NHS
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GM Sustainability Plan

6 September 2024

Part of Greater Manchester
Integrated Care Partnership

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Contents

1. Introduction and summary

This plan

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

Overview – What the Plan Shows

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

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

This plan shows that:

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

The financial bridge – what it shows

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The bridge shows three ‘blocks’ with associated pillars.

Dealing with the current financial deficit

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

- Cost improvement
- System Productivity and Performance
- Optimising care

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

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

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

- Reducing prevalence
- Proactive care

Investment 2027/8-2028/9

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

The financial bridge

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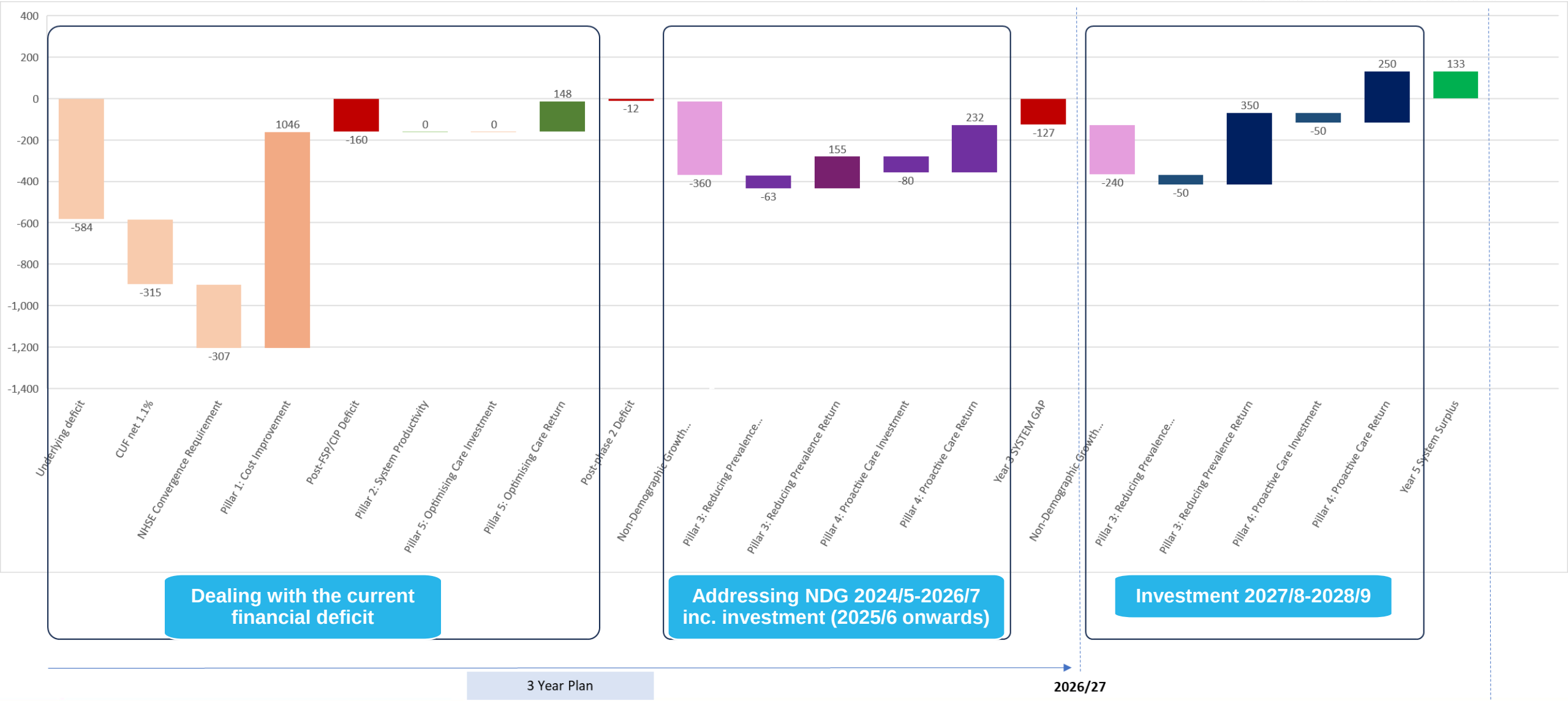

The pillars of sustainability and their contribution

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

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

Cost improvements – Trusts and ICB

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

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

System Productivity and Performance – the programmes

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

Reducing prevalence – programmes and impact

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

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

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

Overall Impact ~£40m (savings – investment)

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

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

Proactive care: programmes and impact

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

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

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

Overall Impact ~£120m (savings – investment)

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

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

Optimising care: programmes and impact

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

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

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

Total savings: ~£149m

The development and delivery of the plan

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

Governance Summary

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

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

Key points for system consideration

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If the remaining deficit is to be addressed:

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

If NDG is to be addressed:

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

If this plan is to be delivered:

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

2. Our strategy and a sustainable system

Our vision and the outcomes we are seeking

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

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Our missions

Strengthen our communities

We will help people, families and communities feel more confident in managing their own health

Recover core health and care services

We will continue to improve access to high quality services and reduce long waits

Help people get into, and stay in, good work

We will expand and support access to good work, employment and employee wellbeing

Help people to stay well and detect illness earlier

We will work together to prevent illness and reduce risk and inequalities

Support our workforce and carers at home

We will ensure we have a sustainable, supported workforce including those caring at home

Achieve financial stability

We will manage public money well to achieve our objectives

Our strategy and our plans

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

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

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

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

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

NHS GM Plan Alignment

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

24/25 Operational Plan

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

Sustainability Plan

A framework including:

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

Joint Forward Plan

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

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

ICP Strategy

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

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

NHS GM Single Improvement Plan

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

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

The Health of our Population

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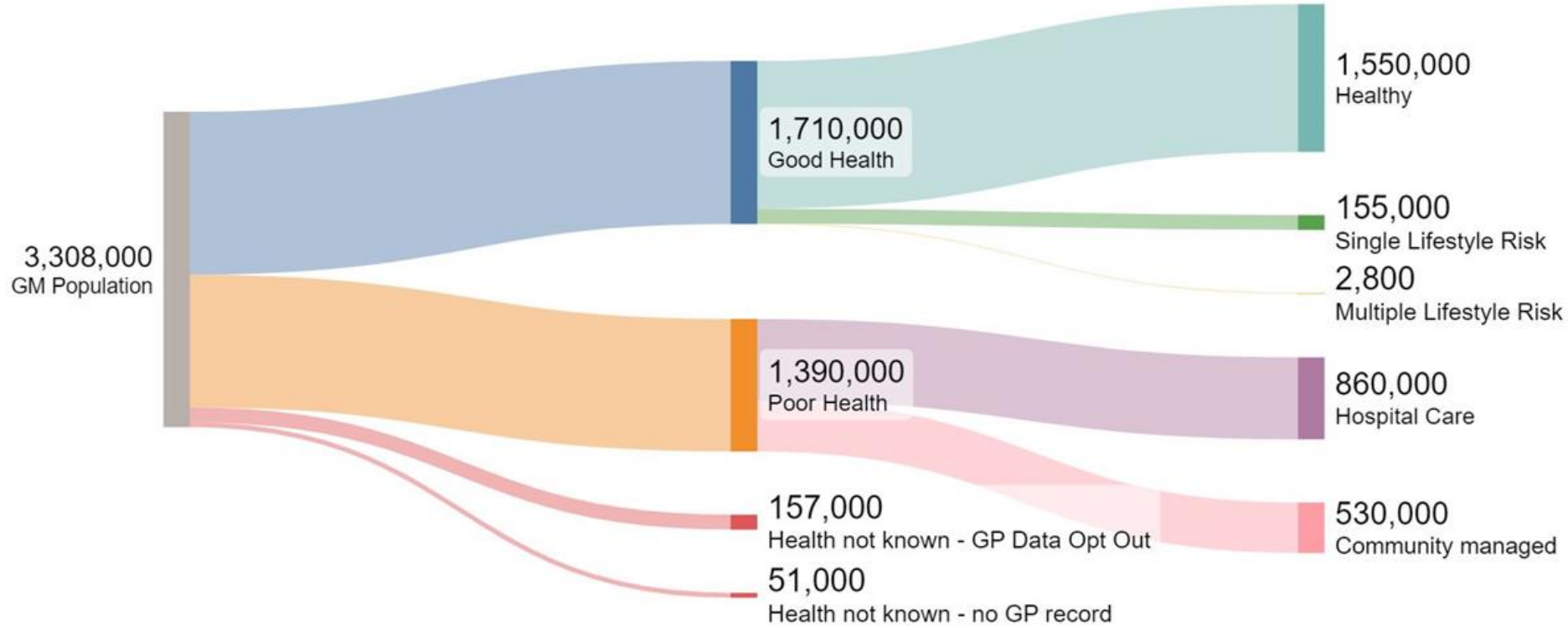
- The strain our system is under reflects the poor health of much of our population. The newly available longitudinal record data which includes both primary and secondary care data shows that around half of the GM population presently have some formally identified poor health
- This is the primary driver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



The changes we need to make

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

The Greater Manchester Model for Health

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

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

The Greater Manchester Model for Health

NHS Greater Manchester

3. The financial bridge

Key finance facts and figures

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

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

Developing the Financial Bridge: the key activities

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Identifying the size of the financial and population health challenge:

Identifying and modelling how we will address the challenge

Dealing with the current financial deficit

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

Addressing population need: priority activity

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

Investment strategy

- Additional population health interventions funded through additional investment

The pillars of sustainability

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

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

The financial bridge

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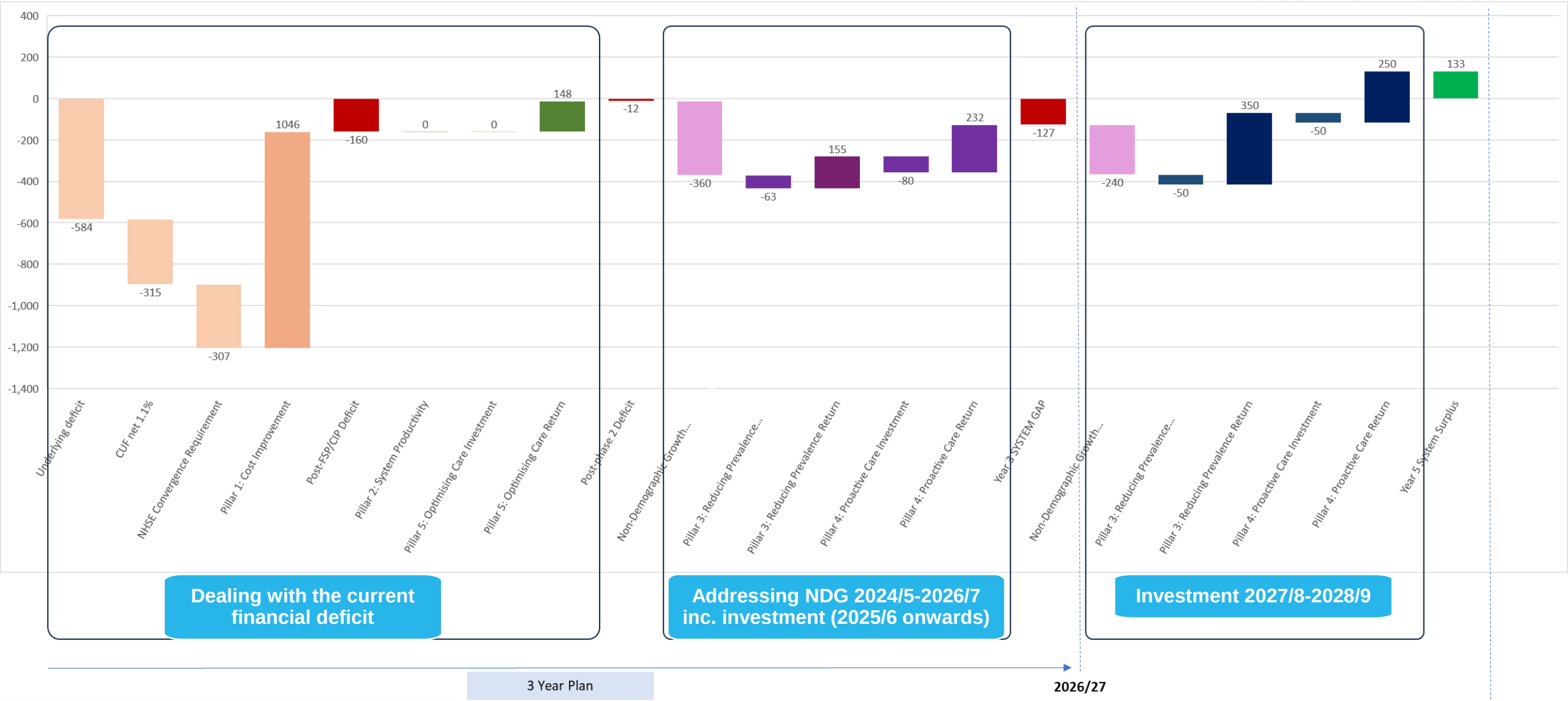

The financial bridge – what it shows

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

Dealing with the current financial deficit

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

- Cost improvement
- System Productivity and Performance
- Optimising care

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

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

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

- Reducing prevalence
- Proactive care

Investment 2027/8-2028/9

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

The financial bridge – the contents

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The bridge shows three ‘blocks’ with associated pillars:

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

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

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

4. The pillars of sustainability

The pillars of sustainability

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

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

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

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

How the pillars of sustainability contribute to our missions

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

The pillars of sustainability

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

Pillar 1: cost improvement

Cost Improvement - Overview

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

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

Principles used in developing this plan

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

Trust cost improvements

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

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

ICB cost improvements

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

Cost Improvement – oversight and governance

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

Financial Sustainability Plans (Detail)

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

- £160m

Gap from FSPs and system repayment by 26/27

60-70%

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

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

Financial Sustainability Plans

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

Pillar 2: System Productivity and Performance

System Productivity and performance improvement

NHS Greater Manchester

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

See Appendix 1 for more details of these programmes

System Productivity – the programmes

NHS Greater Manchester

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

See Appendix 1 for more details of these programmes

System Productivity – the programmes (continued)

NHS Greater Manchester

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

See Appendix 1 for more details of these programmes

System Productivity – the programmes (continued)

NHS Greater Manchester

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

System productivity – oversight and governance

NHS Greater Manchester

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

Addressing non-demographic growth

Understanding the impact of non-demographic growth

NHS Greater Manchester

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

Estimating non-demographic growth impacts

NHS Greater Manchester

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

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

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

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

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

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

The cost of non-demographic growth

NHS Greater Manchester

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

Taking action on non-demographic growth

NHS Greater Manchester

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

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

NHS Greater Manchester

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

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

Tackling inequalities and reducing unwarranted variation

GM Fairer Health for All Framework and CORE20PLUS5

Leading to **Better outcomes**

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

Everybody has an opportunity to live a good life

Harnessing the following system characteristics

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

Leading action on non-demographic growth

NHS Greater Manchester

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

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

Pillar 3: Reducing prevalence

Reducing prevalence

NHS Greater Manchester

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

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

Primary prevention of poor health includes actions to :

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

Benefits

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

See Appendix 2 for more details of these programmes

Reducing prevalence – programmes and impact

NHS Greater Manchester

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

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

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

Overall Impact ~£40m (savings – investment)

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

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

Reducing prevalence – oversight and governance

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

Pillar 4: Proactive care

Proactive care

There are two streams of work in this pillar:

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

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

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

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

Benefits

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

Proactive Care: GM Multi-Year Prevention Plan

NHS Greater Manchester

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

Proactive care: Reducing variation across GM

NHS Greater Manchester

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

Proactive care: the role of commissioning

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

See Appendix 3 for more details of these programmes

Proactive care: programmes and impact

NHS Greater Manchester

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

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

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

Overall Impact ~£120m (savings – investment)

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

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

Proactive care – oversight and governance

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

Improving care for the most disadvantaged communities

NHS Greater Manchester

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

Pillar 5: Optimising Care

Optimising care

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

Health and Care Review

NHS Greater Manchester

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

See Appendix 4 for more details of these programmes

Optimising care

NHS Greater Manchester

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

See Appendix 4 for more details of these programmes

Optimising Care (continued)

NHS Greater Manchester

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

Other programmes to be considered: Procedures of Low Clinical Value

NHS Greater Manchester

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

See Appendix 4 for more details of these programmes

Optimising care: programmes and impact

NHS Greater Manchester

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

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

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

Total savings: ~£149m

Optimising care – oversight and governance

NHS Greater Manchester

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

5. How we will enable sustainability

How sustainability will be enabled

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

Governance summary

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

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

Governance – system groups

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

Investment strategy

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

The Role of Capital

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

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

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

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

Continued grip and control

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

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

Addressing the undertakings

NHS Greater Manchester

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

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

Our Workforce

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

Key points for system consideration

NHS Greater Manchester

If the remaining deficit is to be addressed:

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

If NDG is to be addressed:

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

If this plan is to be delivered:

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

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Appendices

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

Appendix 1

Cost improvement plans (24/5)

Value of CIP programmes

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

Trust cost improvements

NHS Greater Manchester

Key themes in Trust CIPs

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

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

ICB cost improvements

NHS Greater Manchester

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

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Appendix 2

Details of programme plans – System Productivity and Performance

System Productivity and Performance – the programmes

NHS Greater Manchester

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

System Productivity and Performance – the programmes (continued)

NHS Greater Manchester

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

System Productivity and Performance – the programmes (continued)

NHS Greater Manchester

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

System Productivity and Performance – the programmes (continued)

NHS Greater Manchester

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

Appendix 3

Details of programme plans – Reducing prevalence

Reducing prevalence – programmes and impact

NHS Greater Manchester

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

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

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

Overall Impact ~£40m (savings – investment)

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

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

Appendix 4

Details of programme plans – Proactive care

Pillar 4: Programmes – Detail of Savings

NHS Greater Manchester

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

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

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

Overall Impact ~£120m (savings – investment)

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

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

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Appendix 5

Details of programme plans – Optimising Care

Optimising care

NHS Greater Manchester

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

Pillar 5: Pillar Overview (continued)

NHS Greater Manchester

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

Pillar 5: Pillar Overview (continued)

NHS Greater Manchester

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

Optimising Care - Detail of Savings

NHS Greater Manchester

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

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

Total savings: ~£149m