Public Document

GMCA GREATER MANCHESTER COMBINED AUTHORITY

GREATER MANCHESTER

JOINT HEALTH SCRUTINY COMMITTEE

DATE: **Tuesday 15 October 2024**

TIME: **10.00 am**

VENUE: **GM Combined Authority, Boardroom, Tootal Buildings, 56 Oxford Street, Manchester M1 6EU**

AGENDA

1. **Welcome and Apologies**

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

3. **Declarations of Interest** 1 - 8

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 last meeting held on 10 September 2024**	9 - 28

To consider the approval of the minutes of the last meeting held on 10 September 2024.

5.	**Sustainability Plan Update**	29 - 148

Presented by Warren Heppolette, Chief Officer for Strategy & Innovation, NHS Greater Manchester.

6.	**Reconfiguration Progress Report and Forward Look**	149 - 156

Presented by Claire Connor, Associate Director Communications & Engagement, NHS Greater Manchester.

7.	**Health Innovation Manchester**	157 - 180

Presented by Laura Rooney, Director of Strategy Health Innovation Manchester.

8.	**Work Programme for the 2024/25 Municipal Year**	181 - 192

Presented by Nicola Ward, Statutory Scrutiny Officer, GMCA.

9. Date and Time of Next Meeting

Tuesday 12 November 2024 at 10.00am Boardroom, GMCA.

For Information

10. Links to Minutes and Decisions

- NHS Greater Manchester Integrated Care Partnership Board Agenda Pack dated 27 September 2024.
- NHS Greater Manchester Integrated Care Board Agenda Pack dated 18 September 2024.

11. GovWifi Instructions 193 - 194

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Membership of the Greater Manchester Joint Health Scrutiny Committee		
Name	**Organisation**	**Political Party**
Councillor Jackie Schofield	Bolton Council	Labour
Councillor Elizabeth FitzGerald	Bury Council	Labour
Councillor Zahid Hussain	Manchester City Council	Labour
Councillor Eddie Moores	Oldham Council	Labour
Councillor Peter Joinson	Rochdale Council	Labour
Councillor Irfan Syed	Salford City Council	Labour
Councillor David Sedgwick	Stockport Council	Labour
Councillor Naila Sharif	Tameside Council	Labour
Councillor Sophie Taylor	Trafford Council	Labour
Councillor Ron Conway	Wigan Council	Labour

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: jenny.hollamby@greatermanchester-ca.gov.uk

This agenda was issued on 7 October 2024 on behalf of Julie Connor, Secretary to the Greater Manchester Combined Authority, Broadhurst House, 56 Oxford Street, Manchester M1 6EU

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 interest 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 (e.g., employment, trade, profession, contracts, or any company with which you are associated).
2. You and your partner's wider financial interests (e.g., 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 and Scrutiny 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.

   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 interest, you must:

1. Notify the Governance and Scrutiny 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.

SHORT GUIDE

GMCA CODE OF CONDUCT FOR MEMBERS

1. WHO

Mandatory for

The Mayor
Members of GMCA
Substitute Members of GMCA
Voting Co-opted Members of GMCA's committees
Appointed Members of Joint Committees

Voluntary for

Non-voting Co-opted Members of GMCA's committees
Elected members from GM districts when they represent GMCA

2. WHEN

Acting in your official capacity, and

In meetings of:

- GMCA; or
- GMCA's Committees or Sub-Committees, Joint Committees or Joint Sub-Committees

3. CONDUCT

General Principles

Selflessness: the public interest not personal gain
Integrity: avoid undue influences
Objectivity: decisions made on merit

Accountability: scrutiny is the norm

Openness: transparent decisions with reasons

Honesty: declare interests and avoid conflicts

Leadership: lead by example.

DO NOT

- Unlawfully discriminate
- Bully or be abusive
- Intimidate a complainant, a witness, or an investigator under the Code of Conduct
- Compromise the impartiality of GMCA's officers
- Disclose confidential information without authority
- Deny lawful access to information
- Bring GMCA into disrepute
- Abuse your position
- Use GMCA's resources improperly

DO

- Pay due regard to the advice of the Treasurer and Monitoring Officer
- Register your interests
- Declare your interests

INTERESTS

A. Pecuniary interests (you, your spouse or your partner)

Register within 28 days

- Employment or other paid office
- Sponsorship – payment in respect of expenses as a Member of GMCA, or election expenses.
- Contracts – between you/your partner (or a body in which you or your partner has a beneficial interest) and GMCA:

- Land you have an interest in within Greater Manchester
- Corporate Tenancies – where GMCA is the landlord you/your partner (or a body in which you or your partner has a beneficial interest) is the tenant
- Securities – you have a beneficial interest in securities of a body which has a place of business or land in the area of the GMCA

Do not speak or vote at a meeting on a matter in which you have a disclosable pecuniary interest

Disclose the interest at the meeting

Withdraw from the meeting

It is a criminal offence to fail to register disclosable pecuniary interests and to participate in any discussion or vote on a matter in which you have a disclosable pecuniary interest.

B. Other Interests

Personal Interests

You have a personal interest -

- If your well-being or financial position would be affected (i.e. more so than other ratepayers)
- If the well-being or financial position of somebody close to you would be affected or the organisations in which they are employed
- If the well-being or financial position of body referred to below would be affected

  - A body of which you are in a position of general control or management and to which you are appointed or nominated by GMCA;
  - A body of which you are in a position of general control or management which
    i. exercises functions of a public nature;

ii. is directed to charitable purposes; or

iii. one of whose principal purposes includes the influence of public opinion or policy (including any political party or trade union),

- the interests of any person from whom you have received a gift or hospitality with an estimated value of at least £100.

Disclose the interest at the meeting

You may speak and vote

C Prejudicial Interests

You have a prejudicial interest -

Where your personal interest is one which a member of the public would reasonably regard as so significant that it is likely to prejudice your judgement of the public interest and it:

- affects your financial position (or those persons or bodies referred to in section B above); or
- relates to the determining of any approval, consent, licence, permission or registration

Do not speak or vote at a meeting on a matter in which you have a prejudicial interest

Disclose the interest at the meeting

Withdraw from the meeting

Minutes of the Meeting of the Greater Manchester Joint Health Scrutiny Committee held on 10 September 2024, GMCA, Boardroom, 56 Oxford Street, Manchester M1 6EU

Present:

Councillor David Sedgwick	Stockport Council (Chair)
Councillor Elizabeth FitzGerald	Bury Council
Councillor Eddie Moores	Oldham Council
Councillor Zahid Hussain	Manchester City Council
Councillor Peter Joinson	Rochdale Council
Councillor Irfan Syed	Salford City Council
Councillor George Devlin	Trafford Council
Councillor Ron Conway	Wigan Council

Officers in Attendance:

Deborah Blackburn	Director Childrens Commissioning, Nursing and Wellbeing, Salford City Council
Claire Connor	Director Communications & Engagement, NHS Greater Manchester
Mark Fisher	Chief Executive, Greater Manchester
Jenny Hollamby	Senior Governance & Scrutiny Officer, GMCA
Jess Holloway	Strategic Lead – Population Health, NHS Greater Manchester
Jane Pilkington	Director of Public Health, NHS Greater Manchester
Nicola Ward	Statutory Scrutiny Officer, GMCA
Sara Roscoe	Head of Primary Care and Transformation, NHS Greater Manchester

JHSC/55/24 Welcome & Apologies

The Chair opened the meeting and welcomed all those present and thanked them for their attendance.

Apologies for absence were received and noted from Councillor Linda Grooby, Councillor Jackie Schofield, Councillor Naila Sharif, and Councillor Sophie Taylor.

Apologies for absence were also received and noted from Warren Heppolette and Sir Richard Leese.

JHS/56/24 Chair's Announcements and Urgent Business

There were no Chair's announcements or urgent business introduced.

JHSC/57/24 Declarations of Interest

No declarations of interest were received in relation to any item on the agenda.

JHSC/58/24 Minutes of the Meeting held on 16 July 2024

RESOLVED/-

That the minutes of the meeting held on 16 July 2024 be approved as a correct record subject to Councillor Peter Joinson and Councillor Irfan Syed being added to those present.

JHSC/59/24 NHS Greater Manchester Chief Executive's Update

Member's considered a presentation provided by Mark Fisher, Chief Executive, supported by Claire Connor, Director of Communications and Paul Lynch, Director of Strategy and Planning, NHS Greater Manchester, which served as a statement of intent, outlining the significant challenges facing the health and care system in Greater Manchester, including a substantial financial deficit. The presentation

emphasised the need for a new approach to service delivery and announced a collaborative partnership with NHS England to develop a comprehensive Single Improvement Plan. Additionally, the presentation introduced the Fit for the Future Engagement Plan, which aimed to involve stakeholders and the public in decision-making, ensuring that the population health, performance and financial goals were aligned with the needs of the community.

It was reported that despite a significant financial deficit, exceeding £400 million, NHS Greater Manchester also faced challenges related to declining population health. Key areas of concern included health inequalities, obesity and physical inactivity, mental health issues, amongst other public health challenges. To address these challenges, alongside some performance issues, NHS Greater Manchester was collaborating with NHS England to deliver a comprehensive Single Improvement Plan. This strategic document outlined priorities and actions for enhancing the quality of healthcare services in Greater Manchester. The plan was a collaborative effort involving the NHS Greater Manchester Integrated Care Board (ICB), Local Authorities (LAs), and other stakeholders. NHS Greater Manchester was committed to involving staff, residents, and communities across Greater Manchester in the creation of this plan to effectively addressed the region's healthcare needs.

To further increase the awareness of residents regarding the challenges facing the NHS Greater Manchester, the Fit for the Future programme had been launched, which would conclude at the end of the year. The programme provided residents and local communities with the opportunity to discuss pressing issues such as the financial situation, waiting times, and the prevention of ill health. Through on-line surveys and multiple of listening events valuable insights were being gathered from a diverse range of stakeholders. Early results indicated a strong desire for a focus on prevention, improved financial management, enhanced services, reduced waste, optimised medication management, effective prescribing, and continued emphasis on quality care. Members were thanked for joining the conversation and supporting the work at a local level.

An update was provided on the Sustainability Plan, which was the subject of a previous Member Briefing. This plan outlined the system's strategic direction for the coming three years. It addressed all aspects of healthcare delivery, effective use of resources, improved population health, and overall system performance. Building upon previous efforts, the focus extended beyond hospitals and doctor's surgeries to encompass the entire city-region. By collaborating closely with communities and Voluntary, Community, Faith, and Social Enterprise (VCFSE) organisations, the plan aimed to improve health outcomes and address systemic challenges. A stakeholder engagement event was scheduled for 11 September 2024 to gather input and support for the plan. The plan would be presented to the NHS Greater Manchester Annual Meeting on 18 September 2024, and to NHS England. Officers agreed to return to the Committee in future to provide an update on implementation and delivery.

Highlighted as important was a need to show how the system both returned to a financial balance through addressing the underlying financial deficit and secured a sustainable future through tackling where demand on services were expected to increase and implement new models of care. Despite cost improvement programmes, new models of care were needed as the savings were not sufficient to address the deficit.

While no explicit Government directives had been issued, it was anticipated that the focus of the new Government would shift towards prevention and reducing waiting lists. Members were asked to get involved in lobbying work, to influence the Government on certain themes with the emphasis on the prevention first approach.

In collaboration with the GMCA and LAs, Members heard about the transformative work and health programme. This initiative used integrated data to identify, individuals who required a health or skills intervention before returning to the workplace. By connecting job centres, primary care, and GPs, the programme aimed to improve resident outcomes, stimulate economic growth, and ensure a sustainable

NHS. Work was taking place with Health Innovation Manchester to explore how health could be recognised as a key contributor to the city-region's economic development. Additionally, the potential role of life sciences in driving economic growth through advancement of drug testing were being examined.

In terms of capital investment and regeneration, many years of insufficient investment had left the health estate buildings across GM in need of repair, making it difficult to provide high-quality services. Further thought needed to be given as to how the NHS and Government managed capital investment. Examples where current rules prevented the required flexibility of funding included The Christie NHS Foundation Trust, North Manchester General Hospital, and Stepping Hill Hospital. NHS Greater Manchester wanted to partner with Government to connect housing, health, and care to reduce demand. It also had aspirations to completely reform the children's social care market across Greater Manchester which would need capital and direct public sector provision. Lobbying on a new approach to capital investment was already underway via the GM Mayor.

The following current performance metrics, which were not necessarily assessed by NHS England, were reported at the meeting:

- Accident and Emergency (A&E) 4-hour target, which had been challenging to achieve since the pandemic, was 2% better than August 2023 so there had been an improvement. However, in July 2024 it was below the target of 71.6% at 68.6%.
- Ambulance response times in GM were currently exceeding the national targets and were ranked highly in the national ambulance handover statistics.
- There was an increased percentage of patients receiving a faster diagnosis of cancer exceeding the target at the end of June 2024 at 77.2% against a target of 74.6%.
- There was an improving trend around mental health out of area placements, which could prove challenging for the patient or family. The current month to date figure was 81 against an end of August 2024 plan of 73.

- 15% more GP appointments were being provided, which was higher than last year so had significantly improved access.

Recognition was given to the countless individuals working in hospitals, primary care, and community settings throughout Greater Manchester for achieving improved performance in lots of areas. However, it was emphasised that significant challenges remained.

Success was somewhat contingent upon Government re-positioning and a Member inquired about any potential insights. It was anticipated that if there were a greater emphasis on prevention, there could be more flexibility in resource allocation and the focus of performance would shift from hospital performance to overall improved health within the city-region.

A Member enquired about prescribing practices and were informed that the Chief Medical Officer was collaborating with GP practices to enhance prescribing efficiency and reduce waste and duplication. A financial target had been set to achieve these goals with a particular emphasis on encouraging the use of generic drugs over more specialised medication.

Although it was clear that NHS Greater Manchester was passionate about making a difference, members wanted to understand how the goals would be achieved. Additionally, regarding the financial deficit, a Member asked Officers to elaborate on the steps taken to reduce it thus far and provide a timeline for when NHS Greater Manchester expected achieve a balance budget. Hospitals had implemented cost-saving measures through enhanced productivity initiatives, with each Trust having a dedicated Sustainability Plan. NHS Greater Manchester was also focused on optimising their payment system and ensuring that services were delivered efficiently. To reduce demand, priority would be on preventive measures, such as addressing obesity and implementing timely blood pressure monitoring. By targeting resources effectively, it was believed that investing in prevention would contribute to a balanced budget. However, it was crucial to recognise that everyone within the system had a role to play in achieving these goals.

While a Member appreciated the proposed approach, previous discussions with Members had highlighted the limited funding available for prevention and voluntary groups. Given that public health budgets were controlled by Councils and facing increasing pressures, and revenue budgets were relatively fixed, how would the transition of funding be managed. Officers agreed to return to the Committee once the Sustainability Plan was approved to go into detail about how elements were delivered and by whom. Achieving the goals required a collective effort from Locality Boards, Working Neighbourhoods initiatives, hospitals, their leaders, and primary care providers.

Given that some GP practices were no longer suitable for modern healthcare needs, NHS Greater Manchester was asked about capital investment in primary care. This was highlighted as particularly important as outdated facilities could negatively impact recruitment and patient care. Primary care would also benefit from strategic investments in facilities, and there were numerous examples of where services could be improved and delivered more cost-effectively. NHS Greater Manchester would engage with the Government to discuss these opportunities. Additionally, consideration should be given to the optimal locations for primary care services and the appropriate scale of operations to meet the needs of communities.

A Member questioned how NHS Greater Manchester would know that the proposed changes were equitable and address the specific needs of disadvantaged communities. It was also asked; how all demographic groups would be effectively engaged so they could benefit from any changes. To address these concerns, NHS Greater Manchester would focus their efforts on areas with high levels of inequality. With a proven track record of reaching the right target audiences, NHS Greater Manchester highlighted their successful collaboration with community leaders during the pandemic to deliver vaccinations to diverse communities. The same proven approach would be continued to ensure that the any changes were beneficial and that services are accessible and equitable.

A Member referred to the lobbying efforts of the Mayor of Greater Manchester to ensure there was sufficient funds to deliver a sustainable future and asked what work was taking place to support that lobbying and if evidence to show the reduced

financial deficit had been shared. It was also asked about the role of NHS England and if it could be of assistance. Officers had provided input into a letter to Government from the Mayor of Greater Manchester, outlining the urgent need for changes. The letter, supported by case studies from Stockport, Wythenshawe, and The Christie, emphasised the necessity for greater autonomy in capital spending to drive economic growth. Additionally, Officers would ask for a revised resource allocation system to address regional disparities in NHS funding. While NHS England expressed support for these objectives, it was important to adopt an approach that considered the entire healthcare system and broader performance metrics.

A Member raised a question about engagement and referred to the Big Conversation regarding 'Fit for the Future'. Whilst most messages were understood and residents knew the NHS financial position was difficult, they questioned why communication regarding appointments etc was so poor. Officers recognised the problems being experienced and reported that efforts were being made to improve the customer facing service delivery and there had been investment in the Digital Strategy. Reference was made to the successful implementation of the Epic digital system at the Manchester Foundation Trust, which served Trafford. This on-line platform enabled residents to manage appointments efficiently. It was anticipated that this cost-effective system would be adopted by hospitals across Greater Manchester. Moreover, digital platforms would also be used to facilitate communication, engagement, and collaboration with individuals and the wider community regarding NHS Greater Manchester initiatives and important campaigns like the Winter campaign, which emphasised the importance of preventative health measures.

A Member asked about the financial deficit facing NHS Greater Manchester and the planned approach to address it. The Sustainability Plan, a transformative initiative, was poised to address these challenges. Building upon the region's successes in population health, the plan outlined radical yet practical strategies for sustainable service delivery.

While external recognition, such as a beacon status, could be valuable, the Committee agreed that the goal was to improve the health and well-being of residents. A Member suggested that the focus should be on ensuring that the healthcare system delivered the best possible outcomes for individuals and communities. Mark Britnell, Chair of the Health Innovation Manchester Board, and a global healthcare expert, praised the region's exceptional data integration, a key factor in achieving its ambitious goals. Devolution, too, had played a vital role in improving the health of Greater Manchester residents, surpassing comparable areas in England. The Sustainability Plan would help GM to continue this positive trajectory.

Despite the numerous public consultations, a Member questioned how NHS Greater Manchester would address the issue of the public remaining unaware of service changes or losses until they happened. The Director of Communications and Engagement outlined the Reconfiguration Progress Report and Forward Look, which detailed planned or ongoing service changes and associated engagement activities. The monthly update, shareable with colleagues, would disseminate information about upcoming developments and provide opportunities for elected member involvement. Extensive efforts had been made to engage clinical groups, Healthwatch, the VCFSE sector, GPs, and hospitals, ensuring that service users were involved in the consultation processes.

Members were pleased with the reference to proposed works at Stepping Hill in the presentation and expressed strong support for the project, emphasising its urgent need due to the building's deteriorating condition.

RESOLVED:

1. That it be noted that the Chief Executive, NHS Greater Manchester would return to the Committee to discuss the delivery and implementation of the Sustainability Plan.
2. That it be noted that Members were requested to get involved in lobbying efforts to influence Government to shift their performance measures towards a prevention first approach.

3. That it be noted that Members agreed to share the Reconfiguration Progress Report and Forward Look to keep colleagues and residents updated.

JHSC/60/24 Reconfiguration Progress Report and Forward Look

Claire Connor, Director of Communications & Engagement, NHS Greater Manchester, presented a report detailing the latest progress on proposed service redesign projects and associated consultation/engagement activities across Greater Manchester. While the scope of these projects varied, and not all might necessitate a full consultation, it was crucial that the Committee maintained an oversight to ensure transparency and accountability.

A brief summary was provided and noted as follows:

1. Adult Attention-Deficit/Hyperactivity Disorder (ADHD) – this project had passed through the NHS Gateway. The next step was to provide a business case. It was anticipated the consultation would commence in November 2024.
2. Children's ADHD – engagement was being planned to understand user needs and would be launched in early September 2024 for a minimum of eight weeks.
3. In vitro fertilisation (IVF) Cycles – the engagement phase was concluded, and the options appraisal process was underway. The project was advancing through the initial stages of the NHS England assurance process
4. Specialised Commissioning - cardiac and arterial vascular surgery and Northwest Women and Children's Transformation Programme were being considered through scrutiny arrangements as they covered the Northwest region not just Greater Manchester. There would be an opportunity for Members provide their comments when the Committee considered the projects.
5. Specialist Weight Management – early engagement had begun and would continue until October – November 2024.
6. Diabetes Structured Education – this project was about providing consistency across localities.

7. Northwest Women and Children's Transformation Programme – this project would be led by the Northwest Specialist Team and more detail would be provided when it was available.
8. The timeline was to be confirmed for the consultation on children's autism.

Members were encouraged to contact the Director of Communications and Engagement if they had a specific interest in the topics discussed in the report or knew of groups or communities that would be interested in participating.

A Member enquired about engagement with marginal groups like refugees or asylum seekers and asked how the Fit for the Future initiative would reach them. NHS Greater Manchester relied predominately on local healthcare professionals to identify individuals and groups for engagement. Community-based professionals played a crucial role in leading engagement efforts, leveraging their local knowledge and expertise.

The Member suggested that Salford City Council could assist with communications and engagement efforts, emphasising the importance of partner and stakeholder involvement in achieving a successful outcome. The offer of assistance was warmly received. Members' role in promoting NHS Greater Manchester's work, given their broader Councillor responsibilities, was emphasised. Comprehensive Stakeholder Briefing Packs had been distributed to Council Chief Executives, Directors of Place, Chairs of Health Overview and Scrutiny Committees in each locality, Health, and Social Care leads and many more to encourage everyone to contribute to raising awareness of the Fit for the Future initiative and foster meaningful discussion.

A Member enquired about individuals who might be living in Greater Manchester from another area, undetected by authorities, police, local residents, or potentially even originating from another country and living in isolation, who were difficult to reach due to their anonymity. NHS Greater Manchester relied heavily on the VCFSE sector to establish relationships and build trust with individuals who might otherwise be difficult to reach. However, reaching individuals who had not yet been engaged remained an ongoing challenge.

RESOLVED/-

1. That it be noted that the Committee welcomed and endorsed the report.
2. That it be noted that Members were encouraged to contact the Director of Communications and Engagement NHS GM if they had a specific interest in the topics discussed in the report or knew of groups or communities that would be interested in participating in engagement.
3. That it be noted that the timeline be confirmed for the consultation on children's autism.
4. That it be noted that Members were asked to contribute to raising awareness of the Fit for the Future initiative.
5. That it be noted that the Northwest Women and Children's Transformation Programme detail be shared with Members in due course.

JHSC/61/24 Greater Manchester Approach to Obesity Prevention

Jane Pilkington, Director of Population Health at NHS Greater Manchester, Deborah Blackburn, Director of Children's Commissioning, Nursing, and Wellbeing at Salford City Council, and Sara Roscoe, Head of Primary Care and Transformation at NHS Greater Manchester, provided a comprehensive presentation on Greater Manchester's approach to obesity prevention in response to the Committee's request. The presentation outlined the region's obesity rates, their significant impact, and the complex underlying factors contributing to the issue. The presentation also highlighted the current initiatives and future plans to reduce obesity rates across Greater Manchester, showcasing successful healthy weight programmes and a case study from Salford City Council demonstrating effective early years interventions to promote healthy lifestyles.

Obesity and related conditions had become a global health epidemic, leading to a significant increase in early mortality rates. In the UK, approximately one-quarter of adults were obese, while another third was overweight. Greater Manchester faced an even more pressing challenge, with 66% of adults falling into these categories, surpassing the national average of 64%.

Deprived areas were particularly impacted by this crisis. The complex interplay of social, environmental, economic, individual, and biological factors contributed to unhealthy weight. In Greater Manchester, 1.1 million people, or 20% of the population, resided in the most deprived areas in the UK, highlighting the region's unique challenges in addressing this health crisis.

The built environment, where residents lived and worked, significantly impacted sedentary lifestyles. Urban planning initiatives that promoted safer walking, cycling, and recreational opportunities were crucial in addressing obesity. Additionally, the widespread availability and promotion of high-fat, sugary, and salty foods had contributed to the obesity epidemic.

In terms of the Greater Manchester approach a collective responsibility was needed to address the root causes. Tackling childhood obesity was a shared challenge and part of the wider vision for Greater Manchester and was encapsulated in the Greater Manchester Strategy. The ICP six missions were referred to and obesity prevention was weaved across the ambitions. An example of the 12-week digital weight management programme was used to show how obesity prevention touched many different aspects of the programme.

Food and healthy weight were central themes across all Greater Manchester strategies, both at the regional and local levels. Examples such as Bury's Food Strategy and Manchester's Healthy Weight Strategy demonstrated this commitment. Since the pandemic, initiatives had focused on food security, ending holiday hunger (Marcus Rashford campaign), providing healthy start vouchers, supporting those in crisis, and establishing community fridges in Oldham, Salford, and Hyde. Future efforts would prioritise creating healthier environments and addressing the commercial determinants of health.

Addressing the commercial determinants of health was a key priority for the Director of Population Health and the ten Directors of Public Health in every locality. Work was taking place across Greater Manchester to restrict junk food advertising across

the estate and with Action on Smoking and Health (ASH) to end the harm caused by tobacco. It was envisaged that this work would have national significance.

The most significant factors contributing to childhood obesity, as identified by residents, were easy access to unhealthy food, excessive screen time, sedentary lifestyles, junk food advertising, and confusion regarding the nutritional quality of food. To provide Members with insights into their local residents' perspectives, the results of recent Consultation specific to each locality would be shared with Members.

Also mentioned was the survey conducted by youth organisations, which revealed that one-third of young people were influenced by junk food advertising to purchase products. One respondent reported seeing a staggering 178 junk food advertisements during their daily commute to school. Unsurprisingly, Manchester city centre was found to have the highest concentration of such advertisements. The survey results clearly indicated a strong desire among young people to address this issue.

At the national level, the consumption of tobacco, alcohol, and unhealthy food and drink was a significant driver of ill health and economic burden in England. These factors were the leading causes of death in the country. There was a need for greater focus on reducing the consumption of harmful products and finding ways to counterbalance the influence of industry with individuals' rights to a healthy and productive life. The Director of Population Health agreed to address this issue in more detail in a future Committee meeting.

Sara Roscoe, Head of Primary Care and Transformation, presented the Salford Specialist Weight Management Service, a tiered approach offering multidisciplinary interventions for individuals with severe obesity and complex needs. Today's discussion would focus on tier 3 and the challenges faced by several localities across Greater Manchester.

Despite a high demand for tier 3 services, current provision appeared inadequate, with over 6,000 patients on waiting lists and some facing up to a year's delay. Only

40% of referrals were assigned to interventions, and high dropout rates, likely influenced by long waiting times, suggested that the national GP scheme might incentivise referrals for patients not ready to participate.

While around 70% of those assigned to interventions started, only 65% completed a programme. Variations in commissioning, capacity, cost, uptake, and eligibility criteria existed between localities. These factors contributed to the overall challenges in providing effective tier 3 weight management services across Greater Manchester.

The affordability of new weight management drugs recommended by the National Institute for Health and Care Excellence (NICE) for specialist weight management services in Greater Manchester was a complex issue. Drug costs, NICE recommendations, commissioning decisions, prioritisation, and patient access all played a role in determining whether these treatments were accessible to those who needed them. While these drugs could improve patient outcomes, their high cost and potential barriers to access must be carefully considered to ensure equitable healthcare. This development would increase access to effective drugs. However, media attention surrounding these drugs had sometimes conveyed misleading information. Significant engagement was expected in this area, and Officers would return to the Committee to present their findings in due course.

Deborah Blackburn, Director of Children's Commissioning, Nursing, and Wellbeing at Salford City Council, presented the Salford Integration Pilot. Funded by NHS England through a competitive bidding process, the pilot aimed to significantly reduce childhood obesity in the city.

By prioritising physical activity, healthy eating, and good oral health during the antenatal, postnatal, and early years stages, the pilot aimed to prevent the development of unhealthy habits in children. The approach emphasised compassion and empathy to reduce weight stigma. The initiative also facilitated opportunities for families to work together to reduce obesity and manage excess weight

Various initiatives were implemented in Salford to increase the number of children reaching reception at a healthy weight. These efforts included exploring Virtual Care

for Obesity (VCC), Food Clubs, and collaborating with early years settings so they understood their role in supporting the oral and physical health milestones and having a good relationship with food.

Despite a rise in healthy-weight children at reception, weight increased by year 6. Efforts focused on understanding childhood experiences, improving inter-organisational collaboration, and promoting healthy lifestyles (inspired by the Amsterdam model). Barriers to change were also being identified, and Private Voluntary Independent (PVI) nurseries and maternity providers were engaged to support these efforts. There was also a development of supportive services for individuals with a high Body Mass Index (BMI).

The impact and stakeholder feedback from the pilot reported that 18/19 colleagues believed they felt more connected with other organisations and individuals in Salford after the pilot, 16/19 colleagues reported better awareness of support available for families, 12/19 colleagues reported improved connection with another team and 11/19 colleagues reported more frequent contact with external teams, which had improved working and connections.

The Director of Public Health summarised the challenges as, need and demand outstripped commissioned services and current system response, affordability of new weight management drugs (recommended by NICE for special weight management) and lack of sufficient national focus, investment, and population-level approach in this area. The role of the integrated care system was to reduce unwarranted variation in access and outcomes, review of specialist weight management services as part of a whole-system response to obesity, better understand the root causes of obesity and enhanced focus on the commercial determinants of health and their contributing role to obesity prevalence.

The Chair expressed gratitude to the Officers for their informative presentation and appreciated the practical examples that showcased their on-the-ground work.

Member asked about teaching domestic science education in schools and sought advice for individuals seeking to exercise despite limitations. For those with injuries

or heart problems, for example, Exercise on Prescription (EoP) was recommended, along with strategies for managing symptoms, on which there was a big emphasis. In terms of science education, variations existed across localities, leading to a mapping exercise to assess the situation. Through the Food Share Network, initiatives such as food distribution, and cooking classes were implemented to enhance access to healthy food and cooking skills.

The Member from Salford agreed that obesity was a global epidemic and welcomed engagement in the Salford Pilot. It was asked, given there was a shift in attitude towards lifestyle changes, how would the approach be tailored to all demographic groups. Questions were also asked about how the effectiveness of obesity prevention programme would be monitored and evaluated especially in high-risk groups and how would inequalities in service availability be addressed. The Greater Manchester Population Health Committee would monitor through high-level performance indicators. Localities would also review the reports. To address health inequalities, programmes would be tailored to local needs and given the high demand for services, innovative approaches were necessary. Also being explored were challenges in specialist weight management services and with tier 2 partners and strategies to target at-risk groups were being refined. Eligibility criteria from NHS England was expected and would form part of the Greater Manchester work.

A Member highlighted the recurring issue of violence against women and girls, which significantly hindered many individuals' ability to exercise. Feeling unsafe in public spaces, including transportation, cycling paths, jogging routes, and parking areas, discouraged physical activity. Young people had reported a lack of safe public spaces and transportation options, leading to increased sedentary behaviour and screen time. Officers acknowledged the importance of these issues. Collaborative efforts with the Deputy Chair and Transport for Greater Manchester (TfGM) were underway to make green spaces, public spaces, and transportation safer. It was suggested that violence against women and girls be a detailed focus of a future meeting.

A Member asked a comprehensive question about the complex relationship between obesity and poverty. They explored various factors contributing to health inequalities, including low-income families, Free School Meals (FSM) eligibility, accessibility of health services, reaching marginalised communities, extending lifespan, and combating stigma associated with obesity. NHS Greater Manchester had identified several key challenges and opportunities in addressing health inequalities. One significant challenge was the need for greater devolution to address the root causes of health disparities. NHS Greater Manchester had advocated for FSM meals and emphasised the importance of nationwide population-level interventions and lobbying Government. Another challenge was the stigma surrounding obesity, which required a balanced approach that promoted open discussions about health without stigmatising individuals. However, there were also opportunities for progress. NHS Greater Manchester had comprehensive integrated care records that provided valuable data for analysis. A specific target for healthy life expectancy was being considered as part of the government's new missions, in which Officers were involved. Addressing the striking 15-year gap in the onset of multiple morbidities between the most and least deprived areas was a priority, and the Inequalities Strategy for the Integrated Care Partnership outlines steps to address this issue. However, expanded national efforts were essential to bridge this disparity.

Data insights were discussed, and it was asked what specific conversations and interventions had been implemented to address issues at the earliest possible stage. Additionally, it was asked what data was being used to target individuals who required immediate intervention. Individuals and overarching strategies sought to implement early interventions that were culturally sensitive and beneficial for the health service and the economy. While progress has been made, it was acknowledged that current efforts were inadequate. The integrated care system offered the potential to leverage data from various sources to inform these interventions. The Salford Pilot and the appointment of a Transformation Midwife was an example of initiatives aimed at understanding maternity services and engaging in open conversations with parents about their health and lifestyle. NHS Greater Manchester was collaborating with mothers to deliver these messages as early as possible. However, significant work remained to be done, and services would be developed through insights gained from research and public consultation.

Members would be provided with a public consultation information pack for each locality.

RESOLVED/-

1. It was noted that the Committee acknowledged the current challenges around tackling obesity and noted the initiatives underway to reduce prevalence rates Greater Manchester and local levels, whilst supporting people into effective treatment.
2. That it be noted that Members would be sent the outcomes of the public consultation on 'healthy environments' for their locality.
3. That it be noted that the Director of Population Health would return to the Committee at a future meeting to discuss reducing the consumption of harmful products.
4. That it be noted that Officers return to the Committee with the findings from the Specialist Weight Management engagement at an appropriate opportunity.
5. That it be noted that the safety of women and girls when accessing exercise and active travel opportunities be a key theme at a future meeting.

JHSC/62/24 Committee Work Programme for the 2024/25 Municipal Year

Nicola Ward, Statutory Scrutiny Officer, GMCA presented a report, which provided Members with the draft Committee's Work Programme for the 2024/25 Municipal Year. Members were reminded that this was a working document which will be updated throughout the year to reflect changing priorities and emerging issues. The Committee would regularly review and revise the Work Programme to ensure that it remained relevant and effective in addressing the needs of the community.

The Chair and Vice-Chair agreed to work with Officers to further populate the work programme following the meeting.

It was asked that the minutes of the Committee be distributed to LAs so Members could share them with other scrutiny Members.

RESOLVED/-

1. That it be noted that the Work Programme be updated following the meeting in collaboration with the Chair and Vice-Chair.
2. That it be noted that the minutes of the Committee be shared with LAs.

JHSC/63/24 Dates and Times of Future Meetings

All meetings would be held in the Boardroom, GMCA on the following Tuesdays at 10.00 am:

- 15 October 2024
- 12 November 2024
- 10 December 2024
- 21 January 2025
- 18 February 2025
- 18 March 2025

Greater Manchester Joint Health Scrutiny Committee

Date: 15 October 2024

Subject: Sustainability Plan Update

Report of: Warren Heppolette, Chief Officer for Strategy & Innovation, NHS Greater Manchester

Purpose of Report:

The Sustainability Plan shows how the GM System:

- Returns to financial balance through addressing the underlying deficit
- Secures a sustainable future through addressing future demand growth and implementing new models of care year on year

Successful delivery of the Sustainability Plan will facilitate achievement of the outcomes described in the ICP strategy:

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

Recommendation:

The Greater Manchester Joint Health Scrutiny Committee is requested to:

- Note the contents of the Sustainability Plan
- Support the implementation of the Sustainability Plan within localities

Contact Officers:

Warren Heppolette

warrenheppolette@nhs.net

Equalities Impact, Carbon and Sustainability Assessment:

Successful delivery of the GM Sustainability Plan will ensure our vision is achieved:

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

The plan provides the opportunity to improve health and address and reduce disparities in care related to access, experience and outcomes for the most disadvantaged communities which will improve the general health of the population.

Risk Management

We are in the process of developing a risk register as part of our implementation framework.

Legal Considerations

N/A

Financial Consequences – Revenue

Each year NHS GM receives growth funding as part of its national allocation from NHSE. Some of this is contractually allocated to various parts of the system, including providers. However, the remainder could be used (as is its intention) to fund growth in parts of the system determined by the strategy of NHS GM.

In 2024/5 the remainder was ~**£61m**. This varies year on year depending on changes to national contractual arrangements.

To date NHS GM has not spent this funding on growth but has netted it off in their accounts against other costs – usually against convergence costs which are of a similar amount.

If the convergence costs can be covered by savings elsewhere in the system, this growth funding could be used for its original purpose. For the purposes of this analysis, we have assumed **£50m** a year might be available to fund growth (from year 2 – 2025/6).

This proposal requires consideration by the GM system.

Financial Consequences – Capital

Capital is an important enabler to the delivery of the Sustainability Plan.

The Capital Resource and Allocation Group has been tasked with developing a long-term plan for deployment of system capital. This work is focusing on:

- Clearly defining the parameters of what is meant by a sustainable capital plan.
- The investment strategy if we must live within current capital constraints.
- What the system could achieve if it had increases capital to deploy into several key areas (Estates, Digital, Equipment). Particularly linking this to known areas i.e. the £3.4bn of national capital to support productivity.

This work is ongoing and focused on three phases, including a Y1 plan for no increases in capital income, with options for Y2-5 being developed to support strategic requirements.

Number of attachments to the report: 1

Comments/recommendations from Overview & Scrutiny Committee

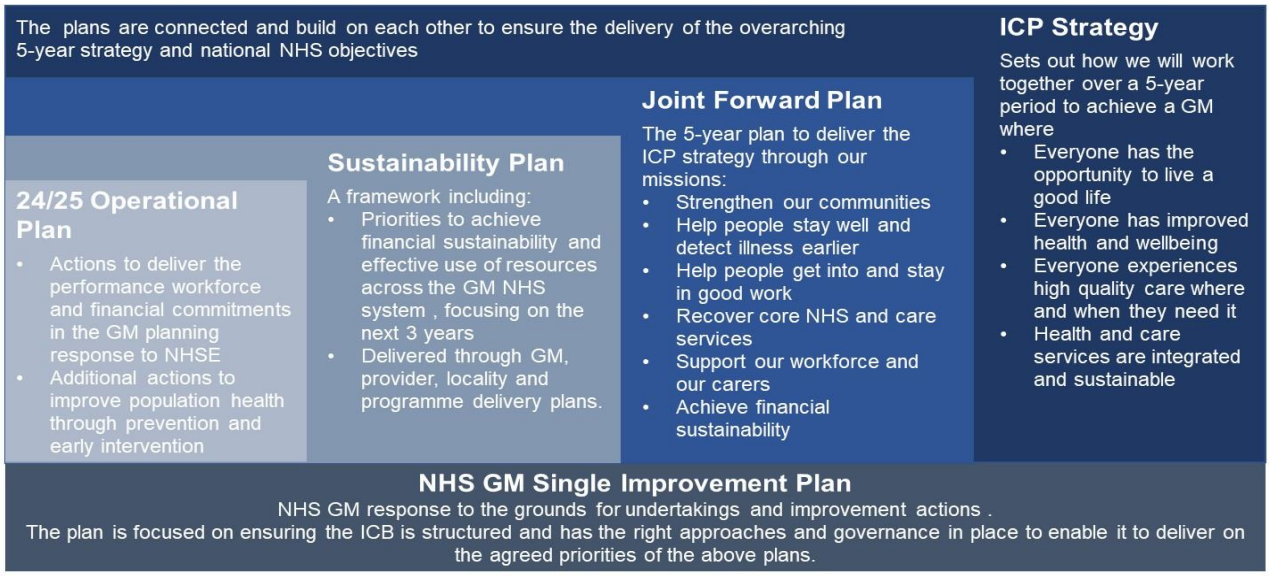
N/A

Background Papers

The Sustainability is a plan of plans that covers five key programmes of work (pillars):

- Cost Improvement
- System Productivity and Performance
- Reducing Prevalence
- Proactive Care
- Optimising Care

The Sustainability Plan, with other system plans is instrumental in delivering the overarching GM ICP Strategy:



Tracking/ Process

Does this report relate to a major strategic decision, as set out in the GMCA Constitution

No

Exemption from call in

Are there any aspects in this report which means it should be considered to be exempt from call in by the relevant Scrutiny Committee on the grounds of urgency?

No

GM Transport Committee

N/A

Overview and Scrutiny Committee

15th October 2024

1. Introduction

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 through working with partners whilst at the same time improving the NHS financial position and health service performance.

1.2. This Sustainability Plan is based on the recognition that system sustainability rests on addressing the challenges we face across finance, performance and quality and population health - and the relationship between these.

1.3. The plans shows ***both how*** the system both returns to financial balance through addressing the underlying deficit ***and*** secures a sustainable future through addressing future demand growth and implementing new models of care year on year

1.4. In developing this plan, the financial and performance position of the 9 NHS providers has been considered, along with plans to transform and optimise care provision, in order to address the underlying financial deficit by the end of the 2026/7 financial year.

1.5. A population-based approach to developing this plan has set out the current and future pattern of demand and associated costs attributable to Non-Demographic Growth (NDG), quantified the opportunities to improve population health, and set out the immediate priorities to inform phasing and sequencing of these opportunities over time

1.6. The plan shows how the current deficit may be compounded by approximately £600m of additional demand but can be addressed over time through a combination of population health measures, system collaboration and provider efficiencies.

2. The Content of the Plan

2.1 This is a ‘plan of plans’ since it comprises plans from across the GM system, categorised under 5 ‘pillars’ of sustainability:

- Cost Improvement
- System Productivity and Performance
- Reducing Prevalence
- Proactive Care
- Optimising Care

2.2 This plan shows that the projected remaining financial deficit could be eliminated over three years through:

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

2.3 The plan shows that with additional investment, the impact of Non-Demographic Growth (NDG) could be mitigated through:

- Assumptions about the impact of reducing prevalence and enabling proactive care on the health of the population

3. Implementing the Sustainability Plan in Localities

3.1 Clear responsibility to deliver against this plan must be allocated to organisations, locality boards and system groups. In the plan we described this as shown in the figure below:

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

3.2 The Sustainability Plan is clear that the projected non-demographic growth in demand and costs can only be addressed through radical changes in both our care model and in tackling the social determinants of health. We will need to apply our place model with greater pace and scale and with more consistency. The focal point for delivery of this model will be our 10 localities. All partners in each locality, including GM-level functions, will need to create the right conditions for the Sustainability Plan to be delivered. The Locality Board (Place-Based Partnership Committee) is the focal point for this.

3.3 GM has integrated neighbourhood teams in place across all localities – with PCNs at the centre and as part of our Public Service reform agenda. These support the delivery of the 'Reducing Prevalence' and 'Proactive Care' pillars of the plan and will enable the theme from the Darzi Report: "Simplify and innovate care delivery for a neighbourhood NHS. The best way to work as a team is to work in a team: we need to embrace new multidisciplinary models of care that bring together primary, community and mental health services."

3.4 Each locality will be asked to develop a place-based version of the Sustainability Plan by the end of December. This is to align with the Greater Manchester planning process for 2025-26. The local plan will need to be quantified and includes the contribution of trusts and other providers in each locality. This to be aligned to the five pillars in the Sustainability Plan and set out impact (including trajectories) against finance, performance, quality and population health.

3.5 Work has already begun on a prototype – being developed through the Four Localities Partnership. This will allow us to test the alignment between the place-based sustainability plan and the plans for the Northern Care Alliance across the four localities.

3.6 There are some important elements that need to be in place to support the locality versions of the plan:

- A breakdown of the commissioned spend for each place
- A breakdown of activity for those resident in each place
- The Non-Demographic Growth projections for each place covering the next five years
- An open book approach to sharing the plans of all partners through the Locality Board
- A plan that covers the whole local system – making sure that the primarily NHS analysis in the Sustainability Plan connects to the local authority position on adults and children's
- The development of a broader set of locality metrics covering the locality role in addressing the social determinants of health - for example, on housing, school readiness, physical activity, community safety
- A clear articulation of how the relationship between GM-wide programmes (for example, the Health and Care Service Review, Digital and Innovation programmes, the work of the System Groups) and place-based plans

4.0 Recommendations

4.1 The Greater Manchester Joint Health Scrutiny Committee is requested to:

- Note the contents of the Sustainability Plan
- Support the implementation of the Sustainability Plan within localities

NHS
Greater Manchester

GM Sustainability Plan

6 September 2024

Part of Greater Manchester
Integrated Care Partnership

NHS Greater Manchester

Contents

1. Introduction and summary

This plan

NHS Greater Manchester

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

Overview – What the Plan Shows

NHS Greater Manchester

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

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

This plan shows that:

- The projected remaining deficit, after Cost Improvement Plan delivery, could be eliminated over three years through
  - Consistent and complete implementation of existing Cost Improvement Plans (CIPs)
  - Complete implementation of system wide plans already developed across GM along with assumptions about those not yet detailed
  - Assumptions on reconfiguration of parts of the system which have not yet been planned in detail
  - Assumptions on reducing the number and scope of procedures of limited clinical value (PLCV), although this is not yet detailed
- With additional investment, the impact of Non-Demographic Growth (NDG) could be mitigated through
  - Assumptions about the impact of reducing prevalence and enabling proactive care on the health of the population

The financial bridge – what it shows

NHS Greater Manchester

The bridge shows three ‘blocks’ with associated pillars.

Dealing with the current financial deficit

Shows how the underlying deficit can be substantively closed in three years, with detailed plans in place for year 1 and the inclusion of assumptions about developing plans for years 2 and 3

- Cost improvement
- System Productivity and Performance
- Optimising care

Addressing NDG 2024/5-2026/7 inc. investment (2025/6 onwards)

Shows how Non-Demographic Growth can be partially mitigated in three years through planned population health interventions where funding is already agreed and the partial impact of additional investment (in years 2 and 3) of £50m per year.

Impacts from population health interventions take time to demonstrate a full effect and so an impact of 1/3rd of the full impact from additional investment has been assumed in years 2 and 3.

- Reducing prevalence
- Proactive care

Investment 2027/8-2028/9

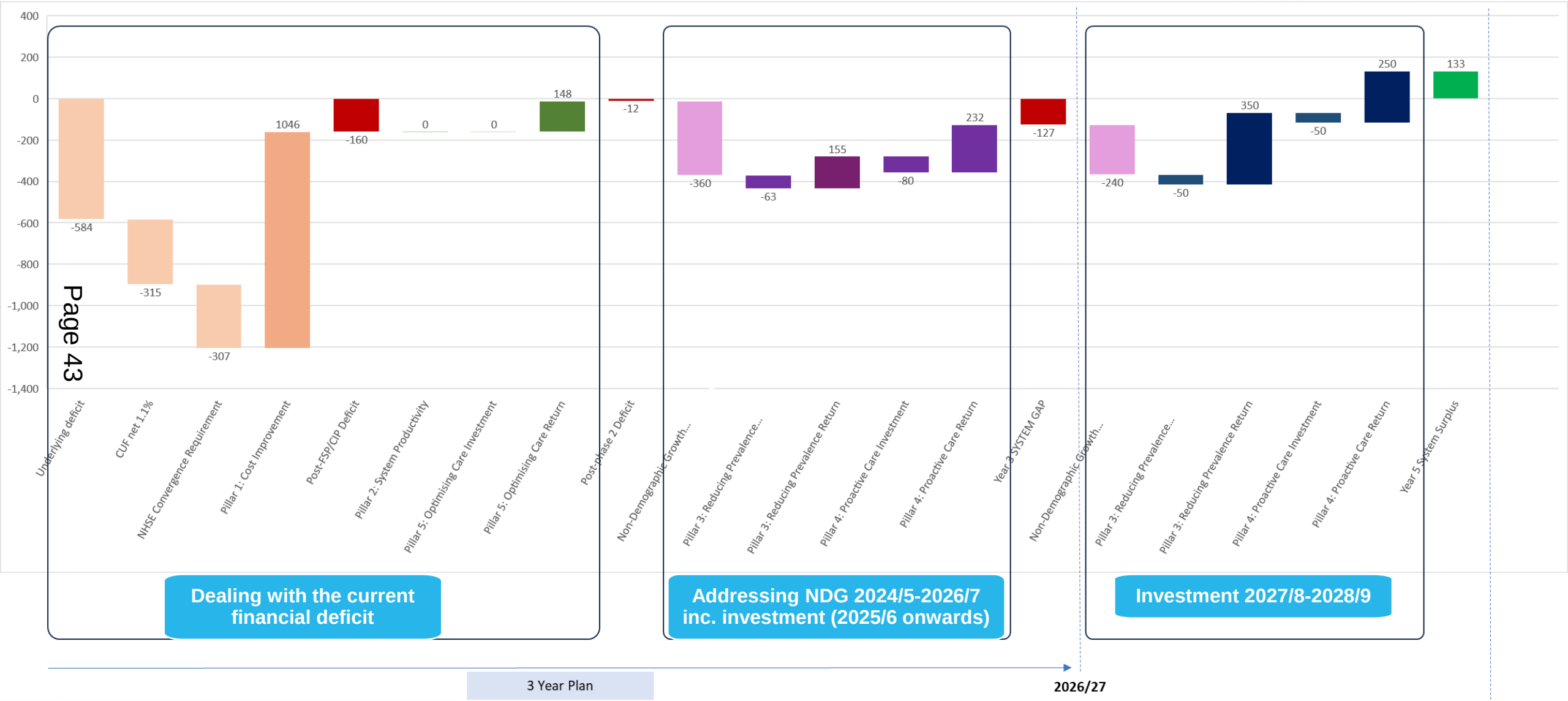
Shows how the remaining NDG ‘gap’ will be mitigated in the following two years (2027-2029) by further full impact from continued investment at the same level

3-year plan

5-year plan

The financial bridge

NHS Greater Manchester



The pillars of sustainability and their contribution

NHS Greater Manchester

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

Cost improvement	System Productivity and Performance	Reducing prevalence	Proactive care	Optimising care
Cost Improvement Plans (CIPs) leading to financial sustainability through Financial Sustainability Plans (FSPs)	**Multi-provider/system activities to improve the use of our resources and our performance**	**Maintaining the population in good health and avoiding future costs through prevention**	**Catching ill health early, managing risk factors, and delivering evidence based, cost effective interventions to reduce the level of harm**	**Transforming the model of care through system actions**
Combined contribution to overall plan leaves an underlying deficit after three years (~£160m) Financial savings through FSPs/CIPS: **£1046m**	Contribution to overall plan through achievement of performance objectives and improved productivity No financial savings	Contribution to addressing non-demographic growth (NDG) of £360m over 3 years ~£40m confirmed ~£67m from additional investment (to be detailed)	Contribution to addressing non-demographic growth (NDG) of £360m over 3 years ~£120m confirmed ~£33m from additional investment (to be detailed)	Contribution to overall plan of £148m (over three years) 40% of this contribution through confirmed plans, with the remainder still to be detailed
		Contribution to addressing non-demographic growth (NDG) of £240m in years 4&5 £300m (reducing prevalence), £200m (proactive care) from additional investment (to be detailed)		

Cost improvements – Trusts and ICB

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

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

System Productivity and Performance – the programmes

NHS Greater Manchester

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

Reducing prevalence – programmes and impact

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

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

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

Overall Impact ~£40m (savings – investment)

Impact from additional investment in three years: £67m (savings – investment)

ROI from additional investment assumed to be 1/3rd of full impact because of the early stage of the programmes

Proactive care: programmes and impact

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

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

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

Overall Impact ~£120m (savings – investment)

Impact from additional investment in three years: £33m (savings – investment)

ROI from additional investment assumed to be 1/3rd of full impact because of the early stage of the programmes

Optimising care: programmes and impact

NHS Greater Manchester

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

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

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

Total savings: ~£149m

The development and delivery of the plan

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

Governance Summary

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

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

Key points for system consideration

NHS Greater Manchester

If the remaining deficit is to be addressed:

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

If NDG is to be addressed:

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

If this plan is to be delivered:

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

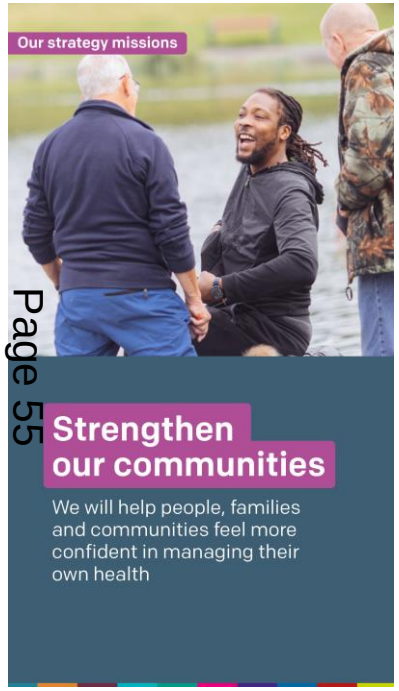
2. Our strategy and a sustainable system

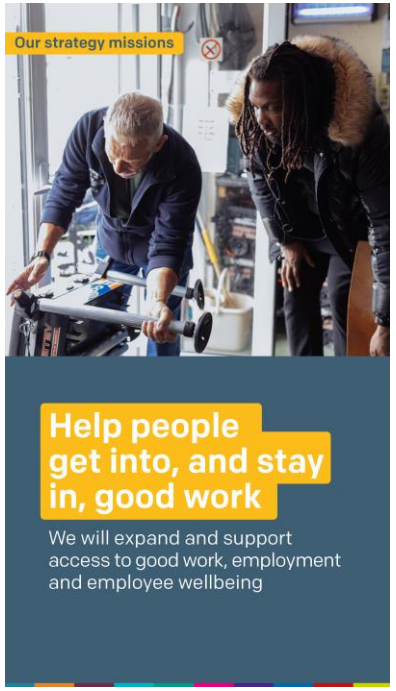
Our vision and the outcomes we are seeking

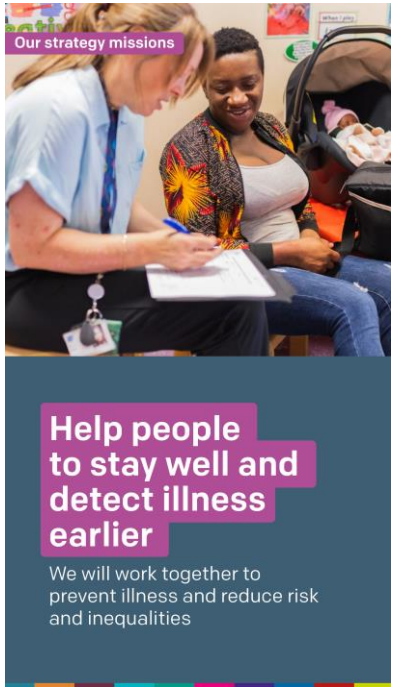
“We want Greater Manchester to be a place where everyone can live a good life, growing up, getting on and growing old in a greener, fairer more prosperous city region”

NHS Greater Manchester

Our missions







Our strategy and our plans

NHS Greater Manchester

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

- The relationship between these plans is illustrated on the next slide. This includes the importance of the Sustainability Plan in addressing the undertakings issued by NHS England

- This Sustainability Plan is needed because the challenges we face now are more complex and acute than we have ever experienced in Greater Manchester. These challenges cover finance, performance, quality and population health. We have a significant underlying financial deficit; we are not consistently meeting core NHS delivery standards; and the health of our population is getting worse

- We know that we need to change what we do and how we do it. We must do this to deliver on our responsibility to improve the health of our population – and to do this within the resources available to us

- We know that this will take longer than a single year, so this plan covers three years initially

NHS GM Plan Alignment

NHS Greater Manchester

The plans are connected and build on each other to ensure the delivery of the overarching 5-year strategy and national NHS objectives

24/25 Operational Plan

- Actions to deliver the performance workforce and financial commitments in the GM planning response to NHSE
- Additional actions to improve population health through prevention and early intervention

Sustainability Plan

A framework including:

- Priorities to achieve financial sustainability and effective use of resources across the GM NHS system , focusing on the next 3 years
- Delivered through GM, provider, locality and programme delivery plans.

Joint Forward Plan

The 5-year plan to deliver the ICP strategy through our missions:

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

ICP Strategy

Sets out how we will work together over a 5-year period to achieve a GM where

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

NHS GM Single Improvement Plan

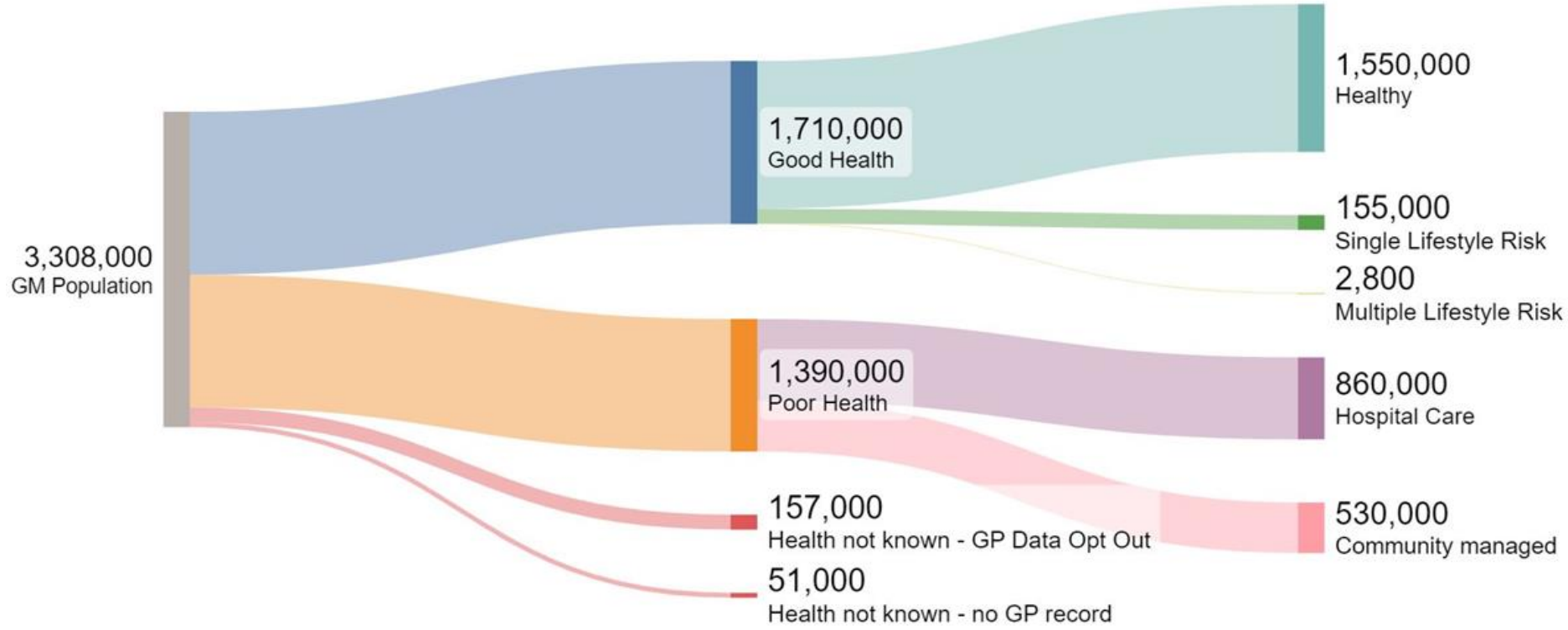
NHS GM response to the grounds for undertakings and improvement actions .

The plan is focused on ensuring the ICB is structured and has the right approaches and governance in place to enable it to deliver on the agreed priorities of the above plans.

The Health of our Population

NHS Greater Manchester

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



The changes we need to make

NHS Greater Manchester

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

The Greater Manchester Model for Health

NHS Greater Manchester

- In the ICP Strategy we set out our Model for Health (see next slide). The model aims to ensure that as many people as possible are supported to maintain good health at home and in their communities – reducing demand on crisis-based and specialist care

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

The Greater Manchester Model for Health

NHS Greater Manchester

3. The financial bridge

Key finance facts and figures

- NHS GM receives income of >£7bn per year

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

Developing the Financial Bridge: the key activities

NHS Greater Manchester

Identifying the size of the financial and population health challenge:

Identifying and modelling how we will address the challenge

Dealing with the current financial deficit

- Confirming the position on the underlying deficit
- Including other projected further movements in the model (e.g. convergence and Cost Uplift Factors)
- Analysing the FSPs from all parts of the system
- The impact of key system programmes
- Modelling the impact of plans to change the model of care (for example, Health and Care Review) to optimise care

Addressing population need: priority activity

- Modelling non-demographic growth to predict future demand
- Priority activity already planned to address population need: reducing prevalence and enabling proactive care

Investment strategy

- Additional population health interventions funded through additional investment

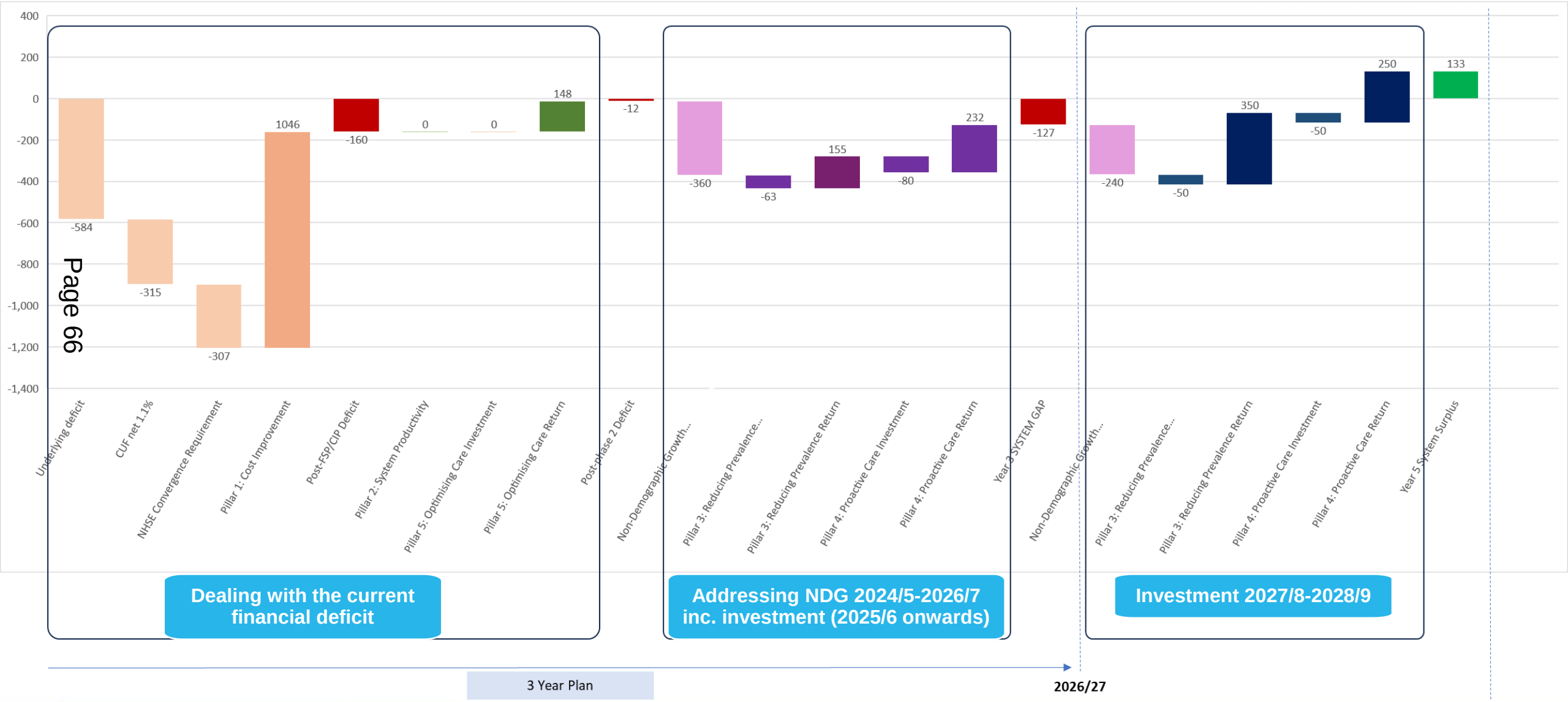
The pillars of sustainability

From the analysis to develop the bridge, we identified five aspects of sustainability which we need to pursue: the ‘pillars’ of sustainability

Cost improvement	System Productivity and Performance	Reducing prevalence	Proactive care	Optimising care
Cost Improvement Plans (CIPs) leading to financial sustainability through Financial Sustainability Plans (FSPs)	Multi-provider/system activities to improve the use of our resources and our performance	Maintaining the population in good health and avoiding future costs through prevention	Catching ill health early, managing risk factors, and delivering evidence based, cost effective interventions to reduce the level of harm	Transforming the model of care through system actions

The financial bridge

NHS Greater Manchester



The financial bridge – what it shows

NHS Greater Manchester

The bridge shows three ‘blocks’ with associated pillars. The figures are shown in the following slide.

Dealing with the current financial deficit

Shows how the underlying deficit can be substantively closed in three years, with detailed plans in place for year 1 and the inclusion of assumptions about developing plans for years 2 and 3

- Cost improvement
- System Productivity and Performance
- Optimising care

Addressing NDG 2024/5-2026/7 inc. investment (2025/6 onwards)

Shows how Non-Demographic Growth can be partially mitigated in three years through planned population health interventions where funding is already agreed and the partial impact of additional investment (in years 2 and 3) of £50m per year.

Impacts from population health interventions take time to demonstrate a full effect and so an impact of 1/3rd of the full impact from additional investment has been assumed in years 2 and 3.

- Reducing prevalence
- Proactive care

Investment 2027/8-2028/9

Shows how the remaining NDG ‘gap’ will be mitigated in the following two years (2027-2029) by further full impact from continued investment at the same level

3-year plan

5-year plan

The financial bridge – the contents

NHS Greater Manchester

The bridge shows three ‘blocks’ with associated pillars:

Dealing with the current financial deficit	
Underlying deficit	-584
Cost Uplift Factor (CUF) ned 1.1%	-315
NHS convergence requirement	-307
Cost improvement (Pillar) – plans	1046
Post CIP/FSP deficit	-160
Optimising care – impact	148
Remaining deficit	-12

Addressing NDG 2024/5-2026/7 inc. additional investment (2025/6 onwards)	
NDG	-360
Reducing prevalence (pillar) - investment	-63
Reducing prevalence (pillar) - saving	155
Proactive care – investment	-80
Proactive care – saving	232
System Gap (3 years)	-127

Additional investment 2027/8-2028/9	
NDG	-240
Reducing prevalence (pillar) - investment	-50
Reducing prevalence (pillar) - saving	350
Proactive care – investment	-50
Proactive care – saving	250
System Surplus (5 years)	133

3-year plan

5-year plan

4. The pillars of sustainability

The pillars of sustainability

Cost improvement	System Productivity and Performance	Reducing prevalence	Proactive care	Optimising care
Cost Improvement Plans (CIPs) leading to financial sustainability through Financial Sustainability Plans (FSPs)	Multi-provider/system activities to improve the use of our resources and our performance	Maintaining the population in good health and avoiding future costs through prevention	Catching ill health early, managing risk factors, and delivering evidence based, cost effective interventions to reduce the level of harm	Transforming the model of care through system actions

These pillars are of course interdependent and cannot exist in isolation.

- For example, collective actions on provider productivity may enhance performance and optimise care as well as contribute to individual provider CIPs.
- Similarly, progress in proactive care delivery may also impact on other financial drivers, such as prescribing costs.

These interdependencies need to be understood as we make key decisions in implementing this plan.

How the pillars of sustainability contribute to our missions

NHS Greater Manchester

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

The pillars of sustainability

NHS Greater Manchester

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

Pillar 1: cost improvement

Cost Improvement - Overview

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

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

Principles used in developing this plan

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

Trust cost improvements

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

Organisation	Locality/ sector
Key themes in Trust CIPs • Income • Corporate services transformation • Digital transformation • Estates and Premises transformation • Medicines efficiencies • Procurement • Service re-design • Pay	Examples include: • Four Localities Partnership • Mental Health Trust collaboration • Joint working Bolton FT & WWLFT

ICB cost improvements

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

Cost Improvement – oversight and governance

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

Financial Sustainability Plans (Detail)

NHS Greater Manchester

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

- £160m

Gap from FSPs and system repayment by 26/27

60-70%

Of Future CIP Recurrent to land the system on a sustainable footprint.

- **Financial Sustainability Plans £160m gap 26/27–** All 10 parts of the system have developed an FSP, whilst at different stages of governance, the table illustrates the output of those documents.
- **Additional to the FSPs, there are two further adjustments:**
  - **System Repayment –** As a result of the deficit in 23/24 and the control total in 24/25, GM has to repay at 0.5% of our allocation c£35-£40m per year.
  - **Optimism Bias –** This is based on elements of the FSP having income assumptions from the ICB that are not agreed or included in ICB FSP. Also, recurrent level of CIP at Providers 14% more in 25/26, than planned in 24/25. Consequently, 25/26 recurrent levels reset to equate to 24/25.

Financial Sustainability Plans

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

Pillar 2: System Productivity and Performance

System Productivity and performance improvement

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

See Appendix 1 for more details of these programmes

System Productivity – the programmes

NHS Greater Manchester

Programme	3-year ambition	Key interventions	Contribution to system sustainability
Programmes to drive performance improvement and quality of care through optimising models of care and implementing new ones in targeted areas			
Elective care	• Reducing waiting list size to c240,000 by March 2027 • Minimise patients waiting over 40 weeks • Achieve national standards for outpatient services	• Single point of access referral gateways for most pressured specialties (elective) • Strategy and plan for surgical hubs and theatre estate optimization	• Reduced waiting times for patients • Reduce variation in access
Cancer	• Deliver sustainable improvements to achieve the NHSE standards for cancer consistently across GM • Deliver the 2028 requirement of 75% of cancers diagnosed at early stage • Deliver optimal pathways for high-risk tumour sites to improve patient outcomes • Deliver personalised care and treatment • Improve health inequalities related to cancer care	• Deliver step change in front end pathway delivery • Optimisation of surgical pathway capacity • Single Queue Diagnostics expansion for specialist / niche diagnostics	• Reduced waiting times and managing growth in demand. • Reduce variation in access and provide service resilience. • Cost avoidance – reduced length of stay and related to anticipated growth in demand, waiting list initiatives, in/outsourcing. • Reduced variation.
Diagnostics	• Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition. • Mature Imaging, Pathology, Endoscopy and Physiological Sciences Networks. • Continued rollout of Community Diagnostics Centre (CDC) programme and system wide process	• CDC utilisation plan and expanded capacity • Performance improvement initiatives	• Wait list reduction • Reduction in outsourcing • Reduced turnaround times for patients

See Appendix 1 for more details of these programmes

System Productivity – the programmes (continued)

NHS Greater Manchester

Programme	3-year ambition	Key interventions	Contribution to system sustainability
Programmes to drive performance improvement and quality of care through optimising models of care and implementing new ones in targeted areas			
Mental Health	• Elimination of Out of area placements (OAPs)	• Quality oversight of OAPs, improving patient flow, effective discharge planning, ensuring appropriate community capacity across all localities. • Increased provision of alternatives to admission and onward care home/supported housing options	• Savings from reduced OAPs can be reinvested in Mental Health services
Urgent and Emergency Care (UEC)	• To recover urgent and emergency care performance across GM ensuring population of GM receive timely and appropriate care in right setting	• Driving standardisation and performance improvement management. • Management of winter pressures and system escalation via System Coordination Centre. • Development of consistent Care Coordination models across the ICS	• Improved patient flow. • Achievement of 95% of patients seen within 4hrs in A&E by March 2027 • Sustain Cat 2 ambulance response times at or above national target
Transform corporate services through innovation and enhanced collaboration, to make them more efficient, resilient and cost-effective			
HR: Scaling People Services Programme	• Reduce corporate running costs with a focus on consolidation, standardisation, and automation to deliver services at scale	• Development of models and shared approaches around: transactional People Services (Recruitment, HR Administration, Payroll); and Occupational Health	• Enabler of realising CIPs • Standardisation of systems/processes and automation will enable efficiencies
Corporate services	• Implement work on transforming specific corporate functions and shared services	• Links to digital – single finance ledger • Collaborative procurement	• Enabler of realising CIPs • Improved workforce resilience

System Productivity – the programmes (continued)

NHS Greater Manchester

Programme	3-year ambition	Key interventions	Contribution to system sustainability
Other programmes			
Workforce	Meet workforce targets on sickness absence, agency spend and turnover	• Workforce Efficiency programme • GM Temporary Staffing Strategy • Wellbeing benchmarking • Ongoing retention projects enabled by the NHS People Promise	• Sickness absence - potential savings contribution to CIPs • Turnover - cost prevention • Reduced temporary staffing and improved capacity
Digital	Rationalisation of systems & infrastructure, including: 1) EPR 2) Common Service Platforms 3) Infrastructure 4) Medicine Optimisation; 5) Digitalisation of Paper 6) Primary Care	• EPR – transition to 'Epic Connect' model which would enable sharing of capabilities across the system, • Infrastructure – rationalisation of Data Centres • Medicine Optimisation – automation of prescribing generic drugs • Digitalisation of Paper - reduction in storage costs • Primary Care - Digital strategy realisation	• Requires significant capital investment • Will then deliver both financial efficiencies and productivity gains

System productivity – oversight and governance

NHS Greater Manchester

Programme	SRO	Programme Lead	Oversight/ Governance
Elective	Fiona Noden & John Patterson	Dan Gordon	GM Elective Care Board to TPC
Cancer	Roger Spencer	Claire O'Rourke	GM Cancer Board to TPC
Diagnostics	Roger Spencer	Chris Sleight	GM Diagnostics & Pharmacy Partnership Group to TPC
Mental Health	Manisha Kumar/ Anthony Hassall	Xanthe Townend	GM Mental Health Partnership Board
UEC	Steve Rumbelow	Gill Baker	GM UEC System Group to ICB Board
Workforce	Karen James/ Janet Wilkinson	Rebecca Steer / Jane Seddon	HRDs to TPC Health & Care Group to People & Culture Committee
HR Scaling People Services Programme	Karen James/ Janet Wilkinson	Rebecca Steer	HRDs to TPC Health & Care Group to People & Culture Committee
Transforming corporate functions	TBC	TBC	TPC
Digital	Anthony Hassall/Alison McKenzie-Folan	Malcom Whitehouse/ Gareth Thomas	GM ICS Digital Transformation Group

Addressing non-demographic growth

Understanding the impact of non-demographic growth

NHS Greater Manchester

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

Estimating non-demographic growth impacts

NHS Greater Manchester

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

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

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

- Our estimates show that the population will tend to move from better health and less costly segments to more complex and costly segments

The consequence of these changes in terms of patient numbers is substantial:

- the number of people in the Mental health illness segment being about 5 times larger in 2030 than it currently is
- The number of people in the Frailty segment (the most costly) being 3 times larger than it currently is

The cost of non-demographic growth

NHS Greater Manchester

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

Taking action on non-demographic growth

NHS Greater Manchester

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

GM Prevention and Early Intervention Framework:
A comprehensive, whole system Population Health approach

NHS Greater Manchester

A comprehensive, whole system approach to population health, prevention and early detection, consisting of a system-wide approach to health creation and delivery of a person-centred upstream social model of care

Shaping GM as a place conducive to good health by working together to address the root causes of ill health	Enabling people to live healthier lives by mobilising comprehensive approaches to tackling behavioural risk factors	Scaling up secondary prevention across all parts of the NHS to allow the early detection of risk and early diagnosis of illness	Supporting people to live well by optimising the treatment and management of health conditions

Tackling inequalities and reducing unwarranted variation

GM Fairer Health for All Framework and CORE20PLUS5

Leading to **Better outcomes**

- Healthy Life Expectancy and Life Expectancy
- Inequalities and variation in health outcomes and experiences
- Avoidable demand and cost
- Increased economic & social productivity due to better health

Everybody has an opportunity to live a good life

Harnessing the following system characteristics

Person and community centred approaches	Strategic Intelligence / PH Management	Whole system partnerships/ collaboration	Public Service Reform / Integration	A highly skilled and prevention focused workforce	Clinical Excellence and Leadership	Finance, contracting and accountability rebalanced towards prevention and early detection	Evidence, research, technology and innovation

Leading action on non-demographic growth

NHS Greater Manchester

- The actions to address the projected non-demographic growth must be place-led.
- This will require an understanding of local projections by population segment, age and deprivation. It will set a clear challenge and trajectory for localities to be measured against and to demonstrate their ability to maintain or improve the health of their population.
- Locality level performance against a comprehensive and appropriate set of preventative measures will be developed with localities each locality. For example:

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

Pillar 3: Reducing prevalence

Reducing prevalence

The opportunity to reduce the growth in prevalence is based on primary prevention

Primary prevention involves taking action to reduce the incidence of disease and health problems within the population. The purpose is to prevent disease or illness from ever occurring.

Primary prevention of poor health includes actions to :

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

Benefits

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

See Appendix 2 for more details of these programmes

Reducing prevalence – programmes and impact

NHS Greater Manchester

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

In addition to the impact from investment already agreed, further impact could be gained from additional investment (see section 5) for the faster and wider implementation of programmes already underway

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

Overall Impact ~£40m (savings – investment)

Impact from additional investment in three years: £67m (savings – investment)

ROI from additional investment assumed to be 1/3rd of full impact because of the early stage of the programmes

Reducing prevalence – oversight and governance

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

Pillar 4: Proactive care

Proactive care

There are two streams of work in this pillar:

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

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

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

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

Benefits

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

Proactive Care: GM Multi-Year Prevention Plan

NHS Greater Manchester

- **Initial focus** on preventing CVD and Diabetes as a significant driver of morbidity, mortality, demand and cost
- Building on our existing evidence-based GM CVD Prevention strategy and GM Diabetes Strategy 2022-2027 and shifting the focus to scaled up delivery.
- Defined evidenced based, cost-effective preventative interventions for CVD and Diabetes
    - Evidenced based population health and secondary prevention interventions for CVD and Diabetes to prioritise for GM in 2024/25 have been identified. Secondary prevention interventions are predominantly clinical in nature and will occur during interactions with the health service. Primary prevention initiatives are described in the 'reducing prevalence' pillar.
- **Looking forward:** in 25/26 we will consolidate and continue to drive delivery of key outcomes re CVD and diabetes and also plan for future years , building an evidenced based approach to prevention priority identification and targeting of resources .

Proactive care: Reducing variation across GM

NHS Greater Manchester

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

Proactive care: the role of commissioning

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

Proactive care: programmes and impact

NHS Greater Manchester

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

In addition to the impact from investment already agreed, further impact could be gained from additional investment (see section 5) for the faster and wider implementation of programmes already underway

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

Overall Impact ~£120m (savings – investment)

Impact from additional investment in three years: £33m (savings – investment)

ROI from additional investment assumed to be 1/3rd of full impact because of the early stage of the programmes

Proactive care – oversight and governance

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

Improving care for the most disadvantaged communities

NHS Greater Manchester

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

Pillar 5: Optimising Care

Optimising care

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

Health and Care Review

NHS Greater Manchester

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

Optimising care

NHS Greater Manchester

Service area	3-year ambition	Contribution to system sustainability	Financial savings (total £m over three years)
Pathology	Development and implementation of a new operating model for pathology	Reduction of outsourcing for reporting and incorporate costs of storage and digitization.	£10m
Dermatology	Implementation of the agreed model of care for dermatology, including the Single Point of Access and community model	Improvement in both performance and in ensuring the patient is treated in the most appropriate setting for their condition.	£19m
Neurorehabilitation	Implement lead provider model		£10m
Vasectomies	Undertake a systematic assessment of services against an agreed set of outcome, efficiency, effectiveness and quality measures to ensure most effective use of resources across GM and reduce inequality of provision.	Reductions in unwarranted variation in cost and quality	£1.125m

Optimising Care (continued)

NHS Greater Manchester

Service area	3-year ambition	Contribution to system sustainability	Financial savings (total £m over three years)
Adult ADHD	A changed approach to the way the ICB responds to Adult ADHD – prioritising access to individuals on waiting lists in most clinical need through a triage assessment model to support GPs and patients in clinical need with wider psychosocial alternatives offer for those not eligible for NHS-funded assessments	• Improved utilisation of limited GM capacity and full pathway capacity and funding to deal with growing backlogs, longer waiting times and risks that are negatively affecting people's day-to-day lives • Reduced risk of uncapped rise in funding pressures from ADHD 'Right to Choose' requests where no clinical rationale	£13.175
Referral Thresholds			£5m
Procedures of Limited Clinical Value (PLCV) – see next slide			
Already agreed: TES and spinal injections	Undertake a systematic assessment of services against an agreed set of outcome, efficiency, effectiveness and quality measures to ensure most effective use of resources across GM and reduce inequality of provision.	Reductions in unwarranted variation in cost and quality	£1.25m
Further areas to be pursued – at greater speed and wider scope than currently planned			£69m

Other programmes to be considered: Procedures of Low Clinical Value

NHS Greater Manchester

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

See Appendix 4 for more details of these programmes

Optimising care: programmes and impact

NHS Greater Manchester

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

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

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

Total savings: ~£149m

Optimising care – oversight and governance

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

5. How we will enable sustainability

How sustainability will be enabled

a) Governance
b) Delivery plans
c) Investment strategy
d) Use of capital
e) Continuation of grip and control
f) Undertakings
g) Workforce

Governance summary

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

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

Governance – system groups

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

Investment strategy

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

The Role of Capital

Capital is an important enabler to the delivery of the Sustainability Plan

The Capital Resource and Allocation Group has been tasked with developing a long-term plan for deployment of system capital. This work is focusing on:

- Clearly defining the parameters of what is meant by a sustainable capital plan.
- The investment strategy if we must live within current capital constraints.
- What the system could achieve if it had increases capital to deploy into several key areas (Estates, Digital, Equipment). Particularly linking this to known areas i.e. the £3.4bn of national capital to support productivity.

This work is ongoing and focused on three phases, including a Y1 plan for no increases in capital income, with options for Y2-5 being developed to support strategic requirements

Continued grip and control

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

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

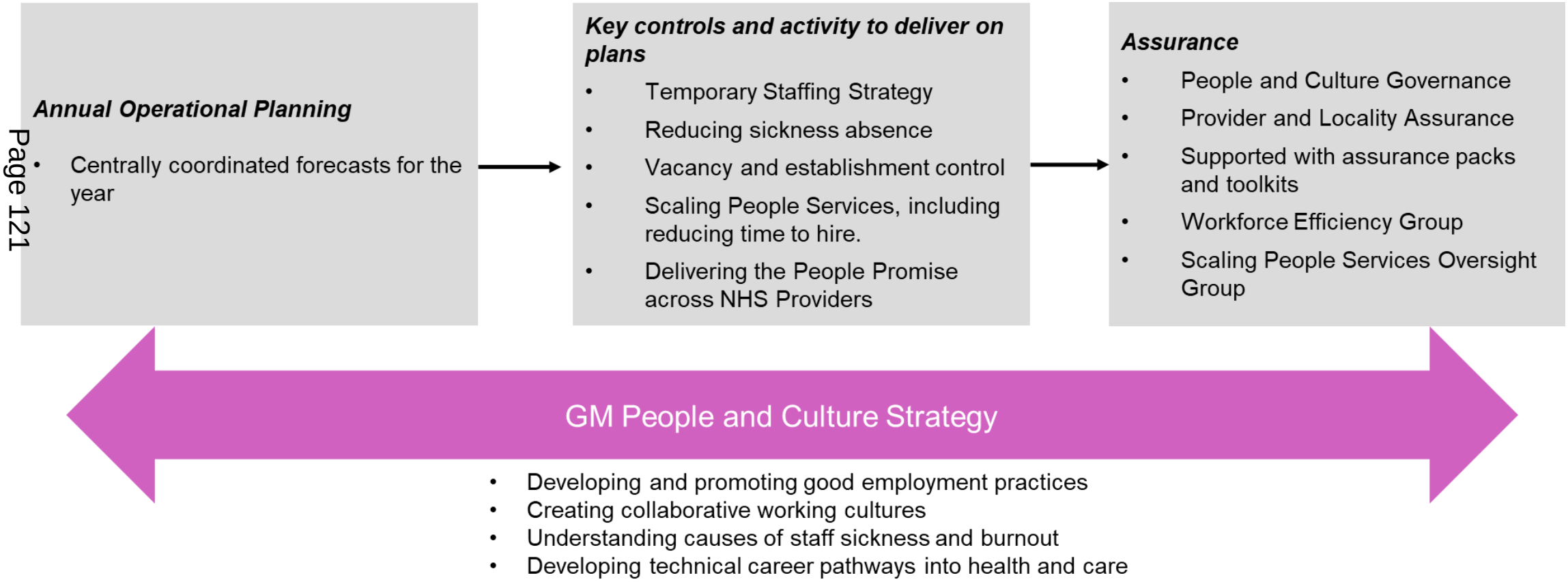
Addressing the undertakings

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

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

Our Workforce

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



Key points for system consideration

NHS Greater Manchester

If the remaining deficit is to be addressed:

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

If NDG is to be addressed:

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

If this plan is to be delivered:

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

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Appendices

Appendix 1: Cost Improvement
Appendix 2: System Productivity and Performance
Appendix 3: Reducing Prevalence
Appendix 4: Proactive Care
Appendix 5: Optimising Care

Appendix 1

Cost improvement plans (24/5)

Value of CIP programmes

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

Trust cost improvements

Key themes in Trust CIPs

- Income
- Corporate services transformation
- Digital transformation
- Estates and Premises transformation
- Medicines efficiencies
- Procurement
- Service re-design
- Pay

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

ICB cost improvements

Programme(s)	2024/5 FY plan (£m)
Continuing Health Care	13.0
Medicines Optimisation	33.0
Mental Health OAPs	10.0
Autism and LD	0.3
Better Care Fund	4.5
Community Services	5.0
Estates	5.0
Independent Sector	3.0
Legal Services	0.5
Locality Individual Schemes	12.1
Non-Healthcare Contract Consolidation (NHCC)s	1.2
Optimal Organisational Structure	8.5
Translation and Interpretation	0.5
Virtual Wards	5.0
Workforce External Drivers	1.5
TOTAL	**103.0**

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Appendix 2

Details of programme plans – System Productivity and Performance

System Productivity and Performance – the programmes

NHS Greater Manchester

Programme	3-year ambition	Key issues	Key interventions	Contribution to system sustainability
Programmes to drive performance improvement and quality of care through optimising models of care and implementing new ones in targeted areas				
Elective care	• Reducing waiting list size to c240,000 by March 2027 • Minimise patients waiting over 40 weeks	• Size of overall wait list: if linear trend was to continue the overall wait list would stagnate at around 500k • Number of long waiters • Underlying demand and capacity	• Introduce GM referral gateway and specialist advice • Increase capacity for Outpatient first appointments • Maximise capacity and utilisation of theatres (inc. new TIF builds) • Embed Mutual Aid policies and processes across the system	• Reduced waiting times for patients • Reduce variation in access • Additional revenue from paid for activity
Cancer	• Deliver sustainable improvements to achieve the NHSE constitutional standards for cancer consistently across GM • Deliver the 2028 requirement of 75% of cancers diagnosed at early stage • Deliver optimal pathways for high-risk tumour sites to improve patient outcomes • Deliver personalised care and treatment • Improve health inequalities related to cancer care	• Managing Demand • Diagnostic Reporting Capacity • Treatment – capacity, volumes, variation • Based on current referral trajectories, we are projecting a potential 7% increase year on year in FDS activity.	• Create ‘step change’ in front end pathway delivery • Full and active commitment to Single Queue Diagnostics expansion • Optimisation of surgical pathway capacity	• Reduced waiting times and managing growth in demand. Reduce variation in access and provide service resilience. • Cost avoidance – reduced length of stay and related to anticipated growth in demand, WLI, in/outsourcing. • Reduced variation.
Diagnostics	• Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition. • Mature Imaging, Pathology, Endoscopy and Physiological Sciences Networks. • Develop digital infrastructure • Continued rollout of CDC programme and system wide process to increase diagnostic capacity and reduce inequalities in access.	• Workforce sustainability • Growing demand and insufficient capacity • System variation • Modelling indicates a potential shortfall in capacity meeting demand.	• Diagnostics performance improvement initiatives • CDC expanded capacity for system increase capacity and mutual aid access • Endoscopy system triage and audit • Operationalise Digital Pathology	• Activity revenue • Wait list reduction • Reduction in outsourcing • Reduced turnaround times for patients

System Productivity and Performance – the programmes (continued)

NHS Greater Manchester

Programme	3-year ambition	Key issues	Key interventions	Contribution to system sustainability
Programmes to drive performance improvement and quality of care through optimising models of care and implementing new ones in targeted areas				
Mental Health	• Elimination of Out of area placements (OAPs)	• For OAPs, a linear trend on growth could see a rise of 198% in March 2027	• Quality oversight of OAPs, improving patient flow, effective discharge planning, ensuring appropriate community capacity across all localities. Increased provision of alternatives to admission and onward care home/supported housing options	• Savings from reduced OAPs can be reinvested in Mental Health services
Urgent and Emergency Care (UEC)	• To recover urgent and emergency care performance across GM ensuring population of GM receive timely and appropriate care in right setting	• Increased demand and acuity, resulting in challenges with patient flow. • The 4hr A&E standard of care not being delivered to all patients. • Management of winter pressures. • Effectiveness of Capacity & Discharge funding.	• Improve efficiency and effectiveness of Hospital at Home Services. • Driving standardisation and performance improvement management. • Ongoing evaluation of schemes from Capacity and Discharge funding. • Management of winter pressures and system escalation via System Coordination Centre. • Development of 3-year UEC System Plan. • Sustain GM hospital handover operational improvement plan. • Development of consistent Care Coordination models across the ICS	• Improved patient flow. • Achievement of 95% of patients seen within 4hrs in A&E by March 2027 • Sustain Cat 2 ambulance response times at or above national target

System Productivity and Performance – the programmes (continued)

NHS Greater Manchester

Programme	3-year ambition	Key issues	Key interventions & mitigating actions	Contribution to system sustainability
Transform corporate services through innovation and enhanced collaboration, to make them more efficient, resilient and cost-effective				
Scaling People Services	Reduce corporate running costs with a focus on consolidation, standardisation, and automation to deliver services at scale	• Demands on HR teams are growing • Expectations of the workforce are increasing	• Development of models and shared approaches around: transactional People Services (Recruitment, HR Administration, Payroll); and Occupational Health	• Enabler of realising CIPs • Standardisation of systems/processes and automation will enable efficiencies
Transforming corporate functions	Implement work on transforming specific corporate functions and shared services	• Workforce resilience • Cost pressures	• Pursuing a single ledger across Trusts • Collaborative procurement e.g. legal services • Route map for system digital architecture	• Enabler of realising CIPs • Improved workforce resilience

System Productivity and Performance – the programmes (continued)

NHS Greater Manchester

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

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Appendix 3

Details of programme plans – Reducing prevalence

Reducing prevalence – programmes and impact

NHS Greater Manchester

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

In addition to the impact from investment already agreed, further impact could be gained from additional investment (see section 5) for the faster and wider implementation of programmes already underway

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

Overall Impact ~£40m (savings – investment)

Impact from additional investment in three years: £67m (savings – investment)

ROI from additional investment assumed to be 1/3rd of full impact because of the early stage of the programmes

NHS
Greater Manchester

Appendix 4

Details of programme plans – Proactive care

Pillar 4: Programmes – Detail of Savings

NHS Greater Manchester

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

In addition to the impact from investment already agreed, further impact could be gained from additional investment (see section 5) for the faster and wider implementation of programmes already underway

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

Overall Impact ~£120m (savings – investment)

Impact from additional investment in three years: £33m (savings – investment)

ROI from additional investment assumed to be 1/3rd of full impact because of the early stage of the programmes

NHS
Greater Manchester

Appendix 5

Details of programme plans – Optimising Care

Optimising care

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

Pillar 5: Pillar Overview (continued)

NHS Greater Manchester

Service area		3-year ambition	Contribution to system sustainability
Vasectomies	To commission more cost-effective procedures, in the community and closer to home.	Vasectomies are a procedure which can safety be delivered in a community setting, under local anesthetic. There is already community provision which works effectively, serving several GM localities however still several patients attending secondary care and other providers for procedures at national tariff. It is the intention to reprocure more cost-effective services in the community which will also free up capacity in secondary care.	Improvement in financial performance Improvement in productivity and performance.
Adult ADHD	A changed approach to the way the ICB responds to Adult ADHD – prioritising access to individuals on waiting lists in most clinical need through a triage assessment model to support GPs and patients in clinical need with wider psychosocial alternatives offer for those not eligible for NHS-funded assessments	Demand for adult ADHD assessments has risen at such speed that services are simply unable to keep up across the country and locally in Greater Manchester Increasing concerns raised by primary care, specialist services and Coroners about increased waiting times, joint working with respect to shared care protocols for medication and the quality of some private providers in delivering whole pathways of support (including under Right to Choose arrangements) Existing growing waiting list for Adult ADHD assessments of more than 20,000 adults (and a recognition that this is increasing by at least 1,500 each month above commissioned capacity and funding). This translates to a waiting list cost pressure of at least £15-20m using existing model	Improved utilisation of limited GM capacity and full pathway capacity and funding to deal with growing backlogs, longer waiting times and risks that are negatively affecting people's day-to-day lives Reduced risk of uncapped rise in funding pressures from ADHD 'Right to Choose' requests where no clinical rationale

Pillar 5: Pillar Overview (continued)

NHS Greater Manchester

Service area	3-year ambition	Rationale for change	Contribution to system sustainability
Referral Thresholds	In order to address referral variation and make optimum use of the capacity we have availably and utilise our finances well, the Clinical Reference Groups (CRG) are tasked with identifying appropriate referrals thresholds for high volume specialties thus allowing as a system for optimisation of our NHS provision with priority being given to Ophthalmology. Working with local and system partners including Getting it Right First Time (GIRFT) team to ensure that the changes we made lead to improved quality, deliver sustainable service provision and wider system efficiencies.	All NHS providers are reviewing their productivity as part of their internal cost improvement programmes, (CIP). There is a need to apply similar methodology across all providers delivering elective care, including reviewing first to follow up ratio's, adherence to service specification and clinical thresholds to manage demand and optimise the use of our available capacity.	Improvement in financial sustainability Improvement in productivity and performance
Procedures of Limited Clinical Value	To review commissioning statements for the procedures of limited clinical value, nationally now referred to as the 'Evidence-based interventions programme',. The EBI programme, is designed to reduce the number of medical or surgical interventions as well as some other tests and treatments which the evidence shows are inappropriate for some patients in some circumstances. The GM Procedures of Limited Clinical Value (PLCV) Steering group has a programme of clinical, evidence-based reviews of procedures which are of low/limited clinical value. The recommendations of the group (decommission, implement clinical thresholds)	The ICB has seen an increase in activity and cost of providers undertaking procedures of limited clinical value (23/24 activity versus 2019/20 (pre covid)), and so there is a need to validate this activity to ensure that providers are only undertaking procedures to those patients who meet the stringent clinical criteria.	Improvement in performance and productivity; Improvement in financial performance.

Optimising Care - Detail of Savings

NHS Greater Manchester

Programme	Year 1 Savings	Year 2 Savings	Year 3 Savings	Savings 3-year total (£m)
Pathology				10
Dermatology	1.5	8.0	9.0	19
Neurorehabilitation	2.0	4.0	4.0	10
Commissioning more effective processes – vasectomies	0.125	0.5	0.5	1.125
Adult ADHD	0.375	6.4	6.4	13.175
Referral Thresholds	1.0	2.0	2.0	5
PLCV - TES and spinal injections	0.25	0.5	0.5	1.25
Totals				**60**
PCLV additional procedures				**69**

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

Total savings: ~£149m

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NHS
Greater Manchester

GM Sustainability Plan

Warren Heppolette

Overview – What the Plan Shows

NHS Greater Manchester

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

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

This plan shows that:

- The projected remaining deficit, after Cost Improvement Plan delivery, could be eliminated over three years through
  - Consistent and complete implementation of existing Cost Improvement Plans (CIPs)
  - Complete implementation of system wide plans already developed across GM along with assumptions about those not yet detailed
  - Assumptions on reconfiguration of parts of the system which have not yet been planned in detail
  - Assumptions on reducing the number and scope of procedures of limited clinical value (PLCV), although this is not yet detailed
- With additional investment, the impact of Non-Demographic Growth (NDG) could be mitigated through
  - Assumptions about the impact of reducing prevalence and enabling proactive care on the health of the population

The financial bridge – what it shows

NHS Greater Manchester

The bridge shows three ‘blocks’ with associated pillars.

Dealing with the current financial deficit

Shows how the underlying deficit can be substantively closed in three years, with detailed plans in place for year 1 and the inclusion of assumptions about developing plans for years 2 and 3

- Cost improvement
- System Productivity and Performance
- Optimising care

Addressing NDG 2024/5-2026/7 inc. investment (2025/6 onwards)

Shows how Non-Demographic Growth can be partially mitigated in three years through planned population health interventions where funding is already agreed and the partial impact of additional investment (in years 2 and 3) of £50m per year.

Impacts from population health interventions take time to demonstrate a full effect and so an impact of 1/3rd of the full impact from additional investment has been assumed in years 2 and 3.

- Reducing prevalence
- Proactive care

Investment 2027/8-2028/9

Shows how the remaining NDG ‘gap’ will be mitigated in the following two years (2027-2029) by further full impact from continued investment at the same level

The financial bridge

NHS Greater Manchester

The pillars of sustainability and their contribution

NHS Greater Manchester

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

Cost improvement	System Productivity and Performance	Reducing prevalence	Proactive care	Optimising care
Cost Improvement Plans (CIPs) leading to financial sustainability through Financial Sustainability Plans (FSPs)	**Multi-provider/system activities to improve the use of our resources and our performance**	**Maintaining the population in good health and avoiding future costs through prevention**	**Catching ill health early, managing risk factors, and delivering evidence based, cost effective interventions to reduce the level of harm**	**Transforming the model of care through system actions**
Combined contribution to overall plan leaves an underlying deficit after three years (~£160m) Financial savings through FSPs/CIPS: **£1046m**	Contribution to overall plan through achievement of performance objectives and improved productivity No financial savings	Contribution to addressing non-demographic growth (NDG) of £360m over 3 years ~£40m confirmed ~£67m from additional investment (to be detailed)	Contribution to addressing non-demographic growth (NDG) of £360m over 3 years ~£120m confirmed ~£33m from additional investment (to be detailed)	Contribution to overall plan of £148m (over three years) 40% of this contribution through confirmed plans, with the remainder still to be detailed
		Contribution to addressing non-demographic growth (NDG) of £240m in years 4&5 £300m (reducing prevalence), £200m (proactive care) from additional investment (to be detailed)		

Governance Summary

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

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

Greater Manchester Joint Health Scrutiny Committee

Date: 15th October 2024

Subject: Monthly Service Reconfiguration Progress Report and Forward Look

Report of: Claire Connor, Associate Director of Communications and Engagement, NHS Greater Manchester

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Purpose of Report:

To set out the service reconfigurations currently planned or undertaking engagement and / or consultation. It also includes additional information on any engagement that is ongoing.

Recommendations:

The Joint Health Scrutiny Committee is requested to:

1. Review the report and highlight any projects they require further information on at this time.

Contact Officers:

Claire Connor, Associate Director of Communications and Engagement, NHS Greater Manchester, claire.connor@nhs.net

Report authors must identify which paragraph relating to the following issues:

Equalities Impact, Carbon and Sustainability Assessment:

Not applicable

Risk Management

This report is to support the risk management of service redesign, ensuring that JHSC has opportunities to review and comment on planned changes.

Legal Considerations

This report is part of the discharge of NHS Greater Manchester's legal duties to engage with scrutiny committees on to consult local authorities on substantial service changes that affect their population (Health and Social Care Act 2006, section 244 and the Local Authority Regulations 2013, section 21).

Financial Consequences – Revenue

Not applicable

Financial Consequences – Capital

Not applicable

Number of attachments to the report: 0

Comments/recommendations from Overview & Scrutiny Committee

Not applicable

Background Papers

Not applicable

Tracking/ Process

Does this report relate to a major strategic decision, as set out in the GMCA Constitution

No

Exemption from call in

Are there any aspects in this report which means it should be considered to be exempt from call in by the relevant Scrutiny Committee on the grounds of urgency?

No

GM Transport Committee

Not applicable

Overview and Scrutiny Committee

October 2024.

1. Introduction/Background

This paper provides an overview of the Greater Manchester wide service redesign projects currently progressing through for engagement and/or consultation. Not all the projects are substantial and therefore not all will be subject to full consultation.

The list or projects will change as projects begin, progress, or are paused or cancelled.

This report will be updated every month to allow JHSC to stay up-to-date with the latest position and to request further information as required.

2. Projects

Project and anticipated level of engagement	Current stage	Overview
Adult ADHD *Consultation*	NHS England review – stage 2	There are currently long waiting times for adult ADHD diagnosis services. Engagement has been completed, along with options appraisal and the first stage of the NHS England assurance process has been successfully completed. We are currently planning for the second stage of the assurance process and the consultation. Date of JHSC: 16th July 2024
Children's ADHD *Engagement followed by possible consultation*	Engagement launched 2nd October 2024	There are currently long waiting times for children's ADHD diagnosis services. Engagement is currently being planned to understand the current experience of the service and the needs of the people who use it. It is launched on 2nd October and will run for 8 weeks. See below for further details. Date of JHSC: January 2025 (TBC)
IVF cycles *Proposed consultation*	NHS GM Board	The number of IVF cycles offered across Greater Manchester varies depending on where people live. This service redesign is looking at a policy that is equitable across Greater Manchester. Engagement and options appraisal has been completed. It is expected to go to NHS GM Board in autumn for approval for consultation. A written briefing on the planned consultation will be provided to GM JHS. **Date of JHSC: 16th July 2024**
Specialised commissioning cardiac and arterial vascular surgery *Engagement followed by possible consultation*	Engagement	The pathway of a very small numbers of patients who need urgent and specialist cardiac or arterial vascular surgery is being reviewed. This covers patients who use hospitals provided by the Northern Care Alliance. Patients may end up at a different location following the service review. Engagement is currently being undertaken. Date of JHSC: Winter 2025 (TBC)

Specialist weight management *Engagement followed by possible consultation*	**Engagement**	**The tier 3 specialist weight management service supports people living with very high BMIs. There are currently different service levels across Greater Manchester.** **Early engagement has begun which is due to continue into October – November 2024.** **NICE guidance is also due out in spring 2024 that may influence this work, so at this time, the engagement is focusing on areas with the least access and specific socio-demographic target groups.** **Date of JHSC: Spring 2024 (TBC)**
Diabetes structured education *Engagement*	Engagement planning	The offer and uptake of diabetes structured education varies across localities. This project is looking at whether there is the potential to create a standardised offer. Date of JHSC: February 2025 (TBC)
Children's autism *Engagement*	Analysis of engagement work to date	Children's autism service pathways are being reviewed. Date of JHSC: to be confirmed
NW Women & Children's Transformation Programme *Engagement followed by possible consultation*	Preparing options appraisal	The NW Women & Children's Transformation programme aims to translate several national reviews and associated standards related to Neonatal Critical Care; Paediatric Critical Care; Surgery in Children; and Children and Young People (CYP) with Cancer into an operational plan for the North West. NB: North West footprint for this work, scrutiny arrangements are to be agreed.

3. Current engagement

3.1. Children and Young People's ADHD Services

This week, NHS Greater Manchester (NHS GM) has launched a public engagement exercise to gather views on children and young people's attention deficit hyperactivity disorder (ADHD) services in Greater Manchester.

We want children and young people to have timely access to support that is tailored to helping them manage their ADHD condition and symptoms, considering their needs as a whole and not focusing on their diagnosis.

The engagement exercise, which runs until 29 November 2024, seeks to address some of the issues including long wait times, levels of ongoing support for patients, the referral and assessment process, and how services vary across Greater Manchester. Our biggest priority is to improve how cases are prioritised, and making sure that children and young people who are most in need, get help quickly.

We have plans on how we can make improvements to children and young people's ADHD services and peoples' experiences. But first, we want to seek views on what matters most to people who use these services, their carers and/or families; and to help shape future services. We are also keen to hear from colleagues working in ADHD services or wider services that support children with ADHD. We are reaching out to community groups, voluntary, community, faith and social enterprise organisations (VCFSE), healtwatches, and service providers to involve them in the engagement.

There are a number of ways for people to share their views, including via an online survey, by email or attending a focus group. To find out more and get involved, visit our website; contact us by email: gmhscp.engagement@nhs.net; or call, text or WhatsApp us on 07786 673762.

3.2. Fit for the future

NHS Fit for the future is a six month programme of engagement with communities and stakeholders to help us design an NHS fit for the future of everyone who lives, works and plays across Greater Manchester.

It focuses on:

- **Happy, healthy lives**
  We need to spend more time focusing on supporting people to live happy, healthy lives by preventing illnesses were possible or identifying them early.
- **Great services**
  We need to make services easy to access with shorter waiting times and fair across Greater Manchester.
- **Financial balance**
  We need to make the most of our money, saving it where we can, to bring the local NHS finances into balance.

The engagement started in August and since then we have been to approximately 50 different locations, community groups, events, sounding boards, etc to either have discussions, hold workshops, have stalls, or do presentations. This includes reaching a huge variety of sociodemographic, condition specific, or geographically based groups. Examples include several pride events, Bollywood fitness groups, men's mental health groups, gateways, community centres and libraries, picnics, D/deaf groups, visual impairment groups, and fresher fairs. We also held both face to face and online launch events. Further face-to-face events will be held in many of the localities across Greater Manchester.

The focus so far has predominantly been on face-to-face engagement with the community, but there has been additional engagement targeted through social media, and an online survey.

An interim report on the discussions, what people have shared with us, and the outcomes of the first phase of engagement is currently being produced, with another due in early January 2025 and the final report in March-April 2025.

Greater Manchester Joint Health Scrutiny Committee

Date: 15 October 2024

Subject: Health Innovation Manchester

Report of: Laura Rooney, Director of Strategy, Health Innovation Manchester

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Purpose of Report:

Health Innovation Manchester's strategy aims to improve lives, transform care, and boost the economy through innovation. It focuses on addressing population health priorities, accelerating innovation adoption, optimising digital solutions, and enhancing the system's capacity to deliver health innovation

Recommendation:

Members are asked to:

a. Discuss the content of the report and supporting presentation, with any points requiring clarification.

b. Note the forward plan of innovation activity and links with Integrated Care System priorities and plans.

Contact Officers:

Laura Rooney

laura.rooney@healthinnovationmanchester.com

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Health Innovation Manchester

Innovation with impact

HInM strategy – 2024/25 to 2027/28

Health Innovation Manchester’s vision is to be world leading in improving the lives of local people, transforming care and boosting the economy through innovation.

Health Innovation Manchester

We are Health Innovation Manchester

Health Innovation Manchester is a place-based innovation organisation.

Since formation in 2017, we have evolved and integrated our operating model and method for how we deploy innovation to deliver demonstrable impact and benefits to local people, system partners and industry.

The four key elements to success are our approach to integrated governance, blending capabilities, industry partnerships and an unrelenting focus on method.

Integrated governance

Whilst we are an NHS hosted organisation, we report to an independent Board comprising the highest-level city region leadership from the NHS, GM universities, the GM Combined Authority, local authorities and influential non-executive directors from global life sciences and medtech industries.

Integrated capabilities

HInM comprises the GM Health Innovation Network (formally AHSN), the Manchester Academic Health Science Centre, the NIHR Applied Research Collaborative and the GM NHS city region digital transformation office.

Whilst recognising their distinct accountabilities, we integrate the components to deliver our mission through blended innovation activities and driving collaboration across GM partners.

Industry partnerships

Greater Manchester's past, present and future is based on compelling partnerships with industry.

We recognise that major innovation supply chain opportunities for health and life sciences are coming from the pharma, biotech and digital industries.

We focus on partnership with industry to accelerate their product lifecycle management process and thereby deliver benefit to industry, as well as accelerated benefits to local people and the health economy.

Unrelenting focus on method

We recognise that reliable delivery of innovation at pace and scale has been a challenge for healthcare systems across the world.

To drive forward our approach in Greater Manchester, we have ensured that we place data and digital approaches at the heart of everything we do, and developed an enhanced innovation method overseen by robust assurance and measurement of impact at the centre of our operating model.

Health Innovation Manchester plan on a page

Our vision

Health Innovation Manchester's vision is to be world leading in improving the lives of local people, transforming care and boosting the economy through innovation.

Impact 1:
Improve lives and outcomes for GM people by addressing the priority drivers of population health.

Impact 2:
Support a safe and sustainable GM health and care system through deployment of innovation at scale.

Impact 3:
Boost jobs and economic growth for the GM city-region through industry collaboration and partnerships.

Objective 1:
Address high priority drivers of population health by deploying proven innovations at scale, with a major focus on primary and secondary prevention.

Objective 2:
Establish GM as a global learning market for accelerated access to novel innovations at scale

Objective 3:
Optimise digital and data products and services to understand the population, define their needs and develop new models and pathways.

Objective 4:
Work with partners to enhance the GM system's capacity and capability to deliver health innovation and demonstrate impact.

Key enablers: GM Care Record, Secure Data Environment, digital transformation, industry partnerships, academic partnerships, system engagement (with commissioners, providers, patients, carers, the voluntary sector and local places), user-led design.

Foundations: OKR framework, HInM people and OD plan, innovation pipeline, innovation culture, benefits measurement

Strategic objective 1

Address high priority drivers of population health by deploying proven innovations at scale, with a major focus on primary and secondary prevention

What does this mean?

- Discover, develop, deploy innovation aligned to most significant priorities and ability to deliver ROI in 3 years
- Major mission on cardiovascular disease
- Broader cardio-renal-metabolic portfolio
- Respiratory disease deployment projects
- Discover/develop for mental health
- Deliver the national HIN activities

Strategic objective 2

Establish GM as a global learning market for accelerated access to novel innovations at scale

What does this mean?

- Improve GM's position as a global city-region for health innovation
- Develop a multi-industry consortium approach with a shared ambition
- Land more clinical trials, real world studies and early value assessments of novel products and therapies
- Attract inward investment and increase Innovate UK grant awards
- Work with academic partners and NIHR bodies

Strategic objective 3

Optimise digital and data products and services to understand the population, define their needs and develop new models and pathways

What does this mean?

- Digital and data will continue to underpin everything we do
- Continue to grow and enhance the GM Care Record for direct care and research, including optimising cohort finding
- Mobilise a full SDE service and attract investment
- Digital industry partnerships to support a shift towards prevention and secondary prevention
- Understand the art of the possible in AI automatic and next generation computing

Strategic objective 4

Work with partners to enhance the GM system's capacity and capability to deliver health innovation and demonstrate impact

What does this mean?

- Help the system to become better at adopting innovation and improving handover to 'business as usual'
- Increase capacity and capability for research and innovation across the system
- Continue to improve our own method and approach to deliver impact
- Deploy the HInM People Plan
- Develop and deploy the outcomes and key results OKR framework across the business

The power of the GM SDE for research and innovation

Understand your population

- Population Segmentation & Risk Stratification
- Cohort Identification
- Benchmarking
- Opportunity Identification
- Sensitivity analysis and prioritisation
- Predictive Analytics & Impact Modelling

Define their needs

- Cohort engagement and co-creation
- Elicitation & problem definition
- Root cause analysis – upstream intervention
- Establish theory of change; define outputs, outcomes, impacts
- Set ambition / targets

Change the way you do and pay for things

- Deep partnership
- Identify evidence-based interventions
- Agile methodology
- Operating model transformation
- Oversight and risk management
- Value based payment models

Monitor and Learn

- Measurement, monitoring, evaluation, visualisation
- Effective risk management
- Continuous improvement
- Fail fast decision making
- Decommission legacy models

The GM secure data environment

Sub-national SDE's for R&D provide unique technical and analytical capabilities to support a range of use cases

By providing secure access to linked longitudinal patient data, the GM SDE for R&D will support research and development throughout the entire innovation lifecycle.

Use cases span from early discovery, through to deployment at scale, into continued operational evaluation

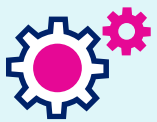
AI/Algorithm Development
Testing, training & validation

Clinical Trial Activity
Feasibility, recruitment, efficacy through short & long term trial follow-up

Real World Studies
Safety, effectiveness, cost-effectiveness and health economics

Translational Research
Academic discovery and implementation of discovery into practice

Epidemiological Studies
Large cohorts for population health research



Health Systems Research
Evaluation of systems or processes, operational and applied research

Source data	GM (only) ICS digital & data assets	Interface	Users	Purposes for access

GMCR

NHS Primary Care, Secondary Care and MH Providers

The GM Care Record

Clinical & non-clinical staff

Public

Direct care
- informing clinical decision making
- care planning
- data quality and audit

Patient held record (local solution to be integrated to NHS App)
- viewing and contributing to own record

GM ADSP

Wider determinants of health and other public sector data

The Analytics and Data Science Platform

Data and dashboards

Health and care organisations

Direct care
- identifying high risk patients and address inequalities

Planning
- population health - identifying high risk cohorts and addressing inequalities
- understanding patient journeys and clinical pathways to inform commissioning

Remit of GM Data Access Committee

GM SDE

The GM Secure Data Environment

A lens defined and agreed within the application, onto deidentified data within the SDE (with virtual walls around it)

Health and care or other public sector organisations

Universities

VCSE organisations

Industry partners

Research and development
- AI/Algorithm Development
- Clinical Trial Activity
- Real World Studies
- Translational Research
- Epidemiological Studies
- Health Systems Research

Remit of GM SDE applications review group

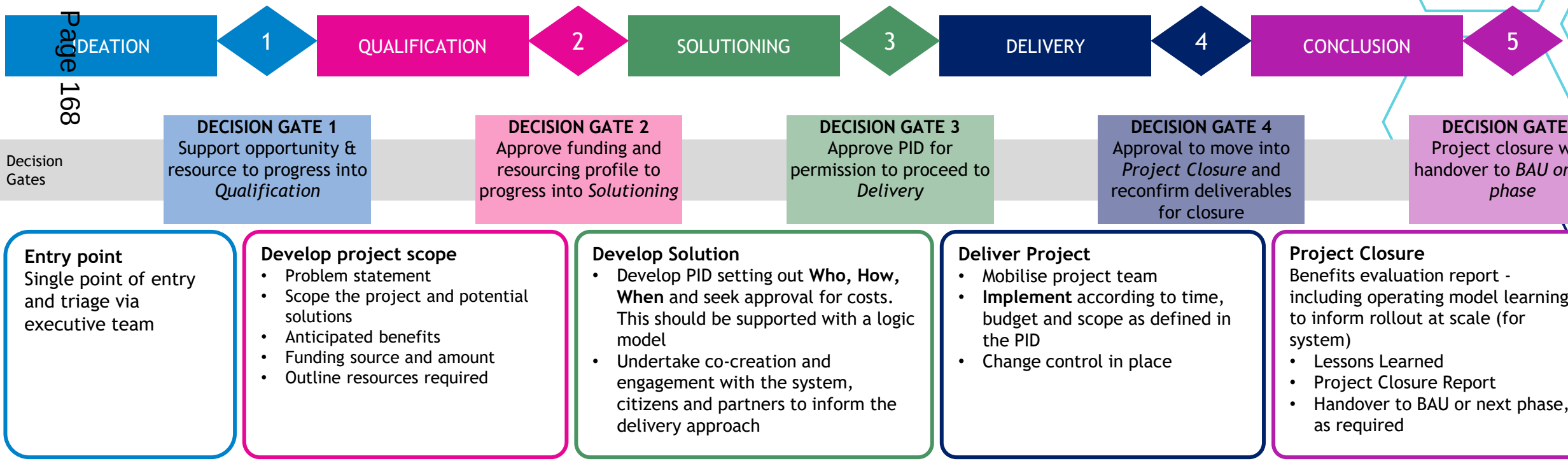
Greater Manchester Integrated Care Partnership

Health Innovation Manchester

HInM'S delivery is underpinned by a rigorous method

Delivery of our innovation activities is underpinned by our robust innovation pipeline method and approach, taking best practice from the tech industry and applying that into practice. This ensures an appropriate level of accountability and decision making, robust governance and assurance, and drives up delivery standards and effectiveness, as well as builds in benefits realisation from the beginning.

We adapt our approach according to the problems we are solving and solutions we are deploying, and have developed a critical set of capabilities and assets that we utilise as part of our overall offer back to the health and care system, academia and industry. It is our blend of in-depth healthcare, industry, digital, academia and engagement expertise that adds value to our partners.



Demonstrating our impact – embedding the logic model approach

	Outputs (Year1)	Outcomes (Years 2-3)	Impacts (Years 3+)
	Measurable/quantifiable results or deliverables from the intervention	*What the programme and initiative lead to Short/medium term consequences*	*Longer term changes in wider contextual factors/issues*
FISCAL	• Shared understanding of population health costs, service capacity and demand, and ROI from intervention • ADSP and SDE platforms fully operational, with a commercial model • Increased leveraged funding and resources from industry and Government agencies	• Increased clinical trials and real world studies • Faster access to new products, diagnosis and treatment • Optimisation of new medicines and therapeutics • Increased efficiency and effectiveness of care models, pathways and services • Increased academic grants	• Health and care cost reduction • Admission avoidance • Reduced length of stay • Optimising clinical capacity for direct care • Reduction in demand for care
SOCIETAL	• Clear evidence base for intervention • Structured deployment method • Cohort finding and risk stratification • Blueprint care models and new clinical guidelines • Demonstrable relational improvements, system capacity and capability to deliver research and innovation	• Improved standard, reduced unwarranted variation • Targeted intervention and precision medicine • Deployment of proven innovation and technology at scale • Enhanced expertise in health economics, analytics, AI, predictive modelling • Increased clinical standards • Academic publications	• Improved health outcomes • Improved care and treatment • Improved patient outcomes and experience • Improved quality of care • Equity of access and care across the system • Better management of long-term conditions and disease progression, including self-management
ECONOMIC	• Deeper understanding of productivity loss against key drivers of population health	• Increased inward investment • Increased foreign direct investment • Increased productivity and employment • Jobs creation	• Economic growth • Growth in highly skilled jobs • Growth in GVA from health innovation • Accelerated market access for industry

Innovation portfolio 24/25

Population health priority innovation projects

Cardiovascular disease

- CVD health economic analysis
- Strategic industry partnerships programme
- Lipids – point of care testing, medicines optimisation (including Inclisiran)
- National familial hypercholesterolemia, and blood pressure optimisation
- Novel diagnostics for heart failure – risk calculator (discovery)
- Chest Pain - PoC Troponin testing (discovery)
- GMCR heart failure care plan and patient held app
- Inequalities programme

Cardio-renal-metabolic

- Obesity discovery and reimagine programme
- Obesity tier 3 digital and therapies transformation (pending)
- Obesity GLP1 real world study (pending)
- Chronic Kidney Disease
- National CKD project
- Optimising Diabetes in GM (ODIN)
- Early detection of liver disease – ID Liver

Respiratory

- Remote Spirometry – community diagnostics (PoV)
- Lung cancer screening – underserved communities
- Improving respiratory outcomes in primary care

Mental health

- Research and innovation discovery project

Underpinned by the GMCR and SDE

Priority industry and digital innovation projects

GM Care Record

- Optimising the GMCR at the point of care (% increase TBC)
- Increasing data feeds, data access and improving quality
- GMCR product development - integrated care plans
- PoV for dementia and heart failure
- PoV for personal held record
- System-wide deployment of integrated care plans (TBC)
- Dementia, heart failure, end of life, frailty

Secure Data Environment

- SDE programme development
- Progression of 'alpha' service and academic and industry projects
- Development of the beta service
- GM SDE live service mobilisation
- North West SDE programme

Industry partnerships

- Strategic industry partnerships programme
- GM health innovation accelerator year 2 delivery
- Commercial model for the GM Secure Data Environment
- SME engagement programme

Other digital projects

- Digital first primary care
- Digital workforce
- Digital inclusion
- NHS at Home at scale (TBC)

Academic partnerships

MAHSC operations

- MAHSC operations
- Research domains x 7
- Translation of research into the HInM pipeline
- Mid-term review priorities – clinical research capacity building, commercialisation of academic assets, data science
- Cross-system bid coordination
- Academic access to the GM Secure Data Environment

NIHR infrastructure engagement

- Greater Manchester NIHR oversight committee
- NIHR Applied Research Collaboration
- NIHR Biomedical Research Centre
- NIHR Clinical Research Networks
- NIHR Clinical Research Facilities
- NIHR Patient Safety Research Collaboration
- NIHR Health Tech Research Centre for Emergency and Acute Care

GM HEI engagement

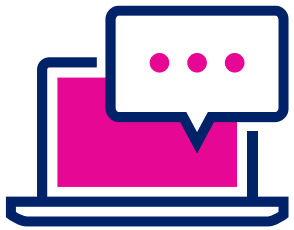
- University of Manchester
- Manchester Metropolitan University
- University of Salford
- University of Bolton

Impact case studies

Enhancing the GM Care Record to inform better patient care

The GM Care Record (GMCR) provides frontline staff with access to vital and up to date information from across GP practices, hospitals and other care providers so they can make better decisions about what care and treatment needs to be provided.

The aim of the GMCR project was to increase clinical use of the GMCR by 20%, to support frontline staff to deliver care and reduce the amount of time spent tracking down important information or repeatedly asking patients.



Key outputs

- Launched new digital care plans for dementia and heart failure – poof of value in Tameside and Glossop
- Launched the My GM Care app for patients to be able to view and contribute to their own care
- Increased access to information with new data feeds and granting access to community pharmacies

Key outcomes

- The GMCR is now used by more than 21,000 frontline staff to support 270,000 patient episodes each month. We have seen a 21% increase in users accessing the GMCR from 22/23 to 23/24.
- 4 condition specific digital care plans have been developed and deployed in proof of value localities, with over 2,900 plans now completed
- My GM Care app launched to 13,000 residents in Tameside. Over 700 downloads on first day and over 400 patient contributions daily

Key impacts

Time saving of £10m each year based on current usage rates

Increasing access to novel therapies for people with high cholesterol

The prevalence of cardiovascular disease in Greater Manchester is disproportionately higher than the rest of the country.

The aim of this project was to optimise the lipids pathway across Greater Manchester, including the targeted deployment of medicines and novel therapies to reduce cholesterol in high-risk groups – delivered through primary care, taking a population health approach.

Key outputs

- Published codesigned clinical pathways and training materials to aid medication reviews
- Developed digital tools to support cohort finding and track delivery in real time
- Mobilised a primary care delivery model with a blueprint approach
- Tracked patient outcomes through the GM Care Record, with an inequalities lens

Key outcomes

- Identified an eligible cohort of 18,904 people for medication reviews and potentially novel therapies
- Enrolled 170 general practices in the primary care delivery model
- Number of new medication orders placed: 4,964 (July 22- March 24)
- 1,179 people have received access to novel therapies, which is approximately 6% of the eligible population at that time

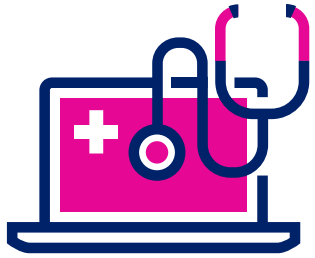
Key impacts

- In very high-risk patients a novel medication has been shown to further reduce LDL cholesterol by 44%
- Novel therapies used alongside standard treatment has the potential to prevent approx. 80 heart attacks and stroke over 5 years in GM and save the NHS at least £2 million – based on modelling a cohort of 5000 patients.

Deploying virtual wards across Greater Manchester

Virtual wards are a new transformational model of care intended to provide acute care and support to patients in their own homes enabled by technology, as an alternative to a hospital stay.

The aim of the project was to design a model for virtual wards across Greater Manchester and support providers to deploy it across the system to deliver 1095 virtual ward beds by March 2024.



Key outputs

- Published a GM virtual wards blueprint based on a standard network model across providers to achieve economies of scale
- Codesigned standard clinical pathways, definitions and data sets to encourage common standards
- Launched an insight-driven communications campaign to raise awareness of virtual wards across the system and to the public
- Completed a HInM benefits analysis and UoM-led independent evaluation

Key outcomes

- Over 12 months, GM trusts reported delivering more than 1000 virtual ward beds, running at an average of 74% occupancy – this is a tripling of the bed occupancy.
- Through this same period, GM virtual wards supported 33,000 patients, saving 96,000 hospital bed days.
- Whilst the reported costs of a general hospital ward bed are £536 a day, provider reported costs of virtual ward bed days in GM average £133 a day.

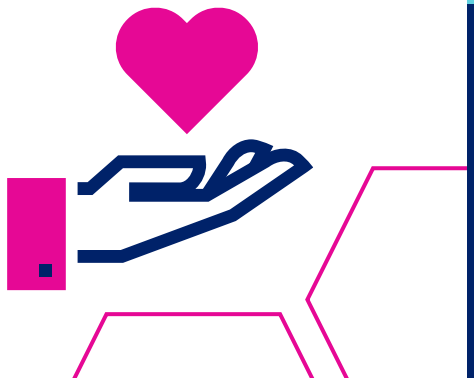
Key impacts (estimated)

- Avoided ambulance conveyance - 11,000
- Avoided hospital admissions – 16,000
- A&E attendances avoided – 28,000
- The potential net saving to the system is estimated to be £13.8 million compared to traditional hospital care models (compared to the cost of a hospital stay).

Understanding the obesity pathway across Greater Manchester

Obesity is a complex chronic condition with close association with the major drivers of population health including heart disease, stroke and diabetes.

The aim of the project was to deepen understanding of the total cost of obesity to the GM system, the current status of weight management and obesity services provision, as well as the potential impact of introducing alternative models of care and novel medicines.



Key outputs

- Completed a detailed report on service mapping of weight management provision across GM, from tier 1 to 4
- Developed a health economic analysis on the full costs of obesity to the GM system
- Reimagined how tier 3 provision could optimise new technologies and novel medicines, modelling capacity and demand costs
- Developed a public attitudes and experiences report of peoples' lived experience and barriers to accessing care and support.

Key outcomes

- Obesity costs the GM system £3.2bn per year in direct health and care costs and wider productivity losses
- Around 1 in 4 adults in GM live with obesity - (27.1%), and £5297 is the average cost per person living with obesity.
- Demand for services is outstripping capacity – 17,313 referrals to T3 (10.1% eligible population), and only 28% go on to enrol in the service.
- Waiting times for services - 12 months for T3, 18 months for T4
- Stigma and language are real barriers for patients seeking care and treatment.

Key impacts (potential)

- Reducing obesity prevalence could have an economic impact of up to £440m – predominately realised by improving productivity.
- Reimagine tier 3 services optimising digital technology and novel medicines for eligible cohorts – promoting increased equity of access and outcomes

Thank you

Health Innovation Manchester

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Greater Manchester Joint Health Scrutiny Committee

Date: 10 September 2024

Subject: Work Programme for the 2024/25 Municipal Year

Report of: Nicola Ward, Statutory Scrutiny Officer

Purpose of Report:

To provide Members with the draft Committee's Work Programme for the 2024/25 Municipal Year (Appendix 1). Members are reminded that this is a working document which will be updated throughout the year to reflect changing priorities and emerging issues. The Committee will regularly review and revise the Work Programme to ensure that it remains relevant and effective in addressing the needs of the community.

Members are encouraged to provide feedback and suggestions on the draft Work Programme.

A list of items to be scheduled into the Work Programme, at the request of Members is available in Appendix 2 and Appendix 3 shows what work has already been considered.

Recommendation:

That Members consider and populate the Committee's draft Work Programme.

Contact Officers:

Nicola Ward, Statutory Scrutiny Officer, GMCA

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Jenny Hollamby, Senior Governance and Scrutiny Officer, GMCA

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Appendix 1

Greater Manchester Joint Health Scrutiny - Work Programme (November 2024 to June 2025)

Date	Item	Lead	Ask of scrutiny
12.11.24	Reconfiguration Progress Report and Forward Look – Monthly Item	• Claire Connor, Director Communications & Engagement, NHS GM	NHS GM must ensure their reconfiguration plans are well-evidenced, address local needs, and follow proper public and stakeholder engagement procedures. This Progress Report and Forward Look will describe the efforts taking place.
10.12.24	Reconfiguration Progress Report and Forward Look – Monthly Item	• Claire Connor, Director Communications & Engagement, NHS GM	NHS GM must ensure their reconfiguration plans are well-evidenced, address local needs, and follow proper public and stakeholder engagement procedures. This Progress Report and Forward Look will describe the efforts taking place.
21.1.25	Reconfiguration Progress Report and Forward Look – Monthly Item	• Claire Connor, Director Communications & Engagement, NHS GM	NHS GM must ensure their reconfiguration plans are well-evidenced, address local needs, and follow proper public and stakeholder engagement procedures. This Progress Report and Forward Look will describe the efforts taking place.

	Workforce Engagement Initiatives and Sustainability Plan	• Janet Wilkinson, Chief People Officer, NHS GM • Anna Cooper-Shepherd Head of Strategy and Business for the Chief People Office, NHS GM	An overview of the NHS GM workforce engagement initiatives and sustainability plan, highlighting key strategies, achievements, and challenges. The aim of the report is to inform the Committee of the progress made in addressing workforce-related issues and ensuring the long-term viability of healthcare services.
	Children's Attention Deficit Hyperactivity Disorder (ADHD) Adult Service Reconfiguration	• Claire Connor, Director Communications & Engagement, NHS GM	There are currently long waiting times for children's ADHD diagnosis services. Engagement is currently being planned to understand the current experience of the service and the needs of the people who use it. It is launched on 2.10.24 and will run for 8 weeks.
18.2.25	Reconfiguration Progress Report and Forward Look – Monthly Item	• Claire Connor, Director Communications & Engagement, NHS GM	NHS GM must ensure their reconfiguration plans are well-evidenced, address local needs, and follow proper public and stakeholder engagement procedures. This Progress Report and Forward Look will describe the efforts taking place.

	Diabetes structured education Engagement	• Claire Connor, Director Communications & Engagement, NHS GM	The offer and uptake of diabetes structured education varies across localities. This project is looking at whether there is the potential to create a standardised offer.
18.3.25	Reconfiguration Progress Report and Forward Look – Monthly Item	• Claire Connor, Director Communications & Engagement, NHS GM	NHS GM must ensure their reconfiguration plans are well-evidenced, address local needs, and follow proper public and stakeholder engagement procedures. This Progress Report and Forward Look will describe the efforts taking place.

Appendix 2

Items to be Scheduled into the Work Programme

Ref	Item	Suggested	Lead
1.	Proposed reconfiguration of the Northwest Children's and Women's Services	TBA	Claire Connor, Director Communications & Engagement, NHS GM
2.	Fit for the Future (Live in June 2024)	Informal briefing 13.08.24 plus regular updates in monthly report	Claire Connor, Director Communications & Engagement, NHS GM
4.	That updates on the ICP Recovery Plan be provided to the Committee as required	13.9.23	Sir Richard Leese, Chair, NHS Greater Manchester Integrated Care and Mayor Paul Dennett, Chair, Integrated Care Partnership
5.	That the Joint Forward Plan and the subsequent steps in the Leadership and Governance Review be considered by the Committee at a future meeting	13.9.23	Sir Richard Leese, Chair, NHS Greater Manchester Integrated Care and Mayor Paul Dennett, Chair, Integrated Care Partnership
6.	Co-occurring Conditions	• Mark Knight, Strategic Lead for Substance Misuse, GMCA	Co-occurring conditions often lead to more complex and severe health outcomes, requiring integrated and coordinated care approaches. By understanding the interplay between these conditions, the Committee can advocate for policies and services that address the holistic needs of

			individuals and improve overall health outcomes.
7.	Review of Arterial Vascular Surgery and Cardiac Surgery Service Reconfiguration	• Claire Connor, Director Communications & Engagement, NHS GM • Louise Sinnott, Head of Place Based Commissioning. NHS GM • Lee Hey, Director of Strategy · Manchester University NHS Foundation Trust	The pathway of a very small number of patients who need urgent specialist cardiac or arterial vascular surgery is being reviewed. This covers patients who use hospitals provided by the Northern Carre Alliance. Patients may end up at a different location following the service review. Engagement is currently being undertaken.
8.	That Officers return to the Committee to discuss the sexual health model of care	• Jane Pilkington, Director of Population Health, NHS GM and Lynne Donkin, Director of Public Health, Bolton Council.	To discuss improving sexual health services in the Greater Manchester area with Members.

9.	Reducing the harm caused by harmful products	• Jane Pilkington, Director of Population Health, NHS GM and Lynne Donkin, Director of Public Health, Bolton Council.	To provide a comprehensive overview of the current state of harmful product consumption in Greater Manchester and outline strategies to mitigate their detrimental health effects.
10.	That Officers return to the Committee with the findings from the Specialist Weight Management engagement	• Jane Pilkington, Director of Population Health at NHS GM • Deborah Blackburn, Director of Children's Commissioning, Nursing, and Wellbeing, Salford City Council • Sara Roscoe, Head of Primary Care and Transformation at NHS Greater Manchester	This aligns with the focus on reducing the harm caused by obesity, and to ensure that the Committee is informed about the specific needs and priorities of individuals seeking weight management support

11.	The safety of women and girls when accessing exercise and active travel opportunities be a key theme at a future meeting	• Jane Pilkington, Director of Population Health at NHS GM	Report to explore the safety concerns faced by women and girls when participating in exercise and active travel activities in Greater Manchester. The report identifies key challenges, assesses the impact on physical and mental health, and proposes strategies to enhance their safety and promote inclusivity.
12.	Digital Investment	• Warren Heppolette, Chief Officer for Strategy & Innovation, NHS GM • Laura Rooney, Director of Strategy, Health Innovation Manchester	Aimed at improving patient care, enhancing efficiency, and supporting the long-term sustainability of the healthcare system.

13.	Specialist weight management Engagement followed by possible consultation	• Claire Connor, Associate Director, NHS GM	The tier 3 specialist weight management service supports people living with very high BMIs. There are currently different service levels across Greater Manchester. Early engagement has begun which is due to continue into October – November 2024. NICE guidance is also due out in spring 2024 that may influence this work, so at this time, the engagement is focusing on areas with the least access and specific socio-demographic target groups. To be considered in Spring 2024 (TBC).

Appendix 3

Previously Considered in 2024/25

Date	Item	Lead	Ask of scrutiny
15.10.24	Reconfiguration Progress Report and Forward Look – Monthly Item	• Claire Connor, Director Communications & Engagement, NHS GM	NHS GM must ensure their reconfiguration plans are well-evidenced, address local needs, and follow proper public and stakeholder engagement procedures. This Progress Report and Forward Look will describe the efforts taking place.
	Obesity Prevention	• Jane Pilkington, Director of Population Health, NHS GM	To provide the Greater Manchester approach and coordination and to understand what is being done across Greater Manchester to prevent obesity and any learning that could be shared from the programme in Salford. Representatives from the grass roots programme in Salford and lead Greater Manchester colleagues on obesity prevention to be invited.
	NHS Greater Manchester Chief Executive's Update	• Mark Fisher, Chief Executive, NHS GM	

16.7.24	Reconfiguration Progress Report and Forward Look – Monthly Item	• Claire Connor, Director Communications & Engagement, NHS GM	NHS GM must ensure their reconfiguration plans are well-evidenced, address local needs, and follow proper public and stakeholder engagement procedures. This Progress Report and Forward Look will describe the efforts taking place.
	Attention Deficit Hyperactivity Disorder (ADHD) Adult Service Reconfiguration	• Claire Connor, Director Communications & Engagement, NHS GM	To update the Joint Health Scrutiny Committee on NHS Greater Manchester's review of adult ADHD services focusing on addressing unmet need, and for public involvement in support of this work.
	In Vitro Fertilisation (IVF) Cycles Eligibility Reconfiguration	• Claire Connor, Director Communications & Engagement, NHS GM • Harry Golby, SRO and Director of Delivery and Transformation (Salford) • Mark Drury, Head of Engagement, Inclusion and Insight, NHS GM	To provide an overview and update.

GovWifi

GovWifi is a new guest wireless service which is designed to work across many public sector locations. GMCA has decided to adopt the service which will provide an improved Guest wireless service across all GMFRS and GMCA locations.

Registering with GovWifi

To use the service you need to register for an account.

You can do this by sending a blank email to **signup@wifi.service.gov.uk** using a .gov email address or anyone can text **'Go'** to **07537 417 417**.

You will be sent a username and password unique to either your email address or mobile number that you can use to login to GovWifi on any of your devices.

Connecting to GovWifi

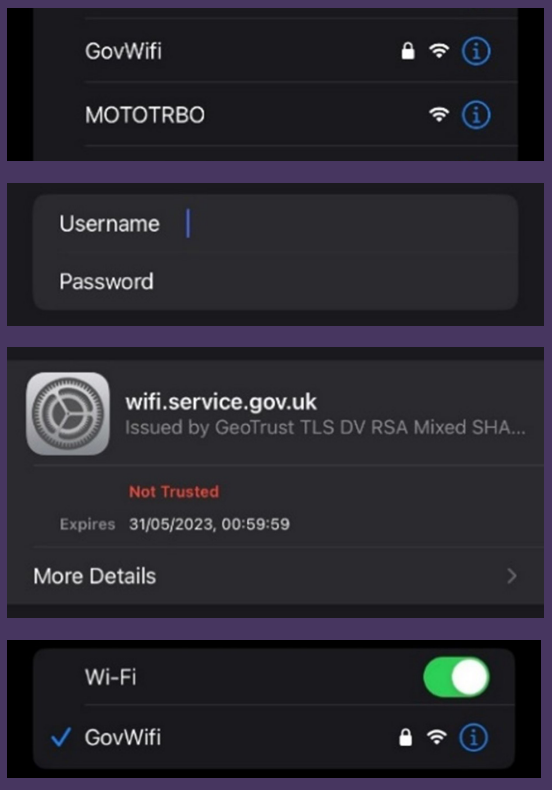
After you have received your username and password open your Wifi settings menu to select the GovWifi option.

Enter the username and password you were sent during registration.

You will be presented with a certificate screen you will need to validate. Check the issuing service is 'wifi.service.gov.uk' and then select the certificate is valid and that it is trusted.

You will then connect to GovWifi this can take a few seconds to complete.

Guidance on how to connect on specific devices can be found here:



Internet access is passing through the GMCA content filtering as per the standard corporate internet access with one exception that personal email is permitted.
In accepting the terms of connection to the GovWifi service you will be agreeing to the acceptable use policy.
If you require any further assistance, please contact the ICT Service Desk on 0161 608 4425 or log your call via the Self Service Portal

The GovWifi Terms of Service can be found here:

GMCA GREATER MANCHESTER COMBINED AUTHORITY

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Joint Health Scrutiny Glossary of Terms

Acronym	Meaning
ADHD	Attention Deficit Hyperactivity Disorder is a neurodevelopmental disorder that affects attention, behaviour, and impulsivity. Individuals with ADHD often have difficulty paying attention, staying organised, and controlling impulses.
ADSP	Advanced Data Science Platform
AIDS	Human Immunodeficiency Virus Infection and Acquired Immune Deficiency Syndrome
Big Conversation	Is a public engagement initiative in Greater Manchester, aimed at shaping the future of health and care services in the region. It is a collaborative effort between the NHS, local councils, community groups, and residents to gather feedback and insights on how to improve the health and well-being of the population
BMI	Body mass index is a measure of body fat based on height and weight. It is calculated by dividing your weight in kilograms by the square of your height in meters.
ASD	Autism Spectrum Disorder is a complex neurodevelopmental condition that affects a person's communication, behaviour, and social interaction. It is a spectrum disorder, meaning its symptoms can vary widely from person to person.
Covid-19 Pandemic	(Coronavirus Disease 2019) is a contagious disease caused by the SARS-CoV-2 virus. It first emerged in Wuhan, China, in late 2019 and quickly spread worldwide, leading to a global pandemic.

CQC	Quality Care Commission is an independent regulator of health and social care services in England. It is responsible for ensuring that these services are safe, effective, compassionate, and high quality.
GM	Greater Manchester
GM AHSN	Greater Manchester Academic Health and Science Network
CVD Prevention	Cardiovascular Disease Prevention
Diabetes	Is a chronic condition that affects how your body processes glucose, a type of sugar.
Fast-Tract Cities	Mayors and other elected leaders have joined forces with public health officials, clinical and service providers, and affected communities in 300+ cities and municipalities to action the Paris Declaration on Fast-Track Cities.
GMCA	Greater Manchester Combined Authority
GM ICP	Greater Manchester Integrated Care Partnership
GM IPC Strategy	Is a comprehensive plan outlining the vision and goals for improving health and care services in Greater Manchester. It sets out how the Greater Manchester Integrated Care Partnership intends to work together to address the health needs of the 2.8 million residents of the region.
HPV	Human papillomavirus
NIHR	The National Institute for Health and Care Research
HCV	Hepatitis C
HIV	Human Immunodeficiency Virus

HIV Action Plan 2021	The UK Government released Towards Zero: the HIV Action Plan for England in 2021, setting out its priorities to end new HIV transmissions between 2022 and 2025. The plan came with £20 million of funding over three years (2022 to 2025) to expand HIV opt out testing in emergency departments.
ICB	Integrated Care Board
ICS	Integrated Care System
JHS	Joint Health Scrutiny
Lived Experience	Refers to the personal experiences and perspectives of individuals who have directly encountered a particular situation or condition.
LGBTQ+	Lesbian, Gay, Bi, Trans, Queer, Questioning and Ace
LTC	Long Term Condition
MAHSC	Manchester Academic Health Science Centre
Mpox	Formerly known as monkeypox is a rare disease caused by infection with the Mpox virus.
NHSE	NHS England
NHS England Service Reconfiguration Gateway	Is a platform or process used by NHS England to manage and oversee changes to healthcare services within the NHS in England. Its purpose is to ensure that any proposed changes to services are aligned with the NHS's strategic objectives, are evidence-based, and will improve the quality and efficiency of care.
NICE	The National Institute for Health and Care Excellence (NICE) is an independent organisation in the United Kingdom that provides evidence-based guidance and advice on health and social care.
O&S	Overview & Scrutiny
PISA	Programme for International Student Assessment

Secretary of State for Health and Care	Is responsible for the work of the Department of Health and Social Care, including: overall financial control and oversight of NHS delivery and performance. oversight of social care policy.
STIs	Sexually Transmitted Infections
Specialist Weight Management Service	A healthcare program designed to provide comprehensive support for individuals looking to lose weight and improve their overall health.
UNAIDS	A high-profile, high-level political advocacy drive to accelerate actions and investments to prevent HIV.
Cardiac and Arterial Vascular Surgery	A surgical specialty that focuses on treating conditions related to the heart, arteries, and veins. It involves surgical procedures to repair or replace damaged blood vessels and address heart problems.
VCFSE	The voluntary, community, faith, and social enterprise sector