Public Document

GMCA GREATER MANCHESTER COMBINED AUTHORITY

GREATER MANCHESTER JOINT HEALTH SCRUTINY COMMITTEE

DATE: **Tuesday 18 March 2025**

TIME: **10.00 am**

VENUE: **Boardroom, GM Combined Authority, 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 - 4

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

BOLTON	MANCHESTER	ROCHDALE	STOCKPORT	TRAFFORD
BURY	OLDHAM	SALFORD	TAMESIDE	WIGAN

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

4. Minutes of the Last Meeting held on 18 February 2025 5 - 14

To consider approval of the minutes of the last meeting held on 18 February 2025.

5. Elective Recovery Update 15 - 22

Presented by Dan Gordon, Programme Director, Elective Recovery and Reform, NHS GM.

6. Reconfiguration Progress Report and Forward Look 23 - 28

Presented by Claire Connor, Director, Communications and Engagement, NHS GM.

7. Greater Manchester Patient Access - Primary and Urgent Care 29 - 60

Presented by Katherine Sheerin, Chief Commissioning Officer, NHS GM.

8. Greater Manchester Major Trauma Provision 61 - 68

Presented by Rob Bellingham, Programme Director for Major Trauma, and Jennie Gammack, Programme Director for Sustainable Services, NHS GM.

9. Work Programme for the 2024/25 Municipal Year 69 - 84

Presented by Nicola Ward, GMCA Statutory Scrutiny Officer and Deputy Head of Governance.

10. Date and Time of Next Meeting

15 April 2025 at 10.00 am, GMCA Boardroom.

For Information

11. Links to Minutes and Decisions

- Greater Manchester Integrated Care Partnership Board Agenda Pack dated 29 November 2024 (next meeting 28 March 2025 – to be confirmed)
- Greater Manchester Integrated Care Board Agenda Pack dated 19 February 2025

12. GovWifi Instructions 85 - 86

13. Glossary of Terms 87 - 92

Committee Membership

Name	Organisation	Political Party
Councillor Ayyub Patel	Bolton Council	Communities First
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 Charlotte Martin	Tameside Council	Labour
Councillor George Devlin	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 10 March 2025 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.

Minutes of the Meeting of the Greater Manchester Joint Health Scrutiny Committee held on 18 February 2025 GMCA, Boardroom, 56 Oxford Street, Manchester, M1 6EU

Present:

Councillor George Devlin	Trafford Council (in the Chair)
Councillor Zahid Hussain	Manchester Council
Councillor Eddie Moores	Oldham Council
Councillor Peter Joinson	Rochdale Council
Councillor Paul Molyneux	Wigan Council

Officers in Attendance:

Sandy Bering	Strategic Lead Clinical Commissioner/ Consultant (Mental Health & Disabilities), NHS GM
Jane Case	Assistant Director of Mental Health Strategic Commissioning, NHS GM
Jenny Hollamby	Senior Governance & Scrutiny Officer, GMCA
Alexia Mitton	Assistant Director, Communications & Engagement, NHS GM
Ben Squires	Director of Primary Care, NHS GM
Nicola Ward	GMCA Statutory Scrutiny Officer & Deputy Head of Governance

JHSC/92/25 Welcome & Apologies

Resolved/

That it be noted Councillor George Devlin was appointed Chair for this meeting only.

Apologies for absence were received and noted from Councillor Ron Conway, Councillor Elizabeth FitzGerald, Councillor Debbie Newall (Substitute), Councillor Irfan Syed and Councillor Wendy Wild (Substitute).

An apology was also received from Claire Connor, Director of Communications and Engagement, NHS GM.

JHSC/93/25 Chair's Announcements and Urgent Business

There were no Chair's announcements or urgent business.

The Chair reported that the Safety of Women and Girls Task and Finish Group, which met on 20 January 2025 focused on addressing women's safety in GM (GM) through a holistic approach, would reconvene in person next week. The Group would review transport policies and best practices, including a site visit to Stockport Interchange in April 2025, with findings to be reported to the Committee.

JHSC/94/25 Declarations of Interest

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

JHSC/95/25 Minutes of the Meeting held on 21 January 2025

Resolved/-

That the minutes of the meeting held on 21 January 2025 be approved as a correct record.

JHSC/96/25 General Practitioner (GP) Access

Members considered a report presented by Ben Squires, Director of Primary Care, NHS Greater Manchester, which provided an overview on access to GP services across GM. GP access had been a significant focus of the NHSE Primary Care Access Recovery Plan (PCARP) released in May 2023, which sat as part of the overall GM Primary Care Blueprint (the GM Primary Care strategic vision for GM). It was noted that GP access had been measured as part of the NHS System Oversight Framework for many years in different ways, at present, it was viewed mainly through the lens of GP appointment access within 14 days (face to face or remote).

Acknowledged were the lingering effects of the pandemic. While data indicated record appointment numbers and timely availability, a persistent public perception of difficulty remained. Regional variations were noted, particularly in Tameside, Salford, and Bolton. Efforts were underway to understand the situation telephone appointments continued to be prevalent, while face-to-face appointments had returned to and surpassed pre-pandemic levels.

It was reported that quality measures, such as Care Quality Commission ratings, were generally strong, though some practices required improvement. National GP collective action had influenced appointment availability. Modernisation efforts focused on enhancing telephony systems, expanding online services through the NHS app, and improving care navigation. Community pharmacies, especially through the Pharmacy First programme, played a significant role in managing demand and relieving pressure on GP services.

A Member raised the issue of GP consistency, specifically concerning turnover, recruitment, and retention. It was explained that despite a perceived national shortage of GP positions, reports indicated GPs were available for recruitment. The Additional Roles Reimbursement Scheme, part of Primary Care Network (PCN) developments, was highlighted, with 56 PNCs having recruited or planning to recruit GPs through this scheme. Efforts were underway to support the remaining nine PCNs. The GM Training Hub was also noted for its work in supporting GP retention and recruitment. Continuity of care was recognised as a crucial aspect for patients, and support was provided to GPs to maintain this.

A Member asked how would NHS GM ensure equitable GP access for all GM residents, acknowledging diverse needs and potential disparities. This was acknowledged this as a challenge and work was ongoing to address variability in access and quality. Mention was made of the review of interpreting services and programmes aimed at supporting practices in understanding diversity, such as the Black Health Improvement Programme and Pride in Practice. The importance of embedding primary care services within neighbourhoods to better reflect community needs was emphasised. Further input from the Committee was welcomed, and the value of patient participation groups in providing local feedback was highlighted.

The Member further enquired about the focus of community engagement and funding, noting the support given to Caribbean and African communities. It was highlighted that the Pakistani community, a significant portion of the population, appeared to receive less focus than other demographic groups of a similar proportion. NHS GM Officers acknowledged the observation and stressed the importance of both local and strategic-level engagement.

A Member reported residents were being denied advance GP appointments, forcing daily 8.00 am calls and being directed to A&E for urgent issues. The Member emphasised the need for flexible booking, particularly for shift workers. NHS GM Officers acknowledged the issue, stating a "one size fits all" approach was unsuitable and would address practice variations and ensure flexibility beyond the 14-day target as part of the work.

A Member highlighted the expansion of GP services in surgeries, including nurse and physiotherapy appointments, which demonstrably enhanced patient access. While acknowledging the convenience of app-based appointment booking, the Member emphasised the importance of maintaining telephone access to ensure inclusivity for individuals with limited technological proficiency.

A Member inquired about the training given to GP staff determining patient care levels, specifically administrative staff. Members were reassured that while practices managed this internally, clinical decisions were be made by clinicians. Telephone triage, where patients spoke directly to clinicians, was often used. The perception of receptionists as gatekeepers was highlighted but it was emphasised that clinical arrangements dictated patient pathways. Administrative staff received care navigation training to guide patients to appropriate services, which could include community resources beyond clinical care.

A Member questioned the adequacy of GP surgery buildings to support expanded services. It was acknowledged some facilities were aging and inadequate, despite some modern practices. While a review of needs was conducted, funding limitations meant estate development prioritised urgent repairs and lease issues. The significant gap between available funds and the necessary upgrades were noted, making it an ongoing challenge.

It was stated that the report's core message was a positive, good news story that contrasted sharply with prevailing local and national perceptions. Careful consideration should be given to how to effectively disseminate this information, ensuring the positive elements of GP access and practice were made readily available to the public. This represented a significant opportunity to align public understanding with the documented reality. In terms of additional indicators, the Committee suggested they should provide a more comprehensive view of GP access and quality should include a focus on patient health outcomes, using a holistic view of all services provided, and considered the impact on individual patients, their families, and the wider community.

Resolved/-

1. That it be noted that the update be received.
2. That it be noted that the Committee recognised the ongoing work to support patient access to GP services in GM.
3. That it be noted that the Committee asked that positive improvements made to GP access and practice be made available to the public.
4. That it be noted that the Committee suggested that additional indicators considered should be to provide a more comprehensive view of GP access and quality should include a focus on patient health outcomes, using a holistic view of all services provided, and considered the impact on individual patients, their families, and the wider community.

JHSC/97/25 Reconfiguration Progress Report and Forward Look

Members considered a report presented by Alexia Mitton, Assistant Director of Communications and Engagement, NHS GM that provided the Committee with the service reconfigurations planned or undertaking engagement and/or consultation. The report also included additional information on any engagement that was going.

The following update was noted:

- Adult Attention-Deficit/Hyperactivity Disorder (ADHD) - service assurance neared completion, with an NHS England outcome expected in weeks, allowing for a March 2025 NHS GM Board decision and a potential late March/early April 2025 consultation launch, pending approval, a Member briefing would be provided.
- In Vitro Fertilisation (IVF) Cycles (as above) - completed final NHS England assurance, with an outcome expected soon. This would allow a March 2025 Board decision for consultation, tentatively set for late March/early April 2025, pending approval, the Committee would receive a Member briefing after the Board's decision.
- Diabetes Structured Education - engagement was ongoing, with approximately two and a half weeks remaining. To enhance engagement, particularly with the Southeast Asian community, face-to-face and focus group sessions were being increased, as this community experienced diabetes at an earlier age compared to the general population.
- Procedures of Limited Clinical Value - engagement was scheduled to commence within the next couple of weeks. The finalisation of informational materials, was underway, with efforts focused on simplification and accessibility. The Committee would receive advanced notification, one week prior to the engagement launch, with all pertinent information, expected within the following one to two weeks.

Resolved/-

1. That it be noted that Alexia Mitton, Assistant Director of Communications and Engagement, NHS GM would provide the Committee with:
    - A Briefing Note on the Improving Adult Attention Deficit Hyperactivity Disorder (ADHD) consultation.
    - A written Briefing on the planned IVF Cycles consultation.
    - Information on the Procedures of Limited Clinical Value engagement.

2. That it be noted that the Committee reviewed the report.

JHSC/98/25 **ADHD Services for Children and Young People: Prioritising those Most In Need**

Consideration was given to a report presented by Sandy Bering, Strategic Lead Clinical Commissioner/Consultant (Mental Health and Disabilities) and Jane Case, Assistant Director of Mental Health Strategic Commissioning, NHS GM that updated the Committee on the work to date and next steps in the plans to improve children and young people's ADHD services.

It was explained that the report outlined a new strategy to enhance ADHD services for children and young people. The initiative arose from the recognition of a significant increase in ADHD prevalence, attributed to improved understanding and broader diagnostic criteria, rather than a physical change in the population. It was highlighted there was a critical need to shift from the unsustainable "first come, first served" model, exemplified by long waiting lists, towards a system that prioritised those with the most severe needs. Faced with a lack of clear national guidance, GM sought to develop its own solution, focusing on providing both timely diagnostic services and broader support for individuals experiencing related symptoms, regardless of formal diagnosis.

The proposed approach involved establishing single, clear points of access in each locality, creating hubs for comprehensive support, and delivering tailored interventions. Officers emphasised the importance of prioritising those with the most severe needs, acknowledging resource limitations and the necessity for face-to-face assessments. Extensive engagement with families and young people revealed a strong desire for practical support, rather than solely a diagnosis. The report detailed significant engagement efforts, ongoing collaboration with lived experience representatives, and alignment with national reports advocating for early intervention.

Officers stressed that this was an initial step in an ongoing process, with plans to adapt and expand the hubs based on experience and evolving needs. Underscored was the importance of integrating this initiative with wider developments in autism, speech therapy, and school-based support, citing successful programmes like Neurodiversity in Schools. Recognising the diverse needs across the region, the strategy aimed to implement tailored solutions in each locality, while also learning from best practices.

A Member noted that the report's strength lay in the detailed account of engagement activities. This detail, provided the necessary foundation for the proposed changes, particularly given the scale of the challenge being addressed.

A Member expressed concern over the backlog in children's ADHD diagnoses, questioning how NHS GM could effectively address the issue without a dedicated budget, especially given the reported surge in cases and the strain on schools. The Member asked if resolution was possible within three years, or if the problem would persist without significant funding. An NHS GM Officer, acknowledged the funding challenges but emphasised that the issue was also about cultural change and increased recognition, not just a surge in cases. Detailed were the efforts to reallocate existing resources, estimating £3.6 million, and stressed was the importance of societal understanding and support, arguing that most individuals with neurodevelopmental required different support. Highlighted was the need for broader societal changes and that the problem extended beyond health services, requiring collaboration with social care and education, and acknowledging the stress faced by families.

A Member proposed a vision similar to the approach taken with dyslexia, suggesting that primary schools become ADHD-friendly environments where support was readily available, minimising the need for formal diagnoses and the associated distress for children. NHS GM Officers fully agreed, emphasising the importance of early intervention and support within primary care, while also acknowledging the challenges of misdiagnosis following COVID-related social isolation. Highlighted was the need to consider teenagers and those already in the system, ensuring continuity of support, particularly regarding medication, through educational stages. The Officer stressed that medication should be a small part of a broader support system, rather than the primary or sole intervention offered.

The Chair expressed that the presented vision was aspirational and, requested information on managing the current waiting list, locality-level partnership work, and a summary of each locality's timescales and actions. The Committee voiced support for the approach. In response, an NHS GM Officers agreed to provide the requested information, and committed to providing updates and acknowledged the priority of addressing the waiting list.

Resolved/-

1. That it be noted that the Committee reviewed and endorsed the approach to improving ADHD services for children and young people across GM.
2. That it be noted that the Committee approved the plans to proceed with implementation based on the outlined model, with a commitment to ongoing engagement with stakeholders including professionals, across health, social care, as well as parents, carers, and young people.
3. That it be noted that NHS GM Officers provide information on managing the current waiting list, locality-level partnership work, and a summary of each locality's timescales and actions.
4. That it be noted that the Committee be provided with regular updates at appropriate opportunities.

JHSC/99/25 Work Programme for the 2024/25 Municipal Year

Consideration was given to the report of the GMCA Statutory Scrutiny Officer and Deputy Head of Governance, which provided Members with a draft Committee Work Programme for the 2024/25 Municipal Year.

Members were reminded that the Work Programme was a working document that would be updated throughout the year to reflect changing priorities and emerging issues.

Resolved/-

That it be noted that the Committee at the next meeting on 18 March 2025 would consider the Reconfiguration Progress report and Forward Look, an Elective Care Wait Times report and a report on the Wider Issue of Access.

JHSC/100/25 Dates and Times of Future Meetings

Resolved/-

That it be noted that the next meeting was scheduled to take place on 18 March 2024 at 10.00 am, Boardroom, GMCA.

GMCA GREATER MANCHESTER COMBINED AUTHORITY

Greater Manchester Joint Health Scrutiny Committee

Date: 18 March 2025

Subject: Elective Recovery Update

Report of: Dan Gordon, Programme Director Elective Recovery, NHS GM

Purpose of Report

The purpose of this report is to update the Committee on the current position for Elective Care across GM, describe the performance of the system in terms of data and trends, highlight driving factors for current challenges and describe the key components of the GM Elective Recovery Plan

Recommendations:

The Committee is requested to:

1. Recognise the improvement made on long-waiting patients and the scale of the challenge to improve access and reduce the waiting list size
2. Support cross-cutting system programmes being taken to improve access across the system and at local provider level

Contact Officers

Dan Gordon, Director Elective Recovery & Reform Programme (Dan.Gordon1@nhs.net)

Equalities Impact, Carbon and Sustainability Assessment:

N/A

Risk Management

N/A

Legal Considerations

N/A

Financial Consequences – Revenue

N/A

Financial Consequences – Capital

N/A

Number of attachments to the report:

0

Comments/recommendations from Overview & Scrutiny Committee

N/A

Background Papers

The data provided in this report have been calculated from Regional and National performance briefings as well as directly from Waiting List Minimum Data Set submissions from NHS Providers across GM

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 n/a

Elective Recovery Update

1. Background: context on elective care

Elective care waiting times began to deteriorate across England in the early 2010s, with a marked reduction from around 2015 and were then progressively worsening up to the start of the pandemic. In Greater Manchester (GM) almost 92% of patients began treatment within 18 weeks in December 2015 but by February 2020 this had fallen to 78%, during this time the elective waiting list had increased almost 50% (from 194,000 in December 2015 to 284,000 in February 2020).

The pandemic accelerated this deterioration. At the start of the pandemic doctors and nurses from elective services were trained and directed to support across the hospital, as elective services were stood back up ongoing safety measures meant fewer patients could be seen in outpatients and theatres, and then later waves of COVID led to periods of reduced elective capacity as staff were moved to cover for colleagues experiencing high rates of sickness. Whilst referrals had initially dropped, they recovered to pre-pandemic levels faster than elective capacity and this meant that for eighteen months new demand was higher than elective capacity.

The impact of the pandemic on elective services was more pronounced in GM. The region was impacted more than the England average, spending a longer period in lock-down and with higher rates of COVID than the England average. The GM elective waiting list size increased from 284,000 in February 2020 to 500,000 by September 2022, following some fluctuation it has since stabilised.

Recovery was hampered by the period of NHS industrial action 2022 to 2024. Industrial action led to reduced levels of elective activity through to 2024. Activity in 2024-25 has bounced back and increased by around 10%, and this has led to most hospitals beginning to reduce waiting lists, however, demand has also increased by around 15% compared to 2022-23 meaning the rate of recovery is slower than otherwise would have been.

A number of specialties in GM are particularly challenged with long waiting times. These include but are not limited to Dermatology, Ear Nose and Throat (ENT), Orthopaedics, Oral Surgery, Gynaecology and Paediatric ENT. These follow a similar national and regional trend.

2. Current Performance: data on wait times, comparisons, and trends

GM has driven one of the fastest and sustained reductions in long-waiting patients of any ICB and has moved from being a significant outlier for long-waiting patients to the England average. In January 2023, GM had more than 15,000 patients waiting over a year and a half but this figure reduced to almost zero by March 2024. In August 2023, GM accounted for 1 in 6 (16%) of all patients in England waiting over 65 weeks but we have been able to reduce this to 1 in 25 (4%) with actual numbers falling from 16,000 to a couple of hundred. Patients waiting over a year has fallen 60% over the same period, exceeding the improvement rate across England.

Most patients in GM start treatment within 18 weeks, but despite some improvement our overall performance against this standard is still amongst the lowest in England. As of November 2024, 53% of patients were waiting below 18 weeks. This is the fourth worst of the 42 ICBs in England. However, wait times vary between providers and specialties. 67% of patients in Tameside are waiting less than 18 weeks compared to 48% at Manchester University NHS Foundation Trust (MFT). Across GM 60% of Ophthalmology patients wait less than 18 weeks, compared to Dermatology and Oral Surgery at 44%.

For 2025-26 hospital trusts are required to see at least 60% of all patients in 18 weeks or if already meeting 60%, improve by 5 percentage points. For GM this translates into an overall improvement from 53% to 61% (Table 1) whereas most ICBs need to improve by 5% overall. To meet the government’s target of 92% patients waiting less than 18 weeks by March 2029, GM will need to improve at twice the rate of the best performing ICBs for the next four years.

Table 1: 25-26 18 week planning target per NHS provider by March 2026

Provider	Nov-24 baseline performance	March-26 target
MFT	48%	60%
NCA	52%	60%
Bolton	54%	60%
WWL	52%	60%
Stockport	54%	60%
Tameside	67%	72%
Christie	97%	97%
GM	53%	61%

3. Contributing Factors: analysis of causes

GM began the pandemic with a deteriorating elective performance that was worse than the England average and had a worse experience of COVID than much of England. Through this time demand for services has grown, particularly in some of the most challenged specialties. For instance, Dermatology, ENT, Oral Surgery, Gastroenterology and Gynaecology all experienced faster than average increases in demand for suspected cancer referrals - and since patients are treated in the same capacity as routine referrals, this effectively crowds out these referrals who then go on to wait for extended periods. The increase in demand has been exacerbated by other significant issues such as estates/capital constraints and workforce challenges.

Elective recovery has been faster in some specialties than others linked to specific factors impacting different specialties. Paediatric services have not recovered as fast as adult services, with particularly acute issues in Paediatric ENT and Paediatric Dentistry. These are specialist areas with a limited workforce, have experienced growing demand due to external factors such as the lack of access to NHS dentistry and poor oral health in some areas of GM, and significantly reduced activity during COVID due to infection control measures in these specialties.

The Independent Sector (IS) in GM has focused on treating a narrow range of conditions, particularly in Ophthalmology and Orthopaedics, meaning the most challenged specialties had no IS capacity to support recovery. More complex patients who cannot be treated by the IS are seen in the NHS and this impacts the productivity of NHS services (such as through a high short-notice cancellation rate

due to patient ill-health). Further, driven by social and economic inequalities, GM patients typically present with worse underlying health than patients in other regions and this impacts where patients can receive care.

Productivity is a challenge but there are different contributing factors. Whilst elective activity is 10-15% above pre-pandemic level, workforce levels are higher and overall productivity has not kept pace with the national economy (although the NHS had exceeded wider productivity growth in the 2010-2017 period). Under-investment in capital is one driver but other factors such as the changing seniority of clinical staff (due to increased retirement/reduced hours), reduced willingness to undertake discretionary work amongst staff and non-elective pressures are all significant.

Finally, whilst GM has a range of hospital providers, patients typically opt for their local hospital and are not choosing hospitals with the shortest waits. Some of this is driven by a lack of visibility for patients of accurate waiting times through the patient choice process and this is a key area of focus for 2025-26.

4. Impacts: consequences for patients' health and well-being

Research indicates that prolonged waiting times can negatively impact patients' health-related quality of life and psychosocial well-being. Studies assessing the impact of waiting for elective general surgery found that longer waiting periods are associated with worse general health perceptions and more problems in quality-of-life domains. Longer waiting times can lead to disease progression necessitating more complex and costly treatments as well as higher rates of employee absenteeism contributing to decreased economic productivity. Delays in care can lead to other developmental issues, particularly in paediatric patients.

These issues are considered in clinical prioritisation, and whilst patients are treated in wait time and clinical priority order, they aren’t always able to be seen in the clinically indicated time-period. The increase in the proportion of clinically urgent patients and their prioritisation is one driver of the subsequently longer waits for routine patients.

5. Actions Being Taken by providers: overview of current plans and their effectiveness

As part of 25/26 planning, elective funding has been set at a ceiling slightly below 24/25 and despite having a bigger elective challenge than the national average, GM will not receive any further national funding. GM are reviewing elective funding in the round whilst hospitals are working to increase activity through productivity.

Hospital providers are working on a range of plans in line with the Elective Reform Plan and include:

- **Increasing Outpatient productivity** through review of clinic templates, job planning, reduction of Did Not Attends (DNAs) and increased use of alternative pathways such as Patient Initiated Follow-Up (PIFU)
- **Driving overall theatre productivity across all sites** through a focus on pre-op pathways, reducing short-notice patient cancellations and through a GM-wide service to share knowledge, expertise and innovative practice across all parts of the surgical pathway
- **Use of digital to undertake validation of waiting lists** ensuring patients waiting to be seen are waiting for the right care and not waiting unnecessarily

6. Recommendations

To increase access to elective services it is recommended that GM focus on several cross-cutting programmes, including:

- **Development of a single point of access that utilises digital technology for elective referrals in GM** to provide 'air traffic control' functionality, supporting patient choice and optimisation of pathways
- **Development of a GM-wide specialist advice service** to support primary care to continue to treat patients, where safe and appropriate to do so
- **Expanded access to community services using a tiered care model approach** focusing on Dermatology, Gynaecology, ENT and Gastroenterology in 25/26, ensuring consistency of commissioning across all localities in GM
- **Optimising use of surgical hubs and Community Diagnostic Centres** to support treatment of patients across GM

GM localities are asked to support on these areas through local elective programmes of work.

7. Summary

GM has made significant progress on reducing the number of patients waiting a very long time for treatment, improving faster than the rest of England, but still has a lot of work to do on the total waiting list size and the average waiting times for patients.

For GM to return to the constitutional standards for elective care by March 2029 it needs to improve at twice the rate as the best performing ICBs but NHS finances for 25-26 mean GM will not receive extra funding to do this.

The Elective Programme in GM is working on interventions that drive recovery as a system-wide effort, including patients and health care providers at all levels. Hospitals are maximising their elective activity through productivity and incremental pathway improvements. Collectively, this aims to increase the proportion of patients seen in 18 weeks to 60% by March 2026.

Greater Manchester Joint Health Scrutiny Committee

Date: 18 March 2025

Subject: Monthly Service Reconfiguration Progress Report and Forward Look

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

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

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 No

Not applicable

Overview and Scrutiny Committee

18th March 2025

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 is 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 *Proposed Consultation*	NHS GM Board	This project has successfully completed the NHS England assurance process and is due at the NHS Greater Manchester Board in March (subject to change) for a decision on whether to proceed to consultation. A written briefing on the planned consultation will be provided to GM JHS. Date of JHSC: 16th July 2024
Children's ADHD *Engagement*	Implementation	There are currently long waiting times for children's ADHD diagnosis services. Engagement ran for 9 weeks and closed on 8th December 2024. Analysis of the engagement is completed and the project is going through governance for implementation. Date of JHSC: 18th February 2025
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. The next stage is a review by NHS GM's Board. 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*	NHS England Assurance	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. The project is preparing for NHS England Gateway 2. **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. 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 2025 (TBC)
Diabetes structured education *Engagement*	Engagement report	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. 8 weeks of engagement ran from January to March and the report is currently being drafted. Date of JHSC: April 2025 (TBC)
Safe and Sustainable Specialised Services for Babies and Children (re-named) *Engagement followed by possible consultation*	Preparing for engagement	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. Engagement is being planned for Neonatal Critical Care which is expected to be the first to go to engagement. NB: North West footprint for this work, scrutiny arrangements are to be agreed.

Procedures of Limited Clinical Value *Engagement*	Engagement planning	Procedures of limited clinical value are medical procedures that the evidence shows will not have a positive impact on most people. Therefore, they are only recommended in certain circumstances. The treatments are currently being audited and engagement is being planned to support any future review. Date of JHSC: 10th December 2024 / 21st January 2025
Major Trauma *Engagement*	Engagement planning	Major trauma services are very specialised services for people who have a one in lifetime event – e.g. major road traffic accidents. Following a review of whether the specialised services for major trauma meet the required specification, further work is being undertaken to consider how the service can be best delivered. Date of JHSC: 18th March 2025

Greater Manchester Joint Health Scrutiny Committee

Date: 18 February 2025

Subject: Greater Manchester Patient Access - Primary and Urgent Care

Report of: Katherine Sheerin – Chief Commissioning Officer, NHS Greater Manchester

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Purpose of Report

To provide an update on primary and urgent care access to the Greater Manchester Joint Health Scrutiny Committee.

Recommendations:

The GMCA is requested to:

1. Recognise the ongoing work to support patient access to GP services in Greater Manchester.
2. Support measures to work with local people to ensure awareness of services available.

Contact Officers

Ben Squires – Director of Primary Care – NHS Greater Manchester; ben.squires@nhs.net

Gill Baker – Greater Manchester Urgent and Emergency Care Director: gill.baker5@nhs.net

Katherine Sheerin – Chief Commissioning Officer, NHS Greater Manchester: katherine.sheerin@nhs.net

Equalities Impact, Carbon and Sustainability Assessment:

It is recognised that people from disadvantaged backgrounds access health services at a later stage of illness. Whilst it is imperative to improve prevention and proactive care for all GM communities, it is also crucial to ensure that urgent care is available when needed. As such, services need to be easy to understand and access appropriately. To support practices to address health inequalities and support diversity in access to services there are ongoing quality initiatives around training and awareness, specifically in regard to LGBTQ+ communities and Black communities.

Risk Management

N/A

Legal Considerations

Delivering and improving primary care and urgent care services are part of the statutory delegated functions of NHS Greater Manchester.

Financial Consequences – Revenue

Financial consequences and healthcare budgets fall within the responsibility of NHS Greater Manchester (Integrated Care Board). Ensuring the right balance of prevention, primary care and urgent care is critical to delivery of the NHS GM Sustainability Plan which offers a financially balanced system focused on improving health outcomes.

Financial Consequences – Capital

N/A

Number of attachments to the report:

N/A

Comments/recommendations from Overview & Scrutiny Committee

N/A

Background Papers

1. Delivery Plan for Recovering Access to Primary Care: www.england.nhs.uk/publication/delivery-plan-for-recovering-access-to-primary-care/
2. Greater Manchester Primary Care Blueprint: www.gmintegratedcare.org.uk/primary-care/

3. Implications of Language Barriers for Healthcare: A Systematic Review (Shamsi et al. 2020): www.pmc.ncbi.nlm.nih.gov/articles/PMC7201401/pdf/OMJ-35-02-1900033.pdf
4. Experiences of NHS healthcare services in England (ONS): www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/datasets/experiencesofnhshealthcareservicesinengland
5. Nest steps for integrating primary care: Fuller Stocktake Report (NHS England): www.england.nhs.uk/wp-content/uploads/2022/05/next-steps-for-integrating-primary-care-fuller-stocktake-report.pdf
6. Summary letter from Lord Darzi to the Secretary of State for Health and Social Care (DHSC Independent Report): www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england/summary-letter-from-lord-darzi-to-the-secretary-of-state-for-health-and-social-care
7. GMICP | Greater Manchester Integrated Care Partnership
8. Greater Manchester Health and Social Care Partnership (GMHSCP), "Greater Manchester Health Trends," 2023
9. Joint Forward Plan | Greater Manchester Integrated Care Partnership
10. King's Fund, "Impact of Primary Care Access on A&E," 2022
11. NHS England » 2025/26 priorities and operational planning guidance
12. NHS England » Neighbourhood health guidelines 2025/26
13. Office for National Statistics (ONS), "Greater Manchester Demographic Data," 2023
14. Public Health England, "Health Inequalities in Greater Manchester," 2022
15. Urgent and emergency care survey 2024 - Care Quality Commission

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?

N/A

GM Transport Committee

N/A

JHS Overview and Scrutiny Committee

18 March 2025

1. Introduction

This report provides an overview of access to primary care and urgent care services for the people of Greater Manchester. Each element is considered separately, and then recommendations are drawn together. It should be highlighted that because the Committee received a comprehensive report on access to GP Services at its February meeting, the primary care element concentrates on access to the other primary care providers – pharmacists, dentist and optometrists.

In order to help Committee members to navigate the report, it is set out in four sections as follows:-

Section 1: General Practice

Section 2: Pharmacy

Section 3: Dentistry

Section 4: Urgent Care

Section 5: Recommendations

Section 6: Glossary of Terms

SECTION 1

GENERAL PRACTICE

Background: **Access to General Medical Services**

The Committee received report on GP Access in February 2025. Key points from this report include:

> 78.3% of respondents in GM reported that their overall perception of experience of their GP practice (for those who tried to contact the practice within the last 28 days) was good. 14.9% said it was neither good nor bad and 6.9% reported their experience as poor (Office for National Statistics (ONS) Health Insights Survey reported on 30th January 2025).

> GP practices across Greater Manchester have continued to deliver increased numbers of appointments since 2019, with 1.37m appointments delivered within 14 days in the month of October 2024 alone. For all GP appointments delivered in October 2024, the figure is 1.79m. Whilst the data indicates seasonal dips in appointment counts, data from December 2024, shows an increase of nearly 20,000 appointments delivered within 14 days compared to December 2023.

As work continues into 2025/26 to improve GP access, it was noted that the Committee suggested that additional indicators considered to provide a more comprehensive view of GP access and quality should include a focus on patient health outcomes, using a holistic view of all services provided, and considered the impact on individual patients, their families, and the wider community.

To build upon this previous GP Access report received by the Committee, this report provides a focus on primary care access to community pharmacy and NHS dental services and urgent emergency care (UEC).

SECTION 2

PHARMACY

2.1 Background

Health and Wellbeing Boards (HWBs) in England hold statutory responsibility to publish and keep up to date a statement of the needs for pharmaceutical services of the population in its area, referred to as a pharmaceutical needs assessment (PNA). PNAs are used by the NHS to make decisions on which NHS funded services need to be provided by local community pharmacies.

PNAs across Greater Manchester have historically recognised that local provision of community pharmacy across the region have been higher than the national position. However, recent years has seen a reduction in the numbers of community pharmacy branches, reflecting national trend. There is currently review of needs assessment taking place across the GM HWBs to update published PNAs.

Greater Manchester currently has **622 branches** of which 51 are distance selling pharmacies

This compares to position in March 2023 with 638 branches of which 15 were distance selling pharmacies at that time.

It has been well documented in the media that community pharmacy providers have faced significant pressures, resulting in a number of closures across the country. There has been particular focus on closures of branches previously delivered by Lloyds This has been particularly notably corporate provision by Lloyds Pharmacies and Boots. Greater Manchester has not been exempted from the impact of these national pressures. However, a number of potential closures have been mitigated by change of ownership and through consolidation of services between two branches in close proximity (for example an application for consolidation in February was between two branches 40 metres apart).

There has been an increase in the number of Distance Selling Pharmacies (DSPs often known as 'Internet Pharmacies') situated within Greater Manchester. These providers offer pharmaceutical services nationwide, but by virtue or proximity supplement local provision. However, it should be recognised that national regulations restrict the provision of face-to-face services by these pharmacies.

Community Pharmacy services are governed by the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. As a primary care provider, community pharmacy is well-known as a dispenser and retailer of medicines, but its role is in fact much broader and includes other NHS and publicly funded services.

NHS patient services delivered by Community Pharmacy include a number of national clinical services:

- Pharmacy First (PF)
- Pharmacy Contraception Services (PCS)
- Hypertension Case Finding (HCF)
- Discharge Medicines Service (DMS)
- Seasonal Vaccination services (Influenza and Covid)

There are also a number of services locally commissioned within Greater Manchester which include:

- Minor Ailments Service (MAS)
- Smoking Cessation Services (SCS) – referred by acute and mental health trusts

To further develop the service, offer of community pharmacy, NHS GM has also engaged in service pilots for:

- Independent Prescribing Pathfinder programme
- MMR vaccination
- Early Cancer Diagnosis
- Electronic prescribing by secondary care services

There are also a number of public health services which are commissioned from community pharmacy by local authorities, such as supervised methadone consumption, needle exchange, smoking cessation and sexual health services.

NHS delivery of clinical services is seen as an important contribution in supporting patient care and reducing demand for GP appointments. Nationally the role of community pharmacy is recognised as part of the Primary Care Access Recovery Programme (PCARP).

As part of the PCARP saw the introduction of national service developments whereby:

- Pharmacy oral contraception (PCS) and blood pressure (HCF) services were expanded and re-launched in December 2023, to increase access and convenience for millions of patients, subject to consultation.

– Pharmacy First was launched in January 2024, whereby community pharmacies are able supply prescription-only medicines for seven common conditions.

Through the introduction of Pharmacy First, the contraception and hypertension services it was anticipated that NHS services could potentially save 10 million appointments in general practice a year.

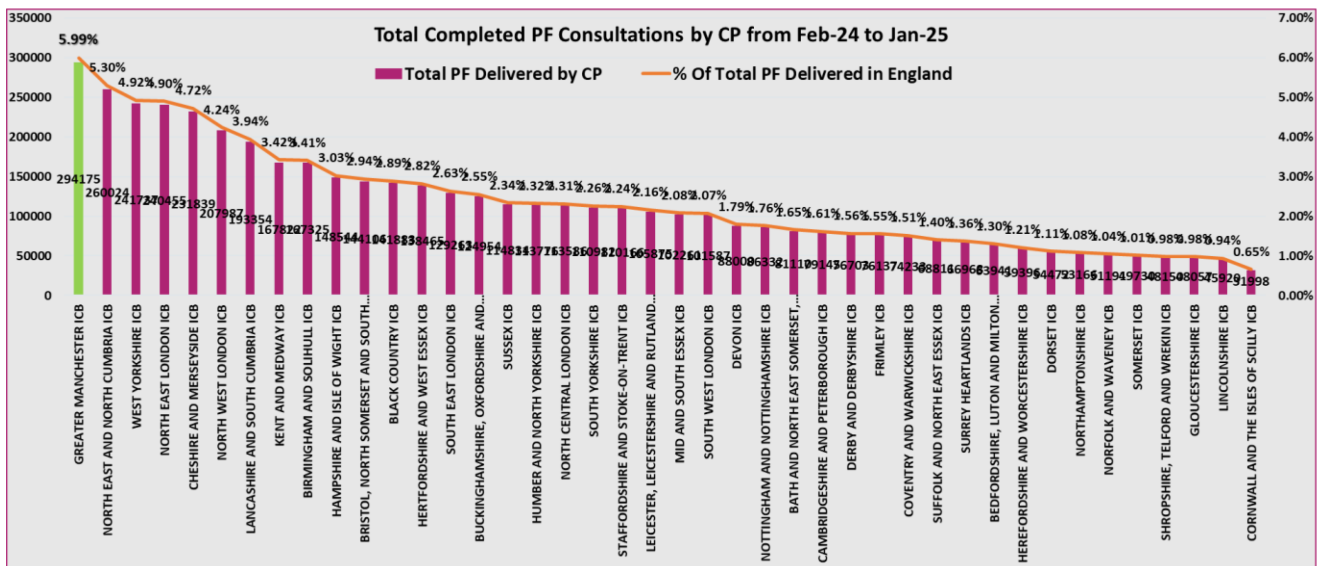
2.2 Pharmacy First

The nationally commissioned Advanced Service: 'Pharmacy First', launched on 31st January 2024 replaced the Community Pharmacist Consultation Service (CPCS). The new service consists of 3 elements: Clinical Pathways, urgent repeat medicines supply and NHS referrals for minor illness.

The 'Clinical Pathways' element includes 7 new clinical pathways which enables patients to be referred, or self-refer, to a community pharmacist for advice and first line treatment for a series of conditions: acute otitis media, acute sinusitis, acute sore throat, impetigo, infected insect bites, shingles and uncomplicated urinary tract infections (UTIs) in women.

Greater Manchester has the highest number of Pharmacy First "completed" consultations across the 42 ICBs in England, at 211,713 since the scheme formally began in January 2024. Work continues to further increase consultation numbers, including engagement with general practices less actively referring into the service and further supporting those /who are. This is to ensure that all suitable patients are referred to community pharmacy to create capacity for general practice to see patients with more complex needs.

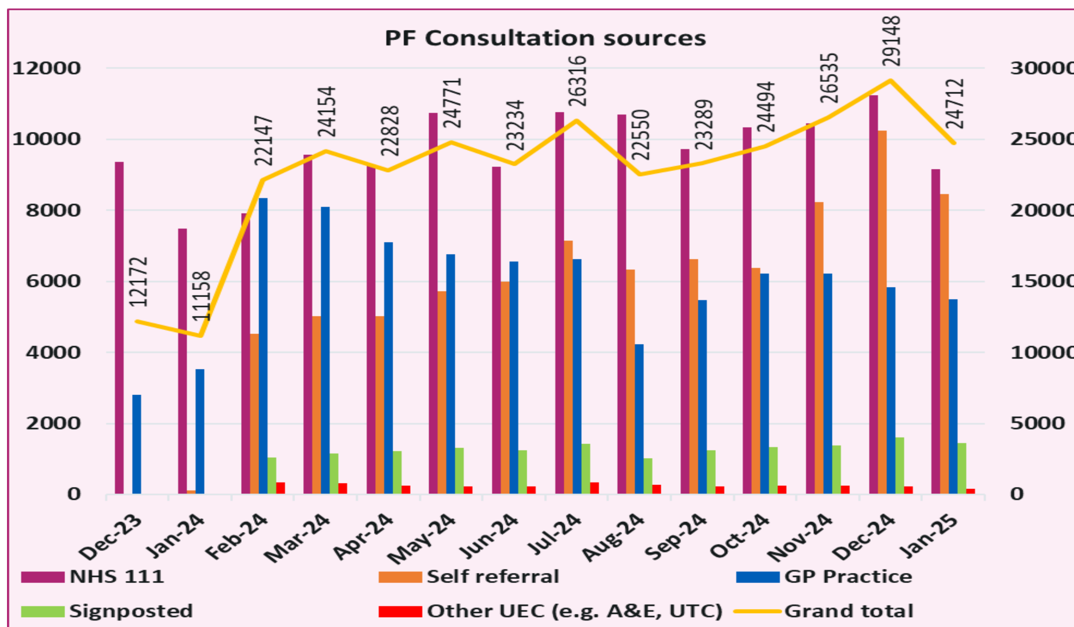
Figure 1: Pharmacy First activity across 42 ICBs (Feb 24 – Jan 25)



Community Pharmacies can receive referrals from a series of routes, such as via General Practice, through walk-ins, via the UEC system and NHS 111.

There is work to progress across Greater Manchester to embed opportunity of referral from UEC services into Pharmacy First services across Community Pharmacy. This will reduce demand at Urgent Treatment Centres and A&E, providing more convenient and appropriate care for patients.

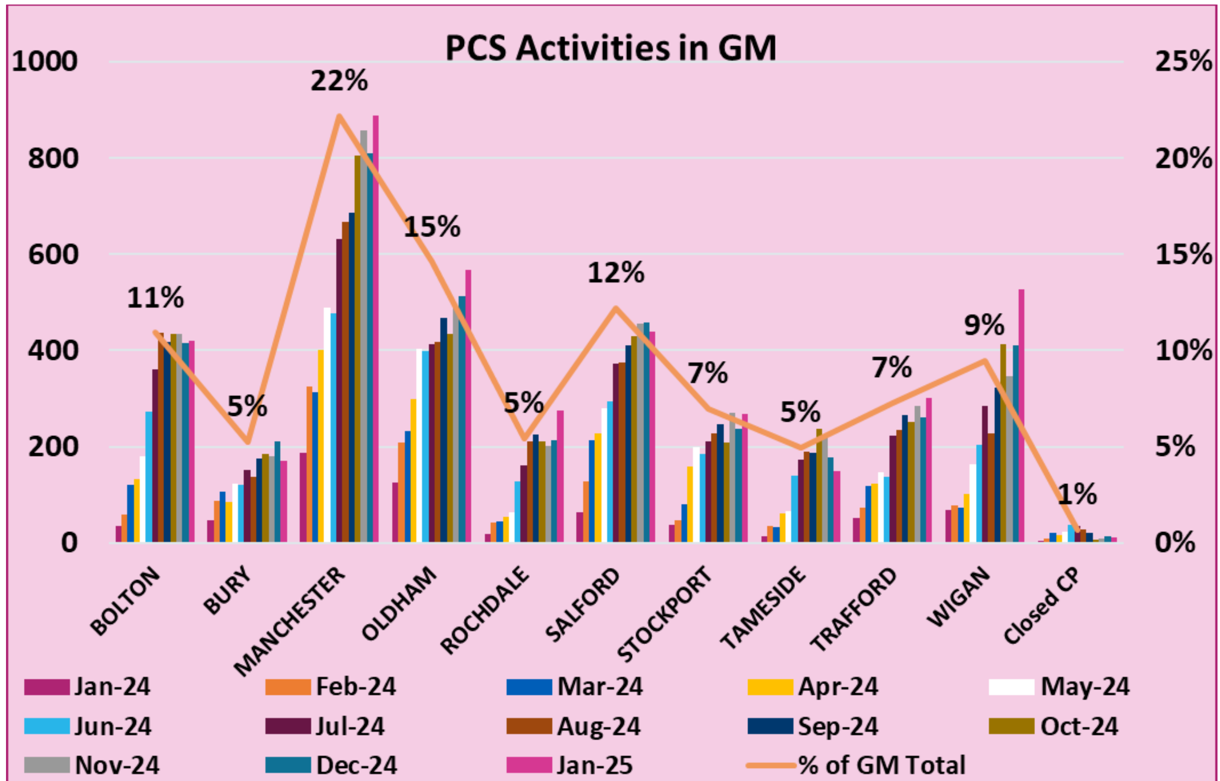
Figure 2: Pharmacy First Consultation Sources (Dec 23 – Jan 25)



Pharmacy Contraception Services

Initiation of contraception by community pharmacists became part of the service in December 2023. The following graph indicates provision of this service across the GM localities.

Figure 3: Contraceptive Services activity across GM (Jan 24 – Dec 24)



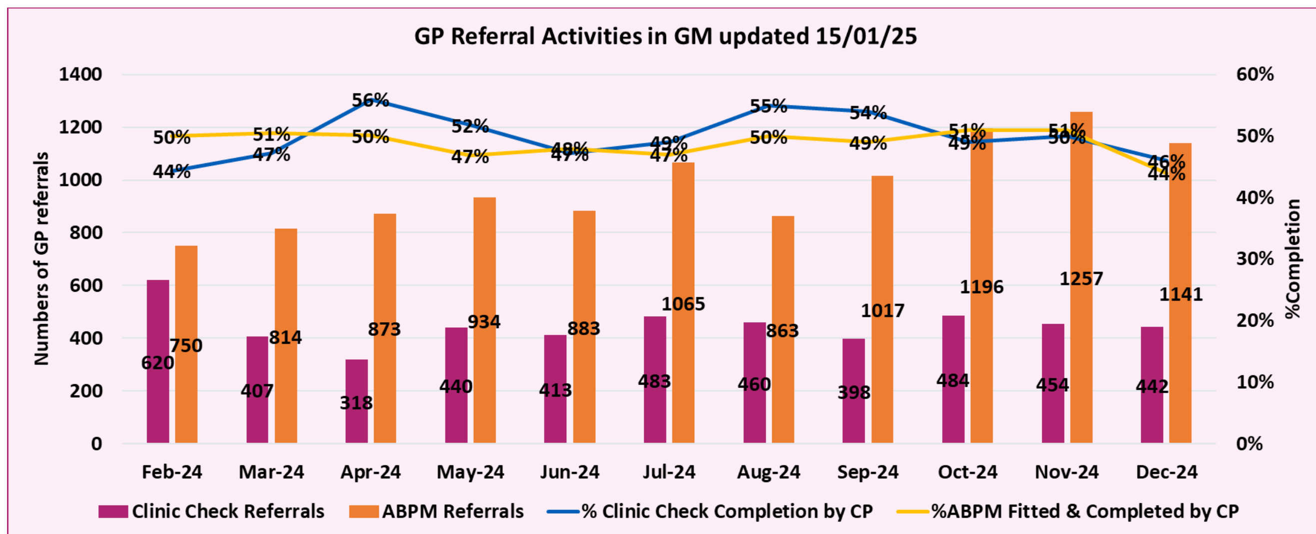
2.3 Hypertension Case Finding

Cardiovascular disease is a critical clinical risk for the population of Greater Manchester. The increased capacity to identify patient risk through hypertension case finding by community pharmacy contributes to the prevention approach within GM.

575 (95%) GM community pharmacies were registered to provide the service up as of 30th December 2024.

GPs can refer any patient requiring a Blood Pressure (BP) check or Ambulatory Blood Pressure Monitoring (ABPM) using EMIS local services button. Patients requiring follow-up by their GP are notified by electronic message, clearly stating the urgency of the follow-up dependent upon BP reading. Activity is set out in the table below.

Figure 4: GP referrals to Blood Pressure checks and ABPM delivered by pharmacies in Greater Manchester (Feb 24 – Dec 24)



"**The blood pressure service finder**" is a patient facing website supporting the public to find a pharmacy which offers NHS free blood pressure services, utilising a post code search tool.

> **www.nhs.uk/nhs-services/pharmacies/find-a-pharmacy-that-offers-free-blood-pressure-checks/**

2.4 Discharge Medicines Service (DMS)

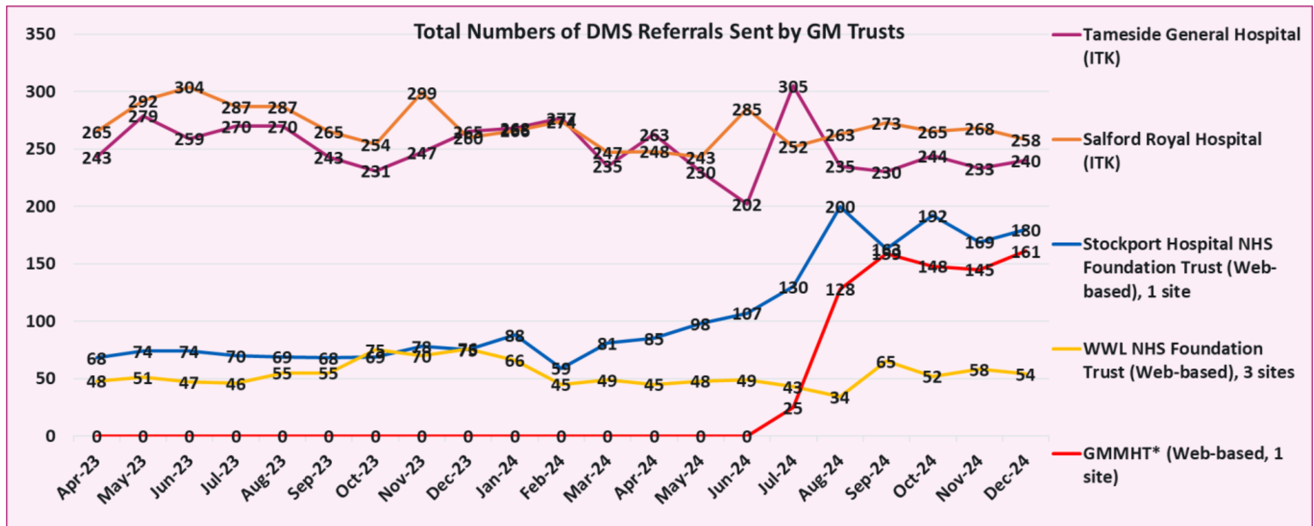
Hospital services are encouraged to consider referral of patients who are admitted to hospital who would benefit from support with their prescribed medicines post discharge.

There are three stages of service provided by community pharmacy:

- Stage 1 comparison of discharge summary to any meds awaiting collection in the pharmacy
- Stage 2 comparison of discharge summary to first Rx received post-discharge
- Stage 3 consultation with the patient

This service is an evidence-based intervention which improves compliance to prescribed medicines and reduces readmission to hospital. Activity is set out as follows:-

Figure 5: DMS referrals by GM Trusts (Aug 23 – Dec 24)



2.5 Minor Ailments Services (MAS)

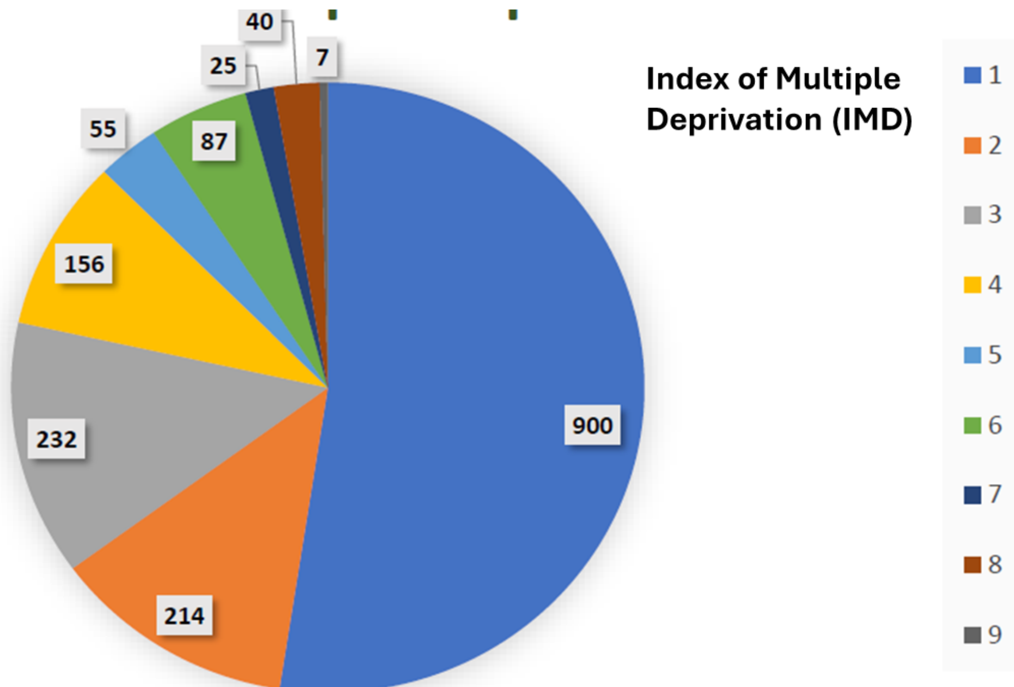
The Minor Ailment Service supplies patients NHS-funded medicines from a restricted formulary for minor ailments such as headlice, constipation and thrush.

This locally commissioned service complements the national Pharmacy First service where a supply can be made under the locally commissioned service following a referral from general practice, reducing escalations back into general practice to request a prescription in circumstances where the patient cannot (or will not) pay for medicines over the counter.

Legacy commissioning arrangements across GM from pre-2023 presented variable arrangements whereby services in some localities delivered to all patients who do not pay for prescriptions, some locality services were just for patients with certain prescription exemptions and some localities had no service. Through response to winter pressures, NHS Greater Manchester has established a consistent service model for the GM population.

Analysis of delivery during December 2024 strongly indicates that this local commission by NHS GM addresses inequalities across the region, whereby more than 75% of MAS activity was delivered by pharmacies in the most deprived areas of Greater Manchester.

Figure 6: Comparison of activity in Dec 2024 vs Index of Multiple Deprivation (IMD)



SECTION 3

DENTISTRY

3.1 Background

Patients are not registered with a General Dental Practice (GDP) in the same way as they are with a GP. Any patient may access dental services from any practice in any area. The spend on NHS Dental Services across Primary, Secondary and Community services in Greater Manchester is in the region of £225 million per annum.

In Greater Manchester there are:

- 347 Primary Care NHS Dental Contracts.
- 2 GM Urgent Dental Care providers delivering through 13 sites linked across networked provision for Greater Manchester. Patients can access urgent dental care at any of the sites across GM by ringing the UDC helpline on 0333 332 3800.
- 37 Urgent Dental Care Hubs that provide additional urgent dental care capacity, which were introduced in response to pressures during the COVID 19 pandemic but have been sustained as demand for urgent dental care access has remained high. Currently these are planned to operate until at least March 2024.

Specialised Dental Services

Community Dental Services (special care and paediatric) clinics delivered by Bridgewater Community Healthcare NHS FT, Northern Care Alliance, and Manchester Locality Care Organisation (MFT) – commissioned to provide specialist dental services to children and adults with additional needs on referral with clinics located within the community.
There are also 40 orthodontic primary care provider contracts and 10 specialist 'Tier 2' contracts for the provision of oral surgery on referral.

Secondary Care Dental Services

12 dental specialities (including Oral Surgery, Maxillofacial Surgery, Restorative Dentistry, Paediatric Dentistry, Periodontics) are available in Greater Manchester, commissioned from Manchester University NHS Foundation Trust, Northern Care Alliance NHS Foundation

Trust, Bolton Foundation Trust, Wigan Wrightington and Leigh Foundation Trust, Stockport NHS Foundation Trust, and Tameside and Glossop NHS Foundation Trust.

3.2 Improving Access to NHS Dentistry

On 7 February 2024 the government announced the national Dental Recovery Plan to be implemented from March 2024.

The national Dental Recovery Plan was launched in February 2024 and is focused on three areas:

- Prevention: For local government to implement focussing on oral health improvement, working with schools and family hubs.
- Access: Credited practice with a new patient activity tariff when they see patients who have not accessed services in the previous two years. This New Patient Premium is delivered within the established contracted activity and payments rather than directly attracting additional payment.
- Workforce: Mirror existing schemes in other contractor areas to support practices to recruit, such as 'Golden Hello's', expand skill mix to increase therapists and hygienist scope of practice.

3.3 Greater Manchester Dental Quality Access Scheme

The Greater Manchester Dental Quality Access Scheme was launched June 2023 and at present there are 149 Practices (43% of GM general dental contracts) are signed-up to deliver this scheme. The scheme was developed to support and sustain practices in being able to offer new patient and urgent care access.

The scheme has continued in 2024/25 and up to19 February 2025 delivered access for 72,731 patients new to the practices and 63,319 urgent appointments. Sadly 16,233 patients failed to attend for new patient or urgent care appointments in this period at participating practices.

The table below shows total number of new and urgent patients see under the scheme over 2023/24 and 2024/25 as well the number of patients that had appointments booked but then failed to attend.

Figure 7: Greater Manchester - number of patients seen under the GM Dental Quality Access Scheme

	2023 / 2024	01/04/24 -19/02/2025
New Patients Seen	105,135	72,731
Urgent Patients Seen	96,119	63,319
Patient Failed to Attend	20,761	16,223

The result of GM practices being signed up to these schemes has resulted in strong performance delivery of contracted activity, with more than 68% of contracts delivering more than 80% of their contracted Units of Dental Activity (UDAs) for the period up to September 2024, higher than 58% which is the national average position. Similarly, less than 3% of GM dental practice had delivered less than 30% of their contract in this period, compared with 6% nationally.

National access to NHS dental services was significantly impacted by the Covid pandemic. Services have continued to recover and access levels for the population are returning to pre-pandemic levels. However, there continues to be variation across the Greater Manchester localities. Through an oral health needs assessment, considering local service capacity, travel distance for services and epidemiology indication of oral health status, is being undertaken to inform possible future commissioning of dental services to address inequalities in dental access.

The following graphs provide indication of access levels across Greater Manchester.

FIGURE 8: Patient Access for Greater Manchester (Patients seen in previous 24 months)

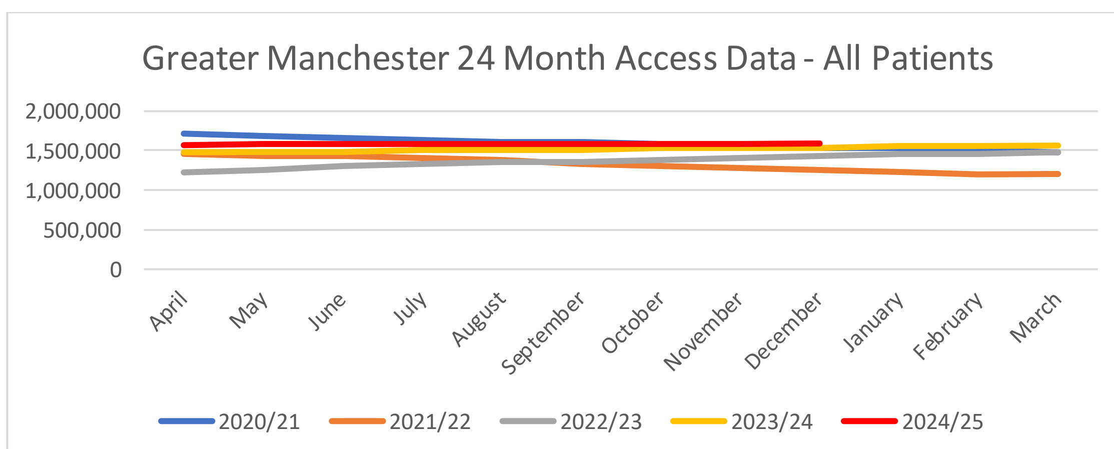


FIGURE 9a: Adult patients seen in the previous 24 months as a percentage of Local Authority population

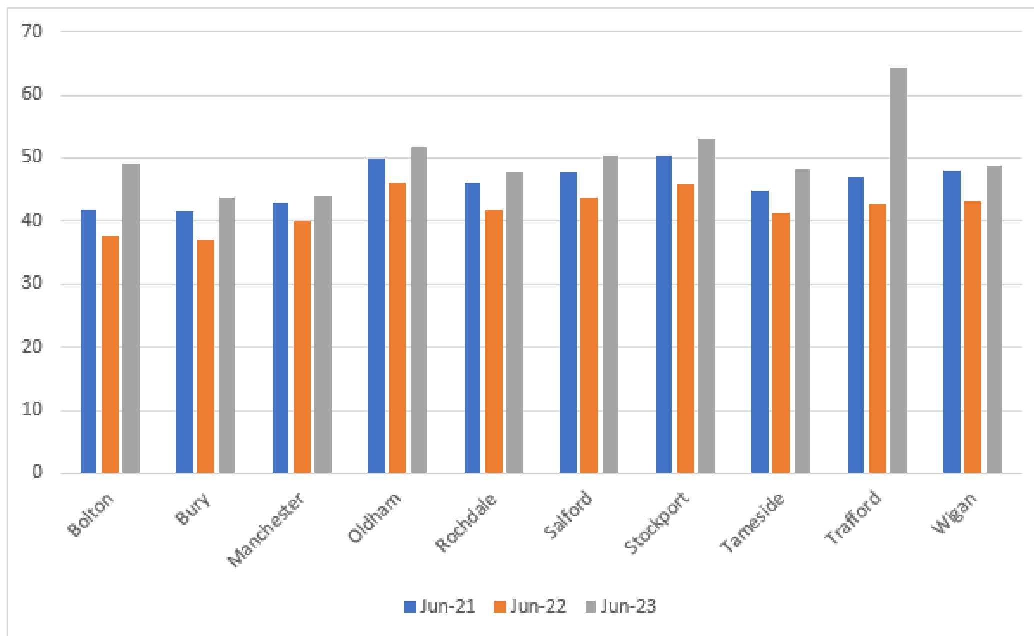
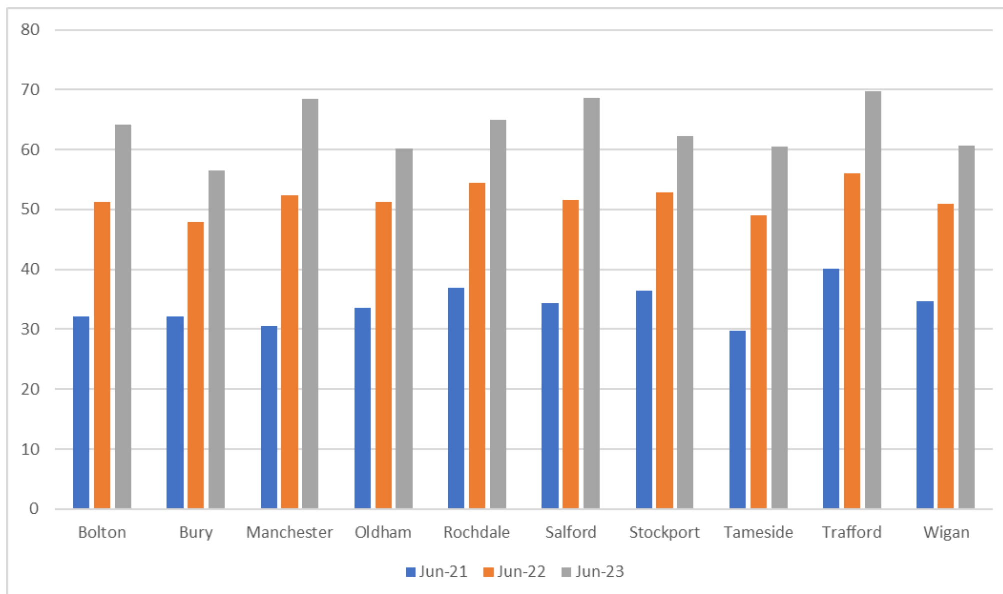


FIGURE 9b: Child patients seen in the previous 12 months as a percentage of the Local Authority population



3.4 Access to Urgent Dental Care

Dental practices offer urgent dental care to their patients.

For members of the public who do not have a regular dental practice, the Greater Manchester Dental Helpline (0333 332 3800) provides advice and clinical triage, booking patients into appointments with Urgent Dental Care services across GM.

Urgent Dental Care is available across Greater Manchester from 8am to 10pm 365 days per week including Bank Holidays. The service is provided according to strict clinical criteria, patients are assessed by a clinical member of the team via telephone and will be offered a face-to-face appointment once triage has been completed.

Urgent dental problems include the following conditions:

- Dental and soft-tissue infections
- Severe dental and facial pain: that is, pain that cannot be controlled by the patient following self-help advice
- Fractured tooth or teeth

The dedicated urgent dental care service operates from 13 different locations across Greater Manchester and patients can choose to be seen at the location most convenient for them.

In addition to the dedicated service, a network of dental practice across GM offers urgent dental care appointments available through the Dental Helpline. This network of providers are known as Urgent Dental Care (UDC) Hubs. The UDC Hubs currently deliver approximately 17,000 appointments for urgent dental care per year.

The government has an explicit manifesto to deliver an additional 700,000 urgent dental care appointments nationally. NHS GM is currently reviewing local arrangements in order to comply with this commitment, taking consideration of emerging NHS planning guidance.

SECTION 4:

URGENT AND EMERGENCY CARE SERVICES

4.1 Background to Urgent and Emergency Care in Greater Manchester

Access to urgent and emergency care (UEC) is a critical component of any healthcare system, ensuring that individuals receive timely and appropriate medical attention during acute health crises. In Greater Manchester (GM), a region known for its diverse population and varying socio-economic conditions, the challenges surrounding access to healthcare are particularly pronounced. Despite the presence of numerous healthcare facilities and services, residents often face significant barriers that impede their ability to obtain necessary care promptly.

The increasing demand for urgent and emergency services has strained the existing healthcare infrastructure. Factors such as an aging population, rising prevalence of chronic diseases, and socio-economic challenges contribute to higher utilisation rates of emergency services. Consequently, emergency departments often face overcrowding, leading to extended waiting times and potentially compromised quality of care.

Moreover, public awareness and understanding of when and how to healthcare services remain challenging. Many individuals are unsure about the appropriate use of emergency services versus other healthcare options, such as NHS 111 or walk-in centres. This confusion can result in the misuse of emergency departments for non-urgent conditions, further exacerbating the strain on these critical services. There is also the perception (and sometimes a reality) of difficulties in accessing primary and community care services. Steps to tackle this are outlined in the sections above.

Addressing these issues requires a multifaceted approach, including improving the distribution of healthcare resources, enhancing public education on healthcare access, and implementing strategies to manage demand effectively. By tackling these challenges, GM can work towards a more equitable and efficient healthcare system, ultimately improving health outcomes for its residents.

4.2 Contributing Factors to Access Challenges

Numerous factors create challenges for our population in accessing urgent and emergency care at the right place and time when needed.

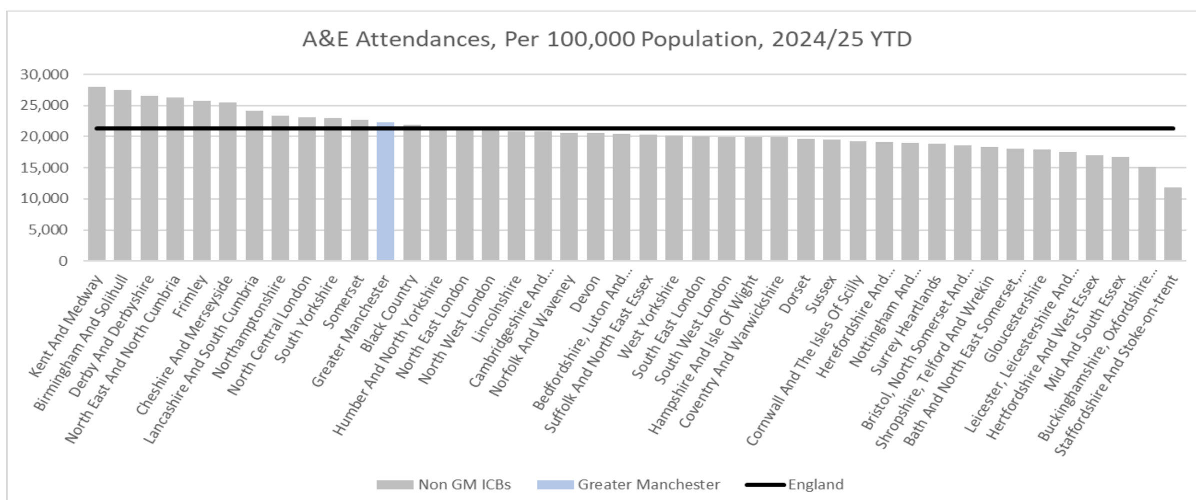
4.2.1 Increased Demand and Acuity

Nationally, A&E departments have seen a rise in demand, with GM experiencing a 15% increase in A&E attendance over the last decade, compared to a national average of around 10% (Public Health England, 2022). This rise is due to factors like population growth, increased chronic illness rates, and healthcare access challenges. In January 2025 GM A&Es saw on average 3,900 attendance per day, this is 0.2% above plan across the GM ICS.

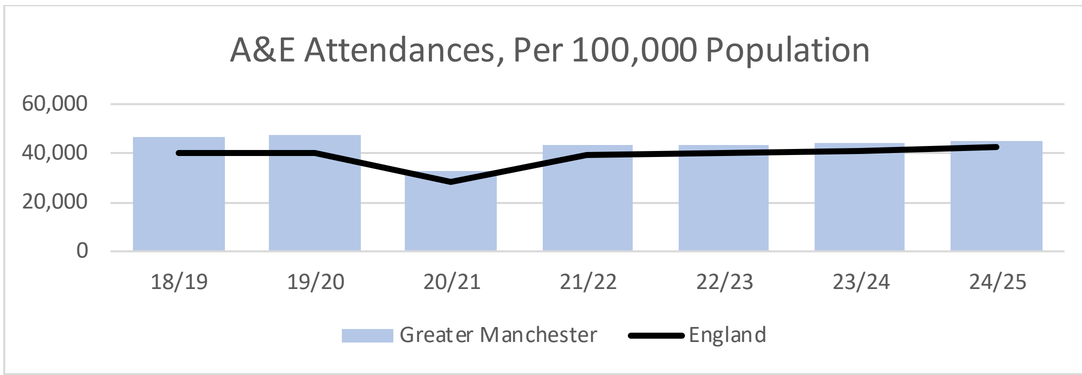
In GM, total A&E attendances have remained relatively stable over the past three years. However, there has been a significant increase in Type 1 demand, indicating a shift in how and where people seek healthcare. GM is in the top quartile for A&E attendances per 100,000 population in the 2024/25 year to date and has been above the national average for attendances per 100,000 population since before the pandemic.

We proportionally have more A&E activity in Type 1 emergency departments than the rest of England. 71.89% of A&E attendees so far in the 2024/25 year have presented at our emergency departments with Type 1 acuity. This positions us 12th out of 42 Integrated Care Boards (ICBs) in terms of this demand in our A&Es and when we use HRG (Healthcare Resource Group) codes we see that acuity has significantly increased, particularly over the past 12 months.

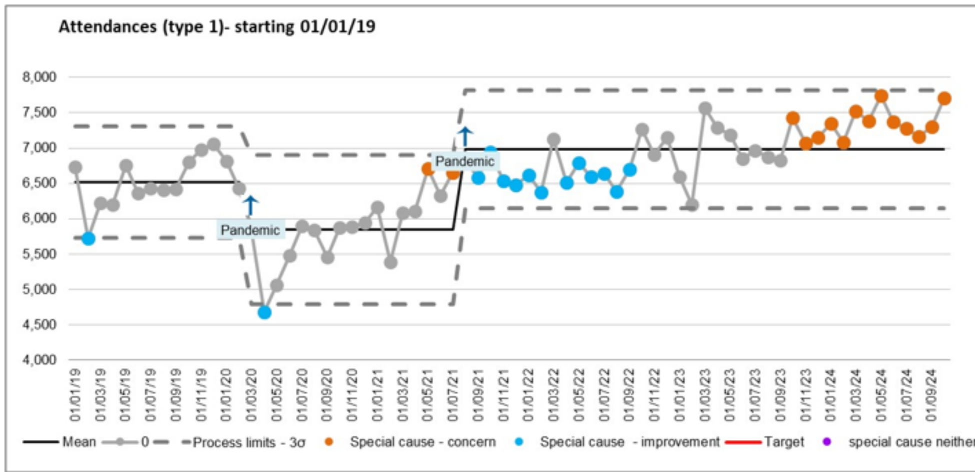
These trends are illustrated in the graphs below.



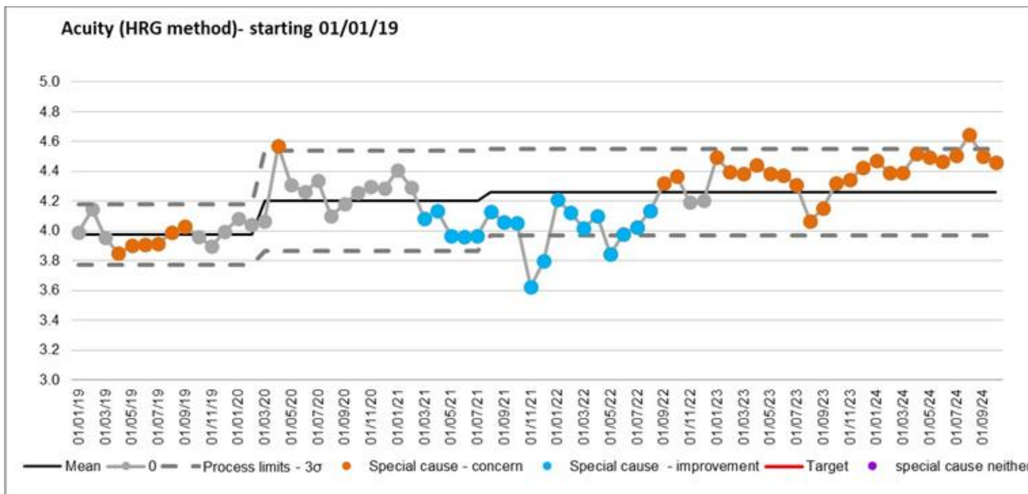
Graph 1 – GM A&E Attendances (all) per 100k population Year to Date 24/25



Graph 2 – GM A&E Attendances (all) per 100k population 2018/19-24/25



Graph 3 – GM A&E Attendances (type 1) 2019-2024



Graph 4 – GM Levels Acuity

4.3 Access to Alternatives

The number of people in GM waiting for planned treatment in secondary care increased over the past decade and was particularly exacerbated by the COVID-19 pandemic. Patients who face long waits for elective procedures often turn to other services such as primary care and A&Es when their conditions worsen, contributing to higher demand in A&E (GMICP Joint Forward Plan).

Access, or limited access, has been linked to a shift in patient reliance from GP services to A&E departments, placing added strain on emergency resources (King's Fund, 2022) According to the 2023 NHS GP Patient Survey, 28% of patients in Greater Manchester reported difficulty in securing a GP appointment. This is slightly higher compared to the national average, where 26.5% of patients across England reported similar difficulties.

However, it should be highlighted that more recent feedback indicates that the perceptions of people in Greater Manchester regarding ease of contacting GP practices is better than for the Northwest and nationally, at 74.5% for GM, 73.9% for the NW and 71% nationally (Office for National Statistics: 2025).

4.4 Population Growth, Demographics & Health Inequalities

GM is one of the UK's most densely populated areas, with around 2.8 million residents and 3.3 million registered with a GP. Over the past decade, GM's population has grown by 7%, a rate 6.3% higher than the national average, driven by urbanisation, internal migration, and international immigration. This growth and high population density increases demand for healthcare services, especially emergency care.

GM faces significant disparities impacting A&E attendance, primarily due to poverty, which is both a cause and consequence of ill health. GM is one of the most deprived areas in England, with 1.1 million residents living in the most deprived 10% of areas in the UK. This deprivation leads to higher A&E attendance rates, often for conditions that could be managed in other settings.

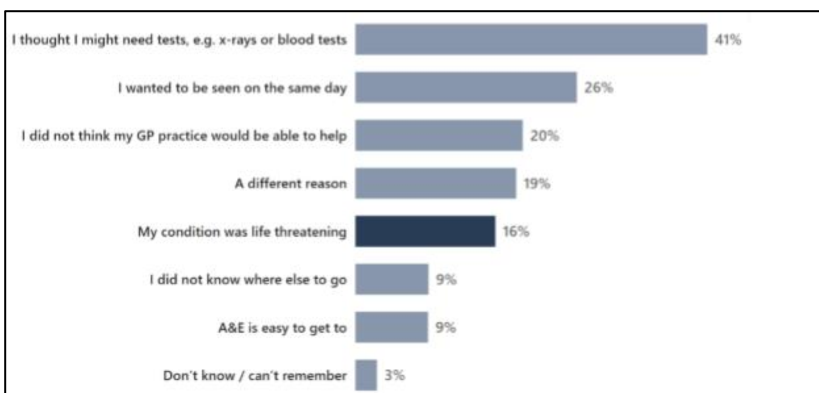
Health inequalities experienced by people in GM result in a cycle of high intensity use of UEC services and deteriorating health. Ensuring our neighbourhoods have the capacity and flexibility to provide intensive and personalised support to our most under-served populations will be a critical success factor on reducing this cycle and improving health outcomes.

4.5 Public Perception

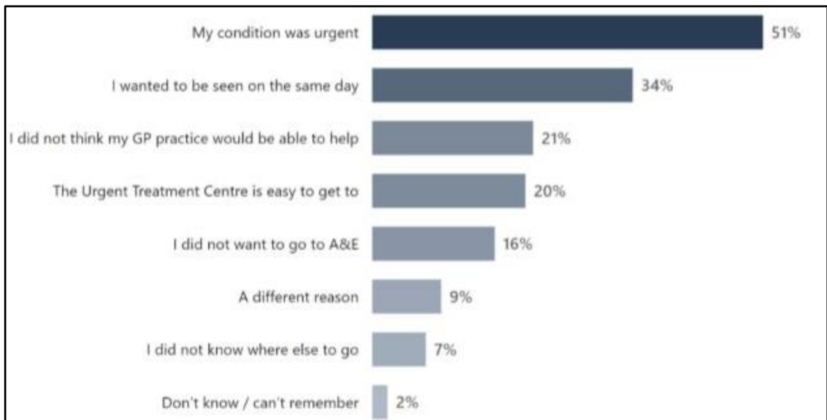
There is a consistent view that easier and extended access to community services like GPs, specialists, or pharmacies would reduce A&E visits. Public perception and experience of A&E services are declining, with concerns about long waiting times and the appropriateness of care received. This feedback highlights the need for improvements in patient experience and service delivery. People describe a complex system, where it is not easy to receive the help that they need.

A public survey conducted by the Care Quality Commission in 2024 asked why respondents attended urgent and emergency care, rather than opting to receive care from another service. Results show that a lack of timely access to other services may be contributing to unnecessary attendances at urgent and emergency care services. Two thirds (66%) of A&E respondents said they contacted another service before attending A&E, while a third (34%) of respondents went directly to A&E.

Of those who went directly to A&E, 20% went because they thought their GP practice would not be able to help (UTC 21%), and 26% wanted to be seen on the same day (UTC 34%), with 9% (20% UTC) of people asked stating ease of access to the A&E department and a further 9% (7% UTC) of people not know where else to go as factors influencing their decision to go directly to A&E. Of those who contacted another service, over a third contacted a GP (A&E 36%; UTC 48%), but 28% of those said the practice did not provide the help they needed (UTC attendance 44%). This is shown in the graphs below.



Graph 5 Reason(s) for attending A&E first for help with a condition.



Graph 6 Reason(s) for attending UTC first for help with a condition.

NHS 111 also has the ability to divert patients to other services, where appropriate, and avoid unnecessary urgent and emergency care attendances. Of those who contacted another service, the NHS 111 telephone service was most commonly contacted (A&E 40%; UTC 37%). However, 12% (UTC 11%) of A&E patients said the NHS 111 telephone service did not provide them with the help they needed.

A public engagement event in 2021 revealed that 70% of A&E attendees had tried to contact another service first, with most contacting their GP practice (27%) or NHS 111 (22% by phone, 6% online), and 5% calling 999. Many attendees (78%) felt their visit was appropriate, but a notable minority felt A&E was their only option due to unavailability of other services or difficulty getting appointments.

Feedback indicated that NHS 111 is often seen as too risk-averse, with less than 50% reporting a positive experience, which discourages its use. Many people are unaware of the full range of services NHS 111 offers, such as booking out-of-hours GP appointments. However, only 18% of patients who contact 111 are directed to urgent & emergency care.

There is a consistent view that easier and extended access to community services like GPs, specialists, or pharmacies would reduce A&E visits. Public perception and experience of A&E services are declining, with concerns about long waiting times and the appropriateness of care received. This feedback highlights the need for improvements in patient experience and service delivery. People describe a complex system, where it is not easy to receive the help that they need.

4.6 System efficiency

System inefficiencies within the NHS create bottlenecks and delays, significantly impacting access to urgent care. These inefficiencies include prolonged waiting times for appointments, inadequate coordination between services, and insufficient staffing levels.

Effective management of patient flow is crucial, as a well-coordinated discharge process improves patient satisfaction and optimises resource use. However, the GM health and social care system often faces challenges that delay discharge, negatively affecting patient flow and outcomes.

Delayed discharges reduce hospital bed availability for new patients, contributing to longer A&E and ambulance waiting times. These delays can also lead to longer hospital stays, increasing the risk of infections and loss of mobility, making it harder for patients to regain independence. GM's performance in managing delayed discharges is challenging, with an increasing number of patients assessed as having 'No Criteria to Reside' (NCTR) remaining in acute beds. On average in January 2025 the ICB was 2.8% behind its target, with an average of 803 (15.3%) beds across its acute hospitals occupied by patients not meeting the criteria to reside.

Reduced patient flow in acute hospitals increases A&E waiting times, worsening patient conditions and leading to more complex and costly interventions. This delay also causes emotional stress and anxiety, reducing patient satisfaction and discouraging individuals from seeking necessary care. Addressing waiting times is essential to ensure prompt and appropriate care, improving both individual health and the efficiency of the healthcare system.

4.7 Current Access to Urgent & Emergency Care

Recovering UEC services within the NHS is essential to ensure timely and effective medical attention for patients in critical conditions. UEC services are the backbone of the healthcare system, providing immediate care for life-threatening situations and urgent medical needs. However, the lack of access to alternative care in the community is impeding timely access for those who need it most.

4.8 Key priorities for improvement

The Urgent and Emergency Care (UEC) Recovery Plan, published in January 2023 by NHS England to improve the quality and access of urgent and emergency care services, includes a number of key priority areas of focus. Combining these with the ambitions for Greater Manchester, to improve quality, experience, and timeliness of service delivery, the following 10 areas are identified as the High Impact changes:

1. **Same Day Emergency Care (SDEC)**
2. **Frailty**
3. **Inpatient flow and length of stay (acute)**
4. **Community bed productivity and flow**
5. **Care Transfer Hubs**
6. **Intermediate care demand and capacity**
7. **Hospital at Home/Virtual Wards**
8. **Urgent community response**
9. **Single point of access**
10. **Acute Respiratory Infection Hubs**

4.8 Greater Manchester UEC Provision

GM has, over the last decade broadened its UEC services beyond the core A&E and Primary care offer and residents have access to a range of urgent and emergency care services across all localities to meet their healthcare needs. These include direct access to Walk in Centres, Urgent Community Response (UCR) Teams, Falls Pick-Up Teams, Urgent Treatment Centres (UTC), 111, 999 & A&E, with many open 24hrs and other for 12hrs a day, every day. From these access points there is further access to pathways that support A&E and acute admission avoidance, ensuring people are treated closer to home in line with the NHSE Neighbourhood Health guidelines, 2025.

The complex nature of urgent and emergency care services, involving multiple healthcare providers and varying levels of care, often leads to challenges in coordination and timely access for patients. A Single Point of Access (SPOA) is crucial for enhancing the efficiency and effectiveness of UEC services by providing a centralized hub for managing patient

referrals and coordinating care. This integrated approach fosters collaboration among community, ambulance, primary care, acute services, and social care, ultimately improving patient outcomes and streamlining care pathways. GM is progressing well with its SPOA development, with each locality having its own SPOA led by multi-disciplinary teams and excellent coverage regarding opening times. These teams have established links and pathways to other services, including 2-hour UCR, SDEC, UTC, community services, and primary care services.

GM has established common standards for Urgent and Emergency Care (UEC) delivery across 10 localities, in collaboration with the localities. Various initiatives have been implemented and progress is regularly assessed using a matrix scoring system. Over the past 18 months, GM has shown significant improvement, with all initiatives reaching mature levels. While core principles for UEC have been developed, there is still some variance in delivery. Efforts are ongoing to standardise the offer and ensure equity for patients.

4.9 Impact on UEC Performance & Outcomes

Current outcomes for patients UEC in GM show a mixed picture, while there have been improvements in some areas, challenges remain. Long waiting times and a lack of primary care appointments can significantly impact patient outcomes. Extended waiting times in emergency departments are associated with higher patient mortality and worse health outcomes. Delays in receiving timely care can lead to the deterioration of health conditions, increased stress, and prolonged recovery periods.

GM has seen improvements in some areas when reviewing performance, in January 2025 GM achieved the Category 2 ambulance response time target of <30mins, with a performance of 28mins 53 seconds and a reduction in 12 hr waits in A&E, and NHS GM continues to perform well when compared to its neighbouring ICB's, reporting only 8.38% of all ambulance handovers in the week commencing 17th February 2025 were delayed over 60 minutes. However, challenges remain in achieving the 4hr Standard of Care target along with other key metrics for UEC.

In terms of outcomes, GM is seeing more positive progress. The GM CAS enhances system capacity by intervening earlier in patient care, supporting the urgent and emergency care system by redirecting activity to lower acuity care or self-care. In 2023/24, GM CAS handled an average of 6,050 cases per month, successfully closing over 50% of 999 calls without needing an ambulance, thus freeing up more ambulance hours daily.

The GM Falls Pick Up service has significantly improved patient self-care support, with an increase from 39% in November 2024 to 71% in February 2025. Additionally, they have reduced the number of patients conveyed to the emergency department from 26% to 21% during the same period, successfully keeping nearly 80% of patients at home.

The Hospital @ Home programme plays an important role in supporting patients to access their treatment at home rather than in a hospital bed. Data has shown that 19,657 patients were admitted to a Hospital @ Home bed in 2024, (Month 1-8), patients who, without access to monitoring and treatment through the hospital @ home programme would be likely to increase demand in other parts of the system.

There are now 13 UTCs (2 awaiting full accreditation) across GM with every locality having at least 1. There are 4 other urgent care facilities that also see type 3 activity. Despite some data issues with Type 3 activity through GM's UTCs, there has been a 22.6% increase in attendances from 2023-24 to 2024-25, compared to a 3.8% increase in Type 1 activity. This demonstrates effective streaming of patients to lower acuity services where appropriate. On average, 96% of patients in this cohort were seen, treated, and either discharged or moved on within 4 hours in 2024-25

All 10 localities in Greater Manchester have a 2-hour Urgent Community Response (UCR) service, who consistently exceed the target of responding to 70% of referrals within 2 hours. During December 2024, 92% of all UCR standard referrals met this target, with referrals into the service increasing month on month and approximately 87% of discharged patients remained in their usual residence during December 2024

4.11 UEC Progress & Plans

Work is continuing across all 10 localities to improve access to services, increase offers, simplify access and reduce variation across our UTCs, UCRs and SDEC pathways to ensure people can access the right care at the right time in the right place, shifting care from hospital to community and treatment to prevention.

The GM Hospital @ Home (Virtual Wards) programme currently has capacity of 940 virtual beds with a plan to reach 970 by March 2025, with consistent 80% utilisation of its capacity. The programme has been reviewed recently and recommendations have been put forward to support improvements to maximise utilisation, re-align bed capacity to fit current demand and address variation in delivery models.

A further opportunity to support access to the right care at the right time and reduce the burden on our UEC services is to wrap personalised care around people with the highest intensity of needs. Health Inequalities experienced by people in GM result in a cycle of high intensity use (HIU) of UEC services and deteriorating health. Ensuring our neighbourhoods have the capacity and flexibility to provide intensive and personalised support to our most under-served populations will be a critical success factor on reducing this cycle and improving health outcomes. Work is underway to understand our current offer for high intensity users.

GM plans to enhance and develop its Single Point of Access (SPOA) system to streamline patient referrals, improve care coordination, and ensure timely access to appropriate healthcare services across the region. A single telephony system is being built and expected to be ready mid-March, with further work underway around identification of services and data to support with referrals. Communications and pathways are being developed with a planned wider roll out following test of change in 3 localities.

Despite good progress with the High Impact Initiatives as set out in the national UEC Recovery Plan, GM is not seeing the benefits in a comparable way to other ICBs. Therefore, a focus purely on improving UEC services in isolation of wider public service reform is unlikely to be enough to deliver the recovery required.

4.12 Conclusion

Greater Manchester's UEC system faces significant challenges due to increasing demand, demographic changes, and health inequalities. To address these issues, a comprehensive transformation of the health and care system is essential. This transformation should focus on delivering more care at home or closer to home, improving access, patient experience, and outcomes, and ensuring the sustainability of health and social care delivery.

Key strategies include enhancing primary care access, expanding community services, implementing Single Points of Access (SPOA) for streamlined referrals, and investing in digital health solutions. Additionally, improving the utilisation of Hospital @ Home beds, addressing health inequalities, and reducing hospital discharge delays through comprehensive planning are crucial steps.

By addressing these areas, Greater Manchester can enhance healthcare access, improve patient outcomes, and create a more efficient and responsive healthcare system, ultimately benefiting its diverse population.

SECTION 5

RECOMMENDATIONS

The challenges faced by GM's primary care and urgent care services are multifaceted and deeply rooted in the region's unique demographic and health profile. To improve access to healthcare for residents, especially in urgent and emergency care, it is recommended that Greater Manchester needs to focus on several key areas.

- Enhancing understanding by the public regarding the range of services available to support urgent care, particularly those in primary care (General Practice, Dentists and Pharmacists), including out of hours.
- Implementing true Single Points of Access (SPOA) for UEC will streamline patient referrals and coordinate care, ensuring patients receive the right care at the right time. Investing in digital health solutions, like telemedicine and remote monitoring, can improve access to care and support self-management of health conditions.
- Improving utilisation of Hospital @ Home beds through enhanced pathways and improved collaboration.
- Additionally addressing health inequalities by providing intensive and personalised support to underserved populations is essential to reduce high-intensity use of UEC services.
- Continuing to reduce hospital discharges though comprehensive discharge planning processes that begin at the time of patient admission.

SECTION 6

GLOSSARY OF TERMS

A Type 1 Accident & Emergency (A&E) department refers to an emergency department (ED) that provides 24-hour, consultant-led care to patients with serious or life-threatening injuries or conditions. In the UK, the National Health Service (NHS) categorizes A&E departments into different types based on the level of service they provide.

- Type 1 A&E: These departments are hospital-based and offer comprehensive emergency care for a wide range of conditions, including major trauma, heart attacks, strokes, and other critical medical situations. A consultant-led team is always available to oversee patient care.
- Type 2 A&E: These are smaller units, typically offering emergency care but with less comprehensive services than Type 1 and may not have full-time consultants available.
- Type 3 A&E: These are "minor injury units" that provide treatment for less severe conditions, like cuts, sprains, and minor illnesses, but they do not handle life-threatening cases.

A&E All-Type 4-Hour Performance: The percentage of patients who are admitted, transferred, or discharged within 4 hours of arrival at the emergency department.

A&E All-Type Attendances: The total number of patients attending the emergency department.

Acute Respiratory Hubs: Specialized centres designed to provide rapid assessment and treatment for patients with acute respiratory conditions.

Admission Avoidance: Strategies and services aimed at preventing unnecessary hospital admissions, particularly for vulnerable populations

Care Transfer Hubs (CTH): Coordinating centres that manage the discharge of patients with complex needs, ensuring they receive appropriate post-discharge care.

Category 2 Ambulance Response Times: This category includes emergency calls for serious conditions such as stroke or chest pain. The target response time is an average of 18 minutes.

No Criteria to Reside (NCTR): A status indicating that a patient no longer needs to stay in a hospital bed based on clinical criteria.

Same Day Emergency Care (SDEC): A model of care where patients are assessed, diagnosed, and treated on the same day without being admitted to a hospital bed.

Single Point of Access (SPoA): A system that provides a single point of contact for urgent and emergency care services, streamlining access and referrals to appropriate care.

Urgent Community Response (UCR): Services that provide urgent care within two hours to prevent hospital admissions, often involving a multidisciplinary team to support patients in their homes.

Urgent Treatment Centres (UTC): Facilities providing urgent medical help for non-life-threatening conditions. They are open at least 12 hours a day and can handle minor injuries and illnesses.

Virtual Wards (VW)/Hospital @ Home: Services that provide hospital-level care at home for patients with complex needs, aiming to prevent hospital admissions and support early discharge.

Greater Manchester Joint Health Scrutiny Committee

Date: 18 March 2025

Subject: Greater Manchester Major Trauma Provision

Report of: Rob Bellingham, Programme Director for Major Trauma and

Jennie Gammack, Programme Director for Sustainable Services,

NHS Greater Manchester

Purpose of Report

To describe the progress of the site selection process for the delivery of Major Trauma Services (MTS) within Greater Manchester (GM).

Recommendations:

The Committee is requested to receive the update and agree to receive further updates as the site selection process evaluates the options being explored in order to support future recommendations to ensure that Greater Manchester has a compliant Major Trauma Provision.

Contact Officers

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Jennie Gammack – Programme Director – Sustainable Services

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Equalities Impact, Carbon and Sustainability Assessment:

A full equalities impact assessment is being developed.

Risk Management

This report is to support the risk management of this proposal, ensuring that JHSC has opportunities to review and comment on the process being undertaken.

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

This proposal seeks to ensure appropriate use of resource in Greater Manchester.

Financial Consequences – Capital

Not applicable

Number of attachments to the report:

Not applicable.

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

18th March 2025

1. Introduction/Background

This briefing is to update the Greater Manchester Health Overview and Scrutiny Committee on the progress of the site selection process for the delivery of Major Trauma Services (MTS) within Greater Manchester (GM). The process has been prompted by findings from a recent national peer review process, (September 2024). NHS Greater Manchester (NHS GM), the commissioning body, is committed to delivering a Major Trauma system that ensures the best patient outcomes while making optimal use of available resources.

2. Trauma Service Configuration

In England, trauma is the most common cause of death in those under 40 years, with survivors often suffering long-term disability. Trauma care is organised using a networked, tiered model of care that provides a balance between access to local care (at Trauma Units and Local Emergency Hospitals) and access to highly specialised, centralised services for those with more severe injuries (at Major Trauma Centres). Pre-hospital teams use triage tools to identify patients who may have suffered severe injuries to determine the appropriate hospital for their care. Major Trauma Centres (MTCs) provide immediate treatment to people with the most serious injuries 24 hours a day, seven days a week. They have the equipment, facilities and teams of trauma experts to ensure effective diagnosis and early treatment of seriously injured patients.

3. Greater Manchester Adult Trauma Services

Adult Trauma services in Greater Manchester are currently configured as follows:

- Two adult Major Trauma Centres:
  - Greater Manchester Major Trauma Hospital (GMMTH), based at Salford Royal Hospital, part of the Northern Care Alliance (NCA). The GMMTH, which opened in May 2024, is a purpose-built facility and forms part of the national New Hospital Programme.
  - Manchester Royal Infirmary, part of Manchester Foundation Trust (MFT).

- Three Trauma Units:
  - Stepping Hill Hospital
  - The Royal Oldham Hospital
  - Royal Albert Edward Infirmary (Wigan)

- Six Local Emergency Hospitals:
  - Royal Bolton Hospital
  - Fairfield General Hospital
  - Macclesfield District General Hospital
  - North Manchester General Hospital
  - Tameside General Hospital
  - Wythenshawe Hospital

Network Configuration

- **Major Trauma Centres (MTC):**
  - Salford Royal Hospital (Northern Care Alliance NHS FT)
  - Manchester Royal Infirmary (Manchester University NHS FT)
- **Trauma Units (TUs):**
  - Stepping Hill Hospital (Stockport NHS FT)
  - Royal Albert Edward Infirmary (Wrightington, Wigan & Leigh Teaching Hospitals NHS FT)
  - The Royal Oldham Hospital (Northern Care Alliance NHS Foundation Trust)
- **Local Emergency Hospitals (LEHs):**
  - Royal Bolton Hospital (Bolton NHS FT)
  - Tameside General Hospital (Tameside and Glossop Integrated Care NHS FT)
  - North Manchester General Hospital (Manchester University NHS FT)
  - Fairfield General Hospital (Northern Care Alliance NHS FT)
  - Macclesfield District General Hospital (East Cheshire NHS Trust)
  - Wythenshawe Hospital (Manchester University NHS FT)
- **Pre-hospital Partners:**
  - North West Ambulance Service NHS Trust **(NWAS)**
  - North West Air Ambulance Charity **(NWAA)**
  - East Midlands Ambulance Service NHS Trust **(EMAS)**

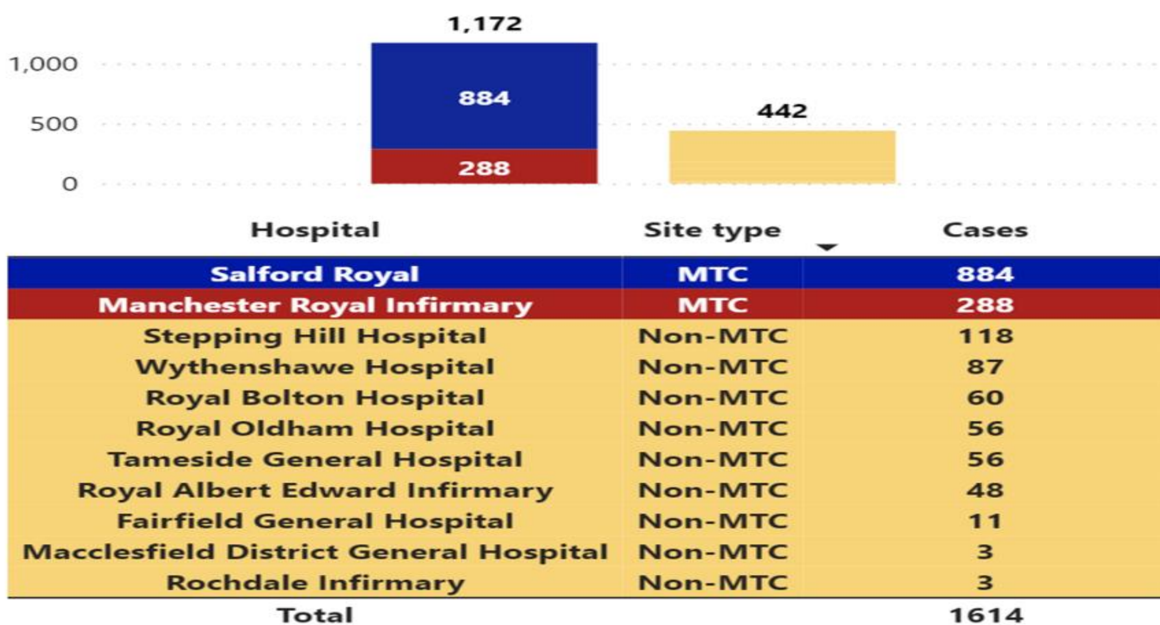
About us - MFT ODN (gmccmt.org.uk)

The Injury Severity Scope (ISS) is an anatomical scoring system that provides an overall score for patients with multiple injuries. Each injury is assigned an Abbreviated Injury Scale ("AIS") score and is allocated to one of six body regions (Head, Face, Chest, Abdomen, Extremities (including Pelvis), and External). Only the highest AIS score in each body region is used. The three most severely injured body regions have their score squared and added together to produce the ISS score. The AIS is an anatomically based, consensus-derived, global severity scoring system that classifies each injury in every body region according to its relative importance on a six-point ordinal scale.

Patients who have an ISS > 15 are defined as having suffered from Major Trauma. In GM, based on this definition, there are circa 1,600 major trauma cases (ISS>15) per year (including Royal Manchester Children's Hospital (RMCH) which accounts for c. 70 cases per year).

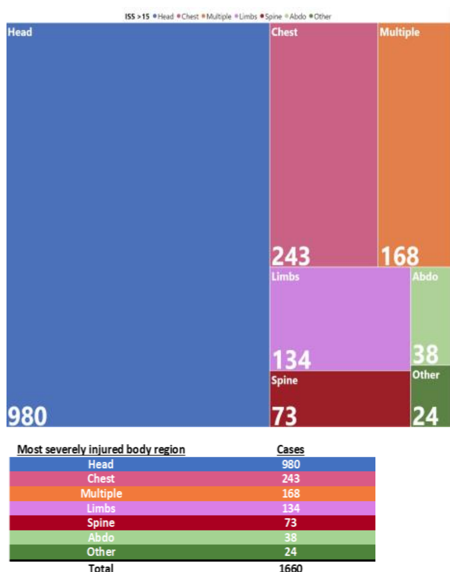
The table below describes, based on the last clinical audit, where Major Trauma patients with an ISS >15 receive their care.

- 55% (n=884) of patients with an ISS>15 receive their definitive care in SRH
- 18% (n=288) of patients with an ISS>15 receive their definitive care in MRI



Hospital	Site type	Cases
Salford Royal	MTC	884
Manchester Royal Infirmary	MTC	288
Stepping Hill Hospital	Non-MTC	118
Wythenshawe Hospital	Non-MTC	87
Royal Bolton Hospital	Non-MTC	60
Royal Oldham Hospital	Non-MTC	56
Tameside General Hospital	Non-MTC	56
Royal Albert Edward Infirmary	Non-MTC	48
Fairfield General Hospital	Non-MTC	11
Macclesfield District General Hospital	Non-MTC	3
Rochdale Infirmary	Non-MTC	3
Total		1614

Most Severely Injured Body Region (ISS > 15)



Most severely injured body region	Cases
Head	980
Chest	243
Multiple	168
Limbs	134
Spine	73
Abdo	38
Other	24
Total	1660

- Head injury predominates
- This replicates national and international injury patterns

4. NHS GM's Commitment

NHS GM is committed to ensuring that the region's Major Trauma service is aligned with the national specification, ensuring that the GM Major Trauma system is financially viable, sustainable, and effective in delivering high-quality outcomes for patients.

The process to achieve this involves a thorough site options appraisal to assess and select the best setting for Major Trauma provision, addressing key areas including the workforce model, activity levels, and costs. The goal is to optimise the use of resources and to develop a model that maximises patient outcomes while ensuring long-term sustainability.

5. Options for Site Selection

NHS GM is considering several options for the delivery of Major Trauma services. These options will be assessed based on criteria such as clinical outcomes, financial viability, workforce requirements, and implementation timelines.

6. Considerations for Collaboration and Sustainability

All options under consideration will require continued collaboration between the two main providers - NCA and MFT. Ensuring that patients receive timely interventions and the best possible outcomes will depend on strong cooperation between the hospitals, particularly in areas like vascular surgery, neurosurgery and trauma care. It is also critical that these options are financially sustainable, contributing to the efficiency of the overall system and ensuring equitable access to care across Greater Manchester.

7. Next Steps

- NHS GM will continue to work closely with NCA, MFT and other relevant partners to develop detailed plans for the preferred option.
- Further assessment of the financial and activity impacts of each option will be undertaken.
- NHS GM will ensure that stakeholders, including the public, are engaged and that the engagement is proportionate to those impacted by Major Trauma.

The Health Overview and Scrutiny Committee is asked to receive the update and agree to receive further updates as the site selection process evaluates the options being explored in order to support future recommendations to ensure that Greater Manchester has a compliant Major Trauma Provision.

Greater Manchester Joint Health Scrutiny Committee

Date: 18 March 2025

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 Work Programme for the 2024/25 Municipal Year attached to the report at 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. Appendix 3 provides items that have previously been considered.

Recommendation:

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

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Appendix 1

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

APRIL 18.4.25	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, Associate Director, 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. Eight weeks of engagement ran from January to March 2025 and the report is currently being drafted.

JUNE 17.6.25	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.
	Engagement Activity regarding the Clinical Commissioning Statements, including Equality Impact Assessment data	• Claire Connor, Director Communications & Engagement, NHS GM	The report should outline the engagement activities undertaken during the development of Clinical Commissioning Statements, including an analysis of Equality Impact Assessment data, emphasising the importance of stakeholder input and the commitment to equitable healthcare outcomes for all residents.

Appendix 2

Items for Potential Inclusion in the Work Programme

Ref	Item	Suggested	Lead
1.	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
2.	Regular updates on the Sustainability Plan and local Sustainability Plans	• Paul Lynch, Director of Strategy & Planning, NHS GM	Localities to have developed their plan Suggested by Committee on 15.10.24.
3.	Dentistry	• Ben Squires, Head of Primary Care Operations, NHS GM	.Suggested by Committee on 15.10.24 and again on 21.1.25. To focus on children and young people.
4.	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.

5.	Specialised Commissioning Cardiac and Arterial Vascular Surgery	• 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. To be considered Winter 2025 (TBC)
6.	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.

7.	The safety of women and girls when accessing exercise and active travel opportunities be a key theme at a future meeting (Now a Task & Finish Group)	• 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.
8.	Safe and Sustainable Specialised Services for Babies and Children (re-named) Engagement followed by possible consultation	• TBC	Options appraisal being prepared. The NW Women & Children's Transformation programmed aimed to translate several national reviews and associated standards related to Neonatal Critical Care; Paediatric Critical Care; Surgery in Children; and Children and Young People with cancer into an operational plan for the Northwest. NB: The Northwest footprint for this work, scrutiny arrangements are to be agreed.

9.	Staff Survey	• Janet Wilkinson, Chief People Officer, NHS GM	That segmented results from the Staff Survey be brought to a future meeting of the Committee and consideration be given to how better information could be obtained from the wider sector, including carers and social workers. Asked by Committee on 21.1.25.
10.	Our People and Culture Strategy	• Janet Wilkinson, Chief People Officer, NHS GM	That the Committee asked to contribute to the metrics behind the Our People and Culture Strategy. Asked by Committee on 21.1.25.
11.	Workforce Strategy	• Janet Wilkinson, Chief People Officer, NHS GM	That Janet Wilkinson to feed back the reflection that the Workforce Strategy might have mitigated any further reduction in diversity (caused by social, political and other pressures) Asked by Committee on 21.1.25.
12.	Single Improvement Plan and Sustainable Finance	• TBC	That an update be provided to a future meeting. Asked by Committee on 21.1.25.

13.	Winter Pressures	• TBC	That an update on winter pressures and the lessons learned to brought to a future meeting. Asked by Committee on 21.1.25.
14.	Specialist weight management Engagement followed by possible consultation (Spring 2025)	• 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.
15.	ADHD Services for Children and Young People: Prioritising those Most In Need	• Sandy Bering, Strategic Lead Clinical Commissioner/Consultant (Mental Health and Disabilities), NHS GM	Members asked (on 18.2.25) that they be provided with regular updates at appropriate opportunities.

Appendix 3

Items Previously Considered in 2024/25

Date	Item	Lead	Ask of scrutiny
MARCH 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.
	Elective Care Wait Times	• Dan Gordon, Programme Director, Elective Recovery & Reform, NHS GM	Suggested by Committee on 15.10.24.
	Wider Issue of Access	• Katherine Sheerin Chief Commissioning Officer NHS Gm	To provide an overview of access to primary care and urgent care services for the people of Greater Manchester.
	Major Trauma Review	• Jennie Gammack Programme Director – Sustainable Services NHS GM	To update the Committee on the progress of the site selection process for the delivery of Major Trauma Services (MTS) within Greater Manchester (GM).

FEBRUARY 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.
	GP Access	• Ben Squires, Head of Primary Care Operations, NHS GM	Suggested by Committee on 15.10.24.
	Children's Attention Deficit Hyperactivity Disorder (ADHD)	• 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.

DECEMBER 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.
	Development of Digital Solutions	• Gareth Thomas, Lead Digital Transformation, Health Innovation Manchester	Development of Digital Solutions (including the public facing version of the digital strategy). Aimed at improving patient care, enhancing efficiency, and supporting the long-term sustainability of the healthcare system.
	Updates on the ICP Recovery Plan and the Joint Forward Plan (including the subsequent steps in the Leadership and Governance Review)	• Sir Richard Leese, Chair NHS GM, Integrated Care Board	To provide updates on the ICP Recovery Plan and the Joint Forward Plan (including the subsequent steps in the Leadership and Governance Review) following his visit to the meeting on 13.9.23.

	Procedures of Limited Clinical Value	• Associate Director – Strategic Commissioning NHS GM Integrated Care	Procedures of limited clinical value are medical procedures that the evidence shows will not have a positive impact on most people. Therefore, they are only recommended in certain circumstances. The treatments have been temporarily paused (with exceptions at clinician request) whilst a review is undertaken with engagement planned to support the review.

OCTOBER 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	

JULY 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.

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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.

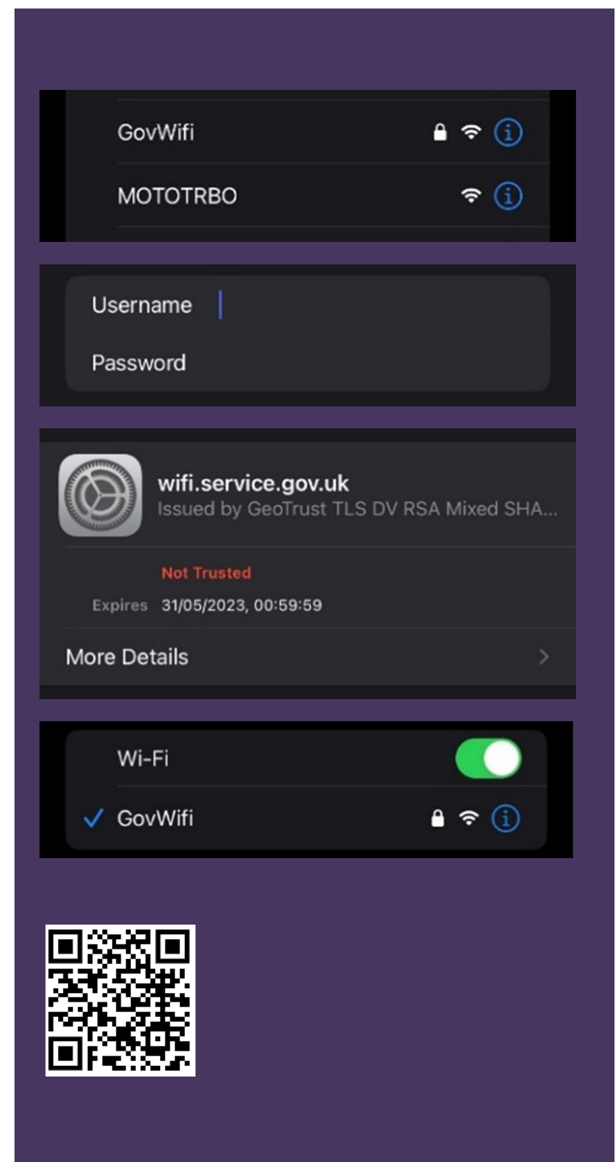
Registering with GovWifi

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
AoMRC	Academy of Medical Royal Colleges
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.

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.
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
Dermatochalasis	A condition that affects the connective tissue under the skin of the palm and fingers, causing the fingers to bend towards the palm and making it difficult to straighten them completely. This condition is more common in adults, particularly in men over the age of 50, and tends to progress slowly over time.
Diabetes	Is a chronic condition that affects how your body processes glucose, a type of sugar.
Dupuytren's Contracture	is a condition that affects the connective tissue under the skin of the palm and fingers, causing the fingers to bend towards the palm and making it difficult to straighten them completely. This condition is more common in adults, particularly in men over the age of 50, and tends to progress slowly over time.

EBI	Evidence Based Interventions
EPaCCS	Electronic Palliative Care Coordinating System
Enforcement Undertakings	Are a formal agreement between NHS England and an NHS organisation, like the NHS Greater Manchester Integrated Care Board (ICB), outlining specific actions the organisation must take to address identified failings or risks. It's a legal commitment to make improvements within a set timeframe.
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
Greater Manchester Care Record (GM Care Record)	A digital resource that consolidates health and care information from NHS and care services across all 10 boroughs of Greater Manchester. This unified record is designed to improve healthcare services and outcomes for the region's 2.8 million citizens.
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.
Hyperhidrosis	A medical condition characterised by excessive sweating that goes beyond what's necessary for regulating body temperature.
ICB	Integrated Care Board
ICS	Integrated Care System
JHS	Joint Health Scrutiny
Labiaplasty	Labiaplasty is a surgical procedure to alter the size and/or shape of the labia, the folds of skin surrounding the vaginal opening.
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.
NDG	Non-demographic growth refers to increases in healthcare spending that are not directly attributable to changes in population size or age structure. It essentially captures the factors beyond basic population growth that drive healthcare costs up.
O&S	Overview & Scrutiny
Orthoses	Are externally applied devices designed to support, align, prevent, or correct deformities or to improve the function of movable parts of the body
Pinnaplasty	Pinnaplasty, also known as otoplasty, is a surgical procedure to reshape or reposition the ears.
PISA	Programme for International Student Assessment
PLCV	Procedures of Limited Clinical Value are medical treatments or procedures that have been identified as having little or no proven benefit for patients, or where the risks may outweigh the benefits.
Rhinoplasty	A medical procedure that involves surgically altering the shape of the nose.
SNM	Sacroneuromodulation is a medical procedure that involves implanting a device to stimulate the sacral nerves, which are located near the tailbone. These nerves control the bladder, bowel, and pelvic floor muscles.
Safety Medication Dashboard (SMASH)	an innovative IT system designed to enhance medication safety in primary care settings. Developed by the University of Manchester, SMASH aims to prevent hazardous prescribing.

Septoplasty	A surgical procedure to correct a deviated septum, which is the wall of cartilage and bone that divides your nostrils.
Single Improvement Plan	The NHS GM Single Improvement Plan is a comprehensive strategy developed by the NHS Greater Manchester Integrated Care Board (ICB) to address various challenges and improve healthcare services across Greater Manchester.
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.
SDE	Secure Data Environment
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.
TES	Trophic Electrical Simulation
TPC	A trust provider collaborative s a group of NHS trusts (that provide healthcare services like hospitals and mental health services) that have joined together to work at a larger scale.
PES	Both ultrasound and pulsed electromagnetic field (PEMF) therapies are non-invasive treatments used to promote healing and reduce pain. They work by stimulating the body's natural repair processes at a cellular level.
UNAIDS	A high-profile, high-level political advocacy drive to accelerate actions and investments to prevent HIV.
VCFSE	The voluntary, community, faith, and social enterprise sector