# Health Scrutiny

Date: 19th June 2025

Subject: Our ambition for health and care in Bury in the Context of NHS Structural Change

Report of: Will Blandamer - Executive Director of Health and Adult Care – Bury Council, and Deputy Place Lead, NHS GM (Bury)

## 1.0 INTRODUCTION

1.1 The Bury Locality Board endorsed a refreshed strategy for the Health and Care systemin Bury at its meeting on 7th April. The Locality Plan describes a strategic ambition for the operation and improvement of the health and care system in Bury, and for improved population health and reducing health inequalities.

1.2 The Locality Plan is presented in the context of the revised Let's Do It Strategy for the Borough (2025), and in the context of the NHS Greater Manchester 3-year Sustainability plan (2025-2027)

1.3 This Locality Plan builds on a period of transformation and improvement in the operation of the health and care system in Bury since 2021. Progress has been built on high quality partnership working and a shared ambition for better outcomes for our residents. However, there is still more to do.

1.4 This plan outlines the next stage of our Health and Care reform journey, connected to the reform of wider public services and the economic ambition in the borough. The detail of the plan focuses on the first 12 months of delivery which includes the asks of the NHS operating plan for 25/26.

1.5 This Locality Plan outlines the current and forecast state of the health of our population, the policy context of this Locality Plan, and describes an ambition for the further reform of our health and care system and for the improved health of all people of Bury.

1.6 The Locality Plan highlights that improved outcomes for Bury residents and a clinically and financially sustainable health and care system is dependent on improved population health, improved prevention, transformed community care and the optimal delivery of health and care services.

1.7 Consequently, the Locality Plan identified 4 key priorities:

| We work together across the Bury Integrated Care Partnership to :- | |
|---|---|
| 1 | **Scale our work on Population Health Management - Improve population health and reduce health inequality of those in the most disadvantaged areas** |
| **2** | **Drive Prevention, reducing prevalence and proactive care – supporting Demand Reduction through primary intervention, secondary preventions and tertiary prevention** |
| 3 | **Transform the Model of Care in the Community - fully realising the benefit of neighbourhood team working with a focus on the assets of residents and communities and providing proactive care** |
| 4 | **Optimise Care in institutional settings and prioritising the key characteristics of reform.** |

## 2.0 NHS STRUCTURAL REFORMS – ANNOUNCED MARCH 2025

2.1 On 13th March, the Secretary of State for Health and Social Care announced that Integrated Care Boards (ICBs) across England would need to reduce their running costs by 50% by December 2025. Each ICB receives an allocation for 'running costs or administrative expenditure'. This sets the amount the organisation can spend on administrative, support and managerial staffing plus.

2.2 The Prime Minister also announced on 13th March that NHS England will be abolished with the majority of its functions expected to be adsorbed by the Department of Health and Social Care (DHSC). Administrative costs will we reduced at DHSC with a cumulative reduction of around 9,000 roles across NHS England and DHSC. There is an additional requirement for NHS provider trusts to reduce their corporate support costs.

2.3 A recent analysis of running costs for the 42 ICBs in England published by the Health Service Journal placed Greater Manchester ICB in the middle group of ICBs for our running costs in comparison to other ICBs.

2.4 A small amount of information has been released to date to follow on from the announcements. A letter from the Chief Executive of NHS England, Sir James Mackey of 1st April 2025 gave an early indication of the areas that ICBs will be expected to prioritise:

- The need to maintain some core staff, such as recently delegated commissioning staff and, in the short term until further options are considered, continuing healthcare staff
- The need to maintain or invest in core finance and contracting functions in the immediate term

- The need to invest in strategic commissioning functions, building skills and capabilities in analytics, strategy, market management and contracting
- The need to commission and develop neighbourhood health.

2.6 Equally, NHS England has indicated the areas where ICBs may wish to look at potential duplication:

- A number of assurance and regulatory functions (for example, safeguarding and infection control) where this is already done in providers and, in some cases, regions, without compromising statutory responsibilities
- Wider performance management (as opposed to contract management) of providers which again already takes place in providers and at regional level
- Comms and engagement which similarly exists in local authorities, providers and regions

2.7 Subsequently a high level ICB blueprint has been made available and this is attached at Appendix 1. In addition NHS England has indicated a predicted running cost reduction for the ICB of £65m – roughly £18 per head) which is just less than half of the running costs NHS GM currently

2.8 In Bury we are determined that we retain the quality of partnership working, transformational ambition, and improvement that characterises the operational of the health and care system.

## 3.0 NHS GM Bury

3.1 NHS GM has a corporate core and then 10 locality teams. In terms of leadership each locality has:

- A place lead (in 9/10 localities also the Council CEO) – Lynne Ridsdale
- A deputy place lead (in 8/10 localities this is a full time role but in Bury a joint appointment) – Will Blandamer
- An P/T Associate Medical Director – Dr Cathy Fines
- An P/T Associate Director Nursing and Quality – Catherine Jackson
- A finance Manager (shared between Bury and Rochdale) – Simon O' Hare
- In Bury Adrian Crook is formally a joint role as DASS in the Council and also Director of Community Commissioning in NHS GM.

3.2 There are a relatively small number of staff managed directly by NHS GM Bury

- The continuing health care /complex care team – mainly nursing staff
- The primary care improvement team

- Transformation capacity (e.g in urgent care, elective care, childrens services, adult mental health, cancer commissioning)
- Corporate support
- Safeguarding for adults and children
- Quality Assurance

3 A number of other functions are locality based and work closely with local stakeholders but actually formally managed on a GM wide basis – e.g finance, medicines optimisation (prescribing support to GPs mostly)

## 3.0 NEXT STEPS

3.1 NHS GM Bury leadership are meeting weekly with all staff (including a number of roles managed centrally) to share information, to ensure all necessary pastoral support, and to distil key messages for escalation to NHS GM.

3.2 NHS GM Bury leadership are working to influence the emergent new operating model for the NHS GM and ensure it retains the conditions as afar as possible to support the delivery of our locality plan.

3.3 At a GM level the ICB alongside the GM Mayor, GMCA and other partners we will seek to influence the direction of the reforms and how they are implemented in GM. This will include retaining the current geographical structure for the NHS in GM – which is coterminous with GMCA and the 10 local authorities.

3.4 Over the period June and July 2024 the ICB will develop its revised operating model – the current thinking on this as attached as Appendix 2.