Public Document

GMCA GREATER MANCHESTER COMBINED AUTHORITY

Greater Manchester Integrated Care Partnership

NHS GREATER MANCHESTER INTEGRATED CARE PARTNERSHIP BOARD

DATE: **Friday, 29th November, 2024**

TIME: **1.00 pm**

VENUE: **Council Chamber, Bolton Town Hall, Victoria Square, Bolton, BL1 1RU (Access via Albert's Hall entrance)**

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.

4. Minutes of the meeting of the Integrated Care Partnership Board held on 27 September 2024 5 - 12

To consider the approval of the minutes of the meeting held on 27 September 2024

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.

5.	**GM Urgent & Emergency Care 4 hour Standard of Care** Report of Colin Scales - NHS Greater Manchester Deputy Chief Executive	13 - 48
6.	**Prevention Demonstrator** Report of Warren Heppolette – Chief Officer – Strategy and Innovation, NHS Greater Manchester	49 - 70
7.	**Greater Manchester Age Friendly Strategy** Report of Paul McGarry, Head of GM Ageing Hub, GMCA	71 - 100
8.	**Date and time of next meeting** 1:00pm on Friday 28 February 2025	

For copies of papers and further information on this meeting please refer to the website www.greatermanchester-ca.gov.uk. Alternatively, contact the following Governance & Scrutiny Officer: Edward Flanagan, Senior Governance & Scrutiny Officer

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

This agenda was issued on Thursday, 21 November 2024
on behalf of Julie Connor, Secretary to the Greater Manchester Combined Authority, Churchgate House, 56 Oxford Street, Manchester M1 6EU

NHS Greater Manchester Integrated Care Partnership Board – 27th September 2024

Declaration of Councillors' Interests in Items Appearing on the Agenda

Name of Councillor……

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

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

Quick Guide to Declaring Interests at GMCA Meetings

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

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

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

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

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

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

Failure to disclose this information is a criminal offence

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

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

Step Two: Determining if your interest is prejudicial

A personal interest becomes a prejudicial interest:

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

For a non-prejudicial interest, you must:

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

To note:

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

For prejudicial interests, you must:

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

You must not:

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

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MINUTES OF THE MEETING OF THE
NHS GREATER MANCHESTER INTEGRATED CARE PARTNERSHIP BOARD
HELD ON 27 SEPTEMBER 2024

PRESENT

Sir Richard Leese	NHS GM Integrated Care (Chair)
Mayor Andy Burnham	GMCA (Chair)
Councillor Sean Fielding	Bolton Council
Councillor Tamoor Tariq	Bury Council
Councillor Thomas Robinson	Manchester City Council
Councillor Barbara Brownridge	Oldham Council
Councillor Daalat Ali	Rochdale Council
Councillor Jane Slater	Trafford Council
Councillor Keith Cunliffe	Wigan Council
Ed Flanagan	GMCA
Jane Forrest	GMCA
Steve Wilson	GMCA
Andrew King	GM Active
Heather Fairfield	GM Healthwatch
Eve Holt	GM Moving
Hayley Lever	GM Moving
James Bull	GM Workforce Engagement Forum
Liz Windsor-Welsh	GM VCFSE Leadership Group
Ben Bridgewater	Health Innovation Manchester
Rob Bellingham	NHS GM Integrated Care
Tom Hollingsworth OBE	Sport England

ICPB/15/24 WELCOME AND APOLOGIES

Sir Richard Leese as Joint Chair welcomed everyone to the meeting.

RESOLVED /-

That apologies be received and noted from Alison McKenzie-Folan (Wigan Council), Mark Fisher (NHS GM), Alison Page (Salford CVS) and Mark Britnell (Health Innovation Manchester)

ICPB/16/24 APPOINTMENT OF JOINT CHAIRS

Members were asked to note that the GM Portfolio Lead for Healthy Lives and the Chair of NHS GM Integrated Care were joint chairs of the Integrated Care Partnership Board as per the terms of reference. It was also noted that Mayor Andy Burnham had taken on the role GM Portfolio Lead for Healthy Lives.

The Chair thanked the previous GM Portfolio Lead for Healthy Lives, Mayor Paul Dennett for his dedication to the role and welcomed Mayor Andy Burnham to the post.

RESOLVED /-

That the appointment of Mayor Andy Burnham and Sir Richard Leese as joint chairs of the Integrated Care Partnership Board be noted.

ICPB/17/24 ICPB MEMBERSHIP

Members were asked to note the membership of the Integrated Care Partnership Board.

RESOLVED /-

That the membership of the Integrated Care Partnership Board be noted.

ICPB/18/24 MEMBERS CODE OF CONDUCT AND ANNUAL DECLARATION FORM

Local Authority representatives were remined of their obligations under the GMCA Member's Code of Conduct and requested to complete an annual declaration of interest form, if they hadn't already, which would be published on the GMCA website.

RESOLVED /-

That the update be noted.

ICPB/19/24 ICPB TERMS OF REFERENCE

Members were asked to note the Integrated Care Partnership Board terms of reference. It was reported that the document would be reviewed to include any minor updates required.

RESOLVED /-

That the Integrated Care Partnership Board's terms of reference be noted.

From this point in the meeting Mayor Andy Burnham chaired the meeting.

ICPB/20/24 CHAIRS ANNOUNCEMENTS AND URGENT BUSINESS

The Chair advised that he wanted to send his thanks and appreciation to all staff in NHS GM and the wider health and care system for their work under very challenging circumstances. He advised that GM partners were working to take pressure off health and care colleagues, giving examples of initiatives already in place and planned.

The Board received an update on the findings of the Lord Darzi independent investigation into the NHS in England. It was noted that the report's findings aligned well with NHS GM's strategic agenda including the recent Sustainability Plan. It was also noted that reform would come with the ability to allocate health resources to NHS GM priorities rather than following historical prescribed spending patterns.

It was reported that the recommendations of the Lord Darzi report would form the basis of the Government's ten year plan for the NHS.

The points raised in the discussion that followed included: -

- It was suggested that many of the pressures faced within the NHS resulted from a lack of a fully funded care service and poor service provision elsewhere in the public sector, such as housing and public transport.
- Solving the problems faced within the NHS would require a whole system approach to addressing socio-economic difficulties, particularly relating to poverty.
- The GM model was set up to support innovation and reform.
- There would be a comprehensive review of the public sector estate in GM to ensure the best use of public sector assets to support the live well agenda.

ICPB/21/24 DECLARATIONS OF INTEREST

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

ICPB/22/24 MINUTES OF THE PREVIOUS MEETING HELD ON 31 MAY 2024

RESOLVED /-

That the minutes of the meeting held on 31 May 2024 be approved as a correct record.

ICPB/23/24 HEALTH, PREVENTION AND GOOD GROWTH

The Board received a report setting out priority areas for prevention, health and good growth. The four policy areas identified were: -

- A Prevention First Approach
- Skills, Work and Health
- Advancing Health Innovation
- Capital Investment and Regeneration

It was reported that the Integrated Care Partnership, working with the Combined Authority was well placed to boost economic growth and improve health.

Further devolution particularly regarding employment support was cited as an opportunity to improve population outcomes in terms of health and employment.

RESOLVED /-

That the update be noted.

ICPB/24/24 LIVE WELL

The Board received a report on GM Live Well, a commitment to provide support to every community in GM. This would include extending existing neighbourhood and prevention approaches to provide holistic person centred support via a network of live well centres, delivered by the VCSE sector and relevant public sector partners.

The outcomes and impact of the model were outlined.

The points raised in the discussion that followed included: -

- £6bn was being spent in the private sector across the UK in terms of employment support. A small proportion of that funding would open massive opportunities in GM for the VCFSE sector to provide whole person tailored support, which would include referrals to NHS services when required.
- Possible access to DWP funding for employment support services in GM would enable an improved service provision.
- Success of Live Well would need to be measured in terms of benefits for the individual, communities and other public services.
- It was suggested that one model would be appropriate to use in each of the 60 neighbourhoods within GM, applying flexibility when needed to meet the needs of individual communities.
- It was stressed that good lives are vital to ensuring good health.

- The were still challenges to address within health services related to the ability to co-locate, providing services outside of health premises. Also relating to NHS finance rules.
- It was stated that the one of the aims of the Live Well model would be to take demand away from NHS services. Consideration was also being given as to how the model could release capacity to support local authorities.
- The Live Well model was a key part of the GM growth plan.

RESOLVED /-

That the contents of the report be noted.

ICPB/25/24 GM MOVING REVISED MEMORANDUM OF UNDERSTANDING AND PROGRESS UPDATE

The Board received an update on GM Moving including the current work taking place across GM to support the integration of physical activity into health, to contribute to addressing health inequalities. A refreshed memorandum of understanding between Sport England and GM partners was appended to the report which sought to make the work being undertaken even more impactful in the future.

It was reported that the relationship between Sport England and GM partners was invaluable, evidenced by the various successful initiatives undertaken.

RESOLVED /-

1. That the contents of the report be noted.
2. That the refreshed memorandum of understanding with Sport England and wider GM Moving Partnership be endorsed.

ICPB/26/24 HEALTH INNOVATION MANCHESTER – THREE YEAR STRATEGY AND 23/24 ANNUAL IMPACT REPORT

The Board received a report on the work of Health Innovation Manchester to deliver, with partners, innovation across GM to improve the lives of local people and boost the economy. Appended to the report was the Health Innovation Manchester strategy for 2024/25 to 2027/28 which included four new strategic objectives: -

- Address high priority drivers of population health by deploying proven innovations at scale, with a major focus on primary and secondary prevention.
- Establish GM as a global learning market for accelerated access to novel innovations at scale.
- Optimise digital and data products and services to understand the GM population, define their needs and develop new, more efficient care models.
- Enhance the GM system's capacity and capability to deliver health innovation and demonstrate impact.

RESOLVED /-

That the report be noted.

ICPB/27/24 DATE AND TIME OF NEXT MEETING

The next meeting would be held at 1:00pm on Friday 29 November 2024.

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NHS Greater Manchester Integrated Care Partnership Board

Date: 29th November 2024

Subject: GM Urgent & Emergency Care (UEC) 4hr Standard of Care Performance

Report of: Colin Scales- NHS Greater Manchester Deputy Chief Executive

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PURPOSE OF REPORT:

Greater Manchester is one of the largest Integrated Care Systems (ICS) in England, serving a population of over 2.8million people, this positions GM as one of the most significant ICSs in terms of both population size and scope. GM is one of lowest performing ICSs in England for A&E wait times. This paper provides a comprehensive update to NHS GM Integrated Care Partnership Board on the circumstances surrounding this situation in Urgent Care including:

- Outlining the current performance against the two key performance recovery indicators in the 2-year UEC Recovery Plan
- Examining the key factors affecting UEC performance in Greater Manchester
- Highlighting the improvement work underway to address the under-performance against the recovery indicators.
- Advising on the next steps for UEC improvement within the context of wider public service reform.

RECOMMENDATIONS:

The NHS GM Integrated Care Partnership Board are requested to:

Note the performance of Greater Manchester against the UEC 4-hour standard of care, which is currently not being achieved.

Discuss the factors affecting GM's performance with reference to the improvement work which is already underway and the opportunities to leverage Live Well and collaboration between the Greater Manchester Integrated Care Board (GM ICB) and the Greater Manchester Combined Authority (GMCA).

Contact officer(s)

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Name: Greg Lawson, Senior Programme Manager, UEC, NHS GM ICB
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Executive Summary

Purpose of Report: This report provides a comprehensive update on the Urgent & Emergency Care (UEC) 4-hour Standard of Care Performance for NHS Greater Manchester (GM). It outlines the current performance, factors affecting UEC performance, improvement work underway, and the next steps for UEC improvement within the context of wider public service reform.

Key Points:

Performance Overview:

GM is one of the lowest-performing Integrated Care Systems (ICS) in England for A&E wait times.
The report sets out the current performance against the two key performance recovery indicators in the 2-year UEC Recovery Plan.

Factors Affecting Performance:

Demand and Complexity: GM has seen a significant increase in A&E attendances, particularly Type 1 cases, which require more comprehensive and immediate interventions.
Patient Flow: Challenges in patient flow, high bed occupancy, and delays in discharge contribute to the GM's current performance.
Workforce: Recruitment and retention challenges, along with high vacancy and turnover rates, impact the delivery of UEC services.
Population Health: GM has a higher proportion of residents with long-term conditions and mental health issues, leading to increased demand for urgent care.

Improvement Work:

Implementation of the 10 High Impact Initiatives (HII) from the UEC Recovery Plan, which include Same Day Emergency Care (SDEC), Frailty services, and Urgent Community Response (UCR).
Investment in UEC services, including additional hospital beds and ambulances, and the development of GM's major trauma centre.

Next Steps:

Strengthening the delivery of responsive services that meet physical health, mental health, and social care needs in neighbourhoods.

Focusing on prevention and early intervention to reduce the need for more intensive health and social care services later.

Recommendations: The NHS GM Integrated Care Partnership Board is requested to note the current performance, and the improvement work underway and consider the next steps for UEC improvement within the context of wider public service reform.

1. Introduction

Systems across the whole of the United Kingdom have seen challenges recovering Urgent and Emergency Care (UEC) performance since the COVID-19 pandemic. NHS England (NHSE) set out a 2-year UEC Recovery Plan spanning 2023/24 and 2024/25 with the aims of improving Accident and Emergency (A&E) performance with 78% of patients being admitted, transferred, or discharged within 4 hours by March 2025, and improving Category 2 ambulance response times relative to an average of 30 minutes across 2024/25.

GM is one of the lowest-performing Integrated Care Systems (ICS) in England for the Accident &Emergency (A&E) 4-hour standard of care. It is also one of the largest ICSs in England. It serves a population of over 2.8 million people, which is larger than the populations of Wales or Northern Ireland. This makes it one of the most significant ICSs in terms of population size and scope.

According to NHS Digital's A&E Activity Statistics (NHS Digital, 2023), ICS regions in urban and metropolitan areas report lower A&E performance due to higher patient inflow, greater density, and more complex cases. However, GM's performance remains below that of similar urban ICSs such as West Yorkshire Health and Care Partnership who in terms of serving a large & diverse population is similar to Greater Manchester, with comparable challenges in terms of healthcare demand and service integration.

This report sets out:

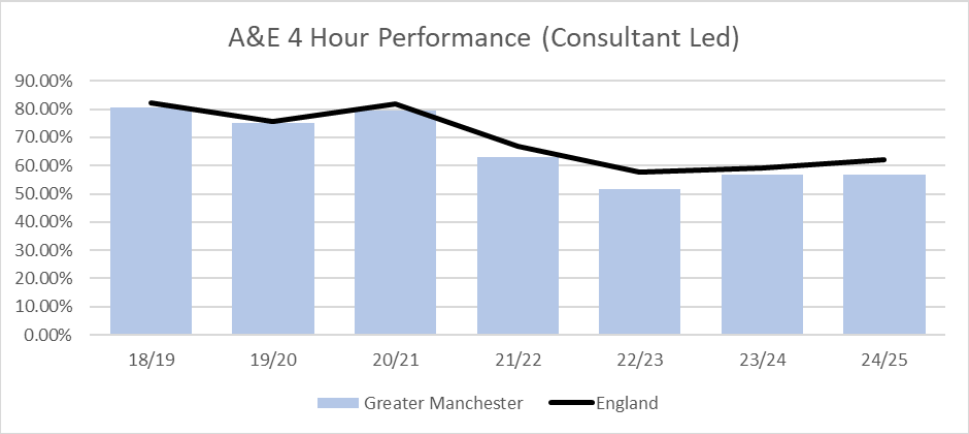
1. The current performance against the two key performance recovery indicators in the 2-year UEC Recovery Plan
2. The factors affecting UEC performance in GM.
3. Improvement work underway in GM to address the current non achievement of the UEC 4hr standard of care.
4. Next steps for UEC improvement in the context of wider public service reform

2. GM UEC Performance

A&E performance in England has consistently struggled to meet the national target of seeing, treating, discharging, or admitting 95% of patients within four hours (NHS England, 2023). This standard, introduced in 2004, remains a benchmark for the quality and efficiency of urgent care services across the country. Over the last decade, national performance has declined markedly, with most parts of the country, including GM, falling short of this standard.

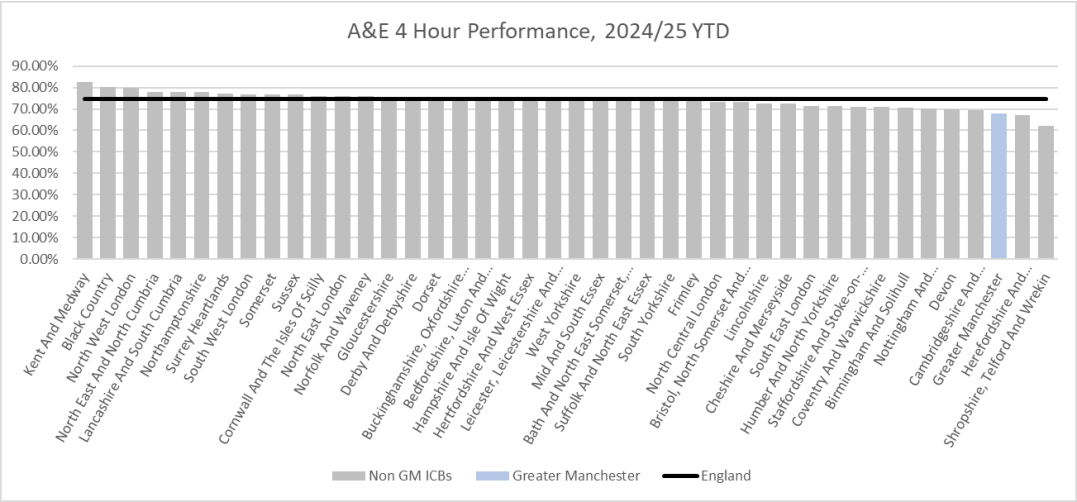
In GM, the A&E 4-hour standard of care has worsened significantly over the past decade. Analysis from NHS England shows that GM's compliance with the 4hr standard of care has decreased more sharply than in many other areas, particularly since the COVID-19 pandemic (NHS England, 2023). Between 2015 and 2023, GM's compliance fell by nearly 20 percentage points, compared to a national average decline of 15 percentage points. However, it should be noted that although this is across the GM area, there is variation between providers/sites. The consistent low performance suggests that local issues, beyond broader national trends, may be driving the low performance in GM.

The graph below illustrates GM's performance against the 4hr standard of care (all types) since 2017/18. As of 2024/25 year to date, NHS GM is 7.5% behind the rest of England, however this gap was as high as 10% in 2022/23, demonstrating improvement in the last 2 years to narrow this gap.



Graph 1 - GM's performance against the 4hr standard of care (all types

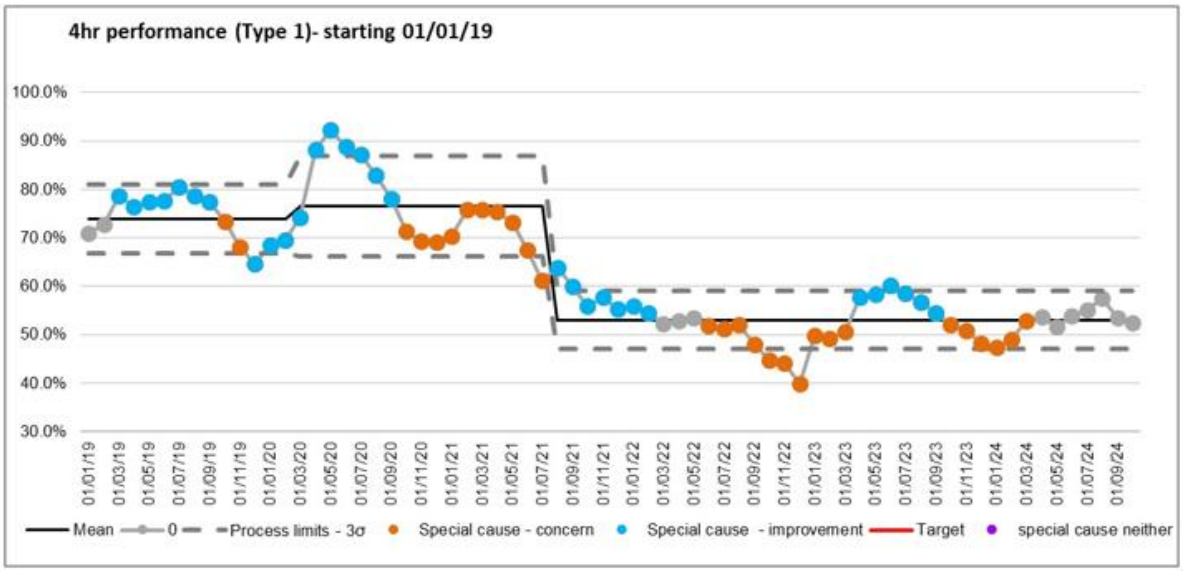
When benchmarked against other Integrated Care Boards (ICBs), NHS GM is ranked 40th out of 42 for the current year to date. This is shown in the graph below.



Graph 2 - GM 4hr Standard of Care Performance 2019-2024 (Type 1) comparison with ICBs

A&E activity types refer to the various categories of emergency care services provided in hospitals. These are classified into four main types: Type 1-4. Type 1 attendances refer to cases that require more comprehensive and immediate interventions, often placing a considerable demand on resources and personnel.

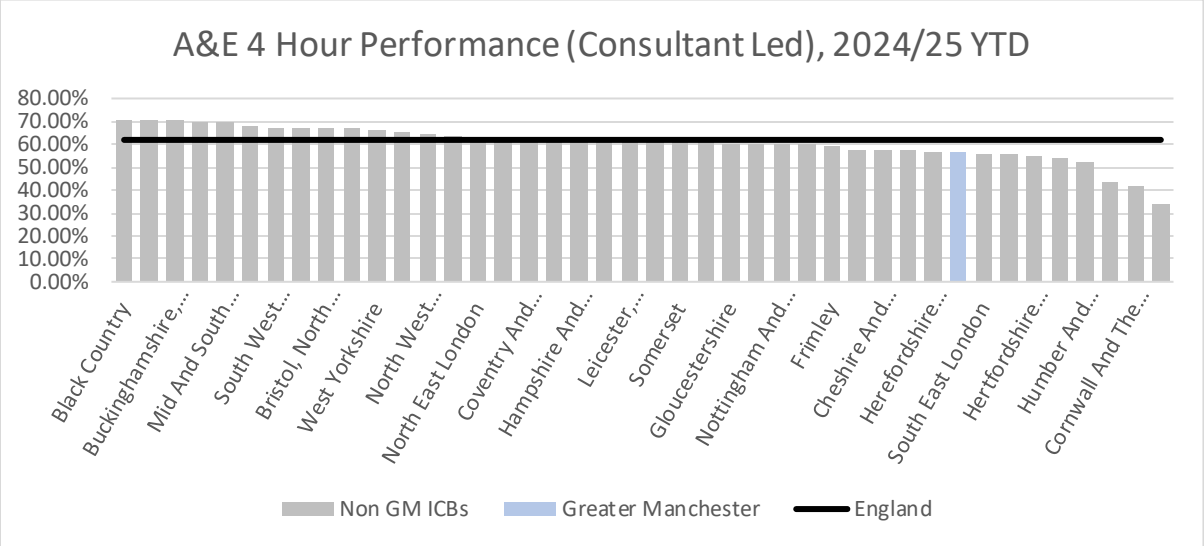
The table graph shows NHS GM Type 1 performance from 2019 to 2024. It shows the deterioration of performance since the Covid pandemic with the lowest performance coming in January 2022, approximately 40%, however since then you can see that performance has improved and NHS GM was at 60% in the summer of 2023 but dips again during the winter months.



Graph 3 – GM 4hr Standard of Care Performance 2019-2024 (Type 1)

When focusing on our Type 1 patients, who are the most acutely unwell, despite not achieving the 4hr standard of care, the situation for GM is better when compared to the ICBs than overall performance (all types).

The graph below shows that GM is 5% behind the rest of England. In terms of ranking among other ICBs, GM is currently 34th out of 42 for Type 1 activity.

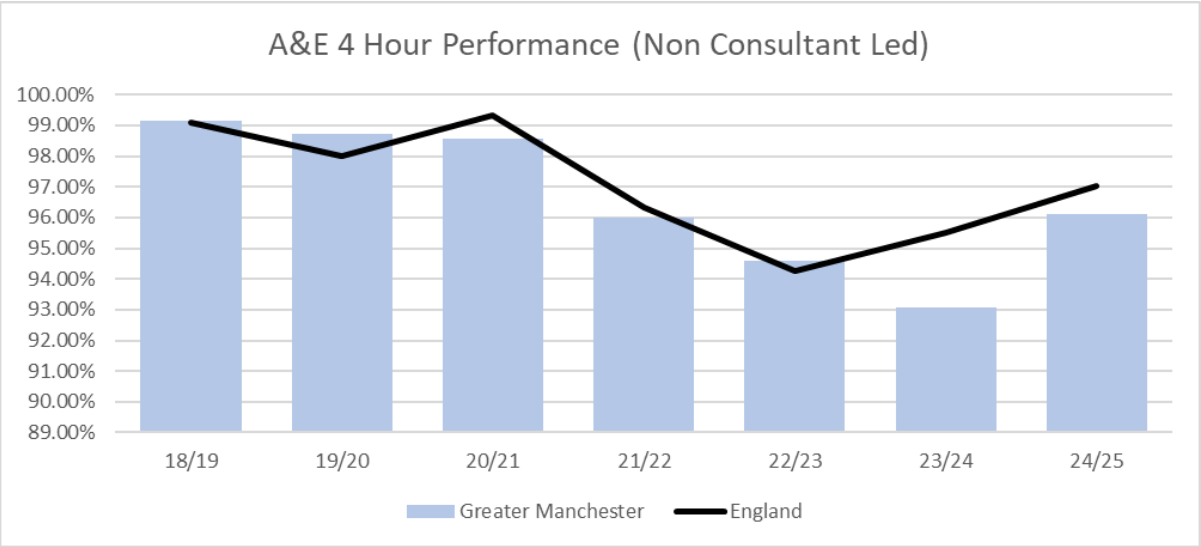


Graph 4 – GM 4hr Standard of Care Performance Year to Date 24/25 (Type 1)

A&E 4hr Performance Type 3 all ICBs

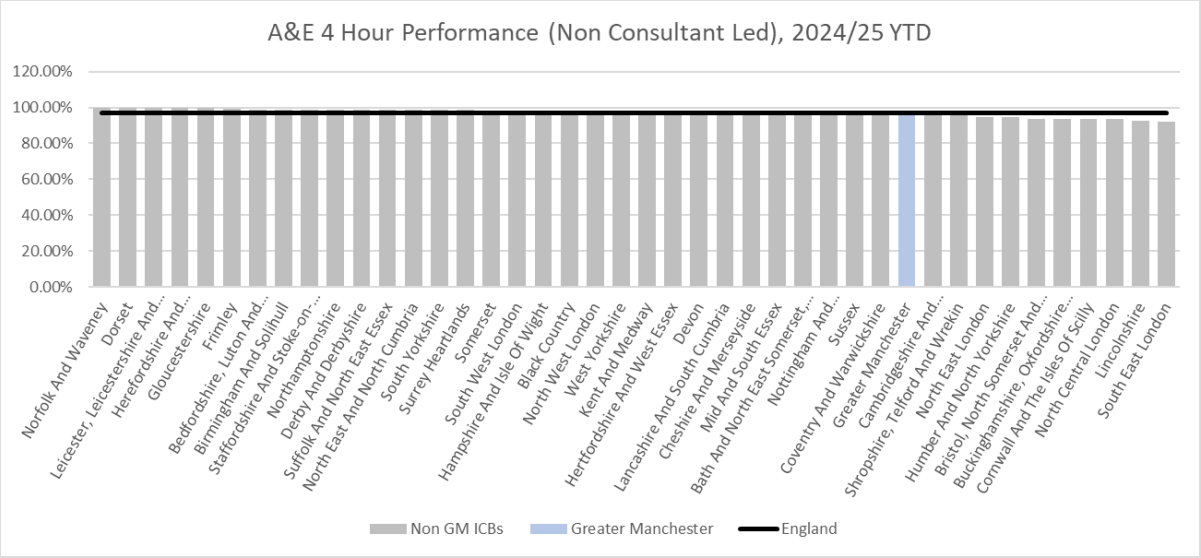
With regards to Type 3 services, they treat patients with conditions such as stomach aches, cuts and bruises, some fractures and lacerations, and infections or rashes. Type 3 services are usually GP-led and open at least 12 hours a day, every day. They can be located in the community or co-located with a major A&E department.

The graph below shows NHS GM Type 3 performance between 2019 and 2024 against the national England average. As you can see, we are below the average but have shown a good improvement in 24/25 when compared to 23/24.



Graph 5 – GM 4hr Standard of Care Performance 18/19-24/25 (Type 1)

If we compare ourselves to the other ICBs from type 3 performance only, you can see from the graph below NHS GM rank 32nd out of 42 performance and are at the national England average of 97%.



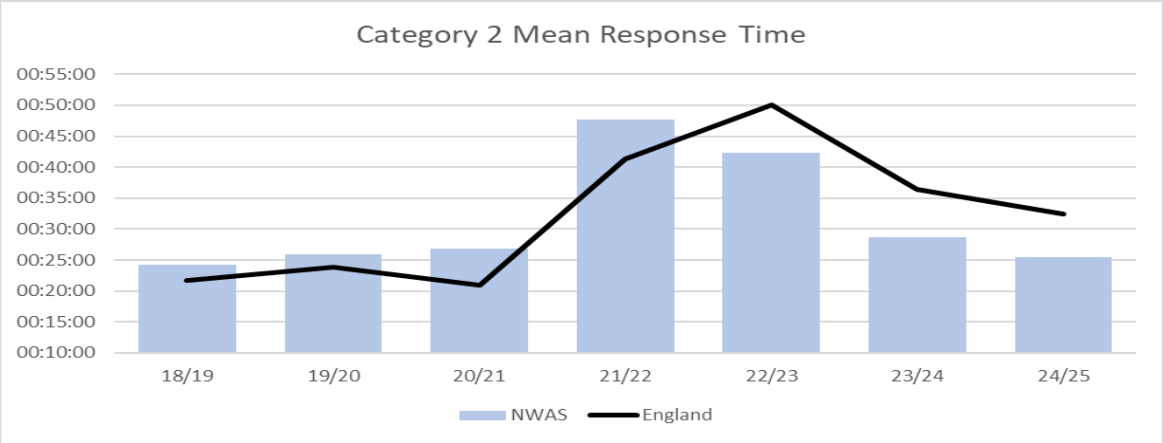
Graph 6 – GM 4hr Standard of Care Performance Year to Date 24/25 (Type 3)

Whilst GM's performance against the 4hr standard is challenged, as an ICS we are performing well against some other key metrics. Performing well in metrics beyond the 4hr standard of care is crucial for a comprehensive approach to patient care and overall healthcare quality. Additionally, focusing on a broader range of metrics encourages continuous improvement across all aspects of healthcare delivery. This balanced approach

ensures that healthcare systems are resilient, sustainable, and capable of meeting diverse patient needs.

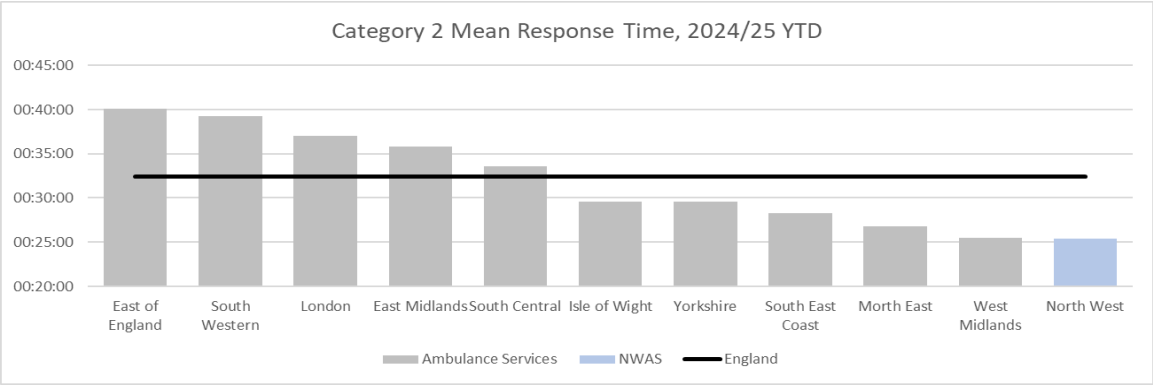
As part of the UEC recovery plan a key metric was to improve category 2 ambulance response times. A category 2 ambulance is for serious but non-life-threatening emergencies that require rapid assessment, urgent intervention, or immediate transport. Examples of conditions that may require a category 2 response include: heart attack, stroke, sepsis, and major burns.

The table below shows the mean response times for category tow ambulances for Northwest Ambulance Service (NWAS) since 18/19. You can see from the graph that since 22/23 NHS GM is performing well and average is s approximately 25 minutes, which is slightly better than the average for England, which stands at 32 minutes.



Graph 7 – GM Average Category 2 Ambulance Response Times 18/19-24/25

With regards to NHS GM 24/25 year to date performance the graph below shows that NWAS is the highest performing ambulance service in England when it comes to category two response times.



Graph 8 – GM Average Category 2 Ambulance Response Times Year to Date 24/25

3. Unveiling the Causes: Key Factors Behind UEC Performance Challenges

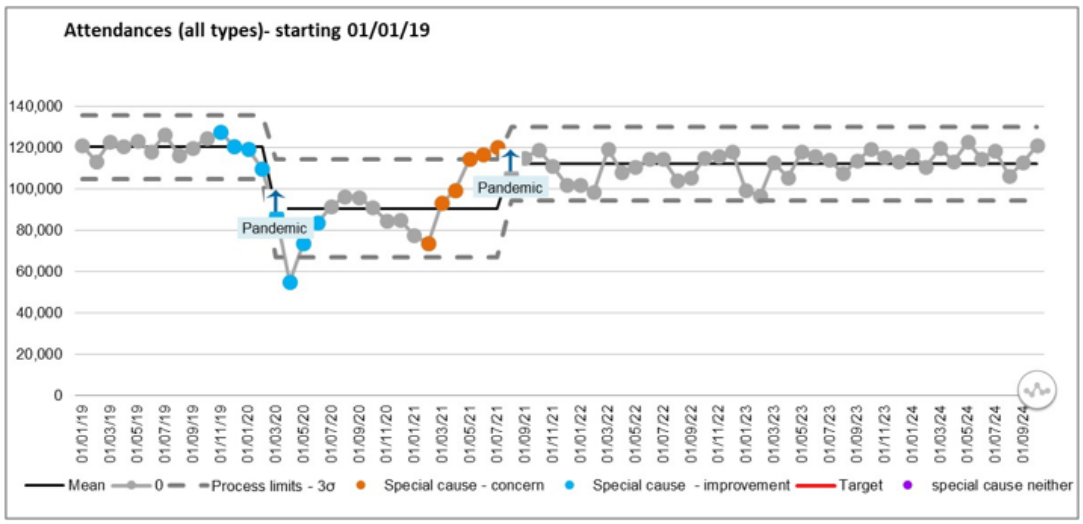
The following section sets out key evidence and analysis into the factors which are impacting on GM's ability to meet the 4-hour standard of care.

3.1. The Changing Landscape of UEC Demand

A&E departments nationally have been experiencing a rise in demand. GM saw a 15% increase in A&E attendance over the last decade, compared to a national average of around 10% (Public Health England, 2022). This increase is attributed to factors such as population growth, a rise in chronic illness rates, and challenges in access to healthcare.

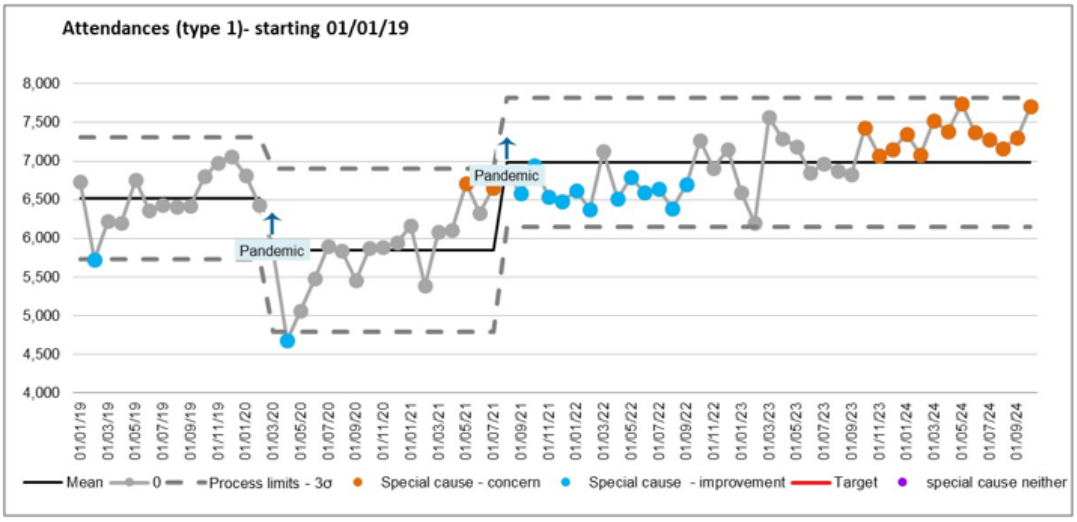
In Greater Manchester total A&E attendances have remained relatively stable over the past 3 years. However, Type 1 demand has significantly increased, which shows a shift in where and how people seek health care.

The graph below shows NHS GM attendances (all types since 2019). This shows a stable position since the Covid 19 Pandemic



Graph 9 – GM A&E Attendances (all) 2019-2024

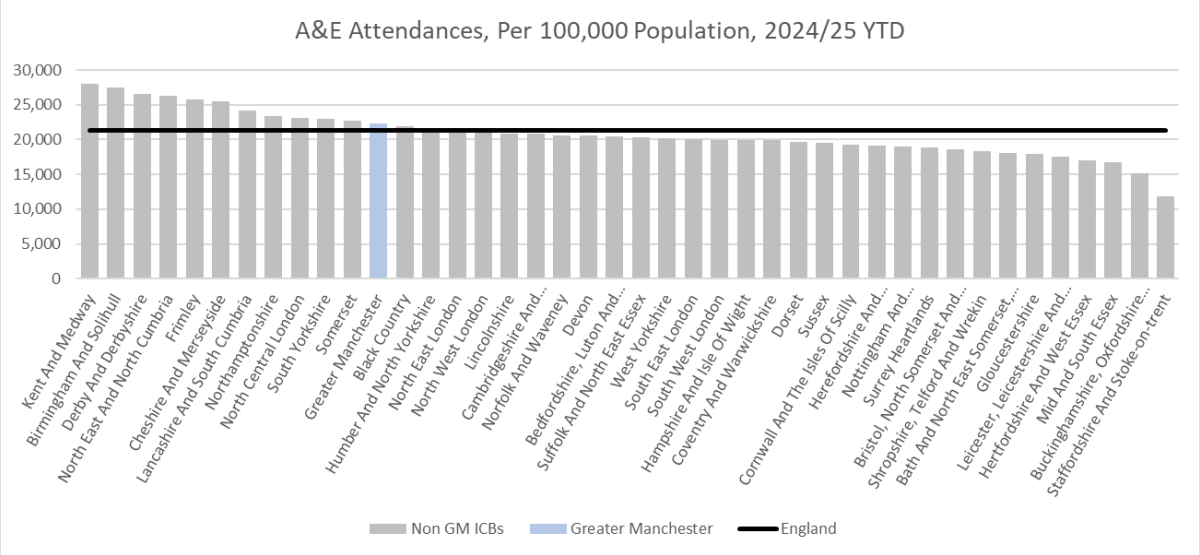
However, when we look at Type 1 attendances since 2019, the graph below shows a sustained increase which could be a contributing factor to NHS GM not currently achieving the 4hr standard of care target.



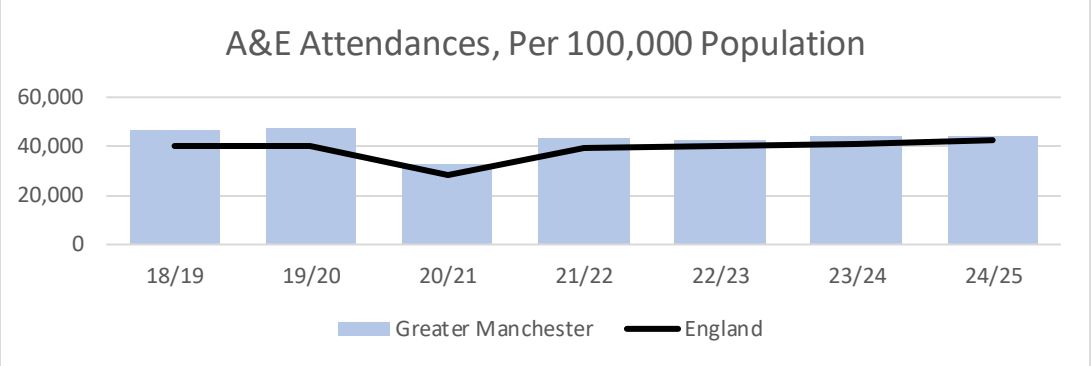
Graph 10 – GM A&E Attendances (type 1) 2019-2024

GM's performance as the second lowest in England highlights specific challenges that distinguish it from other ICS regions. For example, data from the Health Foundation shows that GM has a higher proportion of Type 1 A&E attendances than West Yorkshire, a similar sized and urban ICS, contributing to increased pressure on emergency departments (Health Foundation, 2023). In Q4 of 2022, approximately 80% of GM's A&E visits were Type 1, compared to 65% in West Yorkshire. This comparative discrepancy highlights the need for additional resources and specialised staff in GM's A&E facilities to meet the unique demands of its patient demographic.

To understand whether the growth in A&E attendances in GM is a factor in the UEC low performance relative to other ICSs, we have analysed the data per 100,000 population. GM is in the top quartile for A&E attendances per 100,000 population in 2024/25 year to date (graph 11) and has been above the national average for attendances per 100,000 population since pre-pandemic (graph 12).



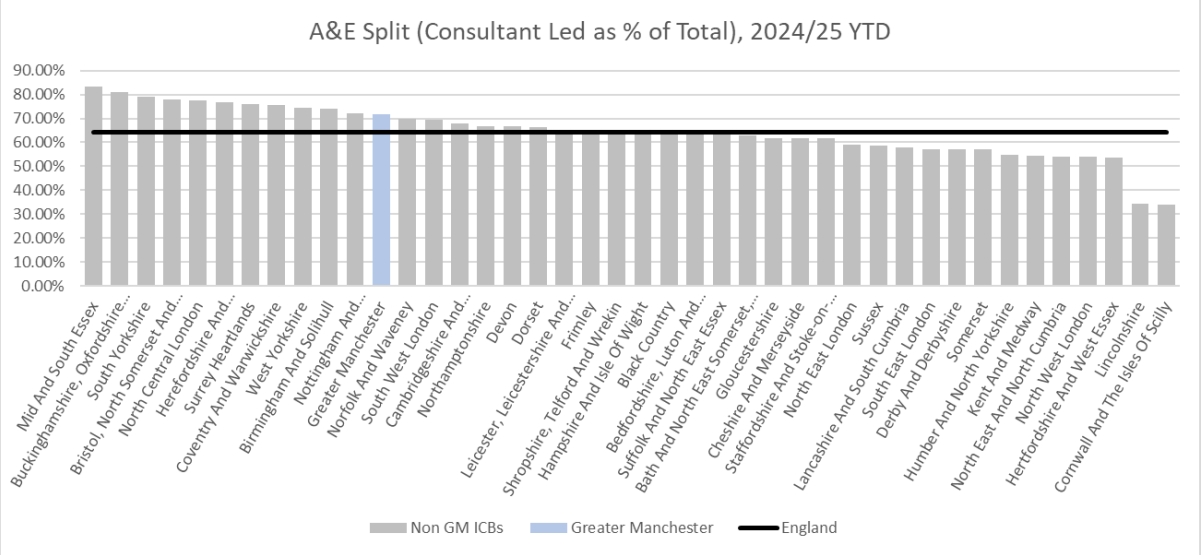
Graph 11 – GM A&E Attendances (all) per 100k population Year to Date 24/25



Graph 12 – GM A&E Attendances (all) per 100k population 2018/19-24/25

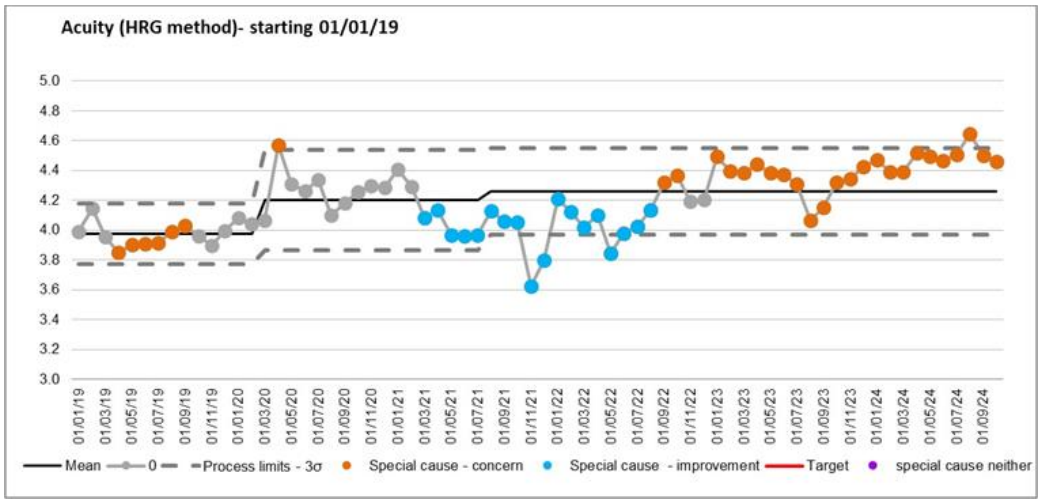
3.2 A Changing Picture in Acuity & Complexity

In GM we proportionally have more of 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 this is shown in the graph below.



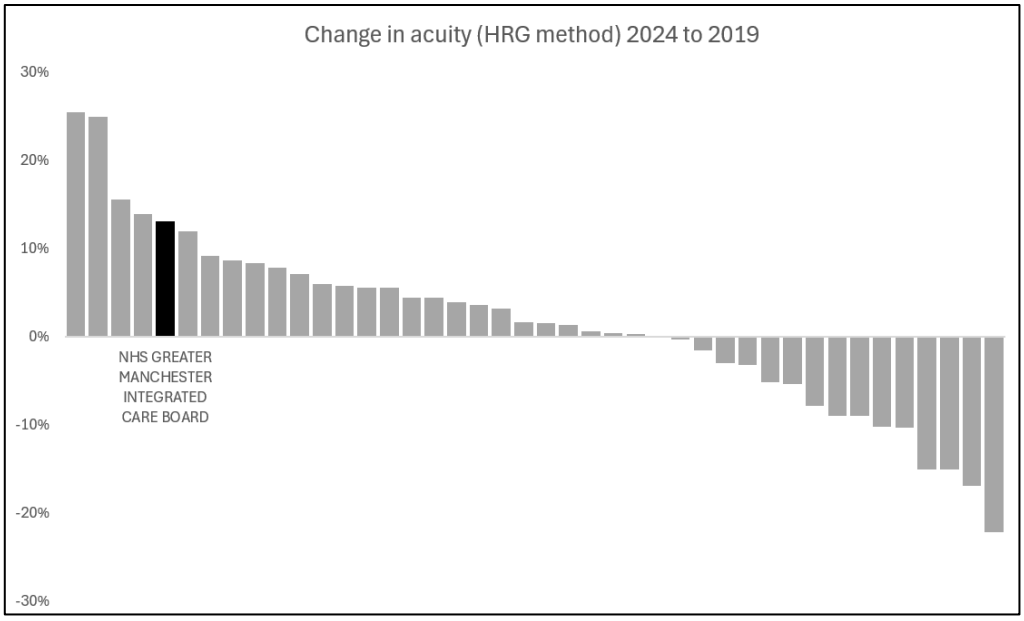
Graph 13 – A&E Type 1 as a percentage of total attendances for all ICBs 24/25 Year to Date

In GM this higher rate of attendance in type 1 A&Es is appropriate as there has seen a notable increase in patient acuity and complexity. When we use HRG (Healthcare Resource Group) codes we see that acuity has significantly increased, particularly over the past 12 months. This is evidenced in the graph below.



Graph 14 – GM Levels Acuity

Data also shows that the increase in GM has been much higher than the majority of England. The graph below shows that the acuity for GM has increased approximately 15% since 2019 and this is at 5th highest rate of the 42 ICBs.



Graph 15 – Historical Acuity ICBs

The poor health of the GM population is a linked factor in this picture of increasing acuity and complexity. More than half of the GM population live with one or more long term condition. Whilst 43.2% of GM's residents described their health as 'very good' in 2021, which was an improvement from 10 years previously, this is still below the national average (ONS, 2023). GM has a growing elderly population, with 623,982 people over the age of 60 years, which naturally leads to higher levels of co-morbidities and chronic conditions. Rates of chronic conditions such as cardiovascular disease and respiratory illnesses are higher in GM compared to other parts of England. This is partly due to higher levels of smoking and other lifestyle factors (Kings Fund 2024).

The pandemic has exacerbated existing health issues and introduced new challenges. The impact of COVID has been deeper and lasted longer on this already very vulnerable population, as well as the workforce, resulting in more individual complexities and an increase of previous unmet demand, many patients now present with more severe conditions due to delayed care during the pandemic. This together with a rise in acute activity across various services, including outpatient, elective, non-elective care, and A&E, has not only increased demand but also reflects the higher acuity and complexity of patients presenting in our UEC services, patients who require more lengthy assessments and diagnostics and potential admission leads to a higher number of breaches against the 4hr standard of care.

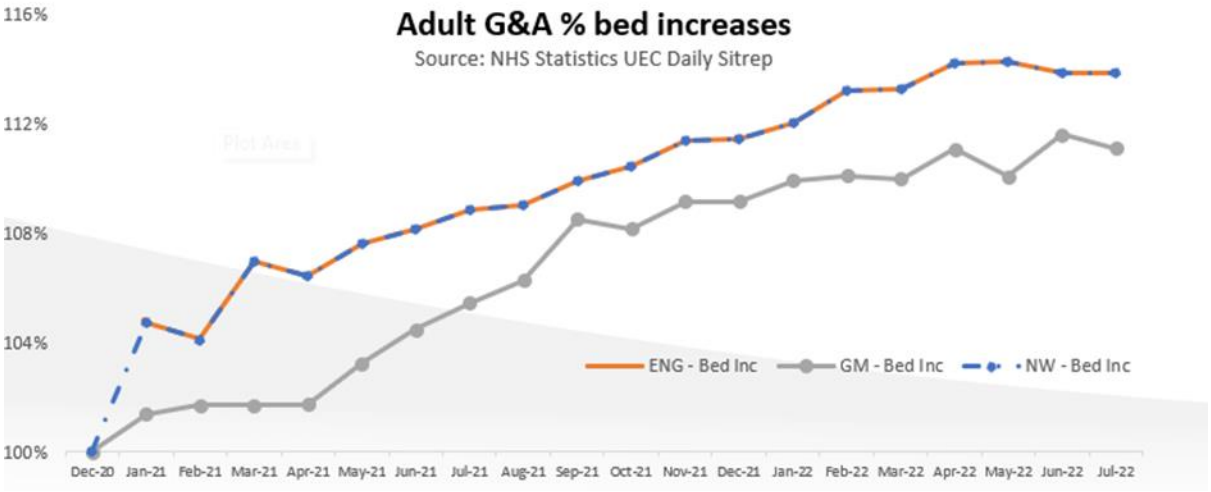
Mental health (MH) issues are also prevalent, with higher rates of depression and anxiety reported in GM compared to the national average. There is a growing recognition of the complexity of mental health needs in GM, with more patients requiring integrated care that addresses both physical and mental health. Patients attending A&E for self-harm should receive a comprehensive biopsychosocial assessment and appropriate care planning. However, assessments may be delayed if the patient is not fit for evaluation (e.g., intoxicated or not medically optimized), impacting the ability to meet the 4-hour target for treatment, discharge, or admission, with 59% of patients who attend A&E with a MH issue waiting over 4hrs.

Delays often occur when mental health (MH) patients require a Mental Health Act (MHA) assessment following the initial liaison assessment. Coordinating and completing this process can take several hours, frequently resulting in breaches of the 4-hour standard of care. Additionally, national pressures on MH beds lead to longer waits for a bed in A&E, which impacts both space and staff availability for further assessments.

3.3 Problems with Patient Flow

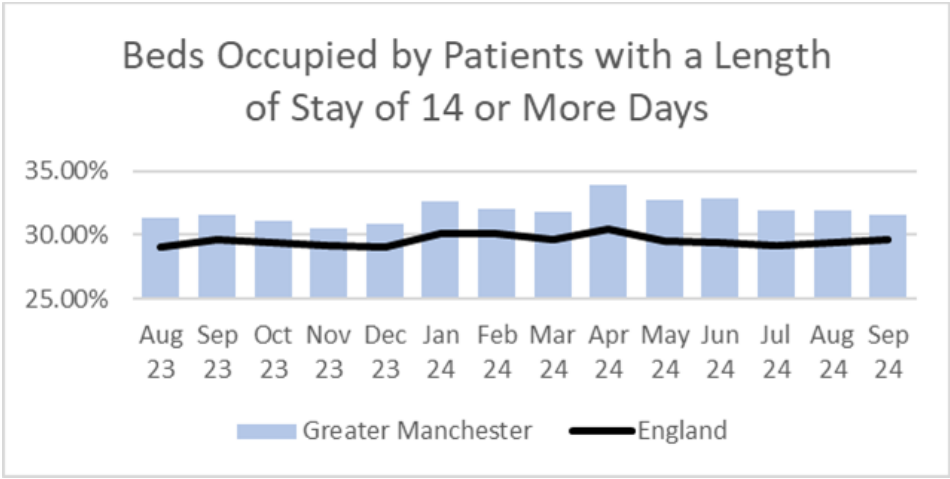
Achieving good patient flow is essential for delivering safe and timely care and meeting the 4-hour standard. Efficient patient flow ensures patients are seen, treated, and either admitted or discharged promptly, reducing A&E congestion, and improving hospital handover and 4-hour performance.

While there have been significant improvements in the urgent and emergency care (UEC) services for Greater Manchester residents, changes in the acute care offer have also occurred. To maintain patient flow, the system requires a sufficient number of acute beds. However, as shown in the graph below, since 2020, GM has increased its bed base at a slower rate than the England average, despite similar growth in bed occupancy and rising demand throughout the system.

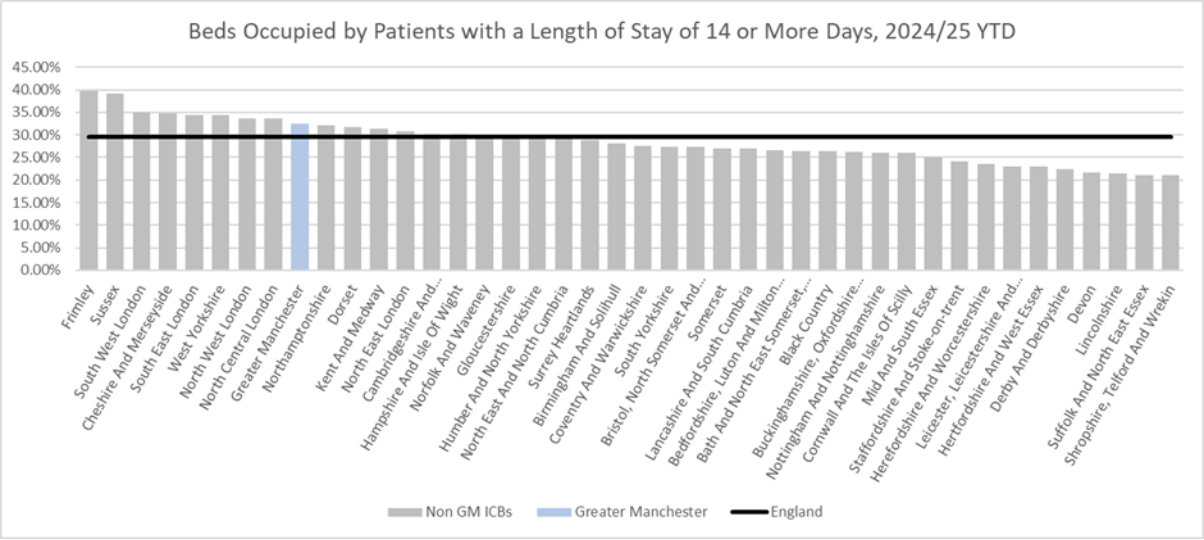


Graph 16 - GM Adult G&A Percentage bed increases

Patient flow is also reliant on timely discharge. Delays in patient discharge are partly due to increased complexity and co-morbidity, requiring longer stays in hospital before discharge can occur. The graph below (graph 17) shows that GM is significantly above the national average in terms of Length of Stay (LoS) of 14days or more and is 9th out of 42 ICBs (Graph 18) for the same metric, illustrating the increased complexity or patients which impact on the flow through the acute system.



Graph 17 - GM Beds Occupied by patients with a LoS >14days.



Graph 18 – GM Beds Occupied by patients with a LoS >14days compared to other ICBs.

Patient flow is significantly impacted by the number of patients with No Criteria to Reside (NCTR). Since January 2022, Greater Manchester has seen a sharp increase in NCTR, driven by recording mechanisms and reduced flexibility in discharging patients post-pandemic. This challenge has persisted, with the region currently 6.9% behind its target as of November 2024. High NCTR numbers contribute to high bed occupancy, disrupting patient flow and adding pressure on A&E departments.

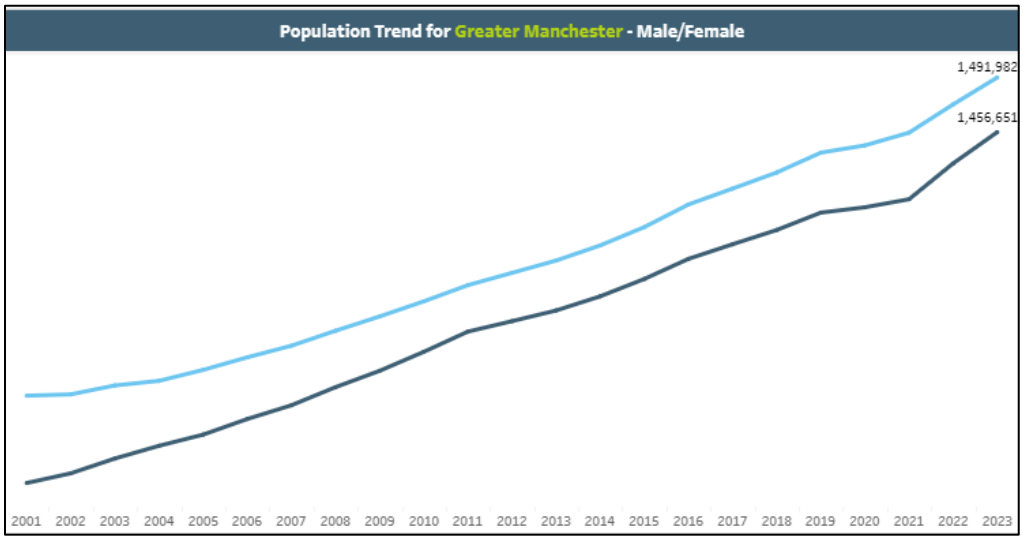
Adult Social Care (ASC) in GM accounts for over a third of local authority spending and supports around 50,000 individuals, including those with disabilities, illnesses, and unwaged carers. Each week, ASC facilitates the discharge of 500 people, primarily through home-based rehabilitation (pathway 1) and short-term beds (pathway 2). The 'home first' approach helps 80% of emergency hospital admissions return to their original homes, promoting independent living. However, the ASC provider market is fragile, with many providers exiting due to financial pressures, including recent wage and insurance cost increases. This fragility impacts patient flow, as available ASC beds may not always be suitable for discharge needs, leading to delays and higher bed occupancy in hospitals.

In GM focussed pieces of work are being undertaken to reduce the numbers of patients in hospital beds that are medically fit for discharge but remain on the NCTR (No Criteria to Reside) list. This included NCTR Sprint, GM Super Multi-agency Discharge Events (MaDE), Weekly Discharge and Flow meetings for mutual aid support.

3.4 Population Density and Growth in Greater Manchester

GM is one of the most densely populated metropolitan areas in the United Kingdom, with approximately 2.8 million residents (ONS, 2023) and around 3.3 million registered with a GP in GM. Over the past ten years, the population in GM has increased by 7%, due to urbanisation, internal migration, and international immigration (ONS, 2023). This is a 6.3% higher growth rate than across England and Wales over the same period (GMICP 2023). This rate of growth and the high density and urbanised nature of GM contribute to a heightened demand for healthcare services, particularly in emergency care, where a denser population correlates with higher A&E utilisation rates.

The graph below shows the population trend for Greater Manchester as you can see from 2020 there has been a steeper increase.



Graph 19 - Population trend for Greater Manchester

3.5 Greater Manchester's Demographics and Health Inequalities

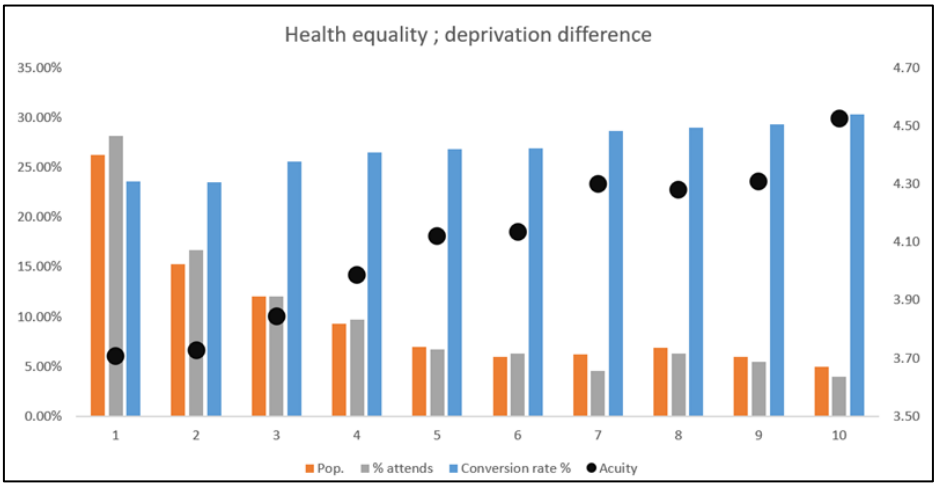
The demographics of GM reveal disparities that impact A&E attendance and strain emergency services.

Poverty is the single biggest driver of ill health, and the relationship is bi-directional: Poverty causes il health, and ill health causes poverty. GM is a disproportionately deprived area within England compared to the other ICSs, having the third highest percentage of the most deprived areas in England. 1.1 million of GM residents live in the most deprived 10% of areas in the UK.

Deprivation and associated poor health outcomes lead to increased demand for urgent care, as individuals in lower-income areas are more likely to suffer from chronic conditions, mental health issues, and acute illnesses.

A study by the Health Foundation found that deprived areas, like GM, report A&E attendance rates up to 30% higher than affluent areas, directly impacting GM's A&E capacity (Health Foundation, 2021).

The effects of deprivation on A&E attendances in GM can be seen in the data below (graph 19). The graph shows that for patients attending any of the type 1 A&Es across GM we can see that patients from a more deprived area attend more frequently but for, potentially, conditions which have could have been seen in an alternative setting. As an example, the proportion of the population that are in the most deprived decile is 26.1% but they represent 28.5% of all type 1 attendances. However, their conversion rate to admission is the lowest (23.2%) and their acuity is also the lowest at 3.71.



Graph 20 - GM Population, A&E attendances, admissions, and acuity by deprivation decile

3.6 Impact of Health Service Availability and Access in Greater Manchester

The 4-hour standard of care performance in GM is impacted by current challenges in access to other services.

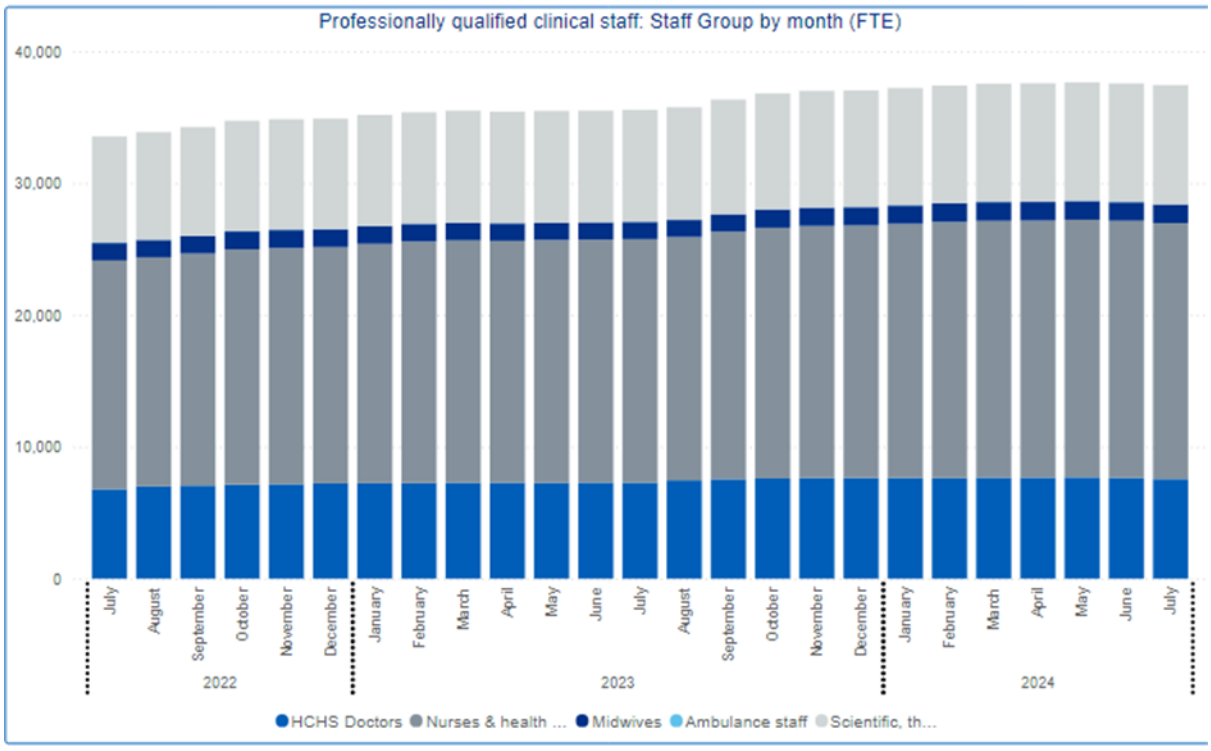
The number of people in GM waiting for planned treatment in secondary care increased over the past decade and was particularly exacerbated by the COVID-19 pandemic. Patients who face long waits for elective procedures often turn to other services such as primary care and A&Es when their conditions worsen,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

3.7 Workforce Impact on UEC Delivery

NHS staff have faced immense pressures in recent years especially during the pandemic. The Covid pandemic showed the remarkable flexibility of our staff to step into new roles, but it has also led to fatigue. While leaver rates reduced at the height of the pandemic, we are now seeing rates rise with vacancy rates at 11.8% across the NHS nationally. Demand for NHS staff is likely to continue to exceed supply over the coming years without any action.

Since the pandemic the overall NHS workforce, when looking at professionally qualified clinical staff in post across the system (including Doctors, Nurses, Health Visitors, Midwives, Ambulance Staff and Scientific, therapeutic, and technical staff), has increased in the GM system. This is shown in the graph below.



Graph 21 - GM Workforce, professionally qualified clinical staff in post.

Equally we have seen an increase of 11.4% in the UEC workforce profile in GM from August 2023- to August 2024, with 3,362 people working in the sector.

Data also shows that in comparison GM has the second highest workforce in terms of Whole Time Equivalent (WTE) per 100,000 weighted population and when compared to the England average GM has 17.9% more workforce WTE per 100,00 population in the UEC sector. (Table 1).

GM and ICS Peer Comparison Table				
ICS Breakdown	Aug-24 WTE	Weighted Patient Population	WTE per 100,000 Population	Patients per WTE
Birmingham and Solihull	949.6	1,627,267	58.4	1,714
Black Country	1,164.3	1,371,392	84.9	1,178
Cheshire and Merseyside	2,461.5	3,063,453	80.3	1,245
Greater Manchester	2,999.3	3,376,872	88.8	1,126
South Yorkshire	1,406.3	1,552,987	90.6	1,104
West Yorkshire	1,676.3	2,666,706	62.9	1,591
ICS Totals	10,657.2	13,658,677	78.0	1,282
England	46,779.8	62,154,630	75.3	1,329

Table 1 - GM / Peers and North-West UEC Workforce by Weighted Population

However, when we look at the UEC workforce of GM in relation to the level of activity and acuity we find that our A&E departments do not have enough clinical workforce to meet the demand, with most A&E departments understaffed (SEDIT Metrics, August 2024). Furthermore, despite workforce increases, GM faces a 7% NHS vacancy rate, 6% sickness rate, and 14% staff turnover rate (GMICP 2022-25). The Adult Social Care sector experiences even higher turnover at 31%. Recruitment and retention are particularly challenging especially given the lack of parity in pay and conditions compared to the NHS (GMIPC 2022-25). However, as we continue to develop integrated provisions, particularly through new blended and hybrid roles and transforming services, we should see a positive impact over time.

A 2024 Emergency Medicine Journal article highlighted a crisis in staff retention in emergency medicine, partly due to concerns over working conditions and practices. NHS providers in GM have long reported challenges in recruiting and retaining staff with the necessary specialist skills for UEC services.

3.8 Public Opinions on UEC Performance

Whilst public confidence in A&Es is falling according to Healthwatch engagement, feedback on people's experience is varied, with some reporting extremely positive experiences. However, engagement undertaken since 2021 regularly shows that more people report difficult experiences than positive ones. In December 2021, we undertook engagement in all A&Es across Greater Manchester, exploring people's decision making and service usage. This was supplemented with an online survey.

In total, over 2,000 people took part in the engagement. The feedback from this told us that most people who attend A&E (70%) have contacted, or tried to contact, another service before attending A&E. The majority had contacted their GP practice (27%) or NHS 111 (22% over the phone, and 6% online), and 5% had called 999 for an ambulance. For the people who had contacted a GP practice, some had been unable to get an appointment, and some had been sent to A&E by their GP.

Many of the people who had gone to A&E (78%) felt that their attendance had been inappropriate. However, there was a notable minority that felt that they did not need A&E, but it was the only option available to them, either because no other service was open, because they could not get an appointment elsewhere, or that NHS 111 had been too cautious.

This feedback that NHS 111 is sometimes too risk adverse is consistent and comes out across wider, more recent engagement too. When asked about 111, less than 50% of people report a positive experience, with the concern that this puts people off using the service, especially if they have a pre-conception that 111 will send them to A&E anyway. Engagement has shown that whilst the majority of people are aware of 111, they do not always understand the wider services that they offer, including, for example, booking out of hour GP appointments.

Feedback on ambulances has remained consistent from 2021 to this year too. There is regular feedback that waits for ambulances are too long, with concerns that people are being advised to make their own way to hospital, or being sent a taxi instead of an ambulance, even for severe asthma attacks. These concerns were exasperated by the fact that when people drove themselves or a family member, there then were difficulties parking that added to the stress and anxiety.

When asked about urgent care, there is a consistent view from people that if people could get help more easily and for longer hours in the community from either GP, specialist services, or pharmacies, they would use those instead.

Feedback about discharge also comes up regularly when discussing urgent care. This includes people being discharged too early before they are either physically or mentally ready, with a perception that this is due to hospitals needing their beds back. Patient experiences include people going to A&E because their package of care was not ready, or their support networks are not strong enough, leading to an exacerbation of their condition and an emergency readmittance.

4.0 Summarising the Causes; The Top 3 Factors

This detailed analysis demonstrates that GM is facing several key factors that contribute to its challenges in achieving the 4hr standard of care in A&E departments which are different to those facing other ICSs:

The most significant issue is the combination of **increased demand and increasing complexity of need.** GM has experienced a notable rise in A&E attendances, particularly Type 1 cases, which require more comprehensive and immediate interventions. Additionally, there has been a rise in patient acuity and complexity, driven by health inequalities, an aging population, and higher rates of chronic conditions and mental health issues.

Connected to this, is **difficulty for our population to receive urgent and emergency care in the right place, at the right time.** Patient flow through GM's hospitals is challenged, with a high number of patients who no longer need acute hospital care remaining in beds due to discharge delays, contributing to high bed occupancy and consequential delays in seeing people quickly within A&E. Access to primary care, mental health care and elective care is a critical factor. Despite improvements in availability of these services, the cycle of high demand and complexity into all parts of the health and care system is felt in UEC services.

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.

These factors collectively contribute to GM's challenges in meeting the 4-hour standard of care in A&E departments, highlighting the need for targeted interventions and strategic improvements. Addressing these issues requires a coordinated effort across the health and care system, including increased investment, better workforce support, improved data management, and innovative care models.

5.0 Improving UEC in Greater Manchester: Successes and Developments

The Urgent and Emergency Care (UEC) Recovery Plan is a two-year action plan published in January 2023 by NHS England to improve the quality and access of urgent and emergency care services. The plan is supported by a £1 billion national improvement package and a £200 million ambulance fund.

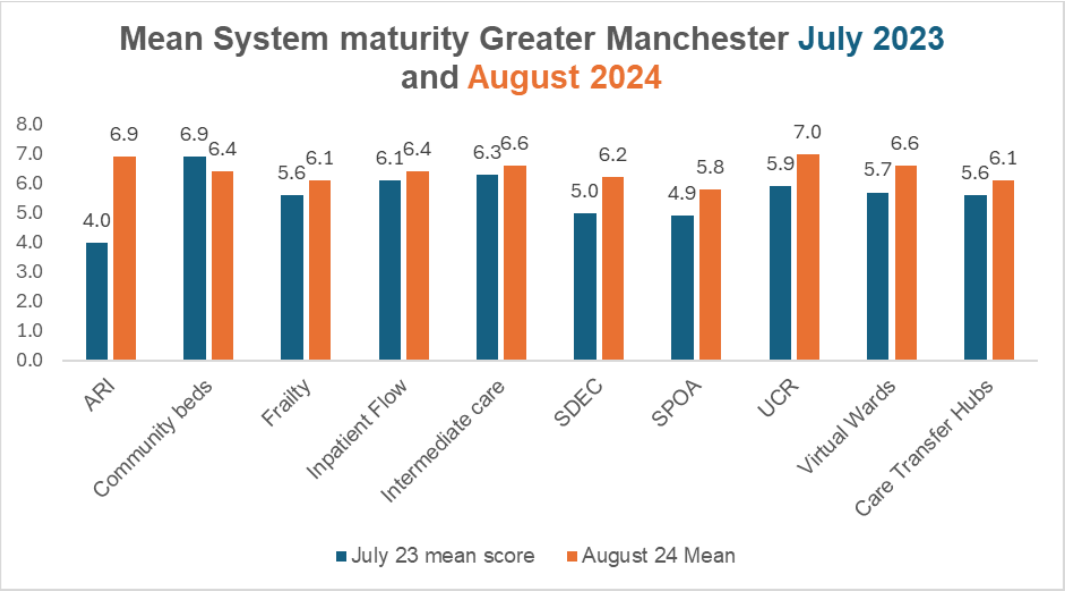
NHSE have applied a tiered approach to the support it provides to ICSs based on their performance against the 4hr standard of care, and GM has been placed in Tier 1 as they are not achieving the metric, meaning that it receives intense support from the Emergency Care Improvement Support Team (ECIST).

To support the recovery of UEC services there are 10 high impact initiatives (HII) that evidence shows will enable systems to make progress in improving quality, experience, and timeliness of service delivery. The HIIs are:

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**

Together with the ICB our locality systems have worked toward the implementation of these initiatives and have been regularly assessed to ensure that progress continues and to understand our successes and areas for continued development. Our achievements are

assessed using a matrix scoring system and GM has shown improvement over the past 18 months with all initiatives scoring as progressing to mature levels.



Graph 22 - GM HII Maturity July 23 v August 24

Key:
0-3 is classified as Early Maturity
3-5 is classifies as progressing Maturity.
6-7 is classified as Maturity.
8 is classified as Benchmarkable.

5.1 The Current Greater Manchester UEC Offer

Over the past decade, the UEC service offer in GM has broadened beyond the core services offered in A&Es and in primary care. This has been in response to the challenges outlined above relating to increased demand and complexity. These developments have been aimed at creating alternatives to A&Es that can treat people more effectively for their level of need. GM ICS have developed a set of common standards of UEC service delivery which each of the 10 localities are expected to achieve:

5.1.1 GM Hospital @ Home (Virtual Ward) Standards

By the end of 2024, Greater Manchester aims to have 936 virtual beds as part of the GM Hospital @ Home (Virtual Ward) programme. Between May 2023 and 2024, there were 36,154 patient admissions to these virtual ward beds, with an average bed occupancy rate of 68%. The University of Manchester's ARC team is conducting a comprehensive review of the programme to assess its effectiveness and outcomes.

5.1.2 2hr Hour Urgent Community Response (UCR)

All 10 localities in Greater Manchester have a 2-hour Urgent Community Response (UCR) service, aiming to respond to 70% of referrals within 2 hours. In August 2024, 89% of UCR referrals met this target. The UEC Recovery Plan has driven a 122% increase in UCR referrals from February 2023 to July 2024, with 37% of referrals coming from the ambulance service, helping to avoid A&E visits. Approximately 84% of discharged patients remained in their usual residence. However, the service is predominantly used by patients identified as 'white,' indicating lower utilisation by minority groups.

5.2.3 Same Day Emergency Care (SDEC)

The long-term plan aims to enhance system maturity for direct referrals to secondary care, reducing A&E demand. Prioritizing access to Same Day Emergency Care (SDEC) is crucial, though further improvements are needed for clinician referrals. Access varies across England, with Greater Manchester having SDEC in all acute hospitals. Efforts are underway to map SDEC provision by locality and improve NHS 111 and ambulance access. A key challenge is the complex referral criteria, which the plan aims to standardize across the Integrated Care Board (ICB) to ensure equal referral opportunities for clinicians.

5.2.4 Urgent Treatment Centres (UTCs)

Introduced in 2017, Urgent Treatment Centres (UTCs) provide urgent medical help for non-life-threatening emergencies. The 2023 Delivery Plan for recovering urgent and emergency care services expects UTCs to increasingly serve as the front door of Emergency Departments (ED), allowing emergency medicine specialists to focus on higher acuity cases. Greater Manchester currently has 10 accredited UTCs, with 3 more working towards accreditation.

5.2.5 Front Door Streaming

The 2022 to 2023 NHS planning guidance emphasizes the need for structured streaming between Urgent Treatment Centres (UTCs) and A&E departments. It mandates that A&E departments have pathways to refer clinically stable patients to community-based alternatives or appropriate on-site specialties, ideally 24/7, but at least 12 hours a day, 7 days a week. This ensures patients receive timely care from the right professionals, reducing congestion and demand in A&E departments.

5.2.6 Primary Care Access

Access to Primary Care is a priority for Greater Manchester's 2.8 million citizens and has been nationally emphasized in the Primary Care Access Recovery Plan (May 2023). Greater

Manchester has pledged to ensure same-day urgent access to General Practice when clinically warranted, eliminate the '8am rush' with improved telephony infrastructure and NHS App usage, and support PCNs. Additionally, they aim to improve NHS dentistry access through a Dental Quality scheme, ensure Community Eye Care service access in optometry, and enhance pharmacy services to reduce health inequalities. Over the past six months, GM GPs have seen a 5% increase in patient visits compared to the same period last year.

5.2.7 NHS111

NHS 111 is a free, non-emergency service in the UK designed to reduce pressure on emergency departments by providing quick healthcare advice. It directs only 12.5% of calls to A&E and resolves 12.8% with no further action. The primary recommendation for 37.8% of calls is to contact Primary Care. In Greater Manchester, call volumes have declined since the introduction of NHS 111 online in December 2017.

5.2.8 GM Clinical Assessment Service (CAS)

The Greater Manchester Clinical Assessment Service (GM CAS) significantly enhances system capacity by intervening in patient care earlier, supporting the urgent and emergency care (UEC) system, particularly 999 and Emergency Departments (ED), by redirecting activity to lower acuity care or self-care. While the savings are not directly cashable, they help mitigate extreme and growing demand. In 2023/24, GM CAS handled an average of 6,050 cases per month, and LCAS handled 6,214 cases per month. The service successfully closes over 50% of 999 calls without needing an ambulance, freeing up more ambulance hours daily.

5.3 Investment in Improving GM UEC Services

UEC services in GM are funded through a range of different contracts with provider organisations including the standard NHS contract and distinct funds for certain contracts or service developments.

The UEC Discharge and Capacity fund is a distinct funding stream that is targeted at achieving the HIIs set out in the UEC Recovery Plan. The main objectives include increasing capacity by funding additional hospital beds and ambulances to handle the rising pressures on hospitals. Another goal is to speed up the discharge process for patients who are medically fit to leave, thereby freeing up beds for new patients. Expanding community services, such as virtual wards and urgent community response teams, aims to reduce unnecessary hospital admissions. Additionally, the funding focuses on growing and

supporting the NHS workforce to ensure there are enough staff to meet the increased demand.

For 2024/25, the Discharge fund increased, with an additional £9.5 million allocated to GM NHS organisations and a further £13 million distributed across GM's 10 Local Authorities as part of the Spending Review. These funds were allocated to each locality based on the relative needs' formula.

Investment has also been made this year in our infrastructure to deliver UEC services in GM. £174 million of GM's capital allocation has been assigned to improving A&E departments in three localities and to the development of GM's major trauma centre.

6.0 Moving Ahead to support UEC Progress

GM's population need and deserve UEC services which can meet their needs in a timely and effective way, now and into the future. 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 ICSs.

Given the challenges of increasing demand and increasing complexity that have been identified as having impact in GM in a disproportionate way to that seen in other ICSs, a focus purely on improving UEC services in isolation of wider public service reform is unlikely to be enough to deliver the recovery required.

There is opportunity to harness the benefits of devolution and mature models of integration in GM to specifically focus on recovery of UEC. Opportunities include:

Strengthening the delivery of responsive services that meet physical health, mental health, and social care needs of GM people in their neighbourhoods. Live Well is GM's commitment to everyday support in every neighbourhood, changing how we work with communities and in public services to grow opportunities for everyone to Live Well. Barriers have existed to how far and how fast we can progress our neighbourhood model which need to be addressed to maximise the potential to meet people's urgent need in community, reserving A&Es for people needing emergency care.

Wrapping 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 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.

Preventing our younger generation from developing ill-health which requires UEC service delivered care in the future. With increasing demand and increasing complexity of need seen in UEC services in GM, combined with growing population size, it is evident that there is opportunity to leverage GM's foundations on prevention to benefit UEC recovery. Prevention involves early intervention and prevention to reduce the need for more intensive health and social care services later. It includes various health promotion activities designed to encourage healthier lifestyles and prevent illness. By engaging with communities, we can address the root causes of health issues and promote sustainable health improvements.

The continued partnership between the GM ICB and GMCA will be key to success, enhanced integration of health and social care services will ensure a seamless patient experience and better health outcomes. Collaborative efforts will enable more efficient use of resources, reducing duplication and ensuring that investments are targeted where they are most needed. Joint initiatives can focus on workforce development, ensuring that staff are well-trained and supported to meet the demands of UEC services and strengthening community-based services through collaboration will help manage patient flow and reduce pressure on A&E departments.

7.0 Conclusion

In conclusion, the challenges faced by Greater Manchester's UEC services are multifaceted and deeply rooted in the region's unique demographic and health profile. The significant increase in demand, particularly for Type 1 emergency services, coupled with a rise in patient acuity and complexity, has placed immense pressure on the system. This has been exacerbated by the COVID-19 pandemic, which has led to a backlog of care and an increase in the severity of conditions presented. The analysis highlights the need for a targeted approach that addresses the specific needs of the GM population, particularly in terms of health inequalities and the provision of integrated care that encompasses both physical and mental health.

Moving forward, it is clear that a holistic approach is required to improve UEC performance in GM. This includes not only focusing on the immediate pressures within A&E departments but also addressing the broader determinants of health and well-being. By strengthening

community-based services, improving patient flow through the system, and investing in the workforce, GM can work towards achieving the 4-hour standard of care. Additionally, strong collaboration between GM ICB and GMCA will support the development a more resilient and responsive healthcare system that addresses the specific needs of the Greater Manchester population, ensuring a concerted effort across the health and care system, with a focus on prevention, early intervention, and the delivery of personalized care to those with the highest needs.

Through these measures, GM can aim to provide a UEC service that is timely, effective, and equitable for all our residents.

8.0 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.

ASC Pathways:

- **Reablement**: A short-term service designed to help people regain independence and confidence after an illness or hospital stay.
- **Extra Care**: Housing designed with the needs of older people in mind, offering varying levels of care and support on-site.
- **Technology Enabled Care (TEC)**: The use of technology to support and enhance the delivery of care services, such as telecare and telehealth.
- **Pathway 1**: A discharge pathway where individuals are discharged home with rehabilitation support.
- **Pathway 2**: A discharge pathway where individuals are discharged into short-term beds for rehabilitation before returning home.
- **Pathway 3**: A discharge pathway for individuals who require longer-term care in a residential or nursing home setting.

Blended Roles: Positions that combine responsibilities from different areas of care, such as health and social care, to provide more integrated support.

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.

Community Bed Productivity and Flow: Like inpatient flow, focusing on community settings to improve care and discharge processes.

Discharge to Assess (D2A): A model where patients are discharged from the hospital to their own home or another community setting to have their long-term care needs assessed.

Frailty: Enhancing acute frailty service provision by improving recognition and referrals to avoid unnecessary admissions.

G&A Bed Occupancy: The percentage of general and acute beds that are occupied.

Health Based Place of Safety (HBPoS): A designated space where individuals detained under Sections 135 or 136 of the Mental Health Act 1983 can be safely managed while undergoing an appropriate mental health assessment.

Healthcare Resource Group (HRG): are standard groupings of clinically similar treatments that use comparable levels of healthcare resources. Within the English National Health Service (NHS), HRGs are designed to help organizations understand their activity in terms of the types of patients they care for and the treatments they undertake. For example, different knee-related procedures that require similar levels of resources may all be assigned to one HRG.

Home First: An approach that prioritizes discharging patients from the hospital to their own homes as soon as they are medically fit, with the necessary support in place.

Hybrid Roles: Roles that involve a mix of in-person and remote work, often utilizing technology to deliver care and support.

ICS (Integrated Care System): A partnership of organizations that come together to plan and deliver joined-up health and care services to improve the health of their local population.

Inpatient Flow and Length of Stay (Acute): Implementing efficiencies and advancing discharge processes to reduce inpatient care variation and length of stay for key pathways and conditions.

Intermediate Care (IMC): Services that provide short-term support to help patients recover and regain independence after a hospital stay or to avoid unnecessary hospital admissions.

Intermediate Care Demand and Capacity: Improving demand and capacity planning for intermediate care, including community rehabilitation, through better data use.

Length of Stay (LoS): The duration a patient spends in a hospital from admission to discharge. It is a key metric for hospital efficiency and patient care quality.

Mean Ambulance Handover Time: The average time taken to transfer a patient from an ambulance to the care of the emergency department.

Multi Agency Discharge Event (MADE): Events that bring together various health and social care professionals to improve patient flow, unblock delays, and streamline discharge processes.

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

OPEL (Operational Pressures Escalation Levels): A framework used to assess and manage the operational pressures within acute hospitals, ensuring a consistent and systematic approach to escalation.

- **OPEL 1**: Indicates that the system is operating within normal parameters, with demand being met by available resources.
- **OPEL 2**: Signifies that the system is starting to show signs of pressure. Focused actions are required to mitigate the need for further escalation.
- **OPEL 3**: Reflects significant pressure on the system, with patient flow being compromised. Urgent actions are needed across the system, and external support may be required.
- **OPEL 4**: Represents extreme pressure, where the system is unable to deliver comprehensive care. Decisive actions are necessary to recover capacity and ensure patient safety, often requiring extensive external support.

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.

The Evidence-Based Treatment Pathway clock (EBTP): A standard used in the NHS to measure response times for mental health crises. It ensures that individuals experiencing a mental health crisis receive timely and appropriate care.

- **Within 1 hour**: A response from a liaison mental health service should be provided within one hour of the service being contacted.
- **Within 4 hours**: An appropriate response or outcome should be in place within four hours of arriving at an emergency department or being referred from a ward.

Tier 1 and Emergency Care Improvement Support Team (ECIST): Teams that provide expert support and guidance to improve emergency care services and patient flow within the NHS.

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.

VCSE (Voluntary, Community, and Social Enterprise): This term encompasses a wide range of organisations that operate for the benefit of society, including:

- **Voluntary organisations**: Groups that rely on volunteers to carry out their activities.
- **Community organisations**: Local groups that address specific community needs.
- **Social enterprises**: Businesses that aim to generate profit while also achieving social, environmental, or community goals.

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

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NHS Greater Manchester Integrated Care Partnership Board

Date: 29th November

Subject: Prevention Demonstrator

Report of: Warren Heppolette – Chief Officer – Strategy and Innovation, NHS Greater Manchester

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PURPOSE OF REPORT:

At the September meeting of this Board, we updated on our work as an Integrated Care Partnership, working within a Mayoral Combined Authority to boost economic growth and improve health through a focus on people, prevention and place, particularly in the context of further devolution.

Building on work with system partners since then, and further discussions with Government, the enclosed slide deck sets out how we can bring existing plans and delivery together around prevention and discuss a specific opportunity to make an 'offer' to Government for GM to deliver a 'Prevention Demonstrator'

RECOMMENDATIONS:

The NHS GM Integrated Care Partnership Board are requested to support the following actions:

- Continue to develop the proposition at pace with the - working with GM partners and Government

- Continue to develop Prevention Demonstrator proposition for inclusion as an intention in the Devolution White Paper

- Further engagement with Leaders and Chief Executives on long-term GM plans for Growth and Prevention (including associated outcomes) working towards 10-year prevention plans

Contact officer(s)

Jane Forrest – Director of Public Service Reform – GM Combined Authority
Paul Lynch - Director of Strategy and Planning – NHS Greater Manchester

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Prevention, Health and Good Growth: Realising Our Prevention Ambitions

The role of a ‘Prevention Demonstrator’ as part of GM Live Well

GM LIVE WELL
local. supportive. personalised.

Where are we now

At the last Integrated Care Partnership Board we:

- Updated on our work as an Integrated Care Partnership, working within a Mayoral Combined Authority to boost economic growth and improve health through a focus on people, prevention and place, particularly in the context of further devolution.

- Discussed how the development of GM Live Well, our existing work in neighbourhoods and wider transformation activity (around the wider determinants of health) have the potential to significantly move our long-held ambitions forward but that this needed to come together across the system to deliver at scale.

Since then:

- Continued to work with government to make the case to expand the current Integrated Settlement to enable locally driven public service reform that provides greater flexibility and innovation in how our systems of support can pivot to prevention.

- Started to refresh the Greater Manchester Strategy with the intention of an underpinning Growth and Prevention Plan to deliver our priorities.

- Identified a significant opportunity for GM to become a national 'Prevention Demonstrator' to further support the case for devolution and reform to improve outcomes for people.

- Set out early thinking around 'Prevention Demonstrator' at the GM Reform Delivery Executive.

Purpose of Today

Today we aim to:

- Set out how we bring existing plans and delivery together around prevention and discuss a **specific opportunity** to make an ‘offer’ to UKG for GM to deliver a ‘Prevention Demonstrator’ on the back of conversations with Secretary of State for Health and Social Care and UKG.
- Grasp the opportunity to realise our long-held **ambitions around preventative public service delivery** and our appetite to further integrate health (particularly prevention and Primary Care) with other public services.
- Set out the purpose of the 'Prevention Demonstrator' and our proposed ‘prevention pipeline; - i.e **to establish GM as national trailblazer area** to understand what it will take to reduce demand across the system, turn around the NHS and make the case for further devolution, including around prevention and public service reform.
- Describe how the prevention demonstrator can support delivery of the Government’s priorities for the NHS – for example, the commitment to a ‘neighbourhood health service’ and taking pressure off A&E and primary care + shifting the balance of spending to focus on prevention
- Highlight the need to bring relevant resources together to further develop the 'business case' (at pace) to government to make this a reality.
- Use this opportunity to support the development and delivery of the Growth and Prevention Plan that will enhance existing neighbourhoods approaches across GM.

Building upon previous work with Central Government

Engagement with Government on Integrated Settlement and Devolution White Paper

Existing Integrated Settlement

Further Devolution to local areas around Reform & Prevention to support ambitions

Good Sustainable Growth

A Live Well model for Residents

Local Growth
Transport
Housing and Regen
Retrofit
Adult Skills

Employment Support

Multiple Disadvantage and Priority Cohorts
(Enhanced Live Well offer)

Prevention & Health

Live Well GM Prevention Demonstrator

Building Upon Existing Approach

‘Total Place 2.0’ approach to public service delivery

A mission-led, reform-driven, technology-enabled approach to funding public services

⬇

Reforming delivery around existing demand

⬇

Keeping public spend to sustainable levels

⬇

Integrated delivery across silos and organisations

⬇

A preventative approach to public service delivery

Co-located, Multi-agency Teams	Agreed Outcomes Measures	Pooled Budgets & Resources	Reprofiled Funding towards Prevention	Digitally Enabled	Workforce	Shared Accountability

Working Across the Range of Prevention

Primary Prevention	Investments and activity which prevent issues occurring in the first place.
Secondary Prevention	Investments and activity with focus on early detection and response. Managing early indications of social or health issues before they can develop
Tertiary Prevention	Managing existing issues to prevent further escalation/complication

All underpinned by a Population Management Approach*

Local areas need to be enabled to coordinate action and investment across the range of preventative activity. This means that devolution and prevention plans needs to include the ability to work across a blend of interconnected areas – We also need a collective view and description of prevention across the system

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*Meaning - Systematically identify and address prevention gaps, diagnosis and treatment gaps and to provide more tailored support . Using evidence base practice and structured data analysis.

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Prevention and the Neighbourhood Model

- Full Live Well Prevention Offer – Primary, Secondary and Tertiary
- Using full range of PHM tools
- Asset Based
- Integrated Leadership Arrangements
- Pooled Budgets

Neighbourhood Offer

- Use Risk Stratification and Proactive Case Finding
- Identify those at risk or approaching crisis
- Integrated response to issue/s and current need
- Proactive plan to prevent future need

- Agreed Outcomes
- Improved Health and Independence
- Reduced Demand on Acute and Crisis-Based Services

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Features of the Neighbourhood Model – Based on Existing Locality Examples

- Co-location of teams and partner agencies. Shared resources, skills and strengths.
- Services wrapped around schools and GP. Integrated public service teams – for example social care, care, therapy, community health and district nurses – new roles such as community coordinators.
- Daily huddles and MDTs, including wider public services such as police and community resilience teams.
- Interventions including employment support, housing standards and support, social prescribing, population health management of long-term conditions – such as diabetes and CVD addressing modifiable risk factors
- Making it easier to respond to the needs of a community, helping prevent people from being admitted to hospital or needing crisis-based care through Live Well approach.
- A more strategic approach to investment to support the model – for example scaled up investment in housing with care.

Integrated Approach to Prevention – 'Prevention Demonstrator' Opportunity

- To fix the foundations of our public services, we need go much further with the integration of health services with local government, wider public services, and other local support along with industry partnerships. We need to invest collectively in prevention at a 'total place' level to improve outcomes and reduce demand and costs – **enabled by deeper devolution**

- To meet these challenges, NHS GM and GMCA are working with Government to develop a **Prevention Demonstrator**

- The Prevention Demonstrator can serve as the vehicle for implementing our Live Well GM ambitions **bringing together existing Live Well work and VCSFE strengths and provision with targeted prevention activity across all public services** (Delivered through Live Well Centres and Spaces)

- Currently some parts of the system aim to prevent ill health, some prevent crime and antisocial behaviour, some prevent escalation of social issues, poor educational outcomes or economic inactivity. **The Prevention Demonstrator is based on the recognition that people often need all of these** – meaning a collective view of prevention and how the system operates to reflect that

- The Demonstrator will be based on the fundamentals of the GM system: our neighbourhood model; Live Well; a blend of primary, secondary and tertiary prevention; and the capability we have through the single GM Health and Care Record and our Population Health Management approach

Prevention Demonstrator – Starting Assumptions

- We **start from the neighbourhood** with a single, integrated team providing a local, person-centred, preventative system of care and support – joining up health with the full range of local support.

- **GM Live Well provides the framework** for accelerating existing prevention approaches so that the full neighbourhood model is consistently available to everyone in GM. It will bring about a radical shift in how we collaborate with people and communities to reduce health, social and economic inequalities.

- Our proposals **will need to show how we shift resources towards neighbourhood provision** which integrates primary care, community care, social care, mental health, employment support and voluntary services to offer coordinated support, reducing our reliance on acute, emergency and high-cost services

- We will work with Government to agree **prevention outcomes supported by a reprofiling of funding** away from dealing with the cost of late intervention to more sustainable upstream and proactive support.

- In doing this we will aim to **ensure the stability of health, care and voluntary services** whilst reducing the need for hospital admissions and with the goal of increasing the number of people who are living healthy lives and are economically active.

What are the unique opportunities to deliver in GM – Hands on all the levers

1 Functional Public Service Region, MCA and ICB shared footprint

GM is the most established and integrated devolved area in the country with a track record of delivery. We have an **established single functional economic area *alongside* a single functional public service area** – there are significant and unique opportunities to use GM to deliver a range of government challenges and ambitions and use GM as a test bed for the rest of the country.

2 Innovation Ecosystem

Health innovation is one of the **GM city region's 'frontier sectors**' owing to its strengths in integrated health and care, academia, digital and life sciences. Unlocking these strengths to address the drivers of population health and deliver economic growth are key priorities.

3 Globally Unique Digital and Data Capabilities

GM partners have developed **best in class digital assets** notably the GM Care Record, the Advanced Data Science Platform (ADSP), the GM Secure Data Environment (SDE) and Electronic Patient Records EPRs). Together these enable us to go deeper and further towards our ambitions of developing and deploying proven innovation to local people and measuring benefits in real time

4 Integrated Delivery Model

GM is the largest city region with an ICS and MCA acting together. This means we can **join up our support to people across all public services and civic society** with a focus on creating the conditions for good lives; getting to the root cause of issues; and reducing our reliance on expensive, crisis-based response. We start from the neighbourhood with a single, integrated team providing a local, person-centred, preventative system of care and support

5 Ability to Pool Resources and Share Accountability

For the past decade, GM has been developing **shared leadership and delivery arrangements at place level** and at a city region level supported by the **necessarily political accountability for significant devolution of the public purse**. Our localities have significant pooled budgets and shared accountability arrangements spanning health and care – we need to develop this further, including other public services, through the prevention demonstrator.

6 Track record in driving population health improvement

We have the right infrastructure to move quickly to implementation – as shown by the Tirzepatide trial in GM, supporting people with weight loss, diabetes prevention and reducing obesity related complications + the success of our work and health programmes. We already have an established multi-year prevention plan up and running – with a year 1 focus on CVD and Diabetes

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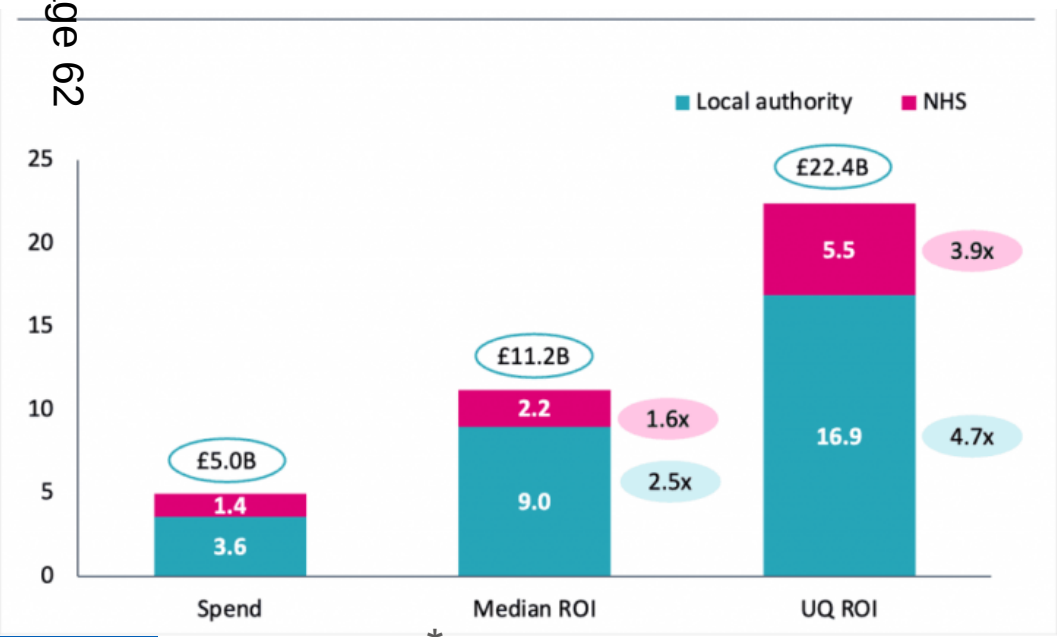
The ‘Size of the Prize’

- We know the potential impact of prevention is significant *if* we have the right flexibilities to both collectively bring together AND reprofile public spend and resources in the system
- The **evidence base and strategic case for prevention is well known** locally, nationally and internationally yet in order to capitalise on the **‘prevention dividend**’ we still need to go further **whole-system reform of public services** and a Total Place approach to public finances.

Example of Return on Investment (RoI) in the system – *based on CF Report (Median RoI for PH interventions)**
A typical median return for an NHS intervention of 1.6 and for a local government intervention of 2.5.

A conservative estimate suggests £11bn more savings per year could be achieved from the £5bn currently spent on the public health grant by local authorities and on health inequalities by the NHS via Integrated Care Boards



*Paving a new pathway to prevention - CF

- Our local research supports this and we already have a range of local innovation with savings attached.
- To achieve this at scale requires the Total Place approach we aspire to with supporting financial reforms and fuller integrated public service delivery
- We need to carry out further in-depth working setting out outcomes we aim to prevent as part of the demonstrator (and 10-year prevention plans)

Prevention Demonstrator will support GM Live Well Outcomes

Live Well Outcomes

1. **More adults in good work**, less in crisis, less inactive and less with poor health.

2. **Fewer children living in poverty**, families being supported to be safe, happy, healthy and successful.

3. **Safer and Stronger, thriving communities** supported by a resilient VCFSE sector.

4. **People living as healthy and happy as they can** meaning reduced demand on the NHS and Local Authorities.

5. **Reduced pressure on public sector finances** through greater efficiency across services, meaning more capacity to tackle the root causes of inequality.

6. **A shift to prevention** in delivery of local services – through primary care, social care, mental health and others.

Example Metrics (to be developed further)

- Increase in GM employment rate and reduced % population economically inactivity, in particular where this is due to health conditions amongst those aged 50+
- Reduced A&E admission and readmission by local population including reductions in violence, alcohol and drug-related admissions.
- Improved housing standards and supported housing provision (link to Housing First metrics)
- Close national performances rates for GLD to improve School Readiness
- Reduced number of children living in relative low-income households after housing costs

Building the Case to Government & Implementation

To take this forward with Government support we need set out our proposition and agree potential outcomes with UKG as part of a **'prevention pipeline'**

This sharpened proposal will need to:

1. Clearly respond to the immediate **'burning platform'** in the system (A&E etc)

2. Recognise the need to tie this into prevention activity with the wider determinants of health

3. Start with our key leverage points in the system around moving people closer to **employment** & responding to demand at **GP surgeries** and in Primary Care

4. Set out how we move to impact interconnected **demand in LA services and Social Care** (children's, adults, Temporary Accommodation etc)

5. Identify starting **geographies alongside priority cohorts** (including those cohorts cross-cutting services/silos – i.e. multiple disadvantage & housing support – homelessness, substance misuse, DA, Mental Health, CJ contact)

We need to be clear that this is only achievable with devolved funding and the right flexibilities to work across the public service system and public purse at a place level

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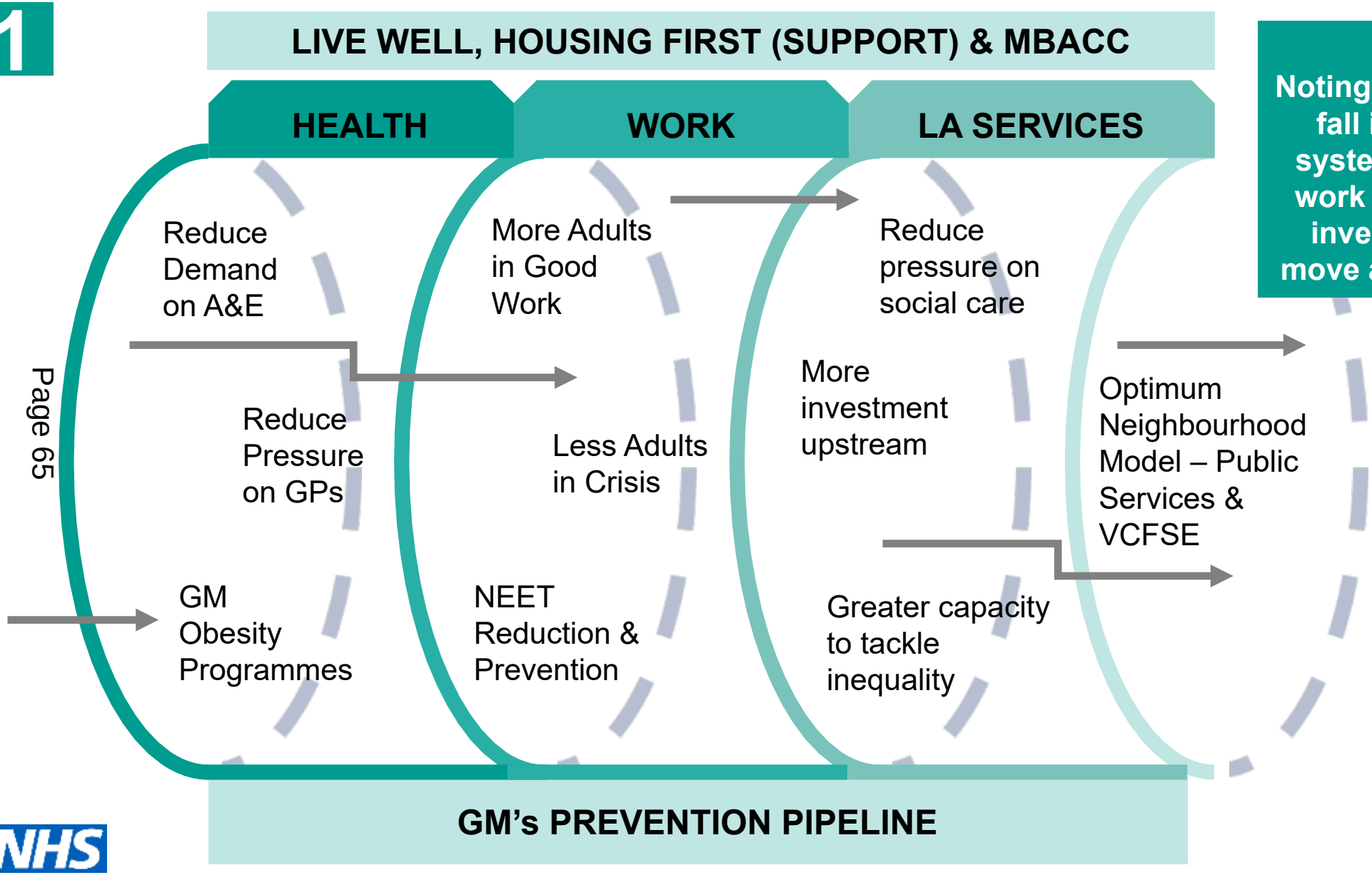
Setting out the outcomes as ‘Prevention Pipeline’

1



IMPORTANT
Noting beneficiaries are likely to fall in different parts of the system to where preventative work is happening. Collective investment which is able to move around the system is Key

Fewer experiencing multiple disadvantage:

- Homelessness
- Substance Misuse
- Domestic Abuse
- Mental Health
- CJS Contact

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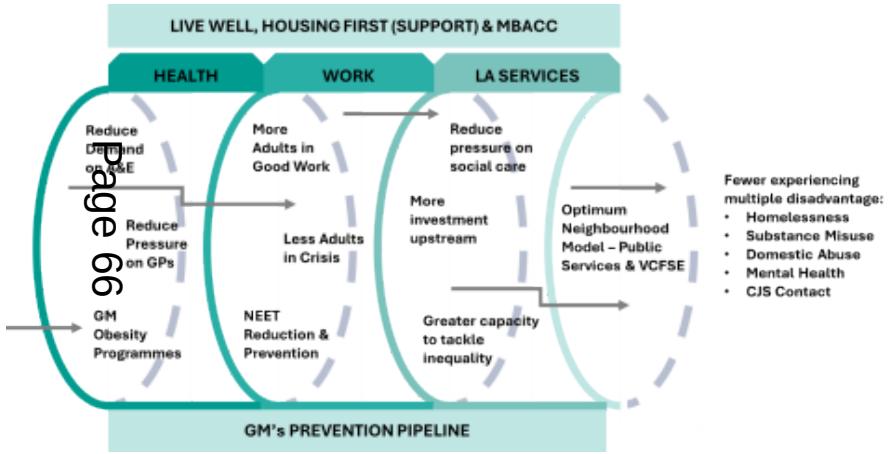
Building the Case to Government to Support Delivery

2



Phase 1

Cohort that intersects GP/Primary Care/A&E demand and economic inactivity (with identified support needs?)

Phase 2

Range of preventative activity in a place
Wider health and social care demand and pressures in public services (Social Care, prevention of crime & violence etc)

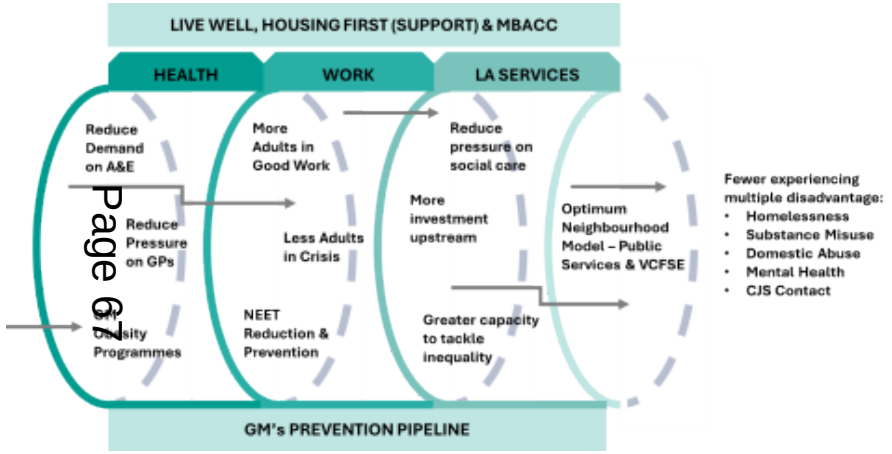
We will need....

- ❑ The right digital & data capability
- ❑ Devolved funding
- ❑ Flexibility to pool resources
- ❑ Estate
- ❑ VCFSE resilience
- ❑ Shared outcomes

Setting out interventions to achieve outcomes

GM Live Well

3



Whole system

Population health management of long-term conditions, social prescribing etc

New model of employment support integrated into neighbourhood teams as part of Live Well Centres

Integrated Support offer across public services and VCFSE in neighbourhoods as part of Live Well GM

Enhanced wrap around support offer for those experiencing multiple disadvantage

Targeted

Targeted Interventions for specific areas e.g. early cancer diagnosis, falls prevention, diabetes prevention, tobacco interventions, GM Moving, violence reduction, Skyline, temporary accommodation & improved housing standards etc

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Starting to Build the Investment Pot

A phased approach to bring together funding for Local Areas to focus on prevention and reduce worklessness & ill health

Employment Support ~£?

+

Social Prescribing £x?

+

Existing Live Well (1.0) innovation £?

+

Flexible Mental Health Support & Living Well £?

+

GM Multiple Disadvantage Investment ~£?

+

% Contribution from existing integrated settlement

+

Additional System Funding £??m

=

Investment Pot Devolved to Localities
+
(Agreed Local Outcomes to Support IS Outcome Framework)

Prevention Demonstrator – Next Steps

- Continue to develop the proposition (at pace) with the support of the ICP (working with GM partners and with Government)

- Continue to build Prevention Demonstrator proposition for inclusion in Devolution White Paper (as part of our existing devolution offer for local areas to have greater flexibilities and resource devolved around Public Service Reform, Employment Support, multiple disadvantage, Prevention & Health – building on integrated settlement arrangement)

- Further engagement with Leaders and Chief Executives on long-term GM plans for Growth and Prevention (including associated outcomes) working towards 10-year prevention plans

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NHS Greater Manchester Integrated Care Partnership Board

Date: 29th November 2024

Subject: Greater Manchester Age-Friendly Strategy

Report of: The Greater Manchester Ageing Hub

PURPOSE OF REPORT:

- Highlight the Greater Manchester Age-Friendly Strategy (2024-34), the strategy's alignment with the missions of the Greater Manchester Strategy (GMS) and the role of the Integrated Care Partnership and NHS Greater Manchester in delivering the strategy's objectives.

- Describe the contribution of the GM Age-friendly Strategy to Greater Manchester's ambitions for Live Well demonstrating how this tackles the inequalities experienced in mid and later life and responds to demand and pressures experienced within the health and social care system.

- Bring the approach to life with a focus on how delivering falls prevention with the GM Falls Collaborative, demonstrates a whole system prevention approach, tackling a key issue creating health demand.

RECOMMENDATIONS:

The NHS GM Integrated Care Partnership Board are requested to:

1. Recognise the role and contribution of the GM Integrated Care Partnership and NHS Greater Manchester as partners in the GM Age-Friendly Strategy 2024-2034, agreeing the delivery and oversight of this via the Ageing Well Steering Group.

2. Support development of a shared approach and investment case for everyday support in neighbourhoods that embeds preventative age-friendly responses within Greater Manchester's Live Well agenda; a blueprint for "Live Well in later life". Demonstrating the impact on key pressures in the health and social care system, such as through an integrated system-wide approach to falls prevention.

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Greater Manchester Age-Friendly Strategy

1. List of appendices:

- Examples of age-friendly prevention in neighbourhoods
- Falls Prevention Data in GM

2. Overview of the Greater Manchester Age-Friendly Strategy

The Combined Authority approved a new 10-year Greater Manchester Age-Friendly Strategy in February 2024.[1]The strategy reiterates Greater Manchester's commitment to delivering an age-friendly city-region to adapt to the challenge and opportunities of changing demography and tackling the inequalities that too many residents experience in ageing. 780,000 residents of Greater Manchester are aged 55 and over, increasing from just over a quarter of our residents in 2011 to almost a third now. This is projected to grow rapidly, in both proportion and number; by 2041, Greater Manchester is predicted to see its population aged 75+ grow by almost 50%, resulting in nearly 100,000 more residents.

The strategy acknowledges the need for the combined contribution of all stakeholders in addressing the strategic gap to prepare and adapt to demographic change. The strategy is based in the understanding of the ageing population set out in the 'State of Ageing in Greater Manchester' (Jan 2024)[2]. [2]

Greater Manchester continues to be a leading member of an international movement convened by the World Health Organisation (WHO) and delivering on the global age-friendly cities and communities' framework and UN Decade of Healthy Ageing (2020-2030). In March 2025, Greater Manchester will host a 3-day conference in collaboration with the WHO, national and regional research partners bringing together 200 leaders, policymakers, practitioners and researchers in the UK and internationally to advance the creation of an age-friendly world.

[1] https://democracy.greatermanchester-ca.gov.uk/documents/s31153/9A%20Greater%20Manchester%20Age-Friendly%20Strategy%202024%20-2034.pdf

[2]https://democracy.greatermanchester-ca.gov.uk/documents/s31153/9A%20Greater%20Manchester%20Age-Friendly%20Strategy%202024%20-2034.pdf

The Age-Friendly Strategy identifies four strategic themes:

1. **Economy, work and money:** building blocks for inclusive societies
2. **Places:** creating strong and supportive neighbourhoods to improve connection, health and wellbeing in later life
3. **Ageing well:** preventive action in mid and later life
4. **Working together:** Greater Manchester as a centre of excellence in age-friendly policy, research and delivery.

Strategy delivery is supported by the Greater Manchester Ageing Hub bringing together public services, VCFSE, research institutes, businesses, older people and national and international partners and facilitated by a core team based in the Public Service Reform Directorate in GMCA. An Ageing Hub Executive Group oversees delivery against a 3-year implementation plan and reports to the GM Reform Board. You can read more about delivery of the strategy at the Ageing Hub web pages here.[3]

The Ageing Hub supports the work of localities through local Ageing Well Boards, action plans and age-friendly leads, alongside GM level thematic strategic groups and programme delivery initiatives. The Ageing Hub works with the GM Older People's Network and GM Older People's Equality Panel to ensure older people's voices are heard in policy making.

NHS GM are represented on the Ageing Hub Executive Group. In May 2024 an Ageing Well Steering Group was established to oversee collaboration with the health and social care system on delivery. It is proposed that the terms of reference, membership and objectives of this group are refreshed to reflect alignment with GM missions and support delivery of a whole system approach to prevention as part of Live Well.

Recommendation 1: Recognise the role and contribution of the GM Integrated Care Partnership and NHS Greater Manchester as partners in the GM Age-Friendly

[3] https://www.greatermanchester-ca.gov.uk/what-we-do/ageing/

Strategy 2024-2034; agreeing the delivery and oversight of this via the Ageing Well Steering Group.

4. Age-Friendly Greater Manchester and the Greater Manchester Strategy

The table below demonstrates alignment of the objectives of the GM Age-Friendly Strategy align with the Greater Manchester missions.

GMS mission	Age-Friendly Strategy delivery
Live Well	**Economy, Work and Money:** supporting over 50s into employment; addressing financial hardship for older people, including promoting take-up of later life benefits. **Places:** creating strong and supportive neighbourhoods to improve connection, health and wellbeing in later life, including the Ageing in Place Pathfinder, Safe and Welcoming Places and Greener Later Life. **Ageing Well:** GM Falls Collaborative; Community Mental Health Transformation; Active Ageing. **Working Together:** growing the influence and impact of the diversity of older people's voice and lived experience on decision-making.
Housing First	Improving the quality and quantity of Age-friendly homes in the city-region and ensuring clear pathways for residents to find the right housing options for them.
Bee Network	**Places:** improving the accessibility and suitability of transport, across the Bee Network, door-to-door provision and increasing active travel.
MBacc	Further development required of an approach to lifelong learning.

5. Age-Friendly Greater Manchester: delivering on Live Well

Live Well is our joint commitment to ensure everyday support is available in every neighbourhood across Greater Manchester - to help people manage the pressures of life, live as well as they can and find purpose through good work. GM Live Well provides a framework to further develop existing neighbourhood and prevention approaches across Greater Manchester. By helping more people to access the support they need to live well, this prevention-first approach will help reduce the need for and demand on both primary and urgent and emergency care.
The Ageing Hub has been working close with colleagues and partners leading on Live Well ambitions over the last 9-12 months to connect, explore and synthesise across the strategies. Highlights of collaboration to date:

- Live Well branded Pension Top-Up Campaign, Oct 2024
- "Ageing in Place Pathfinder, part of Live Well" Annual Report, Oct 2024
- Ageing in Place Pathfinder as key demonstrator in shared work defining GMHP contribution to Live Well
- Voice and lived experience by engaging GM Older People's Network, Older People's Equality Panel and Ageing in Place Pathfinder Partnerships
- Key stakeholder engagement e.g. Age-friendly Local Leads (LAs)
- Working with the Live Well Dementia Offer and Creative Health focus on brain health and ageing (and unpaid carers) as part of Live Well
- Research on financial impact/ return on investment of age-friendly preventative responses.

In the context of Greater Manchester's demographic change, i.e. a growing older population experiencing increasing inequalities (health, social and financial) an age-friendly approach plays a critical part in long-held ambitions on preventative public service delivery. The WHO age-friendly framework for cities and communities supports identification of the barriers to wellbeing and delivery of a whole-system, place-based approach to prevention in neighbourhoods.[4] Greater Manchester has a strong track record and evidence base for the impact of delivery with this approach that supports the core principles and framework of Live Well and a "prevention-first Greater Manchester". Key examples are:

- The Ageing in Place Pathfinder is a £4million investment in a resident-led, place-based approach that is co-producing preventative responses to ageing well in ten GM neighbourhoods. Pathfinder lead organisations are leading on engagement, building capacity and capability with residents and anchoring partnerships with stakeholders including local authorities, primary care, housing providers and VCFSE organisations in neighbourhoods with high levels of income and social deprivation[5] experiencing health inequalities. Co-produced local action plans deliver asset-based projects responding to the specific spatial needs of social infrastructure, the physical environment and local service provision to address social isolation, inclusion, health and financial outcomes. Further information and case studies can be found in the 2024 annual report here.[4]

- Greater Manchester has been prioritising work on older workers through targeted employment support initiatives and work with the Good Employment Charter. Between 2009 and 2022, total employment has increased by 14% from 1.18 million to 1.34 million, the number of older workers as a proportion of total employment has increased from 25% to 33%. A rise in economic inactivity among workers aged 50-64 since the COVID-10 pandemic makes the UK an outlier among OECD countries.

- The Ageing Hub works closely with the GM Older People's Network and the Older People's Equality Panel to ensure that the voice and lived experience of older residents is heard in decision-making. Building co-production and other participatory approaches into the design and delivery of age-friendly responses and understanding the impact this has on outcomes is a key component of the age-friendly strategy and is supported by strong links to research institutions.

[4] https://www.greatermanchester-ca.gov.uk/what-we-do/ageing/the-ageing-in-place-pathfinder/annual-reports

- The GM Ageing Hub provides a regional support and convening role through an extensive cross-sector ageing eco-system delivering knowledge and evidence dissemination, innovation, development of policy and practice and accessing investment for testing and developing new approaches.

6. **Live Well in later life: accelerating the impact of prevention in later life**

Embedding age-friendly and the contributions and challenges of an ageing population within Live Well and Greater Manchester's plan for prevention offers significant opportunity to accelerate the roll-out of initiatives with the potential to impact on key areas of health demand and work demand. Further building and communicating the evidence to shift investment to prevention and understanding the learning on how to address the barriers that are preventing wider system change that could enable:

- Addressing critical demand and pressure in the health and social care system
- Responding to economic inactivity for those over 50 years old
- Targeted action to tackle the inequalities in ageing

The work to embed prevention in mid and later life within the prevention pipeline will focus on priority outcomes that are understood to have the greatest potential for impact on the demands and pressures of the system:

- Health creation: **falls prevention**
- Social connection: **reducing isolation and loneliness**
- Economic inclusion: **over 50s employment and reducing financial hardship for older people**
- With a cross-cutting focus on:
  - Working with primary care providers to share practice and build responses across the range of prevention with communities.
  - Addressing impact of digital exclusion.

This “blueprint” for Live Well in later life will inform prevention plans by:

- Describing a GM vision for “Great everyday support” in mid and later life for local delivery, including the offers from Live Well centres and spaces.
- Making the case for investment by strengthening articulation of the evidence base for reform and prevention, in terms of demand and return on investment.
- Identifying and sharing examples and learning from existing delivery.
- Integrating the current work with Pathfinder lead organisations, Local Authorities, Locality Boards, GMHP and other partners on growing and spreading the learning from the Ageing in Place Pathfinder
- Setting out the functions of the Ageing Hub to deliver the “regionally supported” role
- Identifying priority cohorts and geographies for delivery (building on the spatial analysis work of the Ageing in Place Pathfinder).

6. Falls Prevention – Accelerating impact

Falls prevention will be a key element of a Live Well in later life approach. Falls are the largest cause of emergency hospital admissions for older people; this results in a significant impact on an individual's longer-term outcomes. Falls are a major public health issue in Greater Manchester:

- Every year more than 3 million people agreed 65 and over fall at least once; in 2022/23, there were 209,989 emergency hospital admissions due to falls in people aged 65 and over.
- Of the 209,989, 10,260 were recorded in the NHS Greater Manchester Integrated care system. This is the 3rd largest recording in the whole of England, equating to 2,280 per 100,000.

Falls are not an inevitable part of ageing, and through a whole-system approach and investment in prevention, we can shift the dial and improve overall health and outcomes for the individuals in our communities. With a rapidly growing ageing

population in Greater Manchester the consequences of continuing with *'business as usual'* will:

- Increase patient morbidity, with many experiencing fractures, head injuries, or prolonged hospital stays.
- Grow the existing annual costs associated with falls in Greater Manchester which are estimated to be around £250 million**.**
- Increased pressure on healthcare staff and resources, affecting the overall service delivery.

The Greater Manchester Falls Collaborative

The GM Falls Collaborative was established to oversee and deliver the strategic and operational system level priorities and recommendations for falls prevention, integration and reconditioning across community, clinical and care settings. The collaborative sends a clear message that falls prevention is a continued priority, in enabling improved health outcomes for all, working towards co-created integrated pathways, raising the profile of what works in terms of life course approaches, prevention and evidence-based interventions. The Collaborative delivers on the GM Integrated Health and Care Partnership Strategy and Joint Forward Plan.

The Falls Collaborative works closely with key leaders from the World Health Organisation (WHO) through the Age-friendly Environments Knowledge and Action Hubs[5]on falls prevention, and global leaders in academia at the University of Manchester, Applied Research Collaboration 'Healthy Ageing Research Group', to embed the evidence-base on falls prevention across policy and practice.

Case-Finding for Falls Prevention

The Case-Finding for Falls Prevention project demonstrates a reform-driven and data-led approach to address demand. Grant funding of £100,000 from the Office for Health Improvement Disparities (OHID) and Centre for Ageing Better is supporting the design and delivery of system innovation to deliver a precise and targeted approach to prevention. The project is working with the South Wigan Ashton North

[5] https://extranet.who.int/agefriendlyworld/age-friendly-practices/age-friendly-environments-knowledge-and-action-hubs/

(SWAN) Primary Care Network (PCN) in Wigan, to ensure meets requirements of the primary care system. We intend to use the data in the GM Care Record to identify individuals who are at an intermediate risk (10-25%) of a fall within the next 12 months. We are using the eFalls Tool (embedded in Version 2 of eFI). Those identified as at risk will be contacted and signposted to an evidence-based intervention to reduce their risk and improve their overall health and wellbeing.

Co-design work has been undertaken with older residents living in SWAN area who are engaged with the Ageing in Place Pathfinder to inform the engagement design. We are working to validate this approach, to create a model of working for all PCN's in GM. This way of working demonstrates how we want to work across the range of prevention, being data-driven and utilising the technology we have in the system to improve health outcomes across the city-region.

Recommendation 2: Support development of a shared approach and investment case for everyday support in neighbourhoods that embeds preventative age-friendly responses within Greater Manchester's Live Well agenda; a blueprint for "Live Well in later life". Demonstrating the impact on key pressures in the health and social care system, such as through an integrated system-wide approach to falls prevention.

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Economy, work & money // Financial Resilience

Income maximisation: GM Pension Top Up

Delivered by a partnership of GMCA, LAs and GMHP, supported by Independent Age, Age UK and Citizen's Advice and co-designed with older people. GM campaigns to date have evidenced at least £10 million in additional income claimed.

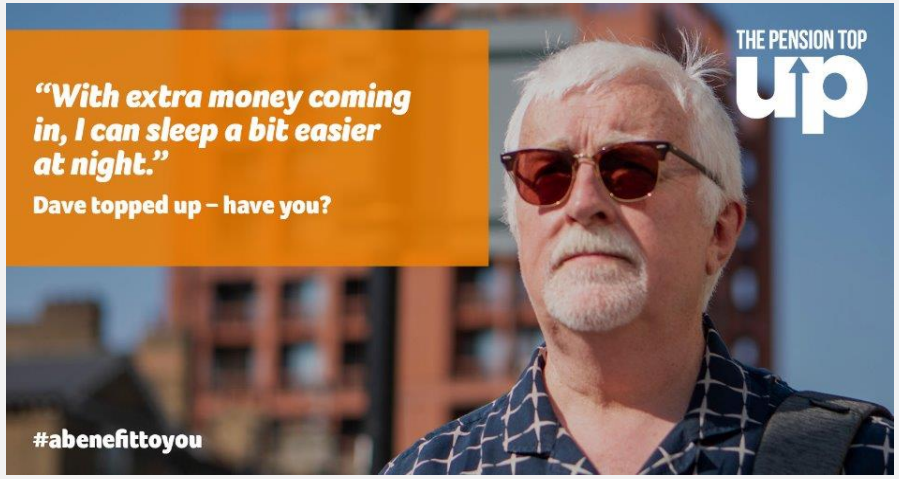
Estimated 39,000 GM households are eligible but not claiming Pension Credit (£95 million per year). Estimated cost to the GM health and social care sector is as much as £181 million per year.

Autumn 2024 a further campaign under the GM Live Well umbrella will focus on increasing take-up of entitlements. National campaign messaging will be amplified, building on learning from previous work and growing the alliance of GM partners to support and deliver engagement.

Community-based cost of living support

Residents in the Ageing in Place Pathfinder in Smallbridge supported by RBH to design and deliver a package of work targeting local cost of living pressures and healthy eating. Focused on skills and knowledge sharing alongside social connection.

Retired school catering manager Lorraine led a one-pot cookery course and published a recipe book working with the Smallbridge Pantry. Citizens Advice Bureau delivered energy tariff information sessions and ran a workshop to create eco-cooker bags, demonstrating how food can cook for 6 hours without fuel. Cadent Gas provided slow cookers, demos and carbon monoxide alarms to residents.



GREATER MANCHESTER
DOING AGEING DIFFERENTLY

Economy, work & money // Employment & Skills Support

Supporting over 50s into employment

Working Well: Support to Succeed is a specialist service to support people not currently engaging with employment support services to achieve their goals.

A dedicated offer for those aged 50+ has been developed by GMCA Work & Skills supported by Centre for Ageing Better. This was informed by a co-design process to understand what people want from employment and skills support and the challenges they face.

Between Jan-Aug 2024 there were 2,674 participants of which 827 were over 50. Those aged 50 and over attending more interventions than any other cohort.

Community reporters

Talking About My Generation is a community journalism project led by older people. It aims to at challenge ageist stereotypes while informing Greater Manchester's older residents about what's happening in their local area.

The project was launched by the social enterprise Yellow Jigsaw in partnership with Greater Manchester Age UKs. It trains older people as volunteer community journalists to create news stories, videos, and podcasts that highlight the experiences, views, and nostalgia of older residents across the region.

The team created videos to promote the GM Winterwise guide and the Talking About My Generation news site enjoys 2.9k unique users every month, with a 5000+ Facebook community sharing daily news and views.

Socially Connected, Healthy Places // Wellbeing

Age-friendly spaces

In the Moorside Pathfinder (Bury) Persona worked with residents to open a community hub and sustainable café in Clarence Park in spring 2024.

The space offers affordable hot and cold food, a calendar of weekly community activities and opportunities for local services to connect with local people for information, advice and other offers. Supporting Sisters are supported to deliver a monthly traditional South Asian breakfast morning. The café acts as a base for launching other community projects in and around the park.

'Who's Art? Who's Culture?'

An intergenerational photography project in the Charlestown & Pendleton Pathfinder (Salford). Inspiring Communities Together and local youth services supported older residents and young people to come together to explore experiences of places that feel safe and unsafe, what matters to them and how generations viewed each other. Following an exhibition the group started an intergenerational growing project and welcomed new people.

Increasing & improving social activities

In the Little Lever (Bolton) Pathfinder, local Peer Navigators responded to residents ask for more varied social activities. A programme of over 14 weekly activities has been curated connecting residents and groups.

Some groups are led by older residents. The Men's Fellowship responds to requests for places to go from socially isolated men. Social prescribers and the home from hospital service signpost and refer.

AGEING IN PLACE PATHFINDER
DOING THINGS DIFFERENTLY FOR GREATER MANCHESTER

Socially Connected, Healthy Places //
Primary & Community Care // Physical Activity

New ways of working with health services

For local GPs, social prescribers and health practitioners attending Pathfinder Partnerships helps discuss local issues, build relationships and identify new ways of working with residents.

The health centre in Little Lever (Bolton) created a weekly informal drop-in space, 'Me You & a Cup of Tea' for residents. In Ridgehill (Tameside) health checks delivered in community settings with the Be Well and Population Health teams and referrals to a local 'Healthier You' course. In SWAN (Wigan) the Pathfinder and Health Centre facilitated micro-grants to residents for small environmental improvement projects.

Green and Growing Spaces

Across the Ageing in Place Pathfinders residents are keen to improve access to the benefits for physical and mental health, social interaction and for the natural environment available in local green spaces.

In Brinnington a shared allotment has been secured and community gardens at First House and Dunton Towers; produce is utilised by local organisations. In Gorton, an "eco-streets" consultation resulted in alleyway clean ups, litter picking, design of walking routes to access green spaces and investment in benches. In Moorside a couch to out and about route has delivered new benches and a community garden has been regenerated led by local volunteers and offering a weekly gardening group.

Walking & Wheeling

Working with residents to create local walking groups, develop routes/ maps, undertake walking and wheeling accessibility audits and install benches for 'couch to out and about' routes is a key activity in the Ageing in Place Pathfinders.

This film from Abbey Hey (Manchester) describes the benefits for residents: social connectedness, peer support, physical and mental health, wellbeing and feeling safer accessing local spaces.

AGEING IN PLACE PATHFINDER
DOING THINGS DIFFERENTLY FOR GREATER MANCHESTER

Age-friendly housing & places // Housing

Housing, Planning and Ageing Group

An interdisciplinary group convened by the Ageing Hub with members from local government, architects, academics, developers, GM housing providers, Centre for Ageing Better and representatives from GM Older People's Network.

Meeting since 2018 the group is committed to the aim of improving the quality and quantity of age-friendly homes and neighbourhoods in Greater Manchester.

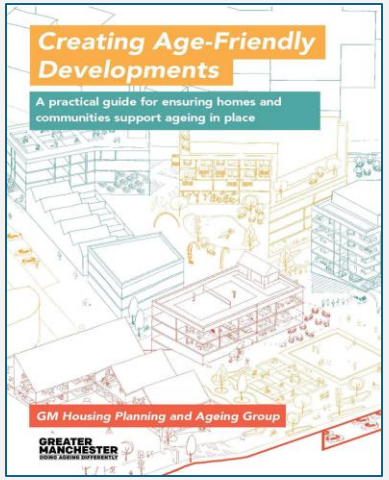
A significant contribution has been made by the group and members to research and the evidence base. This includes working with Manchester School of Architecture and Centre for Ageing Better on Rightsizing and Rightplace to develop new perspectives on older people's housing options.

The groups is focused on continuing to produce and disseminate research, sharing good practice, consulting on developments and influencing people and organisations to join the age-friendly movement.

Creating Age-Friendly Developments

Launched in November 2023, this guide was prepared by members of the Housing Planning and Ageing group. The work was based on feedback from developers that they wanted a more precise guide or checklist to help integrate ageing into the development process.

The guide offers a list of age-friendly considerations that architects, planners and developers should consider when creating new or retrofit urban developments, ensuring we are producing places where everyone can age in place for generations to come.



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NHS
Greater Manchester

directors of adass adult social services
Greater Manchester

TAKING A SYSTEM VIEW ON FALLS PREVENTION – AN OUTLINE BUISNESS CASE

Debra Ward (Assistant Programme Director, Adult Social Care Transformation)

Andrew Binnie (Programme Manager, Proactive Care and Enhanced Health at Home)

Beth Mitchell (Ageing Well Programme Manager)

Part of Greater Manchester Integrated Care Partnership

Background and context

NHS Greater Manchester

Living Well at Home Programme

directors of adass adult social services

Ageing Well steering group – Reformed

Focus/priority – What can we do collectively together to have impact?

Key line of enquiry – Based on our experience and learning from pilots etc. what preventative activity reduces the most falls (and therefore has better outcomes for individuals, and prevents avoidable cost to the health and care system)

Summary of existing falls 'activity' across GM

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NHS Greater Manchester

Research

- Paving a new way to prevention (Value in Health series from the NHS Confederation and CF
- 'Action Falls' fall prevention programme
- Work underway by Clinical Frailty Reference Group and Dementia practitioners' networks

Digital

- Improving strength and balance via Keep on Keep Up app
- Deterioration management tools e.g. Safe Steps digital tool pilot in 37 care homes in Bury
- PIER approach - prevention, identification, escalation and response (PIER) learning from WM region
- Restore 2 and Restore 2 mini
- Tea and tech sessions
- Falls monitoring and response devices

Education

- Education workshops on falls prevention
- Home safety education
- Community awareness programmes e.g. 6 steps to falls prevention
- Public health campaigns e.g. Healthy and Active Ageing and the Move More campaigns

Locality prevention services/support

- Greater Manchester Fire Rescue Service (GMFRS) safe and well checks, home safety checks, falls risk assessment
- Strength and balance classes (leisure centres), Falls Management Exercise (FaME) programme
- Foot care and podiatry services
- Medication review
- Nutrition and hydration support
- Community falls prevention clinics & liaison services (by hospital trusts)
- Integrated falls preventions teams (services)
- Neighbourhood targeted support identifying frail people to offer proactive model of care
- Local falls guide
- Support and social programmes e.g. Brew and chat meetings, peer support groups
- Care on call
- Adult Learning Disability Falls Prevention Programme

Strategies

- Northern Care Alliance frailty strategy
- Fall steering groups (locality)
- GM integrated health and care partnership strategy, joint forward plan
- GM Age friendly strategy
- Enhanced health in care homes framework
- GM Shared Decision making framework for reversible deterioration outside of hospital (Dementia United)

Response services/tools

- iStumble
- Community rehabilitation and reablement short-term support (includes MH), community rehabilitation and falls team (CRAFT)
- Frailty SDEC
- Frailty pathway as part of hospital at home
- Winter scheme falls lifting service
- Acute falls clinics (outpatient)
- Urgent care rapid response team
- Fracture liaison service
- Rheumatologist, and an Osteoporosis Nurse

How do we break this down into ‘manageable chunks’/priority areas?

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Data and Insight-Understand the current landscape and key issues across all areas of GM in terms of cost and demand on the system.

Care Homes–What is working well and where do we need to focus?

Commissioning-What is currently commissioned across the NHS, ASC and Public Health?

Deep Dive in a locality (Salford)-Highest number of Bed Stays post injurious falls.

Population Growth Forecast For Greater Manchester 2020 to 2040

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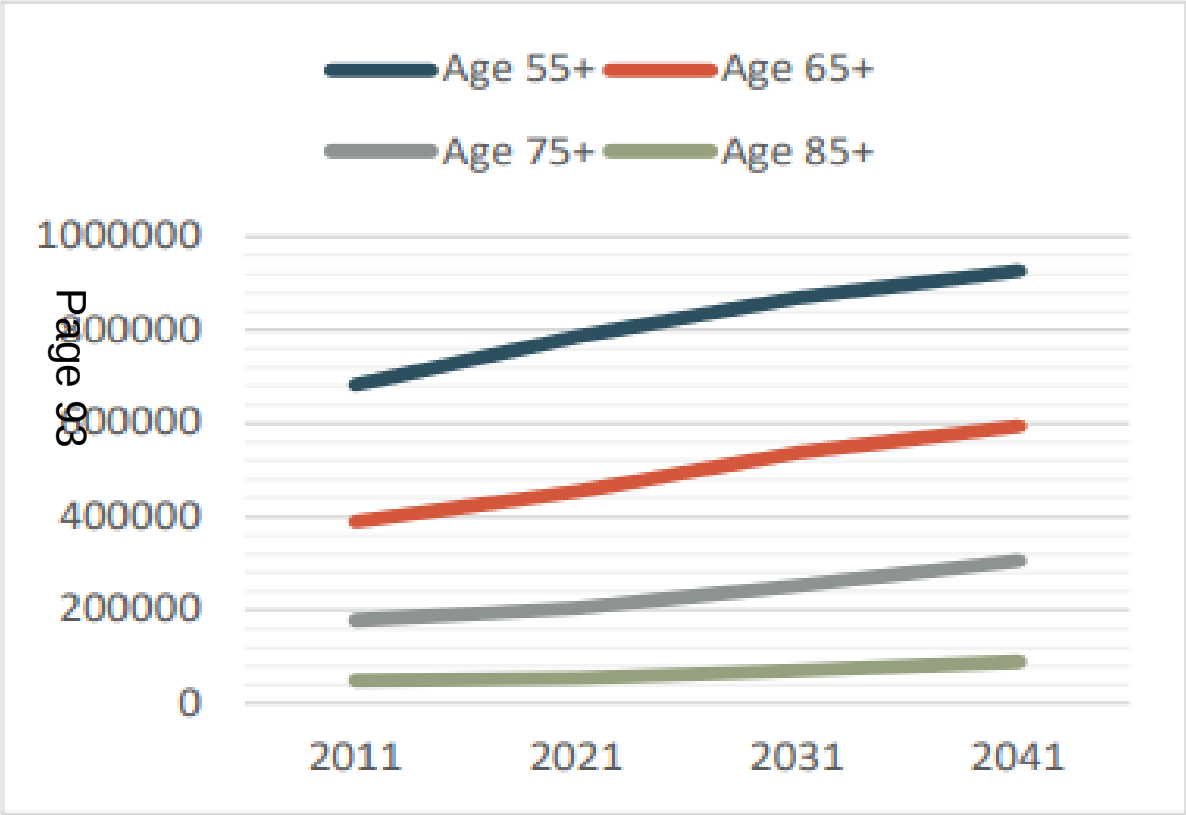

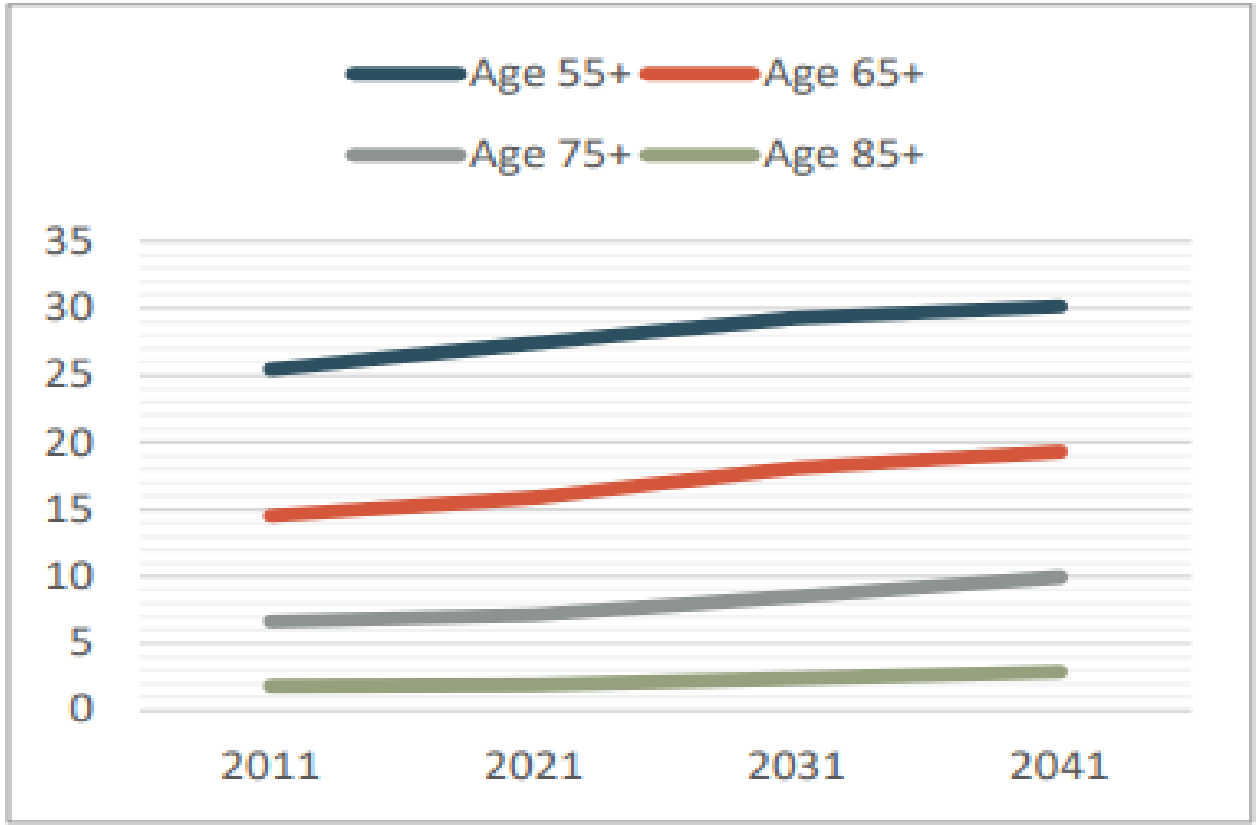

Older GM Residents by Number

Older GM Residents by % of the Population

Falls rates in Greater Manchester are higher than they are for the rest of the country

NHS Greater Manchester

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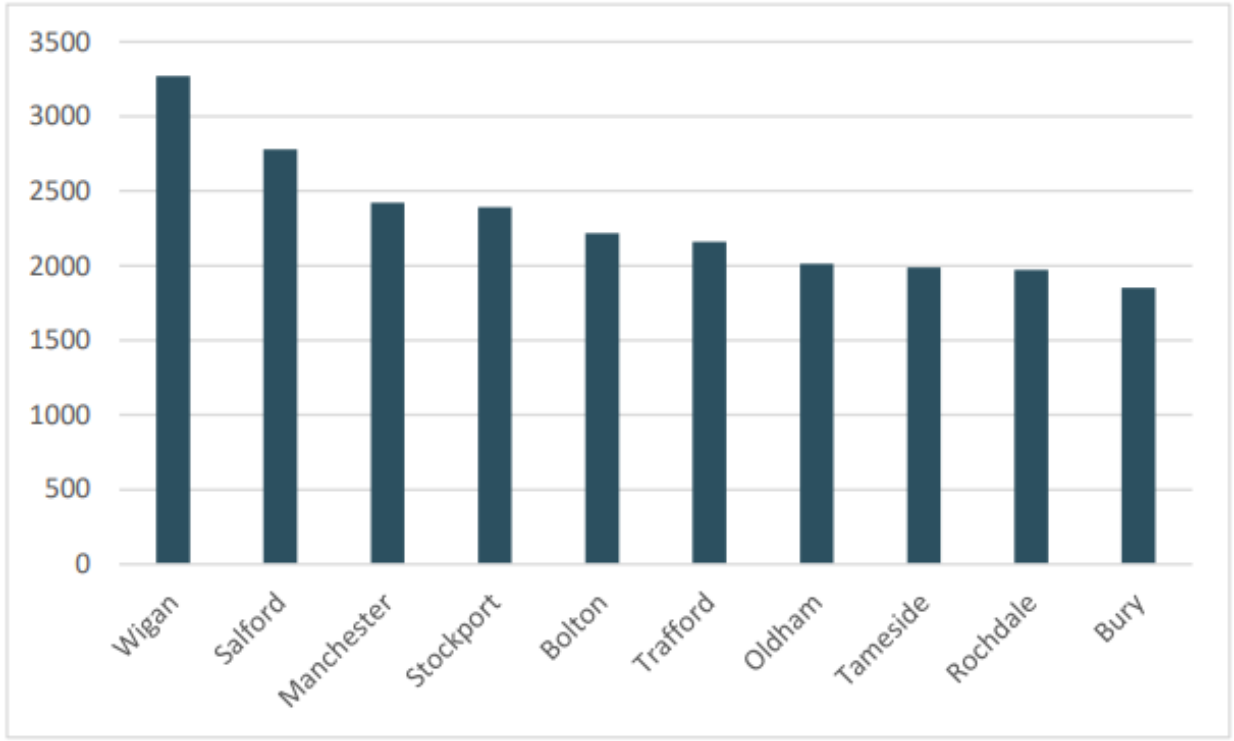
- **Six out of ten** local authorities in Greater Manchester have a higher rate of emergency hospital admissions per **100,000** due to falls in people aged 65 and over than the average across England in 2021/22.
- Those were Wigan **(3,272),** Salford **(2,779),** Manchester **(2,422),** Stockport **(2,392),** Bolton **(2,217)** and Trafford **(2,159).** The average across England is **2,099** per **100,000.**
- The chart shows the rate of emergency hospital admissions per **100,000** due to falls in people aged 65 and over in all local authorities in GM.



Emergency hospital admissions per 100,000 due to falls in people aged 65+

Falls Admissions Increase with Age

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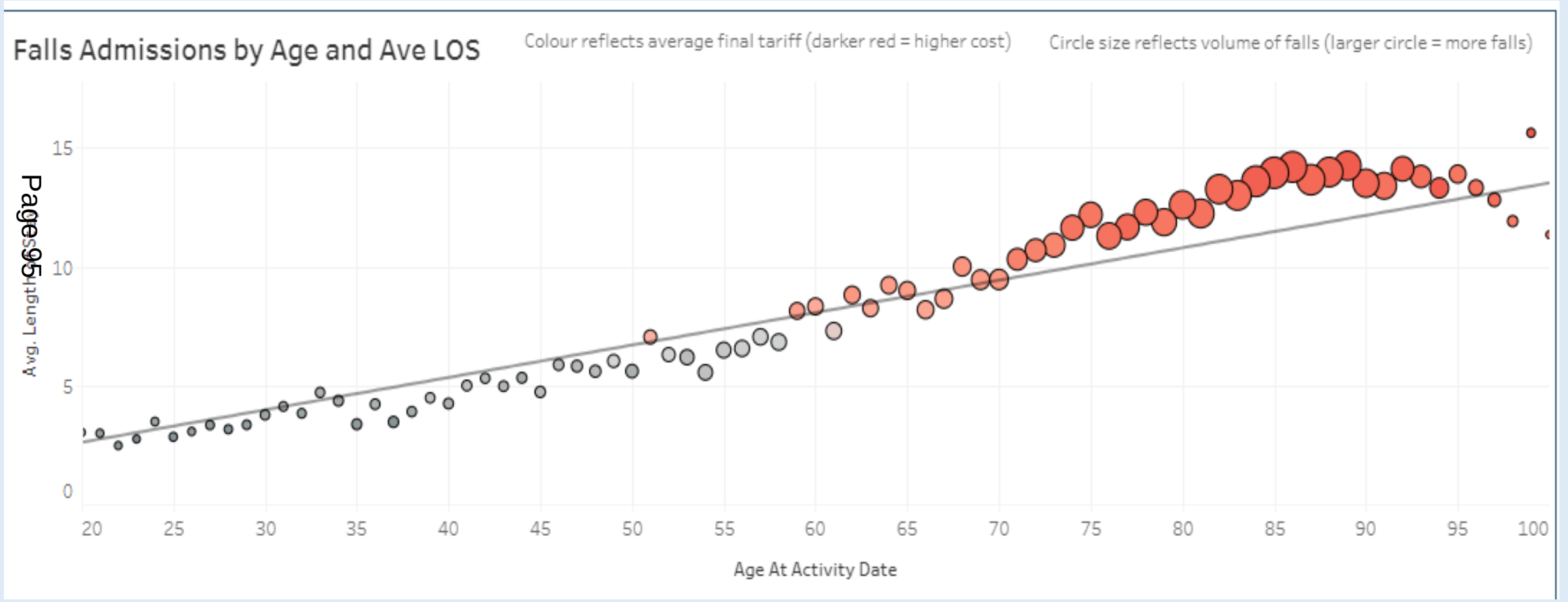

Falls Admissions by Age and Average Final Tariff

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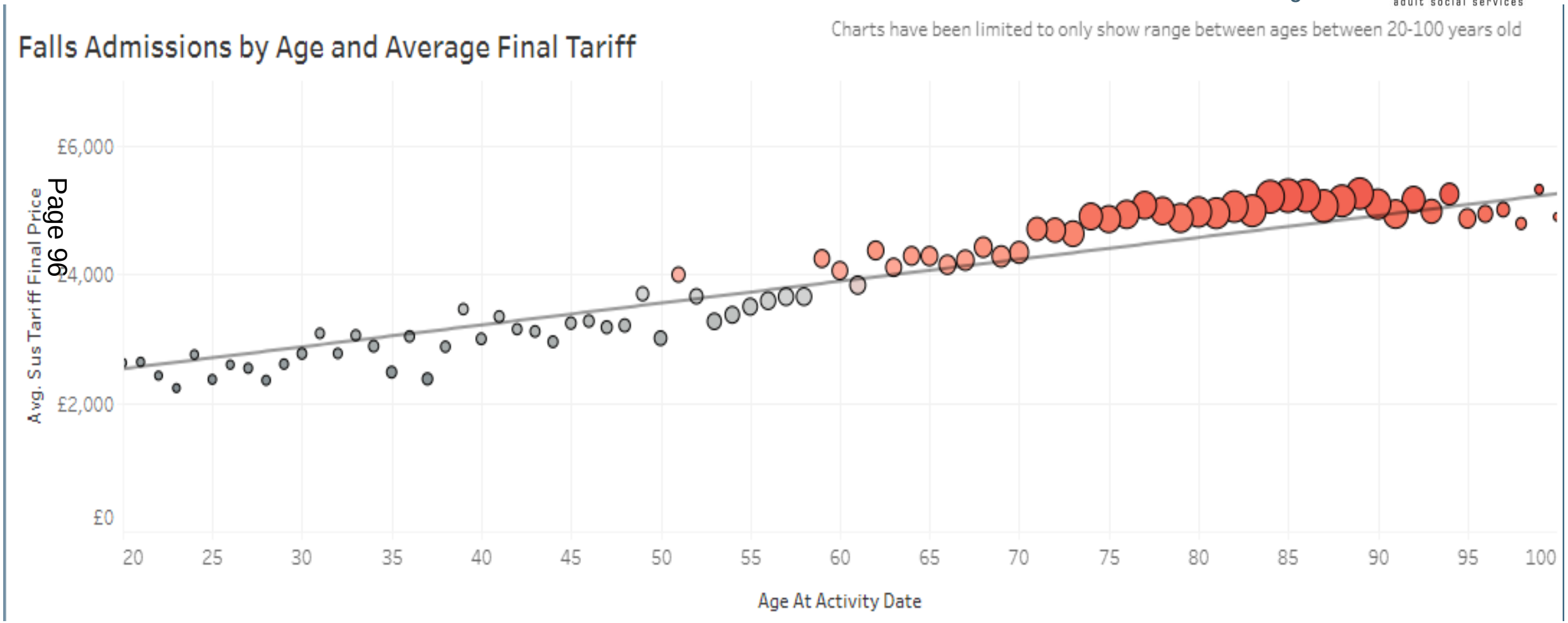


Falls-Related Emergency Admissions by Sub-ICB Locality, PCN and GP

Based on primary diagnosis spell ICD10's between S00-T99 and any subsequent diagnosis codes between W00-W19

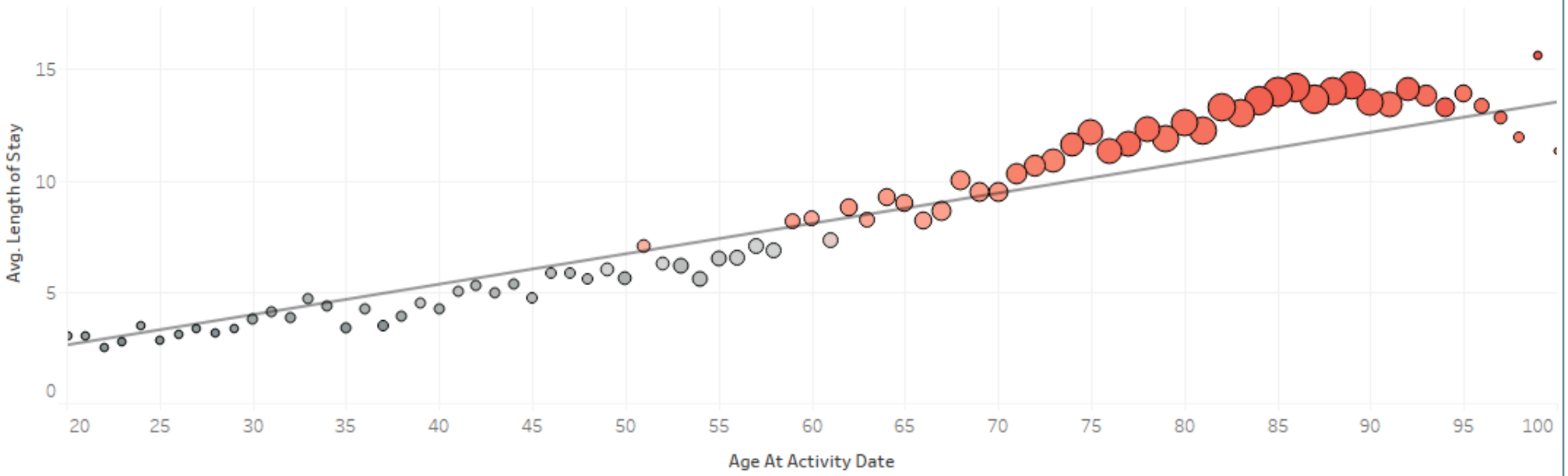
Select from filters below to interact with the data

Sub-ICB Locality	Multiple values
Date Periods	All
Provider Code	All
Commissioner	All
Gender	All
Age Cohort	All
Length of Stay Group	All
Primary Care Network	All
GP Practice Name	All
Neighbourhood (Bolton)	All
Underlying Hypertension?	All
Underlying Diabetes?	All
Underlying Dementia?	All
Underlying Respiratory?	All
Underlying Delirium	All
View FNOF only?	All
Care Home Resident?	All
Main Injury Type	All
Main Fall Reason	All

Falls Admissions by Age and Ave LOS

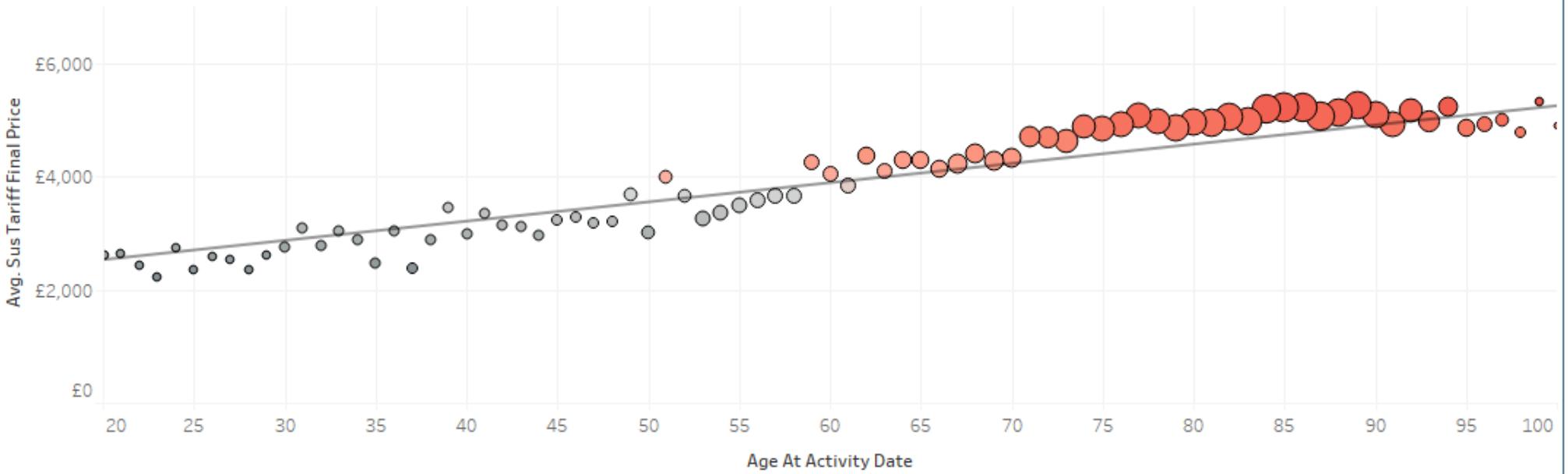
Colour reflects average final tariff (darker red = higher cost)

Circle size reflects volume of falls (larger circle = more falls)

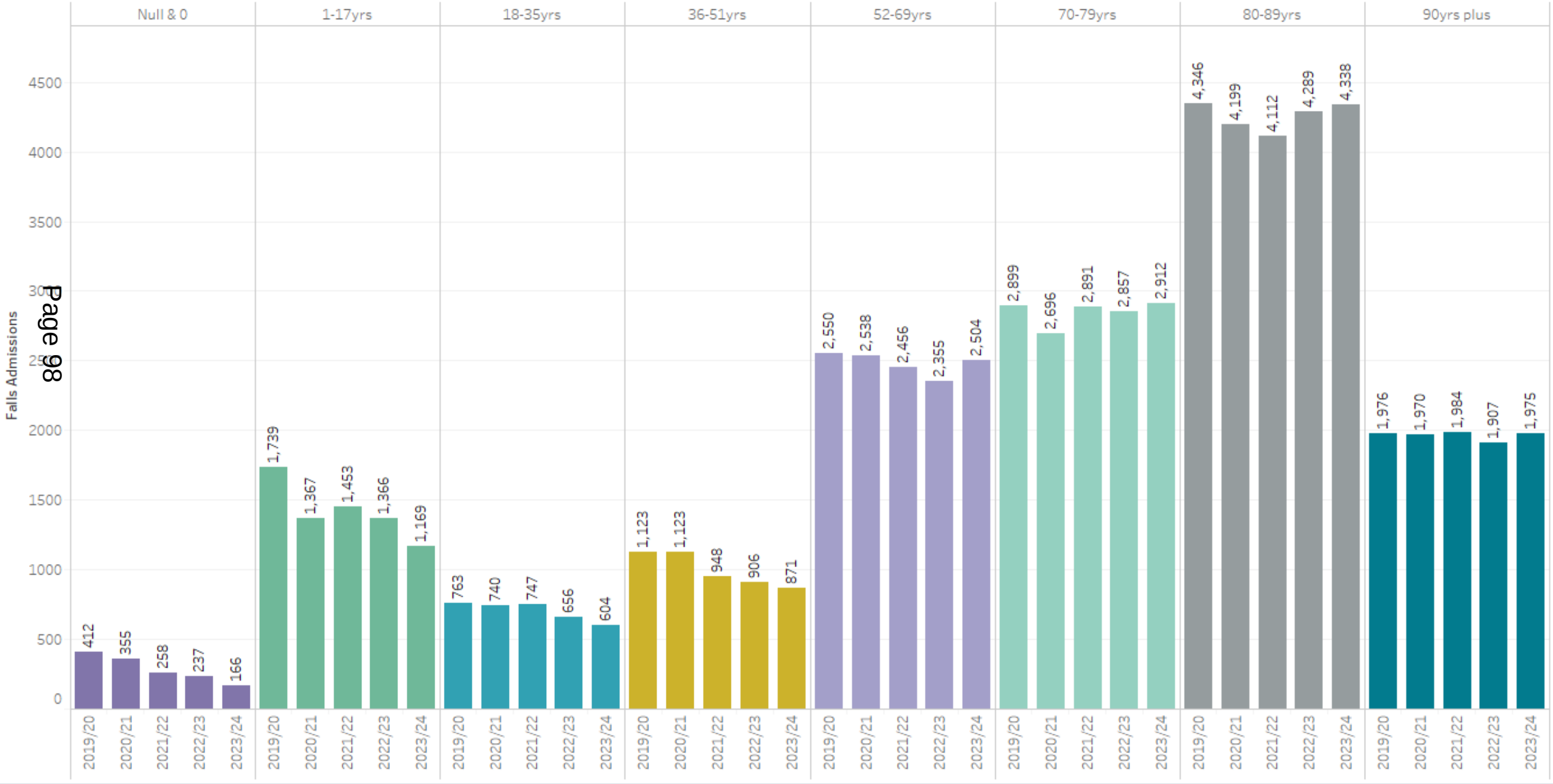


Falls Admissions by Age and Average Final Tariff

Charts have been limited to only show range between ages between 20-100 years old



Annual Falls Admissions by Age Group



Total Bed Days for Unplanned Admissions to Acute Hospitals Top 12 Primary Diagnoses 23/24

GMICB Localities as Commissioning Purchaser to GM Acute Provider Trusts

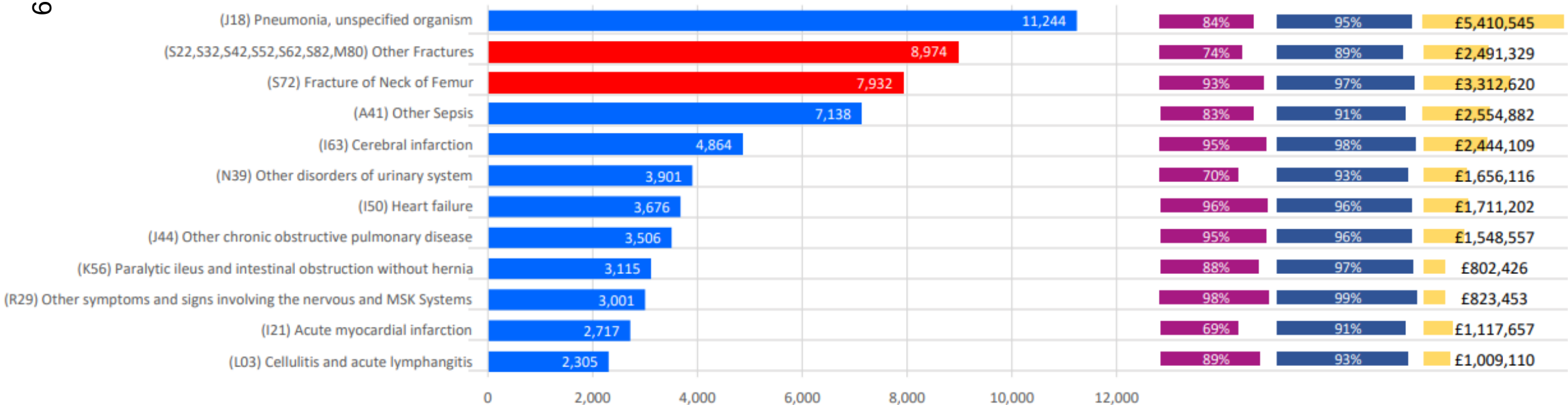
Locality	
Bolton	Bury
Manchester	Oldham
Rochdale	Salford
Stockport	Tameside
Trafford	Wigan

	All Age Emergency Admissions	All Age Total Bed Days	All Age Total Tariff Cost (£)
(J18) Pneumonia, unspecified organism	1,357	11,244	£5,811,530
(S22,S32,S42,S52,S62,S82,M80) Other Fractures	759	8,974	£3,208,796
(S72) Fracture of Neck of Femur	309	7,932	£3,463,922
(A41) Other Sepsis	509	7,138	£2,951,978
(I63) Cerebral infarction	299	4,864	£2,517,002
(N39) Other disorders of urinary system	558	3,901	£1,896,329
(I50) Heart failure	357	3,676	£1,776,488
(J44) Other chronic obstructive pulmonary disease	580	3,506	£1,621,963
(K56) Paralytic ileus and intestinal obstruction without hernia	173	3,115	£878,074
(R29) Other symptoms and signs involving the nervous and MSK Systems	196	3,001	£834,318
(I21) Acute myocardial infarction	353	2,717	£1,291,345
(L03) Cellulitis and acute lymphangitis	253	2,305	£1,095,089

Salford

Total Bed Days for Unplanned Admissions to Acute Hospitals Top 12 Primary Diagnoses 2023/24

% value is the proportion of patients aged over 50yrs on date of admission



Total Bed Days for Unplanned Admissions to Acute Hospitals Top 12 Primary Diagnoses 23/24

GMICB Localities as Commissioning Purchaser to GM Acute Provider Trusts

Locality	
Bolton	Bury
Manchester	Oldham
Rochdale	Salford
Stockport	Tameside
Trafford	Wigan

	All Age Emergency Admissions	All Age Total Bed Days	All Age Total Tariff Cost (£)
(J18) Pneumonia, unspecified organism	1,805	12,434	£7,082,383
(S22,S32,S42,S52,S62,S82,M80) Other Fractures	901	8,597	£3,605,151
(S72) Fracture of Neck of Femur	436	8,011	£4,836,183
(A41) Other Sepsis	658	7,072	£3,445,873
(I63) Cerebral infarction	578	6,807	£4,748,145
(N39) Other disorders of urinary system	842	5,988	£3,099,767
(R29) Other symptoms and signs involving the nervous and MSK Systems	481	4,685	£1,925,613
(I50) Heart failure	597	3,587	£2,146,643
(J44) Other chronic obstructive pulmonary disease	883	3,559	£1,927,352
(I21) Acute myocardial infarction	610	2,888	£1,583,529
(L03) Cellulitis and acute lymphangitis	409	2,600	£1,970,667
(N17) Acute kidney failure	292	2,420	£1,262,676

Wigan

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