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

Present:

Councillor Elizabeth FitzGerald	Bury Council (in the Chair)
Councillor Ayyub Patel	Bolton Council
Councillor Zahid Hussain	Manchester Council
Councillor Eddie Moores	Oldham Council
Councillor Peter Joinson	Rochdale Council
Councillor Wendy Wild	Stockport Council
Councillor George Devlin	Trafford Council
Councillor Ron Conway	Wigan Council

Officers in Attendance:

Gill Baker	GM Urgent & Emergency Care (UEC) Programme Director, NHS GM
Darren Banks	Interim Deputy Trust Chief Executive, Manchester University NHS Foundation Trust
Rob Bellingham	Programme Director for Major Trauma, NHS GM
Rafik Bedair	Executive Medical Director, Northern Care Alliance
Claire Connor	Director, Communications & Engagement, NHS GM
Jennie Gammack	Programme Director for Sustainable Services, NHS GM
Dan Gordon	Programme Director, Elective Recovery & Reform, NHS GM
Jenny Hollamby	Senior Governance & Scrutiny Officer, GMCA
Martin Smith	Emergency/Major Trauma Consultant, Northern Care Alliance
Katherine Sheerin	Chief Commissioning Officer, NHS GM

Ben Squires	Director of Primary Care, NHS GM
Nicola Ward	GMCA Statutory Scrutiny Officer & Deputy Head of Governance

JHSC/101/25 Welcome & Apologies

The Chair welcomed Councillor Ayyub Patel from Bolton Council who had replaced Councillor Jackie Schofield on the Committee.

Apologies for absence was received and noted from Councillor Irfan Syed and Warren Heppolette.

JHSC/102/25 Chair's Announcements and Urgent Business

The Chair informed Members of the announcement last week that all 42 Integrated Care Boards (ICBs) in England would be required to reduce their costs by 50% before the end of December 2025. In addition, the Government had also announced the transfer of NHS England's functions into the Department for Health and Social Care (DHSC). The changes were intended to eliminate duplication and better support frontline services. As the Greater Manchester Joint Health Scrutiny Committee, Members would continue to be informed of any developments and use its function to best navigate any changes as they arose.

The Chair had asked NHS GM colleagues to provide a report on how the announcement would impact delivery of their Sustainability Plan, along with the wider implications for the ICB and NHS Trusts, at the next meeting on 15 April 2025. Additionally, Members were asked to submit any specific areas or issues they wanted the report to address to Jenny Hollamby or Nicola Ward by 25 March 2025

Resolved-

1. That it be noted that NHS GM provide a report at the next meeting on 15 April 2025 regarding the impact of the announcements (that all 42 Integrated Care Boards (ICB) in England would be required to reduce their costs by 50% before the end of December 2025 and that NHS England would be abolished,

transferring its functions to the Department for Health and Social Care) on the Sustainability Plan along with the wider implications to the ICB and NHS Trusts.

2. That it be noted that Members with specific areas or issues they would like this report to cover were asked to return them to Jenny Hollamby or Nicola Ward by 25 March 2025.

JHSC/103/25 Declarations of Interest

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

JHSC/104/25 Minutes of the Meeting held on 18 February 2025

Resolved/-

That it be noted that the minutes of the meeting held on 18 February 2025 be approved as a correct record.

JHSC/105/25 Elective Recovery Update

Members considered a report presented by Dan Gordon, Programme Director, Elective Recovery and Reform, NHS GM, that provided an update on the current position for elective care across Greater Manchester (GM). It described the performance of the system in terms of data and trends, highlighted driving factors for current challenges and explained the key components of the GM Elective Recovery Plan.

It was reported that GM faced a significant elective care backlog, with approximately 500,000 patients awaiting treatment. Pre-pandemic, the region struggled to meet national targets, witnessing a decline in the percentage of patients seen within 18 weeks. The COVID-19 pandemic further exacerbated the situation, dramatically increasing both the waiting list size and waiting times. Long waits, exceeding a year, became common. However, substantial progress had been achieved in reducing the number of patients waiting excessively long periods.

Despite this progress, the overall waiting list remained high, and the 18-week treatment target was still unmet. However, the focus had shifted towards improving overall access to elective care, particularly outpatient appointments, as they constituted the majority of the waiting list growth.

Efforts had also been made to standardise and enhance access to specialist advice for GPs, aiming to manage more patients within primary care. Plans had also developed to expand community-based provision for specific specialties, reducing pressure on hospital services.

Significant variations in provision and wait times persisted across different areas of GM. Initiatives had been implemented to improve patient choice, including providing information on wait times and establishing single points of access. Surgical hubs had been utilised, and direct access to them increased.

A Member raised three key concerns. First, they questioned the true impact of prolonged patient wait times, specifically those exceeding 18 months, asking what future work would assess this beyond current reports. Second, they sought clarity on equality and diversity, requesting details about analyses identifying affected communities and the actions being taken to address performance disparities. Finally, they inquired about workforce capacity, particularly in paediatrics, and the strategies to secure adequate staffing for planned changes. In response, Officers acknowledged long wait times as a challenge, detailing initiatives like community services and workforce expansion, particularly in paediatrics. They addressed socioeconomic disparities affecting appointment attendance, highlighting efforts to improve access and engagement. Ongoing research explored the impact of wait times on urgent care, and a targeted programme aimed to expedite musculoskeletal (MSK) services for unemployed patients.

Regarding inequalities, officers emphasised the importance of equality impact assessments in service redesign and transformation. Highlighted as successful were GP-led gynaecology services in Wigan, which reduced patient wait times compared to other areas, and addressed inequalities related to travel and affordability. Also discussed was ongoing engagement with residents and the voluntary sector regarding ophthalmology services in Tameside, and detailed plans to improve fragmented

dermatology provision across GM through localised services. The Committee was reassured that NHS GM was working closely with citizens and aligning skilled workforce assets to meet community needs.

A Member suggested that high rates of missed appointments among certain socioeconomic groups were likely due to poor communication and insufficient community outreach, rather than patient unwillingness. It was recommended that focused efforts to improve communication and engage with these communities could significantly reduce missed appointments with minimal resource investment, representing a quick win supported by existing evidence.

Faced with financial and workforce constraints, a Member questioned how NHS GM could achieve the 92% 18-week wait target by March 2029 without extra funding. Officers acknowledged the difficulty, highlighting the region's higher improvement rate requirement compared to others, and outlined strategies like enhanced community services, primary care interventions, and surgical productivity. While aiming for 61% next year, 92% was particularly challenging without more resources, emphasising a commitment to maximising current capacity and improving pathways. When pressed for a realistic percentage, it was reported that while interventions could reduce waiting lists by half to two-thirds, reaching the RTT (Referral to Treatment) target was different, and that they must aim for 92% through prevention, shared decision-making, and service efficiency.

In response to a question about poor oral health in children in GM, Members heard that a multiple approach was being implemented, focusing on prevention through a push of the supervised toothbrushing programme in schools, nurseries, and early years settings, aligning with a national programme by the Department of Health, and ensuring access to preventative care and dental services by enhancing primary care dental services and increasing capacity for elective oral surgery. The key challenges in transforming paediatric dentistry services included addressing the existing surgical needs while preventing new demand and overcoming capacity constraints around anaesthesia for children's dental surgery, rather than surgeon workforce.

A Member raised concerns about the diversity of GM and whether commissioning efforts were effectively reaching diverse communities, noting a lack of translation from

equality impacts to community needs and insufficient monitoring. In response, it was acknowledged that this was a general issue, with examples cited in Bolton, and emphasised the need for correct commissioning to facilitate effective monitoring and identification of challenges. Also highlighted was the necessity of a multifaceted approach, including improved contracting, gathering citizen feedback, and better utilising the voluntary sector, with an emphasis on proactively seeking engagement to improve service delivery and ensure that commissioning accurately met the needs of residents.

The Chair reported that she had visited the community diagnostic centre in Salford and was impressed by its convenience, noting that it allowed patients to undergo pre-elective surgery procedures in an easily accessible retail park setting, which reduced any stress a patient may feel about hospital visits.

Resolved/-

1. That it be noted that the Committee recognised the improvement made on long-waiting patients and the scale of the challenge to improve access and reduce the waiting list size.

2. That it be noted that the Committee supported the cross-cutting system programmes being taken to improve access across the system and at local provider level:

    a) Development of a single point of access that utilises digital technology for elective referrals in GM to provide ‘air traffic control’ functionality, supporting patient choice and optimisation of pathways.
    b) Development of a GM-wide specialist advice service to support primary care to continue to treat patients, where safe and appropriate to do so.
    c) Expanded access to community services using a tiered care model approach focusing on Dermatology, Gynaecology, Ears, Nose and Throat (ENT) and Gastroenterology in 2025/26, ensuring consistency of commissioning across all localities in GM.
    d) Optimising use of surgical hubs and Community Diagnostic Centres to support treatment of patients across GM.

JHSC/106/25 Reconfiguration Progress Report and Forward Look

Consideration was given to a report presented by Claire Connor, Director, Communications and Engagement, NHS GM that provided the Committee with the service reconfigurations planned or undertaking engagement and/or consultation. The report also included additional information on any engagement that was ongoing.

The following update was noted:

- Adult Attention Deficit Hyperactivity Disorder (ADHD) – was due to be considered by the ICB Board on 19 March 2025 for approval to move to consultation with a tentative start date of 7 April 2026.

- Children's ADHD – NHS England approval had been received so work would progress in this area.

- In Vitro Fertilisation (IVF) Cycles – would be considered by the NHS GM's Board at their next meeting. A written briefing on the planned consultation would be provided to the Committee.

- Specialised Commissioning Cardio and Arterial Vascular Surgery – the project was being prepared for NHS England Gateway 2.

- Diabetes Structured Education – this project would be considered by the Committee in April 2025.

- Procedures of Limited Clinical Value – the review had taken place and Officers were planning engagement on further changes.

- Major Trauma – following a review of whether the specialist services for major trauma met the required specification. Further work was being undertaken to consider how the services could be delivered.

Resolved/-

1. That it be noted that the Committee received and noted the report.

2. That it be noted that a written briefing on the IVF Cycles planned consultation would be provided to the Committee.

JHSC/107/25 GM Patient Access – Primary and Urgent Care

Presented by Katherine Sheerin, Chief Commissioning Officer, Ben Squires, Director of Primary Care, and Gill Baker, GM Urgent and Emergency Care Director, NHS GM and considered by Members was a report, which provided an update on primary and urgent care access.

Ben Squires, Director of Primary Care introduced the item and reported that in February 2025, the Committee received a report on GP access in GM. The report highlighted that while 78.3% of respondents had a positive experience with their GP practice, 6.9% reported a poor experience. GP appointment numbers had increased since 2019, with over 1.3 million appointments within 14 days in October 2024. At that meeting the Committee recommended a broader assessment of GP access, including patient outcomes.

In terms of community pharmacy services, it was explained that despite a decline in branch numbers, they played a crucial role. The Pharmacy First initiative saw significant success, with GM leading in consultation numbers. National and local services, like hypertension case finding and Minor Ailments Services (MAS), were actively utilised. MAS was shown to heavily benefit the most deprived areas. Regarding dental services, outlined was the structure of NHS dental care, including primary, secondary, and community services. The national Dental Recovery Plan aimed to improve prevention, access, and workforce. The GM Dental Quality Access Scheme increased access for new and urgent patients. Patient access was recovering post-pandemic, though variations existed. Urgent dental care was available through a helpline and hubs, with the government aiming for increased appointments. An oral health needs assessment was underway to address inequalities.

A Member inquired about the common theme contributing to the decrease in patients failing to attend and the associated cost. It was clarified that the decrease in the figure was due to part-year reporting, making the two years not directly comparable. In terms of cost, it was estimated it to be approximately £200k, based on an average patient encounter generating three units of dental activity at approximately £35 per unit.

The Member further asked what would happen to those dental practices not achieving the targets and what action was taken. It was explained that dental contract underperformance was addressed in two ways. First, payments were adjusted if a contractor delivered less than 96% of their contracted activity. For example, 50% delivery equals 50% payment. Second, if underperformance was recurrent over three years, commissioners could rebase the contract to reallocate resources for better patient care.

Given the observed variations in dental service provision across GM localities and the ongoing oral health needs assessment, a Member asked for further information on the assessment's anticipated completion date and its potential impact on future service planning and development. It was reported that the oral health needs assessment was undertaken by dental health experts from NHS England North West. The Lead in GM was working with the ten LAs to improve oral health, including things like toothbrushing programmes. The assessment looked at how easy it was to get dental care, where clinics were and how much dental disease there was, using surveys of children. This work was ongoing and helped NHS GM improve oral health, using information from a recent disease survey.

Gill Baker, Programme Director, GM Urgent & Emergency Care (UEC), NHS GM introduced Section 4 (Urgent and Emergency Care Services) of the report and explained that GM's urgent and emergency care services handled about 3,900 patients daily, including those in Type 1 (higher acuity) and Type 3 (lower acuity) A&E departments. Many arrived on their own, via referrals, or by ambulance. A key issue was issue was patient wait times, with only 69% receiving care within the four-hour standard, below the 78% national target and far from the previous 95% goal.
GM was a Tier 1 challenged system, but improvements had been made, with performance 4-5% better than last year. Ambulance services had consistently met

targets, especially for Category 2 responses (heart attack/stroke), due to strong collaboration with hospitals.

Urgent care was 24/7, but long waits were a problem, particularly for patients needing admission. There was a focus on reducing demand by improving out-of-hospital care through services like 111 and the GM Clinical Assessment Service, and by ensuring equitable access across localities.

A key goal was to establish a single point of access for both patients and professionals to better navigate and access appropriate urgent care services, ultimately reducing unnecessary hospital visits and enhancing overall care quality.

Concerns were raised about the lack of community understanding of available primary and urgent care services, particularly among diverse populations, prompting a discussion on improving communication and engagement. NHS GM acknowledged the need to go beyond current “Get to know where to go” campaigns, committing to targeted outreach, culturally relevant information, and "myth-busting" public perceptions around access. The Committee also discussed the impact of varying service hours across localities, with NHS GM outlining plans to establish core standards for out-of-hospital urgent care to ensure more consistent alternatives to A&E. In response to a request from the Committee, NHS GM agreed to provide updated resources, including a concise information sheet, to support Members in disseminating accurate service information within their communities.

Resolved/-

1. That it be noted that to improve access to healthcare for residents, especially in urgent and emergency care, Members agreed that NHS GM needed to focus on several key areas.

    a) Enhancing understanding by the public regarding the range of services available to support urgent care, particularly those in primary care (General Practice (GP), Dentists and Pharmacists), including out of hours.
    b) Implementing true Single Points of Access (SPOA) for UEC would streamline patient referrals and coordinate care, ensuring patients received the right care at the right time. Investing in digital health solutions, like

telemedicine and remote monitoring, could improve access to care and support self-management of health conditions.

c) Improving utilisation of Hospital @ Home beds through enhanced pathways and improved collaboration.
d) Additionally addressing health inequalities by providing intensive and personalised support to underserved populations was essential to reduce high-intensity use of UEC services.
e) Continuing to reduce hospital discharges though comprehensive discharge planning processes that began at the time of patient admission.

3. That it be noted that the Committee supported measures to work with local people to ensure awareness of services available.

4. That it be noted that an update on NHS England's Oral Health Needs Assessment would be made available to the Committee in due course and alongside a future update on dentistry if required.

5. That it be noted that campaign relation information on choosing the right primary care provision be shared with Members of the Committee for their dissemination.

JHSC/108/25 GM Major Trauma Provision (MTP)

Members considered a report presented by Rob Bellingham, Programme Director for Major Trauma, and Jenny Gammack, Programme Director for Sustainable Services, NHS GM, which described the progress of the site selection process for the delivery of MTS within GM.

Rob Bellingham, Programme Director for Major Trauma, NHS GM introduced the report and explained that the current process around major trauma services in GM was being updated, with this initial overview report provided as a precursor to future recommendations. This process was being led by NHS GM, with significant commitment and engagement from key providers, including the Northern Care Alliance and Manchester Foundation Trust. A Steering Group, chaired by NHS GM, met every two weeks to ensure high-level management and clinical input.

It was reported that major trauma referred to serious or multiple injuries that were life-threatening or could cause long-term disability, often resulting from violence or accidents. The GM Major Trauma System included major trauma centres, units, and local emergency hospitals. A peer review process conducted in September 2024 provided recommendations to review and improve the current model.

The ongoing process aimed to deliver a sustainable, compliant model that built on strengths identified in the peer review and addressed any issues. Engagement work with people who had used major trauma services and equality impact assessments were part of the process. Future updates and recommendations would be presented to the Committee as the work progressed.

A Member asked for an idea of the timescales involved. It was reported that Officers were working through various options and the outcomes would be shared at the next Steering Group meeting on 31 March 2025. The aim was to be in a position to implement some of these recommendations by May 2025. The Committee was assured that the priority was to do this correctly rather than quickly. Officers believed the timeline was achievable, but their focus remained on ensuring the process is thorough and lead to the right decision and outcome. Officers would keep Members closely informed throughout the process.

By invitation of the Chair, Darren Banks, the Interim Deputy Chief Executive, Manchester Foundation Trust, added that the goal was to ensure that decisions made by the Commissioner considered the full implications for all patients, including those receiving care from adult neurosciences services at Salford, children's major trauma services, and vascular services. The process aimed to balance and judge the complementary nature of these services to avoid unintended consequences. The expectation was that this comprehensive approach would be followed to ensure the best outcomes for all involved.

Rafik Bedair, Executive Medical Director, Northern Care Alliance emphasised that the process for updating major trauma services in GM had been highly collaborative, involving multidisciplinary expertise across multiple organisations. The goal was to ensure the best outcomes for patients. Engagement with the public was crucial, not

only during the decision-making process but also in how decisions were communicated and managed. It was important to reassure citizens that decisions were made with their best interests in mind, to prevent unnecessary concern and ensure clear communication.

Acknowledged was the excellent work of Claire Connor, Director of Communications and Engagement, NHS GM and her Team. From a communication and engagement perspective, Claire had been instrumental in providing advice to the Team and her efforts ensured that the approach was proportionate and addressed the issue of clear communication. While engagement was important, clear communication was equally vital to ensure everyone understood the decisions being made and felt reassured about the process.

Resolved/-

That it be noted that the Committee received the update and agreed to receive further updates as the site selection process evaluated the options being explored, in order to support future recommendations to ensure that GM had a compliant MTP.

JHSC/109/25 Work Programme for the 2024/25 Municipal Year

Nicola Ward, GMCA Statutory Scrutiny Officer and Deputy Head of Governance, presented to the Committee its Work Programme for the 2024/2 Municipal Year.

Resolved/-

That it be noted that the Committee at the next meeting on 15 April 2025 would consider:

1. The Reconfiguration Progress report and Forward Look.

2. Diabetes Structured Education Engagement.

3. A report about the impact of the announcements (that all 42 Integrated Care Boards (ICB) in England would be required to reduce their costs by 50% before

the end of December 2025 and that NHS England would be abolished, transferring its functions to the Department for Health and Social Care) on the Sustainability Plan along with the ICB and NHS Trusts.

JHSC/110/25 Dates and Times of Future Meetings

Resolved/-

That it be noted that the next meeting was scheduled to take place on 15 April 2024 at 10.00 am, Boardroom, GMCA.