Manchester City Council
Report for Information

Report to: Resources and Governance Scrutiny Committee – 5 September 2024

Subject: Manchester City Council Connections with the Greater Manchester Integrated Care System and the Manchester Locality

Report of: Place Based Lead, Manchester Integrated Care Partnership

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Summary

This report provides an update on Manchester's connections with NHS GM in relation to governance, partnerships, financial arrangements and future plans within the Manchester Locality. It sets out the historical context which led to the establishment of NHS GM. It then describes the current governance arrangements, GM and locality responsibilities, and provides a high-level summary of the financial relationship between the City Council and NHS GM. The paper concludes with a summary of the priorities for the locality for improving the overall health outcomes for people across Manchester.

Recommendations

The Committee is asked to note and comment on the content of the report.

Wards Affected: All

Environmental Impact Assessment -the impact of the issues addressed in this report on achieving the zero-carbon target for the city	The Greater Manchester Integrated Care Board will oversee the refresh of the GM NHS Green Plan in 2023/24 and NHS organisations in Manchester will continue to contribute to the City's net zero-carbon target.
Equality, Diversity and Inclusion - the impact of the issues addressed in this report in meeting our Public Sector Equality Duty and broader equality commitments	The Greater Manchester Integrated Care System Strategy and Manchester Partnership Board Priority Plan both aim to actively reduce inequalities in health and care outcomes. The NHS GM Manchester Locality and City Council jointly fund the Director of Equality and Engagement post that works across the local system.

Manchester Strategy outcomes	Summary of how this report aligns to the Our Manchester Strategy/Contribution to the Strategy
A thriving and sustainable city: supporting a diverse and distinctive economy that creates jobs and opportunities	Health and social care are an important part of the city's economy including creating significant economic value, jobs, health innovation and through its impact on regeneration
A highly skilled city: world class and home grown talent sustaining the city's economic success	Health and social care support significant jobs and skills development in Manchester
A progressive and equitable city: making a positive contribution by unlocking the potential of our communities	Progressive and equitable is central to the Our Healthier Manchester Locality Plan including all aspects of tackling health inequalities and the Making Manchester Fairer work in the city
A liveable and low carbon city: a destination of choice to live, visit, work	There are many links between health, communities and housing in the city as per the Our Healthier Manchester Locality Plan. Health partners have an important role in reducing Manchester's carbon emissions through the Manchester Climate Change Partnership
A connected city: world class infrastructure and connectivity to drive growth	Transport infrastructure and digital connectivity are critical to providing effective health and care for Manchester residents

Financial Consequences

No direct financial implications arising from the report. The Section 75 agreement and aligned budget arrangements with Manchester Foundation Trust for the Manchester Local Care Organisation will remain in place.

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Background documents (available for public inspection):

The following documents disclose important facts on which the report is based and have been relied upon in preparing the report. Copies of the background documents are available up to 4 years after the date of the meeting. If you would like a copy, please contact one of the contact officers above.

Our Manchester Strategy
Manchester Locality Plan – Our Healthier Manchester (2021)
NHS Long Term Plan (2019)
Thriving Places: Guidance on the development of place-based partnerships as part of statutory integrated care systems (2021)
Health and Social Care Integration: Joining up care for people, places and populations (2022)
Health and Care Act (2022)
GM Integrated Care Strategy (2023)
Joint Forward Plan ICP Board (June 2023)
GM Operating Model (2022)
NHS GM 2024/25 Operating Plan (2024)

1.0 Introduction

1.1 This report provides an update on Manchester's connections with NHS Greater Manchester (NHS GM) in relation to governance, partnerships, financial arrangements and future plans within the Manchester Locality. It sets out the historical context which led to the establishment of NHS GM. It then describes the current governance arrangements, GM and locality responsibilities, and provides a high-level summary of the financial relationship between the Council and NHS GM. The paper concludes with a summary of the priorities for the locality for improving the overall health outcomes for people across Manchester.

2.0 Integrated Care Systems

2.1 In accordance with the 2019 NHS Long Term Plan and the Health and Care Act 2022, on 1 July 2022 Integrated Care Systems (ICSs) were formalised as legal entities with statutory powers and responsibilities around the planning and funding of most NHS services in a given area, replacing Clinical Commissioning Groups (CCGs). There are 42 Integrated Care Systems in England, each of which comprises two key components:

- **Integrated Care Board (ICB):** This is the statutory body with responsibility for the planning and funding of most NHS services in a given area. NHS Greater Manchester is the ICB for Greater Manchester, and is the largest ICB in the country.

- **Integrated Care Partnership (ICP):** This is a statutory partnership, that brings NHS organisations together with local authorities, the VCSFE sector and others to develop a health and care strategy for a given area.

2.2 Integrated care systems were intended to allow a fundamental shift in the way that the health and care system is organised in England. The emphasis for ICSs is on collaboration, and a focus on places and local populations as the driving force for improvement. Each ICS has four key statutory aims:

i. Secure better health and wellbeing for everyone;
ii. Tackle unequal outcomes, experience and access to health and care services;
iii. Enhance productivity and value for money; and
iv. Support broader social and economic development.

2.3 The above aims constituted an evolution of the strategic agenda in Manchester and Greater Manchester rather than a change in direction. They provided an opportunity to accelerate the delivery of Manchester's ambitions to improve health outcomes and tackle health inequalities through further integration of health and social care.

3.0 NHS Greater Manchester

3.1 NHS Greater Manchester is the Integrated Care Board that covers Greater Manchester. Its geography is coterminous with the administrative boundaries of the ten GM local authorities.

3.2 In 2015, the GMCA and the NHS bodies in Greater Manchester jointly published 'Taking Charge', which set out the collective ambition for GM to take on the responsibility for spending and decisions over health and social care across the conurbation. This established the GM Health and Social Care Partnership Board, which had representation from every local authority and NHS body in GM and was intended to allow the NHS and local authorities to come together and undertake joint planning, joint decisions and joined-up delivery.

3.3 'Taking Charge' established the GM model of integrated neighbourhood and place-based working, along with a model of provider collaboration, partnership with the VCFSE sector, and a GM-wide approach to population health management.

3.4 The ICS built on these foundations. In April 2023, the GM ICP approved a five-year strategy to improve the health of the residents of Greater Manchester. This set out six 'missions' for the GM Health and Care system:

- **Strengthening our communities.** This involves helping people, families and communities feel more confident in managing their own health through a range of programmes including social prescribing, closer working with the VCFSE and co-ordinated approaches to those experiencing multiple disadvantage.

- **Helping people get into – and stay in – good work.** This involves maximising the wider social and economic benefits from NHS investment by expanding work and health programmes, improving employee wellbeing via the GM Good Employment Charter, and developing social value through anchor institutions.

- **Recovering core NHS and care services.** This involves improving ambulance response and A&E waiting times, reducing elective long-waits and cancer backlogs, improving access to primary care services and core mental health services, improving quality and reducing unwarranted variation.

- **Helping people stay well and detecting illness earlier.** This involves collaborating to reduce smoking, increase physical activity, tackle obesity and alcohol dependency, doing more to identify and treat high blood pressure, high cholesterol, diabetes and other risk factors for poor health. This also includes taking a comprehensive approach to reducing health inequalities.

- **Supporting our workforce and our carers.** This involves promoting integration, partnership working and good employment practices, supporting the health and care workforce to be well and addressing workplace

inequalities. A key part of this is encouraging people to choose health and care as a career and supporting them to develop and stay in the sector, as well as supporting unwaged carers.

- **Achieving financial sustainability.** This requires an initial focus on financial recovery to achieve a balanced position, taking forward a programme of cost improvement, productivity, demand reduction and service transformation to quantify and tackle the main drivers of the financial deficit in GM.

3.5 The ICP strategy did not shy away from the challenges GM faces in achieving these goals. GM has some of the lowest life expectancy in England, with differences between the most and least deprived areas of 9.5 years for men and 7.7 years for women. There are further differences between communities according to race and ethnicity, gender, disabilities, poverty and social exclusion, sexuality and age. Residents across GM had flagged their concerns around funding and staffing levels, difficulty in accessing appointments and waiting times for hospital care.

3.6 The strategy set out three core elements that outline how the GM system would respond to these challenges:

- **Embedding the GM model for health.** This involves working with communities to create the conditions for good lives, prevent poor health and ensure support is available before crises occur. It is a social model for health, rather than a predominately medical one, focusing on the role of people and communities as well as health and care services.

- **Acting on our missions.** This involves delivering on the six key priorities outlined above, which are intended to address the key challenges faced by communities and the pressures on the system.

- **Monitoring our progress.** The strategy sets out progress measures against the outcomes and missions. These focus on helping people to live good lives, improving health and wellbeing, delivering better standards of care and facilitating the greater integration of services.

3.7 NHS GM then set out a ‘Joint Forward Plan’ (JFP) in June 2023. This is effectively the delivery plan for the Five Year Strategy, and sets out how the ICB proposes to exercise its functions, deliver against the four statutory aims, and make progress against the priorities and outcomes set out in its strategy.

3.8 The Joint Forward Plan sets out the structures that have been established at GM-level and which help health and care providers to work together effectively at scale. These are:

- **The GM Trust Provider Collaborative (TPC).** This is a membership organisation made up of the eleven NHS trusts and foundation trusts who provide NHS funded services across GM. It includes the NHS providers of

111, 999, patient transport services, community and hospital mental and physical health services.

- **The GM Primary Care Board**. This brings together representatives from the four disciplines of primary care (General Practice, Pharmacy, Dentistry and Optometry) to support collaboration and integration at all levels across GM, working with the 67 GM Primary Care Networks (PCNs)

- **GM Directors of Adults' and Children's Social Care,** collaborating to support transformation of social care at scale. For adult social care this also includes joint working with the GM Independent Care Sector Network.

- **Voluntary, Community, Faith and Social Enterprise sector providers.** VCFSE providers are part of a three-way agreement between the GMCA, NHS GM and the VCSE sector, known as the VCSE Accord. The VCSE sector has also established an Alternative Provider Federation as a partnership of social enterprise and charitable organisations operating at scale across GM.

3.9 For each of the six missions, the JFP also sets out where in the system the delivery and system leadership sits. It also sets out a small number of key areas of focus under each mission, with identified actions against each area. This is set out in the table below.

Mission	**Delivery Leadership**	**System Leadership**	**Key areas of focus**
Strengthening our communities	Locality Boards	Population Health Board	1. Scale up and accelerate delivery of person-centred neighbourhood model 2. Develop collaborative and integrated working 3. Develop a sustainable environment for all
Helping people stay well and detecting illness earlier	Locality boards	Clinical effectiveness group, and population health board	1. Tackling inequalities 2. Supporting people to live healthier lives 3. Upscaling secondary prevention

			4. Living well with long-term conditions
Helping people to get into, and stay in, good work	Locality boards	Population Health Board GM Good Employment Charter Board GM Employment and Skills Advisory Board	1. Enhance scale of work and health programmes 2. Develop good work 3. Increase the contribution of the NHS to the economy
Recovering core NHS and care services	Locality boards and Trust Provider Collaborative	System boards, finance and performance recovery board	1. Improving urgent and emergency care and flow 2. Reducing elective long waits and cancer backlogs, and improving performance against the core diagnostic standard 3. Improving service provision and access 4. Improving quality through reducing unwarranted variation 5. Using digital and innovation to drive transformation 6. System resilience and preparedness
Supporting our workforce and our carers	NHS GM People and Culture Function, NHS GM, NHS Trusts, Primary Care providers, Local authorities, Social Care providers, VCSE	GM People Board	1. Workforce integration 2. Good employment 3. Workforce wellbeing 4. Addressing inequalities 5. Growing and developing our workforce 6. Supporting carers

Achieving financial sustainability	Locality Boards, Trust Provider Collaborative	Finance and Performance Committee	1. Finance and performance recovery programme 2. Medium term financial sustainability plan

4.0 Undertakings and System Improvement

4.1 On 17 July 2024, the NHS GM Board agreed a set of formal enforcement undertakings with NHS England. These undertakings reflect NHS England's concerns that NHS GM is failing or has failed to discharge some of the functions set out in the National Health Service Act 2006. In their position as a regulator, NHS England had therefore requested that the ICB formally accept enforcement undertakings to support improvement in key areas.

4.2 There were four key areas highlighted as requiring improvement as part of the undertakings. These were:

- **Leadership and governance.** In particular the ICB has been asked to demonstrate that there are robust controls and processes in place throughout the organisation, which are overseen by appropriate governance arrangements and board level ownership. In addition, the ICB has been asked to provide further assurance around the implementation of an independent review into leadership and governance conducted by Carnall Farrar in 2023.

- **Financial planning.** In 2023/24, the ICS delivered a deficit of c£180m against an original plan to break even. The ICB has been asked to do more to quantify and address the system's underlying deficit, to strengthen its financial governance and management systems and reduce the amount of unmitigated 'system risk'. The ICB has also been asked to provide further assurance around the implementation of a review of the drivers of the financial deficit conducted by PwC in 2023. Further information on the ICB's financial position and the implications for Manchester are set out later in this report.

- **Performance.** The ICB has been asked to take steps to improve the elective long-wait position, and the A&E 4-hour performance position, with both being in the bottom quartile nationally. Issues around the numbers of adult inpatients with a learning disability and/or autism, and the numbers of Mental Health Out of Area Placements were also raised, with a request for improvement plans to be put in place.

- **Quality.** The ICB has been asked to strengthen its processes for holding NHS trusts and foundation trusts to account in addressing quality concerns, and strengthening its processes for oversight of quality functions delegated to place level.

4.3 Since May 2024, the ICB has been developing a Single Improvement Plan (SIP) which responds to the areas set out in the undertakings. The ICB Chief Executive is the senior responsible officer (SRO) for the SIP, and the ICB has established a System Improvement Board (SIB) to oversee the development and delivery of the plan. The SIB reports directly to the ICB Board, and is supported by a System Improvement Team.

4.4 The four pillars of the SIP are set out below. Each of these pillars is led by a member of the ICB Executive team, supported by members of the System Improvement Team. The ICB has also invited independent challenge on the priorities and content of the plan from the Good Governance Institute and Health Innovation Manchester.

4.5 The next steps will be the development of clear and agreed outcome statement and metrics to measure change. These will ensure that the actions have a clear and measurable effect on improvement against the areas highlighted in the undertakings.

4.6 Following this, the ICB Board will begin to receive a regular highlight report, updating on progress around the delivery of actions, mitigation of risks and changes in performance.

4.7 It is anticipated that the implementation of the improvement plan will take between 12 to 18 months. The intention is to develop a stable platform from which further continuous improvement can be made. Completion of the actions within the plan will require sign-off by NHS England through monthly assurance meetings.

5.0 The role of localities within NHS GM

5.1 The NHS GM strategy sets out the approach that the ICB intends to take to ‘place-based’ or ‘locality’ working. This involves capitalising on the connection to neighbourhoods and communities that locality working offers, in particular

around the integration of health with other public services, as well as capitalising on the scale of NHS Greater Manchester – driving consistent improvement, reducing unwarranted variation and making the best use of collective resources.

5.2 This builds on the national policy direction emphasising the importance of neighbourhood and place-based working. In September 2021, the Local Government Association and NHS England published *Thriving Places*, as guidance for the development of place-based partnerships within ICSs. This set out that place-based partnerships should remain the foundations of ICSs, with ICSs able to agree the geography of place-based partnerships in each system, and the purposes and roles for place-based partnerships.

5.3 The Government then published a White Paper on health and social care integration in February 2022, which focused on health and social care integration at place. Which set out a model of local leadership, with responsibility for bringing together partners across the NHS, local government, and the wider public and voluntary sector within each place to deliver the right outcomes and value for money and tackle health inequalities.

5.4 The NHS GM Operating Model sets out a model of ten strong places focused on convening robust partnerships across the NHS and public sector to improve population health and neighbourhood working. These ten place-partnerships are coterminous with the ten GM local authorities. Each place-based partnership is asked to undertake a range of functions, including:

- Developing and overseeing place-based strategies and plans that are aligned with GM-wide priorities;
- Commissioning a range of health services at place, drawing on population health insight, local Joint Strategic Needs Assessments and public engagement;
- Forging strong partnerships across sectors and pathways, creating the conditions to allow further integration of services and approaches; and
- Overseeing progress and support providers to deliver against place-based plans, monitoring quality and performance at place-level to ensure services are safe, effective, patient centred, timely and financially sustainable.

5.5 The Operating Model also set out a place-based leadership structure, whereby each locality would have a Place-Based Lead, who would take overall responsibility for the delivery of NHS GM functions at place, with Place-Based Partnership Committees acting as forums to support the discharge of these functions. The Partnership Committee would bring together local government, NHS GM, local NHS Trusts, and the VCSE, and either be a sub-committee of the NHS GM Board or a Joint committee between NHS GM and the relevant local authority. Each locality would also be responsible for ensuring clinical and care professional leadership as part of place-based working, which may include the development of a place-based provider collaborative. Place-based committees would also act as the organising function for neighbourhood working at place-level.

5.6 The Operating Model also set out the services that would be planned and overseen at place-level within GM. These included:

- Primary care services. Initially local enhanced primary care services, but expanding over time to cover the commissioning of wider primary care (initially commissioned at GM level);
- NHS community services including community nursing and care, health visiting, individual placements, CHC and intermediate care. Work is underway to implement this part of the operating model, with commissioning of NHS community services expected to be conducted at place-level from 2025/26;
- NHS community mental health, learning disability and autism services. Again, work is underway to implement this part of the Operating Model.
- Some public health services including social prescribing, diabetes prevention, and local smoking cessation.

5.7 In the Operating Model, commissioning is led at GM level for all diagnostic services, all secondary acute physical health care, all acute inpatient mental health care and some public health services (including vaccination and immunisation, health check programmes, hospital smoking cessation services and at scale prevention such as air pollution reduction).

5.8 Each locality across NHS GM has a Locality Team to deliver the placed based responsibilities, and those delegated through Pan-GM functions including safeguarding and quality. The Manchester locality team co-ordinates across system partners, supports MPB and the Place-Based Lead. The team is led by the Deputy Place-Based Lead supported by the Manchester Locality Management Team.

5.9 In total there are 157 members of the locality team, co-located with MCC and Manchester Local Care Organisation in the Town Hall extension.

6.0 Manchester within NHS GM: Priorities and Governance

6.1 Manchester has worked effectively in partnership on health and social care for many years. This means the City was well prepared for the establishment of the Integrated Care System. Manchester's original Locality Plan *Our Healthier Manchester* was produced in 2016 and sets out our ambition to improve the health and care outcomes for the people of Manchester within a financially sustainable health and social care system. The initial focus led to a rationalisation of the Manchester system, through the creation of a single commissioning function, a single hospital service and a local care organisation.

6.2 The locality plan was updated in April 2018, set within the context of the *Our Manchester* Strategy, shifting the emphasis away from structural change and towards a focus on Our People, Our Services and Our Outcomes. Following the pandemic, we have continued to refresh the locality plan, ensuring that it

aligns with the overall strategic objectives of the ICS set out in the five-year strategy.

6.3 Since 1 July 2022, the Manchester Partnership Board (MPB) has led the development of Manchester's Locality strategy and operating model for health and social care integration. MPB is chaired by Cllr Bev Craig as leader of Manchester City Council, and comprises executive level representation from Manchester University NHS Foundation Trust (MFT), Greater Manchester Mental Health NHS Foundation Trust (GMMH), NHS Greater Manchester Integrated Care Board (NHS GM), Manchester City Council (MCC), Manchester Local Care Organisation (MLCO), General Practice and the Voluntary, Community, Faith and Social Enterprise sector.

6.4 The Manchester Partnership Board (MPB) is responsible for agreeing the shared priorities and strategic direction for health and social care; ensuring integrated and aligned delivery across health and social care; and agreeing resource allocation within its delegated scope of responsibility.

6.5 Joanne Roney CBE was established as the 'Place-Based Lead' for Manchester in addition to being Chief Executive of Manchester City Council. Tom Hinchcliffe, Deputy Place-Based Lead is taking on the Interim Place-Based Lead role, whilst a permanent recruitment takes place for the MCC Chief Executive.

6.6 The most recent refresh of the locality plan took place in 2023. This set out two overarching priorities for the City's health and care system. These are to:

- *Improve physical and mental health and wellbeing, prevent ill-health and address health inequalities, so that people live longer in good health, wherever they are in the City;*
- *Improve access to health and care services, so that people can access the right care, at the right time, in the right place, in the right way.*

6.7 In January 2024, MPB agreed that these overarching priorities should remain for 24/25. The underlying delivery plan for 2024/ comprises the following proposed system transformation programmes:

- **Management of Long-Term Conditions**: with a focus on Diabetes and CVD Prevention, Children and Young People's Asthma, and the early identification and prevention of Bowel Screening, and hypertension.
- **Health-Care Led Regeneration**; Regeneration of North Manchester (redevelopment of North Manchester General Hospital), and development of an infrastructure for healthcare led regeneration across the city,
- **Transforming Mental Health Services in the Community**: development of the future model for mental health services in the community, with a focus on prevention, early intervention and the primary/secondary care interface.
- **Improving access to Primary Care**:

- **Urgent and Emergency Care Recovery**; Improving patient outcomes, experiences and patient flow through the UEC system:
- **Children and Young People**; strengthen and improve partnership working to improve resilience and outcomes for children and families
- **Optimising the Neighbourhood Approach;** supporting neighbourhoods to become the vehicle for health, care and wider services including optimising opportunities for further integration.

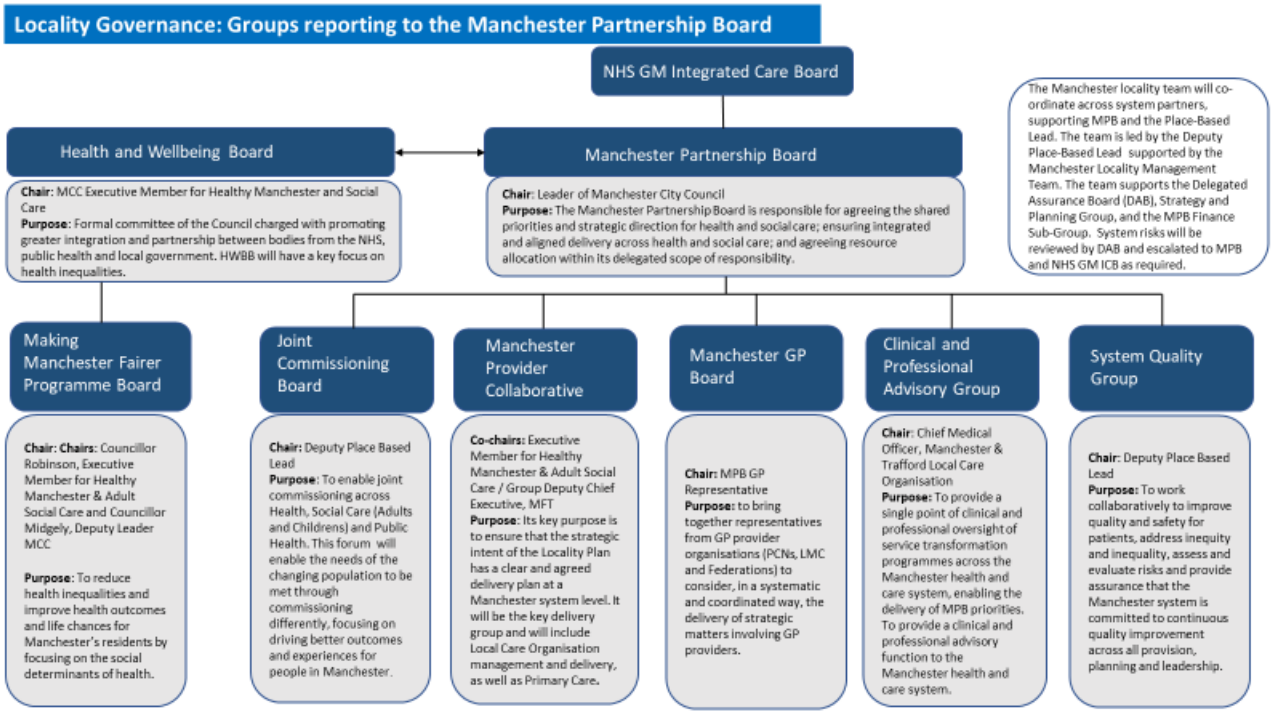
6.8 These programmes represent the areas where significant system transformation is needed to deliver MPB's desired outcomes, and where partners need to come together over the next 12 months to achieve this change. These programmes are supplemented by a range of other activity, broadly mapping to the financial and population health strands of the 'triple deficit'.

6.9 MPB is supported by a series of groups within the locality governance who oversee delivery of its responsibilities, with the support of the NHS GM Manchester Locality Team. The groups have system wide representation and chairing arrangements that reflect both the strong partner relationships across the system and the shift toward integrated working in the locality.

6.10 The Manchester Provider Collaborative Board is a key group within the governance which is responsible for ensuring that the strategic intent of the Locality Plan has a clear delivery plan and is delivered. It is co-chaired by the Executive member for Healthy Manchester and Adult Social Care and the Group Deputy Chief Executive MFT.

6.11 A Joint Commissioning Board has been established to enable joint commissioning across Health, Social Care (Adults and Childrens) and Public Health within Manchester. This forum will enable the needs of the changing population to be met through commissioning differently, focusing on driving better outcomes and experiences for the City's population.

6.12 A summary of the Locality Governance arrangements is shown below.



7.0 National Financial Picture

7.1 The National Audit Office (NAO) estimated the total NHS England resource expenditure for 2023-24 to be £153bn. The aggregate deficit of the 42 ICSs in England is estimated at £1.4bn. Over the decade from 2014-15 to 2023-24, the resource expenditure of the NHS grew on average by 3.2% in real terms, which was less than the long term average. From 1950-51 to 2013-14, resource expenditure on health grew by an average of 3.6% in real terms.

7.1 The pandemic also had a significant impact on the national funding position, with expenditure rising by 2.0 to 2.9% per annum in real terms from 2014-15 to 2018-19, which was followed by a 4.9% to 9.9% a year jump between 2019-20 to 2021-22. In the subsequent years, NHS expenditure has fallen slightly in real terms.

7.2 In 2022-23, the 42 ICSs in England planned for an aggregate deficit (overspend) of £99m against their total allocation of £119bn, with the actual outturn being a £621m deficit. In 2023-24, the 42 ICSs planned a total deficit of £720m, with an actual outturn of £1.4bn.

7.3 The NAO's assessment is that the NHS's financial position is worsening because of a combination of long-standing and recent issues, including failure to invest in the estate, inflationary pressures and the cost of post pandemic recovery. Funding for Covid-19 and pandemic related activities has now ceased, but there remains increased complexity and acuity in patient need, enhanced infection controls and operational and capacity constraints. Higher than expected inflation has increased the cost of medicines and other items beyond the costs budgeted for, with NHS England estimating this additional inflation cost an additional £1.4bn above the budgeted for amount. The

backlog of work needed to maintain the NHS estate has also increased costs, with this estimated at £11.6bn in 2022-23.

7.4 Workforce issues have also contributed to cost overruns. The NAO reports that industrial action and increased levels of sickness absence have required the NHS to spend more on agency staff since 2020-21. Together, these factors mean that the NHS's total agency spend increased from £2.4bn in 2020-21 to £3bn in 2023-24.

7.5 Additionally, the NHS faces challenges around productivity, which declined during the pandemic and has not fully recovered. This means that increases in funding flowing into the NHS have not been matched by increased outputs. In 2021-22, the NHS produced 135% of its 2013-14 output, but for 144% of the input. NHS England has publicly committed to achieving a large increase in productivity growth in return for digital investments, targeting annual improvements of 1.5% to 2% between 2025-26 and 2029-30, significantly above the long-term trend of 0.6% per annum.

7.6 People are also living longer and spending more years in ill health. The Health Foundation projects that the number of people diagnosed with a major illness will reach 9.3m in 2040 compared with 6.7m in 2019, a 39% increase. An additional 29,000 additional general and acute beds would be needed to meet this demand. A greater emphasis on prevention and promoting population health is therefore needed if the aim is to prevent a continuing increase in the size and cost of the NHS and an increase in backlogs and delays for treatment.

8.0 GM Financial Picture

8.1 Greater Manchester Integrated Care Partnership (the ICS) serves the largest population of the 42 ICSs that were established in 2022, responsible for the health and wellbeing of over 2.8 million people across the ten metropolitan districts.

8.2 The ICS in Greater Manchester is made up of nine NHS providers across the geographic footprint, along with the Integrated Commissioning Board (ICB), which serves all ten localities. There are six acute NHS Trusts, including Manchester Foundation Trust (MFT) which provides the majority of secondary care services for Manchester residents, two Mental Health Trusts, with Greater Manchester Mental Health (GMMH) providing most secondary mental health services for Manchester residents, and The Christie, which operates as a regional specialist cancer treatment centre based in the City of Manchester. The ICB commissions the vast majority of primary care, secondary care, community health, mental health, and other NHS funded activities across Greater Manchester, with a minority of specialist services commissioned at national or regional level, via NHS England.

8.3 In 2023/24 the GM system reported a deficit of £180m. National guidance is that this deficit is repaid over the next 2 financial years. Currently three-quarters of integrated care systems are having to repay prior-year overspends.

8.4 Significant work has been undertaken to better understand the “drivers of the deficit” across all providers and the ICB. This work identified six key drivers of the financial deficit in GM, which are consistent with the pressures seen nationally. These six key drivers are:

- **Workforce pressures.** Principally around increasing staff costs, increasing levels of sickness among staff, and use of agency capacity.
- **Acuity and complexity.** Increasing population need and complexity of health conditions within our population.
- **Population activity.** Higher levels of activity and referrals for elective and non-elective care, including A&E admission levels.
- **Provider productivity.** Increases in length of stay within inpatient settings, admissions and under-utilisation of some estate.
- **Care service costs.** Cost pressures on prescribing, mental health, primary care and NHS continuing healthcare.
- **Estates.** Increased costs of estate maintenance and a need for estates rationalisation.

8.5 The ICB has also developed a Strategic Financial Framework (SFF), which looks at the current demand for health services within GM and projects how this demand is likely to change up to 2027-28. This then links back to the expected costs of meeting that demand. The SFF gives an indication of the opportunities to improve the health of the population, the opportunities to deliver care more effectively and efficiently, and the relationship between up front investment to realise these opportunities against the future population health impact and the impact on the financial deficit.

8.6 Overall, the SFF analysis shows that around 28% of GM’s population are in some form of poor health. This encompasses those with one of more long-term conditions (such as diabetes, cardiovascular disease etc), those experiencing a serious mental illness, those with cancer, and those in end of life care.

8.7 78% of GM NHS funding (>£5bn) is spent on the 28% of the population in poor health. The SFF analysis projects that the proportion of the population in poor health will increase by ten percentage points by 2027-28. This would result in an additional 283,000 people being in poor health, with the biggest drivers of this being those experiencing multiple long-term conditions, and those experiencing mental illness – both of which are expected to roughly double over this time.

8.8 Together, this analysis points to a multi-pronged approach. With initial steps being taken to maximise grip and control over day-to-day spend across the health and care system, medium-term plans being delivered across each NHS body to transform services and reduce unnecessary cost from the system wherever possible, and a longer-term population health led approach to keep people well and prevent the deterioration in population health projected through the SFF. This is being taken forward in the form of an NHS GM

Sustainability Plan, which will be finalised by autumn 2024 and is closely aligned to the Single Improvement Plan work referenced earlier in this paper.

8.9 The NHS budget for the ICS in 2024/25 is £7.95 billion, with the system having a planned deficit of £175 million against this total across the nine provider Trusts and the ICB centrally. This planned deficit has been agreed by NHS England. Of the nine trusts, only two (MFT & The Christie) having agreed a surplus plan. The larger deficit plans being attributable to the Northern Care Alliance (£76m), Stockport FT (£44m) and Tameside FT (£38m). NHS bodies are asked to make efficiency savings each year through a 'Cost Improvement Programme' (CIP). The ICB has been asked to reduce it's 'influenceable spend by 5% in 2024/25, which equates to £103 million.

8.10 The ICS is reporting a year-to-date deficit of £95.9m at the end of June 2024, against a planned position of £78.5m deficit. This means a year-to-date pressure of £15.4m for NHS providers, and £2m for the ICB centrally. Drivers of the deficit for providers relate to industrial action costs (£5.6m), non-delivery of expected cost improvements (£4.2m) and temporary staffing costs linked to acuity / safer staffing (£3.1m). The ICB faces pressures concerning mental health out of area placements and increases to placement costs for complex care and NHS continuing healthcare.

8.11 A thorough cost recovery programme has been established to work with providers and across the ICB in order to bring the spend back in line with the agreed plan across the rest of the year. This involves regular Provider Oversight Meetings between ICB and Provider executives, and regular Locality Assurance meetings with the place-based leadership in each of the ten localities.

NHS GM Provider Financial Position, 2024/25 Plan & Month 3 results

	2024/25 YTD			2024/25 Outturn		
GM Providers Income Statement	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
	£m	*£m*	*£m*	*£m*	*£m*	*£m*
Income	1,891.8	1,899.6	7.8	7,589.5	7,591.3	1.8
Pay	(1,241.7)	(1,251.5)	(9.7)	(4,884.8)	(4,886.3)	(1.5)
Non-Pay	(701.4)	(717.1)	(15.7)	(2,768.4)	(2,768.7)	(0.3)
Non Operating Items	(27.2)	(25.0)	2.2	(111.3)	(111.3)	(0.0)
TOTAL Provider Surplus/(Deficit)	**(78.5)**	**(93.9)**	**(15.4)**	**(175.0)**	**(175.0)**	**0.0**
Surplus/Deficit Breakdown						
MFT	(16.8)	(27.7)	(10.9)	3.6	3.6	0.0
Christie	1.8	2.1	0.3	7.0	7.0	0.0
NCA	(27.8)	(29.0)	(1.2)	(75.7)	(75.7)	0.0
Bolton	(5.0)	(4.5)	0.5	(10.2)	(10.2)	0.0
Tameside	(9.7)	(9.4)	0.3	(37.5)	(37.5)	0.0
WWL	(3.2)	(4.4)	(1.2)	(14.2)	(14.2)	0.0
Pennine Care	0.0	0.0	0.0	0.1	0.1	0.0
Stockport	(13.3)	(13.4)	(0.1)	(43.8)	(43.8)	0.0
GMMH	(4.4)	(7.5)	(3.1)	(4.3)	(4.3)	0.0
Provider Surplus/(Deficit)	**(78.5)**	**(93.9)**	**(15.4)**	**(175.0)**	**(175.0)**	**0.0**

NHS GM ICB Financial Position, 2024/25 Plan & Month 3 results

	Budget In Month £m	Actual In Month £m	Variance In Month £m	Budget Year to Date £m	Actual Year to Date £m	Variance Year to Date £m	Budget Annual £m	Full Year Forecast £m	Variance FOT £m
Allocations	**684.9**	**684.9**	**0.0**	**2,025.7**	**2,025.7**	**0.0**	**7,951.5**	**7,951.5**	**0.0**
Admin									
Running Costs	3.9	3.9	(0.0)	11.8	11.8	0.0	47.7	47.7	0.0
Total Admin	**3.9**	**3.9**	**(0.0)**	**11.8**	**11.8**	**0.0**	**47.7**	**47.7**	**0.0**
Programme									
Mental Health	73.1	75.0	(1.9)	216.9	221.2	(4.3)	855.9	876.7	(20.8)
Acute	329.6	331.2	(1.6)	955.5	957.3	(1.8)	3,815.5	3,815.8	(0.3)
Specialised Commissioning	63.1	60.4	2.7	183.9	181.2	2.7	738.5	735.0	3.5
Primary Care	5.2	4.8	0.4	20.4	20.0	0.4	87.9	87.6	0.3
GP Medical, Pharmacy, Dental and Optometry	84.6	84.5	0.1	239.7	239.4	0.3	939.0	938.8	0.2
Prescribing	46.2	46.2	0.0	141.9	141.9	0.0	552.6	552.5	0.1
Continuing Care	22.7	24.4	(1.7)	67.4	71.0	(3.6)	259.3	270.6	(11.3)
Community Health Services	56.8	56.7	0.1	173.2	173.8	(0.6)	687.0	690.3	(3.3)
Programme Operating Costs	7.0	6.7	0.3	21.0	20.3	0.7	85.4	85.5	(0.1)
Other expenditure	(13.1)	(13.3)	0.2	(9.9)	(10.2)	0.3	5.0	4.7	0.3
Earmarked commitments	3.9	0.0	3.9	3.9	0.0	3.9	(122.3)	(153.7)	31.4
Total Programme	**679.1**	**676.6**	**2.5**	**2,013.9**	**2,015.9**	**(2.0)**	**7,903.8**	**7,903.8**	**0.0**
Total Expenditure	**683.0**	**680.5**	**2.5**	**2,025.7**	**2,027.7**	**(2.0)**	**7,951.5**	**7,951.5**	**0.0**
Surplus / (Deficit)	**1.9**	**4.4**	**2.5**	**0.0**	**(2.0)**	**(2.0)**	**0.0**	**0.0**	**0.0**

8.12 The Greater Manchester ICS Capital Pipeline is made up of current and future priorities the partners have identified as their key estates needs to provide health and care for the growing population. Given the current financial climate across the ICS, the primary focus will be on reducing the backlog maintenance relating to health & safety/DDA compliance and improving utilisation of existing estate in the first instance. This will be prior to considering other solutions that can have recurrent capital and revenue consequences. The aims, however, will continue to deliver on strategic criteria such as population benefit, service integration & alignment, access and operational benefit in conjunction with the Estates, Clinical, Digital, People and Green plans.

8.13 Across the ICS, there is an estimated capital requirement of over £6 billion (986 schemes), split into immediate priorities (£956m), medium term priorities (£4.3 billion) and longer term priorities (£781m). These schemes are made up of refurbishments, reconfigurations, relocations, extensions, new builds, and net zero carbon schemes. The immediate priorities in 2024/25 have the majority in progress (£578m of schemes) with the remaining schemes progressing to final approval stage (£378m of schemes).

9.0 Manchester Financial Picture

9.1 The ICB set the 2024/25 budget for the Manchester locality at £272 million. This covers Primary Care prescribing and incentive schemes, NHS Continuing Healthcare (CHC) placements, complex mental health, learning disability and autism placements, and placements for children with complex needs. Manchester's outturn for 2023/24 was £269 million (a £13m deficit on a £256m budget), however in line with the ICB more generally, the locality has been asked to achieve a 5% reduction in spend for 2024/25. This equates to a reduction of around £13m. The locality has a plan in place to deliver this reduction, which involves undertaking further work to reduce primary care prescribing costs, work to manage the costs of complex placements, working with the market to drive best value for money and patient outcomes, and close joint working with local authority and other partners to ensure we are commissioning as effectively as possible and making the best use of the combined resources available to us.

9.2 However, risks remain for the delivery of this saving. We continue to see an increase in complexity and acuity within Manchester, and have seen significant inflation in the costs of complex care placements within the City. Inflation in the cost of medicines also continues, albeit at a more gradual rate than we have seen over the past couple of years. The Manchester locality team continues to work closely with the City council to consider opportunities for joining up our commissioning and market management activity through the Manchester Joint Commissioning Board to drive best value from the funding available. We have identified medicines optimisation, continuing healthcare, and system-wide market management as key areas for the CIP programme in 2024/25.

9.3 The locality is reporting a £1.2m deficit as at the end of June 2024 (Month 3), reflecting pressures within CHC and Mental Health (LD in the main) placements. In line with the expected breakeven plan for the ICB for 2024/25, the locality is now reviewing mitigating actions against this pressure to return to a balanced financial position. This also assumes full delivery of the 5% CIP programme.

Summary	Annual Budget £'000	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000
Community (E.g. MCC, Hospice)	41,316	10,228	10,166	(62)
Continuing Healthcare (CHC)	54,231	14,696	15,414	718
Mental Health	42,598	10,650	11,197	547
Primary Care (inc. Prescribing)	126,586	31,367	31,345	(22)
Discharge funding	5,384	1,346	1,346	0
Other	2,190	548	595	47
Manchester Locality Total	**272,305**	**68,835**	**70,063**	**1,228**

9.4 In its final year of operation (2021-22), Manchester Health and Care Commissioning's running costs were approximately £21m excluding pan-GM services hosted within Manchester. In 2022-23, Manchester locality had running costs of £13.1m and has reduced costs substantially since then through an organisational restructure and participating in two Mutually Agreed Resignation Scheme processes. This reflects a national ask for ICBs to reduce their running costs by 30% over two years. There is an ask to further reduce running costs to £6.4m across 2024/25, which will be challenging and require further work with local partners to look at the operating model across the NHS, Manchester Local Care Organisation and the City Council that best maintains the capacity for us to deliver high quality health and care services for the City's population.

10. Recommendations

10.1 The Committee is asked to note and comment on the content of the report.