Tula, converting inpatient surgery to outpatient procedure, use of surgical hubs and streamlining capacity
- Priority pathways in 2024-25 for Early Diagnosis are: Lower GI, Upper GI, Lung, Breast, Urology (focus on bladder), Gynaecology (focus on ovarian and FDS priorities), Head and Neck. All are pathways where there a high number of referrals and where GM is an outlier when compared to other Cancer Alliances / ICBs from a 'stage at diagnosis' perspective. All will support improvement in FDS performance.
- A whole system Cancer Alliance programme of improvement will support the delivery of these standards, in line with the Cancer Alliance planning pack and deliverables, including primary and secondary care interventions, early diagnosis, personalised care, workforce and education.

5.8 Diagnostics

5.8.1 National Objectives

- We will deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition

In GM we will continue to increase diagnostic activity levels during 2024/5 and work towards the diagnostic waiting time ambition.

5.8.2 Our Delivery Plans

The diagnostic modalities in this plan are MRI, CT, Non-Obstetric Ultrasound, Colonoscopy, Flexi-sigmoidoscopy, Gastroscopy, Echocardiography, Dexa, Audiology

The plan has been developed based on the following **assumptions**:

- That 10% efficiency will be gained from the Imaging and Pathology Digital Programmes (though this may not necessarily translate as a 10% increase in activity)
- That CDC plans and activity will rise for most high volume tests, and that this will translate as clear additionality within Trust plans.

- That Trust plans have been modelled to include the activity required to achieve elective recovery and cancer targets.
- That Trust activity and performance plans have been modelled in the context of sustainable financial and workforce plans.
- That substantial new estates projects planned in 2024/25 will significantly increase Trust and system capacity for specific tests

Demand on services is being managed through a range of programmes:

- Work is progressing on primary care guidance for Endoscopy to reduce demand and inappropriate referrals. This work will be reviewed across all networks to see whether this will be beneficial across other modalities in reducing demand for tests.
- There is a project underway to widen GP direct access and requests to include some CT and MR examinations and to deploy a clinical decision support tool to aid appropriate requesting.
- There are a number of workstreams engaged in developing innovative solutions to the reduction of demand on acute services. For instance, we have the opportunity to utilise Fujifilm 'Diagnostics car' for mobile access to diagnostics outside of the acute setting – this is currently being scoped for potential modalities and capacity.
- The percentage of suspected cancer referrals with an accompanying FIT (Faecal Immunochemical) test have increased recently and we are now amongst the best performing ICBs in England on this metric. The standardisation of FIT secondary care pathways has also been agreed

Capacity is being increased through a range of programmes:

- **Community Diagnostic Centres (CDC)** – significant increases in CDC activity for our most challenged high-volume tests are planned in 2024/25, as more sites go live and activity ramps up in those newly opened: a 73% increase in MRI activity carried out in CDCs, 59% NOU (Non-Obstetric Ultrasound Scan) increase, an 82% CT increase and a 161% increase in Echo activity. We will be continuing to develop clinical pathways through 2024/25 to optimise these resources, supporting primary and secondary care to improve workload and patient outcomes.
- **Endoscopy** is the focus of several programmes. There has been recent agreement to standardise points for endoscopy tests and at 12 points per list, which should increase activity further and bring down waiting times. National Capital Funding has been secured for MFT and WWL for Endoscopy estates projects within 2425, significantly increasing capacity as well as supporting JAG accreditation. There is the further potential to use these as system assets in the future.
- There is a significant programme of work around **workforce**. This includes international recruitment for radiologists and radiographers, continuing liaison with the Regional Team on the development of the staff passport, and in addition Network development of Staff collaborative bank. The networks are encouraging greater collaboration between Trusts to avoid duplication and share best practice and are also sharing training and education resources. The Diagnostics team are operating a 'hub' for this work for Trusts to use via an NHS Futures page.
- There is a significant programme of work attempting to secure funding for imaging equipment, to substantially drive up capacity for some of our most challenged tests, including MR at two sites. Capital underspend bids have also been submitted for ultrasound and mobile equipment.

Delivery plans

- **Productivity improvement** is being actioned within all high-volume tests via the networks. For endoscopy this is a well-established programme, with a set of productivity KPIs agreed and improvement plans requested from trusts. THRIVE is a room-based productivity tool, enables benchmarking within the system, identifying variation and therefore enabling targeted improvement actions to address this variation. The THRIVE tool has been implemented within 5 trusts, and the final trust – Tameside & Glossop – has now agreed funding to implement the system. Sets of productivity KPIs have also been agreed for Imaging and Pathology and these pieces of work are currently in the data sourcing stage, but the intention again is to have trust level improvement plans.
- **Network development** – there are well established networks for Endoscopy, Imaging and Pathology services, and Echo is included within the Cardiac network. The networks are helping to support collaboration, the sharing of best practice and to drive improvements – for example, through agreement of productivity improvement measures and plans, in developing mutual aid processes, co-ordinating digital and workforce programmes and developing system wide strategies. Physiological Sciences networks are currently being implemented, with a Physiological Sciences network and 8 subgroups for the individual tests. Clinical leads have just been appointed for each subgroup and work has started to map priorities in each case.
- **Digital** – the implementation of MRI AAT is continuing at pace – this technology will reduce scanning time which will increase throughput and reduce turnaround times. The introduction of a new LIMs (Laboratory Information Management) should see more efficient reporting across the patch, and Digital Pathology technology will bring a) improved workflow through speeding it up, greater collaboration and cross site reporting, and allows central storage and increased automation, b) reduce turnaround times and c) encourage innovation through specialisation, the ability to work across larger geographies and deliver better tools for training purposes. The introduction of PACS based reporting will facilitate cross-trust reporting – supporting mutual aid where there are reporting backlogs. PACS enables greater efficiency through the sharing of images across multiple users and reduced transport requirements.
- **Mutual Aid** –we will put in place a formal policy across GM, with a set of common agreed principles for all tests and tailored operational solutions appropriate to each modality. For instance, for Endoscopy a 'live' request is being used to test out some draft principles, and to scope what kind of operational solutions need to be put in place with a formalised policy. For Imaging there are a number of technical difficulties related to booking and the viewing of reports, so a working group has been set up with digital and operational colleagues to start to address these technical issues.
- **The GM Commissioning Review** (see section 5.13.1) has identified that there is a potential to commission a more radical operating model for the diagnostic networks as well as how "out of hospital" diagnostics could be commissioned differently. Work is taking place to explore opportunities:
  - Review list of direct access diagnostics available to primary care and ensure no duplication and appropriateness of access
  - Review of clinical pathways (to be determined) to determine efficacy and effectiveness of specific diagnostics, e.g., Gastroscopies
  - Review of AQP (Any Qualified Provider) – diagnostics / duplication of tests, i.e., NOUS, Head and Neck MRI
  - Optimise opportunities for POCT – quicker diagnosis, increased access and build the case for reduction in more costly diagnostics/interventions

5.9 Maternity

5.9.1 National Objectives

- We will continue to make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury
- We will increase fill rates against funded establishment for maternity staff

5.9.2 Our Delivery Plans

- The Local maternity and Neonatal System (LMNS) will continue to work with the system to fully implement the national 3 Year Maternity & Neonatal Plan, including full implementation of Saving Babies Lives (3) and Ockenden recommendations.
- This will be supported jointly through targeted Quality Improvement projects, such as development and implementation of clinical guidelines and the roll out of enhanced continuity of carer, and governance to share learning and monitor delivery.
- The 2nd year of the GM Equity and Equality Plan will be implemented including Baby Friendly Initiative accreditation, development of race /culturally appropriate images, personalised care planning, translation of materials and an early booking campaign codesigned by our VCSE, targeted our communities who experience the greatest inequalities in outcomes.
- The LMNS will develop a GM Maternity Workforce Plan and progress with the implementation of Maternity Support Worker (MSW) training packages, ensuring all Providers have adequate workforce plans in place, adoption of the Core Competency Framework, maximise student placement capacity and explore apprenticeship models.
- All Providers will complete the national Quadrumvirate Cultural; Development Programme and work with Retention midwives to enhance support for existing workforce.
- The LMNS will regularly review PWR data to inform fill rates against establishment.
- As a result of our **commissioning** review, we will implement the recommendations of the GM Assisted Conception review, and the outcome of the review of number of IVF Cycles – ensuring equity across GM.

5.10 Children and Young People

Whilst not included separately in the national NHS objectives, enabling the best start in life is key for our children and young people, and a core element of our strategy and plans. This involves close partnership working between the NHS, the wider public sector and other partners, and we are building on achievements to date and well established and mature relationships across GM and in localities.

There are strong foundations to build on. This includes work over the last decade to develop common practice standards for groups of young people (for example Children with Special Educational Needs and Disabilities and Care Leavers). The specific health case for investment in children is extremely strong. The life course costs of late intervention have been estimated at £17bn across England and Wales (including nearly £4bn borne by the NHS).

We will support our children and young people to get the best start in life through a joined-up approach to their early years' development. We will wrap support around our most vulnerable young people to give every child the opportunity to live their best life through access to quality education and opportunities that respond to their needs. We will give young people a voice in how we develop policy and make decisions that affect their lives.

GM partners (health education, voluntary, criminal justice sectors, GMCA and local authorities) have adopted a system-wide approach, delivered through a combined Children and Young People Plan. The GM Children Board, reporting to the Integrated Care Partnership, and GMCA acts as a system board that represents the range of accountabilities brought together to deliver on the priorities in the Children and Young People Plan.

5.10.1 Children and Young People: priorities

We have set out our priorities for children and young people:

- Early years – Taking an integrated approach to early years recognising the importance of 1,001 critical days and responding to the detrimental impact of Covid-19 on the development of children aged 0-5
- Children and young people with long term conditions – Taking a preventative approach to tackling issues that may contribute to longer term conditions such as obesity and asthma and ensuring those with long term conditions get the high-quality treatment they need in their communities
- Family help (including family hubs) – Working towards a shared vision of family help where families can get the help they need from the right places and people in their communities including health professionals
- Education outcomes – With particular focus on tackling the issues that impact on school attendance/absence
- Mental health and wellbeing – Responding to the rise in the number of children and young people being referred to CAMHS through a focus on earlier support and preventing escalation in the community whilst also having the right pathways in place for those in crisis. This includes responding to #Beewell as an important piece of insight into the wellbeing of GM children
- Care for / care experienced young people – Understanding and responding to the specific health needs of this important group of young people recognising including those placed in specialist residential care units
- Children and young people with SEND – Work together to improve the experience of children and young people with SEND (and their carers) through common standards, joint commissioning and a commitment to addressing inconsistencies in the offer across GM
- Adolescents –Improve the way we work with Adolescents in GM including the implementation of a GM Adolescent Safeguarding Framework
- Children and Young people in the Criminal Justice System – responding to the health needs of young offenders recognising that many of these young people have unidentified needs until they enter the youth justice system

- Domestic Abuse – recognising the significant impact domestic abuse has on the lives of children and young people and the need for a cross sector response to tackling these issues in our communities
- Speech, Language and Communications – Responding to emerging evidence of delayed early language development in under 5s early years due to the impact of children missing out on early education and normal social interactions during Covid-19 in addition to challenges on workforce and waiting times
- Trauma Responsive Care – implement our system plans to become an Adverse Childhood Experience (ACE) and Trauma Responsive system
- Workforce –We must look at how we tackle common challenges across the children's workforce including recruitment and retention in addition to training around core competencies. Continued focus on a Trauma responsive workforce and the importance of neurodiversity

5.10.2 Children and Young People: Learning Disability and Autism

- Demand for **autism assessments for children** is rising, placing pressures on diagnostic pathways. In response, a dedicated programme of work is now being planned to review our existing services, waiting times and waiting lists and embed a sustainable long-term neurodevelopmental pathway. This will be focused on needs led support and build on learning from earlier intervention-based approaches that are already being trialled and implemented, e.g., Manchester/MFT under 5's service. We want to move away from a referral to diagnosis model, embedding multidisciplinary care and support from a range of professionals including the VCSE sector, so that children and families receive the help they need sooner and without long waits. This programme will be overseen by the Children's System Board
- We have now successfully embedded the **Autism in Schools** project in 64 schools across all GM boroughs. This project is built on true co-production and delivered by partnerships of parent/carers, local authority and health-based representatives, children and young people and schools. The project offers a bespoke training package for schools and services working with neurodiverse young people, creates sensory spaces and supports schools to review their policies and practices in partnership with children and young people and parents and carers.
- **Partnership for the Inclusion of Neurodiversity in Schools (PINS)** project will be implemented in 2024-25, funded by the DfE/NHSE. Building on the Autism in schools partnership working approach, this project will target up to 5 days of support to 40 primary schools in GM. Both projects aim to improve the school experience for young people and their families and carers and empower schools to support neurodiverse young people. This is important as we know that the number of children identified with SEND and with EHCPs is rising and more children are being excluded from/not attending school.
- **Dynamic support registers and CETRs (Care Education and Treatment Review)** help us to identify young people at risk of admission and the community-based support that they need. An all-age action plan for GM DSRs is in development, led by the Transforming Care Oversight Group. A GM oversight panel for CETRS has been established, as well as a DSR/CETR support network for locality operational colleagues working with children. The specification for a new CETR hub is also under review with plans to mobilise in 2024/25. The Keyworker service, operated by Barnardo's, support young people identified on DSRs and their families to access support and navigate systems and services. 36 staff are now in post and in Q1-2 2023-24, 93 CYP were supported by the service who will continue to recruit to a full team of 40 keyworkers by the end of this financial year.

5.11 Mental Health

5.11.1 National Objectives

- We will improve access to mental health support for children and young people aged 0-25 accessing NHS funded services
- We will increase the number of adults and older adults accessing IAPT treatment
- We will achieve a 5% year on year increase in the number of adults and older adults with Serious Mental Illness supported by community mental health services
- We will continue to work towards eliminating inappropriate adult acute out of area placements
- We will recover the dementia diagnosis rate to 66.7%
- We will continue to provide perinatal mental health services

5.11.2 Our Delivery Plans

Our primary objective for 2024/25 is to consolidate and stabilise existing essential Mental Health services especially where these services support reducing unwarranted variation, national and NHS GM priorities.

Greater Manchester is in the top quartile for mental health need yet in the bottom quartile for spend. The ICB spends approx. £100m a year less than the national average investment into mental health services.

Demand

- Demand will remain high with high acuity, exceeding the bed capacity in the GM footprint across both NHS and Independent Sector providers.
- Funding has been allocated to existing admission avoidance and discharge schemes. A small amount of non-recurrent funding has been allocated to a 6-month pilot in Manchester for a pathway to recovery team to help improve patient flow. £3.5m of MHIS (Mental Health Investment Standard) has been allocated to the crisis pathway. However, this is primarily focussed on the 'front end' part of the pathway and there remain gaps in crisis alternatives, particularly in the west of GM.
- Pressures in the PICU (Psychiatric Intensive Care Units) pathway remain a particular challenge. Demand for PICU beds has increased significantly which may be linked to the reduction in MS placements/LSU beds (resulting in increased PICU referrals from prison) and continues to be a risk into 2024/25. Whilst there is no direct evidence that the closure of the Edenfield unit at GMMH contributed to the increase in Out of Area Placements (OAPs), it is suggested that this may have had an indirect impact, and as yet the timescale for its reopening is unclear.
- The impact of the introduction of Right Care, Right Person on the crisis pathway and overall demand is also a risk. Improvements depend on system partners being able to make improvements to their parts of the pathway – for example, supported housing, care home capacity etc.
- GM ICB has achieved the CYP (Children and Young People) access target consistently for many months and we expect to continue this high performance throughout 2024/25. However, it is important to note than the increased access is having an impact on waiting times – which are growing.

Delivery plans

Priority actions to reduce **OAPs** are:

- The ICB has, since November 2023, implemented a grip and control process for OAPs which has seen a sustained reduction in the number of placements. - some of this is attributable to the purchase of an additional 15 independent sector beds. This is a key QIPP programme (see section 6.2.2)
- Within Pennine Care Foundation Trust (PCFT) a new OAPs team (funded for 12 months), has increased repatriations, however demand still outstrips capacity.
- PCFT have additionally made a c£1m investment into discharge and flow improvements.
- To reduce OAPs further needs additional investment into alternatives to admission – for example, crisis beds, and support to discharge into social care and housing.
- During 2023/24 a business case was developed to step up activity in the specialist **perinatal** service over three years to reach the target level but, due to limited MHIS (Mental Health Investment Standard) funding, this has not been prioritised for 2024/25 hence no additional investment is available. Due to this, the forecast is for a continuation of current levels.
- No additional funding is being provided for community transformation in 2024/25 so activity forecasts are static except for a small amount of activity growth due to the changed definition for this metric. This assumes that three new neighbourhoods come on board in Manchester during the year. Data about community SMI activity taking place in VCFSE providers needs to be enabled in MHSDS as this is not currently being captured
- Further waves of Mental health Support teams are due to go live in 2024/25, which will see a further increase in volumes of CYP accessing services.
- Implementing a core offer for cared for / care leavers was delayed from 2023/24 but should be implemented in 2024/25.
- Community transformation will continue to be embedded through continuation of the roll out of Living Well across all localities.

5.12 People with a learning disability and autistic people

5.12.1 National Objectives

- Greater Manchester is **planning to deliver the national target** for Adult LDA inpatient rates by March 2025

5.12.2 Our Delivery Plans

- A QIPP programme has been established outlining key priorities and deliverables. This is likely to be a joint piece of work with Directors of Adult Social Care, which will deliver system savings across Health and Social Care. Possible savings £250k

- The complex needs project continues to support discharge. There are currently plans to create homes for 40 people in 2024/25 and a further 2025/26 in addition to the 17 homes already created. The project team work with localities to implement solutions for people, supporting discharges and preventing admission. This project will play a pivotal role in achieving the GM inpatient targets.
- It is assumed that unplanned discharges will continue as a result of the increase in multi-agency discharge event meetings across PCFT/GMMH as part of the reducing mental health OAPs improvement programme.
- Community support initiatives and alternatives to admission including intensive support teams, keyworkers, DSRS/CETRS and admission avoidance facilities continue to prevent admissions of children and young people to hospital ensuring that we continue to meet the target. See also details of programmes for children and young people in section 5.10.2.

5.13 System Transformation

The actions set out in this plan will be enabled by two key approaches to system transformation:

5.13.1 Commissioning

It is a core responsibility for Greater Manchester Integrated Care Board to demonstrate that it is making effective use of public money and that we commission high quality care in the right place, at the right time within the context of our resources, and to deliver our statutory responsibilities, and meet the needs of the population of Greater Manchester.

A commissioning review was undertaken in 2023/24 which will require the system to make key decisions during 2024/25 on:

- Treatment and referral thresholds
- Service access policies, since the ICB inherited differential policies in a number of areas from the 10 former CCGs
- Unfunded/ underfunded/ challenged services, which are being reviewed through our Sustainable Services programme
- Services that are temporarily closed and not being reviewed elsewhere

This will identify commissioning priorities for 2024/25 and commissioning intentions for 2025/26. Service reviews are ongoing, in line with Commissioning for Improved Outcomes process, making recommendations in 2024/25 with a number implemented in year (subject to notice periods/contract end dates/Provider Selection Regime).

Delivery will be managed through the Commissioning Oversight Group (COG) chaired by the Chief Officer for Commissioning and Population Health.

In addition to the commissioning activities covered in the earlier section of this plan, the following areas will also be addressed by COG during 2024/5

- Reviewing the **Sexual Health** pathway and **Termination of Pregnancy** services
- Implementing a new model of care for **ADHD** (adults and children)

- Addressing unwarranted variation in referrals to **Gynaecology** and alignment of capacity in the right place to meet demand. Development of a GP-led gynaecology service
- Implement the agreed business case for **neurorehabilitation.**
- Implement the agreed outcomes of the review of **Hospice provision.**
- Implement the outcome of the review of specialist commissioning for **Arterial Vascular Surgery and Cardiac Surgery**
- Implement the new model of care for **Specialist Weight Management** (Tier 3) services.
- Implement a new **pelvic health pathway** (NHSE funded)
- Review **MSK services** across all care settings to optimize pathways and avoid duplication. MSK is one of the NHSE-defined major conditions.

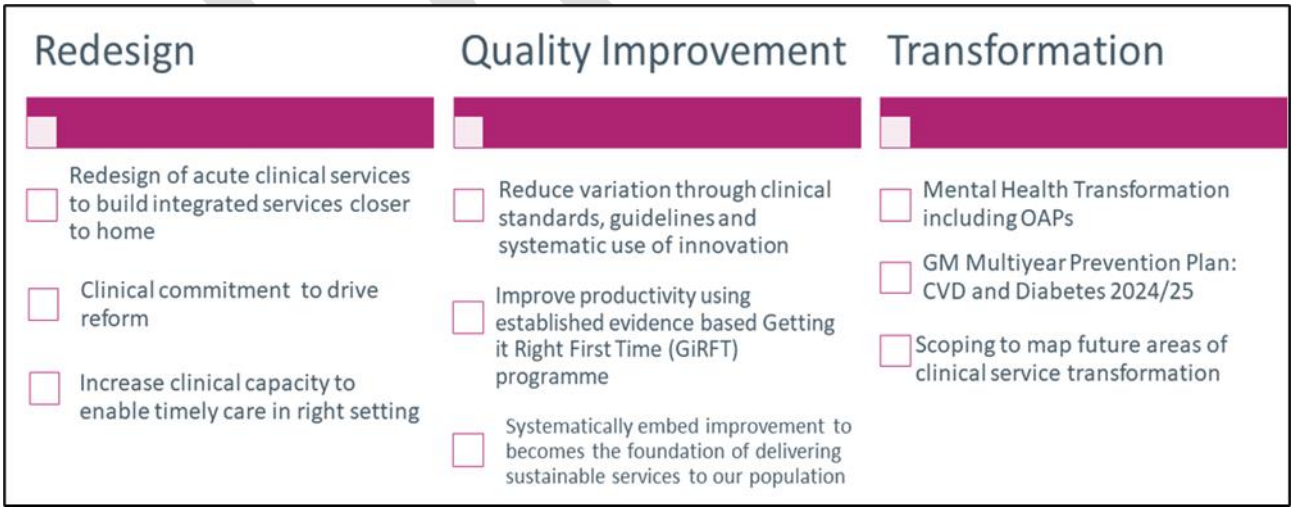
5.13.2 Clinical Services Strategy

The issues and challenges Greater Manchester faces are well understood. Waiting times for elective care remain amongst the longest in the Northwest of England, while non-elective demand continues to rise. Bed availability is amongst the lowest in England, each acute trust faces recruitment and retention challenges, and we have an ageing population.

With a financial deficit and increasing challenging demands, developing extra workforce and estates capacity is unlikely to be an option. However, the system cannot cope with a “do nothing” approach, so we must respond as a system to meet these challenges by transforming the way we work to effectively meet the needs of the population of Greater Manchester through the best use of our collective resources that we have available.

Our clinical services strategy will be clinically led. This co-production will ensure that consideration is given to all parts of our system, so we have truly joined up provision that delivers value for money, improved patient experience and outcomes. We will ensure clear sight of delivery and clear lines of accountability. Our approach to the Clinical Services Strategy is shown in Figure 6:

Figure 6



Whilst the clinical services strategy will be delivered across multiple years NHS GM has determined that in Year 1, we will focus on specialties which have been identified as having sustainability issues which include Dermatology, Gynaecology and Ophthalmology (see section 5.6.2).

The scale of ambition within the clinical services strategy cannot be underestimated and will require deep collaboration between constituent organisations. Genuine partnership working will be required if real culture change and transformation is to take place. We have set out the main benefits flowing from the strategy in Table 5:

Table 5: Aims and Benefits from Clinical Services Strategy

Aims	Benefits
Deliver financial sustainability	Reduce premium cost expenditure and reliance on LLPs, deliver economies of scale and ensure services commissioned are value for money.
Standardise clinical pathways	Reduce variation in access times and improve performance against core quality metrics. Modernise how services are accessed, for example, providing care closer to home.
Achieve Key Quality Standards	Compliance with service specifications and GiRFT recommendations.
Embed Personalised Care	Increased self-management of conditions to reduce service demand and progression to higher levels of care.
Digital Advancements	Single Electronic Patient Record (EPR) to enable system working and to improve clinical practice.
Address workforce issues	Sustainable workforce and fully compliant rotas.
Address repatriation issues	Reduce length of stay and waiting times by developing a rehabilitation model and repatriation protocols.

A key focus in the work on the clinical strategy is to ensure we can deliver and maintain clinically effective and financially sustainable services. We know from the work on the development of our financial sustainability plans that we have opportunities to improve the sustainability of our services. The reasons for this and therefore the solutions are multifaceted will fall into the categories shown in Table 6:

Table 6

Operational	System	Structural
• Inefficiencies compared to peers	• Primary care and intermediate care access and services	• Geographical isolation (rurality and travel distances)
• Scope for improvements in productivity	• Community care being provided from hospital settings	• Geographical inundation
• Low theatre throughput	• Difficulty attracting and retaining staff	• Stakeholder service requirement (e.g., keeping underutilised services open)
• High vacancy/ temporary pay spend	• Insufficient locally agreed tariffs not delivering value for money	• Multi-site operations (further exacerbated by low activity levels)
• Overprescribing		• Estate is too big/old/ poorly laid out and cannot earn market value
		• National market factors (e.g., high premiums)

6 Achieving system sustainability through efficiency and cost improvement

6.1 Using our resources

NHS GM has a statutory responsibility to use the resources it is allocated by NHSE to the best effect for the people of GM. This includes financial resources and the way in which we plan to spend them.

6.1.1 Income

In total NHS GM has an annual allocation of resources (income) of over £7bn a year. These resource allocations cover the costs shown in Table 7 with the categories being defined by NHSE. NHS GM's net opening allocation in 2024/25 plans is £7.2bn. This includes net growth of £241m, a net negative convergence allocation of £60.7m; and a range of other specific recurrent and non-recurrent allocations including £157.8m of Service Development Funding (SDF), and £147.1m of Elective Recovery Funding (ERF).

Table 7

Area	Description	2024/5 Opening Allocation £m
Core Services	The majority of healthcare costs commissioned by the ICB including most Acute, Community, Mental Health, Continuing Healthcare, GP Prescribing, and some locally agreed Primary Care services	6,082.3
Running Costs	To fund the administrative running costs of the ICB including staffing, estates, and other non-pay related costs.	47.6
Primary Medical Care	To fund the national GP Primary Care contracts	601.3
Delegated Primary Care	To fund contracts for Pharmacy, Ophthalmic, and Dental Services (POD).	334.0
Service Development Fund (SDF)	To support targeted investment in specific service areas.	1157.8
TOTAL		**7,223.0**

In addition, the ICB receives separate funding for capital which is circa £5m in 2024/5.

Within these allocations there is funding for growth of £241m which has been utilised to fund price uplifts, demand increases, national policy requirements and to provide for other national agreements. However, this growth funding was limited growth in comparison to recent years, with an expectation that significant efficiencies would be required to maintain financial sustainability.

In addition, the ICB is also assessed to be above its fair share of allocation resource and as a result sees its allocation reduced proportionally again in 2024/25 through what is deemed a convergence adjustment. This is a net negative impact of £60.7m in 2024/25

6.1.2 Expenditure

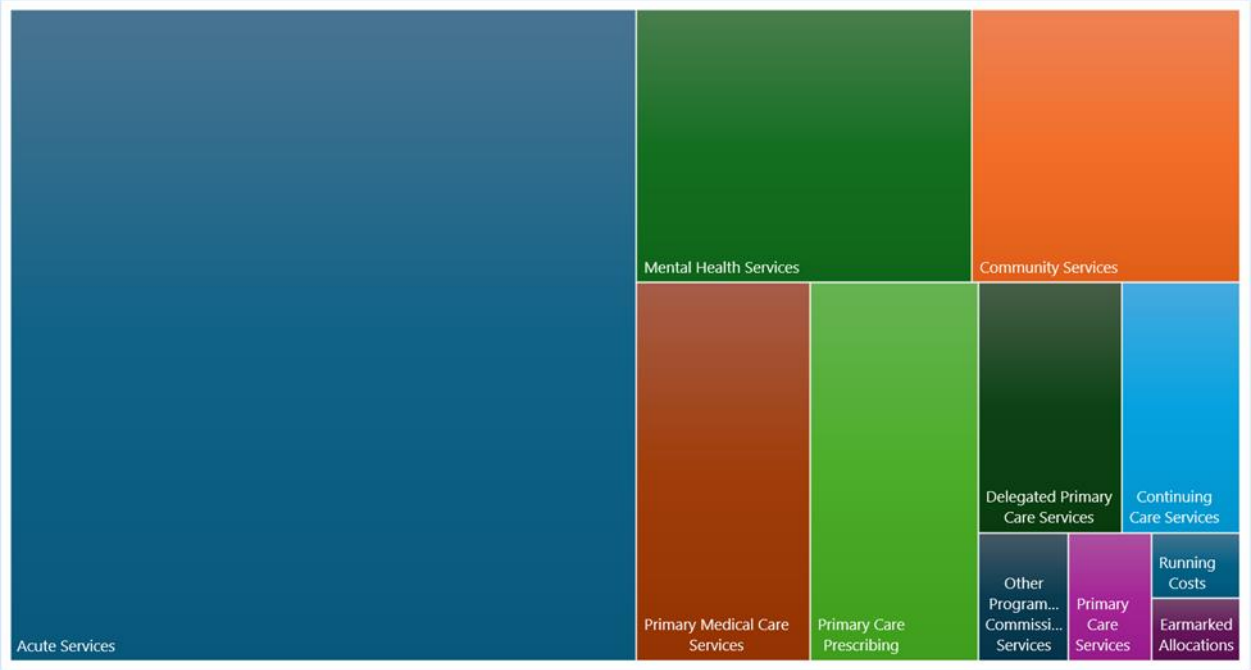
The ICB plans to spend its allocations across a range of areas, as shown in Table 8.

Table 8

Area	Description
Acute Services	By far the largest expenditure area for the ICB. This includes services such as Emergency Departments (A&E), and Inpatient and Outpatient medicine and surgery as well as expenditure on Ambulance Services. The majority of expenditure is with the GM NHS Providers (£3,224m), but services are also commissioned from NHS providers outside of Greater Manchester (£236m) and through Independent Sector providers (£188m).
Community Services	Services generally provided out in the community and in some case in patients own homes. It includes District Nursing, Community Audiology and Optometry, Reablement Services, Termination of Pregnancy, Hospices and Palliative Care, Long Term Conditions services, Wheelchair Services, and Community Children's services. The majority of expenditure is with GM NHS Providers (£360m), and only a small element is commissioned with NHS providers outside of GM (£1m). A large element of spend is commissioned through non-NHS providers which will largely be through Local Authorities, or through the VCSFE sector (£313m).
Mental Health Services	Mental Health, Learning Disability, Dementia and Autism services. It also includes individualised packages of care for these areas, and joint Section 117 Mental Health aftercare in the community packages with Local Authorities The majority of expenditure is with GM NHS Providers (£564m), and only a small element is commissioned with NHS providers outside of GM (£12m). A substantial element of spend is commissioned through non-NHS providers which will largely be for individual packages of care through Independent Sector providers, or through the VCSFE sector (£229m).
Continuing Care Services	Continuing Healthcare placements, including those on personal health budgets, and the cost of Funded Nursing Care. CHC costs include costs of healthcare within Care Home, Home Care, and Supported Accommodation settings, as well as Day-care and associated transport costs.
Primary Care Services	Locally commissioned Primary care services including local enhanced services provided by GP Practices, Opticians and Pharmacies
Primary Care Prescribing	the cost of Prescribing in primary care the vast majority is for prescriptions issued by GP Practices, but a small element relates to the cost of prescriptions issued by other services
Other Programme / Commissioned Services	Estates and Facilities costs, and the costs of Counselling and Interpretation Services
Primary Medical Care Services	National GP Primary care contract costs, and schemes such as the Additional Roles Reimbursement Scheme (ARRS), and the Impact & Investment Fund.
Delegated Primary Care	Costs relating to the primary care provision of NHS Pharmacy services, Ophthalmic Services, and Dental Services, sometimes referred to as POD services. This also includes the costs of Secondary Care dental services
Running costs	The operating costs of the ICB including staffing, estates, and other non-pay related costs.
Earmarked reserves	Funding streams that are Earmarked for specific purposes or historical pressures but that have not yet been transferred to that service area.

Figure 7 gives a visual representation of the proportion of expenditure in each of these areas.

Figure 7[16]



The detail of our planned expenditure for 2024/5 is shown in Table 9.

[16] Included in ICB Board paper for meeting on 20.3.24

NHS Greater Manchester

Table 9[17]

ICB Financial Plan 2024/25	Recurrent £'000s	Non-Recurrent £'000s	Total £'000s
Resource Allocation			**-7,222,962**
Expenditure:			
Acute Services	3,753,850	0	3,753,850
Community Services	672,105	0	672,105
Mental Health Services	842,039	0	842,039
Continuing Care Services	270,841	0	270,841
Primary Care Services	98,178	0	98,178
Primary Care Prescribing	585,905	0	585,905
Other Programme/Commissioned Services	105,777	0	105,777
Primary Medical Care Services	604,949	0	604,949
Delegated Primary Care Services	333,515	-3,192	330,323
Running Costs	53,528	0	53,528
Earmarked Allocations	33,811	16,656	50,467
Programme Slippage	0	-42,000	-42,000
Cost Improvement Plans	-82,450	-20,550	-103,000
Total Expenditure	**7,272,049**	**-49,086**	**7,222,962**
ICB Net Surplus / Deficit			**0**

6.1.3 The Financial Challenge

The ICS has worked with system partners to identify sustainable cost reductions and savings in conjunction with PricewaterhouseCoopers (PWC) and a national turnaround director, to develop credible and robust financial plans for 2024/25. The system is currently forecasting to end the year with a financial deficit of £180m of which £34.7m of the deficit relates to the ICB, and £145.3m of the deficit relates to the nine GM NHS providers.

Our planned revenue expenditure for 2024/5 is currently however larger than our allocations (income) by almost £300m. This is why we must strive to improve our position continuously across 2024/5 – as described in the actions in section 6.1.4.

6.1.4 What we will do

Whilst we are making steady progress, we acknowledge that there is much to do. This plan describes the actions we will take. In 2024/25 we will focus on:

- The continuation and further embedding of grip and control
- A systematic reduction in our dependency on the private sector (see section 6.2.2)

[17] From ICB Board paper for meeting on 20.3.24

- An expectation of recurrent provider and ICB CIP/QIPP 1-2% over and above that required by the tariff deflator in the planning guidance for providers and the ICB (with a minimum recurrent delivery of 75%) – see section 6.2.1
- A running cost and operating cost target for the ICB of at least 10%
- A requirement to reduce the use of temporary staffing and agency spend to 3.7% and to achieve workforce retention of 10.5% by March 2025 (see section 6.1.5)

There are four areas of further work which may be a source of further efficiencies for 2024/25 and 2025/26 and underpin longer term sustainability:

- Deeper provider collaboration for example on shared services and non-clinical support services
- Further savings in the running costs of the ICB itself
- Changes arising from the Clinical Services Strategy work (see section 5.13.2)
- Commissioning key decisions on thresholds, service policies, unfunded/underfunded/challenged services (see section 5.13.1)

These programmes will need to be complemented by 2–3-year transformation plans, put in place by providers and the ICB to address deficits and reach at least median national productivity metrics.

6.1.5 Workforce

Our workforce plans for 2024/25 have been developed in line with the following high level **assumptions**:

- Workforce growth – we will focus on making sure that our workforce is supported to maximise our productivity and only recruit by exception, utilising investments from NHSE specific to service delivery. Maintain future workforce supply and succession planning.
- Workforce efficiencies - adapting skill mix and accelerating the introduction of new roles i.e., PAs, AAs, Apprenticeships, Advanced Practitioners.
- Temporary staffing - Reduce agency spending across the NHS to 3.7% of the total pay bill in 2024/5 which is consistent with the system agency expenditure limits for 2024/5 that are set out separately, working within the Off Framework 0% and Price Cap 60% national targets
- Wellbeing and Retention - Improve staff experience and retention through systematic focus on all elements of the NHS People Promise and implementation of the Growing Occupational Health Strategy improving attendance toolkit

Our plan is based on forecasted and planned predictions which align to workforce, finance and activity assumptions alongside what we know about supply and demand across a range of professional staff groups to deliver the Sustainability Plan over the course of the next 3 years.

NHS providers in GM continue to implement initiatives which have positive effect to improving retention within their organisations. The data, insight, and intelligence modelling during 2023/24 is showing improvements in retention levels which are stabilising, and also considers natural churn where our workforce moves across the system from NHS Provider to Provider. The focus on retention is a long-term commitment which aligns to the delivery of the Long-Term Workforce Plan ambitions and NHS People Promise. Key activities supporting this include:

- Supporting the retention of our workforce through improved employee experience and culture

initiative from OD offers, leadership framework, stay and grow conversations and recognition schemes.

- Relaunch of the Health & Wellbeing Toolkit offer and Employee Assistance Programmes to enable the workforce to seek resources and additional support because of the current economic climate.

A QIPP programme to review external cost drivers for workforce is under development.

6.2 Productivity and Efficiency

6.2.1 Cost Improvement Programmes

NHS planning guidance assumes a minimum efficiency requirement of 1.1% but the ICB is starting 2024/25 from a significant recurrent underlying deficit position and must also offset the negative impact of 2024/25 convergence. Table shows the current Cost Improvement Plans (CIP) included in our plans. This is circa 4.22% for providers and 5% of influenceable spend for the ICB.

There has been a clear expectation that systems would plan for at least 75% of their CIP to be recurrent, with the provider sector currently forecasting 79%. The ICB is planning for a CIP of £103m, of which 80% is deemed recurrent. The ICB CIP Delivery Group will be overseeing the construction of plans that deliver the requisite values.

Table 10

2024/25 Efficiency £m's	Recurrent	Non Recurrent	2024/25 Savings	Recurrent/Non-Recurrent
Providers	251.4	80.4	331.8	76% 24%
ICB	82.5	20.6	103.0	80% 20%
Total	**333.9**	**101.0**	**434.8**	77% 23%

6.2.2 QIPP Programmes and approach

We have identified a series of programmes which will deliver financial efficiencies but also increase quality and productivity. We will work with our providers to review and address unwarranted variation, both nationally and within GM. Providers will need to constructively challenge themselves in respect of benchmarking, productivity and outcomes and optimising patient pathways – for example, patient initiated follow ups, first to follow up ratios, use of advice and guidance and digital appointments. It important to note that, in this section, **any savings amounts are indicative** and are included for "order of magnitude" guidance purposes at this stage.

Significant work has been delivered in 2023/24 to establish work plans to deliver the efficiencies financially but also to increase quality and productivity across NHS GM. The Finance Performance Recovery PMO and Commissioning Oversight Group are interlinked to ensure no opportunity is missed (see section 7.1).

- Work in train as part of 2023/24 plans will support NHS GM CIP in 24/25 as shown in Table 101, where not already described.

Table 101: QIPP schemes continuing from 2023/4

Scheme	Status
Continuing Health Care	Requirement is for effective strategic joint planning for CHC delivery across GM which meets the needs of the community and is financially viable, driven by high quality services. Targeted work on Workforce, Contracting, Package development

	& review, standardisation of CHC policy & procedure to achieve expected outcome. 2023/24 total budget is circa £250m
Medicines Optimisation	A GM Medicines Optimisation QIPP reporting methodology and group is in development For 24/25 contributions to CIP will come from-: • GM locality meds op teams - • GM meds value workstream • Secondary care plans Work ongoing to finalise numbers

- Work is underway to have an aligned view on immediate productivity gains across all providers, including utilising relevant benchmarking and best practice guidance as part of provider CIP.
- Plans are in place to support delivery in 2024/25 with circa £64.5m expected QIPP already planned for. Further work has also been undertaken in respect of reducing baseline budgets and so this figure is reflective of the additional stretch target in these areas – for example, CHC, prescribing, etc.
- There has been a due diligence process developed to ensure pipeline ideas are worked up and have the right assurance and leads in place to deliver. This will ensure that responsibility, risk and efficiencies are managed, and the governance framework will ensure decision making is safe and effective.

6.2.3 QIPP Pipeline

Table 112 sets out the pipeline of QIPP programmes being developed by the system, where not indicated previously.

Table 112: QIPP Pipeline

Scheme	Status
Estates	On going work throughout 23/24 has been picked up as part of the Provider CIP plans. Data analysis is in progress for void building CIP. Following this a CIP relating to subsidies will be developed, the value of which will be informed by the void work.
Non Healthcare Contract Consolidation (NHCC)s	The Non-Healthcare Contracts consolidation and rationalisation project seeks to identify opportunities to consolidate multiple locality/function agreements with a single supplier into a centralised NHS GM contract. Another aim is to explore potential efficiencies where localities/functions commission the same Non-Healthcare service from different suppliers, by instead seeking to procure one supplier to deliver the service across Greater Manchester. The live Non Healthcare database currently includes contracts with a total value of £24,259,150. the work completed to date suggests this would equate to savings of £1,212,957. (£1.2 million) -noting this only tracks contracts which are on the NHCC database, and we have a signed contract for, or we have been informed by the relevant team that the service and contract is being used. This does not include any estimates for areas which are outside of the database and where we continue to incur spend but don't have a contract.
Legal Services	Work is currently being scoped to understand the opportunities to establish a legal services directory of services (DoS) that would allow for a single point of access for all functions and localities to use as a first point of call before contacting legal services to see if advice has previously been paid for. If further advice is required, then a request would be made via a central point to ensure the DoS is effectively updated. Main line of opportunities is around CHC/Complex Care and Contacts & Procurement.
Better Care Fund	The BCF was introduced as a mechanism to support integration at place level. An

	analysis of current BCF plans show that across localities there is funding of circa £10m of NHS contributions over and above minimum BCF contributions. This is not to say that these contributions are not funding services, but it is now timely to undertake a full review to ensure we are clear about where BCF spend is directed and whether any of the funding could be used for other purposes.
Optimal Organisational Structure	We will continue transformation of NHS GM to ensure optimal organisational structure, ensuring all workforce are aligned against the ICS priorities NHS GM met the operational budget in 23/24 however there is an expectation form NHSE we will make a further reduction on ICB running costs by circa 15% (TBC). Before any structures are re modelled a full review of vacancies and an agreement of budgets is required. As part of budget setting budgets have been set at the reduced value to meet the reduced national allocation

6.2.4 Other approaches to improving productivity

As part of the provider contribution to system recovery, one of the key areas identified for targeted action has been on productivity. In August 2023, a dedicated Trust Productivity Improvement Group was established through the GM Trust Provider Collaborative, with a representative/ productivity champion from each trust.

The initial purpose of the group was to ensure we had a clear and accurate understanding of productivity across trusts, and to inform collective and organisational improvement action which is facilitated via peer support and challenge. The aim of the work is to improve GM averages across productivity metrics, support and enable delivery of Trust CIPs and maximise use of resources. The key outputs and outcomes of the group have been:

- Production of a regular productivity pack across a range of productivity metrics (agreed through the group and with the ICB) which provides comparison across GM trusts and has been reviewed by each trust following each publication to identify opportunities for improvement to be explored internally or with other trusts/partners.
- Following the first few iterations of the GM pack, the NHSE North West team requested that the scope of the pack was widened to cover all North West Trusts, with GM asked to lead on the production. As a consequence, the latest packs have provided data across all North West Trusts, enhancing the ability to compare and contrast across peers using a rankings system, aimed to further highlight improvement opportunities.
- Through the meetings of the GM Trust Productivity Improvement Group opportunities to learn across trusts and share best practice areas have been taken up, in areas such as reducing DNAs (Did Not Attends) for elective appointments and improving flow/ discharges.

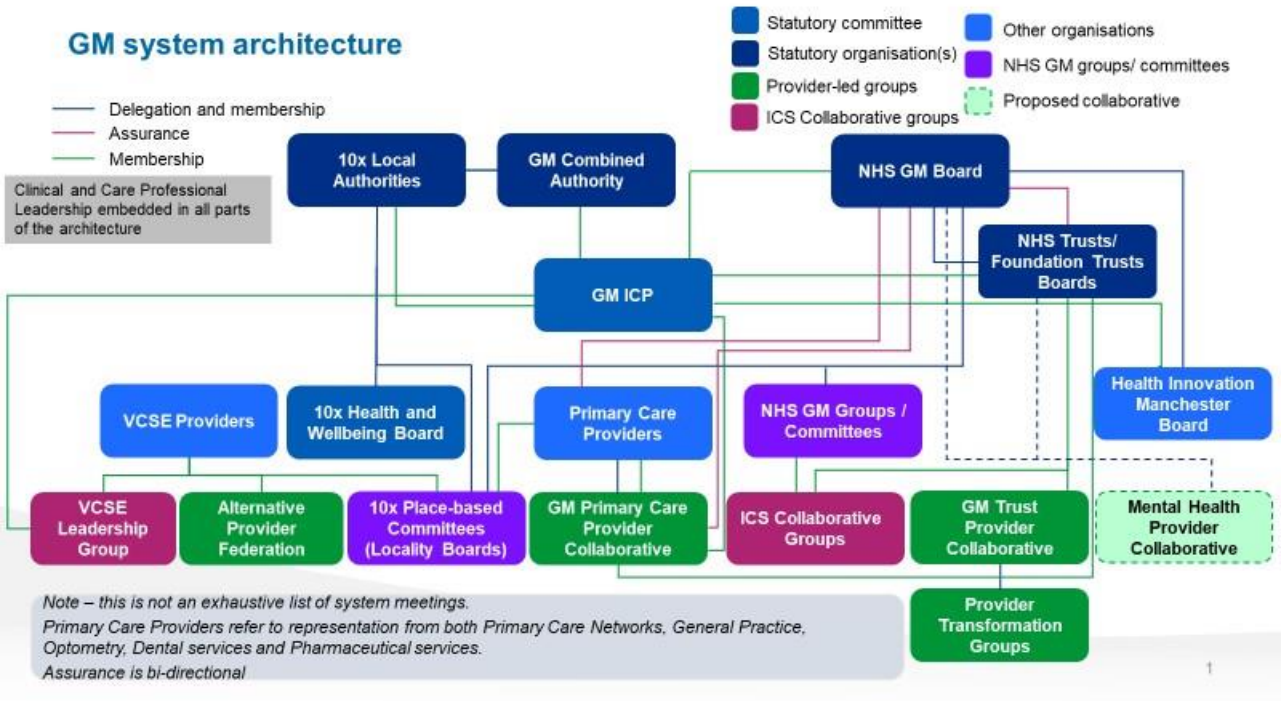
The focus on productivity improvement will continue through 2024/5 and also to support the sustainability plan, targeted work will take place within relevant system groups to drive improvement in productivity at a system level e.g., in elective care.

7 How we will deliver

7.1 Governance and Accountability

All parts of Greater Manchester's governance structure will have a vital role to play in delivering this plan and in providing the necessary assurance to the Integrated Care Board. Our system architecture is shown in Figure 8:

Figure 8

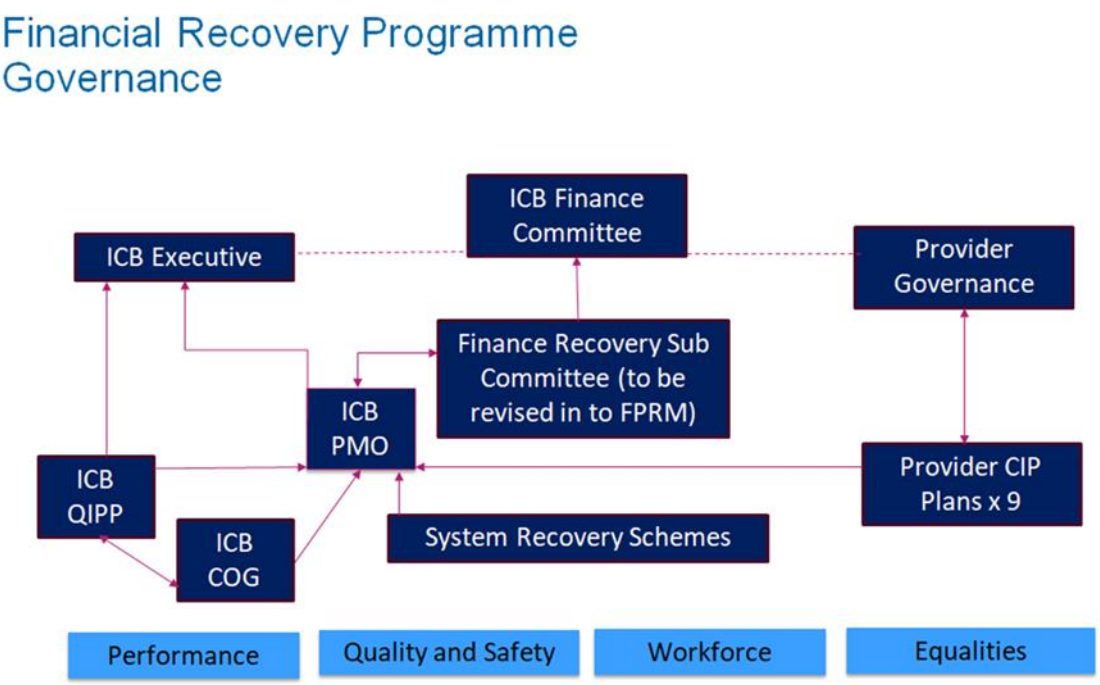


The Quality and Performance Committee (one of the NHS GM Groups/Committees in Figure 8will play a crucial role in assuring the Integrated Care Board that the quality and performance element of the Triple Deficit are continuously improved.

The Committee will give assurance that NHS GM is delivering its functions against each of the dimensions of quality set out in the Shared Commitment to Quality by the National Quality Board (NQB) in 2021. Additionally, the Committee will ensure that both quality and performance data and information is used to support improvements and sustain best practice

Given the importance of system financial recovery in underpinning all that we do, we will need to ensure the continuation of financial grip and control in the system. The financial recovery governance is set out in Figure 9:

Figure 9



In addition, the Commissioning Oversight Group has been established to make recommendations on proposed NHS GM commissioning decisions. The group will do this by undertaking a systematic assessment of services against an agreed set of outcome, efficiency, effectiveness and quality measures. This group is a non-decision-making forum. The group collectively agree where each recommendation should most appropriately be considered from the following.

- NHS GM Executive
- NHS GM Sustainable Services
- NHS GM Finance and Recovery Committee

and ensure that decisions are then made and communicated as appropriate.

The NHS GM Executive team will ensure the management of the functions contributing to recovery is delivered in the most efficient and effective way. The Executive portfolios are described in Figure 10:

Figure 10

7.2 Our approach to planning

For 2024/25 our approach builds on the grip and control measures already in place in Greater Manchester – for example, through Finance, Performance and Recovery Meetings (FPRM) with providers and the ICB.

The range of system contributions to our plans are co-ordinated by the Planning Hub – which meets weekly for three hours and has the relevant leads for each of the supporting processes. It is chaired by the Chief Officer for Strategy and Innovation. The Hub provides weekly briefings for system partners and ensures that key messages are received from, and communicated to, the main governance groups in GM.

For 2024/25, we decided to start the planning process much earlier in Greater Manchester and to base our plans on assumptions generated within the system – using NHS England planning guidance as an important, but not the sole, driver of our plans.

The NHS England guidance is usually published in December – that did not happen for this planning round. Instead, only indicative draft guidance has been circulated at national level. We have therefore continued to work to the assumptions and deadlines developed in GM. This is to ensure that we are developing our own plans as rapidly as possible bringing clarity to our intentions for financial and performance recovery, and population health improvement, notwithstanding the national uncertainty. Our approach has been guided by the importance of bringing a budget and plan for 2024/25 to Board before the end of March – to ensure we can realise the full-year effect of our plans.

In late February and March, we focused on the confirm and challenge stage of the planning process. Each provider plan, and the plan for the ICB, was subject to detailed scrutiny – linked to the FPRM process. This resulted in a set of refreshed plans based on a challenging set of conversations with senior leaders. NHS GM oversaw this process in the context of our role as commissioner for the system and the statutory organisation responsible for the system control total.

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7.3 Embedding the ICS Operating Model

Partners in the ICS agreed a refreshed Operating Model for the system in September 2023. 2024/25 will be the first full year of delivery of the model and it is essential that it drives the realisation of the aims in this plan.

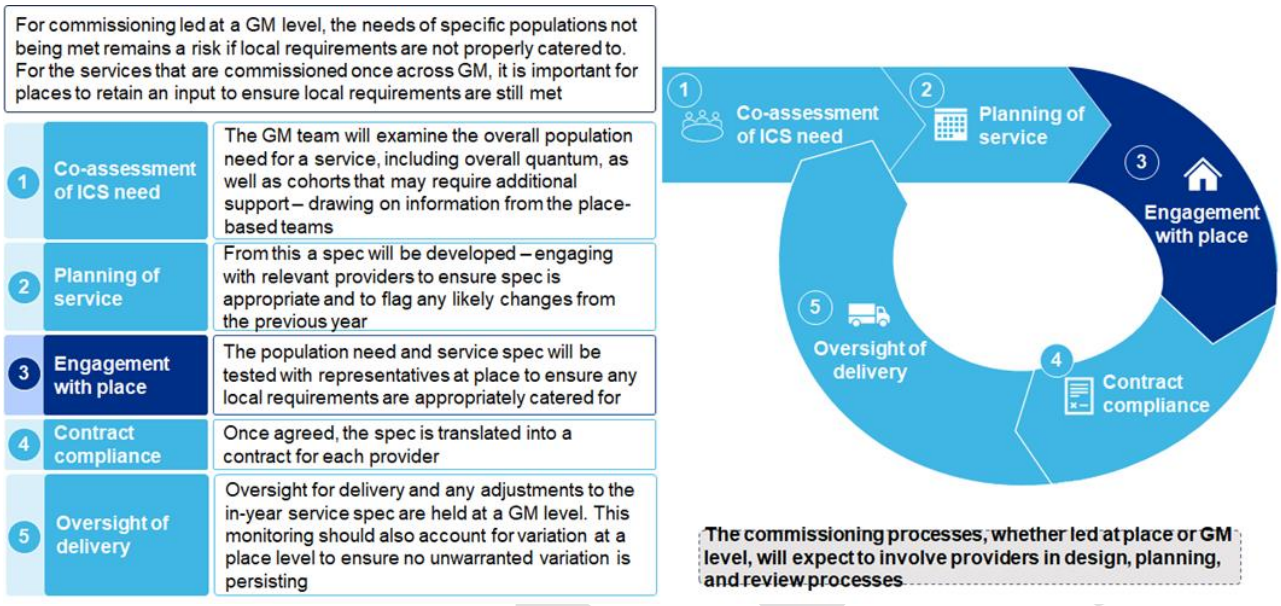
The Operating Model makes the key roles of all partners in strategy, planning and delivery clear as shown in Figure 11 :

Figure 11

Function	ICP	NHS GM		Provider collaboratives	Place-based partnerships	Individual providers	Local authorities
		Across GM	In service of place				
Developing an ICS strategy	Oversees development of strategy	Leads development and coordinates across partners	Oversees development of place strategies	Informs strategy	Articulates local needs to inform strategy	Participates via collaborative forums	Participates via place-based partnerships/ICP
Using joined-up data and digital capabilities	N/A	Utilise joined-up data to drive system-level decisions	Utilise data to drive decisions at place	Utilises data to drive collective decision making	Oversees local data flows and informs local decision making	Participates via collaborative forums	Participates via place-based partnerships
Establishing population health intelligence and analytics	N/A	Create infrastructure and embed capabilities across system	Drive usage of available data to create clear picture of population need	Use information to inform programmes of work	Coordinates usage of information and embeds approach in neighbourhoods	Ensures underpinning dataflows are in place and effective	Ensures underpinning dataflows are in place and effective
Developing a plan to meet the health needs of the population	N/A	Develops overarching plan to meet needs, inc. finance, and NHS objectives	Coordinates place-based plans that feed into overarching plan	Ensures service offer is appropriate to meet needs	Creates place-based plans to feed into overarching plan	Participates via collaborative forums	Participates via place-based partnerships
Establishing and operating governance arrangements	N/A	Oversees development and renewal of ICS operating model. Creates quality and performance management framework.	Ensures clear accountabilities flow through from place	Approves additional governance groups – alongise NHS GM	Oversees development of governance within each place	Ensures participation in system forums. Reports performance and quality into NHS GM	Ensures participation in system forums.
Establishing and supporting joint working arrangements							
Allocating resources across the system	N/A	Determine resource allocation between services and places	Holds allocation at place Develop and operate place based budgets	Articulates resource requirements to NHS GM	Articulates resource requirements to NHS GM	Participates via collaborative forums	Participates via place-based partnerships
Ensuring the system meets financial targets/balance	N/A	Sets plan and oversees delivery for GM-led services	Oversees delivery for place-led services	Develops plans that release cost through scale	Develops plans that release cost through integration	Develops organisation-level plans	Develops organisation-level plans
Commissioning health and care services	N/A	Responsible for commissioning some health services once across GM	Responsible for commissioning some health services in place	Informs service specs and models – supporting reduction of unwarranted variation	Undertakes commissioning of services within each place and oversees delivery	Provides services based on commissioning intentions	Responsible for commissioning LA services
Invest in community organisations and infrastructure	N/A	Make funding available to support community projects	Investing in and working alongside LAs and community partners	Develop roles of providers as anchor institutions	Develop plans that invest in local communities and infrastructure	Participates via collaborative forums	Participates via place-based partnerships
Support delivery of population health management approach	N/A	Provide investment and proliferation of best practice	Ensure data and resource is available to drive within place	Support spread of best practice examples	Deliver approach through neighbourhoods	Participates via collaborative forums	Participates via place-based partnerships
Arrange for provision of health and care services	N/A	Coordinate delivery of system level plans	Coordinate delivery of place-level plans	Oversee delivery of some transformation programmes	Oversee delivery within each place	Participates via collaborative forums	Participates via place-based partnerships
Planning, responding to and recovering from incidents	N/A	Lead on incident coordination	Prepare for incidents alongside place-partners	Support response to incidents	Prepare for incidents within place	Category 1 responders + others support system	Category 1 responders
Undertaking public communications and engagement	N/A	Leading and coordinating engagement	Coordinating engagement at place	Support engagement efforts across GM	Build engagement networks at place	Engagement with local patient groups	Engagement with local groups
Implementation of the People Plan	N/A	Leading delivery of plan and oversight across system	Develop plans to optimise workforce in each place	Coordinate provider response to People Plan via People Group	Oversee delivery of People Plan at place	Participates via collaborative forums	Participates via place-based partnerships
Develop digital solutions across the system	N/A	Develop and oversee delivery of joined-up digital plan	Determine place-specific requirements for digital plan	Coordinate provider response to digital plan via Digital Group	Responsibility for oversight of delivery in each place	Participates via collaborative forums	Participates via place-based partnerships
Develop joint work on estates, procurement, supply chain and commercial strategies	N/A	Set strategies for at scale work	Identify opportunities for improved estates utilisation at place	Coordinate provider collaboration in realising benefits at scale	Agree strategies for collaboration at place (focusing on estates)	Participates via collaborative forums	Participates via place-based partnerships

Within the Operating Model, the application of the Commissioning Cycle will be integral to driving system change. This is outlined in Figure 12:

Figure 12



We will build on the current performance dashboards in the system to develop a Performance Framework, including both NHS operational measures and broader population health measures – covering this plan and our Joint Forward Plan and ICP Strategy. The Framework will apply to both the activities under the direct influence and resourcing of NHS GM and the social determinants of health.

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

Underpinning the Operating Model are an agreed set of ways of working that describe the values and behaviours that guide the way we collaborate in GM (Figure 13):

Figure 13

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7.4 Delivering on our Statutory Responsibilities

NHS GM has 18 core functions, informed by legislation, as shown in Table 3 . We must continue to deliver against all of these areas in 2024/25 as this plan describes.

Table 13

KEY

- NHS GM functions required to fulfil statutory duties of the ICP
- Statutory functions of NHS GM
- Additional functions of NHS GM set out in national guidance

1	**Supporting** the ICP and system partners to develop the **Integrated care strategy** through the provision of resources and advising on requirements as set out in national guidance
2	**Using joined-up data and digital capabilities** to understand local priorities, track delivery of plans, monitor and address variation and drive continuous improvement in performance and outcomes
3	Establishing **population health intelligence and analytical** capabilities to generate insight on variable population needs across the system
4	**Developing a plan** to meet the health needs of the population within GM, including setting out the activities required to deliver the strategy, who is responsible for these, phasing of these activities, monitoring requirements and financial management arrangements
5	**Establishing and operating governance arrangements** to support collective accountability between partner organisations for whole-system delivery and performance to ensure the plan is implemented effectively within a system financial envelope set by NHS England
6	**Establishing and supporting joint working arrangements** with partners that embed collaboration as the basis for delivery of joint priorities within the plan
7	**Allocating resources** to deliver the plan across the system, including allocating resources to provider collaboratives and place-based partnerships based on population needs and priorities
8	Ensuring annual budget, revenue, capital limits and running cost allowance for NHS GM **are not exceeded**, **conducting accounting and banking** in line with legal requirements and **providing relevant financial information** to NHSE
9	**Commissioning** hospital and community NHS services, as well as additional services NHS England will be delegating (e.g., specialised, primary medical, mental health, community pharmacy, ophthalmology and dental)
10	Working alongside councils to **invest in local community organisations and infrastructure** and, through joint working between health, social care and other partners, ensuring that the NHS plays a full part in influencing the wider determinants of health such as social and economic development and environmental sustainability
11	**Supporting the delivery of public health and population health management** across the ICS - taking account of relevant public health laws, regulations and governance structures, and advancing public health research and investment
12	**Arranging for the provision of health and care services** in line with the allocated resources across the ICS through a range of GM-wide and place-level activities
13	**Planning for, responding to, and leading recovery from incidents (EPRR),** to ensure NHS and partner organisations are joined up at times of greatest need, including taking on incident coordination responsibilities as delegated by NHS England.
14	Leading **communications and public engagement** to seek public and patient views on experience to inform service planning and redesign
15	**Leading system implementation of the People Plan** by aligning partners across each ICS to develop and support the 'one workforce' approach
16	**Leading system-wide action on data and digital,** working across the partnership to put in place smart digital and data foundations to connect health and care services and ultimately transform care to put the citizen at the centre of their care
17	**Driving joint work on estates, procurement, supply chain and commercial strategies** to maximise value for money across the system and support these wider goals of development and sustainability
18	Fulfilling **additional legal duties** of NHS GM as set out in various Acts

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Appendix 1

National NHS Objectives

These are the key NHS objectives which NHSE require to be considered in the planning process, and against which we submit regular performance reports to NHSE

Area	Objective
Urgent and emergency care	Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25
	Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25
	Reduce adult general and acute (G&A) bed occupancy to 92% or below
	G&A Beds
Community health services	Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard
	Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals
Primary care	Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need
	Continue on the trajectory to deliver more appointments in general practice
	Continue to grow Primary Care Workforce
	Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels
Elective care	Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)
	Eliminate waits of over 52 weeks for elective care by March 2025 (except where patients choose to wait longer or in specific specialties)
	Deliver the system- specific activity target (agreed through the operational planning process)
	Deliver the system- specific activity target (agreed through the operational planning process)
Cancer	Continue to reduce the number of patients waiting over 62 days
	Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days
	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028
Diagnostics	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%
	Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition
Maternity	Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury
	Increase fill rates against funded establishment for maternity staff
Finance	Deliver a balanced net system financial position for 2023/24
	Financial Plan (March 25) £'s
	Financial Plan (March 25) £'s
Workforce	Workforce - Expected Total Workforce FTE March 25

Area	Objective
	Workforce - Expected Substantive Staff in Post FTE March 25
	Workforce - Expected Bank staff in Post FTE March 25
	Workforce - Expected Agency staff in Post FTE March 25
	Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise
Mental health	Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019)
	Increase the number of adults and older adults accessing IAPT treatment
	Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services
	Work towards eliminating inappropriate adult acute out of area placements
	Recover the dementia diagnosis rate to 66.7%
	Improve access to perinatal mental health services
People with a learning disability and autistic people	Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2025
	Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2025 no more than 30 adults with a learning disability and/or who are autistic per million adults are cared for in an inpatient unit
	Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2025 no more 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit
Prevention and health inequalities	Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2025
	Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%
	Continue to address health inequalities and deliver on the Core20PLUS5 approach

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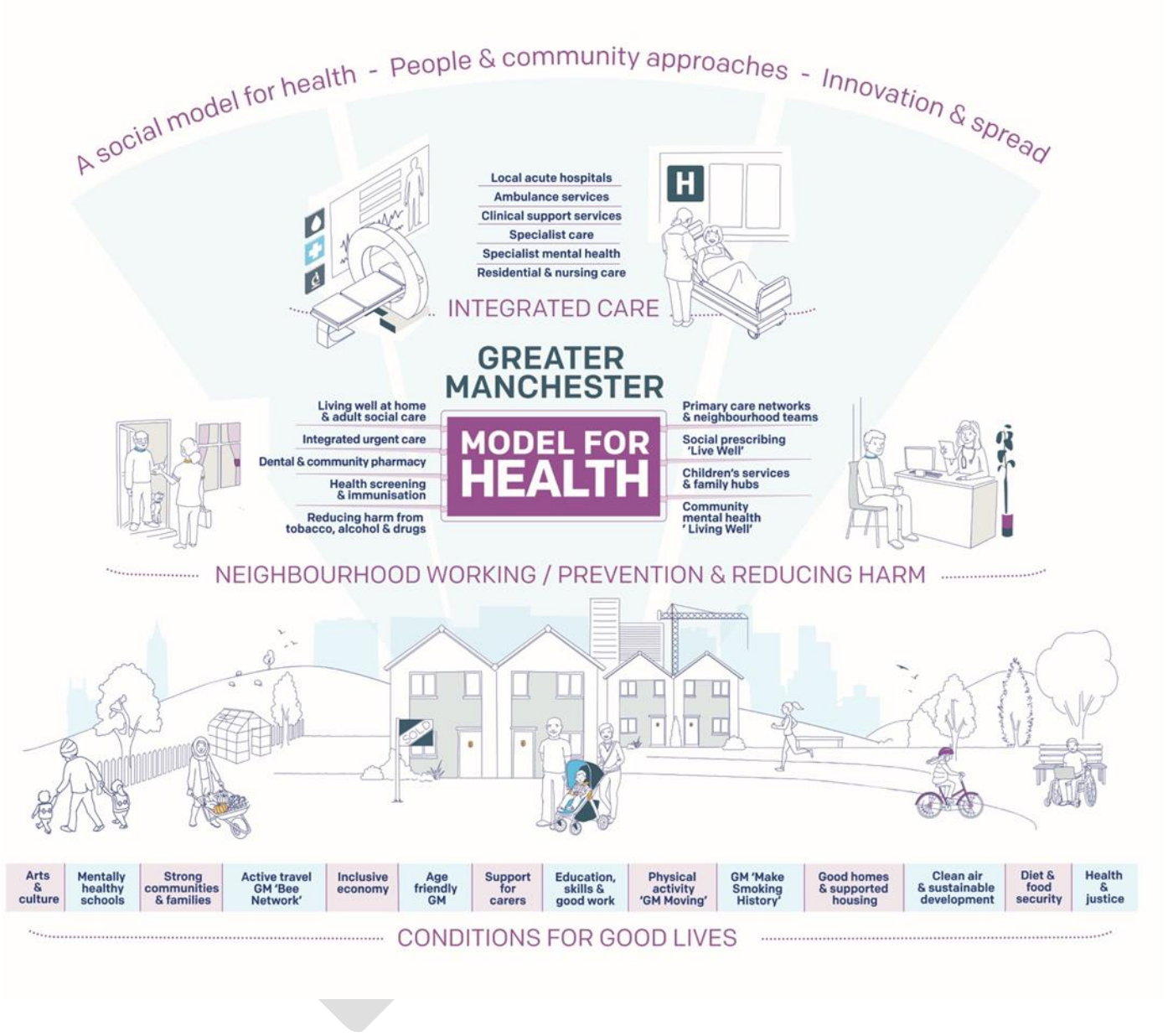
Appendix 2

The Greater Manchester model for health



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Appendix 3

Table 12

Priority 1: Deliver a 3-year programme to prevent Cardiovascular Disease and Diabetes and advance key Joint Forward Plan commitments (particularly Missions 1 to 3) where there is an opportunity to have a significant impact on health outcomes and inequalities, health and care service demand and system expenditure		
Work with partners to tackle the Wider, Social and Commercial Determinants of Ill Health:		
Priority Area of Focus	**Pan-GM Deliverables**	**Suggested Locality Deliverables**
Work and Health	Establish a GM Joint Inclusive Employment Unit, bringing together representatives of GMCA, NHS GM and DWP into a single team, with a 2024/25 focus on co-ordinating the development a GM Joint Inclusive Employment Strategy and shaping the work and skills elements of the GM Devolution Trailblazer deal. Lead the planning and implementation of the GM WorkWell partnership vanguard, including the establishment of a pan-GM WWP Support and Co-ordination function.	Participate in the co-design of a GM Joint Inclusive Employment Unit and a GM Inclusive Employment Strategy. Contribute to the co-design and implementation of the GM WorkWell partnership vanguard, including providing leadership of the establishment of locality WWP delivery functions.
Tackling Poverty as a Driver of Poor Health Outcomes	Co-ordinate a pan-GM training and development programme including poverty awareness training, and specialist training for clinicians. Co-ordinate the development of a GM approach to 'poverty proofing' health and care pathways and services including the development of a 'Tackling Poverty Toolkit' within the FHFA Academy, the use of Population Health Management approaches, and 3 'poverty proofing' reviews focussed on CVD prevention and treatment, Diabetes prevention and treatment, and Screening & Immunisation.	Enable staff to participate in poverty awareness training and development. Contribute to the 'poverty proofing' work programme through involvement in the 3 'poverty proofing' reviews focussed on CvD prevention and treatment, Diabetes prevention and treatment, and Screening & Immunisation, and considering poverty when designing, reviewing and delivering services and pathways.
Housing and Health	Support the development of ECO4 pathways in 4 localities to ensure that people with long term conditions get support to improve energy-efficiency in their homes. Develop evidence-based housing and health tools (comms, policies, referral pathways) that can be adapted for local use and are housed within the Fairer Health for all Academy. Develop reporting tools to monitor health outcomes of ECO4 interventions and wider health and housing interventions.	Develop integrated health and housing pathways to improve household conditions and align resource for remedial action. Contribute to the co-production of housing and health tools. Embed training on housing and health in locality workforce plans (health and care and housing workforce).
Best Start / Children & Young People CORE20PLUS5	Jointly co-ordinate the development of a GM Best Start Plan, and lead delivery of key areas such as smoke free pregnancies, infant feeding and FASD. Develop a CYP Best Start Dashboard (which includes CYP CORE20PLUS5 indicators).	Provide locality-level leadership (including engagement with other key local authority leaders) to contribute to the development and implementation of the Best Start Delivery Plan, including the local design and delivery of family hubs and the locality implementation of priority prevention programmes such as smoke free pregnancies, infant feeding and FASD.

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Priority 1: Deliver a 3-year programme to prevent Cardiovascular Disease and Diabetes and advance key Joint Forward Plan commitments (particularly Missions 1 to 3) where there is an opportunity to have a significant impact on health outcomes and inequalities, health and care service demand and system expenditure		
Work with partners to tackle the Wider, Social and Commercial Determinants of Ill Health:		
Ageing Well	Contribute to the implementation of the new GM Age Friendly Region Strategy.	Connect through NHS GM, as key locality health stakeholders, into the development and implementation of the new GM Age Friendly Region Strategy.
Commercial Determinants of Health	Support the development, and co-ordinate the implementation of, proposals to implement Junk Food Advertising Restrictions on Out of Home Advertising Estate (TfGM and the 10 GM Local Authorities) and review the feasibility of the future inclusion of additional categories such as alcohol. Participate as a partner in the NIHR-funded Bath University research into CDOH.	Lead on the review and implementation of changes to local advertising policy in relation to Junk Food Advertising Restrictions on Out of Home Advertising Estate and oversee political and wider stakeholder engagement and governance.
Making Smoking History	Publish a refreshed GM MSH 2030 Strategic Delivery Framework to ensure achievement of a smoke-free city region where less than 5% of people smoke by 2030. Deliver a comprehensive programme of evidence-based interventions including: Deliver two multi-media population level stop smoking behaviour change campaigns, amplify national campaigns, and provide 'always on' social media coverage. Continued delivery of an illicit tobacco programme focussed on an evidence base review and new research and development and delivery of an illicit tobacco campaign in partnership with Trading Standards NW and other north of England colleagues. Monitor and evaluate the programme of work through the Smoking toolkit monitoring, specific programme evaluation(s) and other research opportunities with a specific focus on the impact of interventions on behaviour and health outcomes (prioritising CVD and diabetes), health and care service demand / expenditure. Ongoing delivery of Social Housing project, Swap to Stop and the GM Smoke Free Spaces project (with a 2024/25 focus on Smoke Free Hospitals). Continue to improve and develop the offer of stop smoking and tobacco dependency treatment services across GM including the digital offer, in 2024/25: Review the LTP model for in-patient delivery in line with funding and embed into business-as-usual operating models – including multiple discharge pathway options that will include the VCFSE sector for mental health.	Endorse, support and deliver the locality 'asks' of the GM MSH 2030 Strategic Delivery Framework. Scope out opportunities for collaboration across localities in relation to TTD discharge pathways and stop smoking services. Participate in the GM Making Smoking History Alliance and provide local leadership on the development and delivery of locality tobacco alliances. Establish national and local reporting to allow monitoring of performance and areas of intervention across all NHS GM sites. Commissioning of VCSFE organisations and post-discharge options in relation to smoking cessation and mental health. Establish locality assurance sessions and co-deliver LMNS SBL assurance sessions. Engage in digital community of practice to drive engagement and stem change as the digital stop smoking system becomes established. Continue to monitor performance towards local and national targets, quality assurance of deliver of all programme elements.

NHS Greater Manchester

Priority 1: Deliver a 3-year programme to prevent Cardiovascular Disease and Diabetes and advance key Joint Forward Plan commitments (particularly Missions 1 to 3) where there is an opportunity to have a significant impact on health outcomes and inequalities, health and care service demand and system expenditure		
Work with partners to tackle the Wider, Social and Commercial Determinants of Ill Health:		
	Creation of a pan-GM tobacco patient level data set and dashboard within Curator and ADSP, to provide monitoring and evaluation, and to enable the application of a Population Health Management approach to programme delivery, as a national trailblazer Continue to oversee and assure the delivery and iterative refinement of the NHSE TTD programme requirements with a specific focus on Mental health Drive delivery of the GM Smokefree pregnancy programme to reach SATOD 4% by 2030	
Tackling Alcohol Harm	Co-ordinate the development of a co-produced and evidenced based GM Alcohol Plan, in recognition that alcohol is a cause of CvD and Diabetes. This will include undertaking the necessary research, creating opportunities for engagement and co-production, and co-ordinating a GM Alcohol Expert Reference Group. Continue to co-ordinate pan-GM activity to enable full compliance with the NICE FASD Quality Standard, as part of the Maternity Equity Plan and our ambition to give every child the best start in life.	Contribute to the development of a co-produced and evidenced based GM Alcohol Plan, including participating in a GM Alcohol Expert Reference Group. Ensure local alcohol harm services are integrated and provide end to end support to individuals with high levels of risk or need (including children, pregnant women and those living with an alcohol-related health condition), including preventative activity, specialist community treatment, and hospital-based provision.
Increasing Physical Activity	Continue to co-ordinate ongoing work to embed physical activity as a consideration across the totality of the health and care system (including prevention of poor health), with a particular 2024/25 focus on the prevention of CvD and Diabetes. Oversee the 3-year (2024/25-2026/27) NHS GM contribution to the GM Moving Strategy co-investment arrangements and ensure that the grant conditions are aligned to the priorities of the multi-year prevention plan, including a year 1 focus on preventing CvD and Diabetes.	Continue local collaboration to implement the ambitions of the GM Moving Strategy, including a specific focus on embedding physical activity as a consideration across the totality of the health and care system (including prevention of poor health), with a particular 2024/25 focus on the prevention of CvD and Diabetes.
Food and Healthy Weight	Interpret and disseminate the outputs and result of the consultation in relation to Childhood Healthy Weight and ensure that this is used to inform strategy development in 2024/25. Co-ordinate the development of a whole system 5-year Strategic Delivery Framework for Food and Healthy Weight (with a focus on Childhood Obesity), as a key determinant of poor health outcomes including CvD and Diabetes.	Participate in, and lead locality input into, the collaborative development of a whole system 5-year Strategic Delivery Framework for Food and Healthy Weight (with a focus on Childhood Obesity), as a key determinant of poor health, including CvD and Diabetes.

NHS Greater Manchester

Priority 1: Deliver a 3-year programme to prevent Cardiovascular Disease and Diabetes and advance key Joint Forward Plan commitments (particularly Missions 1 to 3) where there is an opportunity to have a significant impact on health outcomes and inequalities, health and care service demand and system expenditure		
Work with partners to tackle the Wider, Social and Commercial Determinants of Ill Health:		
	Collaborate with system partners, including the SCN, in relation to the review and strengthening of the LTP requirements in relation to weight management, and the planned commissioning review of Tier 3 provision.	
Improving Mental Wellbeing	Lead the development and implementation of a co-designed delivery plan for the mental wellbeing strategic objectives of the GM Mental Health and Wellbeing Strategy. Develop a cross-programme evaluation framework to evaluate the impact and 'reach' of mental wellbeing programmes, with a particularly focus on the extent to which they improve health outcomes, reduce health inequalities, reduce demand and reduce system expenditure. Collaborate, co-design and produce resources and tools to support the mental wellbeing of GM residents and incorporate these into the Fairer Health for All Academy.	Contribute to the co-design and delivery of a plan for the mental wellbeing strategic objectives of the GM Mental Health and Wellbeing Strategy. Contribute data and insight as needed to build a picture of the impact and reach of mental wellbeing tools and resources, with a particularly focus on the extent to which they improve health outcomes, reduce health inequalities, reduce demand and reduce system expenditure. Co-produce mental wellbeing resources and tools for communities in GM.

Table 13

Priority 2: Fully implement our GM Fairer Health for All Framework and the Population Health System enablers that are set out within it		
Priority Area of Focus	**Pan-GM Deliverables**	**Suggested Locality Deliverables**
Continue to scale up and systematize the development of Trauma Responsive and Person and Community-Centred Approaches including Social Prescribing, Live Well, Personalised Care, Creative Health)	**Further enhancing the NHS GM approach to Person -Centred Care with a 2024/25 focus on:** • The development of a cross GM framework for training and development in person-centred care in Primary Care • Proof of concept and roll out of Integrated Care and Support Plan on GMCR • Development of agreed approach to roll out of Personalised Care and Support Plans for Maternity through a test and learn project • Support a locality to embed person centred approaches to supporting people in Palliative and End of Life care in the community for informing later cross-GM learning/adoption • Cross-GM support for quality and consistency of personal health budgets	Participate and provide locality leadership in relation to proposals to enhance the NHS GM approach to person-centred care
Scale up and	Continue to build VCSE infrastructure	Apply the principles of the VCSE Compact, VCSE

NHS Greater Manchester

Priority 2: Fully implement our GM Fairer Health for All Framework and the Population Health System enablers that are set out within it		
Priority Area of Focus	**Pan-GM Deliverables**	**Suggested Locality Deliverables**
systematize the role of the VCFSE sector as a strategic partner and a provider of services	capacity to ensure direct involvement of the sector in the GM population health and prevention portfolio of activity. Implement the recommendations from the 23/24 VCSE Data and Intelligence and undertake targeted pilots to develop VCSE capacity and capability. Implement a VCSE-led CVD and Diabetes Inequalities Programme. Collaborate with others on the NHS GM application of the implement the Fair Funding Protocol/VCSE Commissioning Principles.	Commissioning Framework and VCSE Fair Funding Protocol/VCSE Commissioning Principles in local planning and decision-making. Collaborate and provide locality leadership in relation to VCSE-led population health activity taking place in localities.
Contribute to the implementation of the Primary Care Blueprint, particularly in relation to the Prevention and Population Health ambitions.	Support the implementation of the Primary Care Blueprint by providing support to Primary Care Networks and partners with a particular 2024/25 focus on: • Improving the uptake, quality and consistency of the NHS Health Check programme (in line with CvD and Diabetes prevention ambitions) and Cancer screening. • Strengthen the NHS GM approach to Social Prescribing by creating easier referral routes into social prescribing, expanding the wellbeing offers to new cohorts (with a focus on children and on people living with dementia), improve the quality of data to measure impact, and establishing green social prescribing as a destination for onward referral. • Maximise testing for HIV in GP in accordance with NICE guidelines, as part of the wider ambition to end new cases of HIV by 2030.	Provide locality input (in partnership with local authority colleagues and aligned to the DPH-led Sector Led Improvement plans) in a review of NHS Health Checks programmes as a means of increasing effectiveness and efficiency, as part of the system focus on preventing CvD. Co-produce and provide local leadership to strengthen Social Prescribing within local neighbourhoods, including creating easier referral routes, expanding the wellbeing offers to new cohorts, improving the quality of data to measure impact, and growing and sustaining destination activities for people to access and benefit from, in line with local need. Continued local collaboration to implement community led health and well-being, social prescribing and targeted secondary prevention. Co-ordinate locality discussions in relation to HIV testing in GP in accordance with NICE guidelines.
Continue to establish GM as an Anchor System	Co-ordinate a GM Anchor network and support alignment to locality, GM and provider governance, accountability and decision making in relation to social value, procurement and employment.	Participate in a GM Anchor network and provide locality leadership to ensure locality delivery, and alignment to locality governance, accountability and decision making in relation to social value, procurement and employment.

Table 14

Priority 3: Ensure that NHS GM meets its statutory s7a Public Health responsibilities, and the NHS England Public Health 'must do's' and strategic priorities for 2024/25		
Priority Area of Focus	**Pan-GM Deliverables**	**Suggested Locality Deliverables**
Statutory S7A Public Health Responsibilities	Commissioning and assurance of the 33 statutory NHS S7A Public Health programmes (12 screening, 18 immunisations	Implement the place level recommendations from the screening and immunisation insight report within each locality for cancer screening/winter

NHS Greater Manchester

Priority 3: Ensure that NHS GM meets its statutory s7a Public Health responsibilities, and the NHS England Public Health 'must do's' and strategic priorities for 2024/25		
Priority Area of Focus	**Pan-GM Deliverables**	**Suggested Locality Deliverables**
	and 3 other services including the child health information service). Co-ordinate, commission and implement the appropriate pan GM recommendations from the screening and immunisation insight report, for cancer screening/winter vaccinations/childhood immunisations. Continue to lead, co-ordinate and commission pan-GM activity, ensuring implementation of the GM MMR elimination strategy action plan. Co-ordinate the development of a pan GM immunisation strategy action plan. • Prepare, lead and co-ordinate the delegation of immunisations to the ICB.	vaccinations/childhood immunisations. Continue to lead and co-ordinate local activity to improve the uptake of MMR, ensuring implementation of the locality MMR elimination strategy action plans. Utilise local data to provide targeted outreach to populations with low uptake of vaccinations. Provide a joined-up prevention and vaccination offer.
Green Plan and Sustainability	Co-ordinate and oversee the delivery of the current NHS GM Green Plan with a specific 2024/25 focus on: Embedding sustainability into the emerging estates infrastructure strategy Shaping sustainable clinical models of care Collaborate with partners and stakeholders to co-produce the next NHS GM Green Plan. Work with GMCA to finalise an equalities and prevention focused GM Climate Change Adaptation Plan (CCAP) and identify priorities for action from 2024/25 onwards. Deliver a city-region Healthy Travel Strategy and ensure NHS voice in the implementation and review of the Bee Network and refreshed Local Transport Plan.	Provide local leadership and co-ordination to ensure current Green Plan principles and priorities are embedded in local plans. This will include participation in Local Authority led climate action activity through NHS GM place leads and 2024/5 focus on raising awareness and promoting action in Primary Care. Participate and provide local leadership relation to the co-design of the next Green Plan
Ending New Cases of HIV by 2030	Oversee the commissioning and delivery of a 3-year plan to continue the prevention, intensive support, and effective treatment components within the wider programme to end all new cases of HIV in GM by 2030 as an international HIV Fast Track City. • Co-ordinate the continued delivery of opt out ED testing for HIV, Hep B and C in Salford and Manchester and the roll out to Oldham, Tameside, Bury and Bolton, and undertake an appraisal during 2024/25 of the costs and benefits of scaling up opt out ED testing for HIV, Hep B and C on a pan-GM basis from 2025/26 onwards.	Continue to develop integrated locality sexual and reproductive health services that can effectively and efficiently prevent HIV and effectively respond to the needs of people with HIV. Participate and provide locality leadership in relation to the roll out of ED opt out testing to hospital sites in Oldham, Tameside, Fairfield and Bolton, and continued delivery in Manchester and Salford. Participate and provide locality leadership in relation to the appraisal of the costs and benefits of scaling up ED opt out testing on a pan-GM basis from 2025/26.

NHS Greater Manchester

Priority 3: Ensure that NHS GM meets its statutory s7a Public Health responsibilities, and the NHS England Public Health 'must do's' and strategic priorities for 2024/25		
Priority Area of Focus	**Pan-GM Deliverables**	**Suggested Locality Deliverables**
Health and Justice Statutory Responsibilities / Preventing Violence and Strengthening Communities	Co-ordinate the delivery and assurance of the statutory NHS GM requirements relating to Health and Justice including Liaison and Diversion, Reconnect and the Voluntary Attendance Pathfinder pilot. Co-ordinate the delivery and assurance of the statutory NHS GM requirements and Gm commitments relating to Gender-based Violence including Sexual Assault Referral Centre and the Mental Health Pathfinder pilot. Embed training on Adverse Childhood Experiences (ACE) and trauma responsive care in primary care workforce development programmes. Support pan-GM implementation of the Serious Violence Duty.	Support locality implementation of the requirements of the Serious Violence Duty including the development of a JSNA, development of a locality Violence Reduction strategy, and engagement with the local Community Safety Partnership. Facilitate primary care uptake of workforce development programmes relating to Adverse Childhood Experiences and Trauma Responsive Care, through engagement with Primary Care Network.

BURY INTEGRATED CARE PARTNERSHIP

Meeting:			
Meeting Date	08 April 2024	**Action**	Receive
Item No.	7	**Confidential**	No
Title	Integrated Delivery Collaborative Update		
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 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	Yes	☐	No	☐	N/A	☒

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

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

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

I would firstly like to thank Jill Stott and Caroline Beirne for their contiributions to the former LCO and subsequent IDC over recent years, which have been greatly appreciated. Jill and Caroline will be leaving Bury for pastures new at the end of March.

Key developments over the past month include:

- Preparing for transition on the 1st April, which includes a reduction in team size and transitioning from the CCG to the NCA IT system. We will try and ensure this happens with minimal disruption, however we ask that partners bear with us through any teething difificulties.
- Defining the priorities for neighbourhood working (see next section).
- Aligning the system and BCO urgent care delivery plans to focus on delivering performance improvement in urgent care. There has been increased scrutiny from a GM perspective on delivery of the 76% A&E performance trajectory.
- Continued focus through the 4LP to define the elective outpatient programme and to determine what is the art of the possible for Bury.
- Finalising the content of the LCS contract
- Preparation for the VCSE and IDC workshop in April to consider opportunities for the development of greater partnership working to support our workforce challenges.
- Supporting system wide discussions to enable a shared understanding and risk management approach of proposed changes to the Primary Care Locally Commissioned Services Contract
- Reviewing exit plans for short term pilots which are due to end in March 2024
- Continued discussions with Health Innovation Manchester to identify opportunities for innovation.

3. Neighbourhood development

3.1 Priorities

a. Developing the relationships across the INT's, particularly connecting to practices. A specific QI programme supported by the NCA will be developed to support integration across the District Nurses, General Practice and Social work team.

b. Review options for greater use of shared information systems and data to support better targeting of services to reduce inequality, improve communication and care co-ordination and reduce inefficiency.
c. Review and agree ACM model including target cohorts and interventions and alignment with proactive personalised care approach, population health and wider system developments.
d. Delivery of Neighbourhood priorities / plans: these will be aligned to opportunities for managing financial risk in the future. Key areas for us include frailty and respiratory alongside the GM CVD targets
e. Deepening integration with the PSR and delivery of People and Communities Plans.
f. Connectivity with other programmes with a focus on urgent care, frailty, community services, major conditions and community mental health transformation.
g. High quality, better integrated service delivery across the INT's.
h. Review and develop governance arrangements that support co-ordinated planning and delivery across Neighbourhood and PCNs

3.2 The Plan

3.2.1 Strategy

a. Redefining the neighbourhood model, neighbourhood working and our commitments
b. Defining how we will measure success

3.2.2 Delivery

a. Stocktake by practice of offers / interventions – to be considered at PCN Boards
b. Implement the MH community transformation inc Living Well model and develop pathways and alignment with ACM and wider Neighbourhood offer
c. Evaluation of 2023.24 Neighbourhood plans – what's been achieved / learnt – what can we build on / embed?
d. Deliver and evaluate PCN Proactive Personalised Care pilots and develop model for PPC in how this aligns with Neighbourhoods / ACM
e. Review / define the potential role of risk stratification [GMCR, EMIS, Ardens?]
f. Horizon scanning – identify and exploit opportunities for new investment and support e.g. through GMICB pilots to deliver tests of change etc [e.g. Electronic Dementia Care Plan]
g. Review of ACM - Defining the ACM cohort and interventions
h. Connectivity with care homes and community pharmacy
i. Maintaining high quality and timely service provision

3.2.3 Technology

a. Embed the use of GMCR to support improved information sharing and care coordination
b. Review potential benefit of shared care plans within GMCR [e.g. EPACCS Electronic dementia care plan, frailty]. Consider Technology Acceptance Model
c. Implement ACM System One module – enhance performance data to support ops management and ACM referral volumes
d. Review potential benefits of implementing interoperability between EMIS and System One as part of wider QI project with DN's
e. Neighbourhood / LCS priorities – frailty / respiratory. Defining the indicators and wider Neighbourhood H&C plans.

3.2.4 Connectivity to the wider PSR agenda

a. Connectivity with PSLT's – Development and delivery of People and Communities Plans
b. Actively explore and pursue estates options to create opportunities for co-location of public services and VCSE at a Neighbourhood level

3.2.5 Enablers

a. Development of the Bury family
b. Videos of INT Professionals to describe what they do and how it reduces demand on primary and secondary care
c. Definition of CD roles – former CCG, PCN and neighbourhood lead roles
d. Confirmation of Neighbourhood GP work plans
e. Governance: defining roles of NCAG / major conditions Board / urgent care Board and PSR Board in connection to neighbourhoods
f. Presentation to locality board in May

4. March IDC Programme highlights:

Urgent and Emergency Care: Review of the delivery arrangements for the urgent care programme connected to the BCO flow programme. Implementation of Consultant led triage at the front door.

Elective Care and Cancer: potential opportunity to explore with NCA further expansion of the diagnostic services offered from the CDCs at Salford and Oldham to support pathway developments for Bury patients - risk remains re: long term funding and sustainability.

Adult Social Care: Seven more councils have been contacted by CQC and will be subject to on-site assessment visits from early April; none of the councils selected are from the North-West. Work continues on drafting Bury's self-assessment that will be reviewed with IDC Board members, as agreed at their November meeting. P

.**Mental Health**

- The all-age MH Liaison pathway at Fairfield General Hospital commenced at the beginning of March 2024
- The main focus of commissioning activity has been the review of all the MH contract service specifications, submission of STAR forms and commencing required re-contracting processes via the appropriate Provider Selection Regime process
- Commissioning and provider partners supported the SEND OFSTED inspection

Neighbourhoods

- The main focus of work over the last period has been on delivering against the LCS Neighbourhood indicators for the final period of the year.
- A cycle of meetings with the aim of improving communication and integrated working between District Nursing and general practice commenced.
- In Whitefield there was the delivery of an SMI One Stop Shop event with partners on 28th February at St Andrew's Church.
- Proposals for Neighbourhood indicators for the LCS have been presented to practices – decision pending.
- High level Neighbourhood programme priorities have been developed for 2024.25 and are currently being consulted on.

Primary Care: Agreed the content of the Locally Commissioned Service contract for 24/25

Community Health Services: review of programme priorities and governance to ensure closer connectivity with major conditions and elective care

Workforce: review of priorities associated with reduced team capacity

5. Performance

The dashboard has been shared to demonstrate current performance against key ICS indicators.

Summary:

- In December 23, the total number of GP appointments decreased by -19.4% on the previous month and also decreased by -5.2% on December 22.
- A&E attendances remain high, however the A&E 4 Hour performance improved, increasing by 0.9% in February and a decreased number of patients experiencing 12-hour waits.
- Elective waits have slightly decreased, with 31,650 patients currently waiting. Patients waiting over 78 weeks decreased by -15.8% in January compared to December, with 32 patients remaining.
- Cancer 28 Days performance has decreased by -6.6% on performance in December, but 97 more referrals were received in January to December.
- NHS Talking Therapies patients seen within 6-week timeframe has decreased in January and Bury is currently performing better than GM.
- The percentage of the Bury population on the palliative care register has increased in January from December.
- UCR 2-hour response was below the target of 70% in February at 57%, this was previously 33% in January

Key indicators are scrutinised with action plans implemented through our programme boards.

6. Risks

The risks over 12 are currently being scrutinised and moderated. A full strategic risk register will be available to Locality Board in June, as there is no meeting in May.

Key risks have been submitted from programme areas relating to the areas of:

- Workforce availability: challenges in recruitment exacerbated by guidance in place to support financial recovery, both clinical and non-clinical
- Estates availability
- Financial challenges of the Borough and resources unavailable to support additional investment in community and mental health service developments
- Performance challenges
- IT and data systems to support transformational change
- Connectivity between the PCN's and neighbourhoods, and utilisation of AARS monies
- High levels of demand across services.
- PCN ARRS investment and risk to the staffing model
- GM funding issues and effects on a number of pilots/schemes in the locality

7. Better Care Fund discharge funding, Urgent and Emergency Care Capacity funding and Virtual Wards funding

The locality receives additional monies into both the council and NHS budgets in the Better Care Fund (BCF) in the form of discharge monies and into NHS only in the Urgent and Emergency Care (UEC) capacity funding and Virtual Wards funding. Council BCF funding is in line with what was expected, as is the NHS BCF, UEC and Virtual Wards funding, however there are conditions attached to the NHS monies.

Quarter 1 funding is guaranteed for the 3 NHS allocations but in order to continue to receive the BCF and UEC funding for quarters 2 – 4, the locality needs to complete a return to NHS GM on the positive outcomes brought by this funding across a number of metrics. This will be done alongside a whole scale review of the whole of the BCF to ensure the best use of these resources, given the very challenged financial position of all partners. The schemes funded from BCF discharge and UEC funding are shown in appendix 1.

With regard to Virtual Wards, again the allocation is guaranteed for quarter 1 but for quarters 2 – 4, funding is dependent upon achievement of pre agreed trajectories. Updates on all of these will be brought to the next locality board.

8. Recommendations

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

The Board are asked to consider the proposed work plan for neighbourhoods and to consider if there are any missing priorities which need to be considered in the development of this plan throughout April.

Kath Wynne-Jones
Chief Officer – Bury Integrated Delivery Collaborative
kathryn.wynne-jones1@nhs.net
April 2024

BURY INTEGRATED CARE PARTNERSHIP

Appendix 1				
2023/24 BCF Discharge and UEC Capacity Expenditure details				
NHS or Council	**Allocation**	**Scheme Title**	**23/24 value**	**Paid to**
NHS	BCF Discharge	Primary Care Additional Support	£450,000	GP Fed
NHS	BCF Discharge	GP Inreach to Intermediate Care	£0	GP Fed
NHS	BCF Discharge	Home From Hospital (Increasing voluntary sector capacity)	£100,000	Age UK
NHS	BCF Discharge	Hospice Services	£99,000	Bury Hospice
NHS	BCF Discharge	Additional G&A beds	£218,000	NCA
NHS	BCF Discharge	Rapid Response Vehicle (PCFT)	£104,000	PCFT
		ICB Discharge Funding Allocation	**£971,000**	
NHS	UEC Capacity	Additional G&A beds	£1,437,000	NCA
NHS	UEC Capacity	Frailty Same Day Emergency Care	£305,000	NCA
NHS	UEC Capacity	NWAS Huddle/MHUT	£53,000	PCFT
NHS	UEC Capacity	VCSE Housing and Welfare Support	£30,000	PCFT
		UEC Capacity Funding Allocation	**£1,825,000**	
Council	BCF Discharge	8 Nursing D2A beds	£407,497	
Council	BCF Discharge	8 complex Dementia beds	£662,000	
		LA Discharge Funding	**£1,069,497**	

BURY INTEGRATED CARE PARTNERSHIP

Meeting: Locality Board			
Meeting Date	08 April 2024	**Action**	Receive
Item No.	8	**Confidential**	No
Title	Update from Bury Strategic Estates Group		
Presented By	Will Blandamer		
Author	Clare Postlethwaite		
Clinical Lead	Cathy Fines		

Executive Summary

The Strategic Estates Group (SEG) within each Greater Manchester locality is a forum that allow multi-agency discussion in relation to estates opportunities and related risks.

This report outlines work over recent months in Bury to strengthen the quality and content of the discussion at the Bury SEG and also outlines key areas of work that are being progressed in relation to the Bury health and social care estate.

Recommendations

The Board are asked to note the contents of this report and in particular to note the key areas of work being progressed in partnership across Locality partners.

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	☐

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

Governance and Reporting		
Meeting	**Date**	**Outcome**
Bury Locality Board	08/04/2024	

BURY INTEGRATED CARE PARTNERSHIP

Update from Bury Strategic Estates Group

1. Introduction

1.1. This paper outlines work across the locality to increase the partnership working and strength of discussion achieved via the Bury Strategic Estates Group (SEG).

1.2. The report also outlines the key areas of ongoing work relating to locality estate along with articulating the related risks that SEG members are being required to manage as individual schemes and projects progress.

2. Background

2.1. Within each Greater Manchester locality is in place a Strategic Estates Group that works to an agenda largely defined at a Greater Manchester level. The group includes multi-agency membership from both key health and social care partners, alongside key commercial landlords.

2.2. Regularly across the locality, the availability of suitable and available estate is a limiting factor in our ability to expand key services across the borough.

2.3. Recognising the severely financially challenged economic landscape both within Greater Manchester and nationally, the strength of partnership working and problem solving via the SEG is increasingly a key enabler in order to unlock estates opportunities in an innovative and cost-effective manner.

2.4. In particular, much of the focus of recent SEG work is to ensure better utilisation of estate across the locality and also to more effectively exploit the professional skills existing within the various partner organisations.

3. Bury Strategic Estates Group

3.1 Prior to SEG groups being in place, often health estate related discussions risked happening in isolation and becoming disjointed from wider social care development opportunities and also wider regeneration opportunities.

3.2 It is now recognised that the most effective utilisation of estate and quality of service occurs when the discussion is focused more widely on both the health need and wider determinants of health – recognising that often patients attending a clinic or service on an appointment basis can at the same time be encouraged to access other public sector support services.

3.3 Whilst the current economic climate does not always enable full scale, multi-agency new build facilities – the focus of the Bury SEG is to ensure that this does not detract from the opportunities that can be exploited through better multi-agency use of the existing estate.

3.4 The quality of SEG discussion within Bury has established strong partnerships and multi-agency relationships that allow a borough wide prioritisation of estates needs to be developed.

3.5 The SEG also recognises the differing skills existing across partner organisations, particularly in relation to technical estates and commercial planning, and has enabled a sharing of resource across the borough to ensure the best outcomes are achieved.

3.6 The major benefit of this group is the ability to connect the discussions regarding health and social care estate with those relating to wider town centre regeneration e.g. in Prestwich, Radcliffe and Whitefield.

4 Key Priority Areas

4.1 A major focus of recent months has been the decant of services to enable Pennine Care to relocate to Knowsley Place. This has enabled both Local Authority and health partners to better utilise their existing estate in order to facilitate this key move that will see both health and administrative services for Pennine Care based in the centre of the town. Multi-agency work continues to ensure that all services based at Humphrey House find an appropriate new base within the locality.

4.2 Within the wider regeneration proposals for Whitefield, significant work continues to focus on the need to achieve a health solution within the proposals. In particular work with both commercial and public sector partners continues, recognising the need to find a long-term solution due to deteriorating nature of the Uplands clinic facility that means it is becoming increasingly uneconomical to maintain the building to a sufficient standard for service delivery purposes. The complexity of this scheme cannot be underestimated and is evidenced by the numerous failed proposals for health in Whitefield that have been attempted over the past 10-15 years. The current discussions represent the last realistic opportunity to find a long-term health solution in this area of the borough and the strength of the partnership working via the SEG continues to be absolutely key to achieving this.

4.3 The Family Hub requirements across the borough remain a major priority within the estates discussions and work continues to articulate the estates functional requirements that could best meet the requirements of a Family Hub. The challenge here is the recognition that it is likely to be necessary to best fit the Family Hub model around existing available estate due to the inability to afford new, purpose built provision in all areas of the borough.

4.4 Within Prestwich, the ambitious town centre regeneration plans aim to include disposal of the existing health centre site in order to enable health to form a key part of the community hub proposals. Discussions and work with the key health partners are well developed and more detailed commercial and design discussions are now being progressed to finalise the health presence within the proposals.

4.5 Recognising the significant pressures on the Fairfield Hospital site and also the desire of other health partners to have a presence in the town centre, discussions are progressing to explore how a health presence within the shopping centre may be achieved. The discussions to date have focussed on the benefits that a health tenant could add to footfall and activity within the town centre alongside, the likely requirements for sessional health accommodation within the centre.

4.6 Across Greater Manchester, Primary Care Networks (PCNs) have been involved in an extensive piece of work to review their service plans against available estate in order to articulate the likely priority areas of focus. Whilst the outputs of this work will not guarantee funding approval for any relating development proposals, a likely requirement of any future Greater Manchester approval will be that any estates proposal moving forward is evidenced within the outputs of this clinically driven toolkit.

5 Associated Risks

5.1 Recognising the financially challenged economic and commercial climate that all partners work within currently, it is recognised that the work of the SEG needs to focus on better utilisation of existing resource in order to respond to service pressures and development proposals. Often the financial flows relating to estates are complex and do not always naturally lend themselves to unlocking cross-organisational estates solutions hence, the need for mature and forward thinking estates discussions to ensure the best outcomes are achieved.

5.2 Economic and resource restrictions often risk limiting the consideration of innovative solutions via the SEG when in fact often, it is these multi-agency discussions that are best able to achieve affordable and effective solutions for the services involved.

6 Recommendations

6.1 The Board is asked to note the content of this report and in particular the key areas of priority work being progressed across the locality and driven by the SEG multi-agency discussion.

7 Actions Required

7.1 The Locality Board is required to:

- Note the contents of this report and in particular note the risks of delivery of the key priority areas described.

Clare Postlethwaite
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April 2024

Meeting: Bury Locality Board			
Date	08 April 2024		Consider
Item No.	9	**Confidential**	No
Title	ADHD / Autism assessment provision		
Presented By	Will Blandamer, Deputy Place Lead		
Author	Ian Trafford, Head of Programmes, Bury IDC		
Clinical Lead	Dr Catherine Fines, Associate Medical Director (Bury), GMICB		

Executive Summary

The paper sets out:

- The background to the current position whereby there is not currently a commissioned provider of adult ADHD and autism assessments for Bury registered patients (although patients are accessing services through 'choice')
- The associated risks;
- The financial position
- The work undertaken to manage the situation;
- The current position in relation to neurodevelopmental provision for children and young people and improvement plans in relation to this area;
- NHS GM ICP proposals;

Recommendations

1. That there is formal escalation of the risks associated with the lack of having a commissioned provider of adult ADHD and autism assessment to the NHS GM Integrated Care Executive Committee.

2. That the Bury Locality Board support the development of commissioning options alongside the other NES localities with the priority being to commission a solution for those patients who were originally referred to LANCuk but not seen.

3. That there is formal representation from the Bury Locality Board to the NHS GM Integrated Care Partnership with the aim of commissioning suitable provision for adult ADHD assessment and treatment and autism assessment at the earliest opportunity.

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	☐
Relevant risks have been reported to: - Bury System Assurance Committee - Bury MH Programme Board - Bury IDC Board - The GM System Quality Group via the Bury locality 'flash' report in the section 'key risk/issues of concern/early warning signs.'						

Governance and Reporting		
Meeting	**Date**	**Outcome**
Bury Mental Health Programme Board	19/12/2023	The following recommendations were approved: 1. To submit a STAR application for funds with a view to recommissioning Optimise Healthcare. 2. To work with NES commissioners to develop commissioning options to address the gap in service provision.

ADHD / Autism Briefing

1 Introduction & background

1.1 The broad context is a significant rise in demand for neuro developmental assessments for both children and young people and adults. This has been particularly marked for adults being referred for an ADHD assessment with over 15,000 people currently waiting for an assessment in Greater Manchester and reported waiting times of up to 7 years. Since 2019 the number of referrals into adult ADHD services have increased 500%, this means on

average these services receive 1,500 referrals a month.

1.2 In Bury the current neurodevelopmental pathway for CYP (up to 18) is delivered by Community Paediatrics (Northern Care Alliance NHS Foundation Trust) and CAMHS (Pennine Care NHS Foundation trust). Previously LANCuk were commissioned to provide adult ADHD and autism assessments and initial drug treatment for ADHD.

1.3 LANCuk ceased to be the commissioned provider for the North East Sector (NES) - Bury, Oldham and Heywood Middleton & Rochdale localities - in Feb 2022 after they had their CQC registration withdrawn.

1.4 Optimise Healthcare were commissioned (up to March 2024) as part of a rapid procurement process to pick up the following cohorts of patients transferred from LANCuk:

- Patients currently on the prescribing list - c212 patients (across the NES)
- Patients recently diagnosed and awaiting prescription - c91 patients
- Patients under shared care - c408 patients

This was because these patients were deemed to be in the greatest need of continuity of care. Optimise were not commissioned to provide new adult ADHD or autism assessments.

1.5 This leaves the NES localities without a commissioned provider for:

- New patients requiring an ADHD assessment
- New patients requiring as autism assessment
- New patients with an ADHD diagnosis requiring a medication initiation, restart or shared care
- Young people with ADHD and on medication transitioning from CAMH or paediatric services requiring shared care under the supervision of an adult service

1.6 There are a significant number of patients who had been referred to LANCuk who were therefore not transferred to Optimise. These include:

- Those referred but whose referral was never processed
- Those who were part way through an assessment with LANCuk

1.7 In the absence of a commissioned provider for adults requiring an ADHD or autism assessment, the current available pathway in Bury is via the patient choice pathway in line with national right to choose guidance. Someone can request referral to a provider of their choice so long as the provider holds an NHS contract, is CQC registered and their GP deems the assessment to be clinically necessary.

2 Children & Young People

2.1 As with adults there has been a significant rise in referrals for ADHD and autism assessments. In Bury c80% of all CAMHS referrals are for a neurodevelopmental assessment. This is placing significant pressure on CAMHS and Community Paediatric services.

2.2 Young people with ADHD and prescribed medication by their GP under the supervision of CAMHS (i.e. under shared care) would normally transition to an adult provider at the age of 18.

2.3 To ensure continuity of care for these young people the agreement secured was that PCFT CAMHS would retain shared care arrangements for those young people requiring ongoing prescribing of medication after their 18th birthday. The current situation does create some service pressure for CAMHS with currently c48 young people retained beyond their 18th birthday. However, as part of the CAMHS expansion there has been recent recruitment of two new medical posts will support with this pressure.

2.4 Some children are assessed and treated for ADHD by the Community Paediatrics Service which works with young people up to the age of 16. The agreement is that these young people's needs will be considered in an MDT meeting with CAMHs. Depending on their needs these children may be picked up by CAMHS on their 16th birthday or there is an agreement with commissioners that they can be referred to the Optimise Healthcare (on a spot purchase basis) for ongoing supervision and medication reviews.

2.5 In some individual cases it has been agreed that that Community Paediatrics will retain care for a young person for a period beyond their 16th birthday.

2.6 Young people who turn 18 while they are on the CAMHS waiting list for a neurodevelopmental assessment will have that assessment completed by CAMHS.

2.7 GP practices and our local parent carer group for children and young people with a SEND (Bury2Gether) have been informed of the current arrangements in relation to children and young people in the absence of a commissioned adult service i.e. that CAMHS will retain care for those young people with ADHD requiring medication beyond their 18th birthday.

2.8 There were a number of waiting list initiatives in 2023 which have had a positive impact on waiting times and additional CAMHS staff have been trained to undertake ADOS assessments. However it is recognised that the retention of relevant young people in CAMHS is causing an additional pressure on that service.

2.9 Since April 2022 Bury has commissioned a service providing specialist support and education to families with children with ADHD and ASD. Through this we have bolstered the availability of evidence-based interventions pre and post diagnosis with availability of Paediatric Autism Communication Therapy and the Rising the Rapids course for parents.

2.10 In 2023 additional investment was secured to significantly enhance our CYP mental health provision and plans include:

- Expanded mental health support in schools provision.
- Development of an early help hub.
- Improved and expanded pre and post pre and post diagnostic support on the neurodevelopmental pathway.
- Progressive implementation of the GM CYP Autism Diagnostic Support Standards.
- Working with GMICB to undertake a trial the use of the Portsmouth Needs-Based Profile tools and Neurodevelopmental Support Hubs.
- Implementation of Dynamic Support Registers of CYP at risk of family and placement breakdown, keyworkers, short-breaks and crisis alternatives to admission, and CYP LDA Intensive Support Teams.

Some of these developments have already commenced and will be accelerated in 2024.

2.11 A range of resources about ADHD, autism and mental wellbeing including sources of support have been made available on-line and are being communicated to children, young people (and adults) to support whilst waiting and to offer advice and guidance .

3 Summary of work since February 2023 – NES & Bury (adult pathway)

3.1 Mobilisation of Optimise Healthcare – routine contract review meetings and dealing with data transfer etc.

3.2 Identification of patients previously under shared care with LANCuk but who were not transferred to Optimise. In most cases this has meant that these patients have been referred to Optimise on a cost per case basis to ensure continued safe prescribing and the maintenance of shared care with a specialist provider.

3.3 Obtaining access to the LANCuk patients lists and records and organising those records to understand the numbers, locality, reason for referral, stage on the pathway. This has proved extremely challenging due to the way in which the records were organised and held by LANCuk. There was no comprehensive electronic patient record system in place and no single complete database of patients.

3.4 Those patients who were referred to LANCuk but not seen (c1,100) were written to explaining the situation and signposting to existing mental health support services.

3.5 Regular communications have been issued to GP practices.

3.6 There has been regular liaison with other stakeholders such as Bury2Gether and PCFT.

3.7 Responding to patient, GP, Councillor and MP enquiries and complaints.

3.8 Working with PCFT to seek to reduce the burden on practices where PCFT consultants or MH practitioners assess a patient as requiring a neurodevelopmental assessment.

3.9 Engaging with GMICB commissioning leads to start to develop a new pathway for ADHD assessment and treatment.

3.10 It should be noted that a high level of resource has been required to support this work across the Bury Commissioning and Quality teams with input from the Associate Medical Director.

4 Governance

4.1 NES commissioners have met on a weekly basis since Feb 2023 with a focus on:

- Mobilising Optimise
- Understanding and organising the patient data from LANCuk
- Developing communications with patients, GPs and other stakeholders
- Identifying and managing risk
- Developing commissioning proposals

4.2 Bury has established a panel consisting of a commissioner, Quality Lead and Associate Medical Director to review complaints, enquiries and where required individual cases e.g. to determine funding approval for individual cases to be referred to a specialist provider for assessment, medication review etc.

4.3 There have been routine verbal and written updates to the Bury MH Programme Board and updates have been provided to the Bury Autism Partnership Board.

4.4 Risks have been reported through to the Bury MH Programme Board, Bury System Assurance Committee and to the Bury Integrated Delivery Collaborative Board since March 2023.

4.5 A summary report from the Bury System Assurance Committee including the risks relation to the lack of commissioned adult ADHD and autism provision is provided to the Bury Locality Board.

4.6 The risks are also included in the Bury locality ‘flash’ report to the GM System Quality Group in the section ‘key risk/issues of concern/early warning signs’.

4.7 The current gap in provision and associated risks have also been raised through the GM ICB via:

- The GM mental health commissioners weekly business meeting
- Directly with the GMICB Medical Director
- Via GMICB quality governance routes as above
- Via email and in direct discussion with GMICB mental health commissioning leads
- Via the GM Adult ADHD commissioning task and finish group

4.8 Bury and the other NES commissioners have formally highlighted the gap in provision in our mental health commissioning priorities submission to GMICB (October 2024).

5 Risks

5.1 At present most of the patients either referred to LANCuk and not seen or who were part way through an assessment when LANCuk was decommissioned have not been picked up by other providers to undertake or complete their assessment. They are not on a waiting list with a provider. There is the potential that the delay in obtaining an assessment and / or treatment and the uncertainty around future arrangements has had a negative impact on some of these patients' mental health and wellbeing.

5.2 The current situation is generating significant numbers of PALS enquiries, complaints, MP enquiries and questions from patient / carers groups and this is having a negative reputational impact.

5.3 It seems likely that the lack of a commissioned provider is driving the volume of referrals under right to choose. This is resulting in an increasing cost pressure. However, at present there is no alternative commissioned pathway for those patients requiring an ADHD or ASD assessment. If those patients who were previously referred to LANCuk were referred to other providers because they have been waiting over 40 weeks to be seen (in line with new elective care guidance) this would substantially increase the cost pressure. In addition, there is already very long waiting lists among all NHS providers and limited capacity among many of the private providers commonly referred to so there would be further long waits for these patients and a risk of de-stabilisation of providers.

5.4 The current situation is having a significantly negative impact on GP practices who are dealing with patient enquiries and complaints arising from the lack of a commissioned provider and clear referral pathway. This is putting an undue burden on resources at a time where primary care is already under pressure. We have a situation where the Bury & Rochdale LMC is now issuing its own guidance to GP practices and letters for practices to give to patients which is in some instances variance with guidance issued by commissioners.

5.5 Reliance on the right to choose pathway has the potential to exacerbate health inequalities. Obtaining a referral for an assessment is reliant on having a knowledge of the regulations, ability to make an appraisal of the providers and whether they meet regulatory requirements and on the ability to self-advocate with a GP for the referral to be made. It seems likely therefore that some of the patients with the greatest level of need are least likely to be able to navigate this process.

6 Finance

6.1 The rise in demand for ADHD assessments and post diagnosis treatment is creating significant financial pressure. Its is estimated that providing and assessment for the 15,000 people currently on a waiting list for an assessment would cost c£8m and adult ADHD services currently cost c£12m per year.

6.2 For the North East Sector the previous cost of the LANCuk contract was £549,186 per annum.

6.3 The current value of the Optimise contract for the cohorts transferred from LANCuk is £303,900.

6.4 It is difficult to estimate the costs of right to choose referrals because we only have reliable referral data from two providers – Optimise and Psychiatry UK. Data from these providers suggests an estimated cost for Bury for 2023.24 of c£250,000.

6.5 Recent data on the number of right to choose referrals (for Autism and ADHD) to these two providers in 2023.24 suggests a projected cost of up to c£2.5m across the NES. This is not all likely to fall in year because of the time lag between referral and the assessment taking place and any subsequent treatment being provided and invoiced for.

6.6 The data on the numbers of patients on shared care with LANCuk was inaccurate. We have identified a number of patients being prescribed ADHD medication by their GP who should have been referred to Optimise but were not. It has been necessary to refer these patients to Optimise on a cost per case basis. For Bury this is currently c16 people at a cost of c£8,000.

7 GMICB proposals – adult ADHD assessment

7.1 Given the rise in demand, long waiting times, lack of capacity and specialist workforce and the associated costs there is increasing recognition that the current pathway of care is not sustainable.

7.2 Right to choose is currently an option but it carries the risk of patients being referred to providers who do not meet expected quality standards, places additional burdens on GPs, carries an unsustainable cost and is likely to mean that those with the highest needs and risks who really need assessment and treatment may be the least likely to get a service in a timely way.

7.3 Proposals have been taken to the GM MH Partnership Board to redesign the ADHD assessment pathway. Core to this is introducing clear triage criteria and a triage model to ensure that those with the greatest needs and risks are prioritised for assessment and treatment.

7.4 On 16th February 2024 the GM Integrated Care Partnership launched a pre-consultation exercise seeking views on people's experience of and views on ADHD services. The details of the consultation can be found at: https://gmintegratedcare.org.uk/adult-adhd-services/.

7.5 It is likely that any proposal to change the current pathway e.g. by introducing referral criteria and triage would require a formal patient and public consultation. There is therefore no firm timeline for the implementation of any changes.

7.6 The proposals for pathway redesign relate only to ADHD and not adult autism assessment.

7.7 As a result, there is currently no proposed, timely commissioned solution for the many people who were referred to LANCuk and were either never seen or were part way through an assessment process for ADHD or autism.

8 Bury Commissioning proposals (adult pathway)

8.1 In December 2023 The Bury Mental Programme Board approved the following recommendations:

1. For NES commissioners to proceed to the STAR process with the intention of recommissioning Optimise Healthcare for a further year with the following contract

variations subject to procurement rules being met.

a. To include capacity for young people being referred in from CAMHS who are currently being prescribed ADHD medication under shared care. This would include the backlog of young people 18 and over who have been retained by CAMHS as well as any new young people reaching their 18th birthday.
b. To include capacity for the transition of appropriate young people with ADHD and on medication from Community Paediatrics on reaching their 16th birthday.
c. To include those patients who should have been on the original shared care transfer list from LANCuk to Optimise but who were missed and have had to be referred to Optimise under cost per case arrangements.
d. To include patients who are moving into the area and require their shared care for the provision of ADHD medication to be transferred to a new specialist provider.

2. For NES commissioners to proceed to work up further proposals in the form of commissioning 'lots' with the priority being to address the needs of those referred to LANCuk and who were partway through an assessment or never seen at the point where LANCuk was decommissioned.

8.2 The STAR form to request funding to fulfil the first of these recommendations has been completed and approved by finance leads and Deputy Place Based Leads across the NES and has been approved by NHS GM.

8.3 The process is now underway to recommission Optimise Healthcare for a further three years to provide a service as described in 2.1.

8.4 Commissioning of ADHD services is a currently delegated function to localities. As such the costs of both the contract with Optimise Healthcare and costs associated with right to choose referrals will come out of locality budgets. This will lead to a significant cost pressure in 2024.25 and in subsequent years with a recurrent cost associated with those patients under shared care.

9 Conclusion

9.1 Recommissioning Optimise Healthcare will provide some medium-term stability and continuity of care for adults currently being treated under shared care for ADHD and will establish a transitions pathway for young people taking some pressure off CAMHS.

9.2 The new investment and plans in place should lead to improvements in neurodevelopmental provision for children and young people over the next two years including a reduction in waiting times for assessment and improved pre and post diagnostic support for children and families.

9.3 While the pressures on adult neurodevelopmental assessment services exist across GM and nationally the absence of a commissioned provider creates particular pressures and risks for the Bury system along with HMR and Oldham.

9.4 There are proposals being developed by the GM Integrated Care Partnership that could ultimately lead to a more sustainable pathway and model of care in relation to Adult ADHD assessment and treatment.

9.5 However, the GMICP proposals offer no short to medium term solution to the gap in ADHD and autism assessment provision for the NES. In particular it does not provide a way forward for those patients who were referred to LANCuk and either never seen or who were part way through an assessment process at the point where LANCuk was decommissioned.

9.6 While the right to choose pathway does provide a route to assessment for our patients

reliance on this is problematic and increasingly unsustainable. This is because of the costs involved, the lack of direct commissioner oversight of providers, the potential for inequitable provision and the increasing reluctance of GPs, supported by the LMC to refer.

10 Recommendation

10.1 That there is formal escalation of the risks associated with the lack of having a commissioned provider of adult ADHD and autism assessment to the NHS GM Integrated Care Executive Committee.

10.2 That the Bury Locality Board support the development of commissioning options alongside the other NES localities with the priority being to commission a solution for those patients who were originally referred to LANCuk but never seen.

10.3 That there is formal representation from the Bury Locality Board to the NHS GM Integrated Care Partnership with the aim of commissioning suitable provision for adult ADHD assessment and treatment and autism assessment at the earliest opportunity.

Health and Wellbeing Outcomes Framework

Locality Board April 2024

Jon Hobday – Director of Public Health

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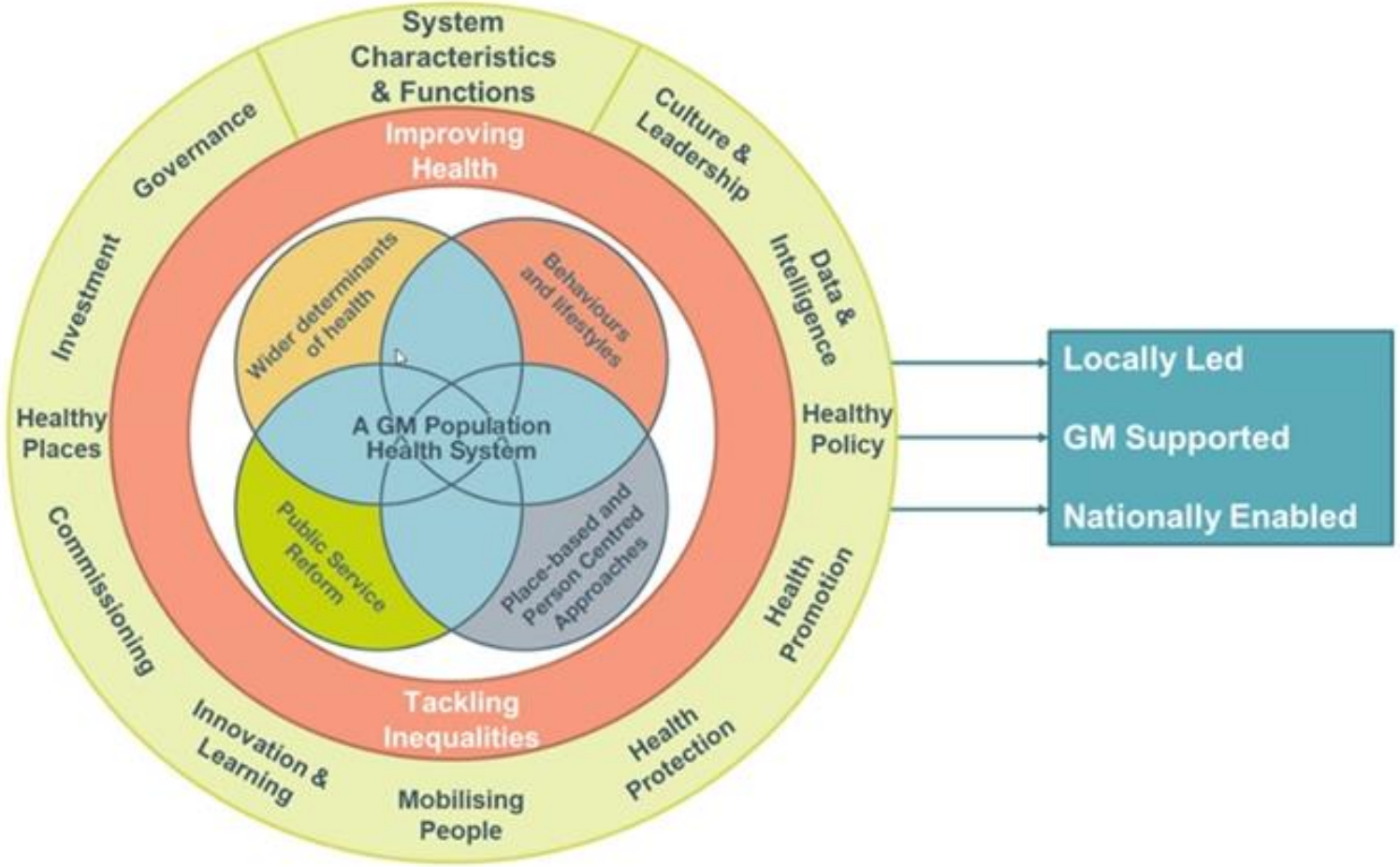
Context

GM Population Health Model



Challenge

- How do we ensure we pick the right indicators?
- Outcomes are influenced by a range of factors
- Outcomes are difficult to improve without investment
- Outcomes cut across several boards / partnerships

Wider determinants

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Indicator	Age	Sex	Period	Unit	Value	Bury Trend (based on 5 recent data points)	Value (Calderdale)	Value (Stockport)	Value (England)	England trend (based on 5 recent data points)	Target (based on Calderdale or if already better improve by 5%)
Employment											
Youth not in employment, education or training (NEET)	16-17 yrs	Persons	2022/23	%	3.9	→	4.4	3.3	5.2	↓	3.7
Percentage of people in employment	16-64 yrs	Persons	2022/23	%	81.6	→	74	80.7	75.7	→	85.7
Economic inactivity rate	16-64 yrs	Persons	2021/22	%	20.5	→	23.7	20.1	21.2	→	19.5
The percentage of the population with a physical or mental long term health condition in employment	16-64 yrs	Persons	2022/23	%	69.9	Not enough data to calculate	64.3	74.8	65.5	Not enough data to calculate	73.4
Gap in the employment rate between those with a physical or mental long term health condition (aged 16 to 64) and the overall employment rate	16-64 yrs	Persons	2022/23	Percentage points	11.7	Not enough data to calculate	9.7	5.9	9.9	Not enough data to calculate	9.7
Housing											
Fuel poverty (low income, low energy efficiency methodology)	Not applicable	Not applicable	2021	%	13.4	Not enough data to calculate	17.1	12.2	13.1	Not enough data to calculate	12.7
Children and Young People											
Number of children in absolute low income families (under 16s)	<16 yrs	Persons	2021/22	%	16.1	Not enough data to calculate	17.2	10.7	15.3	Not enough data to calculate	15.3
Number of children in relative low income families (under 16s)	<16 yrs	Persons	2021/22	%	22.8	Not enough data to calculate	22.2	15.8	19.9	Not enough data to calculate	22.2
Homelessness - households with dependent children owed a duty under the Homelessness Reduction Act	Not applicable	Not applicable	2021/22	crude rate/1000	12.7	Not enough data to calculate	9.1	9.7	14.4	Not enough data to calculate	9.1
Children in care	<18 yrs	Persons	2022	crude rate/10,000	82	Not enough data to calculate	75	72	70	Not enough data to calculate	75
Children who are the subject of a Child Protection Plan – rate per 10,000	<18 yrs	Persons	2020/21	crude rate/10,000	46.5	→	39.8	24.4	41.4	↓	39.8
Child Poverty, Income deprivation affecting children index (IDACI)	<16 yrs	Persons	2019	%	16.9	Not enough data to calculate	19.6	14.6	17.1	Not enough data to calculate	16.1

Behaviour and Lifestyle

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Indicator	Age	Sex	Period	Unit	Value	Bury Trend (based on 5 recent data points)	Value (Calderdale)	Value (Stockport)	Value (England)	England trend (based on 5 recent data points)	Target (based on Calderdale or if already better improve by 5%)
Obesity											
Percentage of adults (aged 18 plus) classified as overweight or obese	18+ yrs	Persons	2021/22	%	64.9	Not enough data to calculate	65.4	65.6	63.8	Not enough data to calculate	61.7
Alcohol											
Adults in treatment - alcohol only	>18 yrs	Persons	2022/23	%	32.0	Not available	28.0	36.0	30.0	Not available	28.0
Successful completions - alcohol only	>18 yrs	Persons	2022/23	%	58.5	Not available	75.2	48.5	57.5	Not available	75.2
Alcohol specific mortality (Directly standardised rate per 100,000)	All	Persons	2017-19	per 100,000	12.9	Not enough data to calculate	16.1	15.7	10.9	Not enough data to calculate	12
Under 75 mortality rate from alcoholic liver disease - 3 years range (Directly standardised rate per 100,000)	<75 yrs	Persons	2017-19	per 100,000	11.9	Not enough data to calculate	12.7	15.1	9.1	Not enough data to calculate	11
Admissions for alcohol-related conditions (Broad) (Directly standardised rate per 100,000)	All	Persons	2021/22	per 100,000	1,587	Not enough data to calculate	1,781	1,891	1,734	Not enough data to calculate	1508
Drugs											
Adults in treatment - opiate	>18 yrs	Persons	2022/23	%	47.0	Not available	47.0	39.0	49.0	Not available	49.4
Adults in treatment - non-opiate only	>18 yrs	Persons	2022/23	%	10.0	Not available	14.0	10.0	10.0	Not available	14.0
Adults in treatment - non-opiate & alcohol	>18 yrs	Persons	2022/23	%	11.0	Not available	11.0	15.0	12.0	Not available	11.6
Successful completions - opiate	>18 yrs	Persons	2022/23	%	15.6	Not available	39.0	16.8	22.6	Not available	39.0
Successful completions - non-opiate only	>18 yrs	Persons	2022/23	%	43.1	Not available	68.0	46.0	51.3	Not available	68.0
Successful completions - non-opiate & alcohol	>18 yrs	Persons	2022/23	%	45.8	Not available	71.0	48.4	48.7	Not available	71.0
Children and Young People											
Obesity in early pregnancy	Not applicable	Female	2018/19	%	22.6	Not enough data to calculate	24.9	20.1	22.1	Not enough data to calculate	21.5
Reception: Prevalence of overweight (including obesity)	4-5 yrs	Persons	2022/23	%	21.9	→	19.2	20.9	21.3	↓	19.2
Year 6: Prevalence of overweight (including obesity)	10-11 yrs	Persons	2022/23	%	39.4	↑	38.3	34.2	36.6	↑	38.3
Baby's first feed breastmilk	Newborn	Persons	2020/21	%	67.1	Not enough data to calculate	72.4	73.1	71.7	Not enough data to calculate	72.4
Breast feeding prevalence at 6-8 weeks	6-8 weeks	Persons	2018/19	%	42.5	Not enough data to calculate	Not available	48.8	46.2	Not enough data to calculate	44.6
Under 16s conception rate (crude rate per 1,000)	<16 yrs	Female	2021	Per 1,000	3.3	Not enough data to calculate	2.1	1	2.1	Not enough data to calculate	2.1
Population vaccination coverage: Dtap IPV Hib (1 year old)	1 yr	Persons	2022/23	%	92.1	→	91.7	95.2	91.8	↓	>95
Population vaccination coverage: Dtap IPV Hib (2 years old)	2 yr	Persons	2022/23	%	93.8	↑	92.4	95.9	92.6	↓	>95
MMR for one dose (5 years old)	5 yr	Persons	2022/23	%	93.7	↓	93.9	96.2	92.5	↓	>95
MMR for two doses (5 years old)	5 yr	Persons	2022/23	%	83.3	↓	86.9	91.3	84.5	↓	>95

Public Service Reform

BURY
LET'S Do It!

Indicator	Age	Sex	Period	Unit	Value	Bury Trend (based on 5 recent data points)	Value (Calderdale)	Value (Stockport)	Value (England)	England trend (based on 5 recent data points)	Target (based on Calderdale or if already better improve by 5%)
Coronary Heart Disease (CHD)											
CHD: QOF prevalence (all ages) actual	All	Persons	2022/23	%	3.1	↓	3.4	3.5	3	↓	2.9
Under 75 mortality rate from heart disease (Directly standardised rate per 100,000)	<75 yrs	Persons	2021	Per 100,000	44.9	Not enough data to calculate	54.5	43.2	40.7	Not enough data to calculate	42.7
Proportion on a long term condition register who have had a check up in the last 12 months (CHD)											
Last BP reading of patients (<80 yrs, with CHD) in the last 12 months is <= 140/90 mmHg (denominator incl. PCAs)	<80 yrs	Persons	2021/22	%	58.9	Not available	63.8	72.2	67.2	Not available	63.8
Last BP reading of patients (80+ yrs, with CHD) in the last 12 months is <= 150/90 mmHg (denominator incl. PCAs)	80+ yrs	Persons	2021/22	%	69.5	Not available	71.9	82.2	77.3	Not available	71.9
Diabetes											
Diabetes: QOF prevalence (17+ yrs)	17+ yrs	Persons	2022/23	%	7.7	→	8.1	7.3	7.5	↑	7.3
Proportion on a long term condition register who have had a check up in the last 12 months (Diabetes)											
Last BP in patients with diabetes is <= 140/80 mmHg (denominator incl. PCAs)	17+ yrs	Persons	2021/22	%	51.6	Not available	49.9	60.3	55.6	Not available	54.2
Mental Health											
Depression: QOF prevalence (18+ yrs)	18+ yrs	Persons	2020/21	%	8	↑	15.8	15.7	12.3	↑	7.6
Proportion on a long term condition register who have had a check up in the last 12 months (Mental Health)											
Record of a BP check in the last 12 months for patients on the MH register	All	Persons	2020/21	%	39.1	↓	43.9	65.4	55.4	↓	43.9
Hypertension											
Hypertension: QOF prevalence (all ages)	All	Persons	2021/22	%	13.7	↓	13.9	14.9	14	→	13.0
Proportion on a long term condition register who have had a check up in the last 12 months (Hypertension)											
Patients (aged 45+) who have a record of blood pressure in the last 5 years	45+ yrs	Persons	2021/22	%	84.1	↓	85.2	86.4	85	↓	85.2
Last BP reading of patients (<80 yrs, with hypertension), in the last 12 months is <= 140/90 mmHg (denominator incl. PCAs)	<80	Persons	2021/22	%	51.8	Not enough data to calculate	55.3	61.1	57.2	Not enough data to calculate	55.3
Last BP reading of patients (80+ yrs, with hypertension), in the last 12 months is <= 150/90 mmHg	80+ yrs	Persons	2021/22	%	66.2	Not enough data to calculate	70.4	77.4	72.2	Not enough data to calculate	70.4
Liver Disease											
Under 75 mortality rate from liver disease	<75 yrs	Persons	2022	Per 100,000	33.8	→	25.9	25.7	21.4	↑	25.9
Screening											
Breast screening coverage	53-70 yrs	Females	2023	%	69.2	↓	64.4	67.9	66.2	↓	72.7
Cervical screening coverage (age 50-64)	50-64 yrs	Females	2023	%	72.7	↓	76.2	77.9	74.4	↓	76.2
Bowel screening coverage	60-74 yrs	Persons	2023	%	70.9	↑	73.9	73.3	72	↑	73.9
Two week wait referrals (indirectly age-sex-standardised referral ratio)	All	Persons	2021/22	Per 100	100	Not enough data to calculate	101	118	100	Not enough data to calculate	101

Marmot Beacon Indicators

BURY
LET'S Do It!

Social determinants of Health Inequalities in Bury	Indicators	Age	Sex	Period	Unit	Value (Bury)	Bury Trend (based on 5 recent data points)	Value (Calderdale)	Value (Stockport)	Value (Greater Manchester)	Value (England)	England trend (based on 5 recent data points)
Early years, children and young peopl	School readiness: percentage of children achieving a good level of development at the end of Reception	5 years	Persons	2022/23	%	65.7	Not enough data to calculate	66.7	67.6	63.3	67.2	Not enough data to calculate
	Psychological Wellbeing	Sourcing data										
	Pupil absences	5-15 years	Persons	2021/22	%	7.1	→	7.4	7.2	Not Available	7.6	→
	Average Attainment 8 Score among children eligible for Free School Meals (FSM)	15-16 years	Persons	2020/21	Score	37.9	Not enough data to calculate	41.5	39.6	Not Available	39.1	Not enough data to calculate
Work and employment	16 to 17 year olds not in education, employment or training (NEET) or whose activity is not known	16-17 yrs	Persons	2022/23	%	3.9	→	4.4	3.3	5.7	5.2	↓
	Unemployment rate (model-based)	16+ years	Persons	2022/23	%	3		3.3	3.2	4.3	3.8	Not enough data to calculate
	Low earning key workers	Will calculate based on estimates from ONS using the 2010 Standard Occupational Classification (SOC) and the 2007 Standard Industrial Classification of Econo										
	Proportion of all employment in non-permanent employment	16-64 years	Persons	2021	%	4.8	Not enough data to calculate	3.3	5.8	5	4.8	Not enough data to calculate
Income poverty and debt	Number of children in relative low income families (under 16s)	<16 yrs	Persons	2021/22	%	22.8	Not enough data to calculate	22.2	15.8	19.3	19.9	Not enough data to calculate
	Proportion of residents reporting difficulty dealing with their current levels of debt	Not Available	Persons	2023	%	42	Not enough data to calculate		41			
Housing, transport and the environme	Housing affordability ratio: Ratio of house price to earning	All ages	Persons	2023	Ratio	7.64	Not enough data to calculate	5.27	9.02	Not Available	8.28	Not enough data to calculate
	Homelessness: households in temporary accommodation	Not Applicable	Not Applicable	2022/23	Crude rate per 1000	1.3	Not enough data to calculate	0.7	0.9	Not Available	4.2	Not enough data to calculate
	Average public transport payments per mile traveled	Not Available										
	Air pollution: fine particulate matter (new method - concentrations of total PM2.5)	Not Applicable	Not Applicable	2021	Mean µg/m3	7.1	Not enough data to calculate	6.6	7.6	Not Available	7.4	Not enough data to calculate
Communities and place	Crime rate per 1000 population	Calculated from raw data for Bury from GMP		2023/24	Crude rate per 1000	82						
	People with different backgrounds get on well together	Not Available										
	Antisocial behaviour	Sourcing data										
Public Health	Proportion of residents reporting bad or very bad health (age-standardised)	All ages	Persons	2021	%	5.8	Not enough data to calculate	5.7	5.2	Not Available	5.3	Not enough data to calculate
	Self reported wellbeing: people with a low satisfaction sc	16+ years	Persons	2022/23	%	4.9	Not enough data to calculate	9.4	3.9	Not Available	5.6	Not enough data to calculate
	Numbers on NHS waiting list for 18 weeks	Sourcing data										
	Emergency readmissions for ambulatory sensitive condit	Sourcing data										
	Percentage of adults (aged 18 plus) classified as overweight or obese	18+ yrs	Persons	2021/22	%	64.9	Not enough data to calculate	65.4	65.6	68.5	63.8	Not enough data to calculate
	Smoking in routine and manual occupations 18-64 (current smokers (APS))	18-64 years	Persons	2022	%	17.1	Not enough data to calculate	19.7	27.9	Not Available	22.5	Not enough data to calculate

Wider determinants

Performing Positively

- % Youth Not in Education, Employment or Training, 16–17-year-olds (NEET)
- % people (16-64 years) in employment

Areas for improvement

- Number of children living in relative low-income families (under 16s)
- Children in care

Behaviour and Lifestyle

Performing Positively

- Admissions for alcohol related harm
- Smoking prevalence in routine and manual workers

Areas for improvement

- Smoking attributable mortality (35+ years)
- Overweight and obesity at year 6
- MMR for 2 doses

Public Service Reform

Performing Positively

- Depression levels 18yrs+ (on QOF)
- Breast screening coverage

Areas for improvement

- % on a CHD register who have had a check-up in the last 12 months with a BP of less than 140/90
- Cervical screening coverage
- % of those on the MH registers who have had their BP checked in the last 12 months

Marmot Indicators

Performing Positively

- % Youth Not in Education, Employment or Training, 16–17-year-olds (NEET)
- Pupil absences (5-15 years)

Areas for improvement

- Number of children living in low-income families

Steps to reduce inequalities

- Use Health and Wellbeing Board as standing commission on health inequalities
- Use population health delivery partnership to drive the activity
- Have a robust implementation plan
- Have a detailed outcomes framework (aligned with Marmot towns 24 indicators)
- Use the wider network community to share and grow good practice

BURY INTEGRATED CARE PARTNERSHIP

Locality Performance Report March 2024

Part of Greater Manchester Integrated Care Partnership

Presentation by:

Contents

BURY INTEGRATED CARE PARTNERSHIP

Headlines

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

In December 23, the total number of GP appointments decreased by -19.4% on the previous month and also decreased by -5.2% on December 22.

A&E attendances remain high, however the A&E 4 Hour performance improved, increasing by 0.9% in February and a decreased number of patients experiencing 12-hour waits.

Elective waits have slightly decreased, with 31,650 patients currently waiting. Patients waiting over 78 weeks decreased by -15.8% in January compared to December, with 32 patients remaining.

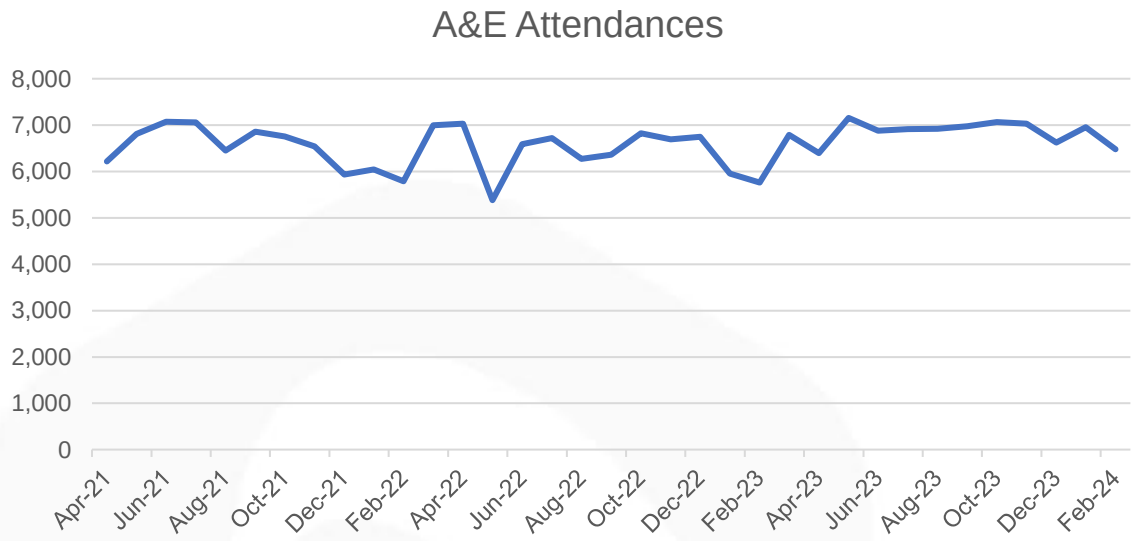
Cancer 28 Days performance has decreased by -6.6% on performance in December, but 97 more referrals were received in January to December.

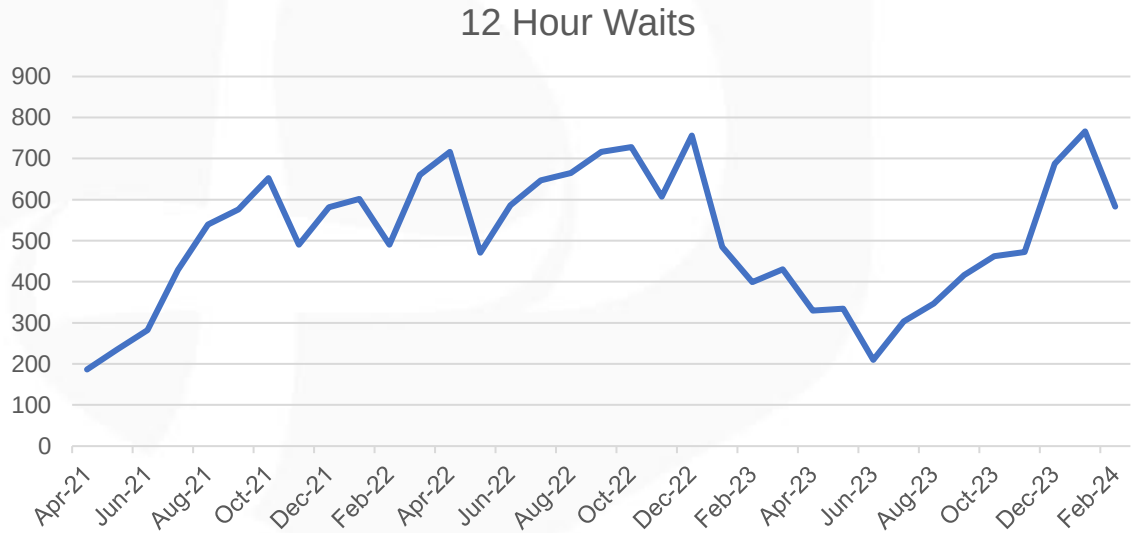
NHS Talking Therapies patients seen within 6-week timeframe has decreased in January and Bury is currently performing better than GM.

The percentage of the Bury population on the palliative care register has increased in January from December.

UCR 2-hour response was below the target of 70% in February at 57%, this was previously 33% in January.

Urgent Care

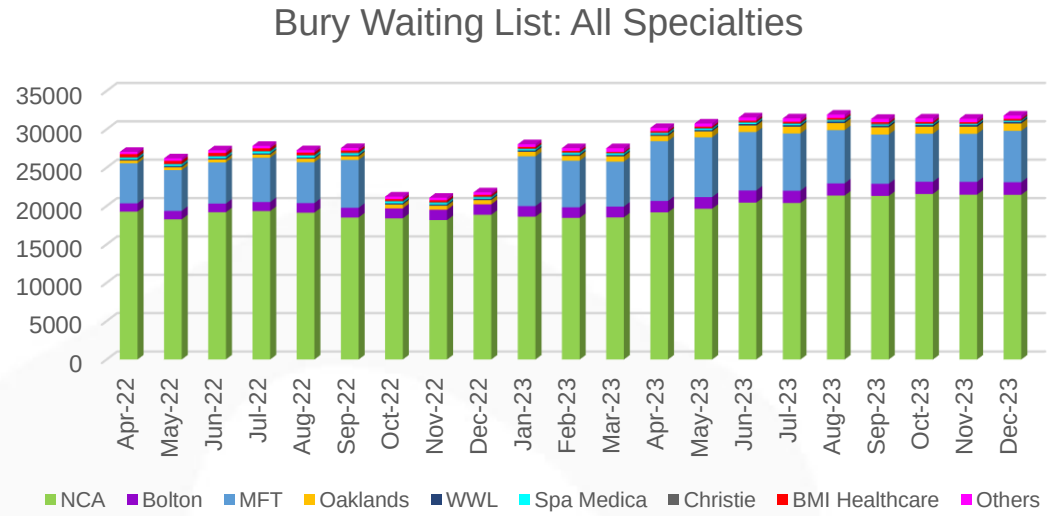


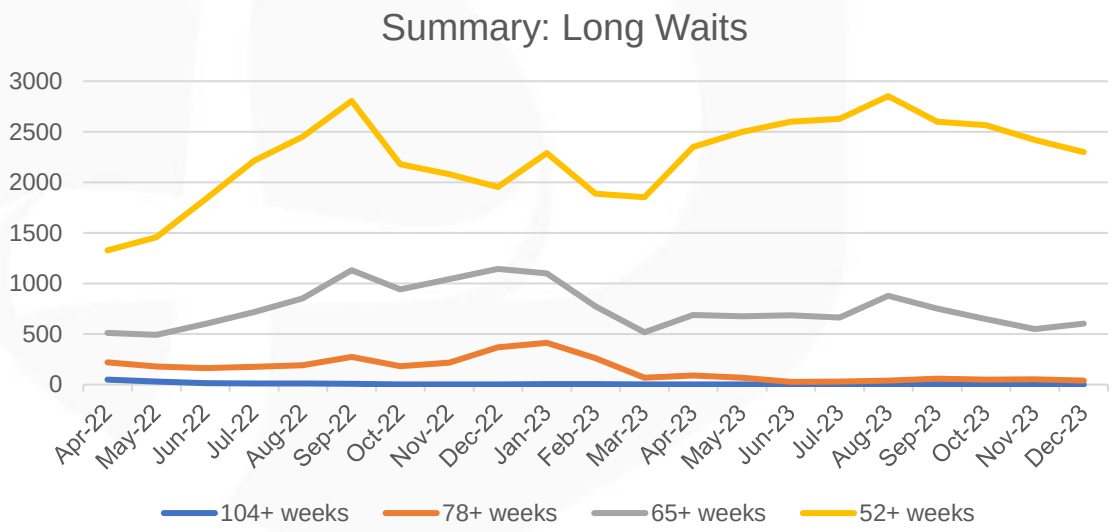


- There were 6,479 A&E attendances from Bury registered patients in February 24, higher than February 23 (5,765). The proportion of Adult attendances increased to 75% of attendances this year compared with 74% in February last year.
- 4-hour performance in February was 59.5%, an increase on the previous month's performance of 58.6%. Lower than February 23 which was 65.3%.
- The number of patients experiencing 12-hour waits (from arrival) decreased in February to 583 from 766 in January. 12-hour waits are higher than February 23 (399).
- A&E attendances for mental health conditions have stayed static in the last few months, however these decreased in February to 210 from 231 in January.

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

Elective Care

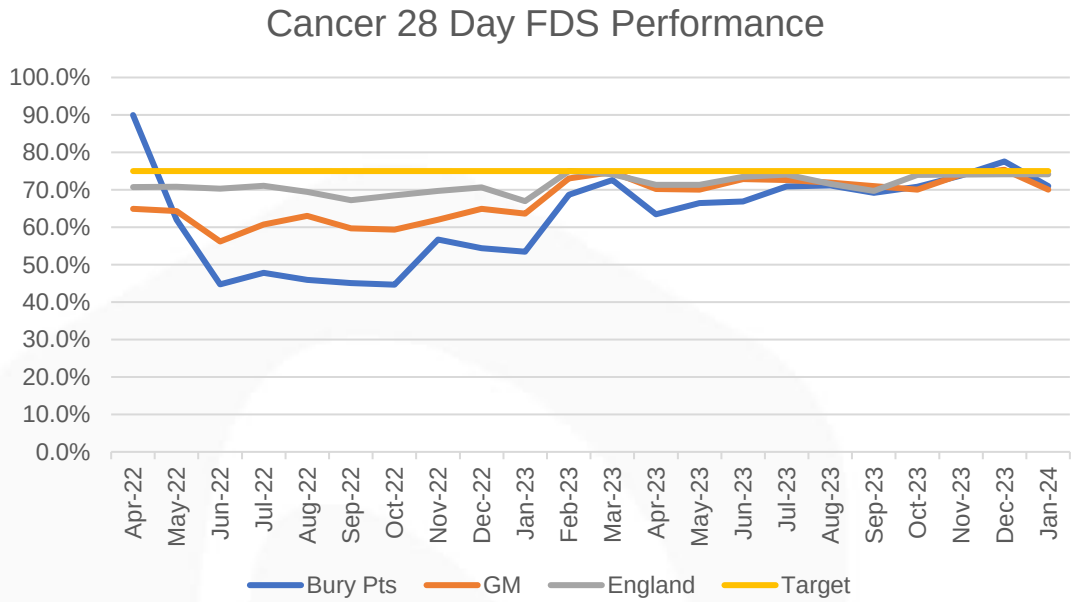




- Oct, Nov & Dec 22 elective waits impacted by lack of MFT data. Published data since January 23 now includes MFT.
- Published January data shows a slight decrease on December 23 (-0.4%, -140 pathways).
- Since December 23 there have been minor increases across some specialties, with Respiratory Medicine showing an increase of 10.2% and Gastroenterology and Cardiology showing an increase of 3.7%.
- Small reductions seen across several specialties in January, Other (-21.7% since December) and Dermatology (-4.2% since December).
- Immediate target was to eliminate 78+ week waits by Apr 23. These have decreased on December's figure by -15.8% (-6 pathways) in January. Primarily the decrease is in T&O(-6 Pathways).

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

Elective Care

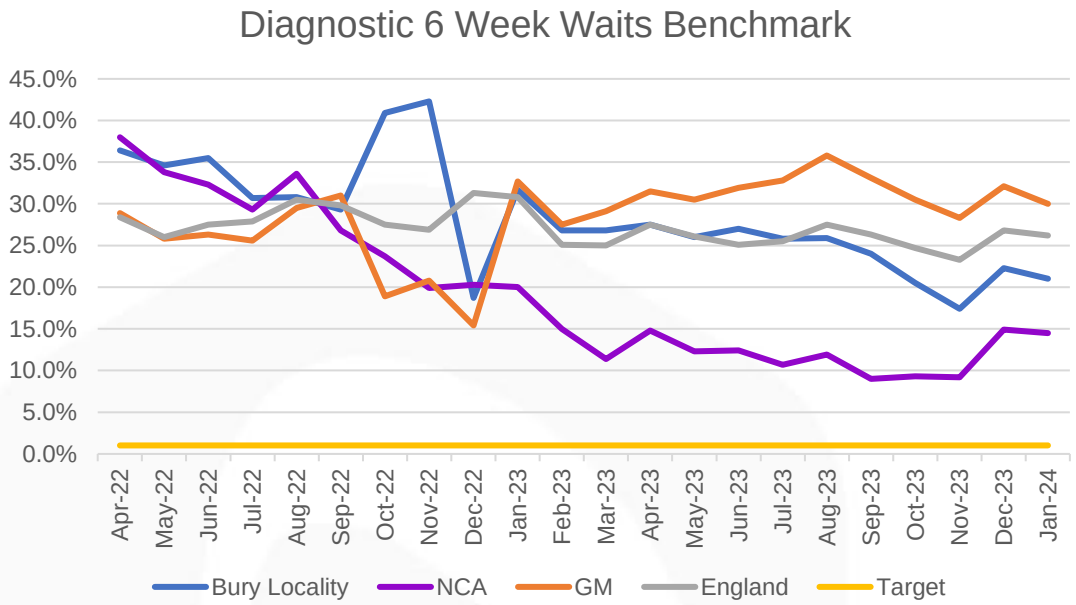


Cancer 28 days FDS:

- Decrease in performance in January to 71.0% for Bury, this is slightly above GM where the performance also decreased to 70.1%, both are below the target of 75.0%.
- Urological cancer performance was at 51% in January, with 36 out of 73 not meeting standard.
- Lower GI cancer performance is 59% for January which is a decrease on 74% in December.
- Skin Cancers Performance for January has increased to 72% from 63% in December.
- 23/24 guidance has restated the requirement to meet the 75% target by March 2024.
- Guidance also sets requirement to increase the % of cancers diagnosed at stages 1&2. Latest unadjusted data (2021) shows Bury as 6th best in GM at 53.6% compared to GM at 54.7%.

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

Elective Care

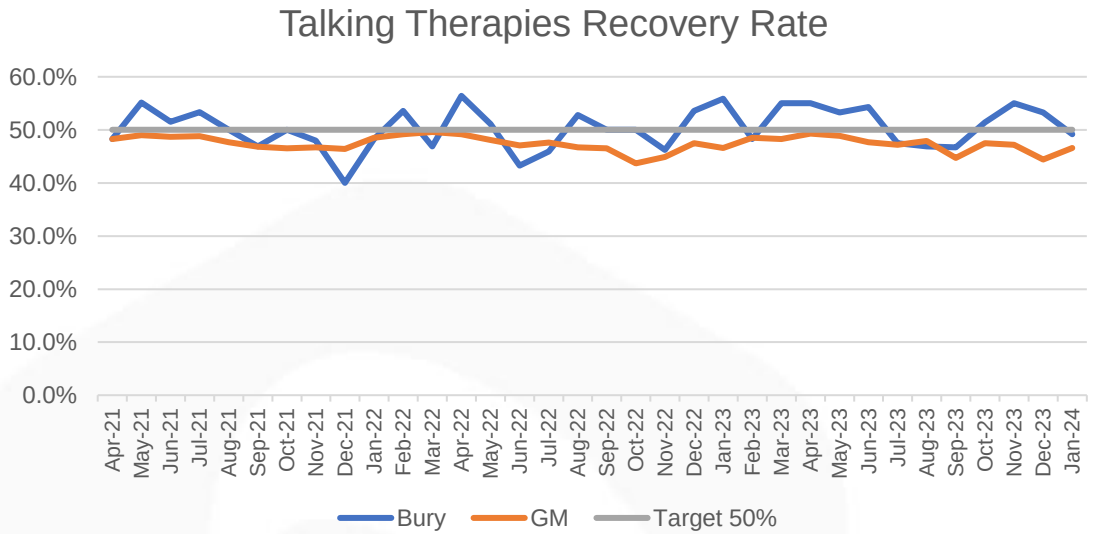


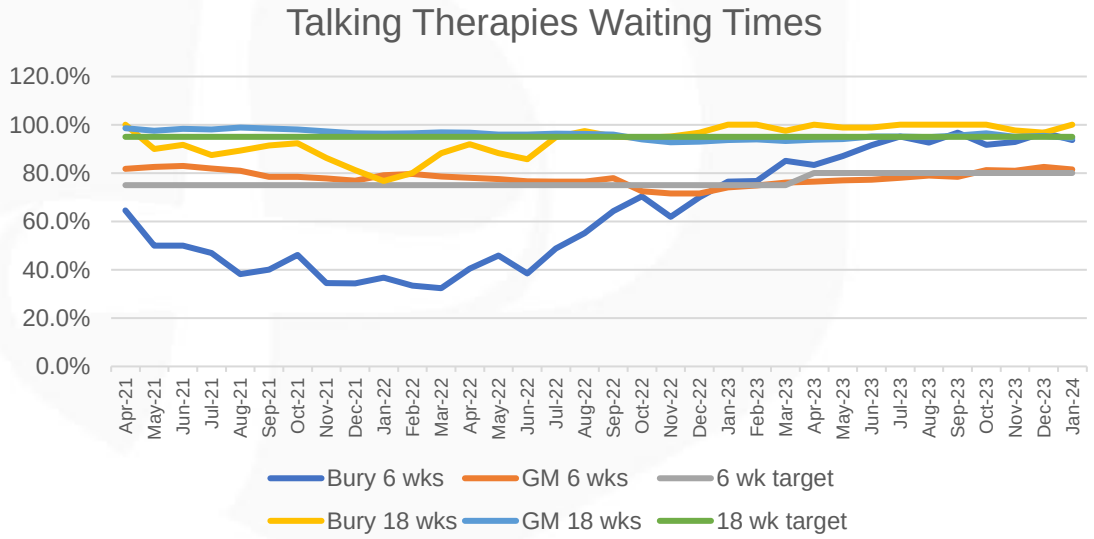
Diagnostic Performance:

- MFT Data is now included from Jan 23.
- January's performance of 21.0% of patients waiting more than six weeks is an increase on the December figure (22.3%).
- Across November to January 23 NCA performance has remained steady but has seen increases and decreases since. Performance increased slightly from 14.9% in December to 14.5% in January.
- GM and England performance also saw a increase in January.
- 23/24 requirement is to continue to work towards 95% of patients receiving diagnostic test <6 weeks by March 2025.

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

Mental Health





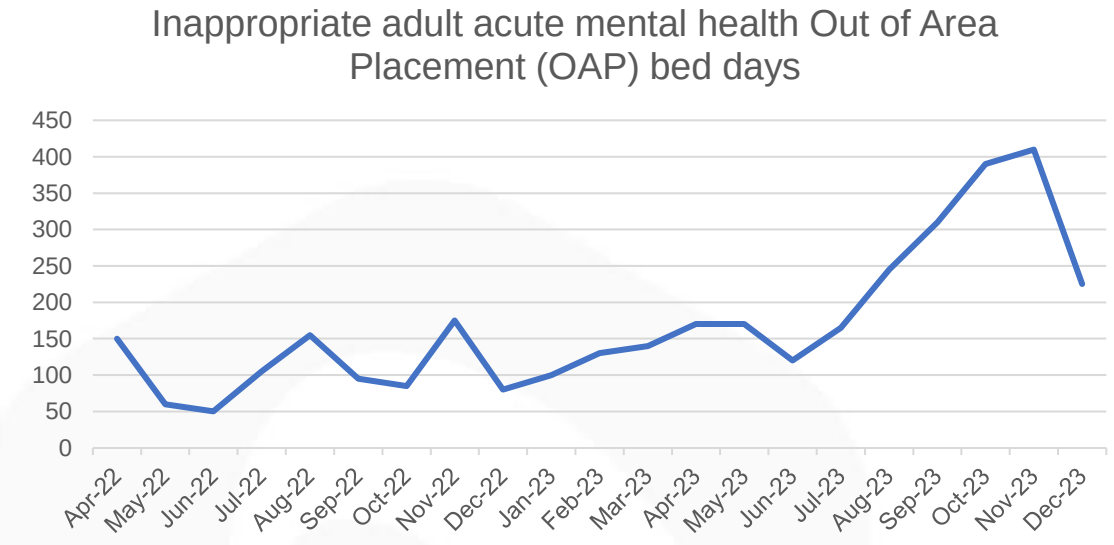
- Talking Therapies: recovery rate – the rate for Bury has decreased from December to January to 49.2% from 53.3%. The GM rate increased by 2.2% in January and is currently at 46.6%.

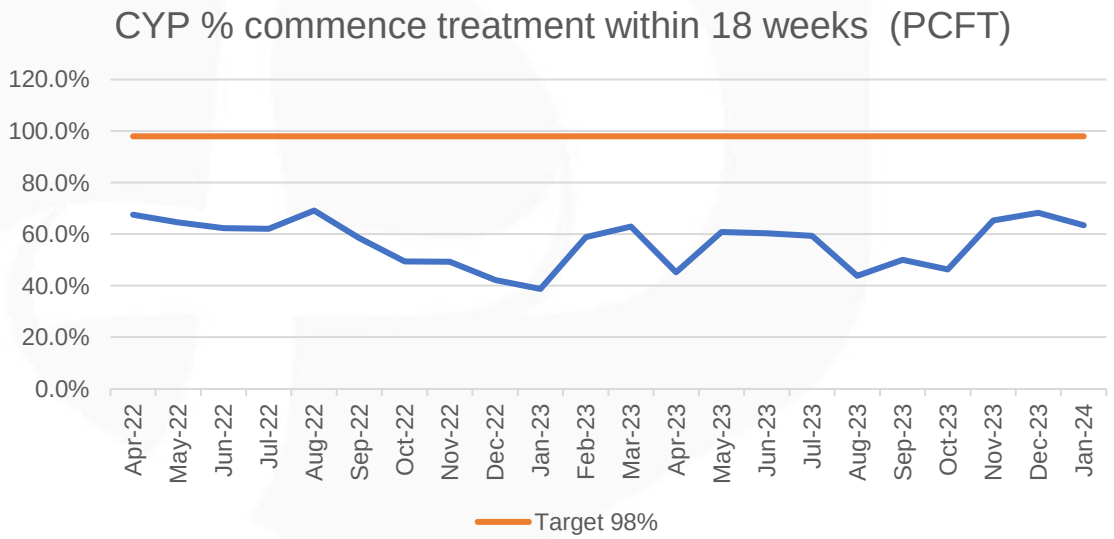
- Talking Therapies: Seen within 6 weeks – the rate for patients seen within 6 weeks has decreased by -3.0% in January with the current rate being 93.7%. This is significantly higher than the GM rate of 81.5%.

- Talking Therapies: Seen within 18 weeks - the rate for patients seen within 18 weeks has increased from December to January from 96.7% to 100%. This is higher than the GM rate of 94.5%, Bury are within the 95% target.

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

Mental Health



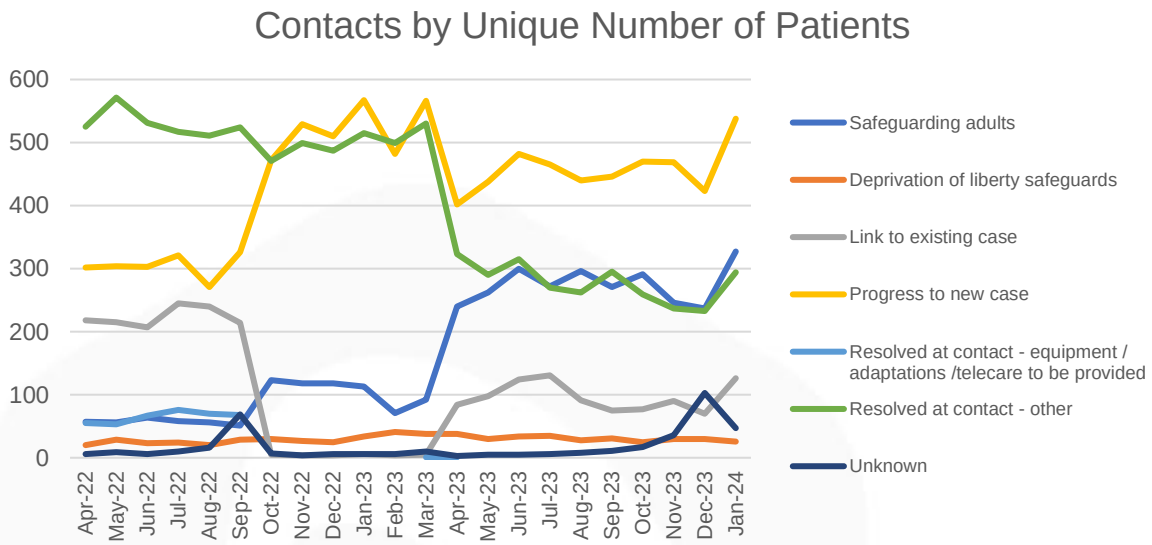


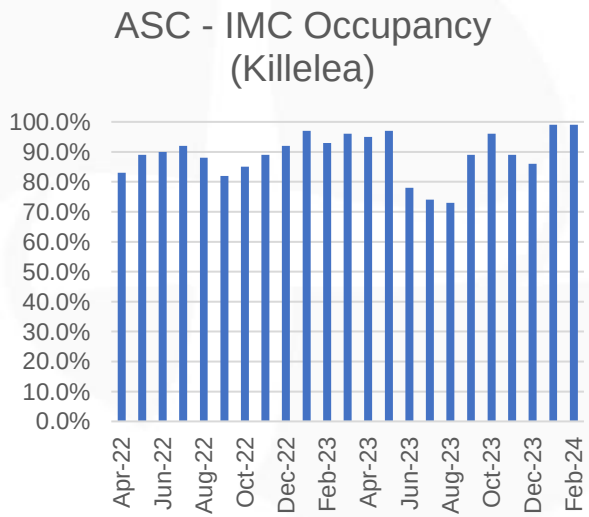
- MH out of area placements – the number of out of area placements in December has decreased by -45.1% since November. Compared to December 22 this has increased by 181.3%, however these are subject to real time daily and weekly monitoring by multi-agency teams and there is a slight lag in the formally reported data.

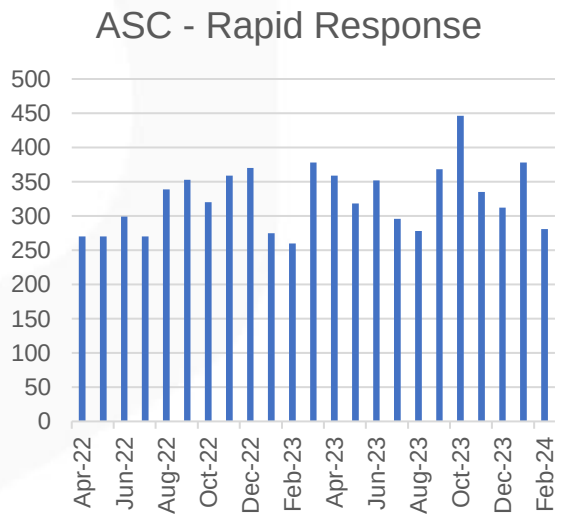
- Access rate to Children and Young People's Mental Health Services – A decline in the proportion of CYP commencing treatment within 18 weeks has been seen at PCFT across 2022/23 and reflects the increasing demand seen since COVID-19. A joint proposed investment plan has been developed for the Bury system which, if approved, would see increased clinical capacity within the core CAMHS service. January has seen a decrease by -4.9% on December's figure, with 63.4% commencing treatment within 18 weeks.

PCFT monthly CAMHS Outcomes Framework report

Adult care



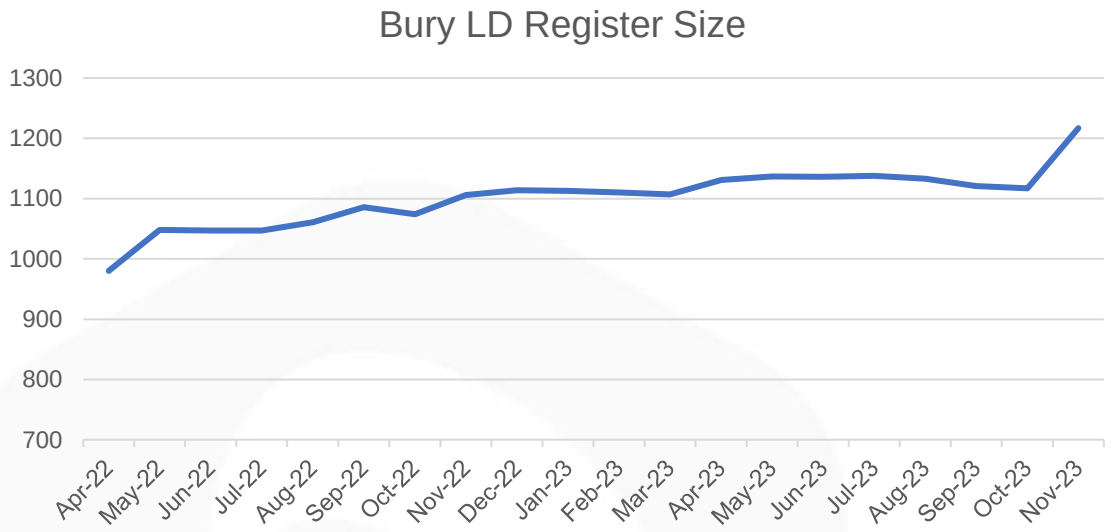


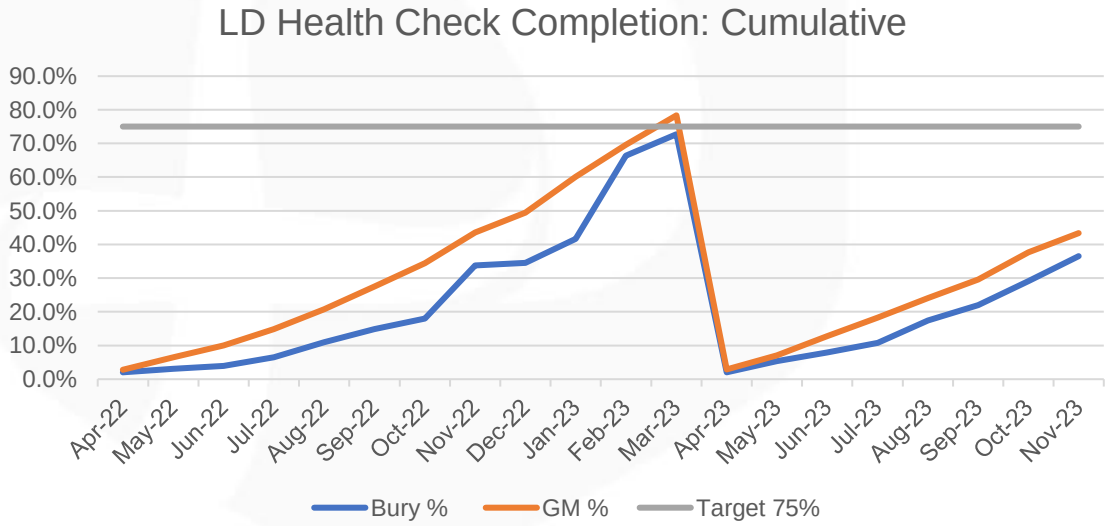


- The contact rate per 1000 population is not currently available from Aug 22.
- Contacts by outcome – 43.7% of contacts progressed to a new case in January, which is an increase on 42.2% in December. 23.3% of contacts resulted in safeguarding in January, compared to 21.4% in December. The percentage of unknown outcomes decreased to 3.0% in January from 8.5% in December.
- IMC Occupancy for Killelea – Bed occupancy remained at 99% in February.
- ASC rapid response – Total referrals decreased by -25.7% to 281 in February from January.

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

Learning Disabilities





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

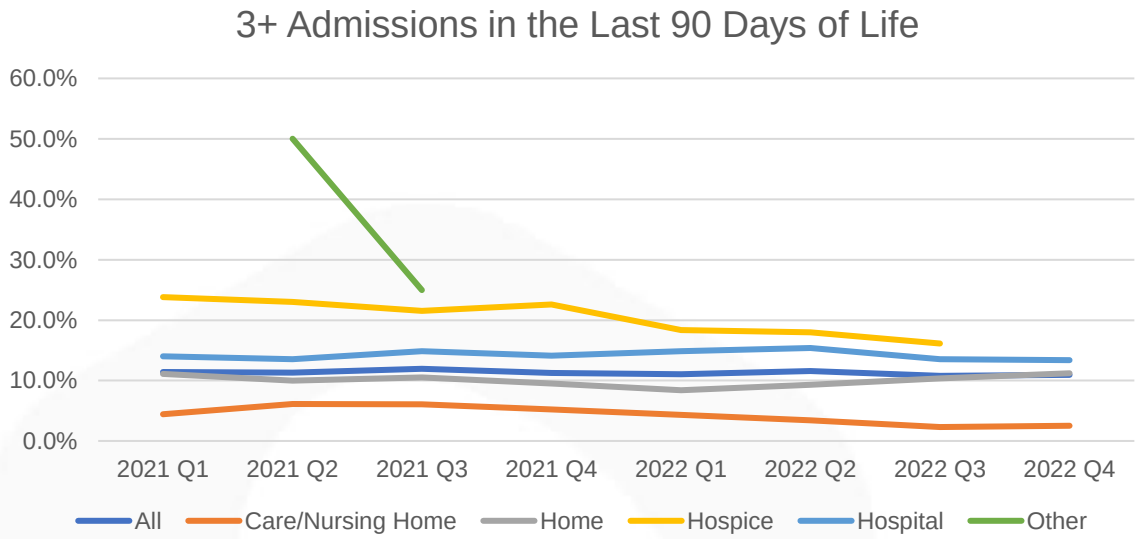
- Register size has increased by 100 in November 23.

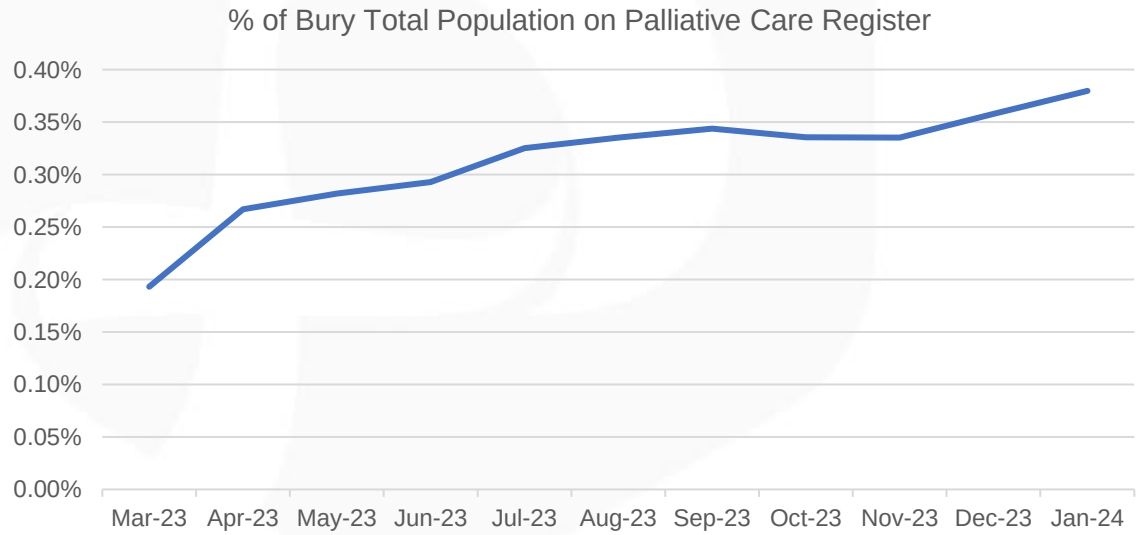
- LD Health checks: The cumulative position in 23/24 to November shows 36.5% of Bury patients have received an AHC. This compares to 43.3% for GM. Most AHC tend to take place in Q4. In November 22 the cumulative position was 33.8% for Bury patients.

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

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

End of Life





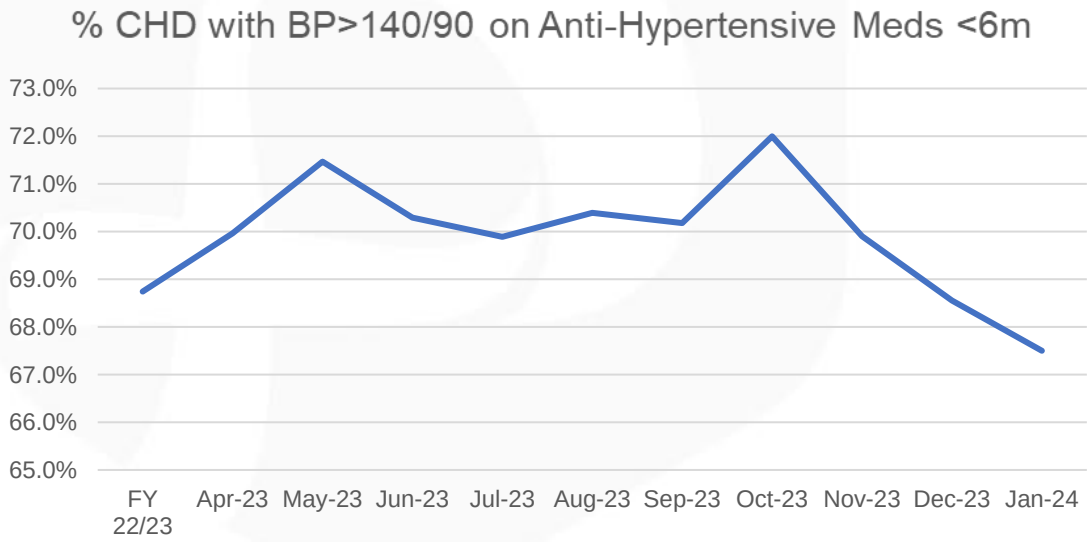
- Percentage of patients with 3+ admissions in the last 90 days of life – 11.0% of all deaths in Q4 of 2022 had three or more admissions in the last ninety days of life. Of those patients that died at home, 11.2% had three or more admissions, which was an increase from 10.4% on Q3.

- The percentage of the Bury population on the palliative care register has remained slightly increased from December to January at 0.38%.

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

Long Term Conditions

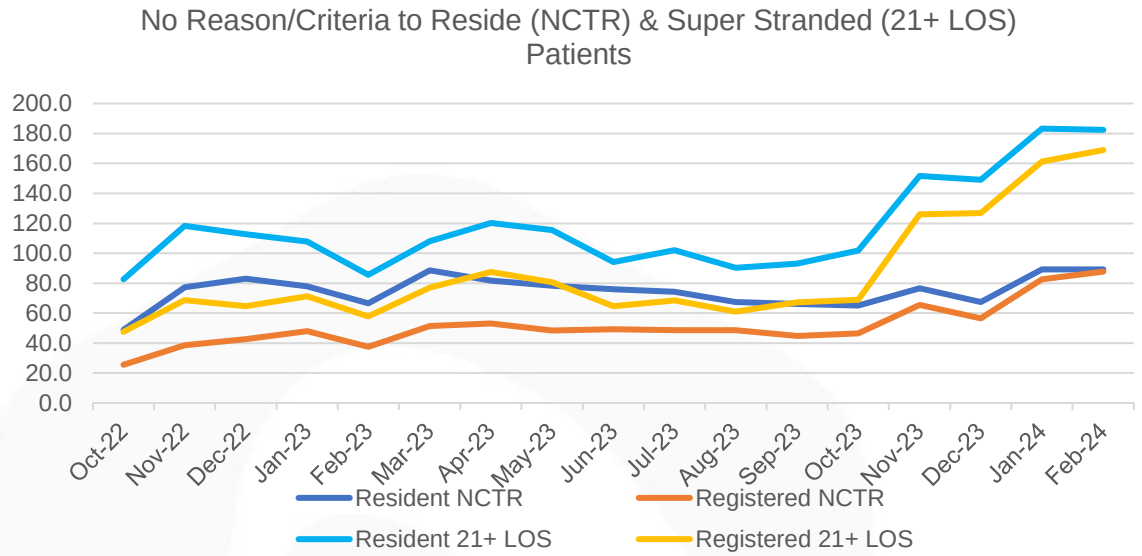
Diabetes Type 1	All Eight Care Processes		
Bury	355	895	39.70%
England	107,795	265,910	40.50%
DiabetesType 2 and other	All Eight Care Processes		
Bury	6,205	12,045	51.50%
England	1,985,545	3,436,315	57.80%

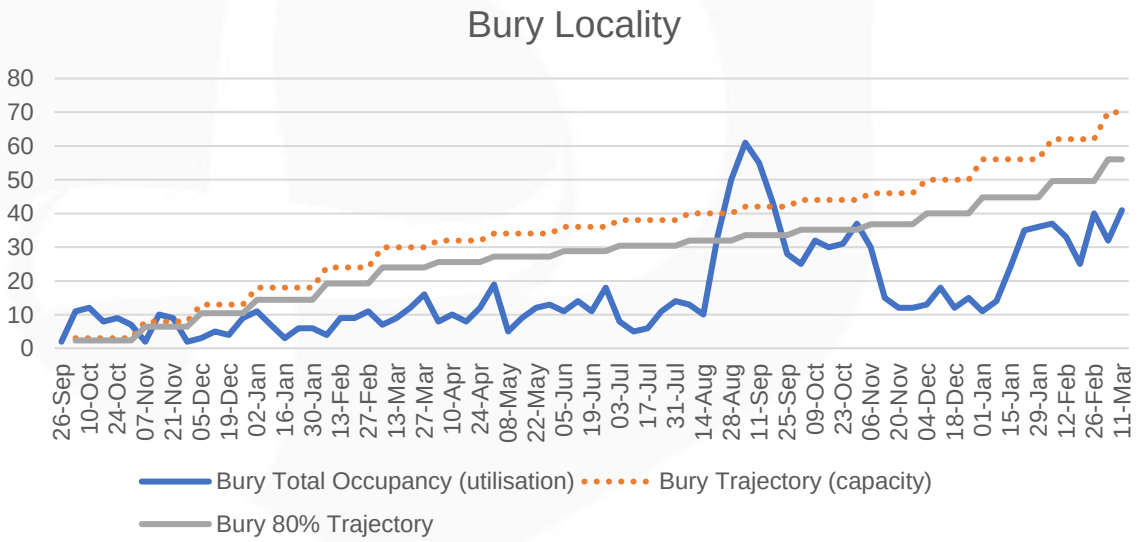


- Diabetes – For the period January 22 to March 23 39.7% of Bury patients with Type 1 diabetes had all eight care processes compared to 40.5% for England. 51.5% of those with Type 2 diabetes had all eight care processes compared to 57.8% for England.

- % of hypertension patients who are treated to target as per NICE guidance – 67.5% of patients were treated within target for January, which is a decrease on December which was 68.6%, however the YTD figure of 69.9% for 23/24 is still above to 22/23 figure of 68.7%

Community Services





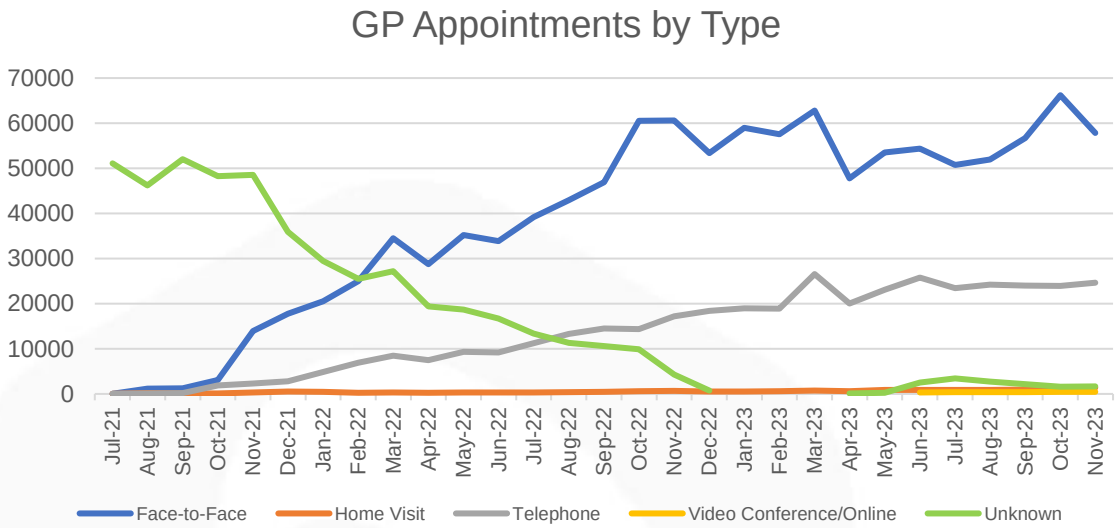
- NCTR monthly average for February was down by -0.1% for Bury residents to 89.1 from 89.2 in January. The monthly average for registered patients in February increased by 6.2% to 87.8 from 82.7 in January.
- The average monthly length of stay since NCTR for residents has increased from January to February, and the average for registered also increased. The average LOS for February for resident was 22.2 days and registered 20.0 days.
- The Super Stranded monthly average decreased in February from January for resident from 183.4 to 182.4. Registered increased by 4.8% from 161.3 in January to 169.0 in February. However, these are subject to real time daily and weekly monitoring by mutli-agency teams and there is a slight lag in the formally reported data.

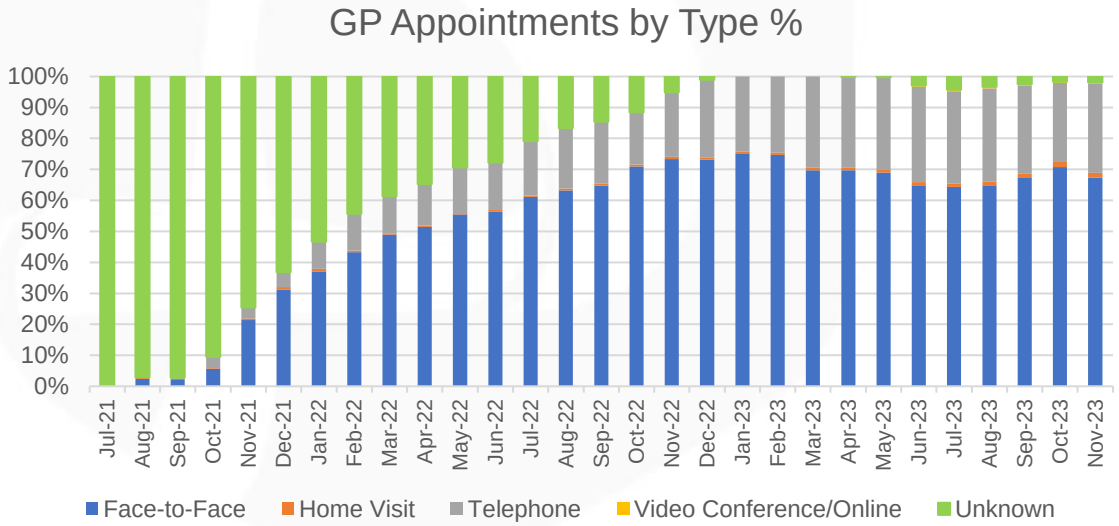
- Virtual Wards data received up to 11/03/24. Occupancy is currently below the 80% trajectory, however, has improved since January 24.

- UCR 2-hour response was below the target of 70% in February at 57%, this was previously 33% in January.

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

Primary Care





- In December 23 the total number of GP appointments has decreased by -19.4% on November 23.
- 66.9% of GP appointments were Face-to-Face in December 23 compared to 67.3% in November.
- Home visits have decreased by -21.9% in December but the percentage split by type is 1.5% of all appointments which was 1.6% in November 23.
- The number of Unknown appointments types has decreased by -35.3% in December to 1046 appointments from 1617 in November.

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

BURY INTEGRATED CARE PARTNERSHIP

Meeting: Locality Board			
Meeting Date	08 April 2024	**Action**	Receive
Item No.	13	**Confidential**	No
Title	Clinical & Professional Senate Update		
Presented By	Kiran Patel		
Author	Kiran Patel		
Clinical Lead	Kiran Patel		

Executive Summary
This report provides the Locality Board with a summary from the Clinical and Professional Senate meeting that took place in March 2024.
Recommendations
The Locality Board is asked to receive the report and share any feedback to the Clinical and Professional Senate for action.

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

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

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

Clinical and Professional Senate Highlight Report – March 2024

1. Introduction

This report provides the Locality Board with a summary from the Clinical and Professional Senate meeting that took place on 27th March 2024.

2. Headlines from the Clinical and Professional Senate

Bury Palliative & EoLC

- Palliative care strategy and the Medical Model described - illustrating the interactions between different services
- Application being put together to secure funding from MacMillan Fund to facilitate some of the ambitions in the strategy – eg single point of contact
- Some extension of licences may be needed from partner organisations to facilitate joit working

Renal A&G Pathway

- Highlighted the CKD epidemic facing the UK – which is worse in the NW
- Burden of kidney disease is increasing - multiple reasons for this
- The service is seeing the wrong patients – 40% - do not get any intervention from renal team and 30% who end up having dialysis have not been seen by renal team in the 12m prior to being put on the program
- Dialysis has a huge impact on the person and is very expensive
- Advice & Guidance – pilot to ensure appropriate patients end up seeing the specialist team has been developed and started
- Pilot approved - although some concern that not aligned to other similar processes (cardiology)
- Piecemeal approach also limits adoption in primary care

Financial Update

- Update from Simon
  - awaiting plan from GM around stopping activity
  - still have a gap of 700k in the 1m saving required in Bury

GM CEG & GMMMG

- Received from Cathy Fines and Salina Callighan
  - 3 year sustainability plan
  - Wigan community services - upskilling their HCSW to relieve pressure on DNs - experiences could be shared

3 Recommendations

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

Kiran Patel
Medical Director IDCB
kiran.patel5@nhs.net
March 2024

Meeting: Locality Board			
Meeting Date	08 April 2024	**Action**	Receive
Item No.	14	**Confidential**	No
Title	Bury Integrated Care Partnership System Assurance Committee summary report		
Presented By	Catherine Jackson, Associate Director for Nursing, Quality and Safeguarding (Bury)		
Author	Carolyn Trembath, Head of Quality (Bury)		
Clinical Lead	Cathy Fines		

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

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

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

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

Governance and Reporting		
Meeting	**Date**	**Outcome**
System Assurance Committee	20/03/2024	Summary to be provided to Locality Board

BURY INTEGRATED CARE PARTNERSHIP

System Assurance Committee Highlight Report – March 2024

1. Introduction

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

2. Background

2.1. This report is a summary of the System Assurance Committee held on 20th March 2024.

3. Headlines from the System Assurance Committee

3.1 Bury CO Community Services Speech and Language Therapy Service

- Detailed report relating to the current risks in the Adult Speech and Language Therapy (SLT) Service relating to workforce, quality and performance.
- There has been a 55% increase in referrals into Adult SLT compared to 202/23 predominantly due to COVID and the increased focus on discharge from acute wards so the complexity of patients being received into the service is increasing. This leads to a challenge in managing the patients in priority order.
- Acute (inpatient) and Community SLT work closely together to manage the workload, however Acute have their own challenges to manage capacity.
- NCA Quality Improvement (QI) work is ongoing to manage the clinical risk.
- A focus is also needed on specific patient demographics and advice to referrers to ensure clinical pathways and patient prioritization can be managed appropriately given resource constraints.
-
- Going forward the CQC are in the process of developing a new assessment approach for all registered providers. The new framework will still look at the five key domains and the four-point rating scale which is what is currently being used.

3.2 Measles

- The local position for measles was provided including the actions underway to prevent the spread and to contain any cases as they arise to minimise the risk of an outbreak.
- Processes for managing how vaccines are provided to ensure maximum uptake was discussed with reference to how this is managed through the locality Vaccine Assurance Group.

- PPE into primary care especially face fit testing for appropriate masks and work is in hand to source this with acute and private providers to enable this across the 65 PCNs (Primary Care Networks) in Greater Manchester.

3.3 Quality Metrics

- Quality metrics are being developed to provide additional assurance along side that provided into each of the Bury Transformation Boards.

- There will be links through this to Patient Safety Incident Reporting Framework (PSIRF) and Learning from Patient Safety Events (LFPSE).

3.4 Quality Report

- Items reported focused on –
  - Ongoing discussions for ADHD/ASD provision both in Bury and wider into GM.
  - Support into Burrswood following their CQC inspection in 2023.
  - Safeguarding adult reviews and oversight from Bury Safeguarding Partnership
  - LeDeR (Learning from access to health and social care for people with a learning disability or autism) oversight
  - NHSE System Oversight Framework (SOF) for providers rated 'requires improvement' (SOF 3) or inadequate (SOF 4) and Bury locality support.

3.5 Risk Management

- Risk Performance and Scutiny Group now established and working alongside the GM Risk Management Team.

- Reviewing locality processes to enable a consistent way of being able to score all risks across each of the Transformation Programmes to confirm what needs to be reported into Locality Board and escalated into GM.

4 Associated Risks

4.1 Capacity in Bury locality to enable provider oversight of system risks across the items in this report even with the establishment of the Risk Performance and Scrutiny Group.

5 Recommendations

5.1 None

6 Actions Required

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

BURY
INTEGRATED CARE
PARTNERSHIP

Carolyn Trembath
Head of Quality
carolyntrembath@nhs.net
March 2024

Bury Primary Care Commissioning Committee (PCCC) Highlight Report

Chair: Will Blandamer
Reporting period: March 2024
Attendance: Acceptable

This report updates / informs the NHS Greater Manchester PCCC on the Bury PCCC work to date. It also provides an opportunity to raise any issues and inform of any changes that may affect the progression of work.

Key updates:

GP Core Contract Arrangements 2024/25 - noted the imposed contract and discussed several concerns regarding the impact that this lack of investment would have on the resilience of general practice. Members were informed that a crisis meeting is to be convened by Bury and Rochdale LMC on the 23rd of April 2024.

In addition PCCC where presented with updates regarding:

- The latest CQC position of practices in the borough and future inspection changes
- Quality Outcomes Framework (Quality Improvement Indicators) - Process and timelines
- The General Practice Leadership Collaborative
- GM PCCC Terms of Reference (TOR)
- Primary Care Programme
- Primary Care Risk Register

Priority actions in coming period:

The Bury LCS – Neighbourhood targets to be finalised. Further communications with practices regarding GM requirements including providing static patient list.

Enhanced Access – Deep dive, understanding offers and utilisation across practices in triangulation with other services

Primary Care Quality Visits – Year end review and recommendations for 24/25

Quarterly contractual update – All contracts

Decisions made:

The Bury Locally Commissioned Service (LCS) - Approved the service specification for 24/25 which includes GM requirements. PCCC supports the ambition around the standardisation of the of elements of the LCS contract but continues to advocate on behalf of Bury to encourage GM colleagues to recognise that standardisation requires a degree of consistency of funding to support this.

Agreement to recommission the following contracts for 2024/25:

- **Quality Assured Spirometry (QAS)** – Service provision est. till September 2024. Options regarding future service delivery to be presented to PCCC no later than July 2024.
- **Paediatric Phlebotomy** - Pathway redesign discussions to take place for 25/26.
- **Minor Surgery** - agreed uplift in line with Heywood Middleton and Rochdale colleagues. GM review and standardisation exercise anticipated to take place during 24/25 as part of the beyond core review group.
- **Special Allocation Scheme** - with the inclusion of a telephone tariff and recharge for Out of Area patients.
- **Sexual Health PMS +** - Service to be reviewed in 24/25 as part of the Women's Health Hub pathway discussions.

Enhanced Access – Committee members where made aware that a calculation error has meant that PCNs have been monitored against the wrong list size for the minimum requirements of the EA specification. In terms of fairness the committee therefore agreed that any clawbacks should therefore be against this calculation too.

Top 3 risks & mitigation:	RAG rating
Recruitment and retention of the workforce including ARRS recruitment/spend – work is in hand in understanding the risks associated with any underspend and of future planning in anticipation of the allocation for 24/25.	
Estates - The lack of suitable PC estate is impeding the way in which providers work and services are delivered. No mitigations in place, currently working beyond core hours to deliver services where necessary	
24/25 Budget Setting – allocation for Place and QIPP targets	

Any other information:

Key escalations for NHS Greater Manchester PCCC:

GM PCCC be advised on the position of Bury in relation to LCS payments, namely 1) any further standardization must be predicated on equalization of available funding, 2) that we recognise the arrangements in 24/25 as an initial year of implementation, and 3) that the year 24/25 must be focused on identifying opportunities for 'left shift' to secure further services appropriately in primary care for the benefit of patients and in the context of the urgent requirement to address GP financial sustainability.