Public Document

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS GREATER MANCHESTER

INTEGRATED CARE PARTNERSHIP BOARD

DATE: **Friday, 22nd March, 2024**

TIME: **1.00 pm**

VENUE: **The Council Chamber, Civic Centre, West Street, Oldham. OL1 1UJ**

AGENDA

1. **Welcome and apologies**

2. **Chair's Announcements and Urgent Business**

3. **Declarations of Interest** 1 - 4

   To receive declarations of interest in any item for discussion at the meeting. A blank form for declaring interests has been circulated with the agenda; please ensure that this is returned to the Governance & Scrutiny Officer at least 48 hours in advance of the meeting.

BOLTON	MANCHESTER	ROCHDALE	STOCKPORT	TRAFFORD
BURY	OLDHAM	SALFORD	TAMESIDE	WIGAN

Please note that this meeting will be livestreamed via www.greatermanchester-ca.gov.uk, please speak to a Governance Officer before the meeting should you not wish to consent to being included in this recording.

4. **Minutes of the meeting of the NHS GM Integrated Care Partnership Board held on 15 December 2023** 5 - 14

To consider the approval of the minutes of the meeting held on 15 December 2023.

5. **Implementing the Integrated Care Strategy - Mission on Recovery of Core NHS and Care Services** 15 - 82

Report of Warren Heppolette, Chief Officer for Strategy & Innovation

6. **The development of the Greater Manchester Joint Forward Plan for Children & Young People** 83 - 92

Report of Mandy Philbin - Interim Deputy Chief Executive and Chief Nursing Officer, NHS Greater Manchester Integrated Care
and
Caroline Simpson - Chief Executive & Place Based Lead
Stockport Metropolitan Borough Council | Greater Manchester Integrated Care

7. **People and Communities Participation Strategy** 93 - 122

Report of Warren Heppolette, Chief Officer for Strategy & Innovation, NHS Greater Manchester and Claire Norman, Director of Communications & Engagement, NHS Greater Manchester

8. **Date and time of next meeting**

The next meeting will be held on 31 May 2024.

For copies of papers and further information on this meeting please refer to the website www.greatermanchester-ca.gov.uk. Alternatively, contact the following

Governance & Scrutiny Officer: Edward Flanagan, Senior Governance & Scrutiny Officer

✉ edward.flanagan@greatermanchester-ca.gov.uk

This agenda was issued on Thursday, 14 March 2024

on behalf of Julie Connor, Secretary to the Greater Manchester Combined Authority,

Churchgate House, 56 Oxford Street, Manchester M1 6EU

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Declaration of Councillors' Interests in Items Appearing on the Agenda

Name and Date of Committee……………………………………………………………………

Agenda Item Number	Type of Interest - PERSONAL AND NON PREJUDICIAL Reason for declaration of interest	NON PREJUDICIAL Reason for declaration of interest Type of Interest – PREJUDICIAL Reason for declaration of interest	Type of Interest – DISCLOSABLE PECUNIARY INTEREST Reason for declaration of interest

Please see overleaf for a quick guide to declaring interests at GMCA meetings.

Quick Guide to Declaring Interests at GMCA Meetings

Please Note: should you have a personal interest that is prejudicial in an item on the agenda, you should leave the meeting for the duration of the discussion and the voting thereon.

This is a summary of the rules around declaring interests at meetings. It does not replace the Member's Code of Conduct, the full description can be found in the GMCA's constitution Part 7A.

Your personal interests must be registered on the GMCA's Annual Register within 28 days of your appointment onto a GMCA committee and any changes to these interests must notified within 28 days. Personal interests that should be on the register include:

1. Bodies to which you have been appointed by the GMCA
2. Your membership of bodies exercising functions of a public nature, including charities, societies, political parties or trade unions.

You are also legally bound to disclose the following information called Disclosable Personal Interests which includes:

1. You, and your partner's business interests (eg employment, trade, profession, contracts, or any company with which you are associated).
2. You and your partner's wider financial interests (eg trust funds, investments, and assets including land and property).
3. Any sponsorship you receive.

Failure to disclose this information is a criminal offence

Step One: Establish whether you have an interest in the business of the agenda

1. If the answer to that question is 'No' then that is the end of the matter.
2. If the answer is 'Yes' or Very Likely' then you must go on to consider if that personal interest can be construed as being a prejudicial interest.

Step Two: Determining if your interest is prejudicial

A personal interest becomes a prejudicial interest:

1. where the wellbeing, or financial position of you, your partner, members of your family, or people with whom you have a close association (people who are more than just an acquaintance) are likely to be affected by the business of the meeting more than it would affect most people in the area.
2. the interest is one which a member of the public with knowledge of the relevant facts would reasonably regard as so significant that it is likely to prejudice your judgement of the public interest.

For a non-prejudicial interest, you must:

1. Notify the governance officer for the meeting as soon as you realise you have an interest.
2. Inform the meeting that you have a personal interest and the nature of the interest.
3. Fill in the declarations of interest form.

To note:

1. You may remain in the room and speak and vote on the matter
2. If your interest relates to a body to which the GMCA has appointed you to, you only have to inform the meeting of that interest if you speak on the matter.

For prejudicial interests, you must:

1. Notify the governance officer for the meeting as soon as you realise you have a prejudicial interest (before or during the meeting).
2. Inform the meeting that you have a prejudicial interest and the nature of the interest.
3. Fill in the declarations of interest form.
4. Leave the meeting while that item of business is discussed.
5. Make sure the interest is recorded on your annual register of interests form if it relates to you or your partner's business or financial affairs. If it is not on the Register update it within 28 days of the interest becoming apparent.

You must not:

Participate in any discussion of the business at the meeting, or if you become aware of your disclosable pecuniary interest during the meeting participate further in any discussion of the business,
participate in any vote or further vote taken on the matter at the meeting.

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GMCA GREATER MANCHESTER COMBINED AUTHORITY

Greater Manchester Integrated Care Partnership

Minutes of the meeting of the

NHS Greater Manchester Integrated Care Partnership Board

held on Friday 15 December 2023 at Manchester Town Hall

Present

City Mayor Paul Dennett	NHS GM Integrated Care (Chair)
Sir Richard Leese	NHS GM Integrated Care
Councillor Linda Thomas	Bolton Council
Councillor Thomas Robinson	Manchester City Council
Councillor Barbara Brownridge	Oldham Council
Councillor John Merry	Salford City Council
Cllr Keith Holloway	Stockport Council
Councillor Eleanor Wills	Tameside Council
Councillor Jane Slater	Trafford Council
Councillor Keith Cunliffe	Wigan Council
Warren Heppolette	NHS GM Integrated Care
Luvjit Kandula	NHS GM Integrated Care
Claire Norman	NHS GM Integrated Care
Rob Bellingham	NHS GM Integrated Care
David Boulger	NHS GM Integrated Care
John Herring	NHS GM Integrated Care
Stephanie Butterworth	Tameside Council
Chris McLoughlin	Stockport Council
Eamonn Boylan	GMCA
Steve Wilson	GMCA
Gemma Marsh	GMCA
Andrew Lightfoot	GMCA
Elaine Mottershead	GMCA

ICPB/31/23 Welcome and Apologies

Resolved /-

That apologies be received and noted from Alison Page, Councillor Bev Craig, Debbie Watson, Dharmesh Patel, Jane Pilkington, Janet Wilkinson, Joanne Roney, Kathy Cowell, Mandy Philbin, Manisha Kumar, Noel Sharpe, and Sam Simpson.

ICPB/32/23 Chair's Announcements and Urgent Business

There were no announcements or urgent business.

ICPB/33/23 Declarations of Interest

There were no declarations received in relation to any item on the agenda.

ICPB/34/23 Minutes of the Previous Meeting held on 29 September 2023

Resolved /-

That the minutes of the meeting held on 30 June 2023 be approved as a correct record.

ICPB/35/23 Implementing the Integrated Care Strategy – Mission 3, Helping People to get into, and stay in, good work

This agenda item was presented by NHS GM Officers David Boulger and John Herring with GMCA Officer Gemma Marsh. A presentation had been circulated with the agenda pack and slides 1-23 were highlighted to the Committee.

Comments and questions

- A member asked about people with learning disabilities and autism as a considerable cohort that typically face challenges when looking for work. It was suggested that jobs and recruitment could be structured differently to remove some of the barriers. In response, it was noted that the data intelligence and evidence would be crucial to helping make improvements. At the same time, there would be further work to do with employers. Members were directed to information about existing programmes, contained in the appendices, with an acknowledgement that more work needed to be done. It was also noted that a report was commissioned last year through the Greater Manchester Disability Panel. and Breakthrough UK which could be shared with

members if required. The report was based on the experiences of staff working in local authorities and health settings and suggesting what employers could do to improve the experiences of people with neuro-diverse challenges.

- There was a discussion about barriers in recruitment, from the application process to the language used. "Over-professionalism" often resulted in recruiting from the same groups of people. Recruitment should consider characteristics and not just skills, particularly in the health and social care sector. A member reported on very successful local jobs fairs and officers confirmed that, whilst they had not attended on the day, they had some involvement in the events, worked with local officers and provided the recruitment toolkit.

- It was acknowledged that there were some challenges around pay and conditions for people who worked in health and social care. A member highlighted that one school leaver in every ten needed to choose a career in health and social care work to meet future demand. This might not happen if the sector conditions remained the same. There needed to be further work and training, particularly with colleges and universities to develop a single career pathway that people aspired to. In response, it was noted that work was ongoing around the provision of different routes eg. the technical pathway alongside the academic pathway. There were still challenges to meet such as the costs involved for employers in apprenticeships and T levels but there should be recognisable career paths. Partnership work was ongoing with GM Apprenticeship and Career services, the NHS, schools, colleges etc. The Adult Education Budget was a significant resource that had been devolved to GMCA with opportunities to direct it to help move, shift, and upskill people into the right areas.

- A GP representative talked about their experience of being one of the members of the Good Employment Charter. Most health and care providers were motivated to work in the sector to care for patients and residents and, in addition, to look after their staff. It was important for the employers to get the support and links to their services which would enable them to do this. The Chair acknowledged the importance of sharing good practice amongst good employment charter members, particularly smaller

providers that might face more challenges in meeting some requirements. The comments were noted by officers who gave an example of working with a Credit Union to establish an offer that had been made available to all health and care staff which could be accessed directly by individuals and was independent of their employment status.

- A member raised concern about demographic and geographic disparities in employment rates and education opportunities. Reassurance was given that data evidence and intelligence sat at the heart of the integrated care model and Greater Manchester was using it in innovative ways to drive delivery. There was a wider conversation ongoing within NHS GM about how the data could highlight those who were most likely to be economically active and the impact that could have. It should also be recognised as an opportunity to unlock potential rather than attempting to fix a problem.

- A member welcomed the information about technical career pathways as another route for people who could benefit from alternatives to the traditional academic pathways. It was important that any jobs created needed to be "good work" as poor-quality work often led to illness and further support needs. In response, it was agreed that young people leaving school could be confused about their choices and there needed to be clear and equal access to jargon-free information that helped people to make informed choices about jobs and education.

- Devolution had already given opportunities to do things differently alongside ongoing partnership work between relevant organisations and mainstream provision with opportunities for co-design.

- Officers welcomed the Committee's input in ensuring that they reached their communities. The aim now was to see measured increases in the data on apprenticeships, technical education pathways and employment.

- A member talked about concerns around the adult social care sector facing a recruitment crisis and acknowledged that the lack of a clear career path contributed to that. There was also a crisis with GPs that were migrating to other countries because of work pressures in the UK. Not enough was being done to encourage new GPs to enter the profession. Officers responded that work was already ongoing with colleagues in Tameside on blended roles for social care and how, for example, the district nurse pathway could be developed. The technical education route would give further opportunities for aligning roles to a path in social care. The comments about GPs were acknowledged and it was noted that there was similar concern about social workers. The Good Employment Charter was one way of looking at some of the issues such as pay, conditions and work pressures as it promoted flexible work and good culture in organisations.

- There was a suggestion that whilst the programmes and pathways were being developed, we should also look to the public procurement framework contracts and build in some of the standards around training, development, and career progression .

- There was discussion about workforce planning for the future. Long-term illness affected 50% of an ageing population and this, with medicalisation of a whole range of conditions, highlighted serious challenges to the long-term sustainability of health and care in its current format. To make “working well” type programmes successful, there needed to be more business planning and expenditure at a local level to ensure to maximise the local benefits. It would be crucial for more people to choose a career in health and social care and that would mean more attractive career options. There were currently approximately 90,000 full-time equivalent employees in NHS GM and more in the wider care sector. These employees could be good ambassadors for the future generation of employees providing they did not feel undervalued, demoralised and under pressure. It was acknowledged that the current pressures of the sector could be creating mental and physical health problems amongst the employees, who would then become future patients.

- It was noted that the good employment charter and the NHS as an anchor institution would be crucial to inclusive employment. There should also be a focus on the fact that poverty could occur within employment and progression was therefore equally important.

- The correlation between half a million people on medical waiting lists in Greater Manchester and the difficulties in getting people into, and staying in, work was noted. The two highest ranking conditions for economic inactivity were mental health and musculoskeletal conditions.

- Officers highlighted that national conversations illustrated that Greater Manchester was coming from a position of relative strength. Whilst there was still much more work to be done, our peers were not in the same position in terms of partnerships and integrated work across health, local government, GMCA and other key stakeholders such as the Chamber of Commerce and the Growth Company.

- An example was given of a programme some years ago when the University of Manchester and the Central Manchester Hospitals, worked together to recruit locally from the immediate vicinity i.e. Ardwick, Hulme, Moss Side and Rusholme. The programme focussed on making entry-level employment more accessible to local residents and, as a result, the reputation of the employers within the community changed. The local workforce was committed, productive and retention rates rose. Local recruitment events would be a good way of reaching communities and replicating these outcomes. Officers acknowledged this and there was already ongoing work for similar programmes in different areas

- There was a business case to be made about the wider benefits of people being in work and how and where those benefits could be realised. Further conversations were needed with the Government about the holistic economic impact of employment and health and where future investment should be targeted. There should be consideration to health investment and how it could contribute to the public purse through economic growth, tax benefits etc. There was a strong cost-benefit analysis

undertaken on the first health and work programme and this should be repeated, not least for the purpose of making a case for further devolution.

- An example was given about a programme in Wigan, approximately four years ago, where an ethical framework was developed for home care providers with the intention of ensuring better conditions e.g. staff being paid for travel time. It resulted in more contracts being awarded locally. The groundwork of this collaborative approach with providers proved beneficial during the pandemic when companies shared staff to maintain services. It was highlighted that 41% of all home care visits in Wigan were now done by walking or cycling; 86% lived in the locality where they provided the care; 50% of the workforce were under 30 years old despite the general demographic of health and care workforce being 50+. This was a good example of how recruitment and employment could impact on other areas such as congestion, clean air, and active travel.

- A representative from the Directors of Children's Services talked about the sophisticated data available across Greater Manchester to indicate the barriers of employment connected to the availability and affordability of childcare. The Greater Manchester School Readiness Board provided a good opportunity to make links in this area. Officers welcomed this given there was a timely piece of work looking at the Adult Education budget and the proportion that was spent on learner support and specifically childcare in excess of the free 30 hours.

- The Chair commented on how this employment and health agenda linked to the housing and homelessness crisis. Many people across the region did not currently have safe shelter and this would clearly impact on their ability to be economically active. There was a three-year budget for the NHS and GMCA to tackle homelessness and rough sleeping and more connections needed to be made. Officers responded that the increase of good available data intelligence and engagement promoted inclusion across health groups in the broadest sense and the groups that faced the most significant multiple challenges to achieving good health would be the focus.

The Chair summarised the key headings from today's discussion:

- Business planning.
- The importance of organisational culture in attracting and retaining staff.
- Recruitment – the processes and the language used
- The challenges faced in losing staff to international markets.
- The future of devolution and the opportunities that might present.
- Good employers and the opportunity for the NHS and local government to be leading examples.
- Sharing best practice across the region.
- The work needed to assist people with neuro-diverse challenges to access good employment and education options.
- Data intelligence and evidence to address geographical and demographic inequities and proportionate universalism.
- Simplification of pathways to employment, education, and training.

Resolved /-

- That the report, *Foundations for Change,* commissioned through the Greater Manchester Disability Panel. and Breakthrough UK, be shared with members.

- That the recommendations as set out in the report be agreed:

  - The update on Mission 3 be noted and reaffirmed as a priority for the NHS GM Integrated Care Board

  - The following key next steps be agreed:

    - Establishment of a GM Joint Inclusive Employment unit.
    - Bid to become an NHSE Work Well partnership vanguard

- Continuing to pursue the implementation of the Real Living Wage.
- Development of the health and care sector workforce development response to the opportunities within the GM devolution trailblazer deal.
- Continuing to identify and advance opportunities to further strengthen the role of the health and care sectors as an anchor system
- continuing to take practical steps to implement Social Value across the GM health and care system.

ICPB/36/23 Date and Time of Next Meeting

It was noted that the next meeting would be held on 22 March 2023 at 1pm.

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GMCA GREATER MANCHESTER COMBINED AUTHORITY

Greater Manchester Integrated Care Partnership

NHS Greater Manchester
Integrated Care Partnership Board

Date: 22 March 2024

Subject: Implementing the Integrated Care Strategy – Mission on Recovery of Core NHS and Care Services

Report of: Warren Heppolette – Chief Officer – Strategy and Innovation

Purpose of Report

- The Integrated Care Partnership Strategy was approved by the ICP Board in March 2023
- The Joint Forward Plan is the delivery plan for the ICP Strategy and was approved in June 2023
- Part of the Board's role in the implementation of our strategy and plan will be to examine in depth the delivery of the six missions in the Strategy and Joint Forward Plan with a focus on the key system actions we can take collectively to deliver the missions.
- This is the fourth mission that the Board has examined in detail – Recovery of Core NHS and Care Services
- The update on this mission is presented in the form of the draft 2024/25 Operational Plan for the ICS – which is focused on system recovery across population health quality and performance and finance.

Recommendations:

The Integrated Care Partnership Board is requested to:

- Note and discuss the update on the Mission on Recovery of Core NHS and Care Services

Contact Officers

Paul Lynch – Director of Strategy and Planning

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
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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/

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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.

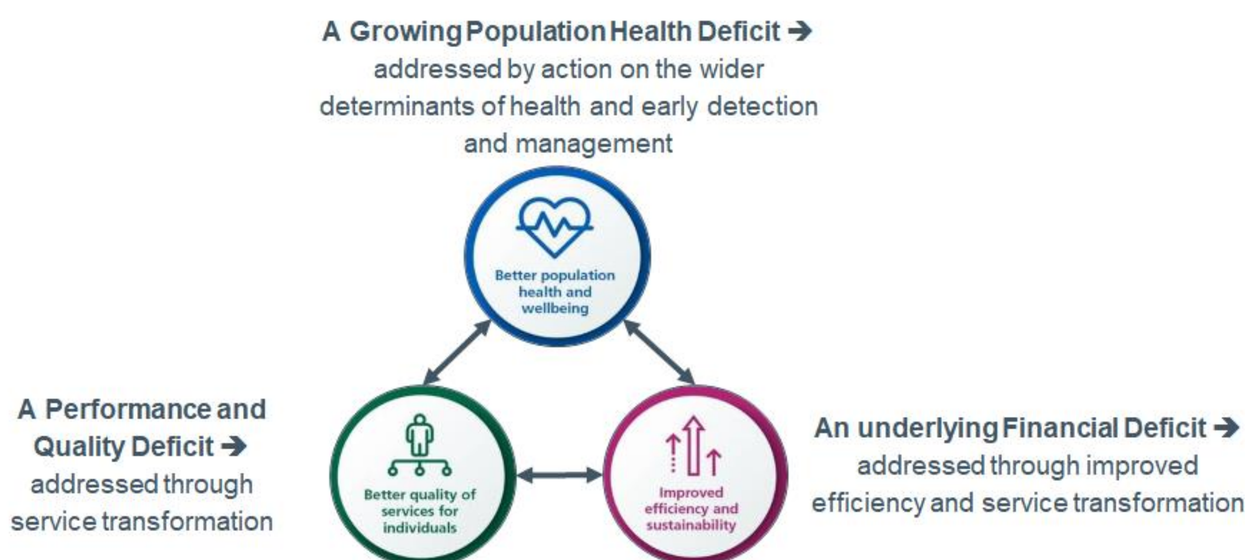
These plans are set in the context of our five-year Integrated Care Partnership Strategy and Joint Forward Plan – this Operational Plan represents the 2024/25 update of our Joint Forward Plan. Through our short, medium and long-term plans we must avoid escalating future costs through a system endeavour 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/

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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).

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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).

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

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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.

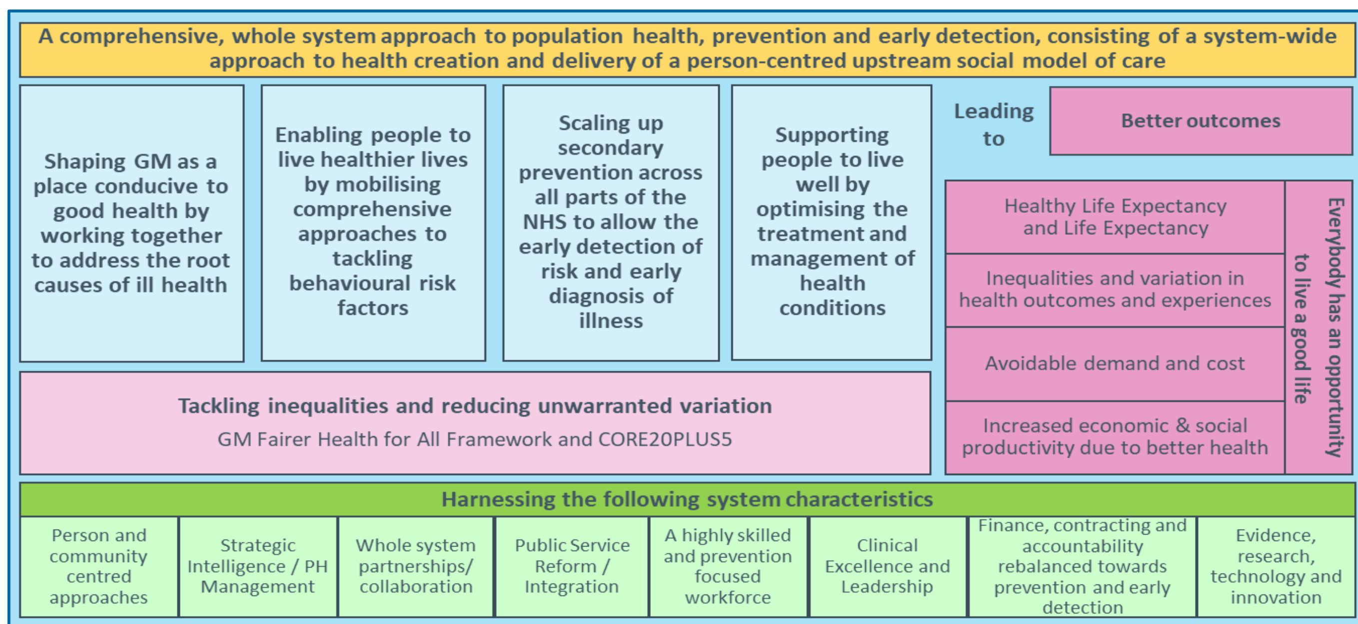
4.2 National NHS objectives

- 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

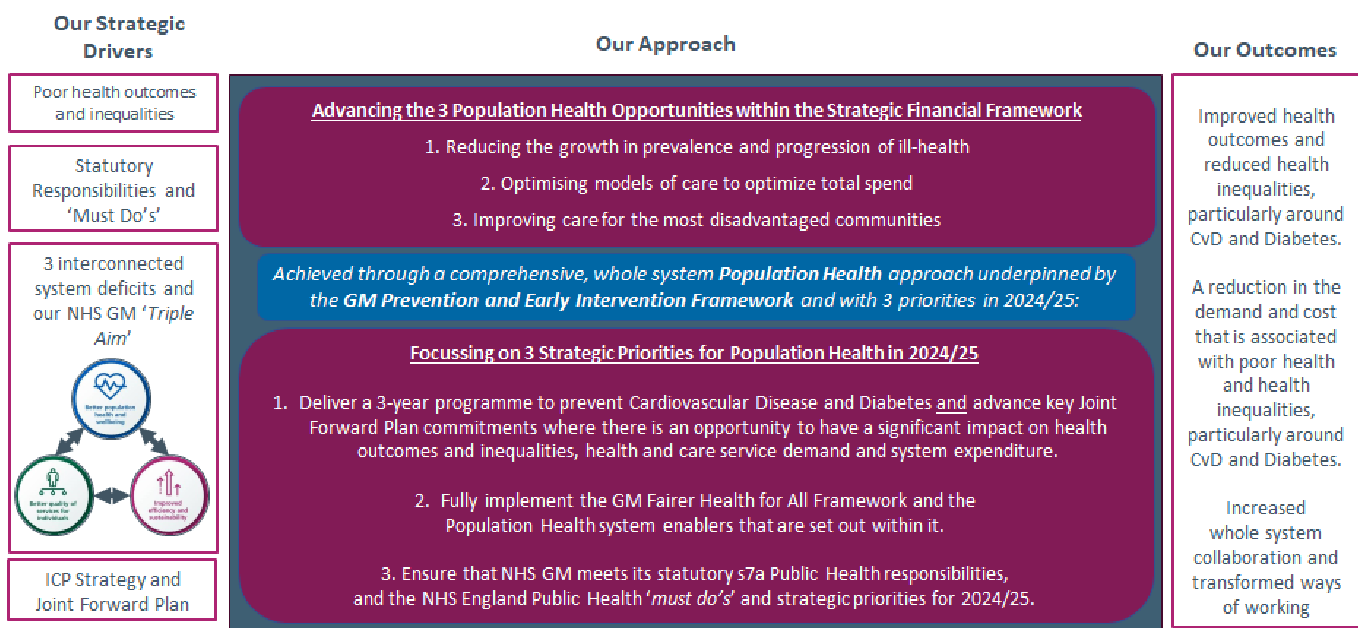
The **GM Prevention and Early Intervention Framework** describes the comprehensive and whole system approach to prevention that is required to generate a step change in population level health outcomes. The Framework is outlined in Figure 2:

Figure 2



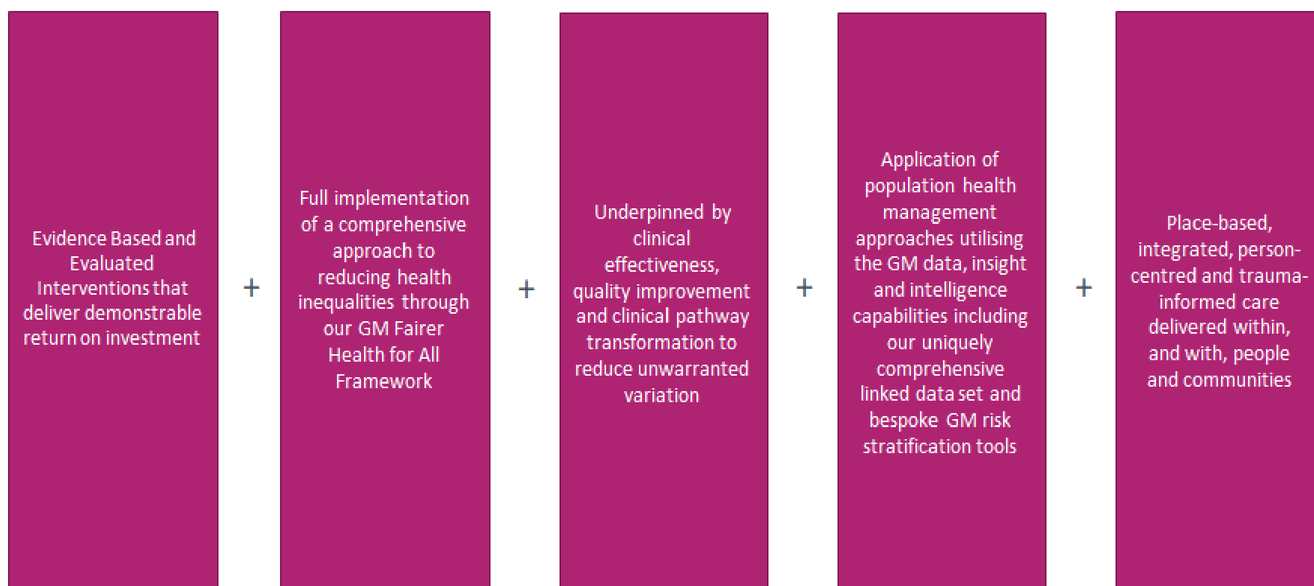
Our priorities for population health in the coming year will be delivered through a comprehensive, whole system approach underpinned by the GM Prevention and Early Intervention Framework. This is illustrated in Figure 3:

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.

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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

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- 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 Size of the Prize - Hypertension | Tableau Public	**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 Size of the Prize - Cholesterol | Tableau Public	**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.

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[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,

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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:

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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.

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[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

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- 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

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- 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.

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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

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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.

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- 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

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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.

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[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/

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- 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

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- 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.

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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.

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- 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.

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- 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.

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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

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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

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- 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.

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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.

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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

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- 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)

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- 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

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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.

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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.

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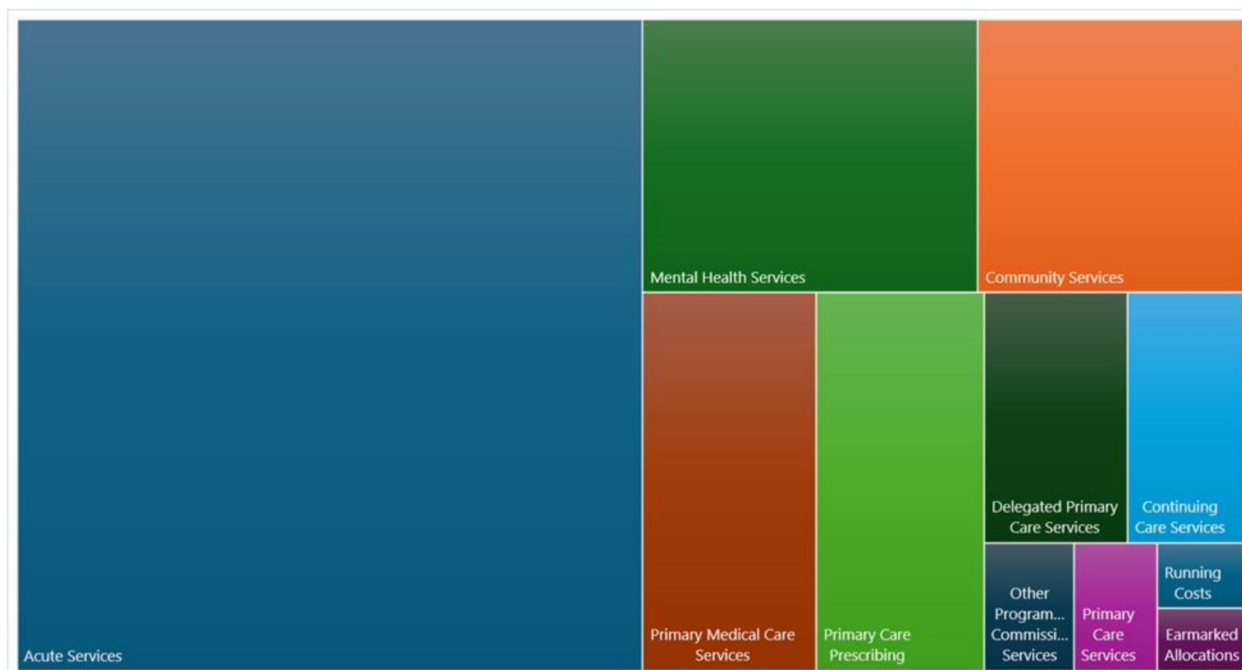
Figure 7 [16]



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

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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

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- 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

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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

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	& 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

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	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:

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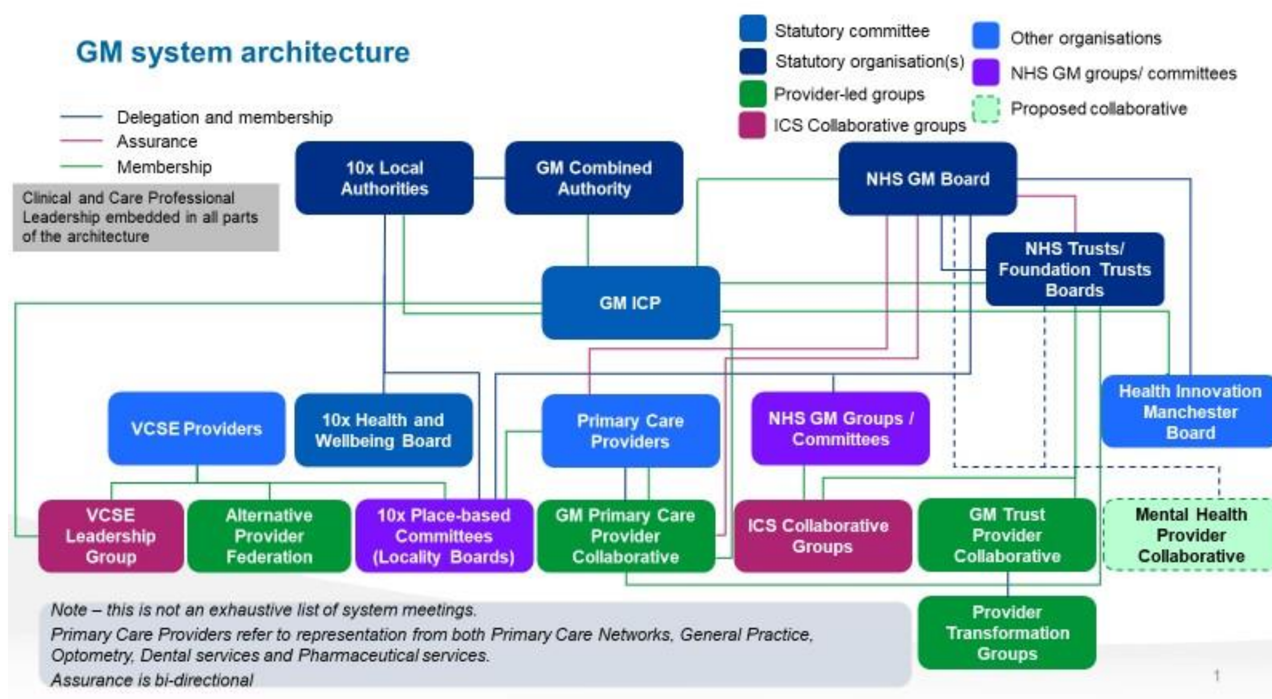
Figure 8



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:

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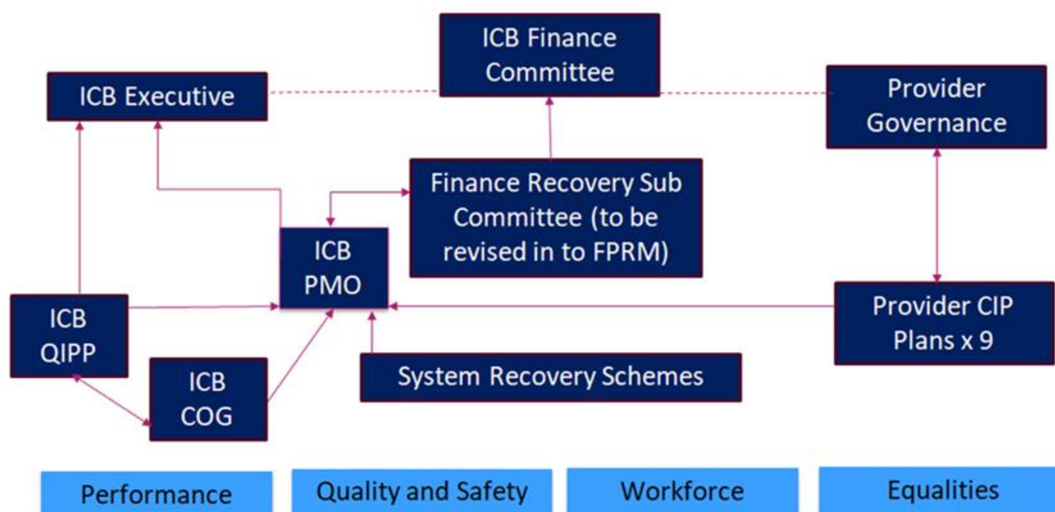
Figure 9



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:

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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.

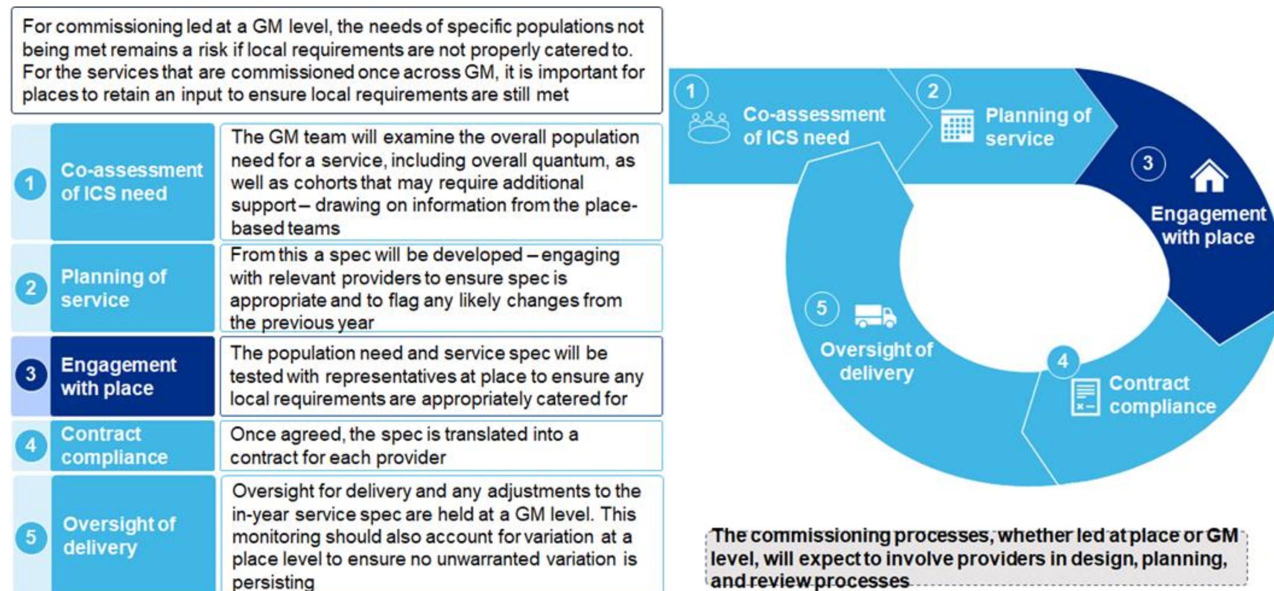
The Operating Model makes the key roles of all partners in strategy, planning and delivery clear as shown in Figure 11 :

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 **Establishing and supporting joint working 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.
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):

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Figure 13

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

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.

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.

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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:		
	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.

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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:		
	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

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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.

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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

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.

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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.

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GMCA GREATER MANCHESTER COMBINED AUTHORITY

Greater Manchester Integrated Care Partnership

NHS Greater Manchester

Integrated Care Partnership Board

Date: 22 March 2024

Subject: The development of the Greater Manchester Joint Forward Plan for Children & Young People

Report of: Mandy Philbin - Interim Deputy Chief Executive and Chief Nursing Officer

NHS Greater Manchester Integrated Care

Caroline Simpson - Chief Executive & Place Based Lead

Stockport Metropolitan Borough Council | Greater Manchester Integrated Care

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Purpose of Report:

This report provides an overview to the Integrated Care Partnership board on the partnership approach being taken in relation to the development of a Joint Forward Delivery Plan for Children & Young People (CYP) within the Strategic Financial Framework for CYP across Greater Manchester in order to:-

- have a single set of system strategic priorities for CYP.
- enable strategic business planning moving forward.
- inform planning & commissioning through a joined up approach as defined in place driven by user experience and feedback
- enable a re-purpose of resources
- develop and implement new delivery models to improve service performance and optimise models of care eg Balanced System for SEND
- achieve an understanding of cost v impact on outcomes

BOLTON MANCHESTER ROCHDALE STOCKPORT TRAFFORD
BURY OLDHAM SALFORD TAMESIDE WIGAN

Recommendations:

The Integrated Care Partnership Board is requested to:

1. Endorse the ambition for our Children & Young People across Greater Manchester through the development of a whole system Integrated Care Partnership approach to the delivery of the 'Giving every child and young person the best start in life' part of the Joint Forward Plan in line with the Strategic Financial Framework.

Contact Officers

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1. Introduction/Background

1.1. Greater Manchester (GM) Integrated Care System (ICS) provides healthcare for 3m people living in 10 places. As a system, GM has sought to improve population health whilst at the same time improving the financial position and service performance.

1.2. The establishment of the GM Integrated Care System on 1st July 2022 presented a major change to the way in which heath and care will be delivered nationally and here in Greater Manchester. There are strong foundations to build on in our ambitions to improve outcomes for children & young people. Over the last 5-10 years multi-agency partnerships at both the local and GM level have worked on a range of transformation programmes designed to improve the offer for GM children and young people. This includes work to improve common practice standards for particular groups of young people (eg. SEND, Care Leavers), developing solutions to common challenges and spreading innovative practice across boundaries.

1.3. Through our Joint Forward Plan (JFP) we have adopted a system wide approach across Greater Manchester of understanding and meeting need and delivering models of care with partners (health, education, voluntary, criminal justice sectors, GM Combined Authority and local authorities). The JFP builds upon our existing local work and plans. The JFP cannot describe all of the detail of each GM programme of work in a single document so the JFP refers to and cross-references other strategies and plans.

1.4. Greater Manchester is passionate about ensuring that all our children and young people get the best start in life and are cared for, nurtured and supported to grow up well and achieve their ambitions in life. Currently CYP related activity is captured under the headline mission in the JFP of 'Giving every child and young person the best start in life'

2. Development of our ambition

2.1. Aligned to the JFP is the financial context within which GM ICP sits. Greater Manchester Integrated Care System has set out it's draft Strategic Financial Framework 23/24 - 27/28. The Strategic Financial Framework (SFF) sets out the baseline position, the" do nothing" forecast, quantifies the population health opportunities, sets out the phasing and sequencing over time and considers the position of the 9 NHS providers. The plan sets out the "do nothing" scenario and the alternative scenario of addressing the financial challenge over time through a combination of population health measures and provider efficiencies.

2.2. The SFF advocates three population health opportunities to optimise the allocation and support of health and care services in better, more efficient, ways in order to address the growing needs for health care for our population: -

1. reducing prevalence growth - opportunities to prevent prevalence and progression of ill health relative to baseline trend based on targeted prevention and early detection activities.

2. optimising models of care – to deliver more consistent proactive care to support effective population health management.

3. addressing inequalities in access – opportunities to improve health and address and reduce disparities in care for people in deprived socio- economic groups.

2.3. In February 23 the Integrated Care Partnership received a paper that made the case for ensuring CYP are seen as a priority group and as part of this paper it was agreed that having a commitment to a set of shared ambitions for our Children & Young People, understanding & tackling inequalities, incorporating the voice of CYP and taking a partnership approach and longer term view to resourcing our priorities is key.

2.4. Since that report, work has begun in earnest to take forward the development of this ambition. Under the leadership of Mandy Philbin, Chief Nursing Officer and Executive Director for Corporate Services, who is the ICB Executive lead for Children & Young People, and Caroline Simpson, Chief Executive at Stockport

MBC in her Place Based CYP Lead a whole CYP ICP system delivery plan is being developed aligned to the 3 population health opportunities within the SFF.

2.5. The development of this plan requires a culture shift recognising that the solution to the challenges currently faced cannot be the sole responsibility of any single organisation or sector and that taking a partnership approach enables us to draw on a wider range of levers to influence health outcomes.

2.6. This approach will set alongside identification of likely resource requirements and enable prioritisation of programmes of work taking into account cost and impact on outcomes for CYP and their families. It is expected that there will be opportunities to shift spend across different parts of the system enabling a reduction in inequalities in provision.

2.7. With this in mind it is important that locality leads and practitioners within localities shape and influence the programme to ensure delivery against local area identification of need. Discussions have already taken place within various groups and committees that have led to the current list of CYP priorities being identified. The proposed approach has been very well received with partners keen to support the ambition and approach. To date Bury, Oldham, Rochdale, Stockport & Tameside locality committees have discussed the approach and priorities with plans in place for the other locality committees to discuss. It is recognised that in the short term at least we may not be able to progress activity across all the work programmes listed below in year one, therefore we are also seeking guidance from localities around their most pressing areas of concern.

2.8. The supported work programmes are currently as follows: -

i. **Child Development in the Early Years** includes:
   - EY pathways
   - Maternity (Saving Babies Lives, Neonatal, Assurance)

ii. **School-Age Children Wellbeing** includes:

- SEND – Data dashboard, Preparation for Adulthood, Alternative Provision and Change Programme.
- Learning Disability & Autism – ND Pathway (autism & adhd) , Dynamic Support Register, Crisis, Autism in schools.
- Foetal Alcohol Syndrome
- Speech, Language & Communication - Balanced system roll out
- Emotional Wellbeing – Emotionally Based School Avoidance

iii. **Long-Term Physical Conditions** (Core20Plus5) includes:

- asthma,
- epilepsy,
- diabetes,
- CYP acute mental health &
- oral health.

iv. **Mental ill Health** (responding to the rise in the number of children & 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.) includes:

- Perinatal & Parent Infant Mental health
- Mental Health Support Teams
- Childrens Eating Disorders
- CAMHS
- Crisis

v. **Vulnerability, Risk and Complex Care** includes:

- cared for/care experienced CYP,
- CYP in the criminal justice system,
- victims of/at risk of exploitation,
- victims of domestic abuse

- CYP with experience of other forms of trauma/adverse childhood experiences.
- Unaccompanied asylum seekers
- Complex Safeguarding

vi. **Family help** - 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 support for families of CYP who are on health waiting lists pre and post diagnosis includes:
   - Family Hubs
   - Supporting CYP & their families while they wait
   - Challenging Behaviours & Sleep Patterns
   - Interpretation Services

2.9. The Priorities are a summary of a more detailed set of information. Delivery of the programmes of work will take place within and across localities. The system ambition is for this work to be delivered by a matrix of multi-disciplinary teams across the ICP, work programmes are aligned to address the key CYP challenges and that appropriate programme management and support will need to be aligned to this. Taking a programme approach will enable projects to adapt to external drivers such as responding to the outcomes of SEND & ILACS Inspections and respond to new and emerging National developments and priorities.

2.10. At the core of the programme plan is the voice of our children and young people and their families and carers. CYP partners across the system will work together to ensure that principles of communication, co-production and co-design are applied appropriately and opportunities for this take place in the most appropriate way.

2.11. Data will be aligned to the programme development and delivery. Whilst data is available across various parts of the system, work has begun to develop a comprehensive CYP dashboard that will be used to inform the CYP programme. The data will be used to understand high cost/low outcomes, inform decision making and commissioning intentions.

3. Governance

3.1. Greater Manchester Integrated Care Partnership and the Greater Manchester Combined Authority CYP System Group will monitor progress of the Delivery Plan and the newly established ICB CYP Strategic Group will support with overseeing progress against the overall programme operational implementation. This group will ensure appropriate linkages and relevant and appropriate reporting takes place via other thematic partnerships such as Mental Health Board and Autism Partnership. Locality programme updates will be provided via locality committees and partnership groups.

3.2. The Greater Manchester Integrated Care Partnership and the newly established ICP CYP Strategic System Group will support with overseeing progress against the overall programme operational implementation. Risk escalation and decisions will be made via the appropriate governance routes. Resourcing and leadership still need to be defined (primarily commissioning support)

3.3. The CYP Strategic System Group has membership and representation from across the ICP that includes Childrens Services, Public Health, Health Providers, Voluntary sector and Children & Young People. It will monitor progress of the Delivery Plan and support with overseeing progress against the overall programme operational implementation. This group will ensure appropriate linkages and relevant and appropriate reporting takes place via other thematic partnerships and groups with responsibility for the delivery. Locality programme updates will be provided via locality committees and partnership groups.

3.4. The GM Childrens Board, chaired by the political lead for CYP in GM and attended by all Exec members, DCSs and senior representatives from partner agencies ensures there is a multi-agency forum providing oversight of our approach to improving outcomes for children. This will include oversight of our approach to the delivery of the ‘Giving every child and young person the best start in life’ part of the Joint Forward Plan.

4. Recommendations

The Integrated Care Partnership is asked to:

Endorse the ambition for our Children & Young People across Greater Manchester through the development of a whole system Integrated Care Partnership approach to the delivery of the 'Giving every child and young person the best start in life' part of the Joint Forward Plan in line with the Strategic Financial Framework.

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GMCA GREATER MANCHESTER COMBINED AUTHORITY

Greater Manchester Integrated Care Partnership

NHS Greater Manchester

Integrated Care Partnership Board

Date: 22nd March 2024

Subject: People and Communities Participation Strategy

Report of: Warren Heppolette, Chief Officer for Strategy & Innovation, NHS Greater Manchester and Claire Norman, Director of Communications & Engagement, NHS Greater Manchester

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Purpose of Report

To set out the People and Communities Participation Strategy for discussion and noting by the Board.

Recommendations:

The Integrated Care Partnership Board is requested to discuss and note the People and Communities Participation Strategy.

Contact Officers

Claire Connor, Associate Director of Communications & Engagement, NHS Greater Manchester

Claire.connor@nhs.net

BOLTON BURY MANCHESTER OLDHAM ROCHDALE SALFORD STOCKPORT TAMESIDE TRAFFORD WIGAN

1. Background

1.1 NHS Greater Manchester (NHS GM) was required to produce a people and communities engagement framework when the Integrated Care Board was formed. However, we wanted to move to a more co-produced and partnership approach.

1.2 The People and Communities Participation Strategy sets out a new vision and ways of working with local residents and communities across the partnership that brings together and builds on the strong existing participation work that already takes place within localities.

1.3 We have chosen to use the term participation instead of engagement. This is because it's clearer and simpler and describes what we're trying to achieve – that we build relationships and trust with the people of GM to enable them to participate in discussions and decisions about their own health and services. It's an active term and one people understand, including partners who are critical in this. Engagement is more of an NHS term and, while we were developing this, caused some confusion with staff and stakeholder engagement.

1.4 It has been through locality partnership boards during January 2024 to March 2024 for discussion and feedback and it has been to the NHS GM Board for discussion in December 2023 and approval in March 2024.

1.5 The strategy has been developed with the support of key stakeholders, including representatives from localities, GMCA, Healthwatch, 10GM and GM=EqAl.

2. Key Messages

2.1 The People and Communities Participation Strategy focuses on building a long-term systematic model for participation in health and care using a partnership approach that compliments the myriad of participation activities that take place across Greater Manchester and within localities.

2.2 It sets out why and how we will work with partners, individuals, families, children and communities to understand what matters to them; find the solutions to the challenges that face us; and, better enable them to participate in discussions and decisions about their own health and services.

2.3 The strategy aligns to the GM ICP Strategy and key system priorities, as well as to the participation approach of partners, including the GMCA's emerging focus on participation.

2.4 The Strategy sets out how we will:

- **Deliver participation systematically and with purpose**, being clear about why we are talking to people, what the purpose is, what the right tools are for that piece of work and the outcome we collectively hope to achieve. Sometimes that will mean listening, sometimes gathering data, sometimes consulting, sometimes co-producing and sharing power, and sometimes a mix; all of these methods are valuable, all will build the trust needed to mobilise people around their own health and the required outcomes will determine the methodology mix.

- **Target communities who experience the greatest health inequalities**, using participation to support the reduction in health inequality wherever possible.

- **Work in partnership to make the most of the great relationships, infrastructure, assets and ongoing pieces of work which already exist in partners and communities** and continue to build on and develop them, augmenting rather than duplicating. We are not reinventing the wheel, we are refining and improving its performance with partners across GM so we augment rather than duplicate existing work and talk to people once where than can be done.

- **Use the right people and places to reach the right people and places** working with all partners so each can play to its strengths, maximising the breadth and depth of reach of conversations.

- **Meet our statutory duties to involve**, whilst going beyond that to mobilise people to improve their own health.

- **Ensure strong governance and oversight**, taking a partnership approach to both.

- **Focus delivery in localities** with locality-specific plans and resources and avoiding a one-size-fits-all approach, recognising that demographics vary

2.1 The strategy aligns to the GM ICP Strategy and key system priorities, as well as to the participation approach of partners, including the GMCA's emerging focus on participation.

2.2 It sets out an 8-week cycle of planning and delivery, that creates constant and systematic participation. An example is included of how the approach will work in practice over a two-year period to mobilise people and communities to take charge of their own health, focusing on those who experience the greatest health inequalities. The topic of this two-year programme will be determined by the outcome of the Strategic Financial Framework and aligned to the GM ICP Strategy missions.

2.3 Delivery of the strategy will be locality focused, with the resources aligned to localities. This includes delivery of locality key priorities and GM-wide priorities within localities. As each locality has a different demographic profile, delivery within localities will need to reflect this, rather than a one-size-fits-all approach. The balance between GM-led and locality-led participation will vary to reflect the needs of the localities and central priorities at any given time.

2.4 A key part of this work is to reduce duplication by working across the partnership and to use the resources available to us via front-line teams like library staff, receptionists, community nurses, etc.

3. Feedback

3.1 Feedback from partners, locality boards, providers and teams across Greater Manchester has varied, depending on their current focus on participation.

3.2 Broadly, the strategy has been welcomed with many feeling it is ambitious.

3.3 Key, consistent points have included:

- The strategy was too focused on individuals, with not enough reference to children and families.
  The strategy has been updated to reflect this.

- It is important that duplication is avoided across Greater Manchester and partners.
  This is a key focus of the strategy and the locality and system participation groups.

- Localities need to be able to support participation around their priorities.
  The strategy supports this and it is an important part of implementation.

- Locality governance needs to be reflected in the locality participation groups, as it is important that they are connected locally.
  The strategy has been updated to reflect this.

- There was significant support for the approach being taken with the Voluntary, Community and Social Enterprise (VCSE) sector, with the importance of resources being attached to this highlighted.
  The strategy supports this and it is included in implementation.

- Localities are in different places with regards participation and it is important that this is taken into account in implementation, and that there shouldn't be a focus on standardising to the middle ground.
  This is an important part of implementation.

4. Recommendations

4.1. That the Board discuss and note the strategy.

People and Communities Participation Strategy

Strengthening communities by building systematic participation in health and care

Version control

Greater Manchester Integrated Care Partnership

#	Date	Group engaged	Summary of amends made based on feedback
0.1	12.09.2023	Population Health	Strengthened importance of long term relationships. Strengthened reference to impact participation has on reducing demand, improving outcomes and making savings.
0.2	13.09.2023	NHS GM Engagement Team	Minor amends to language and strengthened references to ongoing conversations, and existing locality infrastructure.
0.3	15.09.2023	10GM Directors	Amendments to reference continuous participation and structural health inequalities; updates to the priorities slide to remove reference to "competing" priorities, update the diagram and how we will decide priorities. Further amends to the governance slide to show the relationship between different groups.
0.4	26.09.2023	Senior leadership	Changes to the formatting of the GM approach slides, and additional slides added for the GM approach, current priorities, and planning and governance.
0.41	29.09.2023	Engagement Team	Final draft for wider discussion
0.5	24.10.2023	Senior leaders, 10GM; Equality, Diversity & Inclusion Team; Healthwatch	Updated to reflect the need for mobilising communities, involving businesses and wider partners and on feedback from partners and teams. Reviewed for accessibility.
0.6	11.03.2024	Locality Boards, GM Directors of Public Health, Engagement professionals from across Greater Manchester	Updated following feedback from across the Boards and groups, to make sure that there was clear reference to children and families, the importance of localities, local flexibility and locality governance, amongst other minor amends.

Contents

Greater Manchester Integrated Care Partnership

- Introduction
- What is participation: purpose, methods, design and evaluation
- Why is it important and what are the opportunities
- The Greater Manchester approach to participation
    - Our strategic commitments
    - Tackling health inequalities
    - Principles
    - Partners
    - Building on the strong foundations at GM and locality level
    - Working systematically with our VCSE sector
- Governance and assurance
- Current priorities and plans for delivery

Introduction

Greater Manchester Integrated Care Partnership

It is vital that we enable participation with our communities. This participation must have purpose, to both improve services, but more importantly, to improve lives. We must use participation to mobilise local people, including individuals, families and children, and communities, making the most of the abundant assets we have in our localities across Greater Manchester's partner organisations, anchor institutions, voluntary, community and faith groups, employers and business, large and small.

This strategy sets out in broad terms why participation is important and how we intend to work with our partners and communities in neighbourhoods and localities to solve the problems that face our health and care system. It is important that we combine efforts with partners across local authorities and trusts to avoid duplication and make the best use of our resources. This includes working with people who are already connected to our residents, for example, library staff, outreach workers, community nurses, etc.

Much of the work must be targeted at reducing the health inequalities that are embedded within our communities. It is important that we work with these front-facing colleagues, and also the VCSE sector to help us to directly reach the people who experience the greatest health inequalities, build trusted relationships with them, and create ongoing conversations that lead to change.

This strategy will be supported by specific plans and frameworks (e.g. children and young people participation framework) that will detail how we will deliver bespoke participation activities that focus on mobilising people, communities and assets to tackle the biggest challenges facing our system.

What is participation?

"NOT JUST THE RIGHT THING TO DO, IT IS THE SMART THING TO DO"

(from City Leader Guide On Civic Engagement produced by Bloomberg Center for Cities at Harvard University)

Participating means including the voices, ideas and capacity of residents and communities in our work. It means finding out what matters to people and shaping our services according to that.

It provides opportunities for the health and care system to work with people and communities to realise solutions together – beyond what is required by law.

It creates a relationship with the public as collaborators engaging in ongoing conversations rather than obstacles to be approached when there is an issue.

Approaching this in a new and systematic way will give us the best chance of successfully delivering our priorities.

This strategy sets out how we will build on our existing strong foundations to create a systematic model for continuous participation - always with a purpose, involving partners, local Healthwatch, the VCSE sector and communities.

We want to work with residents to solve problems together, this is known as the participation paradigm:

What is participation?

Greater Manchester Integrated Care Partnership

There are many different recognised forms and degrees of participation.

The type of participation to be used will depend on the purpose of exercise, the outcomes that are being sought and the people/group being targeted.

Participation with people, families and children, and communities may be delivered by many different parts of the system, both across GM and in the localities.

All types of participation are legitimate and bring value to the system and are all valid methods of delivering this strategy. At different times, depending on the project, we may be listening, or gathering data, or consulting, or co-producing, or a combination of these elements.

Type	Description
Devolving	Placing decision-making in the hands of community and individuals. For example, Personal Health Budgets or community development approach.
Collaborating	Working in partnership with communities and patients in each aspect of the decision, including the development of alternatives, and the identification of the preferred solution. This includes co-production and co-design.
Involving	Working directly with communities and patients to ensure that concerns and aspirations are consistently understood and considered. For example, partnership boards, reference groups, and service users participating in policy groups.
Consulting	Obtaining community and individual feedback on analysis, alternatives and/or decisions. For example, surveys, door knocking, citizens' panels and focus groups.

What does well designed participation look like?

In a systematic approach, we will promote participation which has **clarity in its purpose and its design**, with activities not commencing until there are complete answers to four critical questions:

Why are we asking people to participate?

- ✓ Establish the exact problem or opportunity, the purpose of participation, and the desired outcome

What is the topic and the scope?

- ✓ Set a clearly defined role for residents / partners

Who will be asked to participate?

- ✓ Identify all essential voices

How will participation be done?

- ✓ Choose appropriate, accessible methods for essential voices to contribute – these will be different according to each community need and the project's scope, time, budget and audience.

  They could range from rapid polling of insight to focus groups or assemblies, detailed programme co-design or participatory budgeting.

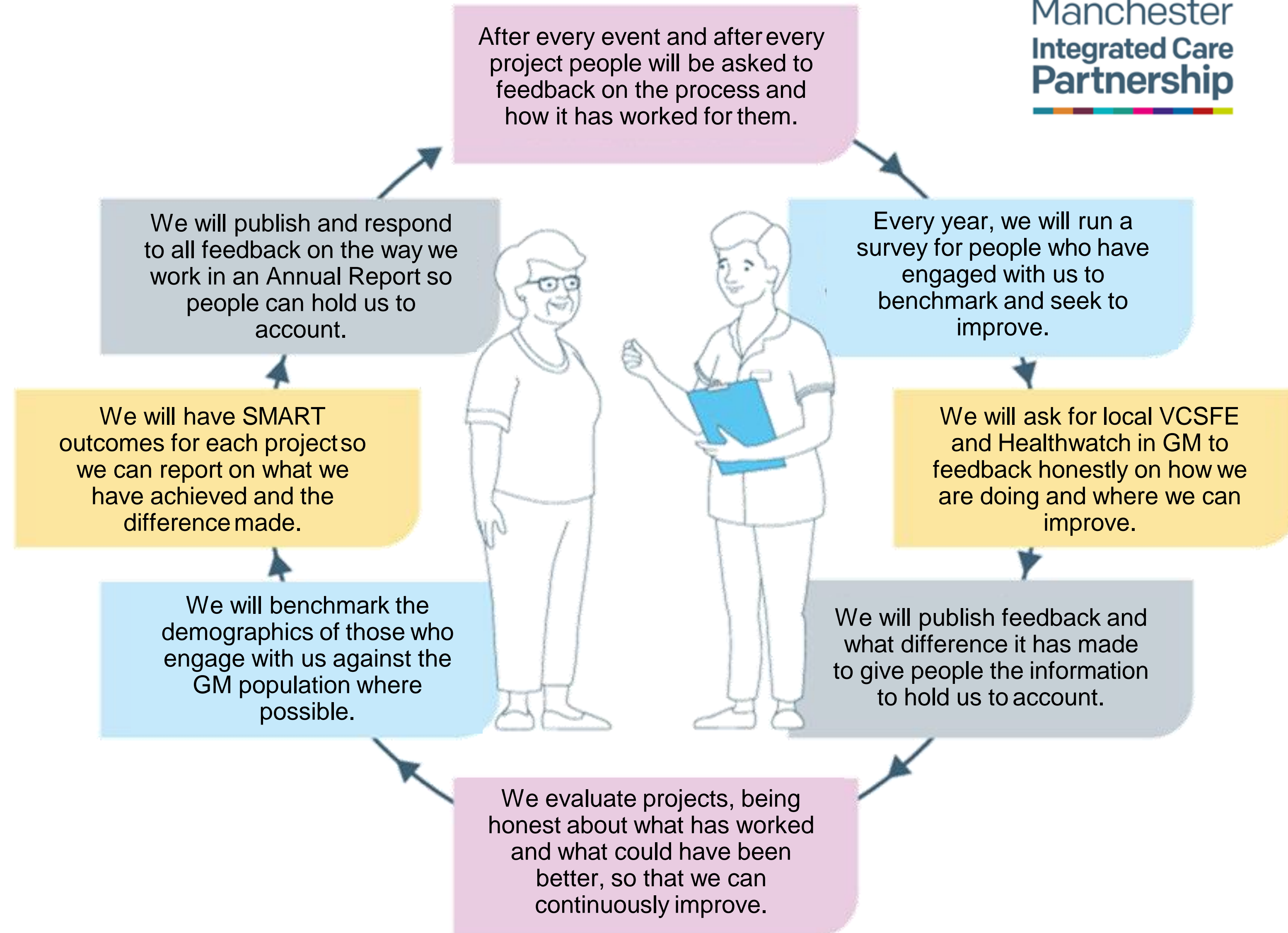
Evaluation

We will create a cycle of evaluation to measure both our delivery against the strategy and plans and the quality of the participation.

This will include asking our partners and the people who participate and work with us for their feedback and suggestions for improvement.

Every year we will publish an annual report on our website about what we have done, the difference it has made and how we can improve.

The Involvement Assurance Group also will provide feedback and assure the evaluation process and annual report.



Why is it important?

Greater Manchester Integrated Care Partnership

There is increasing **access to mis- and disinformation** – impacting on what people know and understand about public sector actions and intentions (Covid 19 and vaccinations).

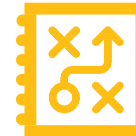
Mistrust is growing – internationally and in Great Britain, over 4 in 10 people do not trust Government

(2021 data, from OECD Trust Survey)

Overall satisfaction with the NHS fell to the lowest level since being recorded in 1983 (*British Social Attitudes Survey 2022*)

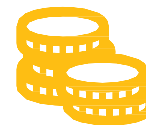
Calls for **social and racial justice** – lack of involvement, fairness, transparency and accountability is increasing disparities, anxieties and disengagement in some communities

A majority (60%) of respondents feel they do not have a say in what happens in their local area (*GM Residents' Survey 2023*)



There are vital, long-standing and adaptive **challenges which cannot be solved by public sector services alone**, for example, systematic health inequalities. A significant step change in action by everyone is essential

Strengthening Communities. Only 76% of GM residents said they had people to call on if they wanted company compared to 93% nationally (GM residents' survey 2023)

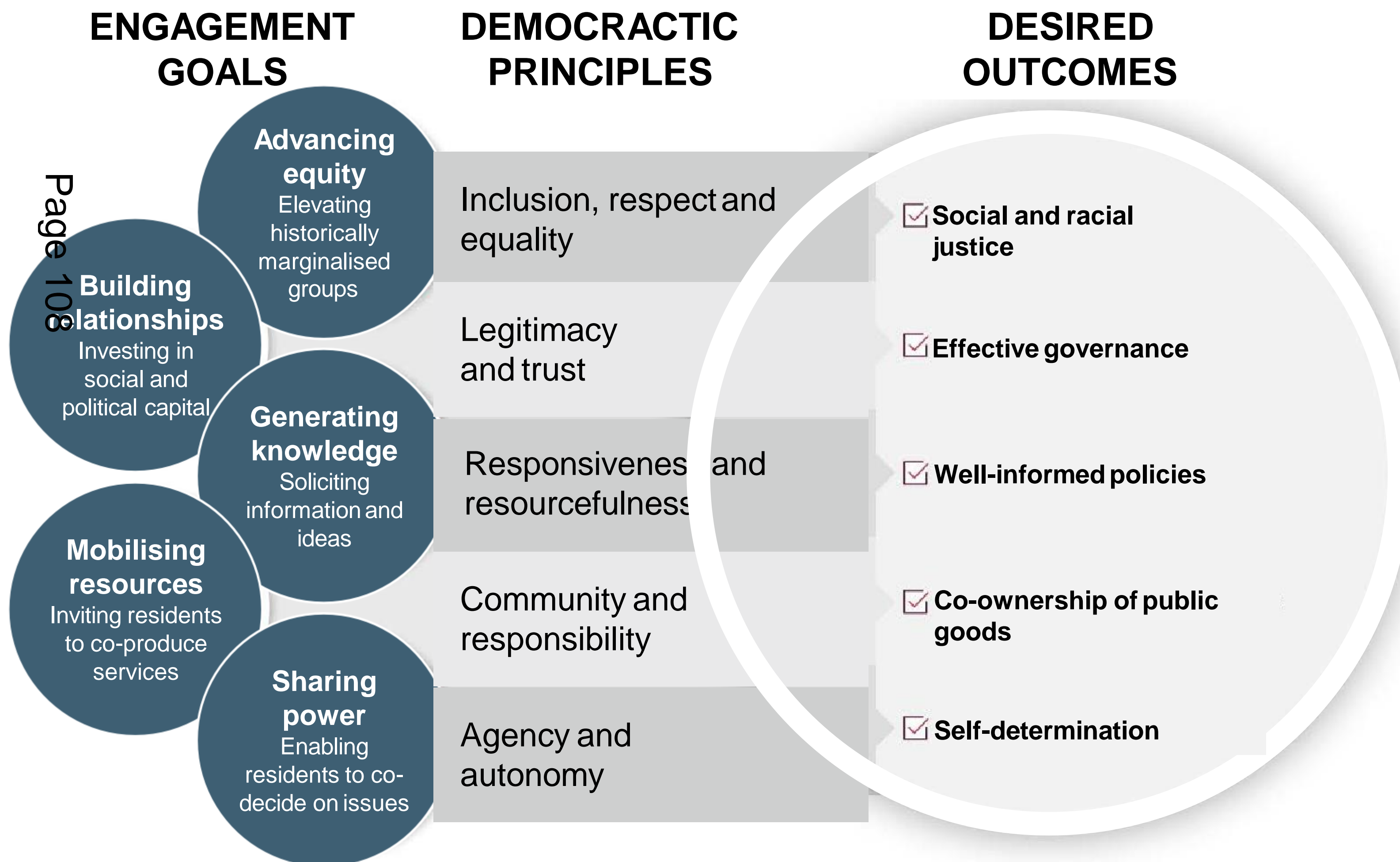


Public sector services are needing to do more with less to tackle big issues and meet public demands. This includes:

- reducing demand on public services while addressing residents' inequalities, costs of living, wellbeing and the wider economic environment
- safeguarding resources by doing things effectively, in a way that meets public needs

Opportunities

Greater Manchester Integrated Care Partnership



BENEFITS & OUTCOMES FOR GREATER MANCHESTER

Historically marginalised groups are elevated and existing health inequalities addressed

Participation is rooted in Greater Manchester's health and care policy development, decision making and governance

People are empowered to create choices, as well as being offered choices to make

Participation is part of coordinated attempts to promote or support behaviour change, improve outcomes and strengthen communities

Participation approach is delivered at scale, and at all levels of the Greater Manchester health and care system

(adapted from City Leader Guide On Civic Engagement produced by Bloomberg Center for Cities at Harvard University)

The Greater Manchester Approach

Greater Manchester Integrated Care Partnership

Our strategic commitments

The GM Integrated Care Partnership Strategy sets out our ways of working with partners:

We will:

- ✓ Involve communities and share power
- ✓ Take action to understand and tackle inequalities
- ✓ Share risk and resources
- ✓ Spread, adopt and adapt
- ✓ Be open, invite challenge, take action
- ✓ Listen – people are names, not numbers

Find out more about the strategy on our website.

GM ICP Strategy Missions

- Strengthening our communities
- Helping people get into, and stay in, good work
- Recovering core NHS and care services
- Helping people stay well and detecting illness earlier
- Supporting our workforce and our carers
- Achieving financial sustainability

Participation can add most value

The Greater Manchester Approach

Greater Manchester Integrated Care Partnership

Our commitment to tackle health inequalities shapes all that we do

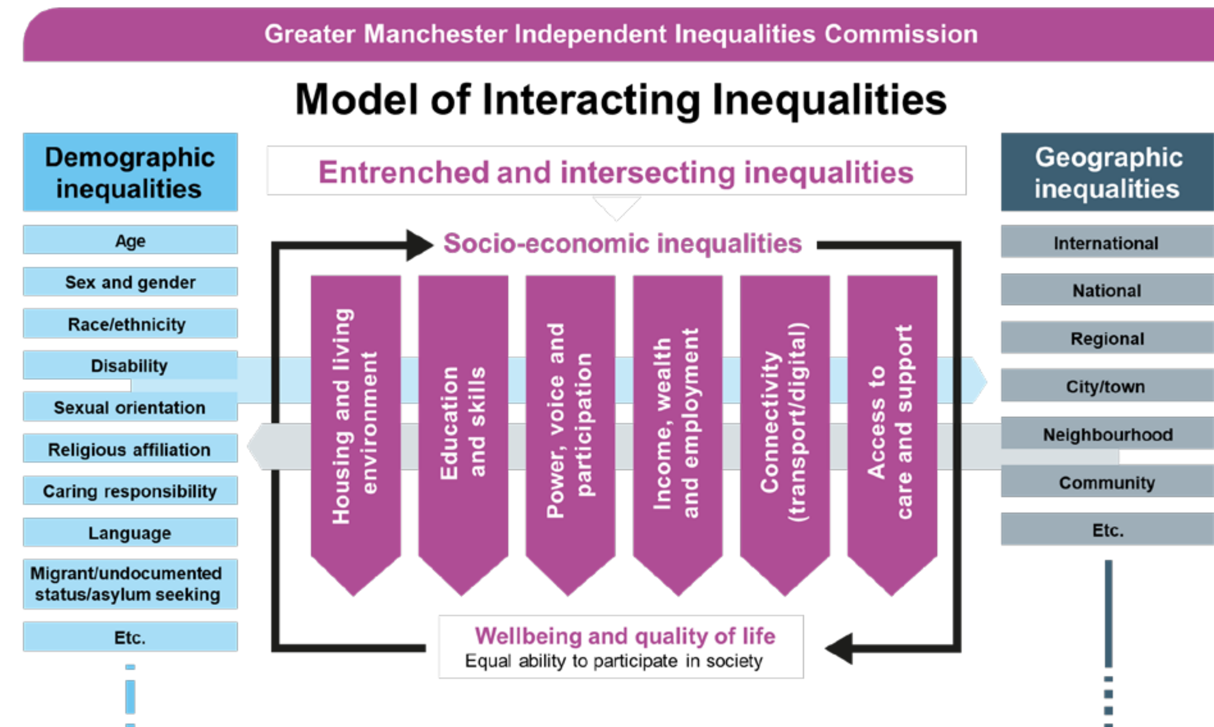
The Greater Manchester Independent Inequalities Commission and Marmot reports call for greater people power to create Good Lives for All. We are committed to supporting this and working with our communities and VCFSE sector to enable resident led problem-solving.

The GM Fairer Health for All is the health and care response to the Marmot and IIC reports and provides the framework for tackling health inequalities in the city-region.

Greater Manchester has some of the lowest life expectancy in England, with differences between the most and least deprived areas of nearly 10 years for men and nearly 8 for women. Further differences exist between communities according to protected characteristics. Some of these health inequalities are systematic and will be difficult to change.

Our GM Integrated Care Partnership Strategy and Joint Forward Plan sets out how we are embedding the people- and community-focused "GM Model for Health" to change this.

This participation strategy will take the same health inequalities focused approach and support delivery of the strategy and forward plan – in particular, the mission to "strengthen our communities".

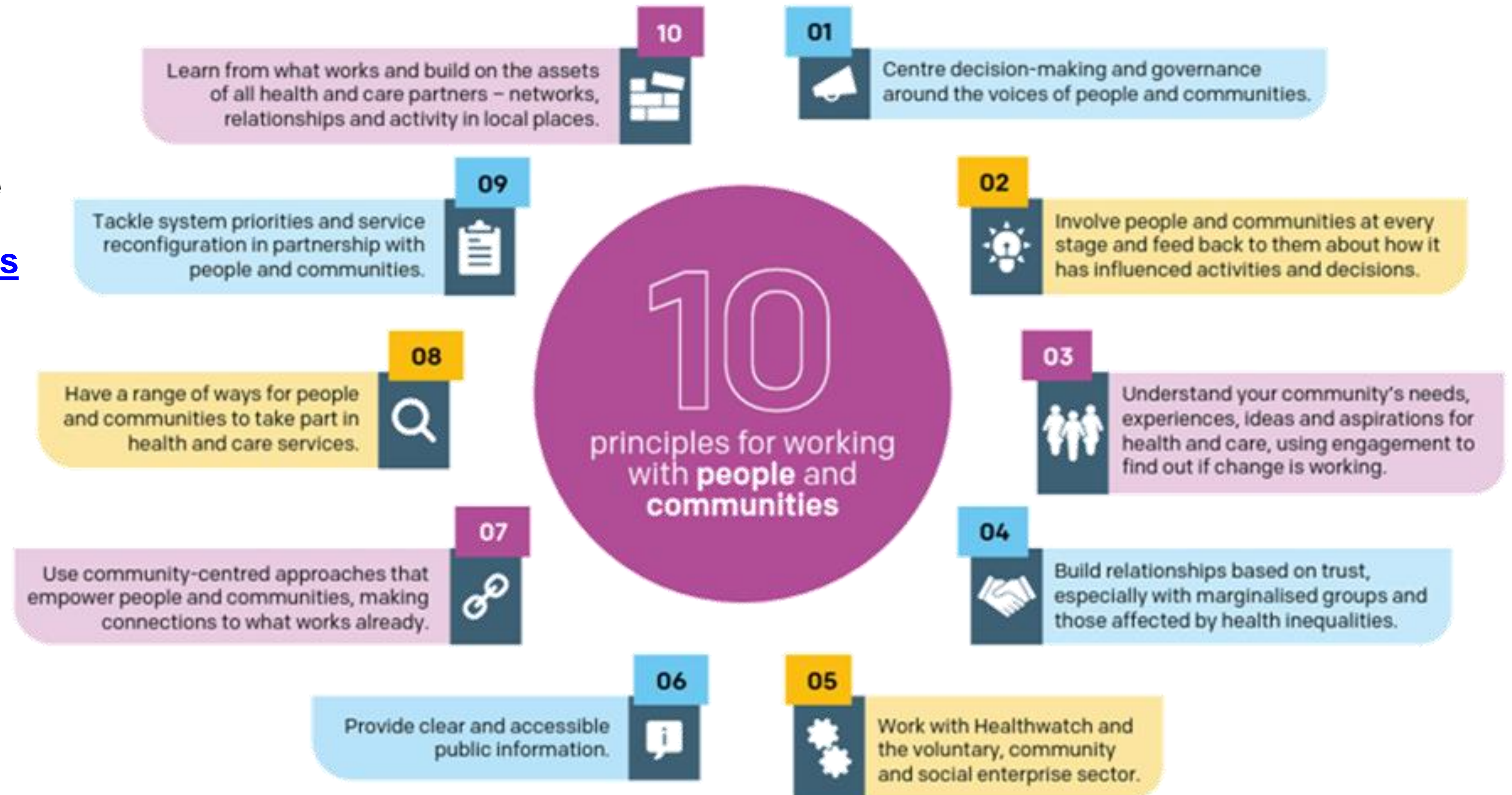


The Greater Manchester Approach

Greater Manchester Integrated Care Partnership

Our principles

Throughout our participation work, we will adopt NHS England's [10 principles] for working with people and communities to support integrated care systems.



The Greater Manchester Approach

Greater Manchester Integrated Care Partnership

In localities and at Greater Manchester level, we have many partners that are vital to delivering our participation strategy:

People

Connections are made by people, families, children and communities speaking to each other and sharing their knowledge, ideas and networks. People whose gift is to find and create those connections and build social capital are called connectors. We will take the time to find out about individuals and build relationships and trust with them, person by person.

Institutions

We believe that all businesses operating in Greater Manchester have a part to play in supporting the partnership to achieve our missions. Although some institutions may not have an explicit remit in promoting health and wellbeing, they should be vested in keeping their workforce, customers and stakeholders happy and healthy – and will be looking at ways that they can fulfil their corporate social responsibility duties. We will make the best use of these assets for our engagement work.

VCSE and Healthwatch

The pandemic has shown us that our VCSE sector and healthwatches have the networks and relationships to harness the greatest reach and to get to the widest and most diverse groups of people and their communities. The VCSE are ideally placed to support us to have ongoing meaningful conversations with the communities they work with and to help us build trust and direct relationships.

Physical environment

These are assets which naturally attract people to visit. They may include places of faith / workshop, parks, open land, buildings, public realm space, shopping centres, marketplaces and streets. We will make best use of these assets when undertaking engagement activities and base ourselves in these places to undertake opportunistic conversations with members of the public who happen to be there.

The Greater Manchester Approach

Greater Manchester Integrated Care Partnership

We have many tools and resources already to achieve a systematic approach

IN LOCALITIES…

WE HAVE:

- ✓ We have strong partnerships that provide a solid base for building effective participation
- ✓ We have some effective groups with committed residents and patients
- ✓ We have strong local connections within the partnerships to providers, businesses, local healthwatch and VCSE sector – these will help us build/expand local engagement groups
- ✓ We have a great history of delivering participation and mobilising communities with a variety of approaches and methods, from health partners, public health teams, adult and children social care teams, and others.

WE WILL CREATE:

- ✓ We have undertaken a mapping exercise of the localities to identify both good practice we can roll out and areas that need more focus to bring all the localities up to the same high standard (see some examples below).
- ✓ We will further strengthen joint delivery with the local VCSE and faith-based organisations and have undertaken system mapping with our partners to identify opportunities and challenges.
- ✓ We will have **Local Participation Groups** that will focus on systematic, continuous participation within all localities. These may be new or existing groups. They will work within the locality to foster collaboration, reduce duplication and feed into local governance structures.

EXAMPLES FROM LOCALITIES:

- Salford has longstanding relationships with their voluntary and community sector
- Manchester have a very strong Patient Involvement Group
- Bolton work closely with their faith sector.
- Wigan has a well-established Equality Reference Group that supports their work.
- Trafford have an active engagement professionals' group with partners.

The Greater Manchester Approach

Greater Manchester Integrated Care Partnership

We have many tools and resources already to achieve a systematic approach

ACROSS GREATER MANCHESTER…

WE HAVE:

- ✓ A GM ICP strategy that clearly sets out our missions
- ✓ A VCSE Accord where we commit to working with them as equal partners
- ✓ 10 strong local Healthwatch and have funded a Network Chief Co-ordinating Officer for Healthwatch Greater Manchester
- ✓ Work ongoing to link more closely with our local businesses, employers, universities and anchor institutions through the Good Employment Charter
- ✓ Many regular surveys and insight work already in place, e.g. GM resident survey, Bee Well survey
- ✓ The Fairer Health for All Academy is working to upskill professionals across GM in tools to tackle inequality and teams focusing on Person and Community Centred Care and Fairer Health For All

WE WILL CREATE:

- ✓ We know that we need more behavioural and population health insight to help drive this work forward further and mobilise communities and we will invest in gathering insight through a variety of methods from all parts of our communities working with population health colleagues.
- ✓ We will have a GM wide **System Participation Group** which will link to Local Participation Groups and will focus on planning delivery across GM. It will make sure that participation is continuous and embedded in everything.
- ✓ We will strengthen relationships with the VCSE and Healthwatch in GM, working in closer partnership with them.

The Greater Manchester Approach

Greater Manchester Integrated Care Partnership

Working systematically and strategically with our VCSE sector

The Voluntary, Community and Social Enterprise (VCSE) sector is a rich tapestry of community and faith groups, clubs, associations and local charities. They are the fabric of communities and the places where people come together to do things that matter to them.

These groups are typically run by and for local people and are often relied on and trusted in ways that big public sector organisations aren't.

They can engage with people, families and children who may not want to engage directly with public sector organisations – including people who experience systemic health inequalities. We intend to work in partnership with the VCSE sector in localities and across GM to open up greater participation for marginalised and disenfranchised communities.

This will help us to build relationships and trust.

Such sustained commitment will mean more systematic funding and long-term planning than have happened before.

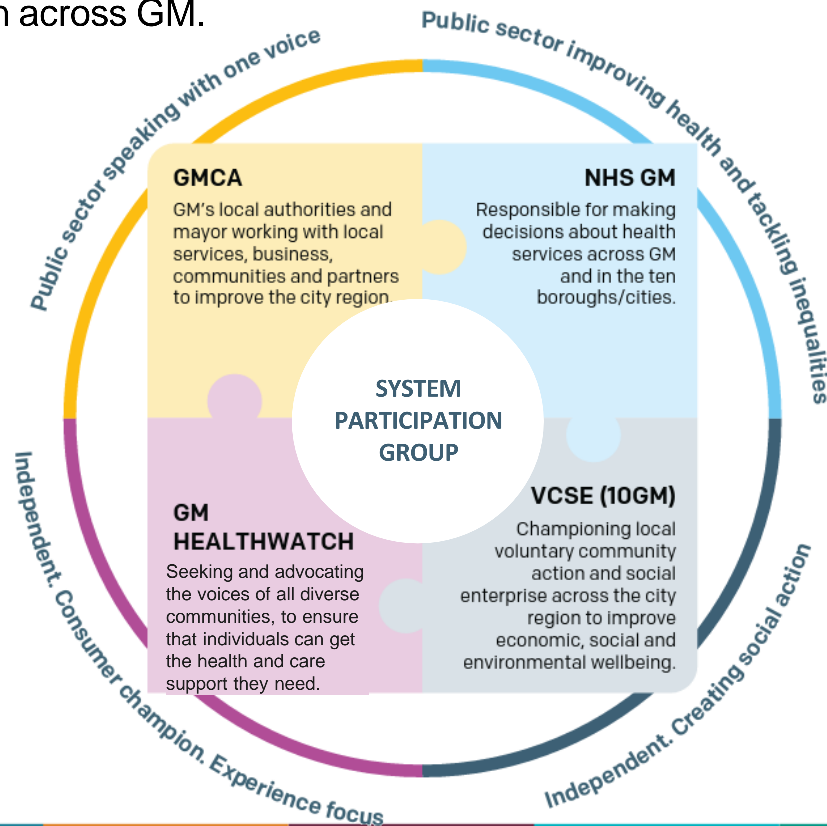
Working with the VCSE sector across GM and in localities will mean that we can:

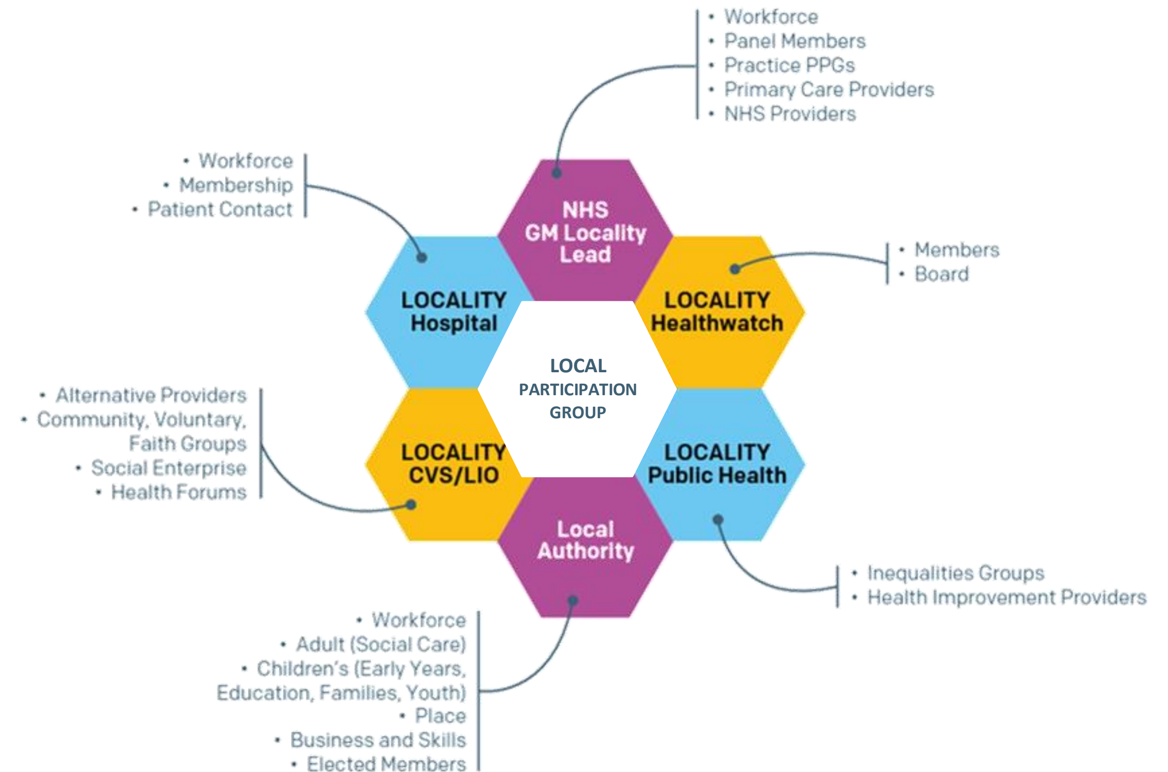
- ✓ Tackle health inequalities by harnessing lived experience
- ✓ Build trusted relationships with communities
- ✓ Invest in our communities and VCSE-sector
- ✓ Plan together, over the longer-term
- ✓ Work in partnership

Planning & Governance

Greater Manchester Integrated Care Partnership

The System Participation Group will agree the priorities for Greater Manchester with membership from local authorities, NHS GM, trusts, VCSE, Healthwatch. It will also be responsible for assuring the delivery of this strategy. The 10 Local Participation Groups will be responsible for delivering locality work and GM-wide priorities that affect their locality (e.g. GM wide service redesigns); they will align to local governance arrangements. The LPG membership, purposes and delivery will be driven by the needs of their population and priorities, and so there will be variation across GM.



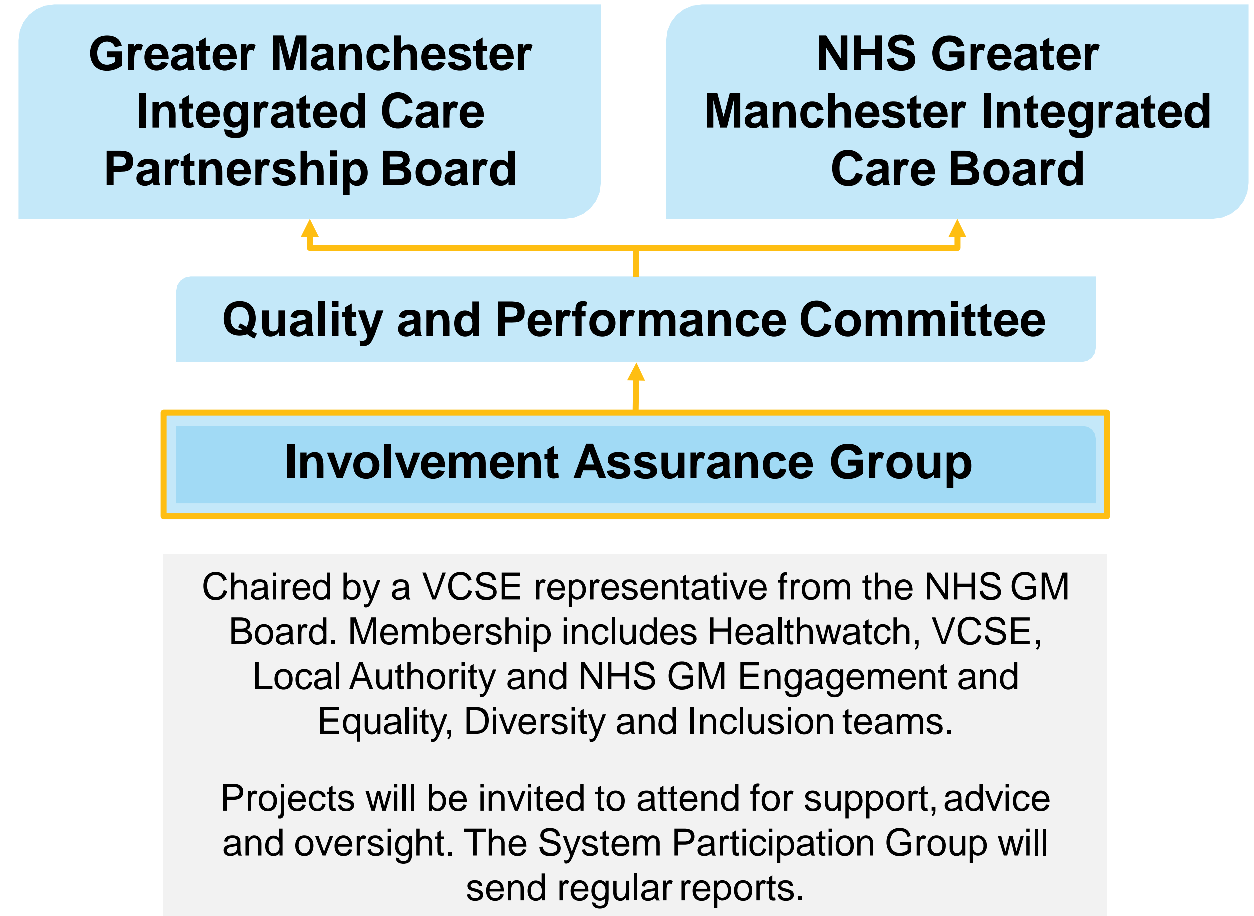


Assurance

NHS Greater Manchester's **Involvement Assurance Group** (IAG) will provide assurance to the Board for the delivery of the statutory duties at GM and local level. GM and locality commissioners and service providers can all seek support and assurance from the IAG.

It will provide oversight of all participation and involvement work, with a focus on delivering the statutory duties.

The IAG is a sub-group of NHS GM's Quality and Performance committee, which receives patient complaints and experience information, giving a place to triangulate this insight and feedback.



Current priorities

Greater Manchester Integrated Care Partnership

There are four main participation priorities to deliver:

Mobilising people and communities to take charge of their health

- ✓ Developing a long-term GM-wide project to mobilise resources, people, communities and wider assets around a specific health-related goal and seeking to use insight to create change and influence behaviours to encourage people to take charge of their health. This work, delivered through a cycle of ongoing participation over several years, will focus on an opportunity identified through the Strategic Financial Framework. This will enable us to identify a cohort, which can be refined based on people who experience health inequalities.

Fulfilling statutory duties:

- ✓ Working with commissioners on service redesign, for example, Trafford's long-term urgent care conversation with residents
- ✓ Advising and supporting providers with delivering service transformation programmes, for example the ongoing disaggregation of services between Manchester University Hospitals NHS FT and Pennine Acute Hospitals NHS Trust.
- ✓ Supporting primary care colleagues to make changes, for example, GP Practice mergers in Wigan Borough and list dispersal in Trafford.

Delivering insight:

- ✓ Working to improve roll out of public health programmes, for example, GM-wide community engagement with the winter vaccine target groups to encourage uptake and understand vaccine hesitancy, and the ongoing behavioural research targeting health inequalities to understand perceptions and behaviours of at risk groups around cancer screening (bowel, bladder and cervical) and immunisations (flu, Covid and childhood) to improve uptake.

Responding to feedback and lived experience:

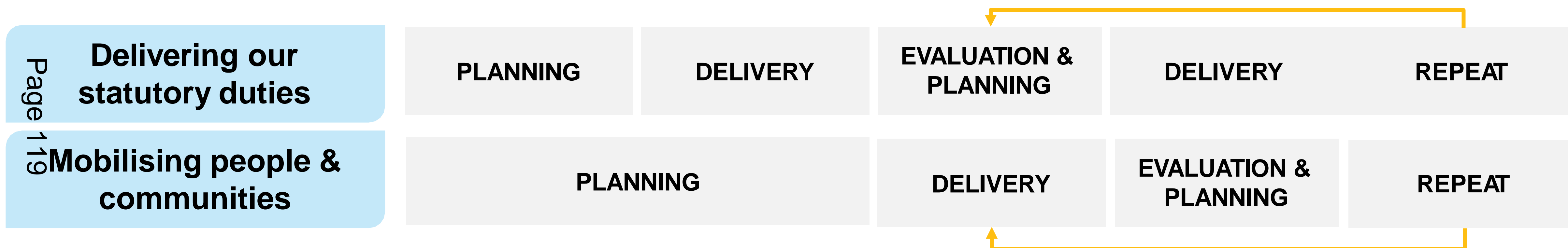
- ✓ Responding to feedback on patient experience, for example, Wigan's SEND 12-month engagement project with partners
- ✓ Responding to VCSE feedback, for example, Salford's work with the deaf community following concerns about barriers to access.

Delivering the priorities

Greater Manchester Integrated Care Partnership

Delivery against the main two priorities requires systematic planning and a long-term approach, whilst maintaining the flexibility to be reactive when required.

Alternating 8-week cycles for planning and delivery, will mean a constant programme of participation:



The programme for statutory duties will focus on sustainable, affordable and accessible services, and engagement for key strategies, for example, the Primary Care Blueprint. These cycles will be flexible when necessary to allow for emerging priorities, including from localities, whilst maintaining the 8-week planning and delivery cycle.

The programme for Mobilising people and communities will be a long-term 2-year plan to support the organisational priorities coming out of the strategic financial insight work. There are more details about how this will be delivered on the following pages.

Mobilising people and communities

Greater Manchester Integrated Care Partnership

The plan for delivering this priority will run over two years: 2024-2026.

It will be designed to **respond to the challenges identified** in the Strategic Financial Framework, focusing on a specific element to use a participatory approach to mobilise people and communities to create change in communities who experience health inequalities.

It will be delivered through a series of 8-week cycles of planning and delivery taking the learning from each phase to develop and inform the next. This will lead to **insight driven targeting, messaging and support that enables people to take charge of their health** and stay well.

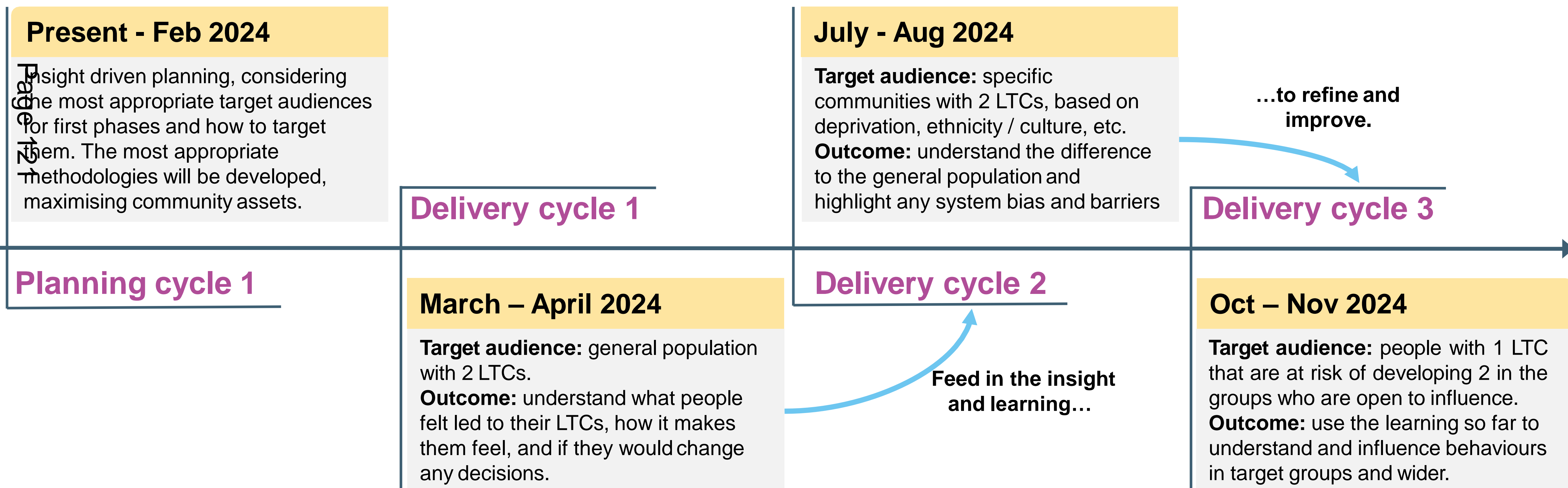
We will take an **asset-based approach**, maximising the use of existing community opportunities and promoting them to support growth in the community. We will also make the most of existing work with NHS GM teams, partners, businesses, anchor institutions and VCSE organisations.

An example of how this might work is given on the following page, looking at targeting people at risk of developing **multiple long-term conditions**.

Mobilising people and communities - Example

Greater Manchester Integrated Care Partnership

Focus: people at risk of developing multiple long-term conditions (LTC)
Outcome: support the reduction of people developing multiple long-term conditions



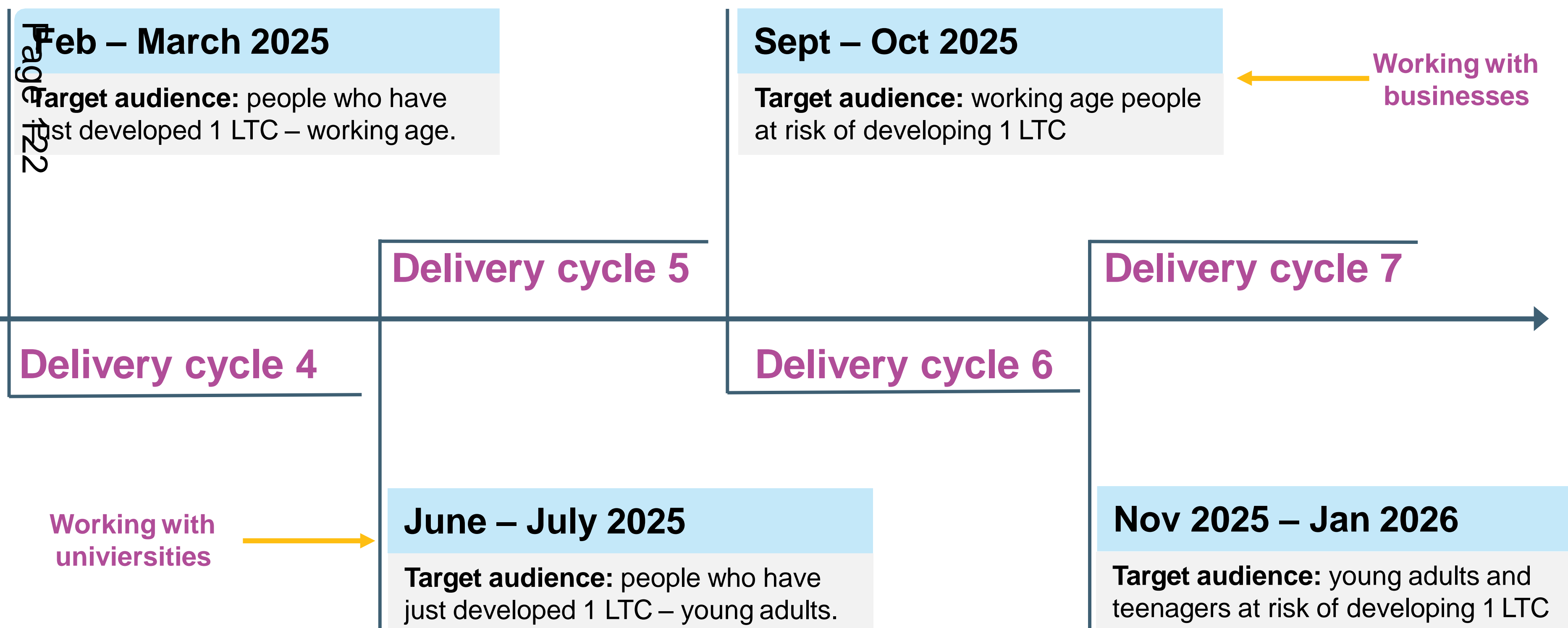
NB. Programme liable to change based on learnings and insight throughout the phases. Delivery of other priorities will be ongoing throughout.

Mobilising people and communities - Example

Greater Manchester Integrated Care Partnership

Focus: **people at risk of developing multiple long-term conditions (LTC)**
Outcome: **support the reduction of people developing multiple long-term conditions**

YEAR 2



Throughout, we will:

- ✓ Identify and upskill community champions.
- ✓ Deliver information on support available and how to live well with LTCs and health advice, e.g. diet, alcohol, exercise, etc.
- ✓ Use methods that offer support to the people who participate, e.g. support groups, cooking sessions, health checks, etc.

NB. Programme liable to change based on learnings and insight throughout the phases. Delivery of other priorities will be ongoing throughout.