AGENDA

1 **AGENDA** *(Pages 3 - 172)*

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Agenda

Locality Board – Bury Town Hall

Date: 05th October 2026

Time: 4.00 pm – 6.00 pm

Venue: Committee Rooms A and B, Bury Town Hall, Knowlsey Street, Bury

Chair: Dr Cathy Fines

Full agenda pack begins on next page.

Date and time of next meeting
05th October 2026

If you wish to attend this meeting, please contact the Bury Corporate Team at; gmicb-bu.corporateoffice@nhs.net
If you would like to ask a question of the Bury Locality Board, please submit it by **email to** gmicb-bu.corporateoffice@nhs.net **no later than 01st October at 12 noon.** Questions received after this time will be taken to the following meeting.

Please note that due to the limited time we have, we cannot respond to public questions within the Locality Board meeting. We will acknowledge all the questions we receive and will respond to them formally in writing within 20 days.

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BURY INTEGRATED CARE PARTNERSHIP

Agenda

Locality Board – Meeting in Public

Date: 5th October 2026

Time: 4.00 pm – 6.00 pm

Venue: Committee Rooms A and B, Bury Town Hall, Knowlsey Street, Bury

Chair: Dr Cathy Fines

Item No.	Time	Duration	Subject	Paper Verbal	For Approval Discussion Information	By Whom
1.0	4.00 – 4.05	5 mins	Welcome, apologies and quoracy	Verbal	Information	Chair
2.0			Declarations of Interest	Paper	Information	Chair
3.0			Minutes of previous meeting held on 7th September 2026 and action log - Ratification of decisions made at the September 2026 meeting.	Paper	Approval	Chair
4.0			Public questions	Verbal	Discussion	Chair
Place Based Lead Update						
5.1	4.05 – 4.10	5 mins	Key Issues in Bury	Paper	Discussion	Lynne Ridsdale
5.2	4.10-4.15	5 mins	Place Partnership documentation update	Paper	Discussion	Will Blandamer
6.0	4.15-4.35	20 mins	NCA Improvement Plan update	Verbal	Discussion	Will Blandamer/Lorna Allan
Neighbourhood Plan						
7.0	4.35-4.50	15 mins	Bury Estates Update	Paper	Discussion	Clare Postlethwaite
Integrated Delivery Update						
8.0	4.50-5.00	10 mins	Integrated Delivery Collaborative Update	Paper	Discussion	Kath Wynne Jones
9.0	5.00-5.15	15 mins	3 Year Development Plan for Adult Social Care	Paper	Discussion	Adrian Crook

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10.0	5.15-5.30	15 mins	Mental Health commissioning intentions	Paper	Approval	Ian Trafford
Committee/Meeting updates						
11.0	5.30-5.40	10 min	Population Health and Wellbeing update	Paper	Information	Jon Hobday
Closing Items						
12.0	5.40	5 mins	Any Other Business		Verbal	
	_____	_____	**Date and time of next meeting in public - Monday, 2nd November 2026, 4.00 - 6.00pm on Microsoft Teams**		_____	

13.0		5 mins	Post Meeting Reflection	Verbal/All

BURY INTEGRATED CARE PARTNERSHIP

Meeting: Locality Board			
Meeting Date	05 October 2026	Action	Consider
Item No.	2	Confidential	No
Title	Declarations of Interest		
Presented By	Chair of the Locality Board		
Author	Emma Kennett, Head of Locality Admin and Governance (Bury)		
Clinical Lead	N/A		

Executive Summary

NHS GM has responsibilities in relation to declarations of interest as part of their governance arrangements (details of which can be found outlined in the NHS Greater Manchester Integrated Care Conflict of Interest Policy version 1.2).

NHS GM (Bury Locality) therefore, has a requirement to keep, maintain and make available a register of declarations of interest for all employees and for a number of boards and committees.

The Local Authority has statutory responsibilities detailed as part of Sections 29 to 31 of the Localism Act 2011 and the Relevant Authorities (Disclosable Pecuniary Interests) Regulations 2012. For other partners and providers, we understand that conflicts of interest are recorded locally and processed within their respective (employing) NHS and other organisations as part of their own governance and statutory arrangements too.

Taking into consideration the above, a register of Interests has been included detailing Declaration of Interests for the Locality Board.

In terms of agreed protocol, the Locality Board members should ensure that they declare any relevant interests as part of the Declaration of Interest Standing item on the meeting agenda or as soon as a potential conflict becomes apparent as part of meeting discussions.

The specific management action required as a result of a conflict of interest being declared will be determined by the Chair of the Locality Board with an accurate record of the action being taken captured as part of the meeting minutes.

There is a need for the Locality Board members to ensure that any changes to their existing conflicts of interest are notified to NHS GM (Bury Locality) Corporate Office within 28 days of a change occurring to ensure that the Declarations of Interest register can be updated.

Recommendations

It is recommended that the Locality Board:-

- Receive the latest Declarations of interest Register;
- Consider whether there are any interests that may impact on the business to be transacted at the meeting on 5th October 2026 and

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- Provide any further updates to existing Declarations of Interest within the Register.

OUTCOME REQUIRED *(Please Indicate)*	**Approval** ☐	**Assurance** ☐	**Discussion** ☐	**Information** ☐
APPROVAL ONLY; (please indicate) whether this is required from the pooled (S75) budget or non-pooled budget	**Pooled Budget** ☐	**Non-Pooled Budget** ☐		

Links to Locality Plan priorities	
Scale our work on Population Health Management - Improve population health and reduce health inequality of those in the most disadvantaged areas	☒
Drive prevention, reducing prevalence and proactive care – supporting Demand Reduction through primary intervention, secondary preventions and tertiary prevention	☒
Transforming Community Care in Neighbourhoods - fully realising the benefit of neighbourhood team working with a focus on the assets of residents and communities and providing proactive care	☒
Optimise Care in institutional settings and prioritising the key characteristics of reform.	☒

Implications						
Are the risks already included on the Locality Risk Register?	Yes	☐	No	☒	N/A	☐
Are there any risks of 15 and above that need to be considered for escalation via an NHS GM Statutory Committee or Board in line with the Risk Escalation process ?	Yes	☐	No	☒	N/A	☐
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☒	N/A	☐
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☒	N/A	☐
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☒	N/A	☐
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☒	N/A	☐
Are there any financial Implications?	Yes	☐	No	☒	N/A	☐
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☒	N/A	☐
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒

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Implications						
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☒	No	☐	N/A	☐

Governance and Reporting		
Meeting	**Date**	**Outcome**
N/A		

Committees and Sub-Committees

Locality Board

Declaration of interest as per policy:
- Declare in meetings where relevant
- Not to be sent papers where conflicted
- Not to be involved in any decision making where conflicted (which may then also involve the following action to be taken at a meeting:
- Remaining present at the meeting but withdrawing from the discussion and voting capacity
- Remaining present at the meeting and participating in the discussion but not involved in any voting capacity
- Being asked to leave the meeting

Name			Current Position	Declared Interest- (Name of organisation and nature of business)	Type of Interest			Is the Interest direct or indirect?	Nature of Interest	Date of Interest		Comments
					Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests			From	To	
Voting Members (Pooled Budget & Aligned & Non-Pooled Budget)												
Cllr	O'Brien	Eamonn	Leader of Bury Council & Joint Chair of the Locality Board	Young Christian Workers	X			Direct	Member		Present	As per policy - see details above
				Labour Party		X		Direct	Member		Present	
				Bury Corporate Parenting Board		X		Direct	Member		Present	
				No Barriers Foundation		X		Direct	Trustee		Present	
				CAFOD Salford		X		Direct	Member		Present	
				Catenian Association		X		Direct	Member		Present	
				USDAW		X		Direct	Member		Present	
				Prestwich Methodist Youth		X		Direct	Trustee		Present	
Cllr	Tariq	Tamoor	Executive Member of the Council Adult Care and Health	Welspun UK LTD				Indirect	Spouse/Civic Partner Employed		Present	
				GMICP		X		Direct	Member		Present	
				The Derby High School			X	Direct	Governor	Apr-18	Present	
				Health & Wellbeing Board Member		X		Direct	Member		Present	
				Unite the Union		X		Direct	Community Member	May-12	Present	
				Labour Party		X		Direct	Member	Jun-07	Present	
Dr	Fines	Cathy	Place Clinical Director	GP Federation	X			Direct	Practice is a member	2013	Present	Declaration of interest as per policy as detailed above (Y,Y,Y,Y,Y)
				Tower Family Health Care	X			Direct	Partner in a member practice in Bury Locality	2017	Present	
				Horizon Clinical Network	X			Direct	Practice is a member	2019	Present	
				Greater Manchester Foundation Trust				Indirect	Husband is employed		Present	
	Downes	Catherine	Associate Director Improvement and Personalisation	Northern Care Alliance				Indirect	Partner is a Director at the Northern Care Alliance	2019	Present	As per policy - see details above
	Ridsdale	Lynne	Chief Executive for Bury Council	Bury Council		X		Direct	Chief Executive	Mar-23	Present	As per policy - see details above (Y,Y,Y,Y,Y)
Dr	Kumar	Manisha	Chief Clinical Officer, NHS Greater Manchester	Robert Darbishire Practice	X			Direct	Salaried GP	2024	Present	
				University of Salford		X		Direct	Honorary Professor University ofSalford	May-23	Present	
				Primary Eye Care Services LTD			X	Indirect	Husband is Operations Director	2021	Present	
				General Optical Council			X	Indirect	Husband is Case Examiner	2019	Present	
	Kissock	Neil	Director of Finance/Section 151 Officer	None Declared					Nil Interest	Aug-24	Present	
Voting Members (Aligned & Non-Pooled Budget)												
Dr	Parekh	Nina	Divisional Managing Director - Bury Community Services Division	None Declared					Nil Interest	Nov 23	Present	
	Allan	Lorna	Chief Digital and Information Officer Digital Services, NCA	Host Non Exec of Aqua (Advancing Quality Alliance)		X		Direct	Host Non Exec	Sep-24	Present	
Dr	Patel	Kiran	Member of the Locality Board	Tower Family Health Care - Primary Care General Practice	X			Direct	GP Partner	Jul-18	Present	As per policy - see details above (Y,Y,Y,Y,Y)
				Bury GP Federation - Enhanced Primary Care Services	X			Direct	Medical Director	Apr-18	Present	
				Laserase Bolton - Provider of a range of cosmetic laser and injectable treatments	X			Direct	Medical Director	1994	Present	
				Laserase Bolton - Provider of a range of cosmetic laser and injectable treatments				Indirect	Spouse is a Shareholder	2012	Present	
				Tower Family Health Care - Primary Care General Practice				Indirect	Spouse is a Director	Jul-18	Present	
	Kennedy	Karen	Director of Strategy, NCA	None Declared					Nil Interest	July 2026	Present	
	Preedy	Sarah	Chief Operating Officer, Pennine Care NHS Foundation Trust	None Declared					Nil Interest	Nov 23	Present	
	Tomlinson	Helen	Chief Officer, Bury VCFA	Bury VCFA (Voluntary, Community, Faith & Social Enterprise)	X			Direct	Chief Officer in organisation which may seek to do business with health or social care organisations	Nov-21	Present	As per policy - see details above (Y,Y,Y,Y,Y)
	Blandamer	Will	Place Partnership Director	Ashton on Mersey Football Club Trafford			X	Direct	Chairman	2024	Present	As per policy - see details above (Y,Y,Y,Y,Y)
				Manchester Football Association			X	Direct	Non Exec Director (Board Champion for Safeguarding)	2018	Present	
				Francis House Hospice (Manchester)				Indirect	Spouse is a Registered Nurse	2024	Present	
				University Hospital of Wales				Indirect	Daughter is a Foundation Year 1 Doctor	2024	Present	
				Stockport NHS Trust				Indirect	Daughter is a Foundation Year 1 Doctor	Jul-25	Present	
	Richards	Jeanette	Executive Director of Children and Young People, Bury Council	None Declared					Nil Interest	Nov 23	Present	
	Hobday	Jon	Director of Public Health	None Declared					Nil Interest		Present	As per policy - see details above
	Vermeulen	Elaine	Associate Director of Strategic Finace - Bury & Salford	Public sector director on MAST LIFTCo Board		X		Direct	Director	01-Nov-23	31-Mar-27	As per policy - see details above. (Y,Y,Y,Y,Y)
	Bulman	Richard	Director of Nursing, Bury Care Organisation	None Declared					Nil Interest	2025	Present	
	Crook	Adrian	Director of Adult Care & Neighbourhood Delivery	Bolton Hospice			X	Direct	Trustee	Jul-05	Present	As per policy - see details above (Y,Y,Y,Y,Y)
Non-Voting Members												
				KWJ Coaching and Consulting	X			Direct	Owner	July 21	Present	

	Wynne-Jones	Kath	Chief Officer, Bury Integrated Delivery Collabrative	Roots and Branches CIC	X			Direct	Director	Nov 23	Present	As per policy - see details above (Y,Y,Y,Y,Y)
				The University of Manchester - Elizabeth Garrett Anderson programme	X			Direct	Tutor	Oct-22	Present	
	Richardson	Stuart	Chief Executive, Bury Hospice	None Declared					Nil Interest	Mar-25	Present	
	Passman	Ruth	Chair of Bury Healthwatch	None Declared					Nil Interest		Present	As per policy - see details above
	Beesley	Mark	Chief Officer	Bury GP Practices Limited	X			Direct	Chief Officer & Director	Jul-21	Present	
				Greater Manchester GP Federation	X			Direct	Director	Oct-21	Present	
Invited Members												
Cllr	Birchmore	Carol	Attendee of the Locality Board as Radcliffe First Councillor	Radcliffe First		X		Direct	Member		Present	
				St Phillips Community Centre Committee			X	Direct	Member		Present	
				Radcliffe Rotary			X	Direct	Member		Present	
				Barge Garden Radcliffe			X	Direct	Organiser		Present	
				St Thomas, St Johns & St Phillips			X	Indirect	Spouse is a acting Treasurer		Present	
Cllr	Rydeheard	Jack	Attendee of the Locality Board as Reform UK Councillor	Reform UK		X		Direct	Member		Present	
				Association of Reform Councillors (ARC)		X		Direct	Member		Present	
				Royal British Legion			X	Direct	Member		Present	
				Conservative and Unionist Party		X		Direct			Present	
Cllr	Walmsley	Sandra	Attendee of the Locality Board as Labour Councillor	GMB Union		X		Direct	Member		Present	
				Bury North Constituency Labour Party		X		Direct	Chair		Present	
				Labour Party		X		Direct	Member		Present	
				LGBT (Labour)		X		Direct	Member		Present	
				Labour Women's Network		X		Direct	Member		Present	
				Moorside Branch Labour Party		X		Direct	Vice Chair		Present	
				Bury Local Government Committee		X		Direct	Member		Present	
				Voluntary Trustee at the Fusilier Museum (Bury)		X		Direct	Trustee		Present	

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Meeting: Locality Board			
Meeting Date	05 October 2026	Action	Approve
Item No.	3	Confidential	No
Title	Minutes of the Previous Meeting held on 7th September 2026 and action log		
Presented By	Chair of the Locality Board		
Author	Emma Kennett, Head of Locality Admin and Governance (Bury)		
Clinical Lead	N/A		

Executive Summary
The minutes of the Locality Board meeting held on 7th September 2026 are presented as an accurate reflection of the previous meeting, reflecting the discussion, decision and actions agreed
Recommendations
It is recommended that the Locality Board:- • Approve the minutes of the previous meeting held as an accurate record; • Provide an update on the action listed in the log.

OUTCOME REQUIRED *(Please Indicate)*	**Approval** ☒	**Assurance** ☐	**Discussion** ☐	**Information** ☐
APPROVAL ONLY; (please indicate) whether this is required from the pooled (S75) budget or non-pooled budget	**Pooled Budget** ☐	**Non-Pooled Budget** ☐		

Links to Locality Plan priorities	
Scale our work on Population Health Management - Improve population health and reduce health inequality of those in the most disadvantaged areas	☒
Drive prevention, reducing prevalence and proactive care – supporting Demand Reduction through primary intervention, secondary preventions and tertiary prevention	☒
Transforming Community Care in Neighbourhoods - fully realising the benefit of neighbourhood team working with a focus on the assets of residents and communities and providing proactive care	☒
Optimise Care in institutional settings and prioritising the key characteristics of reform.	☒

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Implications						
Are the risks already included on the Locality Risk Register?	Yes	☐	No	☒	N/A	☐
Are there any risks of 15 and above that need to be considered for escalation via an NHS GM Statutory Committee or Board in line with the Risk Escalation process ?	Yes	☐	No	☒	N/A	☐
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☒	N/A	☐
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☒	N/A	☐
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☒	N/A	☐
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☒	N/A	☐
Are there any financial Implications?	Yes	☐	No	☒	N/A	☐
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☒	N/A	☐
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☒	No	☐	N/A	☐

Governance and Reporting		
Meeting	**Date**	**Outcome**
N/A		

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Draft Minutes

Date: Locality Board – Meeting in Public – 7th September 2026

Time: 4.00pm – 6.00pm

Venue: Microsoft Teams

Title	**Draft Minutes of the Locality Board**
Author	Emma Kennett
Version	0.1
Target Audience	Locality Board
Date Created	7th September 2026
Date of Issue	
To be Agreed	
Document Status (Draft/Final)	Draft
Description	Locality Board Minutes

Document History:

Date	Version	Author	Notes
	0.1	Mrs E Kennett	Draft Minutes produced
Approved:			
Signature:			..... **Add name of Committee/Chair**

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Locality Board

MINUTES OF MEETING
Locality Board Meeting in Public Microsoft Teams 7th September 2026 4.00 pm until 6.00 pm **Chair – Cllr O'Brien**

ATTENDANCE

Voting Members
Cllr Eamonn O'Brien, Leader of Bury Council (Chair) Dr Cathy Fines, Senior Clinical Leader for the Borough Cllr Tamoor Tariq, Executive Member of the Council for Adult Care and Health Cllr Sandra Walmsley, Executive Member of the Council for Children and Young People Ms Lynne Ridsdale, Place Based Lead Ms Lorna Allan, Chief Digital and Information Officer, NCA Ms Sarah Preedy, Chief Operating Officer, Pennine Care Foundation Trust Ms Helen Tomlinson, Bury VCFA (Voluntary, Community, Faith & Social Enterprise) Mr Will Blandamer, Deputy Place Based Lead, Executive Director of Health and Care (for part) Mr Adrian Crook, Director of Adult Social Services and Community Commissioning Ms Jeanette Richards, Executive Director of Children and Young People, Bury Council Mr Jon Hobday, Director of Public Health, Bury Council Ms Elaine Vermeulen, Associate Director of Strategic Finance – Bury & Salford Dr Manisha Kumar, Executive Lead, NHS Greater Manchester Ms Karen Kennedy, Director of Strategy, Manchester Foundation Trust
Non-Voting Members
Mr Mark Beesley, Chief Officer, Bury GP Federation Ms Kath Wynne-Jones, Chief Officer, Bury IDC
Invited Members and Observers
Cllr Jack Rydeheard, Leader, Reform UK Cllr Carol Birchmore, Leader, Radcliffe First Ms Rebecca Jackson, The Big Fandango Dr Rafiq Bedair, Chief Medical Officer, NCA Dr Jay Naisbitt, Intensive Care Unit consultant, NCA Ms Zoe Alderson, Senior Programme Manager, Neighbourhood Health & Care (Bury) Mrs Emma Kennett, Place Partnership Lead, NHS Greater Manchester (Bury) Ms Chloe Ashworth, Democratic Services, Bury Council

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MEETING NARRATIVE & OUTCOMES

1.	Welcome, Apologies and Quoracy
1.1	The Chair welcomed all to the meeting.
1.2	Apologies were received from: - • Mr Stuart Richardson, Chief Executive, Bury Hospice • Ms Catherine Jackson, Associate Clinical Director (Bury) • Mr Neil Kissock, Section 151 Officer • Dr Kiran Patel, Medical Director, Bury IDC
1.3	The meeting was declared quorate.

2.	Declarations Of Interest
2.1	NHS Greater Manchester has responsibilities in relation to declarations of interest as part of their governance arrangements (details of which can be found outlined in the NHS Greater Manchester Integrated Care Conflict of Interest Policy version 1.2).
2.2	NHS Greater Manchester (Bury Locality) therefore, has a requirement to keep, maintain and make available a register of declarations of interest for all employees and for a number of boards and committees.
2.3	The Local Authority has statutory responsibilities detailed as part of Sections 29 to 31 of the Localism Act 2011 and the Relevant Authorities (Disclosable Pecuniary Interests) Regulations 2012. For other partners and providers, we understand that conflicts of interest are recorded locally and processed within their respective (employing) NHS and other organisations as part of their own governance and statutory arrangements too.
2.4	Taking into consideration the above, a register of Interests has been included detailing Declaration of Interests for the Locality Board.
2.5	In terms of agreed protocol, the Locality Board members should ensure that they declare any relevant interests as part of the Declaration of Interest Standing item on the meeting agenda or as soon as a potential conflict becomes apparent as part of meeting discussions.
2.6	The specific management action required as a result of a conflict of interest being declared will be determined by the Chair of the Locality Board with an accurate record of the action being taken captured as part of the meeting minutes.
2.7	There is a need for the Locality Board members to ensure that any changes to their existing conflicts of interest are notified to NHS Greater Manchester (Bury Locality) Corporate Office within 28 days of a change occurring to ensure that the Declarations of Interest register can be updated.
2.8	Cllr Tariq declared an interest in relation to Agenda Item number 7 – NCA update in light of being a member of the GMICP. The Chair noted the declaration for information and highlighted that no further action needed to be taken in respect of this specific agenda item.

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ID	Type	The Locality Board	Owner
D/09/01	Decision	Received the declaration of interest register.	

3.	Minutes Of the Last Meeting and Action Log
3.1	The minutes from the Locality Board meeting held on 6th July 2026 were considered as a true and accurate reflection of the meeting.
3.2	Updates were received in respect of the Action Log and the log was updated to reflect this.

ID	Type	The Locality Board	Owner
D/09/03	Decision	Accepted the minutes from the previous meeting as a true and accurate reflection of the meeting and noted the updates in respect of the actions from the last meeting.	

4.	Public Questions
4.1	There were no public questions received.

ID	Type	The Locality Board	Owner
D/09/04	Decision	Received the update.	

5.	Key Issues in Bury
5.1	Ms Ridsdale presented the latest Place Based Lead update to the Locality Board. It was reported that: - • In relation to the Pennine Care Base at 3KP, Pennine Care were thanked for the invitation to the opening of the Bury town centre base for mental health teams and services. • Bury Council had received the keys for the Radcliffe hub which was the multi-million-pound provision of leisure centre, library, staff bases and community space at the heart of the Radcliffe Town Centre masterplan. • Substantial investment had been secured in primary care facilities across the borough through the utilisation management fund and was delighted to confirm planning permission approval and an expected start on site date in autumn for the reprovision of the Uplands GP practice in Whitefield. Funding had also been secured for the substantial improvement of the reception of Radcliffe Primary Care Centre to meet characteristics of a live well centre with the provision of a range of community facilities. • Bury continued to be at the vanguard of the model of neighbourhood working in Greater Manchester. The model was based on the 5 neighbourhoods and reflected the continued maturity of integrated neighbourhood team working in health and care, the maturity of public service leadership team working, an increasing focus on children's and families reform including best start, family hubs, families first, and SEND reform framed by our wider neighbourhood approach and the implementation of live well – best exemplified by the live well centres in Whitefield and shortly in Radcliffe. A number of visits had been hosted in this area which had included Baroness Casey who visited Bury last Thursday as part of her national work on the future of adult care provision,

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	and the NHS Greater Director of Transition Jo Street in August. It was noted that both visits provided strong external validation of the progress in Bury. • Locality Board members would recall consideration of the different elements of the ICB articulation of place working, including a place partnership agreement, a place outcomes framework, a place team concept, and a place budget (in developing building out of the Better Care Fund). Feedback from previous Locality Board conversations has been provided to the ICB and a wider consultation framework has been concluded. We await final versions of documentation for the consideration of partners and hope this will be available in October or possibly November 2026. Subject to agreement of partners, there would be a need to move to recast the Locality Board to be the Place Partnership board for Bury, and retain the work of the Integrated Delivery Board, and the work of the Health and Well being Board focusing on health inequalities and wider population health determinants. • In terms of NHS GM place team hosting, Locality Board members would be aware of the ICB proposal to TUPE NHS GM place-based staff to another organisation in the context of the place partnership agreement to be finalised. This work was progressing with NCA having expressed an interest in hosting. Mobilisation arrangements at a Greater Manchester, 4 localities partnership (NCA footprint) level, and local level are developing. • Youthwatch Bury had launched a new Bury Youth Physical Activity and Wellbeing Survey (Ages 13-25) to better understand the experiences, needs and priorities of children and young people across the borough. This had been developed in partnership with Public Health and the Children and Young People's Partnership Board, the survey aimed to gather feedback directly from young people about physical activity, wellbeing, barriers to participation, and what support they need to live healthy and active lives. As the statutory, independent champion for people using health and social care services in Bury, Healthwatch Bury was committed to ensuring that young people's views were heard and used to influence local decision-making. The survey provided an opportunity for children and young people to share their experiences. Youthwatch Bury (www.youthwatchbury.co.uk)is keen to hear from a much wider range of young people to ensure the findings reflect experiences from across the borough.
5.2	The following comments/observations were made by Locality Board members: - • Officers were thanked for making the Baroness Casey visit a success.

	Type	The Locality Board	Owner
D/09/05	Decision	Received the update.	

6.	VCFE focus – The Big Fandango
6.1	Ms Rebecca Jackson from The Big Fandango was in attendance to provide a presentation in relation to the work of The Big Fandango. It was reported that: - • The Big Fandango was a Community Based Interest Company that opened in June 2021 with the aim to reduce suicide across Bury by creating a safe space where people can come together to learn sewing and craft skills to combat loneliness and isolation and support mental wellbeing. • There were a number of events coordinated to raise awareness around suicide and suicide intervention skills training provided to members of the community. Each year

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on World Suicide Awareness Day, a vigil was hosted in the centre of Bury for families left behind.

- There is a Peer support Group for adults who are bereaved by suicide and this summer a young person's group supporting children 11 – 17 years who are bereaved by suicide was set up.
- It was important that in order to have a robust Suicide Strategy, there was a need to include post suicide support.
- The figures for children/young people under the age of 25 committing suicide were sadly on the increase and action was needed to reduce these figures.
- In terms of suicide prevention work in the community, training was being provided across the pub and hospitality industry in Bury which licensed premises had all signed up to.
- A Bury Suicide Prevention Conference 2026 - The Big Fandango conference had been arranged for the 14th October 2026 which partners were welcome to book on and attend. It was hoped that there would be an increase in the number of schools across the borough booking on the conference.

6.2 The following comments/observations were made by Locality Board members: -

- It was great to hear about the positive work being undertaken by the Big Fandango
- There would be more schools booking and attending the Suicide Prevention conference.

ID	Type	The Locality Board	Owner
D/09/06	Decision	Noted the update.	

7.	**NCA Update: Current Position, Improvement Activity and System Response**
7.1	*Mr Blandamer, Dr Kumar, Ms Allan and Dr Naisbitt and Dr Bedair supported the presentation of this item.*
7.2	Members received copies of a report that provided the Locality Board with an overview of recent concerns relating to the Northern Care Alliance NHS Foundation Trust (NCA), the actions being taken by the Trust and the wider NHS system, and the implications for services used by Bury residents.
7.3	The report had been prepared following significant national and local media coverage concerning patient safety, governance, organisational culture and the management of concerns within the Trust. It also reflects recent regulatory action taken by NHS England and the Care Quality Commission (CQC).
7.4	It was reported that: - • The Northern Care Alliance began operating as a group partnership in 2016 and Northern Care Alliance NHS Foundation Trust was formally established as a single NHS foundation trust in 2021 and provided hospital and community services across Bury, Rochdale, Oldham and Salford, including services delivered from Fairfield General Hospital in Bury and associated Bury Community Services.

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	• Over recent months a number of concerns relating to patient safety, quality governance, organisational culture and leadership have received increased public attention through media reporting and regulatory scrutiny. These concerns have included: - Historic failures in spinal surgery services that were examined through the independent Carlo Breen review. - Concerns within gynaecology services relating to governance, administration and patient follow-up. - Issues relating to incident management, complaints handling and organisational learning. - Concerns regarding Freedom to Speak Up arrangements and whether staff consistently feel able to raise concerns. - Ongoing challenges in urgent and emergency care, patient flow and workforce pressures. - Wider concerns regarding organisational leadership, governance and improvement capacity.
7.5	It was noted that some of these issues related to historic events and services, whilst others related to how effectively the organisation identifies, manages and learns from risks across the Trust. The cumulative effect has resulted in increased regulatory oversight and public concern.
7.6	It was highlighted that many of the issues were now receiving public attention and were already subject to varying degrees of regulatory oversight, review activity and improvement programmes before the recent media coverage. What has changed is the level of public visibility, the accumulation of concerns across multiple service areas and the subsequent decision by regulators to introduce enhanced improvement and assurance arrangements.
7.7	It was reported that over the last two years the Northern Care Alliance had been subject to a range of reviews and oversight processes relating to quality, safety and governance. These have included: • Independent review of spinal services. • Rapid Quality Reviews relating to spinal and gynaecology services. • NHS England quality oversight activity. • Care Quality Commission inspections and warning notices. • Wider governance and leadership reviews.
7.8	In summer 2026, NHS England issued formal enforcement undertakings to the Trust. These identified concerns relating to quality governance, management of risk and progress in addressing known issues within certain clinical services. It was noted that the Care Quality Commission has also issued a Section 29A Warning Notice following its Well Led assessment. The notice identified concerns relating to: • Investigation and learning from patient safety incidents. • Complaints management and organisational learning. • Oversight of Freedom to Speak Up arrangements. • Governance and risk management processes. • Workforce wellbeing and equality-related workforce issues.
7.9	It was reported that the Northern Care Alliance had acknowledged the seriousness of the issues raised and has stated publicly that patient safety remained its primary concern. In terms

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	of the next steps and actions being undertaken from an NCA perspective, this included the development of an Integrated Improvement Plan, Changes to Clinical Leadership, appointment of an independent senior nurse to strengthen arrangements for handling staff concerns and ensuring that any immediate patient safety issues are escalated appropriately with further External Reviews planned.
7.10	It was highlighted that NHS Greater Manchester, as the Integrated Care Board, had significantly increased its oversight arrangements relating to the Northern Care Alliance via a number of different governance mechanisms. A particular focus for NHS Greater Manchester has been working with NCA around service response to Industrial Action. The action has impacted theatre waiting lists and critical care capacity throughout July. No further strike dates have been confirmed at presented. The ICB have taken an action to support and pursue discussions with Unison and support the development of derogation and minimum service level arrangements. Dr Rafiq commented that the industrial action had been extremely challenging from an NCA perspective.
7.11	In terms of governance and accountability, it was important to recognise that the Northern Care Alliance was an NHS Foundation Trust with its own Board of Directors and statutory responsibilities for the quality and safety of services it provides. Oversight of provider quality, performance and regulatory compliance sits through established NHS governance arrangements involving the Trust Board, NHS Greater Manchester, NHS England and the Care Quality Commission.
7.12	The inaugural meeting of the System Improvement Board took place last week and this Board would have oversight of the Integrated Improvement Plan. An initial draft of the plan had been produced and would be shared more widely with partners over the coming weeks. The plan would cover 17 programmes of work across 6 key strategic themes.
7.13	It was reported that the concerns outlined above had understandably generated significant interest amongst Bury residents, elected members, Healthwatch and wider system partners. Given the importance of Northern Care Alliance services to the borough, local partners have sought ongoing assurance regarding patient safety, service continuity and delivery of the improvement programme.
7.14	It was noted that Fairfield Hospital remained open and continued to provide services to local residents. There are currently no planned service changes linked to the improvement programme. Patients were being advised to continue attending appointments unless contacted directly by the Trust.
7.15	It was highlighted that Bury Council, NHS Greater Manchester Bury locality partners and elected members have sought assurances that: • Services provided to Bury residents remain safe. • Any historic or current patient harm is identified and addressed appropriately. • Improvement activity is robust and transparent. • Local partners are kept informed of progress. • Public confidence is maintained through clear communication.
7.16	The following comments/observations were made by Locality Board members: -

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	• There was a need to ensure that the new ways of working/clinical model within the NCA aligns with the neighbourhood working approach within localities. • The Integrated Improvement Plan may provide an opportunity for some positive changes across the various work programmes. • The need to ensure that patients/residents are at the forefront of the improvements/actions being taken to address the issues encountered. • A query in relation to the leadership challenges and governance gaps and how the Locality Board and Public could be assured that the changes made would be robust enough during this challenging time and whether there would be capacity to maintain a business as usual approach whilst addressing the Improvement Plan. • A question as to whether the new process for raising concerns would build confidence amongst staff that their concerns would be heard. • Whether there were plans for a public apology being issued to staff and residents given the significance of the ongoing issues at the Trust. • A query as to when patients would start to see improvements as a result of the changes being made. It would be really helpful to have one improvement plan/update to all four localities, but the opportunity for Members to scrutinise locally from the perspective of Bury residents. The role of the Locality Board was to support assurance and give confidence back to residents as both staff and patients. • The need to consider NCA representation at future Locality Board meetings in context of the Improvement Plan given the recent departure of some Locality Board representatives.
7.17	Dr Bedair responded to a number of the questions raised by the Locality Board and welcomed the opportunity to work together with partners to develop a shared understanding in the reshaping of the NCA programme of work. It was reported that: - • there was a need to maintain integration with place and population as part of the changes in line with the neighbourhood priorities set out in the NHS 10 Year Plan. • In relation to leadership capacity, additional resources had been made available to ensure the Trust would be able to manage the broad spectrum of what was required. • In relation to the governance undertakings, a substantial amount of work had been undertaken within the Trust to date which had been a focus of the Board. • There was a need to ensure that patients were not avoiding accessing services in light of the issues highlighted in the press. • In terms of apologies, there had been specific apologies issued at the time of the spinal report being issues and in response to issues documented in the media and some discussions with staff in this regard
7.18	Dr Kumar reported that there had been a commitment made by the NCA Team to share the Improvement Plan with the Locality Board as soon as the final version was available.
7.19	Ms Allan welcomed the comments/feedback received from the Locality Board and emphasised that the NCA want to make positive improvements to services/patient care as part of the plans.
7.20	Dr Naisbitt provided a clinical perspective on the current situation and the anticipated improvements made as part of the new clinical leadership model adopted within the Trust in the context of unwarranted variation across Greater Manchester.

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7.21	In conclusion, there would need to be further discussions in relation to the Improvement Plan via the local Scrutiny Committee in Bury, the 4LP Scrutiny Committee and individual Locality Board meetings and would be helpful to formally feedback the comments made at today's Locality Board meeting in relation to this agenda item to both the ICB and NC following the meeting

ID	Type	The Locality Board	Owner
D/09/07	Decision	Noted the contents of this report.	
D/09/08	Decision	Noted the actions being taken by the Northern Care Alliance, NHS Greater Manchester and NHS England Northwest.	
D/09/09	Decision	Noted that there are currently no proposed service changes affecting Bury residents as a consequence of the improvement programme.	
D/09/10	Decision	Requested a further update once the Northern Care Alliance Integrated Improvement Plan has been finalised and agreed with regulators.	
A/09/01	Action	The comments made at today's Locality Board meeting in relation to this agenda item to be fed back to both the ICB and NCA following the meeting.	Cllr O'Brien/Mr Blandamer

8.	Locality Plan Refresh. Delivery Plan – neighbourhood working and Primary Care/Beccor proposal
8.1	Ms Wynne-Jones provided a brief presentation in relation to the Locality Plan Refresh and the Delivery Plan for Neighbourhood working. It was reported that: - • The Bury health and care system – referred to as the Bury Integrated Care Partnership - developed a Locality Plan in 2021 and updated it in January 2023. • The Locality Plan described a strategic ambition for the operation and improvement of the health and care system in Bury, and for improved population health and reducing health inequalities. • This document was the refreshed Locality Plan for 2026/27, developed in the context of the revised Let's Do It! Strategy for the Borough (2025), the NHS Greater Manchester Commissioning Strategy, and the launch of the national Neighbourhood Health Framework. • The Locality Plan built on a significant period of transformation and improvement in the operation of the health and care system in Bury since 2021. Progress had been made through high quality partnership working and a shared ambition for better outcomes for residents. However, there was still more to do. • The plan outlined the next stage of the health and care reform journey, connected to the reform of wider public services and the economic ambition in the Borough. The Delivery Plan focused on the first 12 months of delivery which included the asks of the Neighbourhood Health Framework for 2026/27. • The deadline for submission of the Neighbourhood plan to Greater Manchester ICB was the 30th September 2026.

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8.2	Dr Fines referred to the Beccor proposal and plans that had been written from the ground upwards by Practices. The purpose of the scheme was to identify and engage patients with high unmet need or poor engagement with traditional primary care pathways.
8.3	It was reported that each place partnership had a neighbourhood prevention allocation (a financial allocation) to fund additional costs for partnership activities in the Neighbourhood Plans. For the purposes of financial flows, the default position was that this allocation goes via GP Practices (the alternative option being partial or full reimbursement via the PCN) North, West, East and Whitefield Neighbourhoods have opted to retain reimbursement via the practice. Prestwich have opted for the funding to go via the PCN. It was noted that the ICB would support the release of funding once the plans have been approved by Locality Board.
8.4	The following comments/observations were made by Locality Board members: - • This documentation provided a helpful snapshot of the work being undertaken in Bury and was a question raised in relation to the work being undertaken around primary care variations and whether the available data and dashboards were helpful in this regard. It was reported that this was a separate programme of work being progressed by the GP Board (previously discussed via the Primary Care Commissioning Committee) which was then linked back to Beccor.

ID	Type	The Locality Board	Owner
D/09/11	Decision	Approved the Locality Plan and associated Delivery Plan (this decision would need to be ratified at the next face to face Locality Board meeting in October 2026)	
D/09/12	Decision	Approved the Beccor plans (this decision would need to be ratified at the next face to face Locality Board meeting in October 2026).	

9.	Mental Health Update
	Pennine Care Update
9.1	Ms Preedy submitted a set of slides in relation to the latest Pennine Care developments. It was reported that: - • Pennine Care had been rated as 'Well led' following its recent CQC inspection and gave the trust an overall rating of good for its leadership, culture and governance. • Funding had now been secured to address the precious gap in the Crisis Service, the new Crisis Resolution & Home Treatment Team (CRHTT) was a standardised crisis response service across PCFT localities. The service would provide a consistent, 4-hour community crisis response including rapid assessment and short-term crisis resolution support alongside home treatment would be available as an alternative to admission. • As mentioned earlier in the meeting, the official opening and ribbon cutting of 3 Knowsley Place took place on the 23 July 2026 supported by system partners. The building was a community hub in the heart of Bury bringing together a range of mental health and learning disability services, The hub would strengthen partnership working and make it easier to provide joined up care and support across Bury. The building

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	included 15 consultation rooms and will support more than 8000 appointments each year. • In relation to the Mental Health Neighbourhood Model, a risk remained around commissioned service capacity and there was a need to address the wider determinants of health and embed mental health support within neighborhood delivery. It was noted that a Pilot evaluation would inform long-term sustainability and future strategic focus.
9.2	The following comments/observations were made by Locality Board members: - • It would be helpful to have an update on the progress made with CAMHS particularly in relation to neuro diversity at a future meeting. • The relocation to 3KP had been a positive step with partnership working going from strength to strength.

ID	Type	The Locality Board	Owner
D/09/12	Decision	Noted the update.	
A/09/02	Action	An update on CAMHS to be provided to a future meeting of the Locality Board	Ms Preedy

10.	North Manchester Redevelopment Update
10.1	Ms Kennedy provided a presentation in relation to the North Manchester redevelopments. The presentation covered: - • The timeline for building a new North Manchester General Hospital with an end date of 2035. • This was a once in a generation investment with the patients at the centre of care. • The NMGH New Hospital Project commenced RIBA Stage 1 at the end of April 2026 for the main acute hospital. • In relation to the Standalone outpatient building, the outpatient building was a priority as it would support the transition planning as the new main hospital building was built, The NMGH New Hospital Project commenced RIBA Stage 1 in June 2026 for the standalone outpatient building. To support this a design group had been established with representatives from MFT's clinical groups providing outpatient services on the NMGH site. • Planning was underway for the next design phase: RIBA stage 2, known as Concept Design. This is an exciting phase in the development of the new hospital where there would be engagement with the clinical and non-clinical design groups to explore how departments should be arranged. This phase is expected to be from Sept 2026 through to summer 2027 • In this phase, the design team also begins to develop engineering, digital and sustainability strategies while ensuring the emerging design remains affordable and aligned to the agreed Schedule of Accommodation. • New governance arrangements would support the NMGH New Hospital Project as it moves into the next phase. A NMGH New Hospital Partnership Group was being developed to provide a formal forum for engagement to update health economy partners (NHSE, GM ICB, MCC, Locality representatives (Manchester, Bury, Rochdale, Oldham and Salford) on progress to deliver the New Hospital Project and Transformation Project and for partners to provide their insight and views, and update

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	on related initiatives. The Group would be Chaired by Ann Bracegirdle. A summary of the working draft Terms of Reference for this Group has been shared with colleagues from partners organisations. • Continued support and input was welcomed as this project starts to take shape.
10.2	The following comments/observations were made by Locality Board members: - • A question as to whether Ms Kennedy would you be able to share how the locality can connect into the OP transformation programme in terms of the SPOA/tier 2 work? Ms Kennedy agreed to check with the relevant colleagues leading on this work and report back to Ms Wynne-Jones.

ID	Type	The Locality Board	Owner
D/09/12	Decision	Noted the update.	
A/09/03	Action	MFT to share how the locality can connect into the OP transformation programme in terms of the SPOA/tier 2 work	Ms Kennedy

11.	Performance and Quality Group update
11.1 11.2	Members received copies of the latest report from the Performance and Quality Group meeting for information and assurance. The paper provided an update to the Locality Board on meetings, activity and discussions in relation to performance, IDCB work and quality.

ID	Type	The Locality Board	Owner
D/09/15	Decision	Noted the report.	

12.	Any Other Business
17.1	There were no items raised.

ID	Type	The Locality Board	Owner
D/09/17	Decision	Noted the information	

18.	Date and time of next meeting
18.1	**Date and time of next meeting in public - Monday, 5th October 2026, 4.00 - 6.00pm** **In Committee Rooms A and B, Bury Town Hall**

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Locality Board Action Log – September 2026

Status Rating - In Progress - Completed - Not Yet Due - Overdue

Date	Reference		Action	Lead	Status	Due Date	Update
2nd March 2026	A/03/01	Action	The questions raised as part of the Maternity item to be raised with the LMNS and the particularly the availability of a workplan/timescales for the Bury specific data being available.	Dr Fines		April 2026	Email sent and response received following the March meeting to state: - The current GM dashboard does not have the capability to break down service user by postcode, although this is an ambition that we would like. The new national maternity E&E dashboard also unfortunately does not break down by locality:Maternity and Neonatal Equalities dashboard - NHS England Digital We are currently looking to utilise MSDS data which may give us that functionality. Fingertips is currently the only source I am aware of that provides some specific outcomes for Bury relating to maternity .Child and Maternal Health - Data | Fingertips |

							Department of Health and Social Care MNVP are aligned to maternity provider however they will be collecting information from all localities and share the demographic breakdown quarterly with the system group. I have copied in Natalie who can advise whether the North Manchester service user feedback is identifiable by post code. Update April 2026 – Members discussed the current gap in relation to the availability of maternity data for Bury residents and the need to accelerate process given the links to the first 1001 days and setting the foundations for lifelong emotional and physical wellbeing. There was a query as to whether NHS numbers and home post codes could simply be used to extract some of the Bury maternity data given does not have a single maternity provider in the locality. It was highlighted

							that other localities would also be in this position as residents may choose to go to other areas for maternity care and vice versa so data still include residents from other areas. It was highlighted that there was still a need to obtain some more definitive timescales for this work and availability of the Bury maternity data. There was also a query as to whether this would link into the Population Health work. It was noted that this was the intention. Update June 2026 - In relation to the availability of local maternity data, the risks around this had been raised with the ICB in relation to this issue and confirmation that this area of work would be prioritised had been received. It was agreed that this action should remain open on the action log for now until the maternity data issue has been resolved by the ICB.

13th April 2026/6th July 2026	A/04/01	Action	A further update/items for approval on the Place Partnership arrangements to be provided to the Locality Board in June 2026.The specific governance arrangements would need to be agreed given the timing of the June meeting.	Mr Blandamer		June 2026	Included on the agenda for June 2026. Final version to be brought back to the Locality Board in October 2026
1st June 2026	A/06/03	Action	Further discussion on the national diabetes programme to be scheduled for the Major Conditions Board	Ms Wynne-Jones		July 2026	
7th Sept 2026	A/09/01	Action	The comments made at today's Locality Board meeting in relation to this agenda item to be fed back to both the ICB and NCA following the meeting.	Cllr O'Brien/Mr Blandamer		October 2026	
7th Sept 2026	A/09/02	Action	An update on CAMHS to be provided to a future meeting of the Locality Board	Ms Preedy		November 2026?	
7th Sept 2026	A/09/03	Action	MFT to share how the locality can connect into the OP transformation programme in terms of the SPOA/tier 2 work	Ms Kennedy		October 2026	

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Meeting: **Locality Board**			
Meeting Date	05 October 2026	**Action**	Receive
Item No.	5.1	**Confidential**	No
Title	Place Lead Report		
Presented By	Lynne Ridsdale – Place Lead, NHS Greater Manchester (Bury) and Bury Council Chief Executive		
Clinical Lead	Dr Cathy Fines		

Executive Summary
To provide an update on key issues in the Health and Care System in Bury.
Recommendations
The Locality Board is asked to note the update.

Links to Locality Plan priorities	
Scale our work on Population Health Management - Improve population health and reduce health inequality of those in the most disadvantaged areas.	☒
Drive prevention, reducing prevalence and proactive care – supporting Demand Reduction through primary intervention, secondary preventions and tertiary prevention.	☒
Transforming Community Care in Neighbourhoods - fully realising the benefit of neighbourhood team working with a focus on the assets of residents and communities and providing proactive care.	☒
Optimise Care in institutional settings and prioritising the key characteristics of reform.	☒

Implications						
Are the risks already included on the Locality Risk Register?	Yes	☐	No	☐	N/A	☒
Are there any risks of 15 and above that need to be considered for escalation via an NHS GM Statutory Committee or Board in line with the Risk Escalation process ?	Yes	☐	No	☐	N/A	☒
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☐	N/A	☒
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☐	N/A	☒
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☐	N/A	☒
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☐	N/A	☒
Are there any financial Implications?	Yes	☐	No	☐	N/A	☒

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Implications						
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☒
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☒

Governance and Reporting		
Meeting	**Date**	**Outcome**
N/A		

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1. SEND Reform

Further to previous updates to the Locality Board, I am pleased to advise that DfE have confirmed out Local SEND Reform plan has been supported. Key aspects of the response are below.

> *"your plan has met the required threshold and provides a positive foundation from which to move into delivery. It also recognises the progress that your partnership has made in strengthening local leadership, relationships and governance, and the ambition underpinning a shared plan for improvement.*
>
> *Your local area partnership has demonstrated good momentum and a willingness to work collectively across education, health and care. Whilst this government's wider assessment is that your partnership is making progress, further action will be needed to strengthen capability, governance, partnership working and delivery disciplines so that the plan translates into sustained improvements for children, young people and families.*
>
> *As you move into delivery, it will be vital to sustain the progress that you have made and to strengthen the maturity of your partnership. Successful delivery will require clear collective ownership, effective oversight and a sustained focus on measurable outcomes. We expect the partnership to move from planning into implementation with clear senior accountability, proportionate performance monitoring and early evidence that delivery is leading to improved experiences and outcomes for children and young people with SEND and their families."*

A cornerstone of the national SEND reforms and our local plan are the arrangements to strengthen inclusion in schools through the design and development of the "Experts at Hand" programme and a subgroup continues to refine the solutions in Bury.

2. NCA

Further to discussion at the previous Locality Board, thank you to NCA colleagues for attendance at the subsequent NCA wide Health Scrutiny Committee, and Bury Health scrutiny committee.

I note the continuing work of NCA to address some of the issues raised via regulatory intervention and national publicity around management culture. I note the steps being taken to strengthen the Executive capacity of the organisation and I was pleased to have the opportunity to meet with the recently appointed interim Chief Executive Kevin McGee. We discussed the development and implementation of the Improvement Plan to be agreed with NHSE and CQC, and we discussed the continuing imperative for a proactive NCA leadership presence relating to the operation of the 4 localities.

3. GM Commissioning Framework

I note and commend the NHSGM's Commissioning Framework for 2027/28 which was been published on Friday and has been shared with NHS providers. The commissioning framework is attached as an Appendix to this report.

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The framework presents an ambitious and exciting programme of work which will take us forward in delivering the ambitions set out in our Five-Year Strategic Commissioning Plan.

I am pleased to see that Neighbourhood Health is at the centre of this; the commitment of NHS GM to ensure that people in Greater Manchester have access to preventive, proactive care in their local community wherever appropriate, with services joined together and shaped around people to improve their lives.

Following approval in a recent Locality board of our refreshed Locality Plan and Neighbourhood Plan we are confident that the work Bury is doing is entirely congruent with the commissioning framework and can amplify delivery in this borough.

Given the short notice of the circulation of this paper, we will revisit the document at the next Locality Board.

4. NWAS Annual Stakeholder Feedback Questionnaire.

A number of colleagues will have received the above from Paul Beech – partnerships and integration manager at NWAS, requesting completion of the survey to support NWAS understand how their relationships are developing, what's working well and where there may be opportunities to improve how they work with partners.

Please complete the questionnaire **by 16 October 2026**. **The survey is available here:** https://www.surveymonkey.com/r/TZF9VZM

5. Place partnership documentation and mobilisation

This agenda provides an update on the development and finalisation of the place partnership documentation. I would advise that final versions of the documentation are being developed for consideration by next month's locality board. Locality Boards will note that we have included outcomes framework as an appendix for reference.

Locality Board colleagues will also wish to know that the hosting agreement for NHS GM staff in Bury (and Salford, Oldham, and Rochdale) to be hosted by NCA - subject to consultation – is being finalised this month for consideration by NCA. Further information on this timeline including staff consultation will be made available at future meetings.

6. NHSE NW Winter planning event

Thank you to a number of colleagues from across the system who last month attended the annual NHSE NW Winter planning event. The event tested system readiness with a number of scenarios, and some lessons were learnt for us in Bury around further preparation, communication and clarification of opel 4 arrangements.

A key theme for the event was an invitation to reflect on the performance of the system going into the winter period. In this the Bury system felt confident – we go into winter with the 2nd best RSV vaccination rates in GM and an expectation that Covid and flu vaccination will once again perform strongly. We have been able to sustain a step change improvement in 4hr and 12hr waits and corridor

care in FGH, have historically low levels of DKAFHS (delayed discharges), and confidence in our Intermediate care provision via virtual wards, rapid response, reablement and bedded provision at Killalea. We have also seen a step change improvement in mental health waiting times in ED with thanks to some great partnership working between Pennine care and NCA. We will shortly be standing up the primary care respiratory hub – well evaluated intervention and note the establishment of the crisis response service.

We are however not complacent – we have already seen Pennine Care and also MFT declare opel 4 recently – and in the case of Pennine care we are committed to a whole system response to addressing a substantial growth in delayed discharges. We believe there is further work to do on staff flu vaccination across all settings.

Thankyou to partners across the health and care system for the quality of the joint working on winter planning and delivery, co-ordinated excellently by David Latham from NHS GM in Bury.

NHS GM is convening a winter planning evening on 5th November, and invitations will be sent to colleagues shortly.

7. Cardiac and Vascular Surgery Consultations

The GM wide consultations closed on Tuesday 22 September after a 12-week period of engagement and we are grateful to everyone who took the time to share information with their networks, encourage participation and help ensure local people had the opportunity to have their say.

In total, 1,757 people took part across the two consultations. For vascular services, 909 people were consulted: 437 completed a survey and 472 took part in face-to face engagement or focus groups across 30 sessions. For cardiac services, 848 people were consulted: 403 completed a survey and 445 took part in face-to-face engagement or focus groups across 20 sessions. This represents valuable insight to help inform the future of these important specialist services, and reflects the importance of these proposals to patients, families, staff and communities across Greater Manchester and Eastern Cheshire.

The findings will be brought together in detailed consultation reports and considered alongside other relevant evidence. NHS GM will then review all of this information before determining the next steps. We will keep stakeholders updated as this work progresses and will share the outcome of the consultations once decisions have been reached.

8. Frailty

Last week there was a GM wide event on frailty led informed by a keynote presentation from Professor Tom Downes, National Clinical Director for Frailty at NHS England. Professor Downes delivered an excellent presentation highlighting the significant challenges facing the NHS. He shared that approximately 1.4 million people in England are living with moderate or severe frailty, representing around 2.4% of the population but accounting for 66% of non-elective bed days. He described the current pressures across the NHS very starkly as the system being “on fire”.

I am delighted to report that Bury was repeatedly referenced as an exemplar across a number of areas, and I believe this reflects the strength of our partnership working and the progress being made collectively across the borough.

Work on frailty in Bury has been led by Clare Hunter from the Bury integrated care partnership and

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Adrian Crook, and Clare, Adrain and NCA colleagues Dr Jason Raw, Medical Director and Managing Director, and Dr Emma Vardy, Consultant Geriatrician and NCA Frailty Lead attended the event.

While our outstanding relative progress in this area was noted, the team are committed to further improvement and will be visiting a national exemplar of best practice in Walsall to identify further opportunities.

Lynne Ridsdale
Place Lead NHS GM (Bury)
Chief Executive Bury Council
1/10/26

NHS Greater Manchester

NHS Greater Manchester's 2027/28 Commissioning Framework

September 2026

Part of Greater Manchester Integrated Care Partnership

NHS Greater Manchester

NHS Greater Manchester has ambitious plans to improve the health of our population. We have a Five Year Strategic Commissioning Plan which outlines our ambition and the core deliverables for our organisation.

It is imperative that we act upon the delivery of this strategy and to ensure that we start to make significant change in 2026/27. This document sets out our Commissioning Framework to make this happen.

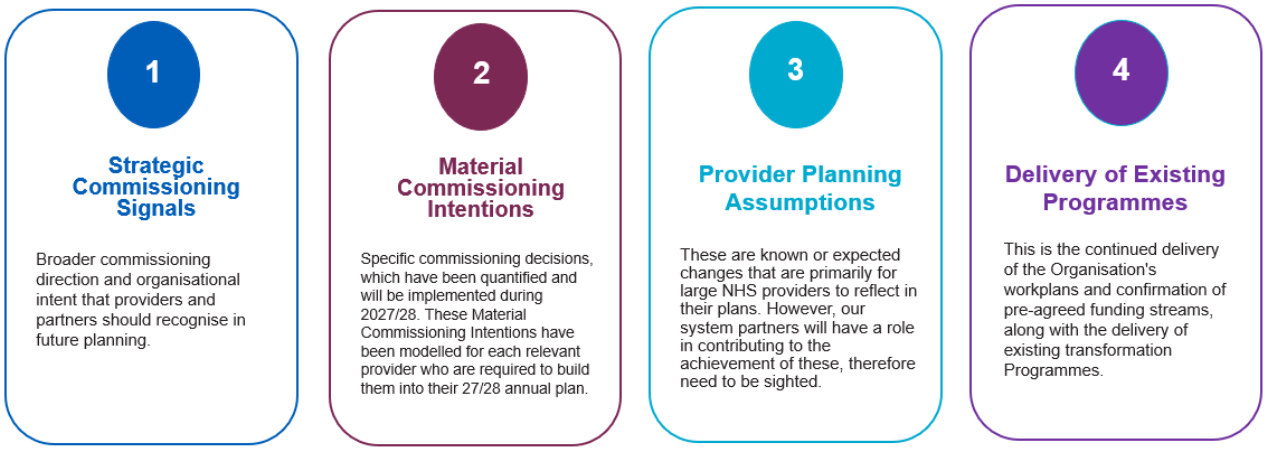
The framework will be our mechanism to embark on our major transformation plans, which are far reaching and require all our Providers and their workforce to be come together to achieve. Everyone has a role to play in the realisation of these ambitions, with clinical leadership at the heart of every part of our system.

The delivery of Neighbourhood Health is the keystone to this transformation agenda; we will expand further on this throughout this document.

The 27/28 Commissioning Framework is to be utilised alongside the National Planning Guidance issued by NHS England, which clearly outlines the required national constitutional standards for the system.

This framework is applicable to all our commissioned providers, and it is important that all our partners are sighted on our 27/28 Strategic Commissioning Plans.

The Framework consists of the following 4 components: -



There are elements of the framework that are tailored specifically to large NHS Providers, who are required to submit an annual finance and activity plan, as per the National Planning process.

This document sets out the detail of the 4 components above.

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1 Strategic Commissioning Signals

Neighbourhood Health

Our Strategic Commissioning Plan 2026-2031 (finalised in July 2026) describes what and how we will commission over the next five years to ensure high-quality service provision and sustained improvement in the health of our population.

The Plan emphasises that the 10 places in Greater Manchester, and the 67 neighbourhoods within them, are where we must start to meet need differently. This begins with Live Well as the most significant commitment that Greater Manchester has ever made to addressing the social determinants of health which drive much of the pressure on NHS services.

This means we are not only integrating health and care services but, through Live Well, uniting the full range of public services and support (including the VCFSE) into a fully integrated, preventative system to meet need in a different way and reduce demand on services.

Place partnerships are integral to the delivery of neighbourhood working, prevention and Live Well. We have therefore designed our Place Partnership Model to enable this delivery. We have done this through a combination of:

- A Place Partnership Agreement
- Place Outcomes
- Place Fund
- Place Teams

Integrated Place Partnerships require the commitment of all our providers working together to deliver the outcomes that have been set for them.

We have set out the core standards for Neighbourhood Health that people in Greater Manchester can expect whichever locality or neighbourhood they are in. This starts with a core set of functions that each neighbourhood will need to carry out. This is summarised below:

Needs Assessment and Planning	Risk/Need Stratification	Integrated Neighbourhood Teams	Metrics and Outcomes
• JSNA carried out in each locality to inform Neighbourhood Health Plans • Single Neighbourhood Plan for each locality – including alignment to national and GM requirements	• Risk/Need stratification process for every neighbourhood • Agreed set of GM digital products to be used in every place and neighbourhood	• Full coverage of whole locality population • Named clinical and operational leadership for each INT • Set of core service offers	• Single Place Outcomes Framework used consistently across GM • Core set of performance and quality metrics used in every neighbourhood • Focus on reducing inequalities

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This leads into the core functions and requirements for each Integrated Neighbourhood Team as shown below:

Core Requirements

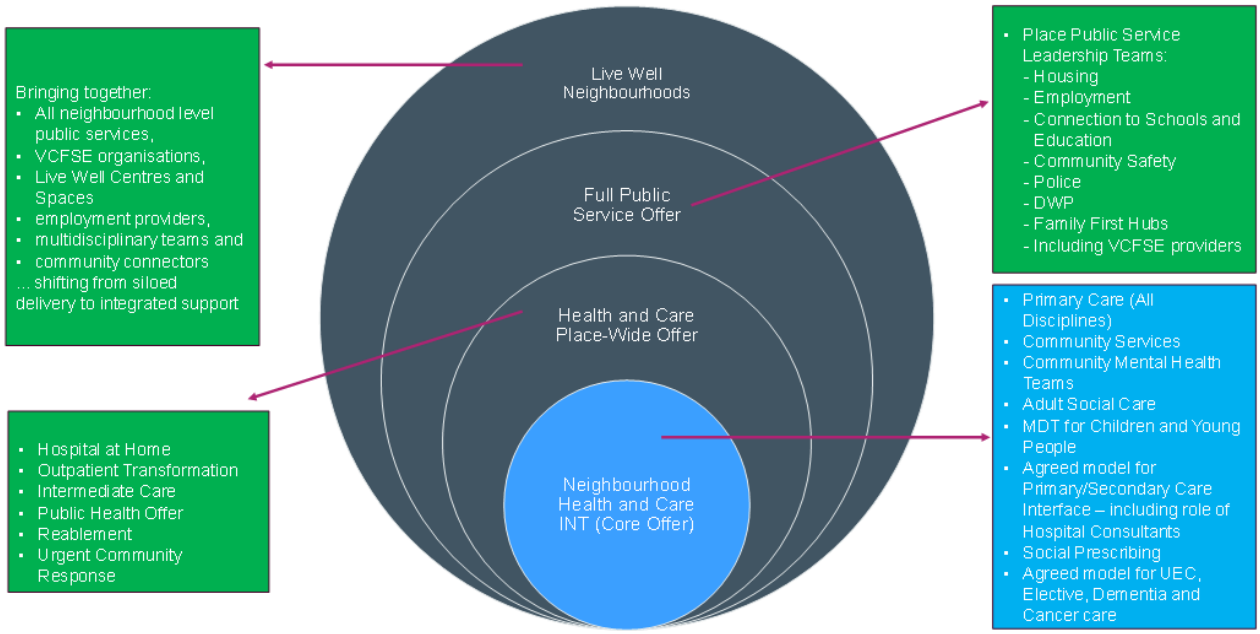
- Based on confirmed geographies that all partners work to for planning and delivery – coterminous with PCNs or with full aligned working arrangements
- All age model
- Offer that spans physical and mental health and connects to the social determinants
- An identified clinical lead who chairs or co-chairs neighbourhood MDT forums, sets the clinical priorities for proactive and preventative care, and ensures alignment with wider delivery plans
- An operational lead who coordinates the activities and connects to the VCFSE, Live Well and other public services such as housing

Core Functions

- Care coordination via MDT approach
- Prevention and Targeted In Reach
- Proactive community-based care
- Demand Management
- Risk/Need Stratification and Population Health Management
- Primary/Secondary Care Interface
- Operating as part of Live Well Neighbourhood, with interconnectedness to wider offers
- Including VCFSE partners where relevant, and with strong interface with VCFSE
- Connection to wider public service neighbourhood teams

Integrated Neighbourhood Teams for Health and Care form the central part of the model and should be available consistently across Greater Manchester. These teams will be complemented by the wider infrastructure in the locality as part of Live Well. This is depicted below:

Neighbourhood Health as part of Live Well – Our Delivery Model



Each locality is currently finalising its Neighbourhood Health Plans, as per the National Framework, and these plans will run through to March 2028. NHS GM is committed to a GM-wide soft launch of Integrated Neighbourhood Teams in all 10 places from the start of Q3 27/28.

Neighbourhood Profiles

Each of our 10 localities has a detailed neighbourhood profile pack. The packs support localities and neighbourhood teams on where to target their interventions. The packs include the following sections:

Theme	Content
Population and Prevalence	• How the population is structured. • Which long-term conditions (LTCs) are most prevalent. • How does this differ by age group. • How does this differ by ethnicity. • How does this differ by deprivation • How does this differ by sex
Activity	• What LTCs are associated with the highest activity? • What LTCs are associated with repeat activity? • How does this differ by age? • How does this differ by ethnicity? • How does this differ by deprivation? • How long do people stay when they are admitted?
Conditions of Concern	To aid a deeper understanding about the conditions that may be of concern to the locality including: • How much of a concern are the identified conditions when compared with other localities? • How has this changed over time? • Where are there particular problems for these conditions? The conditions vary for each locality but typically include Frailty; CVD; Respiratory and Depression

The Neighbourhood Packs are available for all ten place teams and have been developed to support the objectives of the Neighbourhood Health Improvement Programme (NNHIP).

In addition to these a significant amount of work has been done regarding predictive modelling; we expect that this is taken into consideration as part of our transformation journey.

Place Outcomes Framework

As previously mentioned, our strategy for Neighbourhood Health is based on role of our 10 Place Partnerships in bringing together partners to deliver a shared set of outcomes.

The Place Outcomes Framework defines what success looks like for the Place Health and Care Partnership and the neighbourhoods within it; translates the ambition into agreed measures and clear outcomes; and focuses on impact rather than activity, with transparent tracking of progress.

A copy of the outcomes Framework is included in this pack.

We expect all of our providers to be working in partnership through the Integrated place partnership arrangements to ensure the delivery of these outcomes. We will be holding to account the Integrated Place Partnerships for the delivery of the outcomes framework.

The roles of providers in delivering prosperous Neighbourhood Health.

As we increasingly work on neighbourhood footprints, the ICB and partners will focus on changing culture in the system, breaking down barriers between sectors and services and working to place and neighbourhood before organisation. This will include how we strengthen the connection between Live Well and Neighbourhood Health and secondary care clinicians whose practice, we expect, will be increasingly defined by population health rather than waiting lists and bed numbers.

The ICB will increasingly commission these models and create the right conditions for all providers to work together to deliver them.

We expect our provider collaboratives, encompassing all sectors of the system, to play a vital role in this: the Trust Provider Collaborative (TPC); Primary Care Provider Board (PCPB); and the Alternative Provider Collaborative (APC).

Whilst there are important bilateral relationships between the ICB and individual providers, there is more benefit to come from GM providers working as one, on key service and delivery challenges. We are working closely with TPC on how we will realise this opportunity. Notwithstanding the pan-GM, regional or national services provided by some of our trusts, there are opportunities for greater collaboration between trusts covering neighbouring geographies in GM. These opportunities are as follows:

- In the north of the conurbation collaboration between Wigan Wrightington & Leigh NHS FT, Bolton NHS FT and the Northern Care Alliance NHS FT
- In the south of the conurbation collaboration between Stockport NHS FT, Tameside and Glossop Integrated NHS FT, East Cheshire NHS Trust and Manchester NHS FT
- Collaboration between the two largest, multi-site trusts – Manchester NHS FT and the Northern Care Alliance NHS FT
- Further collaboration between Greater Manchester Mental Health FT and Pennine Care NHS FT

As we work with the system on the development of these opportunities, we will be examining the future of our District General Hospitals and the types of services that they deliver in the future.

Children's & Young People's Services

As stated in our Five Year Strategic Commissiong Plan, it is imperative for us to ensure we are meeting the needs of our population in the younger years of their lives. As a result, Children's Services will receive a disproportionate level of attention in our transformation plans throughout 27/28.

To ensure the achievement of this, we will be undertaking a Commissioning review of community Paediatric Services. This review will consider current capacity, demand and any future needs analysis.

Our expectation is that Children's Services will form part of Neighbourhood Health models, and we will be working with existing service providers, to carry out this review.

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Beyond Core (BeCCoR) – supporting primary care to 'go beyond' their contractual obligations

In 26/27 NHS GM invested further in BeCCoR and launched a consistent GM BeCCoR General Practice scheme from April 2026. The delivery of this scheme is underway and encompasses 5 pillars of work which General Practice are currently delivering:

- Quality and Sustainability: supporting general practice to develop via a quality improvement framework to evidence and measure impact across essential and aspirational criteria
- Prevention, Proactive Care and Neighbourhoods: delivering proactive and preventative care to those with the highest unmet need in Cardiovascular disease, Respiratory disease and Renal disease and those at risk of falls and confusion in relation to polypharmacy.
- Elective Quality Improvement: to take a quality improvement approach to demand management by optimising alternatives to referral and embedding and Advice First approach.
- Medicines Optimisation: quality and safety work across key medicines priorities such as Antimirrobial Stewardship
- Locally retained services: maintaining stability of current core offer through local service delivery

The evidence of benefit is from BeCCoR is clear. For example, the BeCCoR CVD work has supported GM in an accelerated improvement in NOF CVD metrics, in reducing service utilisation in relation to CVD for both planned and unplanned admissions and in a demonstrable reduction in admissions due to MI (heart attacks) since the work began in 2024.

Given this evidence of benefit, this investment and programme of work, delivered through our primary care providers, will be maintained through 27/28. The 2027/28 scheme will be updated based on learning and early evaluation of the current delivery.

Our intention is to expand BeCCoR across Community Pharmacy, Optometry and Dental Primary Care Providers, embedding the learning and evidence from the BeCCoR work done across General Practice. This will be a multiyear programme starting over 2027/28, within available prioritisation of budgets. Further information on this will be provided throughout the year.

The impacts of BeCCOR schemes over 2027/28 will contribute to contribute to GM key priority areas:

- Measurable quality and patient safety improvements, including for medication safety and targeted ICB NOF metrics
- Prevention/Proactive care: contributing to demand management, improvement in health of GM population and reduction in unplanned admissions/clinical complexity/multiple LTCs
- Acceleration of neighbourhood working for the BeCCoR 'high unmet need' cohorts of our population
- Contribution to Elective demand management through adoption of advice first approach, and in future years will support elective transformation through neighbourhoods.

Elective Care

Outpatient transformation represents a significant opportunity for early progress and impact. A review of evidence indicates that c40% of new Outpatient demand from a primary care referral could be managed outside of hospital. You will see our commitment to supporting the achievement of this described in our Material Commissioning Intensions, later in this document.

As part of our plans for elective care, we have considered some of the types of patients who might benefit from Neighbourhood Based Elective Care. This includes:

- **Single-condition, episodic care need**: for less complex patient cohorts in certain (medical) specialties, moving setting of care out of hospital and into neighbourhoods.
- **Multi-condition, complex care needs**: for more complex patient cohorts with certain overlapping characteristics, implementing an MDT approach and joint working between GPs and specialists.
- **Paediatrics**: combination of single-condition episodic care and community paediatrics.
- **Case finding of at-risk patients and proactive intervention:** patients who do not have a referral, are not on a waiting list and therefore are not "known" to the health system yet are likely to have or to develop poor health.

It is anticipated that these cohorts of patients will form a majority of those likely to access neighbourhood services for elective care and will form the focus for service design.

In addition to the above, key areas of focus for providers are as follows: -

- Implementation of outpatient templates, in line with GiRFT targets.
- Implementation of outpatient follow-up protocols at a pathway level.
- Full utilisation of Elective Hubs
- Achieve optimum day case rates, in line with BADS targets
- Ensure optimum levels of theatre productivity (Theatre utilisation & theatre estate utilisation)

Urgent & Emergency Care

Our approach to improving Urgent and Emergency Care is through the management of demand and supporting patients to stay well, preventing them from escalating into Urgent Care Services. This is the role of our Integrated Place Partnerships.

The primary tool to deliver this will be through the Neighbourhood Health model described earlier in this document.

However, to ensure good safe quality care for our patients, we will be expecting NHS Acute providers to continue to develop and embed their models of Integrated Urgent Care SPoAs, contributing to the demand management and left shift agenda. Some excellent examples of well develop Integrated Urgent Care SpoAs have already been established in the system, and we will be expecting providers to share their best practice and to build on the momentum that these models are achieving.

We will also be expecting the further embedding of the national best practice principles outlined in the Model ED framework. These tools are key to reducing long waits in Emergency Departments and improving the quality of care for patients. Corridor Care and 12hr waits in Emergency

Departments need to be eradicated, this will be achieved by all providers implementing the GiRFT Operational clinical standards within the Model ED framework.

NHS GM is committed to co-designing a single model for frailty across GM, ensuring the mechanisms are in place for the early identification of this co-hort of patients, with the appropriate pathway support and management of care.

Within this work, the approach to supporting patients who have higher than expected contacts in the UEC system will be addressed. This co-hort of patients is typically described as “High Intensity Users” and have varying reasons as to why they regularly access urgent care. The appropriate holistic management of these patients can and will improve their outcomes. This will be a key role for Integrated Place Partnerships.

Mental Health Services

NHS GM is committed to a more preventative, neighbourhood model of mental health, which requires greater collaboration between the two specialist mental health trusts in GM. There is an opportunity to accelerate single delivery models of specialist and community mental health services consistently across GM, drawing from the best of both providers and building on their strengths.

The key opportunities for us to transform mental health provision in Greater Manchester will come from the two mental health trusts stepping-up their approach to GM-wide collaboration, and drawing-in contributions from other providers on mental health and care, specifically to:

- Accelerate the single delivery model of specialist and community mental health services consistently across GM, drawing from the best of both providers and building on their strengths. Eliminating duplication potentially by a single approach to a mobile population, reducing hand-offs of care and improving the consistency of excellent care across the GM system.
- Take the opportunity to go further, faster and drive improvements in safety and quality of care and reduce variation, through unified, multi-disciplinary clinical leadership and move towards a standardised model of delivery across all ten boroughs, promoting a recovery approach. GM is working on a standard operating model for neighbourhood health teams, but there is more to do to see a unified, clinically-led approach to both community and inpatient care delivery and standards and evidence shows that where we have strong, dedicated leadership that is associated with better patient outcomes, including reduced mortality rates and higher patient satisfaction.
- Build on the fact that together, the organisations are the largest research active organisations in mental health and learning disability in England and very large providers of health education, including medical education. Historically, competition between the organisations for research funding and competing research priorities has impeded the cultivation of opportunities for research driven innovation and change, which, leading to the implementation of new, more efficient models of care, which is crucial for addressing the increasing demand for mental health services.

The Mental Health Integrated Fund (MHIF) is a key enabler to achieving our ambition. In 2025/26, to support the ‘Left Shift’ in investment flow from hospital beds to community services, the MHIF was developed and implemented. It is our vehicle for significant investment in resilient community mental health services, which align to the GM Live Well model, and our shared strategic drive for prevention

and early intervention to be at the heart of our neighbourhood model of care. We are committed to this approach in 27/28 and will continue to work with providers of our Mental health services on the delivery of this. The focus on effective and high-quality community and crisis offers for the population and partnership with primary care are a commissioning priority in 27/28 building on the strategic direction from Year 3 of the Mental Health and Wellbeing strategy.

In addition to this, a key focus for us is the improvement in services in the community for our population with a learning disability. Greater Manchester has a number of providers of community Learning Disability services for children, young people and adults. This creates inequity in access and pathways. We will be undertaking an options appraisal for these services and following the selection of a preferred provider, we will co-design a new model of care and undertake a procurement for a lead provider.

The MH capital programme will be integrated in the wider GM system transformation programmes for MH EDs, NMHCs, LDA and digital.

New Modern Service Frameworks

There is an expectation that throughout 27/28 our providers will work to embed new Modern Service Frameworks, as part of their service delivery. These include CVD & Cardiac, palliative and end-of-life care (Including Hospice Care), frailty & dementia.

Strategic Commissioning of Medicines

NHS GM will commission medicines as a strategic investment in population health, rather than as an isolated prescribing cost pressure. Medicines investment decisions should be embedded within clinical and commissioning strategies, considering their impact on patient outcomes, prevention, health inequalities, secondary-care demand, system capacity, sustainability and overall cost-effectiveness.

We will adopt a whole-pathway approach to recognise where investment in medicines can improve outcomes, prevent or delay disease progression and enable more effective models of care.

We will use multi-year horizon scanning and population health intelligence to anticipate emerging clinical needs, innovation and medicines-related financial pressures. This should enable earlier incorporation into pathway development, neighbourhood delivery, service design and medium-term financial planning.

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2 NHS Greater Manchester's Material Commissioning Intentions

The following list of material commissioning Intentions are primarily pertinent to the providers who are contracted to deliver these services. However, all providers will need to be aware of this work and any impact that it may have on levels of activity in their services as a result.

Material Commissioning Intention	Impact
GM Community Tier 2 ENT and Audiology Offer – expansion of the Tier 2 and Audiology offer to increase the number of pathways that can be seen and treated in a community setting.	Reduction in RTT and patient pathways for ENT.
GM Community Tier 2 ENT and Audiology Offer (GPwER training) - Train 20 GPwER so they are competent and able to independently deliver community clinics	Expansion of the skilled workforce in primary / community care to deliver community based ENT pathways.
GM Community Gynaecology Offer - expansion of the Tier 2 and Audiology offer to increase the number of pathways that can be seen and treated in a community setting.	Reduction in RTT and patient pathways for Gynaecology.
GM Community Gynaecology Offer (GPwER training) - Train 10 GPwER so they are competent and able to independently deliver community clinics as part of a neighbourhood offer	Expansion of the skilled workforce in primary / community care to deliver community based Gynaecology pathways.
GM Community Cardiology Offer – to commission a community cardiology offer for appropriate common Cardiology presentations that are assessed, investigated or managed through a community specialist pathway	Reduction in RTT and patient pathways for Cardiology.
GM Community Cardiology Offer (GPwER Training) - Train 40 GPwER so they are competent and able to independently deliver community clinics as part of a neighbourhood offer	Expansion of the skilled workforce in primary / community care to deliver community based ENT pathways.
GM Community Dermatology Offer – mobilisation of new GM Community Dermatology Offer following procurement of a new GM wide provider	Reduction in RTT and patient pathways for Dermatology conditions that can be assessed, investigated and managed in the community.
GM Community Vasectomy Offer – to deliver all vasectomies undertaken by local anaesthetic in a community setting, therefore freeing up capacity in secondary care	Reduction in RTT and patient pathways for Urology.

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GM Integrated MSK Community Tier 2 Service – the mobilisation of an integrated MSK Community Tier 2 service in accordance with the new GM service specification.	NHS GM will issue a new service specification to providers in October to consider and include as part of their planning submissions.
GM Community Services; District Nursing Specification – implementation of new, GM service specification	NHS GM will issue a new service specification to providers in October to consider and include as part of their planning submissions.
Decommission five Inpatient Unit Beds-Neuro Rehabilitation (Trafford Unit) – Unit is currently commissioned / funded for 40 beds, of these 35 are operational.	To decommission the 5 beds which are no longer operational.
Mobilisation of the new non-emergency Patient Transport Service	It is anticipated that the new service will have an impact on reduced length of stay and delayed discharges.
Development of day case model for people with Eating Disorders (all age) and full implementation of ARFID services for CYP	Timely support to people with an Eating Disorder in community/day case setting to prevent inpatient admissions, reductions in length of stay, left shift of care from acute, earlier intervention and support.
Development and implementation of new pan GM model of MH Crisis Care for vulnerable CYP to prevent admission	The implementation of the new pan GM model will reduce admissions to inpatients, reduced length of stay, improved outcomes for CYP and families/carers, reduced A&E attendances.
GM and East Cheshire arterial vascular surgery reconfiguration - Preferred option transfers Royal Oldham arterial vascular surgery activity to MRI to establish a single arterial centre. Royal Oldham will continue to operate as a vascular spoke site. Anticipated benefits include improved workforce resilience, reduced patient transfers, shorter waits, enhanced clinical responsiveness and strengthened research capability. Business case expected in Q1 2027/28. Wider GMEC network and spoke arrangements remain subject to agreement.	Activity assumptions, patient flows, workforce impacts and financial implications will be confirmed through development of the Decision Making Business Case. It is assumed that Royal Oldham will continue to provide spoke site functions, although the scope of activity to be retained locally remains subject to final service design and approval. Commissioning implications are therefore indicative at this stage.
Develop and implement a **sustainable GM Familial Hypercholesterolaemia Service** model to improve identification, treatment and prevention of cardiovascular disease.	Improved identification and treatment of FH, reducing future cardiovascular events and improving equity of access across GM.
Commission and implement an equitable all-age respiratory diagnostics model to improve access to spirometry, FeNO and other respiratory diagnostic services across Greater Manchester.	Improved equitable access to respiratory diagnostics, reduced diagnostic variation and earlier diagnosis of respiratory disease.

Implementation of CYP2C19 genotyping in stroke services	Estimated reduction in future stroke/bleeding events in 90 days of 18 events, rising to 46 events avoided in 5 years.
Commissioning a new model for Shared Care of Medicines focusing on Mental Health, ADHD, Gender Transition.	Commissioning implications are indicative at this stage and will be dependent on the outcome of the test of change during 26/27.
The Implementation of a single Greater Manchester Major Trauma Service, across 2 sites	NHS GM will issue a new service specification to the MTC providers providers.

3

Provider Planning Assumptions

Based on our analysis of the current delivery of services, the demand profiles from previous years, our material commissioning intensions and the systemwide improvement work that will be taking place in 27/28, we have modelled some assumptions on the key aspects of our service delivery.

Urgent and Emergency Care

The Greater Manchester urgent and emergency care system continues to face sustained demand growth driven by demographic change, increasing acuity and rising utilisation of emergency services. Modelling based on the current 2026/27 forecast outturn indicates that, without further intervention, A&E attendances would increase from approximately 1.59 million to 1.65 million during 2027/28, representing growth of around 4.1%, with non-elective admissions increasing by approximately 13,400 admissions.

To mitigate this growth, NHS Greater Manchester will continue to invest in and support delivery of a comprehensive urgent and emergency care transformation programme. This includes Urgent Community Response services, Hospital at Home, Same Day Emergency Care, Single Point of Access models, Clinical Assessment Services, Urgent Treatment Centres, frailty services, falls prevention initiatives, community pharmacy support and mental health crisis alternatives.

Collectively, these interventions are expected to reduce forecast A&E attendance growth from 4.06% to 1.96%, resulting in planned activity of 1,618,635 attendances during 2027/28. Non-elective admissions are expected to increase from 387,623 to 395,754, representing residual growth of 2.10% after the impact of the planned interventions. Providers should therefore plan on the basis of growth significantly below underlying demand trends, while supporting delivery of provider-led, place-based and system-wide transformation initiatives. The scale of both demand growth and the impact of mitigating actions will vary between providers and places, reflecting differences in population need, existing service models and local transformation programmes.

Elective Care

Elective demand is expected to continue increasing during 2027/28, reflecting demographic growth and increasing healthcare need across Greater Manchester. The Greater Manchester planning assumption is based on 2.28% underlying growth, comprising 1.28% demographic growth and a further 1.0% non-demographic growth assumption, although provider-specific assumptions vary according to local population need.

NHS Greater Manchester's approach is to manage this demand through a significant expansion of community and neighbourhood-based elective care. Material commissioning intentions include expanded Tier 2 ENT and Audiology services, community gynaecology services, community

cardiology pathways, implementation of a Greater Manchester dermatology model, expansion of Advice and Guidance, further development of Single Point of Access models and redesign of vasectomy pathways.

Collectively, these initiatives are expected to transfer substantial volumes of appropriate activity from acute settings into community-based models, including capacity for approximately 10,000 ENT and Audiology pathways, 14,000 Gynaecology pathways and 4,000 Cardiology pathways.

In addition to the demand reduction because of the material commissioning intentions, there is an expectation on the delivery of productivity and improvement initiatives, such as the further roll out of Elective Care SPoAs and A&G. As a result, providers should be assuming 1% growth in their plans.

Cancer

Demand for Urgent Suspected Cancer referrals is expected to continue increasing during 2027/28. With the support of the Greater Manchester Cancer Alliance, NHS GM has set an underlying “do nothing” growth assumption of 4% for Urgent Suspected Cancer referrals in 2027/28.

To moderate this growth, the Cancer Alliance will continue delivery of pathway optimisation, neighbourhood and Live Well initiatives, primary care engagement, referral management support, self-request pathways, public awareness campaigns and innovation programmes designed to improve pathway efficiency and earlier diagnosis.

As a result, providers are asked to plan on the basis of net urgent suspected cancer referral growth of 2% during 2027/28.

Mental Health, Learning Disabilities and Autism

NHS Greater Manchester intends to continue the shift towards earlier intervention, community-based support and prevention across mental health, learning disability and autism services. Key commissioning intentions include development of an Eating Disorders day-case model, expansion of Avoidant Restrictive Food Intake Disorder provision, implementation of the Skyline model for children and young people with complex needs and development of a Greater Manchester-wide mental health crisis response offer for children and young people.

These programmes are intended to provide earlier intervention, improve outcomes and reduce reliance on crisis and inpatient services. Together, the Skyline and pan-Greater Manchester crisis support offers have an estimated annual reach of 32 children and young people with complex needs. The services are intended to reduce repeated A&E attendance, avoid inappropriate admission, improve placement stability and reduce escalation into high-cost residential care. ARFID expansion is expected to provide support for more than 400 additional children and young people each year.

The proposed direction of travel reflects increasing demand for specialist support and builds on evidence of significant crisis activity across Greater Manchester. Together, these initiatives support a shift towards earlier intervention, strengthened community mental health services, reduced

reliance on crisis and inpatient services, and improved outcomes for some of the most vulnerable children and young people in the system.

Long Term Conditions and Prevention

A central assumption within the 2027/28 planning framework is that improved identification, prevention and management of long-term conditions will make an increasingly important contribution to moderating future demand across urgent, elective and acute pathways.

NHS Greater Manchester therefore intends to progress several system-wide commissioning initiatives during 2027/28, including development of a sustainable Greater Manchester Familial Hypercholesterolaemia service, implementation of an all-age respiratory diagnostics model and introduction of CYP2C19 genotyping within stroke services.

These initiatives are intended to improve diagnosis, reduce variation, support preventative care and reduce future demand generated by avoidable disease progression and acute exacerbations. While immediate activity impacts may be modest, they form an important component of the wider strategic objective to improve population health, reduce health inequalities and moderate long-term growth in acute demand.

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4

Delivery of our Existing Programmes & Strategic Finance

In addition to the specific elements that we have outline in components 1, 2 & 3 of our Commissioning Framework, we are committed to the continuation and progression of our existing transformation work programmes.

These programmes of work will involve all our commissioned providers and may result in some in year changes to commissioned services as a result. Any changes that are recommended and are approved through our appropriate governance routes, will be communicated in a timely manner with the relevant providers throughout the course of the year. We will utilise our existing business processes to enact these changes, such as the contract variation process.

Closing the Gap

The mitigating actions described within this framework are expected to reduce, but not eliminate, underlying demand growth. The resulting net demand growth will continue to place pressure on provider capacity, finances and operational performance during 2027/28.

NHS Greater Manchester is therefore asking providers, both individually and collectively through the Trust Provider Collaborative and Place Partnerships, to identify and deliver their own productivity and transformation priorities. These should include adoption of nationally recognised models of care, such as Model Emergency Department, alongside locally developed initiatives that improve outcomes, productivity and value.

The ICB will continue to work with providers, Place Partnerships and system leaders to identify further commissioning, transformation and service redesign opportunities that help close the remaining gap between underlying demand and available resources.

Finance and Contracting Arrangements

NHS Greater Manchester will be working with the system to develop and utilise new contracting models. These will include Lead Provider arrangements, Multi-Neighbourhood Providers and Single Neighborhood Providers.

We will be developing our model of commissioning enabling some of our NHS providers to take the lead for end-to-end pathway delivery for our patients, such as the delivery of Gynecology and ENT. This will require all our providers working together to ensure our patients get the best possible experience, through potential sub-contracting arrangements. Specifically, these models will include:-

- lead provider arrangements through MFT and application of IHO principles.
- lead provider arrangements for cancer care through the Christie with partners across GM
- lead provider arrangements for LDA with our two mental health trusts.

This will include commissioning arrangements with the VCFSE sector, with contracting models which promote partnerships across the sector and with statutory services being activity explored. Work is underway to produce a Market Development Strategy which will strengthen our commissioning arrangements with the sector and embed more innovative and sustainable contracting arrangements.

Deconstruction of the block contracts

For acute services we have made significant progress on improving the transparency between contract income and service / activity delivery. There does, however, remain £94m of historic block items within acute contracts which are currently being reviewed with providers. The objective is to complete this work ahead of 1st April 2027 so that we have full line of sight on all contract income. We await the national guidance for 2027/28 on how financial differences are to be treated and the pace of change. To inform this, we will work with providers using month 6 activity data to generate a forecast year end position, onto which we can model the 2027/28 national payment guidance/tariffs when they are published.

For community and mental health contracts, the recent work provides a good baseline to take this work forward. For example, two next steps are:

- Specifically, how we address the issues with activity data capture?
- We will establish an agreed understanding of historic financial contract adjustments, which total £129m.

As with acute services, we await national guidance on how this work will be used in 2027/28 operational planning.
Work is also in progress for specialised commissioning. This is taking longer than anticipated because of the scale of local tariffs/arrangements, in addition to the added complexity of disaggregating the data by commissioner. The expectation is that all specialised services are within scope (delegated, retained and secure mental health).

Local Financial Planning Assumptions

- National funding from NHS England for Diagnostic Networks ceased in 2025/26. The ICB agreed to provide transitional funding in 2026/27 for the diagnostic network. This funding will cease at the end of 2026/27.
- Return to constitutional standards capital - consistent with the bids, providers should not be assuming incremental revenue funding.
- Non-Recurrent funding (acutes) - for planning purposes, where applicable, providers should assume the following services continue with the exact funding to be agreed as part of contract setting: Alcohol care teams, Medical examiners, Community diagnostic centres, Lung health checks.
- Demand and Capacity Funding - during quarter 3 we will review the impact of the current demand and capacity schemes on managing and reducing UEC demand. This will be used to inform 2027/28 operational planning with the finalisation of schemes and funding in quarter 4.

BURY INTEGRATED CARE PARTNERSHIP

Meeting: Locality Board			
Meeting Date	05 October 2026	**Action**	Consider
Item No.	5.2	**Confidential**	No
Title	Place Documentation update		
Presented By	Will Blandamer, Place Partnership Director - NHS GM (Bury)		
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Executive Summary

The Bury Locality Board has reviewed draft iterations of Place Health and Care Partnership (PHCP) document suite at its meetings in recent months.

The latest document suite was presented and was broadly supported at the GM Chief Officers this week (w/c 28th September 2026) and the final version will be shared with partners in the coming weeks.

It is anticipated that the final document suite will be available in time for the November Locality Board meeting and a number of update reports are being shared today to ensure the Board are being kept up-to-date on the latest developments. The following updates are included with the report: -

1. Engagement feedback outcome reports (short read slide deck and long read paper)
2. Updated PHCP Document Suite summary slide deck
3. A timeline which shows key steps and changes from now until 1st April 2027.

Recommendations

The Locality Board are asked to note the: -

(i) Engagement feedback outcome reports (short read slide deck and long read paper)
(ii) Updated PHCP Document Suite summary slide deck
(iii) A timeline which shows key steps and changes from now until 1st April 2027
(iv) The intention to share the final Place Health and Care Partnership (PHCP) document suite at the November Locality Board meeting.

OUTCOME REQUIRED *(Please Indicate)*	**Approval** ☐	**Assurance** ☐	**Discussion** ☒	**Information** ☐

BURY INTEGRATED CARE PARTNERSHIP

APPROVAL ONLY; (please indicate) whether this is required from the pooled (S75) budget or non-pooled budget	**Pooled Budget** ☐	**Non-Pooled Budget** ☐		

Links to Locality Plan priorities	
Scale our work on Population Health Management - Improve population health and reduce health inequality of those in the most disadvantaged areas	☒
Drive prevention, reducing prevalence and proactive care – supporting Demand Reduction through primary intervention, secondary preventions and tertiary prevention	☒
Transforming Community Care in Neighbourhoods - fully realising the benefit of neighbourhood team working with a focus on the assets of residents and communities and providing proactive care	☒
Optimise Care in institutional settings and prioritising the key characteristics of reform.	☒

Implications						
Are the risks already included on the Locality Risk Register?	Yes	☐	No	☐	N/A	☒
Are there any risks of 15 and above that need to be considered for escalation via an NHS GM Statutory Committee or Board in line with the Risk Escalation process ?	Yes	☐	No	☐	N/A	☒
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☐	N/A	☒
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☐	N/A	☒
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☐	N/A	☒
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☐	N/A	☒
Are there any financial Implications?	Yes	☐	No	☐	N/A	☒
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☒
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						

BURY INTEGRATED CARE PARTNERSHIP

Implications						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☐

Governance and Reporting		
Meeting	**Date**	**Outcome**
N/A		

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Place Health and Care Partnership Document Suite

Engagement Feedback Outcomes

SUMMARY SLIDE PACK

What we heard, what changed and what happens next

Part of Greater Manchester Integrated Care Partnership

This summary connects the engagement, the changes and the resulting arrangements

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Engagement undertaken 1

Who contributed and the scale of the response

What we heard 2

The strongest recurring messages from partners

How feedback was considered 3

A structured review, assurance and alignment process

What changed 4

The most significant changes across the suite

Resulting position 5

What is now clearer, and what has not changed

Next phase 6

Approval, mobilisation, readiness and improvement

The full Outcome Report provides the detailed narrative and rationale. The PHCP Overview Summary Pack explains the operating model and how the document suite fits together.

Engagement reached across the Greater Manchester partnership

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A broad and multi-disciplinary response informed the review of the full document suite.

280
distinct feedback points

26
formal submissions or source documents

24
organisations, Places or teams represented

Contributors included

- Place Health and Care Partnerships
- Local authorities
- NHS trusts and foundation trusts
- General practice and wider primary care
- Mental health and children's services
- VCFSE organisations
- Clinical and professional groups
- Finance, legal, workforce and governance teams
- Wider public service partners

Accountability, participation and finance dominated the feedback

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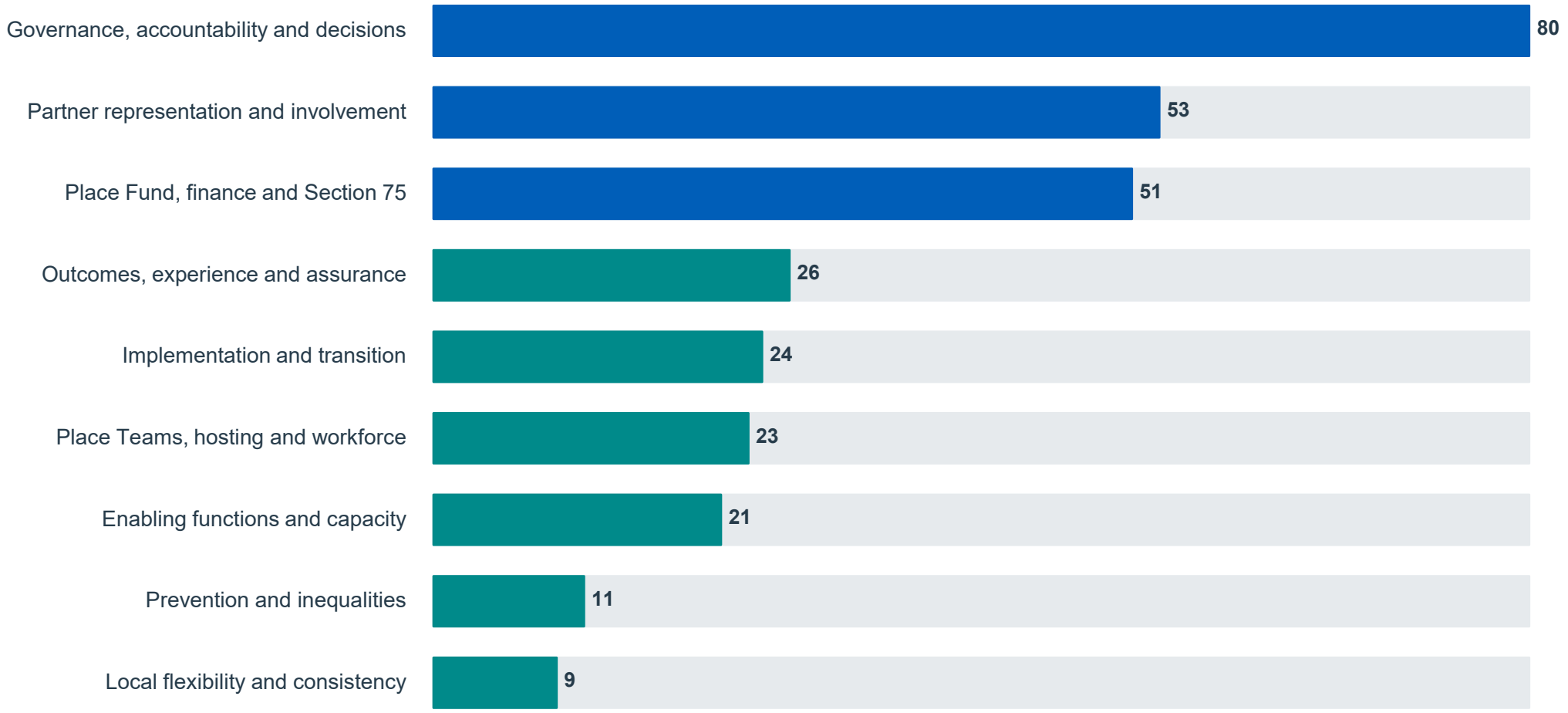
The prevalence chart shows the relative volume of themes identified across the feedback received.



Key message: practical clarity and safeguards mattered most.

The central message was support for Place working, coupled with a call for greater practical clarity

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Strong support for Place working

Partners consistently supported effective Place partnership working as a means of improving outcomes, reducing inequalities and supporting neighbourhood delivery.

Greater practical clarity was needed

Contributors sought clearer arrangements for decision-making, accountability, finance, workforce, representation and assurance.

Retained responsibilities must remain visible

Collective working should strengthen collaboration without diluting statutory, contractual, professional or organisational accountabilities.

Consistency and flexibility must work together

A common Greater Manchester framework should preserve appropriate flexibility for local relationships, priorities and delivery arrangements.

Overall, feedback was detailed, constructive and wide-ranging. The strongest request was not for a different direction, but for a clearer and more operationally useful framework.

Feedback was considered through a structured six-stage review and assurance process

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Each point was assessed on its own merits, then considered across the whole suite so that individual changes did not create contradictions elsewhere.

Engagement strengthened the entire document suite

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Clearer accountability

A sharper distinction between collective Place working and retained organisational responsibilities.

More meaningful participation

Stronger recognition of local authorities, primary care, providers, VCFSE partners, residents, patients, carers and communities.

Clearer financial boundaries

The Place Fund is more clearly defined, with stronger transparency, reporting and governance arrangements.

Stronger focus on outcomes

Greater prominence for prevention, inequalities, mental health, children and young people, experience and wider determinants.

Clearer workforce and hosting

Improved definition of the Place Team, hosted service, employer responsibilities and workforce safeguards.

More coherent assurance

Stronger links between outcomes, governance, resources, assurance and escalation.

The revised suite is clearer about both what it enables and what it does not change

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NOW CLEARER

- How collective decisions relate to formal authority
- How disagreements and disputes are managed
- How financial governance operates
- How hosting arrangements work
- How partners influence priorities and delivery
- How assurance and escalation operate
- Where consistency is required and local flexibility remains

NOT CHANGED THROUGH THE SUITE ALONE

- Statutory responsibilities have not automatically transferred
- The Partnership Board does not hold delegated financial authority
- The Place Team is not a separate legal entity
- Hosting does not give the host authority over the whole partnership
- Wider budgets have not automatically become part of the Place Fund
- Future delegation or pooling has not already been agreed

Changes were made across every key document

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Partnership Agreement & Board Terms of Reference

- Clearer status and purpose
- Stronger decision-making arrangements
- Improved representation and participation
- Clearer escalation and dispute processes

Place Outcomes Framework

- Greater focus on prevention and inequalities
- Stronger mental health and children's outcomes
- More prominence for experience
- More focused and meaningful measures

Place Fund & Section 75 Arrangements

- Clearer 2026/27 scope
- Stronger financial governance and transparency
- Clearer risk and accountability boundaries
- Clearer approach to future development

Place Team, Hosting & Transfer Arrangements

- Clearer wider Team and hosted-service distinction
- Stronger workforce safeguards
- Better-defined host responsibilities
- Stronger delivery and accountability arrangements

Governance, Accountability, Oversight & Assurance

- Clearer accountabilities and decision routes
- Stronger NHS GM and Place links
- More proportionate assurance
- Clearer escalation and system leadership

The resulting framework is clearer, more connected and more operationally useful

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1

A clearer and more connected framework

The documents now operate more effectively as a single integrated suite.

2

Clearer accountability and decisions

Roles, responsibilities and decision routes are more explicit.

3

Stronger participation

The breadth of partners and communities is more clearly recognised.

4

Consistency with local discretion

A common Greater Manchester framework with appropriate local flexibility.

5

Stronger focus on outcomes

More emphasis on prevention, experience, inequalities and neighbourhood delivery.

6

Clearer resources and hosting boundaries

Financial and workforce arrangements are more clearly defined.

The next phase moves from document finalisation to approval, mobilisation and improvement

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1

Approval and adoption

Progress documents through the appropriate governance and approval routes.

2

Complete local arrangements

Finalise local governance, membership and implementation arrangements.

3

Mobilise workforce, hosting and support

Complete hosting, workforce and enabling service arrangements.

4

Confirm readiness and transition

Ensure governance, workforce, financial and operational readiness.

5

Implement, learn and improve

Continue learning, evaluation and refinement through operation.

Key principle: existing lawful arrangements remain in place until replacement arrangements have been approved and are ready to take effect.

Further information is available through the wider reporting package

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PHCP Overview Summary Pack

To understand the operating model

Explains the role of Place Partnerships and how the document suite works together.

Engagement Feedback Outcomes Report

To understand the engagement process

Provides the full narrative, analysis and rationale for the changes made.

Final Place Partnership Document Suite

To understand the final arrangements

Sets out the approved arrangements supporting implementation and mobilisation.

Together, these products provide the operating model, the evidence of engagement and the final arrangements.

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Place Health and Care Partnership Document Suite

Engagement Feedback Outcomes Report

September 2026

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1. Introduction

1.1 Background

Place Health and Care Partnerships bring together local authorities, NHS organisations, primary care, the voluntary, community, faith and social enterprise sector, wider public services and communities. Their shared purpose is to improve health and wellbeing, reduce inequalities and support more coordinated health and care for local people.

During 2026, NHS Greater Manchester developed a suite of documents to provide a clearer and more consistent framework for Place partnership working across Greater Manchester. The documents cover the principles and arrangements through which partners work together, agree priorities, oversee shared outcomes, use Place resources and support local delivery.

The draft suite was developed within the wider context of NHS reform, the future role of NHS Greater Manchester as a strategic commissioner and the continued importance of Place and neighbourhood working. It was intended to provide a common Greater Manchester framework while recognising the different relationships, arrangements and levels of maturity within each Place.

1.2 Purpose of the engagement

NHS Greater Manchester invited partners and stakeholders to review the draft document suite during June, July and August 2026. The purpose was to test whether the proposed arrangements were:

- clear and understandable;
- workable in practice;
- appropriately representative of the organisations and communities involved;
- sufficiently clear about accountability and decision-making;
- aligned with statutory and organisational responsibilities; and
- capable of supporting effective Place and neighbourhood delivery.

The engagement was also intended to identify areas where further detail, safeguards or supporting arrangements were required before the documents progressed towards approval and implementation.

1.3 Purpose of this report

This report explains:

- how the engagement was undertaken;
- the breadth and volume of feedback received;
- the principal themes raised by contributors;
- how the feedback was reviewed and considered;
- the main changes made to the document suite;
- the resulting final document suite; and
- how the documents will now support Place transition and mobilisation.

This report provides an account of the engagement, the principal themes raised and the changes made to strengthen the Place Partnership arrangements.

A concise summary slide pack is also available. It provides a visual overview of the engagement, the main feedback themes, the changes made and the next steps for use in briefings and presentations.

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The reporting package

Outcome Report	The overall narrative and thematic account.
Summary slide pack	A concise visual briefing.
Final document suite	The resulting Place Partnership arrangements.

1.4 Scope of the report

This report focuses on the system engagement on the Place Partnership document suite and the changes made in response. The wider NHS Greater Manchester organisational change process and the separate formal employment consultation relating to affected staff are covered through their respective formal processes and documentation.

These processes are connected, particularly where the Place Team, hosting and mobilisation arrangements are concerned. This report therefore refers to the wider transition context where it is relevant to understanding the Place Partnership arrangements.

2. The engagement process

2.1 How the engagement was undertaken

Engagement on the draft Place Partnership document suite took place during June, July and August 2026. Contributors were invited to consider the individual documents and the extent to which the suite worked as an integrated framework.

Feedback was received through several routes, including:

- formal written submissions;
- Place and partnership forums;
- professional and representative groups;
- meetings and workshops;
- direct correspondence;
- discussions with Place and system leaders; and
- engagement with the organisations and teams affected by, or responsible for implementing, the proposed arrangements.

This mixed approach enabled organisations to provide detailed written comments while also allowing issues to be explored through discussion and professional challenge.

2.2 Who was involved

Feedback was received from across the Greater Manchester health and care system. Contributors included representatives of:

- Place Health and Care Partnerships;
- local authorities;
- NHS trusts and foundation trusts;
- general practice and the wider primary care family;
- Local Medical Committees;
- mental health services;
- children's services;
- the voluntary, community, faith and social enterprise sector;
- professional and clinical groups;
- finance, legal, workforce, governance and assurance functions;
- providers working across more than one Place;
- wider public services and partnership bodies; and
- Place and system leadership teams.

Some submissions represented the collective view of a board, partnership, provider collaboration, professional group or wider team. The number of people whose views informed the engagement was therefore greater than the number of formal submissions received.

The engagement brought together different organisational perspectives and responsibilities. In some areas, contributors expressed different preferences about how the arrangements should operate. These differences were an important part of the review because they highlighted where the final documents needed to distinguish more clearly between collective partnership working and the responsibilities retained by individual organisations.

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2.3 Engagement at a glance

280 distinct feedback points	26 formal submissions and source documents	24 organisations, Places and teams represented

Several submissions represented wider boards, partnerships, professional groups or provider collaborations. Some source documents contained multiple detailed points. Each distinct issue was recorded separately so that the full breadth of feedback could be reviewed.

2.4 Key stages

Figure 1. Key stages in the engagement and review process.

The timeline summarises the principal stages from engagement through to approval and mobilisation.

3. What we heard

3.1 Overall picture

The feedback was detailed, constructive and wide-ranging. It demonstrated strong support for effective Place partnership working but also identified areas where the original proposals needed greater clarity, stronger safeguards or more practical detail.

Contributors were particularly interested in how the arrangements would work in practice. Many comments focused on who would make decisions, how partners would be held to account, how statutory and organisational responsibilities would be protected, how financial resources and risks would be managed, how different partners would have meaningful influence, what capacity and support would be available to Place, how outcomes would be measured and assured, and how the arrangements would be implemented without creating gaps, duplication or unintended consequences.

The feedback did not present one single view. Contributors approached the documents from different legal, financial, organisational, professional and community perspectives. Some supported greater consistency across Greater Manchester, while others emphasised local flexibility. Some sought stronger collective authority at Place, while others stressed the need to protect the lawful authority and responsibilities of individual organisations.

The review therefore needed to balance these perspectives rather than simply adopt one organisational preference. The final suite aims to establish a clear common framework while preserving appropriate local flexibility and retained organisational accountability.

3.2 Main feedback themes

Governance, accountability and decision-making

This was the most frequently raised area. Contributors asked for clearer decision rights, delegations, reserved matters and lines of accountability between NHS Greater Manchester, Place Partnerships and individual organisations. There was a strong expectation that partnership working should not dilute or override statutory, contractual, financial, clinical, professional, safeguarding or regulatory responsibilities. Contributors also asked for practical arrangements for recording decisions, managing disagreement, resolving disputes and escalating matters to the organisation or forum holding the appropriate authority.

Partner representation and meaningful involvement

Contributors wanted representation to provide genuine influence rather than attendance alone. Feedback sought clearer and more meaningful roles for local authorities and elected members; general practice, primary care and Local Medical Committees; NHS providers; mental health and children's services; the voluntary, community, faith and social enterprise sector; residents, patients, carers and communities; providers working across several Places; and wider public services and statutory partnerships. Contributors also recognised that partners operating across several Places may need coordinated and proportionate arrangements rather than identical representation in every local structure.

Place Fund, Finance and Section 75 arrangements

Financial governance was a significant area of feedback. Contributors asked for greater clarity about the scope and status of the Place Fund, the use of Section 75 arrangements, formal financial authority, overspends and underspends, risk allocation and potential gain-share, reporting and audit trails, Place-related resources, and protection against unfunded work or unilateral risk transfer. Feedback also highlighted the need to distinguish the immediate arrangements from longer-term ambitions to align or pool additional resources.

Outcomes, experience and assurance

Contributors supported a shared focus on outcomes but asked for the framework to be more balanced and meaningful. Feedback sought greater focus on outcomes rather than activity; stronger recognition of prevention, inequalities, mental health and children's outcomes; greater prominence for resident, patient

and carer experience; recognition of neighbourhood variation and wider determinants; fewer and more purposeful measures; and proportionate assurance that uses existing reporting wherever possible.

Prevention, Live Well and wider determinants

Contributors asked for greater alignment with Live Well and a more consistent commitment to prevention, early intervention, health equity and neighbourhood working. They also emphasised the influence of housing, employment, skills, transport, community resilience and other wider determinants on health and wellbeing.

Place Team, hosting and workforce arrangements

Feedback sought clearer definitions of the Place Team and the workforce and service intended to transfer. Contributors asked for clarity about the roles of NHS Greater Manchester, Place leadership and the receiving organisation; host responsibilities; workforce protection and deployment; delivery accountability; employment consultation; funding and liabilities; access to enabling services; conflicts of interest; and safeguards against redirection to unrelated organisational priorities.

Enabling functions and capacity

Places asked for confidence that they would have access to data, digital, finance, estates, clinical and professional leadership, quality and safeguarding expertise, workforce support, programme support and engagement capability. Contributors recognised that not every specialist function could be replicated in every Place, but asked for clear service interfaces and realistic access to the required support.

Local flexibility within a consistent Greater Manchester framework

Feedback generally supported a common Greater Manchester framework but asked for clearer application of subsidiarity and space for local relationships and arrangements. Contributors wanted the suite to distinguish between minimum expectations, matters requiring consistent legal or governance treatment, and areas where Places can design arrangements around local context.

Implementation and transition

Contributors asked for realistic sequencing and greater clarity about how the suite would move from policy into practice. Feedback highlighted the need to align governance, financial, contractual and workforce changes; protect staff and service continuity; avoid governance gaps; complete schedules and Terms of Reference; manage approvals; communicate clearly; test readiness; and retain opportunities for learning and improvement.

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3.3 Relative prevalence of the themes

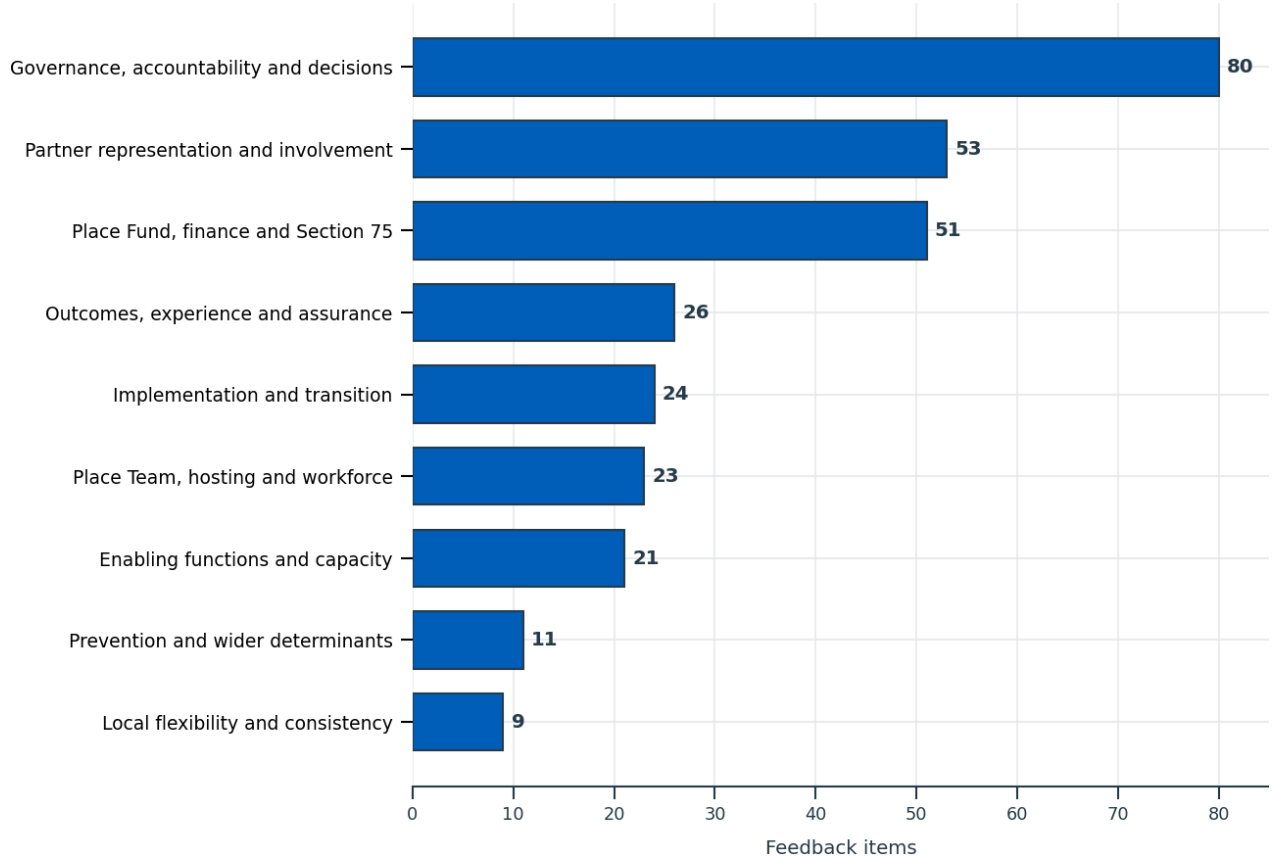

Figure 2. Relative prevalence of the principal feedback themes.

Method note: some feedback points related to more than one theme and are therefore reflected in more than one category. The figures illustrate the relative prevalence and breadth of the themes and are not intended to sum to the 280 distinct feedback points.

3.4 Interconnected nature of the feedback

Many comments could not be resolved within one document alone. Financial decision-making depended on the Place Fund, Section 75 arrangements, partnership governance and formal delegations. Workforce hosting depended on employment arrangements, the service specification, governance and contractual safeguards. Outcome assurance depended on the Outcomes Framework, governance arrangements, access to evidence and the contribution of partner organisations.

Primary care feedback affected representation, retained commissioner responsibilities, contractual safeguards, clinical leadership and local delivery. Children's services feedback affected representation, outcomes, statutory interfaces, safeguarding and wider partnership working. The final review therefore considered the suite as a connected framework rather than treating each document in isolation.

4. How the feedback was considered

4.1 A structured review

All feedback received through the engagement was brought together into a single record. Each distinct point was logged alongside its source, the document or documents to which it related and the proposed response.

The feedback was then grouped by theme and allocated to the area of expertise best placed to consider it. This included input from colleagues with expertise in partnership and Place leadership; governance and assurance; legal arrangements; finance and Section 75 agreements; workforce and employment; clinical and professional leadership; quality and safeguarding; outcomes, data and intelligence; primary care; children's services; local government; hosting and service arrangements; and transition and mobilisation.

The purpose was not simply to count how often an issue was raised. Each point was considered in relation to its substance, the responsibilities of the organisations involved and its implications for the wider suite.

4.2 How decisions were reached

For each feedback point, the review considered:

- the issue being raised;
- whether similar or related feedback had been received elsewhere;
- the intended purpose of the relevant document;
- applicable statutory, contractual and governance requirements;
- financial, workforce and service implications;
- the impact on other documents within the suite;
- whether a common Greater Manchester position was required;
- whether the matter should be determined locally;
- whether further engagement or specialist advice was needed; and
- whether the issue related to immediate implementation or future development.

This led to several possible outcomes:

1. A change to the relevant document.
2. A change across more than one document.
3. Additional clarification or supporting documentation.
4. An implementation or mobilisation action.
5. Further specialist review or targeted engagement.
6. No change, where the existing position remained appropriate or the proposal could not be adopted.

Where feedback did not result in a direct change, the reason was recorded. This may have been because the matter was already addressed, sat outside the purpose or legal status of the document, needed to remain subject to local determination, required a separate agreement or approval, related to future development, conflicted with a statutory responsibility, or could not be resolved without further design, evidence or agreement.

4.3 Review across the document suite

A central part of the process was checking the effect of proposed changes across the full suite. Partnership

documents describe shared intent and ways of working. Terms of Reference set out membership and decision-making arrangements. Section 75 agreements govern legally operative financial arrangements. Hosting and service documents set out employer and provider responsibilities. The governance and assurance framework explains how the different arrangements connect.

A change made in one document therefore needed to be checked against the others to avoid inconsistent terminology, conflicting responsibilities, duplicate governance routes, gaps in decision-making authority, unintended financial or employment implications, and differences between the partnership narrative and legally operative arrangements.

The review included cross-document consideration of legal, financial, workforce, governance, assurance and implementation matters. A final consistency and legal review was then used to identify any remaining areas requiring clarification before approval and execution.

4.4 Targeted follow-up

Some feedback required further discussion rather than an immediate drafting decision. This was particularly relevant where contributors raised material concerns about financial responsibilities and risk; primary care and general practice representation; the relationship between Place and retained NHS Greater Manchester functions; children's services and statutory interfaces; clinical, quality and safeguarding accountability; employment and hosting safeguards; and local implementation arrangements.

Where appropriate, these matters were considered through targeted discussions with relevant professional, organisational and subject matter leads. Some detailed arrangements will continue to be completed through legal drafting, local approvals and mobilisation activity.

4.5 Principles applied throughout the review

Listen to the substance of the feedback	Comments were considered for their implications, not only by the number of times they appeared.
Protect statutory and organisational responsibilities	Collective partnership working should strengthen coordination but should not obscure or transfer responsibilities without lawful agreement.
Make accountability clear	The documents should explain who decides, who delivers, who provides assurance and where concerns are escalated.
Use the right document for the right purpose	Detailed legal, financial and employment requirements should sit in the documents capable of giving them effect.
Balance consistency and local flexibility	All Places should operate within a clear common framework, while retaining appropriate flexibility for local context and relationships.
Avoid unnecessary duplication	Existing governance, evidence and assurance processes should be used wherever possible.
Be clear about what is agreed and what remains in development	The final suite should not imply that future delegation, pooling or service changes have already been agreed.
Support safe and practical implementation	Changes should be capable of being mobilised, supported by appropriate approvals and managed without avoidable gaps in authority or service continuity.

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4.6 How feedback informed the final suite

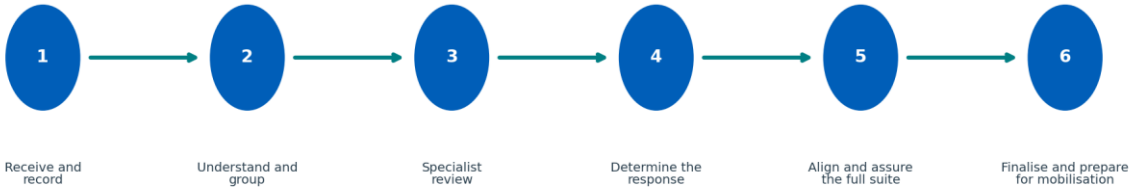

Figure 3. How feedback informed the final document suite.

5. Feedback and changes by document

The following chapters describe the principal feedback received on each document or linked group of documents and the changes made in response. They focus on the matters specific to each part of the suite. Cross-cutting themes, including accountability, retained organisational responsibilities, local flexibility and implementation, are referenced where they have a direct bearing on the document concerned.

5.1 Place Partnership Agreement

Feedback on the Place Partnership Agreement focused on its purpose and status, collaborative decision-making, partner sovereignty, local flexibility, representation and the relationship with the wider document suite. The Agreement and the template Terms of Reference for the Place Partnership Board were revised together to provide a clearer and more balanced framework for partnership working.

A consistent theme was the need for greater clarity about the purpose and status of the Agreement, the responsibilities of signatories and the relationship between collective partnership decisions and the statutory, contractual and sovereign responsibilities of individual organisations. The revised Agreement makes these boundaries clearer. Participation in the Partnership does not transfer or override partners' legal duties, contracts or accountabilities, and signing the Agreement does not mean that every partner endorses every subsequent decision. We have also strengthened the provisions covering conflicts of interest, amendment, variation, withdrawal and termination so that the processes and responsibilities are easier to understand.

We heard a strong call for decision-making to be collaborative, transparent and capable of resolving disagreement fairly. The Agreement now contains clearer provisions for recording decisions, managing differing views and escalating or resolving disputes. These arrangements are intended to apply equitably across the partnership and to respect the contractual and statutory position of every partner. We have therefore not created separate veto or dispute processes for individual sectors or organisations. Instead, safeguards have been strengthened so that no partner should be subject to an uncontracted transfer of work or an unfunded liability without explicit agreement, while each organisation retains the right to act in accordance with its statutory and legal responsibilities.

Feedback also emphasised the importance of balancing consistency across Greater Manchester with local flexibility. The final drafting gives greater prominence to the principle of what is best for Place and what is best for Greater Manchester, recognising that decisions should be taken at the most appropriate level and informed by local need, existing strengths and established partnerships. The Agreement establishes a common set of principles and expectations, but it does not prescribe identical membership, representation or delivery arrangements in every Place. Detailed governance, membership and decision-recording arrangements will be set out through local Terms of Reference and supporting documentation. To support Places in applying these arrangements consistently and make the overall suite easier to use, we have also developed a template Terms of Reference for the Partnership Board to sit alongside the Agreement. This has been updated to reflect the changes made to the Agreement, including clearer provisions on partner sovereignty and Reserved Matters, membership, collective decision-making, objections to unfunded impacts, escalation, information sharing and links with Health and Wellbeing Boards.

Representation and meaningful influence were prominent themes. We have strengthened recognition of general practice and the wider primary care family, the VCFSE sector, residents and communities, local authorities, providers operating across more than one Place, and wider public service partners. We have also strengthened references to children and young people and the importance of ensuring that families, children's services leaders and wider partners are appropriately reflected within Place arrangements and delivery priorities. The Agreement supports inclusive and proportionate participation, while allowing each Place to determine the arrangements that best reflect its population, priorities and partner landscape. Local Medical Committees have an important representative and advisory role in relation to general practice, but the mechanism for consultation and for identifying representatives will remain locally determined. The revised drafting also provides greater clarity regarding primary care representation, consultation and influence, while recognising that existing contractual, statutory and professional responsibilities remain with the relevant organisations and representative bodies. Similarly, co-option may be appropriate for some organisations, but it will not be the only route to involvement. The final arrangements should enable

residents, communities and VCFSE partners to influence priorities, delivery and evaluation, not simply contribute as delivery partners. The most appropriate way to reference the VCFSE Accord will be confirmed through the remaining legal and partner review rather than predetermined in this response.

The engagement also reinforced the importance of shared leadership, equitable partnership behaviours and collective stewardship of resources. Contributors also emphasised the importance of prevention, Live Well, mental health and children and young people being reflected consistently within the Partnership's purpose, priorities and approach to improving outcomes. The Agreement has been strengthened to reflect co-production, evidence-led and equitable decision-making, financial sustainability, risk awareness and the need to manage organisational pressures without undermining shared Place priorities. It provides for collective visibility and oversight of relevant risks and financial pressures, while recognising that organisations holding or hosting resources remain accountable for them. Detailed financial transactions, hosting responsibilities and formal assurance mechanisms sit within the relevant Section 75, hosting and governance arrangements and are cross-referenced rather than duplicated in the Partnership Agreement.

Finally, contributors asked for clearer links between NHS Greater Manchester, Place Partnerships, provider and commissioning arrangements, Health and Wellbeing Boards and partners' sovereign governance. The Agreement has been revised alongside the wider Governance, Accountability, Oversight and Assurance Framework so that these relationships and retained responsibilities are clearer. It also gives greater recognition to the enabling capabilities partners contribute, including data, digital, estates, finance, strategic commissioning and specialist expertise. Some detailed local schedules, Terms of Reference and implementation arrangements will continue to be completed through mobilisation and the final legal and consistency review. This does not diminish the feedback received. It reflects the need to place detailed provisions in the document or governance mechanism where they can operate most effectively and be maintained over time.

5.2 Place Outcomes Framework

Feedback on the Place Outcomes Framework focused on its breadth, balance and practical value. Contributors asked for a stronger focus on mental health, prevention, inequalities, children and young people, resident experience, wellbeing and the wider determinants of health, alongside a more focused and proportionate set of measures.

A consistent message was that the framework should reflect the full breadth of what Place Partnerships are seeking to achieve. This includes not only health service activity and physical health outcomes, but also mental health, prevention, inequalities, children and young people, resident experience, wellbeing and the wider determinants of health. The overall balance of the framework has therefore been reviewed, incorporating relevant updated national outcomes measures and strengthening its alignment with Live Well and other established Greater Manchester and national frameworks, as better data becomes available. The metric set has also been rationalised to remove avoidable duplication and ensure it remains focused on the measures that best demonstrate progress against shared outcomes.

Resident, patient and carer experience has been given greater prominence. Activity and performance measures alone cannot tell us whether people experience care and support as accessible, joined up and responsive to what matters to them. The framework includes measures relating to access, personalised care, shared decision-making and experience. It also considers people's experience of neighbourhood care, ease of navigating services, involvement in decisions and the experience and wellbeing of unpaid carers.

The revised approach also recognises that reductions in referrals, attendances, admissions or conveyances must represent better outcomes and earlier support rather than new barriers to access. These measures should therefore be understood alongside appropriate balancing information on access, outcomes, inequalities and experience. Wherever the underlying data allows, outcomes should also be examined by neighbourhood, population group, protected characteristic and service pathway so that overall improvement does not obscure unequal access or outcomes.

The framework is intended to provide a consistent GM-wide core, but it must also recognise that population needs, starting points and levels of system maturity differ across the ten Places. Baselines, trajectories and implementation will therefore need to be considered proportionately and in local context. Places can and should supplement the shared framework with locally agreed measures that reflect their own priorities,

partnerships and population needs. This local flexibility is intended to complement the GM-wide framework, rather than create ten separate or competing approaches.

Some of the measures and analytical capabilities needed to realise the full ambition of the framework are still developing. The framework will continue to align with existing system dashboards and intelligence, including relevant work on neighbourhoods, prevention, wider determinants and digital exclusion, rather than recreating reporting that already exists. Where consistent data is not yet available, limitations will be made clear and the framework will be strengthened as the quality, availability and interoperability of data improve.

The Place O y conditions or limits, and the person or body accountable for implementation. Financial information, approvals, actions and escalations should provide a clear and auditable trail, supported by regular reporting on expenditure, forecasts, delivery, outcomes, risks and mitigations. These provisions strengthen transparency and collective stewardship while retaining the statutory, financial and contractual accountability of the organisations that hold and transact the funding.

Feedback also asked for greater visibility of Greater Manchester-held and Place-related budgets and clearer routes for Place partners to influence resource decisions. We recognise the importance of this ambition. The revised document provides a clearer baseline for the agreed Better Care Fund services and explains the common categorisation applied across all ten Places. It also makes clear that the Place Fund does not provide a complete Place-level view of all health and care expenditure. Existing NHS Greater Manchester reporting and published accounts remain important, but further development would be required to provide a consistent and sufficiently detailed Place-level view of wider budgets. The current document therefore does not imply that resources outside the Better Care Fund have been delegated to, or are controlled by, the Place Partnership Board.

Several contributors raised concerns about the treatment of financial risk, overspends, gain-share, reinvestment and the possibility of unilateral risk transfer. These are important issues, but many relate to services and funding outside the agreed 2026/27 Place Fund. Within the current scope, partners are expected to operate through the existing Better Care Fund and Section 75 arrangements and manage expenditure within available resources. Continuing healthcare, jointly funded packages, Section 117 utcomes Framework should therefore not be viewed as a fixed or final product. It provides a common starting point for shared accountability, learning and improvement, and it will be kept under review as priorities change, new evidence becomes available and our collective capability develops. In particular, we intend to review the framework towards the end of this financial year, alongside the wider Neighbourhood workstream, to consider its alignment with the developing approach to neighbourhood metrics and any further refinements needed for the next financial year. Thereafter, we propose to undertake a proportionate review at least annually, while retaining the flexibility to consider material updates sooner where significant changes in policy, evidence, data or delivery arrangements make this necessary. This review approach will allow the framework to evolve without creating unnecessary reporting or redesign activity. The feedback received has already helped shape that next stage of development.

5.3 Place Fund and Section 75 arrangements

Feedback on the Place Fund and Section 75 arrangements focused on scope, financial authority, transparency, risk and the distinction between the immediate arrangements and possible future development. Th

e revised framework provides a clearer and more appropriately bounded description of the 2026/27 position.

A consistent message was that the scope and status of the Place Fund needed to be clearer. The revised document now confirms that, for 2026/27, the Place Fund comprises the agreed Better Care Fund services and is established and transacted through existing Section 75 and Better Care Fund arrangements. It is not a delegated budget, and the Place Partnership Board does not hold delegated financial authority. Place partners will provide joint oversight and influence within the agreed arrangements, but formal decisions must remain with an authorised NHS Greater Manchester or local authority decision-maker acting through the authority and governance applicable to the funding concerned. The term shadow year has also been clarified so that it does not imply a commitment or timetable for future delegation.

We heard a strong call for greater clarity about how financial decisions will be made, recorded and assured. The revised framework now states that decisions must identify the responsible decision-maker, the authority relied upon, the funding affected, an

arrangements, core general practice funding, specialist mental health services and wider pooled commissioning matters remain subject to their existing statutory, contractual and governance routes. This boundary is intended to avoid the Place Fund inadvertently changing existing responsibilities, funding splits or liabilities. More detailed risk-sharing or gain-sharing arrangements would need to be agreed for any future services before they were brought within the Fund.

We also recognise the concern that reclassification of expenditure could be interpreted as a reduction in services or the withdrawal of investment. The revised document makes clear that reclassification does not, in itself, stop the funding or activity. Where spend has moved outside the Better Care Fund, it remains within the relevant NHS Greater Manchester budget line and continues to be managed through the applicable commissioning, contractual and governance arrangements. The revised wording therefore distinguishes more clearly between improving the consistency and transparency of the Better Care Fund baseline and making a substantive change to service funding.

The ambition to support prevention, neighbourhood delivery and a sustainable shift towards community-based care remains important. However, the revised framework does not present future pooling, delegation or resource transfer as already agreed. During 2026/27, partners may use learning from operation of the Place Fund to strengthen governance, controls, reporting and assurance and to inform future proposals. Any addition of services or budgets from 2027/28 will require separate development with relevant partners, a clear assessment of financial and service impacts, agreed decision rights, transition and risk arrangements, and approval through the legal and governance mechanisms applicable to the funding concerned. The Place Fund and Section 75 arrangements will continue to be aligned with the Partnership Agreement and the wider Governance, Accountability, Oversight and Assurance Framework.

5.4 Place Team, Hosting and Transfer arrangements

Feedback on the Place Team, Hosting and Transfer arrangements focused on the definition of the Place Team, the role of the host, workforce safeguards, accountability, capacity and the relationship between partnership leadership and employer responsibilities. The Place Team document and associated arrangements were substantially clarified in response.

A consistent message was that the term Place Team needed much greater definition. The revised document now distinguishes between the wider multidisciplinary Place Team, the NHS Greater Manchester-funded Place Delivery and Integration Service, the host provider, the Place Health and Care Partnership and NHS Greater Manchester as commissioner and funder. The wider Place Team is a collaborative, multi-organisational model rather than a separate legal entity or employing body. The Place Delivery and Integration Service is the identifiable service and dedicated workforce intended to transfer, while staff and expertise contributed by other partners remain employed and accountable through their substantive organisations unless a separate arrangement is expressly agreed.

We also heard the need for greater clarity about the hosting and employment model. The revised framework now describes the host as the substantive employer of the transferring workforce and sets out its responsibilities for employment, workforce support, digital services, information governance, estates, equipment and agreed corporate infrastructure. At the same time, the Place Delivery and Integration Service will remain a defined and ring-fenced Place resource. It should not be absorbed into the host's wider establishment, redirected to unrelated organisational priorities or included in cost-improvement activity unless this is expressly agreed through the relevant governance, contractual and workforce processes. The detailed employee transfer arrangements, including assignment, consultation, due diligence and applicable employment protections, will be confirmed through the formal workforce process through the formal workforce process.

Feedback raised an important concern that hosting could inadvertently give the host greater authority over Place priorities or make it accountable for matters beyond the hosted service. The revised document makes clear that hosting does not confer additional partnership decision rights. The Place Health and Care Partnership will continue to agree local priorities and oversee delivery, while the host retains the legal and

regulatory responsibilities that come with being the employer and contracted service provider. NHS Greater Manchester remains the commissioner and funder of the Service and retains its statutory, strategic commissioning, financial, contractual, quality and assurance responsibilities. The host is not responsible for the whole multidisciplinary Place Team, the Place Fund or all Place outcomes. Where a proposed decision creates an employment, legal, regulatory, financial or safety concern, it will be considered through the agreed governance and escalation arrangements.

Contributors also asked for clearer expectations about capacity, capabilities and partner contributions. The revised document sets out the broad capabilities required, including Place leadership, clinical and professional leadership, neighbourhood development, population health intelligence, programme and transformation support, commissioning, finance, governance, engagement, workforce, digital, data, information governance and estates. These capabilities may be provided through dedicated Place roles, partner contributions, footprint-based services or Greater Manchester-wide functions. Not every organisation will be expected to replicate specialist capacity within every Place. Participation should be purposeful and proportionate, recognising the position of providers and partners operating across several Places, while local arrangements should make contributions sufficiently clear to avoid unfunded expectations, gaps in support or over-reliance on the host organisation.

The revised framework also strengthens the distinction between partnership leadership, day-to-day deployment and formal employer accountability. The Place Partnership Director will lead the Place Delivery and Integration Service and coordinate the wider Place Team, with priorities and expected outcomes set through Place partnership arrangements. The host will retain responsibility for formal employment decisions and employer duties. Staff contributed by other organisations will retain their existing employment, professional accountability and line-management arrangements unless separately agreed. The associated contract and local governance documentation will set out reporting, performance requirements, establishment controls, liabilities, change control, escalation, dispute resolution and exit arrangements, together with the relationship between the hosted Service, the Place Fund and relevant Section 75 arrangements.

Some feedback concerned matters that cannot be resolved through a single common document, including the preferred host in an individual Place, detailed local reporting lines, exact partner contributions, local clinical leadership arrangements and the timing or sequencing of mobilisation. These matters will be determined through local approvals, due diligence, workforce consultation and mobilisation within the common Greater Manchester framework. Host suitability, conflicts of interest and ongoing assurance will be addressed through the contractual and governance arrangements, with appropriate review and escalation rather than ad hoc judgement. The documents will continue to be aligned with the Partnership Agreement, Place Fund and the wider Governance, Accountability, Oversight and Assurance Framework.

5.5 Place Governance, Accountability, Oversight and Assurance

Feedback on Place Governance, Accountability, Oversight and Assurance highlighted the need to move beyond an options appraisal and explain how the proposed model will operate in practice. The integrated framework, Place Lead role and accountabilities, supporting governance arrangements and mobilisation approach were developed further in response.

A consistent theme was the need for clearer accountability between NHS Greater Manchester, Place Partnerships, Place leadership and individual partner organisations. The revised framework now distinguishes more clearly between collective accountability for agreed Place outcomes and the statutory and organisational responsibilities retained by individual partners. These include statutory, contractual, financial, clinical, quality, professional, safeguarding, employment and regulatory accountabilities. The framework does not itself delegate statutory functions or give one organisation or individual authority to direct another outside formally agreed arrangements. Delegations and decision-making authority will continue to be set out through the appropriate Terms of Reference, schemes of delegation, Section 75 arrangements, hosting agreements and organisational governance.

Feedback also highlighted the need for greater clarity about where decisions are made and how Place governance connects with Health and Wellbeing Boards, NHS Greater Manchester and partners' sovereign governance. The revised approach establishes a common core for Place Partnership governance, centred

on an effective Place Partnership Board, appropriate delivery arrangements and clear interfaces with statutory and organisational forums. Health and Wellbeing Boards retain their independently established statutory role and local democratic accountability. Places will continue to have flexibility to reflect local relationships, priorities, capacity and maturity, but should be able to demonstrate clearly how decisions, referrals, assurance and escalation operate and how unnecessary duplication is avoided.

A further theme was the need to strengthen the relationship between Place and NHS Greater Manchester. The revised framework therefore describes assurance as a reciprocal process. Place provides local intelligence, evidence, challenge and escalation in relation to shared priorities and outcomes, while NHS Greater Manchester provides transparency on strategic commissioning intentions, assurance on functions it retains, enabling support and a clear response to matters raised through Place. Where Place advice or recommendations are not taken forward, the rationale and any mitigating action should be communicated through the appropriate governance route. This is intended to strengthen local influence and collective problem-solving while maintaining NHS Greater Manchester's statutory commissioner responsibilities and the responsibilities of other partners.

The revised arrangements also provide greater clarity on outcome ownership, recovery, escalation and assurance. Agreed Place outcomes provide the basis for collective oversight. Existing governed evidence should be considered alongside neighbourhood intelligence, inequalities information, lived experience, delivery knowledge and clinical and professional insight to develop a rounded understanding of progress, risk and the action required. The Place Partnership Board has a role in testing this position collectively and agreeing appropriate actions, which may include action by individual partners, collective recovery activity, additional support or escalation through the relevant organisational or Greater Manchester route.

An important principle is that Place assurance should add value rather than create an additional reporting system. The intention is therefore to reuse existing evidence, governance and assurance mechanisms wherever possible. Material themes, strategic risks, support requirements and learning arising through Place can then inform wider Greater Manchester oversight and assurance through agreed routes. This should support a proportionate approach that combines formal evidence with local intelligence and professional judgement while avoiding unnecessary duplication.

Feedback particularly emphasised the importance of maintaining clarity around clinical, professional, quality and safeguarding accountability. The framework makes clear that Place Partnerships can consider how these issues affect shared outcomes, convene partners, identify cross-system concerns and support collective learning and improvement. They do not, however, assume or replace the statutory, professional or regulatory responsibilities of NHS Greater Manchester, providers, local authorities or other organisations. The same principle applies to organisational performance, contracts, finance, workforce and employment responsibilities. Concerns should be managed and escalated through the route appropriate to the issue, with differences in assurance judgement recorded transparently alongside the evidence, rationale and action required.

The Place Lead role has also been revised to align with the framework. It distinguishes the Place Lead's system leadership and convening responsibilities from the collective responsibilities of the Place Partnership Board, operational accountability for delivery and any functions formally delegated by NHS Greater Manchester. The role supports partners to work collectively around shared priorities and outcomes, strengthens the connection with neighbourhood delivery and supports effective stewardship of Place capacity and resources. It also supports reciprocal assurance between Place and NHS Greater Manchester. The Place Lead does not, however, have authority to bind partner organisations outside agreed governance arrangements or assume responsibilities that have not been formally delegated.

Finally, feedback highlighted the importance of aligning implementation across governance, delegation, Section 75 arrangements, hosting and employment arrangements. Some elements of the future model remain subject to formal decisions, legal drafting and local or organisational approval processes. These dependencies will therefore be managed through an integrated mobilisation approach, with sequencing, transitional risks and interim controls considered together. Formal implementation will need to be supported by clear approval routes and appropriate arrangements remaining in place until replacement arrangements are confirmed.

Overall, the feedback has helped strengthen the proposed model and provide greater clarity on how Place Partnerships operate within the wider Greater Manchester system. The revised framework is intended to

support clearer accountability, stronger reciprocal relationships, proportionate assurance and effective local partnership working while preserving the statutory and organisational responsibilities of individual partners. The framework and supporting products will continue to be refined through final legal, governance, consistency and implementation review.

NHS Greater Manchester

6. The final position

6.1 A clearer and more connected framework

The engagement and review process has resulted in a clearer, stronger and more coherent framework for Place partnership working across Greater Manchester.

The final document suite establishes a common foundation while recognising that each Place has different population needs, relationships, structures and levels of maturity. It provides greater clarity about the arrangements that should be consistent across Greater Manchester and the areas in which local flexibility remains appropriate.

The suite is designed to be read as a connected framework. Each document has a distinct purpose:

- the Place Partnership Agreement establishes the shared principles, commitments and ways of working between partners;
- the Place Partnership Board Terms of Reference set out the core governance, membership and decision-making arrangements;
- the Place Outcomes Framework provides a shared basis for understanding progress, inequalities, experience and improvement;
- the Place Fund and Section 75 arrangements describe the scope, governance and operation of the agreed financial arrangements;
- the Place Team, Hosting and Transfer arrangements define the service, workforce, host and partner responsibilities;
- the Place Governance, Accountability, Oversight and Assurance Framework explains how accountability, assurance, escalation and retained responsibilities connect across the wider system; and
- the Place Lead role and accountabilities set out the system leadership, convening and assurance responsibilities associated with the role.

Together, these documents provide a more complete account of how Place Partnerships will operate, how decisions will be made and recorded, how resources and responsibilities will be managed, and how partners will work collectively around shared outcomes.

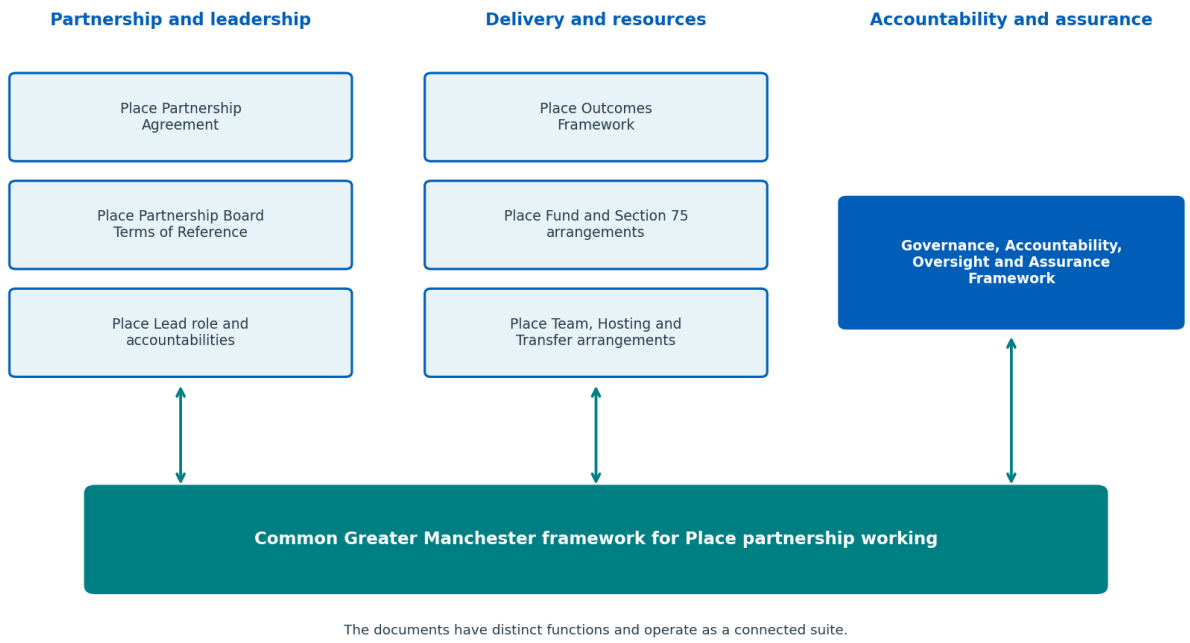

Figure 4. How the Place Partnership document suite fits together.

6.2 Clearer accountability and decision-making

A central outcome of the review is a clearer distinction between collective partnership working and the statutory, contractual and organisational responsibilities retained by individual partners.

Place Partnerships provide a forum through which partners can agree priorities, coordinate delivery, oversee shared outcomes, consider risks and support collective improvement. They do not replace the lawful authority, governance or accountability of the organisations involved.

The final arrangements make clearer:

- which matters can be considered and agreed collectively;
- where formal authority remains with an individual organisation or authorised decision-maker;
- how decisions and the authority supporting them should be recorded;
- how objections, disagreements and conflicts of interest should be managed;
- how concerns should be escalated through the appropriate route; and
- how statutory, financial, clinical, professional, safeguarding, employment and regulatory responsibilities are protected.

This provides a stronger basis for collaboration without creating ambiguity about who remains responsible for formal decisions, resources, services or organisational duties.

6.3 Stronger and more meaningful participation

The final suite gives greater recognition to the breadth of partners and communities involved in Place working.

This includes clearer consideration of:

- local authorities and elected members;
- general practice and the wider primary care family;
- Local Medical Committees;
- NHS providers, including those operating across several Places;
- mental health and children's services;
- the voluntary, community, faith and social enterprise sector;
- residents, patients, carers and communities;
- clinical and professional leadership; and
- wider public services and statutory partnerships.

The arrangements support meaningful and proportionate participation rather than prescribing one identical model for every Place. This allows local membership and engagement routes to reflect the population, partner landscape and established relationships within each Place.

Participation should enable partners and communities to influence priorities, decisions, delivery and evaluation. It should also recognise that organisations operating across several Places may need coordinated arrangements that provide effective involvement without unnecessary duplication.

6.4 A balanced approach to consistency and local flexibility

The final suite establishes a common Greater Manchester framework while preserving appropriate local flexibility.

Consistency is particularly important where arrangements concern:

- statutory and organisational accountability;
- formal financial authority;
- decision-making and record keeping;

- employment and host responsibilities;
- quality, safeguarding and professional accountability;
- assurance and escalation; and
- transparency about the status and scope of the arrangements.

Local flexibility remains important in areas such as:

- detailed membership and participation routes;
- local delivery and supporting governance structures;
- engagement with residents and communities;
- partner contributions and service interfaces;
- locally agreed outcomes and measures;
- clinical and professional leadership arrangements; and
- the sequencing of local mobilisation.

This approach supports subsidiarity by enabling decisions and delivery to take place at the most appropriate level while maintaining the safeguards and consistency required across Greater Manchester.

6.5 A stronger focus on outcomes and improvement

The final arrangements strengthen the collective focus on improving outcomes for local people rather than concentrating only on organisational activity or performance.

The Place Outcomes Framework gives greater prominence to:

- prevention and early intervention;
- reducing inequalities;
- mental health;
- children and young people;
- resident, patient and carer experience;
- neighbourhood variation;
- wider determinants of health; and
- the contribution of communities and the voluntary, community, faith and social enterprise sector.

The framework also recognises the importance of interpreting individual measures in context. Changes in demand, referrals, attendances or admissions need to be considered alongside information about access, experience, outcomes and inequalities.

Place assurance will draw on existing governed evidence wherever possible, supplemented by neighbourhood intelligence, lived experience, clinical and professional insight, and local delivery knowledge. This is intended to provide a rounded understanding of progress and risk without creating an additional or duplicative reporting system.

6.6 Clear boundaries around resources and hosting

The final suite provides greater clarity about the present scope of the Place Fund and the arrangements for the Place Delivery and Integration Service.

For 2026/27, the Place Fund comprises the agreed Better Care Fund services and operates through the applicable Better Care Fund and Section 75 arrangements. It is not a delegated budget, and the Place Partnership Board does not hold delegated financial authority. Formal financial decisions remain with the authorised NHS Greater Manchester or local authority decision-maker responsible for the funding concerned.

The final arrangements do not assume that wider budgets, services or financial risks have transferred to Place. Any future proposal to add services or resources will require separate development, assessment,

agreement and approval.

The Place Delivery and Integration Service is the identifiable NHS Greater Manchester-funded service and workforce intended to transfer to the agreed host. The host will become the substantive employer and contracted service provider but will not acquire additional authority over Place Partnership priorities.

The Service will remain a defined Place resource. The host, NHS Greater Manchester, the Place Partnership and the Place Partnership Director each have different and complementary responsibilities. These distinctions provide safeguards for staff, partners and participating organisations while supporting coordinated Place delivery.

6.7 What remains locally determined or subject to mobilisation

The final suite provides the common framework but does not attempt to prescribe every aspect of local operation.

Some detailed arrangements continue to be completed through mobilisation and the relevant local, organisational and statutory processes. These include, where applicable:

- local Terms of Reference and supporting schedules;
- detailed governance and reporting routes;
- the identification and approval of host arrangements;
- workforce consultation and transfer activity;
- due diligence and contractual documentation;
- detailed service specifications and performance arrangements;
- local partner contributions and service interfaces;
- clinical and professional leadership arrangements;
- information, digital, estates and corporate support arrangements;
- local implementation sequencing; and
- transitional controls and readiness activity.

These matters will be progressed within the agreed Greater Manchester framework. They do not alter the principles, boundaries or responsibilities established through the final suite.

7. Next steps

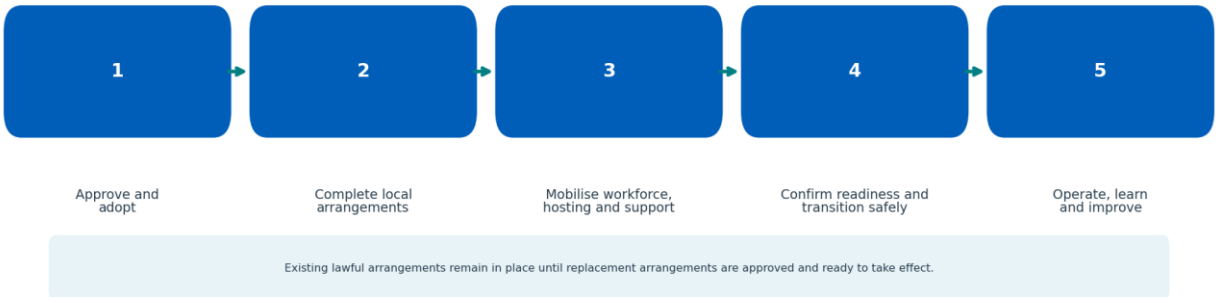

Figure 5. Approval, mobilisation and implementation pathway.

7.1 Approval and adoption

The final document suite will progress through the governance and approval routes applicable to each document and participating organisation.

Different parts of the suite have different legal and governance functions. The approval route for a partnership agreement or Terms of Reference is not necessarily the same as the route required for a Section 75 agreement, hosting contract, workforce transfer or formal delegation.

Approval activity will therefore be coordinated while respecting the decision-making requirements of the organisations involved. This will include ensuring that:

- the correct organisations and decision-makers consider each document;
- statutory and organisational governance requirements are met;
- any required legal agreements and schedules are completed;
- dependencies between documents are identified and managed; and
- the final versions remain aligned through approval and execution.

Existing lawful arrangements will remain in place until replacement arrangements have been approved and are ready to take effect.

7.2 Local mobilisation

Each Place will use the common framework to complete its local mobilisation arrangements.

This will include translating the document suite into practical operating arrangements that reflect local relationships, structures and priorities. Local mobilisation is expected to cover:

- confirmation of Place Partnership governance and membership;
- completion of the Place Partnership Board Terms of Reference;
- clarification of decision, referral, assurance and escalation routes;
- confirmation of partner participation and representation;
- alignment with Health and Wellbeing Boards and other relevant statutory partnerships;
- confirmation of the local outcomes and assurance approach;
- preparation for operation of the Place Fund within the agreed scope;
- completion of hosting and service arrangements;
- confirmation of enabling support and service interfaces; and
- communications with staff, partners and wider stakeholders.

Mobilisation plans will need to address local dependencies while remaining consistent with the common Greater Manchester framework.

7.3 Workforce, hosting and service transition

The transfer of the Place Delivery and Integration Service will be progressed through the formal workforce, legal, contractual and organisational processes.

This will include:

- workforce consultation and engagement;
- confirmation of the staff and roles within scope;
- employment and assignment information;
- organisational and workforce due diligence;
- confirmation of host responsibilities and liabilities;
- completion of the service specification and hosting contract;
- establishment and funding controls;
- digital, information governance, estates and equipment arrangements;
- performance, assurance and reporting arrangements;
- change control, escalation and dispute resolution processes; and

- continuity and transition planning.

The workforce process will determine the detailed employment arrangements and applicable protections. Place mobilisation and workforce transition will be coordinated so that governance, service and employment changes remain aligned.

7.4 Enabling support and system interfaces

Effective Place working depends on access to appropriate enabling capabilities and clear interfaces with functions retained by NHS Greater Manchester and other partners.

Further mobilisation activity will clarify how Places access support relating to:

- finance;
- data, insight and intelligence;
- digital and information technology;
- information governance;
- estates and equipment;
- workforce and organisational development;
- quality and safeguarding;
- clinical and professional leadership;
- strategic commissioning;
- programme and transformation support; and
- communications and engagement.

Support may be provided through dedicated Place capacity, partner contributions, services operating across more than one Place or Greater Manchester-wide functions. The aim is to provide clear and proportionate access to the capabilities required without unnecessarily replicating specialist functions in every Place.

7.5 Readiness and transition assurance

Readiness will be considered across the full set of governance, financial, contractual, workforce and delivery arrangements.

This will include consideration of whether:

- the required approvals have been obtained;
- decision-making and escalation routes are clear;
- necessary contracts, schedules and Terms of Reference are in place;
- workforce and host arrangements are ready;
- financial controls and reporting arrangements are established;
- statutory and organisational responsibilities remain protected;
- enabling support and service interfaces are understood;
- staff and partners have received appropriate communication;
- transitional risks and dependencies are being managed; and
- service continuity and safe operation can be maintained.

Where an element is not ready to transition, the appropriate existing or interim arrangement will remain in place until the required conditions have been met.

7.6 Learning, evaluation and ongoing development

The document suite provides the framework for implementation, but effective Place working will continue to

develop through experience and learning.

Operation of the arrangements will provide an opportunity to test:

- whether decision-making routes are sufficiently clear;
- whether partners and communities have meaningful influence;
- whether assurance is proportionate and adds value;
- whether Places can access the required enabling support;
- whether hosting arrangements protect the Place resource and support delivery;
- whether the Outcomes Framework provides a balanced and useful picture of progress;
- whether the Place Fund arrangements provide appropriate transparency and control; and
- whether the balance between Greater Manchester consistency and local flexibility is working as intended.

Learning will be considered through the relevant Place and Greater Manchester governance routes. Material issues may lead to clarification, supporting guidance, changes to implementation arrangements or formal amendments where the appropriate approvals are obtained.

The Place Outcomes Framework will be reviewed periodically to reflect developing neighbourhood measures, data availability, evidence and delivery priorities. Any wider development of the Place Fund, delegations or pooled arrangements will be treated as a separate proposition and will require appropriate engagement, assessment and approval.

7.7 Maintaining transparency

The Outcome Report, summary slide pack and final document suite together provide a transparent account of the engagement and its outcomes.

The Outcome Report explains the principal themes and resulting changes. The summary slide pack provides a concise briefing, while the final document suite sets out the arrangements themselves.

These products will support continued communication with the organisations, partnerships, staff and communities involved as the arrangements move into mobilisation and implementation.

8. Conclusion

The engagement generated detailed and constructive feedback from across the Greater Manchester health and care system. Contributors supported the importance of effective Place partnership working while asking for clearer accountability, more meaningful participation, stronger safeguards and greater practical detail.

The review has resulted in a more coherent and appropriately bounded document suite. The final arrangements provide greater clarity about collective partnership working, retained organisational responsibilities, financial authority, outcomes, hosting, workforce arrangements, assurance and local flexibility.

Not every issue can or should be resolved through a single common document. Some matters remain subject to local determination, formal workforce processes, contractual arrangements, organisational approvals or future development. The suite now makes these boundaries clearer and provides the framework within which the remaining work will be completed.

The next phase is to translate the agreed framework into safe, practical and locally effective arrangements. This will require coordinated approval, mobilisation and transition activity, supported by clear communication, appropriate assurance and continued partnership working.

The resulting framework provides a stronger foundation for Place Partnerships to work collectively around local priorities, improve outcomes, reduce inequalities and support coordinated health and care for the people and communities of Greater Manchester.

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Greater Manchester

Place Health and Care Partnership Document Suite

Summary Slides

Part of Greater Manchester Integrated Care Partnership

About This Document and Contents

NHS Greater Manchester

This summary explains how the coordinated Place Health and Care Partnership document suite turns the Greater Manchester operating model into practical arrangements for Place partnerships, teams, host employers and local authority partners. Together, the documents define shared purpose, outcomes, resources, decision-making, hosting, transfer and accountability.

1 **Executive Summary and Introduction:** Summarises how PHCPs enable Greater Manchester to deliver reform through prevention, neighbourhood care and system-wide collaboration.

2 **Partnership Agreement:** Sets the shared intent, principles, governance and mutual accountability for how Place partners work together.

3 **Place Outcomes Framework:** Defines the outcomes PHCPs seek to improve and the shared basis for measuring progress and collective assurance.

4 **Place Fund:** Sets out the 2026/27 Better Care Fund scope, financial stewardship, accountability and decision-making arrangements.

5 **Place Team and Hosting Arrangements** Defines the Place Delivery & Integration Service, the wider multidisciplinary Place Team and the arrangements that support workforce integration and neighbourhood working.

6 **Governance, Accountability, Oversight and Assurance Framework:** Sets the common three-layer architecture, retained accountabilities and approach to Place assurance and improvement.

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Executive Summary and Introduction

Foreword

Greater Manchester has long been at the forefront of health and care integration, and this Place Health and Care Partnerships (PHCP) document pack represents the next deliberate step in that journey. Together, the Place Agreement, Outcomes Framework, Place Funding, Place Team and Hosting Arrangements document and Governance, Accountability, Oversight and Assurance Framework describe how we will continue to lead through reform, respond to national policy change, and deliver locally for the people and communities we serve.

This pack builds on previous work to define and develop our operating model, which is fundamentally our local response to the Integrated Care Board (ICB) model blueprint. It describes how we will maintain what is distinctive and successful about the Greater Manchester way of working while adapting confidently to NHS reforms, the 10-Year Health Plan, and future national direction. It provides clarity and stability at a time of change, ensuring we remain focused on delivery, outcomes and collaboration.

At their core, the PHCPs will be key vehicles through which our city region will deliver shifts described in the 10 Year Health Plan:

- from treatment to prevention,
- from hospital to community, and
- from analogue to digital

By strengthening leadership at Place, aligning strategy and resources at Greater Manchester level, and setting out clear expectations for how these interact, the model creates the conditions for prevention-led, neighbourhood-based and population-focused approaches to flourish.

This document pack is also intentionally designed to enable future models of care and development set out in national policy, including neighbourhood health and the emergence of Integrated Health Organisations (IHOs). At the same time, it is closely aligned with wider local policy ambitions, particularly with elements of the Greater Manchester Strategy and the Live Well agenda. Place Partnerships sit in the middle of these agendas, acting as the point where NHS, local authority, VCSE and community leadership come together to translate strategy into real change on the ground.

This document pack has been developed to bring clarity to the reciprocal relationship between the Place Health and Care Partnerships, the ICB, and Greater Manchester–wide functions. PHCPs are empowered to lead local delivery, shaped by deep community insight and strong local relationships. GM-wide teams focus on strategy, resource allocation, specialist expertise and system stewardship, ensuring equity, consistency and scale across all ten Places. Together, they continue to operate as a single system through a shared strategic commissioning cycle.

This clarity also extends to the neighbourhood layer and the future direction of travel, including IHOs. The PHCPs provide the scaffolding to support neighbourhoods as the engine room for integration, while ensuring they are connected to Place and GM priorities. This creates the flexibility needed to test, grow and embed new models of care over time without losing coherence or accountability.

Colleagues from across Places, GM teams and portfolios have shaped these documents collaboratively through design groups, feedback and iterative discussion. That approach has allowed us to build on what already works well, address where arrangements have been unclear or challenging, and ground the model in real operational experience. The result is a framework that is both strategic and practical.

Taken together, the PHCP document pack is both a statement of intent and a tool for delivery. It reinforces our shared vision, supports integrated working at every level, and provides a stable platform from which Greater Manchester can continue to lead nationally as we work together locally, collaboratively and in service of developing our thriving city region where everyone can live a good life.

Professor Colin Scales
Acting Chief Executive
NHS Greater Manchester

Alison Mckenzie-Folan
Chief Executive of Wigan Council
Place Lead for Health and Care Integration

Integrated working between our Place Partnerships and Strategic Commissioning teams is at the heart of our new model

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System Convenor – to enable delivery of the ICP strategy

Improving Population Health Outcomes / Reducing Inequalities / Social & Economic Development / Statutory Accountabilities / Constitutional Standards / System Resilience

Strategic Commissioner

Needs Assessment & Outcomes Setting

- In-depth population analysis
- Analysis of resource utilisation (finance)
- Clinical-led evidence on opportunity
- Health economics (Public Health)

Strategy and Planning

- NHS GM / ICP / GMCA partnership priorities
- Assessment of national policy and local analysis (Planning)
- Setting system strategic ambition and place expectations.
- Setting clinical and professional commissioning policy for the system (Clinical)
- Setting financial policy rules (Finance)
- Strategic resource allocation (Finance)
- Operational planning (Planning)
- Agree transformation priorities based on constitutional standards
- Strategic digital leadership and development

Contracting & Evaluating Impact of System

- Manage market rules and core NHS contracts
- Assure delivery at place, provider, system groups
- Quality improvement

Clear Accountability and Trust

Ten Integrated Place Partnerships

Local Insight-led Planning

Develop priorities and plans to address:

- Agreed strategic goals and outcomes
- Utilising value based analytical capability
- JSNA, in-depth population analysis & community insight (BI / Planning / Insight)

Integrated Delivery at Place

- Engage partners, clinicians and communities in designing solutions to deliver priorities.
- Integrated Neighbourhood Health - work with partners to create neighbourhood health model
- Drive benefits realisation (Planning)
- Demand management
- Supporting the system wide Live Well model
- Population Health
- Co-design with communities
- Single view of allocation of place allocation

Aligning Partnership Incentives & Resource

- Coordinate the resources across pathways and partners to achieve shared outcomes.
- Support the development / strengthening of provider partnerships.

Enablers: portfolio/s to encompass all of these functions

Clinical & Professional Leadership	Communications & Engagement	Corporate & Clinical Governance	Digital & DII	EDI	Finance	People & Culture	Programme Management	Quality & Safety (Experience)

Our Place Health and Care Partnerships will be guided by eight key principles

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Taken together, these principles will ensure that Place Partnerships can consistently maximise their contribution to health and care outcomes for their population, as well as working effectively with GM-wide teams.

1. We have a clear view – consistent across GM – of the functions to be discharged through Place Partnerships.
2. The discipline of population health improvement must be the goal of all ten places and their strategies and plans must articulate how they will achieve this. This includes recognising cultural, social and economic factors and their impact on health.
3. Each Place Partnership will deliver core features of a neighbourhood health model (Live Well), where primary and community services will be central to multi-agency teams working to deliver services and support closer to people's homes.
4. Each Place Partnership has a workforce united in improving health, wellbeing, and independence for all, and striving to be representative of the communities it serves.
5. Every Partnership has a clear line of sight to the total Place spend on health and care, understands what aspects of that are influenceable, and has clarity about what spend the Place Partnership is directly charged with control of.
6. Strengthened accountability for all ten Place Partnerships between partners.
7. Place Partnerships will measure success by ensuring equitable access, experience, and outcomes, not just outputs.
8. We will use the reform agenda to set a new course, re-balancing power and leveraging community strengths, with Place Partnerships at the forefront of involving citizens.

Our ten Place Partnerships will convene the full spectrum of health and care resources around six key activities

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1 Improve population health, wellbeing & tackle inequalities,	2 Integrating services	3 Delivering care	4 Delivering the 10 year plan	5 Coordinating financial spend	6 Driving partnerships
Maximising the opportunities of Live Well through a community-first and community-involved mindset, helping people to take responsibility for their own health, connecting to wider public service reform and neighbourhood working.	Integrate services across NHS, local government, VCFSE and wider public service at strategic at place and neighbourhood levels.	Deliver proactive, equitable, accessible, high quality and person-centered care using population health management to tailor approaches, recognising each partner's full range of statutory duties.	Shift from reactive support to prevention and early intervention, hospital to community and analogue to digital, reducing need, promoting independence and avoiding escalation.	View and track total health and care spend, enabling joint delivery and the use of pooled/aligned budgets to optimise impact.	Drive effective multi-professional, partnership working through shared strategy, integrated delivery models, collaborative leadership, and an inclusive and supportive culture.

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Introducing the PHCP Document Suite

How the core operating-model documents work together

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Partnership Agreement

The principal partnership framework: purpose, membership, outcomes, decision architecture, accountabilities and relationships between partners and NHS Greater Manchester.

Place Fund

For 2026/27, comprises agreed Better Care Fund services operating through existing Section 75 and BCF arrangements.

Supports joint oversight and influence; it is not a delegated budget.

Place Outcomes Framework

Defines the outcomes the partnership is collectively seeking to improve.

Provides the organising framework for evidence, Place assurance and improvement.

Place Delivery & Integration Service

Dedicated hosted capacity supporting the Partnership and neighbourhood delivery.

Forms part of the wider multidisciplinary Place Team.

Place sets priorities; NHS GM commissions and funds; the host remains employer.

Governance, Accountability, Oversight & Assurance

Links partnership governance, resources and hosting, and assurance of outcomes.

Sets a consistent GM core with local flexibility.

Recognises statutory, financial, contractual, quality and employment accountabilities.

Logic Model - Place Delivery

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Inputs

Governance inputs:

- Partnership Agreement
- Place Fund
- Place Team
- Place Governance

Investments into:

- Place Delivery & Integration Service
- Place Grants
- Neighbourhood services through contracts

Key Activities

Activity in Live Well Centres and Spaces

Primary Care activity

Integrated Neighbourhood Team Activity

Demand Management Initiatives

Community Services Activity and Access

Metrics and Outcomes

Outcomes: longer term impact measures, consistent across the 10 places with varying levels of ambition based on starting point

Delivery Measures: Uniform across the 10 localities

Place Specific

Supported by measures to show demand reduction and cost avoidance

Contributing to GM Strategy

NHS Strategic Commissioning Plan Overarching Goal
People in Greater Manchester Live in good health for longer, and we reduce the gap in healthy life years between our communities

Helping achieve the Greater Manchester Vision:
A thriving city region where everyone can live a good life

Leading to Change in Place and System

- **Shift in Spend to Prevention**
- **Shift in Care Delivery to Neighbourhood**
- **Shift to Shared Leadership and Co-Owned Delivery with Partners**
- **Shift in Power to Communities**

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Partnership Agreement

Part of Greater Manchester
Integrated Care Partnership

Partnership Agreement

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- Acts as the **overarching agreement** for the PHCP document suite
- Sets the **shared intent and principles** for Place Partnership working
- Provides **a stable, common foundation** for collaboration across the system
- Aligns partners to **collective action that adds value beyond single organisations**
- Is a formal document but **does not create a legal entity** or alter statutory accountability
- Is the **primary document for formal place sign-off**

Partnership Agreement: Structure by section

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1 **Purpose, Parties and agreement status**
Defines why the Place Health and Care Partnership exists, who is involved, and how Partners will work together under clear principles while retaining their statutory independence.

2 **Commencement and Term**
Explains when the Agreement starts and ends, and how it will be reviewed, updated and kept relevant as national policy, GM arrangements and local priorities evolve.

3 **Shared Vision, Purpose and Strategic Context**
Sets a shared vision and purpose for Place, aligning local priorities with Greater Manchester's wider health and care ambitions.

4 **Strategic Priorities and Outcomes Framework**
Sets out the Place's agreed strategic priorities and establishes the Place Outcomes Framework as the main tool for measuring progress and accountability.

5 **System Characteristics, Leadership and Culture**
Describes the leadership behaviours, culture and ways of working that enable Partners to act as one system while remaining sovereign organisations.

6 **Roles, Responsibilities and Collective Capability**
Clarifies shared and individual responsibilities and explains how Partners will combine resources, skills and capacity to deliver outcomes effectively.

7 **Place Funding**
Defines how Partners will align and steward financial resources through a shared Place Funding Framework focused on outcomes, prevention and neighbourhood delivery.

8 **Governance and Decision Making**
Sets out the governance structure, decision making principles and accountability arrangements for Place Partnerships.

9 **Transparency, Information and Learning**
Commits Partners to open information sharing, lawful data use and continuous system learning to support effective decision-making and improvement.

10 **Clinical Strategy**
Explains how clinical leadership, quality, safety and medicines optimisation at Place align with NHS Greater Manchester clinical governance and strategy.

11 **Problem Resolution and Escalation**
Provides a clear, proportionate process for resolving disagreements and escalating issues while protecting relationships and continuity of services.

12 **Review, Variation and Evolution**
Confirms the Agreement as a living document, setting out how it will be reviewed, amended and evolved over time through collective stewardship.

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Place Outcomes Framework

Part of Greater Manchester
Integrated Care Partnership

Place Outcomes Framework

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Defines **what success looks like** for the Place Health and Care Partnership

Provides a **shared basis for collective accountability** for health, wellbeing and equity

Translates ambition into **agreed measures and clear outcomes**

Guides **decision-making, prioritisation and investment** across partners

Focuses on **impact rather than activity**, with transparent tracking of progress

Place Outcomes Framework – Linking delivery measures to outcomes

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Outcome 1
Keeping people healthy and preventing ill health

Outcome 2
Providing care in the right place and implementing neighbourhood health and care

Outcome 3
Supporting staff wellbeing and retention

Outcome 4
Integration and collaborating across health, care and wider public services.

- Common place priorities
- Measured quarterly
- Focused (not exhaustive) outcomes framework aligned to national and GM goals.

Uniform across all 10 PHCPs

Delivery measures

PHCP Specific

- PHCP delivery measures showing how each Place implements neighbourhood plans,
- Tracked at least quarterly,
- Aligned where needed to national and GM priorities and monitored at neighbourhood level over time.

Outcomes Framework composition

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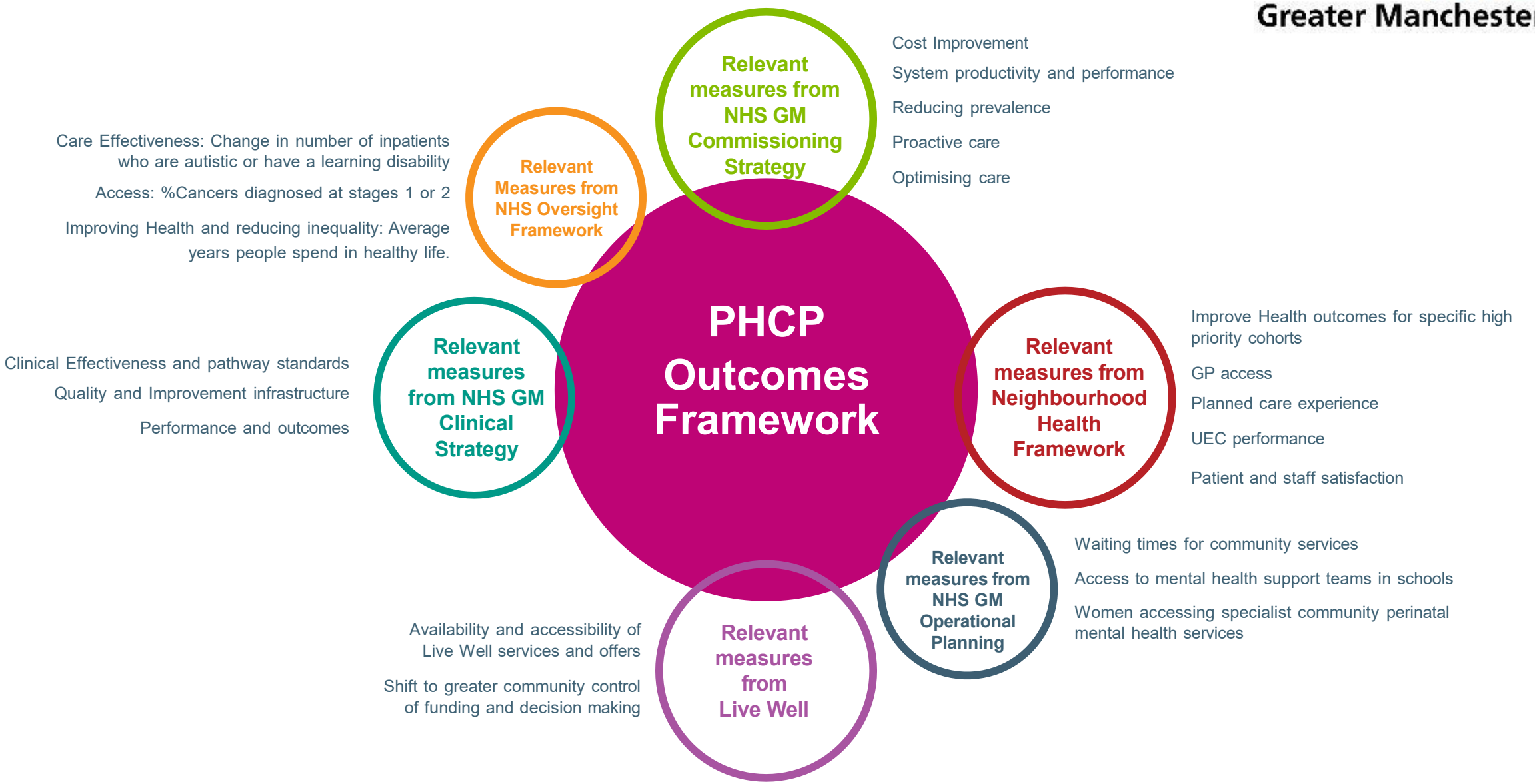

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Place Fund

Place Fund

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Agreed BCF services only. This is the Place Fund scope for 2026/27.

Existing legal mechanism. The Fund operates through Section 75 and Better Care Fund arrangements.

Not a delegated budget. The Place Partnership Board has joint oversight and influence, not delegated financial authority.

Authorised decisions. Formal decisions remain with the relevant ICB or local authority decision-maker.

Wider spend stays outside. Aligned expenditure may inform the Place picture but remains under its existing governance.

Shadow year, no formal change. 2026/27 supports learning and stronger controls; it does not set a future delegation timetable.

Future additions need approval. Scope, funding, decision rights, impacts, governance and transaction routes must be agreed first.

The Place Fund supports collective stewardship while preserving the statutory, financial and contractual accountability of the organisations that hold and transact funding.

What is included in the Place Fund?

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2026/27 Place Fund – agreed scope

Agreed Better Care Fund services only.
Established and transacted through existing Section 75 and BCF arrangements.

- Not a delegated budget; the Partnership Board provides joint oversight and influence.
- Formal decisions remain with authorised ICB or local authority decision-makers.

Aligned expenditure – outside the Fund

Wider place-relevant spend may inform the overall financial picture but is not part of the 2026/27 Place Fund.
It remains subject to the relevant organisation's governance and accountability.

- Current exclusions include, for example core primary care, continuing healthcare, children's social care and specified mental health services.

Potential future additions

Any proposal from 2027/28 is subject to separate design, stakeholder agreement and formal approval.

Before inclusion it must define:

- Scope, funding flows and decision rights
- Financial impacts, with transition arrangements
- Governance, assurance and the transaction mechanism

Future change is not pre-authorised: timing, scale and destination require separate assessment and approval, without destabilising existing services.

Place Fund: How this works in 2026/27

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2026/27: Shadow Year for the Place Fund

The agreed BCF services operate through existing Section 75 and Better Care Fund arrangements.

“Shadow year” does not confer delegated financial authority.

The Partnership Board shapes priorities and recommendations; formal decisions remain with authorised ICB or local authority decision-makers.

Financial information, approvals, actions and escalations must provide a clear, auditable trail.

Wider aligned expenditure remains outside the Fund and under existing organisational governance.

Learning and Development In-Year

During 2026/27 partners may use learning to:

Confirm the operating arrangements, governance and controls for the agreed BCF scope

Develop and test neighbourhood investment, left-shift and risk/gain-share approaches

Strengthen reporting, assurance and record keeping

No future delegation or launch date is committed; any later model requires separate agreement and approval.

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Place Team

including Place Delivery & Integration Service (providing dedicated hosted capacity for delivery, integration, improvement, performance, risk and assurance).

The Place Delivery and Integration Service forms part of the wider multidisciplinary Place Team: Place governance sets priorities, NHS GM commissions and funds the service, and the NHS host remains the employer.

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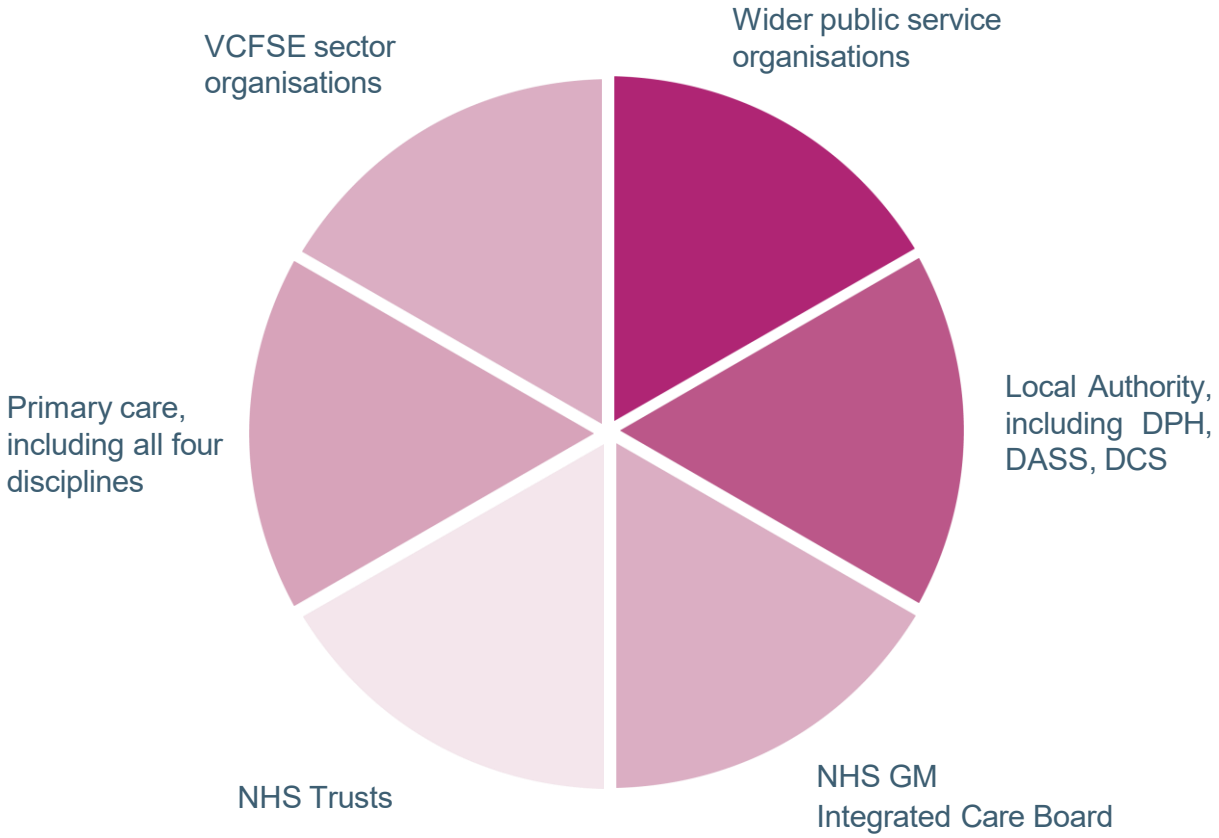

Creating success through:

1. System Leadership and Alignment
2. Frontline service integration and transformation
3. Place planning and resource allocation
4. Data, Intelligence and Improvement
5. Shared vision, goals and priorities
6. Collaborative Culture
7. Citizen and Community voice and co-design
8. Clear governance and accountability
9. Commitment of capacity

NHS GM contributes to the Place Team through leadership aligned to national policy, with specific investment in people and leadership roles to enable and drive integration, tailored to the local place context.

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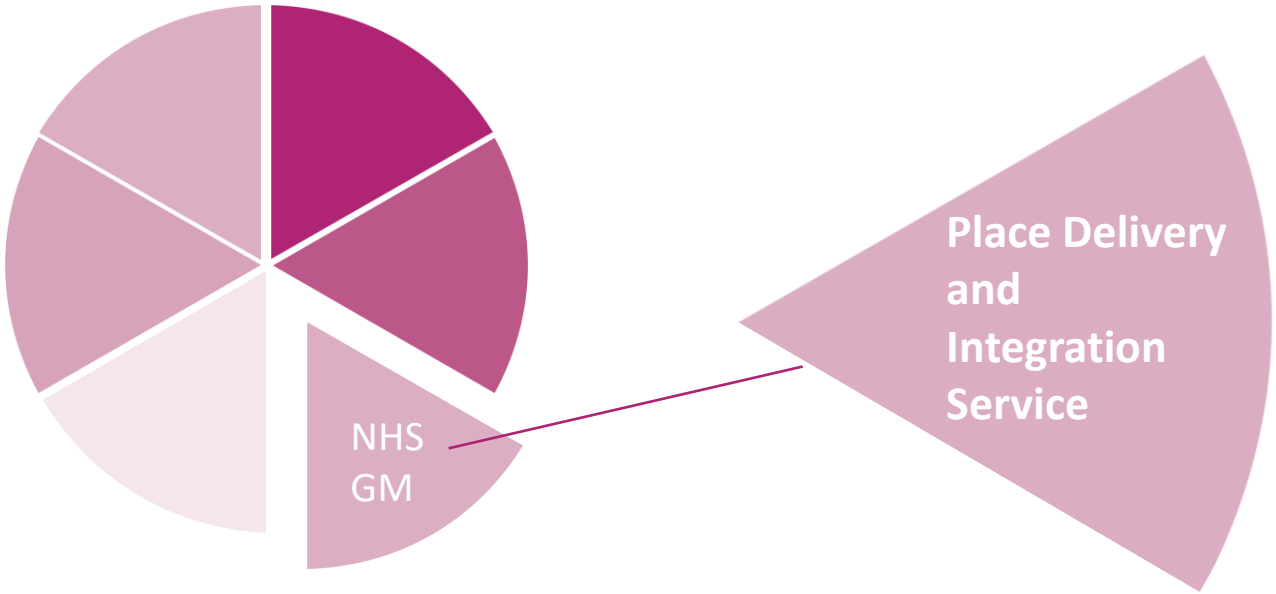
NHS GM contributes alongside all partners

1. Setting Strategic direction
2. Providing population health intelligence
3. Allocating resources
4. Enabling provider collaboration
5. Strengthening cross- sector partnerships
6. Leading system governance
7. Evaluating impact

Components of the NHS GM Model Place Team



- Place Leadership & Integration
- Live Well & Neighbourhood health and care
- Pathway development & demand management
- Place governance and administration
- Clinical and care leadership

Setting up Place teams will be informed by context in each place rather than a one-size-fits-all.

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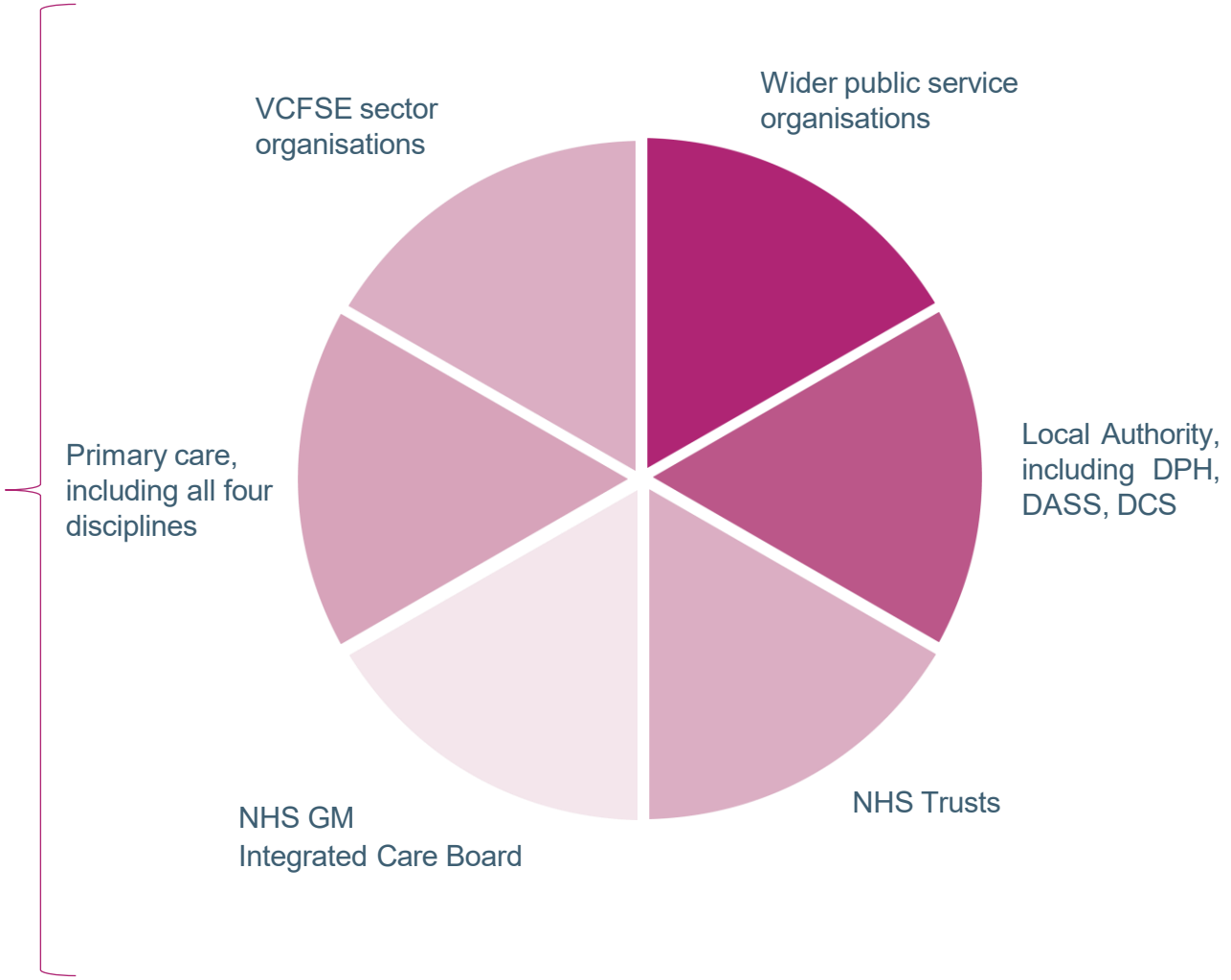
A series of potential scenarios is featured below:

Model	Scenario Summary
Fully Integrated	A single, fully integrated Place Team hosted and line-managed by one organisation, with staff from all partners collectively accountable to the Place Lead and Place Partnership, enabling clear ownership, strong leadership and rapid, joined-up delivery.
Hybrid	A core, hosted and line-managed Place Team provides coordination and continuity, while additional partner capacity is contributed through matrix working, balancing integration with flexibility and reducing risk for partners.
Dispersed	Staff remain fully employed and line-managed within their own organisations, working together through a matrix arrangement aligned to place objectives, preserving organisational autonomy while relying on strong leadership alignment and governance.
Fluid	Partners “offer in” time-limited staff capacity against agreed priorities and programmes, retaining employment and management arrangements, allowing high flexibility, targeted use of specialist skills, and early mobilisation with minimal structural change.



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Governance

Governance, Accountability, Oversight and Assurance Framework

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- The framework links three layers: partnership governance; resources and hosting; and accountability, oversight and assurance of outcomes.
- It establishes a consistent Greater Manchester core with local flexibility while preserving each organisation's retained statutory and contractual responsibilities.

Element	Arrangement	Governance
Outcomes & assurance	Place Outcomes Framework	Partnership Board owns the collective Place assurance position
Place Fund	2026/27 agreed BCF scope Operates through existing Section 75 arrangements	Authorised ICB / local authority decisions
Place Delivery & Integration Service	NHS GM commissions and funds NHS Trusts hosts the dedicated service Wider Place Team remains multi-partner	Place oversight; host retains employer duties Retained organisational accountabilities continue

The framework does not itself transfer statutory functions, create a separate legal entity or replace operative agreements. Detailed authority and obligations remain in the Partnership Agreement, Terms of Reference, Section 75 and hosting arrangements.

Layer 3 turns shared outcomes into accountable action

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One governed evidence base drives Place judgement, named action and proportionate escalation - without diluting partners' retained duties.

1 EVIDENCE	2 INTERPRET	3 PLACE JUDGEMENT	4 ACT & RECOVER	5 ESCALATE / CLOSE
Agreed outcomes, neighbourhood intelligence, delivery updates and risks form one governed evidence pack.	Expert review tests trends, inequalities, variation, partner contribution and improvement confidence .	The Partnership Board records assured, partially assured or not assured—and the rationale.	Each action has an owner, deadline and milestones; support or a deep dive is used only where it adds value.	Material issues and themes move through GM and partner routes, with review dates and explicit de-escalation criteria.

ACCOUNTABILITY AND DECISION RIGHTS

- **Partnership Board** owns the collective assurance position for agreed Place outcomes and partner contributions.
- **Place Lead and delivery leads** convene the system and own operational action, improvement and review.
- **Partner organisations** retain statutory, financial, contractual, clinical, quality, safeguarding and employment duties; authority exists only through formal delegation.

REPORTING AND RECENT ACTIVITY

- **Routine reporting** quarterly review using one Place narrative: outcomes, inequalities, risks, actions and confidence.
- **Open design** metrics/data owners/thresholds, expert-review cadence and the detailed GM reporting route.

Place Partnerships Mobilisation Swimlanes

Employment, contractual and governance milestones | September 2026 to 1 April 2027

Programme activity / preparation	Provisional / decision required	Confirmed / stated milestone	Risk / adverse consequence

Swimlane	Sep 2026	Oct 2026	Nov 2026	Dec 2026	Jan 2027	Feb 2027	Mar 2027	1 Apr 2027
EMPLOYMENT	Confirm host-employer model scope, transfer dependencies and required legal, organisational, tax and VAT review.	Develop transfer arrangements, hosted-service contract and accountability provisions.	Confirm intended employment transfer timing and alignment with governance changes. Latest date for start of consultation for Jan 1st Transfer	Prepare workforce transition arrangements and identify delegation or voting impacts.	Any pre-April transfer must preserve NHS GM governance legitimacy. Review Locality Board membership, quorum and NHS GM representation requirements before implementation. Interim arrangements may be required where PPDs transfer before governance changes take effect.	Complete consultation, approvals and mobilisation required by the agreed transfer approach. Latest date for start of consultation for Apr 1st Transfer	Alternative transfer 31 March/1 April. PROVISIONAL. This would align employment change with formal go-live.	Place Teams operate through agreed Foundation Trust host-employer and hosted-service arrangements.
CONTRACTUAL	Confirm scope of Place Fund and hosting arrangements, including relationship with existing BCF Section 75 agreements.	BCF Phase 1: review agreements, map Locality Board responsibilities and obtain initial legal advice.	Agree amendment scope and future governance model. Map Local Authority and ICB approval routes.	BCF Phase 2: draft revised Section 75 agreement, governance schedules and financial schedules.	Complete legally reviewed first draft. Develop Place Fund transaction and host-governance arrangements. Confirm whether specific BCF / Section 75 governance requirements require continued formal governance arrangements beyond Place Partnership Board recommendations. (Jan to Feb)	Complete partner engagement, resolve material issues and finalise legal amendments. Agreement ready for approval.	Secure Place Partnership, Local Authority and ICB approvals. Execute revised Section 75 agreements.	Revised BCF / Section 75 and Place Fund arrangements go live. Formal transactions follow host governance.
GOVERNANCE	Finalise the three-layer framework, minimum governance expectations, accountability and assurance products.	Map Locality Board responsibilities, governance gaps, schemes of delegation and transition controls.	NHS GM decision on future Place Partnership governance. Confirm shadow and formal implementation model.	Prepare revised terms of reference, governance documents, delegations, assurance routes and transition plan.	Place Partnership Boards operate in shadow form from January to March 2027. Locality Boards remain formally constituted NHS GM sub-committees until 31 March 2027 to maintain BCF / Section 75 governance and audit assurance. Review Locality Board Terms of Reference, quorum requirements and NHS GM membership implications arising from workforce transfers (Jan - Feb) Develop and agree future BCF and Place Fund governance arrangements, including assurance, decision-making and transaction routes required from 1 April 2027 (Jan - Mar)	Progress Local Authority approval routes. Test reporting, assurance, escalation and decision interfaces.	Complete terms of reference, schemes of delegation and replacement arrangements for Locality Board functions.	Place Partnership Boards and new Place governance become formally operational.

BURY INTEGRATED CARE PARTNERSHIP

Meeting: Locality Board			
Meeting Date	05 October 2026	Action	Receive
Item No.	7	Confidential	No
Title	Neighbourhood Working / Locality Estates Development Update		
Presented By	Clare Postlethwaite		
Author	Clare Postlethwaite		
Clinical Lead	Cathy Fines		

Executive Summary

It is recognised that the ageing estate across many parts of the locality risks being an obstacle to service change and expansion. The ability of the estates solution to sufficiently respond to service need is particular challenging due to the economic and financial constraints that exist both within our locality and across Greater Manchester more widely.

The Locality Board was last updated in October 2025 and over recent months, significant work has been progressed to ensure that, despite financial and economic constraints, the locality estate plans are sufficiently developed to ensure that the local estates solution continues to be a key enabler to the delivery of service and place-based change within the borough.

Recognising the current financial climate across all areas of public service, recent work has focused on the ability of innovative work at partnership level to ensure that focused estates solutions can still be found. The focus of the work remains to ensure that the estate enables neighbourhood working and also provides the accommodation necessary to enable left-shift service discussions.

This report provides an update of key estates development work over recent months and also aims to articulate the priority areas moving forward for the locality.

This report also outlines the importance of the estate in the delivery of the neighbourhood working proposals across Bury.

This report also provides a specific update on some assets identified as tail estate to ensure that the Board is updated on the current position.

Recommendations

To note the content of the report and in particular the key role of partnership working in continuing to strive for aspirational and innovative estates solution across the locality.

To note the importance of estate as an enabler to establishment strong neighbourhood working arrangements in each borough.

To note in particular the progress made in a number of areas and also the updated position with regard to some tail assets within the locality.

BURY INTEGRATED CARE PARTNERSHIP

To note the continued focus of the partnerships established in Bury to continue to strive for a locality estate that enables service change across the borough.

OUTCOME REQUIRED *(Please Indicate)*	**Approval** ☒	**Assurance** ☐	**Discussion** ☐	**Information** ☐
APPROVAL ONLY; (please indicate) whether this is required from the pooled (S75) budget or non-pooled budget	**Pooled Budget** ☐	**Non-Pooled Budget** ☒		

Links to Locality Plan outcomes	
To support a local population that is living healthier for longer and where healthy expectancy matches or exceeds the national average by 2025.	☒
To achieve a reduction in inequalities (including health inequality) in Bury, that is greater than the national rate of reduction.	☒
To deliver a local health and social care system that provides high quality services which are financially sustainable and clinically safe.	☒
To ensure that a greater proportion of local people are playing an active role in managing their own health and supporting those around them.	☒

Implications						
Are the risks already included on the Locality Risk Register?	Yes	☒	No	☐	N/A	☐
Are there any risks of 15 and above that need to be considered for escalation via an NHS GM Statutory Committee or Board in line with the Risk Escalation process?	Yes	☐	No	☒	N/A	☐
Are there any quality, safeguarding or patient experience implications?	Yes	☒	No	☐	N/A	☐
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☒	No	☐	N/A	☐
Have any departments/organisations who will be affected been consulted?	Yes	☒	No	☐	N/A	☐
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☒	N/A	☐
Are there any financial Implications?	Yes	☒	No	☐	N/A	☐

BURY INTEGRATED CARE PARTNERSHIP

Implications						
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☒	No	☐	N/A	☐
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☒	N/A	☐
If yes, please give details below: Will be progressed as necessary on a scheme specific basis.						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☒	N/A	☐

Governance and Reporting		
Meeting	**Date**	**Outcome**
Bury Locality Board	05/10/2026	

BURY INTEGRATED CARE PARTNERSHIP

Neighbourhood Working / Locality Estates Development Update

1. Introduction

1.1. It is recognised that the current state of many areas of the local estates infrastructure within Bury risk being a limiting factor in the delivery of service change across the borough. In particular, reconfigured estate in all boroughs remains absolutely key to enabling neighbourhood working proposals across Bury,

1.2. This report outlines key areas of development work in relation to local estates solutions that are being developed in partnership with key partners in order to ensure that there is a continuous drive for responsive and fit for purpose estate across Bury.

1.3. In particular, this report outlines significant progress in a number of areas across Bury that allows us to move towards an estate that can respond and support service transformation across the borough.

1.4. The report also provides specific updates with regard to specific assets labelled as tail estate.

2. Background

2.1. Whilst aging estate remains a limiting factor to service delivery and aspirational change, it is recognised that financial and commercial pressures across all public sector partners risks constraining the strategic ambition within estates plans across the borough.

2.2. Local estates planning is further complicated by health funding structures which often mean that the impact of backlog maintenance issues are not funded at a local level hence, are not easy to demonstrate as a basis of required change and estates solution. Currently, it is also the case that many of the estate solutions needed require budget support from areas no longer delegated to locality control hence, detailed prioritisation and assessment at a Greater Manchester level is required.

2.3. Accepting that financial constraints may delay progress in some areas, over recent months close partnership working and collaborative discussions have continued in order to find innovate and low-cost solutions to ensure responsive estates solutions can still be achieved.

2.4. It is clear from progress being made across the borough, that the strength of partnership working within Bury enables pragmatic estates solutions to be reached, even in the face of challenging economic conditions both nationally and locally.

3. Key Areas of Estates Development Planning

3.1 The key driver for estate project prioritisation across Greater Manchester remains the outputs of the PCN estates toolkit project. This project was a nationally driven initiative, supported by Community Health Partnerships, that involved detailed work at Primary Care Network (PCN) level to understand current pressures alongside longer term clinical plans within each area. The output projects resulting from this PCN level work were then scored and ranked at a locality level.

3.2 Alongside the data and project listings included within the PCN estates project toolkit, over recent months this work has been refined to ensure an ongoing focus on both the national Neighbourhood Health Centre programme and also local aspirations and targets relating to the Greater Manchester Live Well initiative.

3.3 The focus within the locality, since the last update to the Locality Board, has remained securing a

BURY INTEGRATED CARE PARTNERSHIP

solution for the two major priority schemes identified by the toolkit (Uplands proposal (Whitefield) and the Prestwich community hub regeneration proposal) alongside keeping pace with emerging need across our borough.

3.4 Strategic estates work over the past twelve months has also focused on defining a solution in each borough of Bury that enables the Integrated Team in each borough to be based within the locality in which they work. This work is now well developed with the strategic direction in each borough of Bury now better understood, namely :-

East Bury – solution focused around existing estate, potentially New Kershaw Centre.
North Bury – solution focused around Tottington and Ramsbottom health centres and Ramsbottom library linking to wider regeneration proposals eithin the town centre. Plus outreach provision in some areas of borough.
Whitefield – establishment of Live Well Centre, Whitefield,
West Bury – solution working across Radcliffe Hub and Radcliffe Primary Care Centre.
Prestwich – Prestwich Health Centre solution, linked to wider regeneration of Town Centre.

3.5 Recognising the need for a joined-up response to future development residential proposals, as a locality, collaborative work continues to ensure that the Health and Wellbeing Strategic Planning Document is inclusive and ensures that health infrastructure need is fully considered in response to any planning submission. Work continues in this regard locally with ongoing advisory support from the national NHS Property Services planning team, with outputs to date recognised as setting a precedent for good practice in strategic planning across Greater Manchester.

4 Associated Project Developments

4.1 The identified site of the Uplands Project redevelopment (Whitefield) was purchased by NHS Property Services in July 2025, with a planning consent achieved in July 2026 - alongside a related tender process for the construction contract for this scheme. After many months of work on the current scheme, in August 2026 confirmation from NHS England was received to approve the additional funds required to progress this project. On this basis, a contract award has now been made with a start on site being planned towards the end of November 2026/early December 2026 (subject to the necessary pre-planning conditions being met.) Tenders received estimate a construction period of circa ten months hence, a new facility is now expected to be ready for occupation around September/October 2027.

4.2 Detailed discussions continue to secure a solution in Prestwich, whilst aspirations to achieve a joint service solution for Prestwich remain – currently a solution on the existing health centre site may offer the most deliverable solution hence, the site has been reclassified as core estate to aid in discussions to this regard. Since the last update to the Locality Board, Prestwich has been identified by NHS Greater Manchester as a key strategic scheme noted with strategic capital allocated to the scheme on this basis. This securing of capital funds has enabled more specific and advanced discussions to be progressed by locality partners and NHS Propoerty Services to identify the most appropriate and achievable solution for this site.

4.3 Bury was successful in securing funds for a number of Utilisation and Modernisation Fund (UMF) schemes across Bury GP practices – a national release of capital grant funds to deliver additional clinical capacity within GP primary care estate. The locality had 5 schemes approved with total funds secured of circa £227k via the first round of funds allocated – work on all of these schemes has now been completed. The second round of funding secured an additional £462k against 3 identified schemes within Bury and work is now progressing to support the practices involved to deliver these schemes. It is important to note that to date, all UMF schemes submitted by practices within the borough have been successful in securing the funds required. Of the initial 5 schemes progressed,

BURY INTEGRATED CARE PARTNERSHIP

one practice is yet to have the required funds released due to some queries over the timing of the works undertaken, the locality continues to support a formal appeals process to attempt to ensure that the funds committed are released in full to the practice involved.

4.4 Radcliffe Primary Care Centre is the only LIFT asset within the Bury estate and work has been ongoing to ensure better utilisation of the building to ensure a service offer in line with the requirements of the local population and also fully in line with the Live Well aspirations for the borough. In particular, significant work in partnership with the corporate collections and support team has enabled a refocused reception provision at the centre that enables full-service integration – the aim being to allow all residents access to a full range of support services in one place. In May 2026, a visit to the site of the Chief Executive of Community Health Partnerships was convened to showcase the commitment of all Bury partners to an innovative and forward thinking service offer – discussions that followed were successful in securing £2.74m for the site via the Neighbourhood Health Centre programme, with this being the only Greater Manchester scheme to have secured funds in the first round of issue. The scheme has now been recognised as an exemplar for joint service working and has been confirmed as a fast-track delivery project on this basis, with a target financial close of March 2027. The capital funds secured will enable conversion of the disused single chair dental suite (no longer compliant for dental service delivery) alongside a redesign of the reception atrium space to enable a true integrated service offer.

4.5 Noting the success of the service integration at Radcliffe Primary Care Centre, work continues in partnership with the corporate collections and support team to achieve a similar model of joint service delivery across other sites in Bury.

4.6 The framework for an integrated care team base in each borough of Bury has now been agreed in principle, subject to further work to agree the scope and funds available to deliver each element. Due to funds already secured in Radcliffe (NHC national funds) and Whitefield (Live Well delivery funds), the solution in both of these boroughs are now being progressed – noting the opening of the Whitefield Live Well Centre in August 2026.

4.7 NHS partners have worked together with Local Authority colleagues to enable the refurbishment of 'The Ark' and the opening of the Bury Live Well pilot site in Whitefield. This scheme opened in August 2026 with it to be the integrated care team base for this borough.

4.8 Work is now also progressing with key system partners to attempt to achieve a 'Health on the High Street' solution for Bury with this scheme noted by NHS Greater Manchester as a potential future call on Neighbourhood Health Centre funds available.

5 Sunnybank Clinic – Disposal of Tail Estate

5.1 Further to previous Locality Board approval to dispose of this site, once the site had been vacated in full – the site was sold at auction in July 2026.

6 Associated Risks

6.1 Whilst the intent and strength of partnership across the borough continues to ensure innovate and forward-thinking estates solutions to be considered, it is recognised that there remains a risk that financial constraints at a local and also Greater Manchester level create a risk to the ability to deliver proposals as quickly as hoped.

6.2 It is recognised that external factors, such as the planning and contractual tendering process for all schemes, may delay current anticipated completion dates – it is also important to note the new local

BURY INTEGRATED CARE PARTNERSHIP

NHS Greater Manchester guidance with regard to approvals required for additional GP accommodation that will need to be factored into approvals processes for all schemes moving forward.

7 Recommendations

7.1 To note the content of the report and in particular the continued efforts to work in partnership to enable strategic estates change, despite the challenging financial and economic climate.

7.2 To note the continued strength of partnership working across Bury that continues to allow innovative solutions to be achieved in line with local aspirations for neighbourhood working.

8 Actions Required

8.1 The Locally Board is required to:

- Note the progress to date on schemes across the Borough alongside recognising the related risks to delivery.

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Clare Postlethwaite
Associate Programme Director (Bury Locality)
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October 2026

BURY INTEGRATED CARE PARTNERSHIP

Meeting: Locality Board			
Meeting Date	05 October 2026	Action	Receive
Item No.	8	Confidential	No
Title	Chief Officer's Report		
Presented By	Kath Wynne-Jones		
Author	Kath Wynne-Jones		
Clinical Lead	Kiran Patel		

Executive Summary
This paper is intended to provide an update to the Locality Board of progress with the work of the IDC, and progress with the delivery of programmes across the Borough.
Recommendations
The Locality Board are asked to note the report.

OUTCOME REQUIRED *(Please Indicate)*	**Approval** ☐	**Assurance** ☐	**Discussion** ☒	**Information** ☐
APPROVAL ONLY; (please indicate) whether this is required from the pooled (S75) budget or non-pooled budget	**Pooled Budget** ☐	**Non-Pooled Budget** ☐		

Links to Locality Plan priorities	
Scale our work on Population Health Management - Improve population health and reduce health inequality of those in the most disadvantaged areas	☒
Drive prevention, reducing prevalence and proactive care – supporting Demand Reduction through primary intervention, secondary preventions and tertiary prevention	☒
Transforming Community Care in Neighbourhoods - fully realising the benefit of neighbourhood team working with a focus on the assets of residents and communities and providing proactive care	☒
Optimise Care in institutional settings and prioritising the key characteristics of reform.	☒

Implications						
Are the risks already included on the Locality Risk Register?	Yes	☒	No	☐	N/A	☐

BURY INTEGRATED CARE PARTNERSHIP

Implications						
Are there any risks of 15 and above that need to be considered for escalation via an NHS GM Statutory Committee or Board in line with the Risk Escalation process ?	Yes	☒	No	☐	N/A	☐
Are there any quality, safeguarding or patient experience implications?	Yes	☒	No	☐	N/A	☐
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☐	N/A	☐
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☐	N/A	☐
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☐	N/A	☐
Are there any financial Implications?	Yes	☒	No	☐	N/A	☐
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☐
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☐
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☒	N/A	☐

Governance and Reporting		
Meeting	**Date**	**Outcome**
N/A		

BURY INTEGRATED CARE PARTNERSHIP

Bury Integrated Delivery Collaborative Update

1. Context

This report is intended to outline to the Locality Board progress which has been made with the key programmes of work within the IDC.

2. Programme Delivery

- The majority of the new ICB Place Based Partnership Team are now in post. We are now defining the roles and responsibilities across the totality of the resource we have in Place.

- The Locality Plan, the Delivery Plan and the BECCOR plans have now been signed off by the Integrated Delivery and Locality Boards and submitted to GM. We are now gearing up our governance arrangements to assure delivery and reviewing Terms of Reference for all parts of our system

- We are in the process of reviewing our delivery arrangements for our Integrated Neighbourhood Teams. Given the CLM changes at the NCA and statutory requirements of the council, we have needed to relook at the single line management arrangements that are in Place, and in the process of Consultation with teams. However the principle of neighbourhood approach will remain at the heart of everything we do.

- An outline of the 4LP programme of work with the NCA has now been agreed. We are in the process of scoping the content of these programmes.

3. IDC Programme Highlights:

3.1 Frailty and Falls

- Planning for **Falls Prevention Week** (21st - 25th September 2026) **is underway**, supported by local team initiatives, the publishing of 7,000 bespoke fall prevention booklets and working with Public Health to develop a landing page on Falls Prevention for the duration of next week.

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- **The NCA Frailty SDEC and Geriatrician GIRFT report** has been shared. A meeting has been scheduled to review the findings and to look at any improvement opportunities. Key highlights from the report include:
    - Fairfield demonstrates the strongest early assessment and discharge performance across NCA sites.
    - Fairfield has been recognised as having outstanding acute frailty performance.
    - The population aged over 85 is projected to increase by approximately 4% per year over the next 20 years.
    - Admissions of patients aged over 75 have increased by 10% over the last 12 months.

- **Urgent Community Response, the falls and fracture prevention service and MFT** will be attending the GP Webinar on 29-09-26 to promote alternatives to hospital admission by maximising the use of community-based services, offers and update on new pathways.

BURY INTEGRATED CARE PARTNERSHIP

- Phase 2 of the **Geriatrician led Fairfield Care Home Outreach Programme** will begin in October, introducing two monthly MDTs to support GPs with advice and guidance for care home residents at risk of deterioration and hospital admission. Comms will be circulated to all assigned care home GPs in September 2026.

  Discussions have taken place this month with NCA rheumatology colleagues to help shape the emerging **Fracture Liaison Service business case**, ensuring it reflects local needs and existing prevention activity. Primary Care, Community and Pharmacy will be helping shape that in the coming months.

- The latest **EPaCCS Task and Finish Group** has taken place, with a briefing paper produced for the PEOLC Board on implementation progress. The project manager has worked with NCA IT to develop a SystmOne EPaCCs notification, to alert community staff when an EPaCCs record is live. Conversations have also taken place around piloting EPaCCs for Children, the NCA will commence with HMR with a view that Bury will shortly follow.

  A bi-monthly meeting has been established with the PEOLC Programme Lead to strengthen alignment between the Frailty and End of Life Care programmes.

3.2 Mental Health

Strategic / commissioning:
- Bury Mental Health Strategy Refresh – approved by Locality Board.
- MH Programme delivery plan revised and updated and incorporated into Locality Plan – update to come to MHPB in October.
- Advocacy STAR resubmitted to GM ICB by Bury Council – recurrent funding approved.

Coping & Thriving**:**
- Bury Live Well Centre opened in Whitefield.
- Connect 5 and Helping Yourself to Wellbeing delivery progressing with Bury Adult Learning Centre and Creative Living for Talking Therapy waiting lists.

Suicide prevention:
- The Bury Suicide Prevention Day Vigil and Walk of Remembrance took place on Thursday, 10 September 2026 to observe World Suicide Prevention Day.
- Ongoing planning for Bury Suicide Prevention Conference – 14th October.

Primary & Community**:**
- Ongoing engagement and planning for test of change to involve wider group of community partners in East Neighbourhood mental health huddle – commenced at the beginning of September 2026.
- Performance concerns in relation to waiting times for NHS Talking therapies raised at meeting with PCFT in August – awaiting further assurance and improvement plan – due to be considered at PCFT CRM in September.
- Escalated Neighbourhood Mental Health Service VCSE funding situation to Finance Review Group.

Crisis & inpatient:
- Second meeting held between ASC MH, Housing and PCFT ward managers to develop joint protocol.

BURY INTEGRATED CARE PARTNERSHIP

- Bury community based 24/7 Crisis Resolution Service will launch at the end of September. Comms has been produced for stakeholders including Primary Care. An update is being provided for MHPB and the Bury Primary & Secondary Care Interface meeting in September.
- Days Away from Home Pilot completed, and Outcomes/Next Steps Report produced for MHPB.
- The Section 117 Aftercare Review Programme continues to make good progress and remains on track to deliver against its agreed objectives. An update report has been shared with MHPB.

CYP:

- Further planning with partners to re-establish multi-agency / disciplinary triage panels for new referrals for CYP autism and ADHD assessments in line with the new GM model of care. Triage panel recommenced on 2nd September.
- Further impact assessment and planning work pending the decommissioning of the domestic abuse support provider for children & young people, Talk, Listen Change from end of September 2026. Briefing provided to the Bury Domestic Abuse Partnership Board and referrers. Agreement that interventions will be completed for all CYP currently in receipt of a service. Referrers of CYP on the waiting lists are being written to with a list of alternative sources of support. The list of CYP on the waiting lists being reviewed by Children's Service to identify any specific needs / risks.
- Planning work to mobilise and promote the GM commissioned Chat Autism & ADHD service to bury CYP and parents and carers.
- Some additional capacity to support Community Paediatrics to undertake ADOS assessments / observations for children on the autism assessment pathway implemented as a short-term measure. The indications are that this has reduced overall wating times for assessment. Discussions underway about potential to extend the initiative.

Misc:

- The second Bury Armed Forces Covenant Conference takes place on Thursday, 17 September 2026 at the Fusilier Museum in Bury. Mental health, wellbeing, social isolation, and local support networks for veterans, service personnel, reservists, and their families.

3.3 Neighbourhoods

Programme wide:

- Completion and Locality Board approval of BeCCoR section 3 Neighbourhood Health Action Plans with a focus on prevention and population health:

NEIGHBOURHOOD	FOCUS
East	High respiratory need / COPD. Stretch to cover patients with co-morbidity in relation to CVD. Focus on 'missing pts', from COPD cohort and remaining 5 cohorts. Includes focus on reviews, vaccination uptake, self-management and engaging missing patients involving community partners.
West	CVD, high QRisk and childhood asthma. Includes community outreach, prevention initiatives and health promotion.
Prestwich	CVD Need cohort focused on high-risk patients with significant cardiovascular unmet need. Includes targeted outreach to improve engagement and completion of high need reviews.
Whitefield	CVD cohort (including hypertension, AF and diabetes). Includes

BURY INTEGRATED CARE PARTNERSHIP

	engagement with *hard-to-reach* groups through the Whitefield Live Well Hub and neighbourhood events.
North	CVD Core, CVD Stretch and primary prevention cohorts. Focus on proactive identification and engagement of patients who have historically not attended reviews

- Workforce consultation in relation to changes in Neighbourhood Lead roles.
- Successful expression of interest to national programme of consultancy support to enable Health & Wellbeing Boards to oversee the implementation of the NHSE Neighbourhood Health Framework – initial meeting held with consultants.
- Baseline audit of progress in implementing the requirements of the NHSE Neighbourhood Health Framework completed.
- Revised SOP for ACM circulated with strengthened recording requirements.
- Work ongoing through Neighbourhood Leadership Teams to review cohorts of risk and develop action plans.

West**:**
- Attendance at Growing Together monthly stall to promote ACM on 14th August 2026.
- Ongoing work on project to implement patient led ordering of medication with GPs and community pharmacies.
- Health and social care partners are working with members of the PLST and focusing one area of Radcliffe due to social isolation, drug use, criminality and mental health. Looking at ways to improve support to vulnerable people while GMP focussing on criminality.
- Ongoing design and development work in relation to the establishment of Live Well spaces and the Live Well offer in Radcliffe.

East:
- Ongoing engagement and planning for test of change to involve wider group of community partners in East Neighbourhood mental health huddle – commenced at the beginning of September 2026.
- East neighbourhood event – Hoyles park

Prestwich:
- Meeting at Ezra care holding a workshop face to face for the Jewish community with social prescriber – held every 2nd Wednesday of the month. Great attendance.

Whitefield:
- Formal opening of Bury's first Live Well Hub in Whitefield: https://buryvcfa.org.uk/news/whitefield-welcomes-new-live-well-centre-community-celebration.

3.4 Cancer

Cancer
- Launch of VCSE grants through the VCFA for the Neighbourhood Cancer Live Well Fund 26/27. The grants are designed to support local VCSE organisations to deliver community-led projects that improve cancer awareness, reduce inequalities and help people in Bury live well with and beyond cancer. Grants close 4th October.

BURY INTEGRATED CARE PARTNERSHIP

Early cancer diagnosis position

A significant improvement in our performance. Bury have exceeded the 3% improvement target set by GM Cancer for 2025/26 and have also moved above the Greater Manchester average, as illustrated in the graphs below:

- **April 2025:** 56.7% (8th position in Greater Manchester)
- **March 2026:** 62.0% (4th position in Greater Manchester)

This represents an improvement of 5.3% over the year and a rise of 4 places within the Greater Manchester ranking, reflecting the positive impact of the work undertaken to support earlier cancer diagnosis across the system.

Whilst it is challenging to attribute this improvement to any single initiative, it is clear that it reflects a sustained collective effort across the system. A range of interventions through programmes in Bury have contributed to strengthening early cancer diagnosis performance over the past year, including:

- Development and delivery of Early Diagnosis Action Plans across all four PCNs, supported by GM Cancer Primary Care Facilitators.
- Full rollout of the Lung Cancer Screening Programme across all PCNs
- Inclusion of cancer emergency presentation and referral activity within the Primary Care Quality Visits to support identification and reduction of unwarranted variation
- Delivery of tumour-specific education through the GP Clinical Masterclass programme, led by NCA Consultants which has been extended to other NCA localities through our training hub
- Embedding cancer awareness and prevention messaging within NHS Health Checks as well as practitioner training, supported by the Public Health Team
- Cancer awareness campaigns developed by GM Cancer shared through VCFA, PSLTs, council and Primary Care

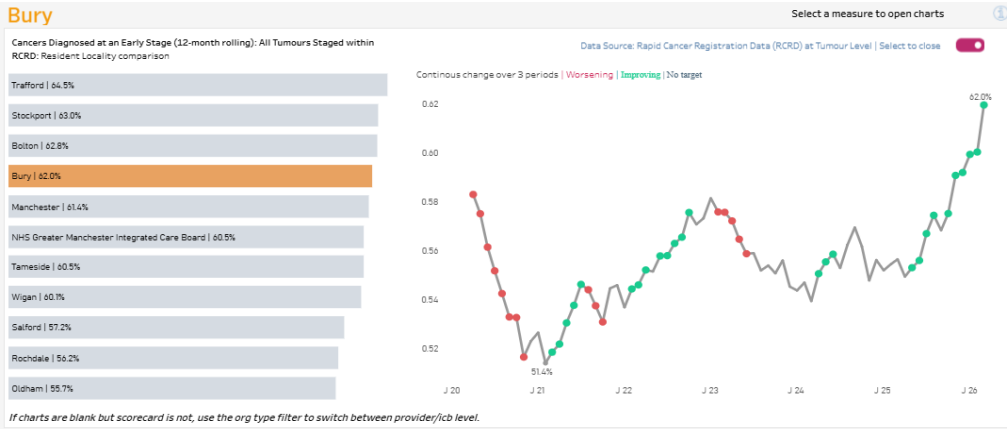
The improvement in performance is a testament to the collaborative work undertaken by primary care, GM Cancer, Public Health, secondary care partners and VCFA supported through our neighbourhoods and wider system to improve earlier diagnosis and outcomes for our population.

As always, we remain cautiously optimistic, whilst this improvement is very positive and reflects the collective efforts across the system, there is still more work to do as the GM Cancer improvement target remains at 3% for 2026/27.

April 2025

BURY INTEGRATED CARE PARTNERSHIP

March 2026



3.5 Neighbourhood Health and Care

GP Board Plan on a Page submitted to IDC along with other programme plans.

<u>GOAL 1 IMPROVE HEALTH OUTCOMES (high-priority cohorts)</u>

- BeCCoR Schemes 26/27 approved
- Respiratory Diagnostic Hub 26/27 Scheme – Revised specification received and STAR form submitted to GM
- Paediatric Phlebotomy - 26/27 Scheme – agreed through STAR
- Quality Visits – Several visits now in the diary

<u>GOAL 2 IMPROVE ACCESS TO GENERAL PRACTICE</u>

- 90% of clinically urgent appointments to be delivered on the same day
  - Only 4 practices currently achieving requirement
  - NHS E seeking assurance for those under 60% achievement. For Bury this is Greyland, Monarch and Blackford House.
- Enhanced Access 26/27
  - Utilisation remains a concern across all PCNs
    - July and August data received for Horizon – data shows over offer in hours and increased utilisation
    - July and August data received for Prestwich and Whitefield – data shows an under-offer in hours against contract which has been flagged with the provider for resolution
    - July and August data outstanding for Bury PCN
- Estates – Work continues to improve premises across the borough, both through new developments and reconfigurations
- Patient-led ordering and increase NHS App uptake – Knowsley & Rock meeting on 04/08/26 with Sharon. Monarch/ Radcliffe- agreed for Sept go live. Mile lane not responded. Whittaker Lane, Walmersley Road & Ramsbottom have not engaged – information shared with practice.

<u>GOAL 3 IMPROVE EXPERIENCE OF PLANNED CARE</u>

- SPOA - Concerns remain regarding the impact on General Practice and patient choice implications (discussions ongoing).

BURY INTEGRATED CARE PARTNERSHIP

GOAL 4 IMPROVE URGENT AND EMERGENCY CARE PERFORMANCE

- Data now being received monthly for the Acute Visiting Services, Rapid Response and Hospital at Home

GOAL 5 IMPROVE PATIENT AND STAFF SATISFACTION

- GP Patient Survey - results analysed and paper drafted for September GP Board
- Practice/PCN Survey –all practices/PCNs have returned their staff lists
- Workforce Strategy (including training and education) - Paper submitted to the HIVE for ownership moving forward

OTHER PROGRAMMES

- RACI – Work ongoing to determine alignment of PC functions between GM and Place
- Annual eDeclaration - submission analysed and outcomes shared with September GP Board

3.6 Social Care

Older People and Aging Well & Dementia

Progress and Challenges

- Care at Home tender underway, significant time currently being spent on evaluation of bids.
- Reablement Transformation programme underway, delivery group established and Discovery Phase complete, QA Officer to undertake a 'deep dive' assessment.

LD and Autism

Progress & Challenges

- More Providers who support complex and challenging behaviour now working in Bury eg Amore. Dedicated Provider Forum/GM Framework/ relationships.

Carers, Prevention and Physical Disabilities

Progress and Challenges

- Co-production Framework approved and published. Team pack prepared.
- Prevention- Information and Advice- 12 weeks of engagement activities progressing through localities.
- Improvement and Adaptation Board established- work streams defined. Foundation commissioned approved for Housing Assistance Policy.

Mental Health

Progress and Challenges

- Scoping ASC commissioning intentions- aligned with wider Mental Health Strategy

3.7 CVD/Diabetes

- A standardised pathway for onboarding patients onto Hybrid Closed-Loop has been developed across NCA, enabling effective and consistent patient management throughout the pathway
- Successfully delivered a Pathway 2 Remission session through the GP webinar, increasing knowledge and awareness of the pathway and its benefits among primary care professionals.
- Development of a new Structured Diabetes Education referral template to facilitate a simpler, more consistent referral process for clinicians and improve patient access to education services.

BURY INTEGRATED CARE PARTNERSHIP

3.8 Community and elective

- Dermatology – GM has started the second procurement for Community Dermatology services which form part of the GM Dermatology MoC, Gm has started the decommissioning of the dermatology SPA provided by Accenda, The SPA will be built into the new community dermatology services.
- Mobilisation of the GM wide A&G initiative provided through Consult Connect (CC) is now complete with all GP practices having access to A&G, ties into improvement plans for BeCCoR for primary care – The CC contract is being discuss within GM a quarterly progress report is being prepared for October.
- NCA FLP - Currently undertaking a scoping exercise of the Community Health Service contract, Bury will be part of community dietetic service review.
- GM MSK Model of Care review, Bury place and Bury NCA colleagues are part of a GM wider working group to develop a single GM MSK pathway.
- Mandatory Elective SPOA is being rolled out, with NCA has implemented Gynae and Castro working towards and working on cardio and ENT following with Urology, Trauma/Ortho, Paediatrics, Respiratory, Rheumatology, Neurology, IECP.
- NCA supported by Place reps are mobilising tier 2 Gynae and ENT services funded through NHS GM until April 2027, NCA is also working on a sustainability plan presented through a MOU to be signed off by the DPBLs and sent through to GM NHS.

3.9 Palliative and End of life

- Implementation of the Rapid Discharge checklist for PEoLC patients – awaiting sign off from the Admissions, Discharge & Transfer group for approval. pilot wards continue using document.
- NCA has developed a draft Business Case for 7 day community palliative care service currently going through a NCA Governance process.
- Expanding EPaCCS across other services.

4. Recommendations

The Locality Board are asked to note the progress and risks outlined within this paper.

Kath Wynne-Jones
Chief Officer – Bury Integrated Delivery Collaborative
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September 2026

BURY INTEGRATED CARE PARTNERSHIP

Meeting: Locality Board			
Meeting Date	05 October 2026	Action	Receive
Item No.	9	Confidential	No
Title	Bury Adult Social Care Business Plan		
Presented By	Adrian Crook		
Author	Adrian Crook		
Clinical Lead			

Executive Summary
This paper contains the 3 year business plan for the Adult Social Care Department in Bury
Recommendations
The Locality Board is asked to note the contents.

OUTCOME REQUIRED *(Please Indicate)*	**Approval** ☐	**Assurance** ☐	**Discussion** ☐	**Information** ☒
APPROVAL ONLY; (please indicate) whether this is required from the pooled (S75) budget or non-pooled budget	**Pooled Budget** ☐	**Non-Pooled Budget** ☐		

Links to Locality Plan priorities	
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Drive prevention, reducing prevalence and proactive care – supporting Demand Reduction through primary intervention, secondary preventions and tertiary prevention	☒
Transforming Community Care in Neighbourhoods - fully realising the benefit of neighbourhood team working with a focus on the assets of residents and communities and providing proactive care	☒
Optimise Care in institutional settings and prioritising the key characteristics of reform.	☐

BURY INTEGRATED CARE PARTNERSHIP

Implications						
Are the risks already included on the Locality Risk Register?	Yes	☐	No	☐	N/A	☐
Are there any risks of 15 and above that need to be considered for escalation via an NHS GM Statutory Committee or Board in line with the Risk Escalation process ?	Yes	☐	No	☐	N/A	☐
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Governance and Reporting		
Meeting	**Date**	**Outcome**
N/A		

Bury Council

OUR PLAN FOR ADULT SOCIAL CARE 2026-29

LET'S BE INDEPENDENT

LET'S BE INVOLVED

LET'S BE CONNECTED

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Published May 2026

A Summary of Our Plan

Our Vision

"The people of Bury will have independent lives, involved and connected to their communities"

Our Priorities

- Promoting independence.
- Delivering best ever services.
- Making Bury a great place to work.

All the work that we do will be informed by:

- **Coproduction** – working in partnership with people who draw on care and support, carers and residents.
- **Inclusion** – reducing inequalities in care and support by ensuring services meet the diverse needs of all communities.
- **Quality assurance, evaluation and continuous improvement** across all our services.

Our Story in Bury

Our story in Bury

Living in Bury

Bury Metropolitan Borough is made up of six towns: Bury, Ramsbottom, Tottington, Radcliffe, Whitefield, and Prestwich. People in Bury are proud of their community, the busy market, and the area's history with textiles.

About 195,000 people live in Bury (2021 census). The average age is 40. There are more people over 50, and fewer people aged 35 to 49. This means more people may need support in the future, so we need to be ready to help and make a real difference.

Adult social care is part of the council's bigger plan, called "Let's do it!". This plan is about working together, joining up public services, and making Bury better for everyone. We want Bury to improve more than other similar towns in the North. We asked our community about this vision, and adult social care is committed to making it happen.

Population	Deprivation	Life expectancy	Age distribution
195,500	**10%**	**77.2** Years **80.9** Years	**59%** aged 18-64 years **18.5%** aged 65+ years

Bury Council

LET'S do it! Shared success across Bury

Challenges

Bury faces significant challenges in relation to rising demand for a range of services across the council create unsustainable pressures on council services and budget, this is identified in our Corporate Risk Register. This also includes demand pressures via the NHS, which affect the Council's demand profile. In particular, the Locality Plan identifies:

- The need to strengthen our model of neighbourhood working.
- The need to ensure the prioritisation of prevention and early intervention.
- The need to ensure greater engagement of people in co-design and coproduction.
- The need for financial stability within locality budgets.

These challenges must be addressed within the context of the local authority's statutory duties, primarily described in the Care Act 2014 which includes:

- Promoting wellbeing
- Providing advice and information
- Providing prevention activity
- Assessments and review
- Support for people who meet Care Act eligibility
- Support for unpaid carers
- Safeguarding adults at risk of abuse of neglect
- Independent advocacy
- Market shaping
- Integration of care and support with health services

We will ensure that we are prepared for any forthcoming changes to legislation or our national and regional operating frameworks.

What we have achieved so far

- Improved independence and outcomes for our learning-disabled residents evidenced by our spending on younger adults only increasing by 23% compared to 37% nationally.
- Only 8% of our residents with learning disabilities who require supported living are now out of borough compared to regional average of 28%. This means we have right sized our offer, and we are keeping people closer to their communities.
- We have some of the best cancer screening rates in Greater Manchester for the learning disability population. We are focused on tackling heath inequalities experienced by those with learning disabilities. Health checks are currently at 83% compared to only 47% 3 years ago.
- Best performing local authority in Greater Manchester against targets for discharging people from long stay hospitals 2024/25 and 2025/26.
- Significant reductions in home care and care home staff vacancies – because of our work on provider support and the real living wage etc. the care sector in Bury is a good place to work.
- Top 8 in the country for the number of care homes ranked as good or outstanding by the Care Quality Commission (CQC).
- All care categories are above England average as rated by CQC.
- No provider failure in the last 2 years.
- Urgent community response is the best in Greater Manchester in performance terms and the busiest service per head of population.
- Better than England average for keeping people at home following discharge from hospital.
- Better than England average on patients discharged on discharge ready date.
- Significantly below the England average for delayed discharges from hospital.
- Number of student placements up 150% in one year, and social work apprenticeships nearly quadrupled in 4 years. Vacancy rate at only 2%. Bury increasingly seen as a great place to be a social worker.
- Adult and Carer feeling of safety is above or matching England averages.
- Consistently high levels of outcomes being asked and met in Safeguarding.
- Advocacy provided for people being safeguarded is above the England average.
- A steady and sustained reduction in safeguarding required in care homes as care home quality has improved.
- Rapid improvement in carer satisfaction score. We are now at the England average, but we are ambitious to do more.
- Carers able to find information is now above the England average.

Our Adult Social Care Principles

Our Adult Social Care principles guide how we work. Staff from different teams, including social workers, commissioners and many others helped to create these principles. We kept our ‘Let’s do it!’ strategy front of mind and talked about what makes good adult social care and what people need from us.

We will use these principles to guide how we work with our communities.

1. Listen. We listen, keep you in the loop and act on what matters.

2. Strengths. We support your strengths and local opportunities.

3. Trust. We are committed to honesty, building trust.

4. Together. Everyone has something to offer and we work together.

5. Choice. You know your life best, and we know your neighbourhood.

6. Learning. We keep learning from you.

7. Co-production. We will work with you to create and improve services.

Priority - Promoting Independence

Bury's strengths-based practice journey has evolved over five years. Our work puts people at the centre, focusing on what matters most to the people living in our neighbourhoods, empowering them to take control of their health and well-being using an asset and strengths-based approach. Our approach has progressed from ethnographic approaches to collaborative models supporting independence. Key principles are person-centred and relational practice, supported by social work training offer.

We will:

1. Embed strengths-based practice in social work and occupational therapy.
2. Redesign the adult social care front door.
3. Deliver a commissioning strategy for supported living.
4. Deliver our autism strategy and design services for autism.
5. Transform our reablement services.
6. Collaborate with young people and their families on preparing for adulthood.
7. Coproduce a young adult carers service.

Priority - Delivering Best Ever Services

Co-ordination of support through our Integrated Neighbourhood Teams bring together health, social care, and voluntary sector services in the community. They deliver and co-ordinate person centred care through detailed assessment of clinical, social and environmental needs working with the individual to plan and enable independence. Our strong belief in doing things together enterprisingly sees the council lead on the delivery of intermediate care services, including our urgent community response service, falls pick up service and hospital at home service.

We will:

1. Develop an enablement and community offer for mental health and adults with learning disabilities.
2. Develop and deliver a social care performance improvement programme.
3. Transform our Mental Health services including mental health aftercare.
4. Improve the customer journey for people who need care and support.
5. Deliver the Carers Strategy and strengthen our approach to supporting unpaid carers.
6. Increase our availability of therapy in our social work services.
7. Deliver and embed our outcome focused safeguarding process.

Priority - Making Bury a Great Place to Work

Our workforce is our biggest asset. A diverse workforce brings various perspectives and experiences, enhancing creativity and problem-solving. It also increases staff satisfaction, retention, and morale, which helps reduce turnover and support consistency and quality in practice.

Our Adult Social Care Provider Workforce Support Offer and Centralised Permanent Recruitment Function support providers with requirements, recruitment and retention. Bury Flex is a centralised shared workforce function that gives providers access to a “ready to work “bank of flexible staff, greatly reducing agency usage.

We will:

1. Deliver a refreshed Adult Social Care workforce strategy.
2. Deliver our Providers workforce strategy and care academy.
3. Develop a workforce that reflects the borough’s population.
4. Develop Provider workforce skills to support people to live independently.
5. Develop clear career development pathways for all staff and apprenticeships.

Cross-cutting workstreams

Coproduction

Co-production is the idea that commissioners and providers of services should work in partnership with people who draw on care and support, carers and residents to design, commission, deliver and contribute to the ongoing improvement of care and support.

- We will develop a strategic approach to co-production, building on our existing networks.
- We will ensure that co-production runs through the culture of the department
- We will ensure commissioning of services use co-production approaches in development and reviewing.

Inclusion

Our Inclusion priorities are to:

- Create a workforce that reflects the diversity of our communities by identifying and removing barriers to equality and discrimination.
- Embed inclusion across the department with robust governance to ensure accountability and impact.
- Address and reduce inequalities in care and support by ensuring accessible services meet the diverse needs of all communities.
- Build a stronger data foundation for insight-driven equality.
- Deliver our Sensory strategy.

Quality Assurance, evaluation and continuous improvement

Our Social Work Quality Assurance Framework aims to set direction, support delivery, manage risk, monitor and review practice and outcomes for adults and carers with care and support needs and ensure our stated priorities are being met, guaranteeing the voice of the person using services is heard.

The Council utilises an in-depth Quality Assurance Audit to assess and support providers with a robust Quality Assurance and Improvement Framework that captures all QA processes, including renewed governance arrangements and feedback mechanism as well as providing detail on how the authority supports and manages the provider markets.

There is a dedicated Quality Assurance Framework for the Intermediate Tier, which provides a structured and consistent approach to monitoring quality, safety, effectiveness and experience, drawing together audit, performance monitoring, learning from incidents and complaints, feedback from people using services, carers and staff practice standards.

We plan to embed a Departmental Quality Assurance Framework that provides evidence of how the council is performing against achieving outcomes and experiences for residents.

Measuring Success

We propose to use the following set of headline measures to track the achievement of our vision:

Our Vision
"The people of Bury will have independent lives, involved and connected to their communities"

Independent lives

Quality of life of people and carers who used ASC services
Overall satisfaction of people and carers who used ASC services
No ongoing support following reablement (ST-Max)
Permanent admissions to residential/nursing care (65+)
Long-term support users living at home/with family – learning disability (18–64)
Peopler in receipt of care and receiving direct payments

Involved

People who have control over their daily life
Carers who feel involved in discussions about the person they care for

Connected to their communities

People and carers who use ASC services find it easy to find information about support
People who feel safe
People and carers who use ASC services have as much social contact as they wanted

Additionally, we will report the following measures through our corporate and departmental performance reporting:

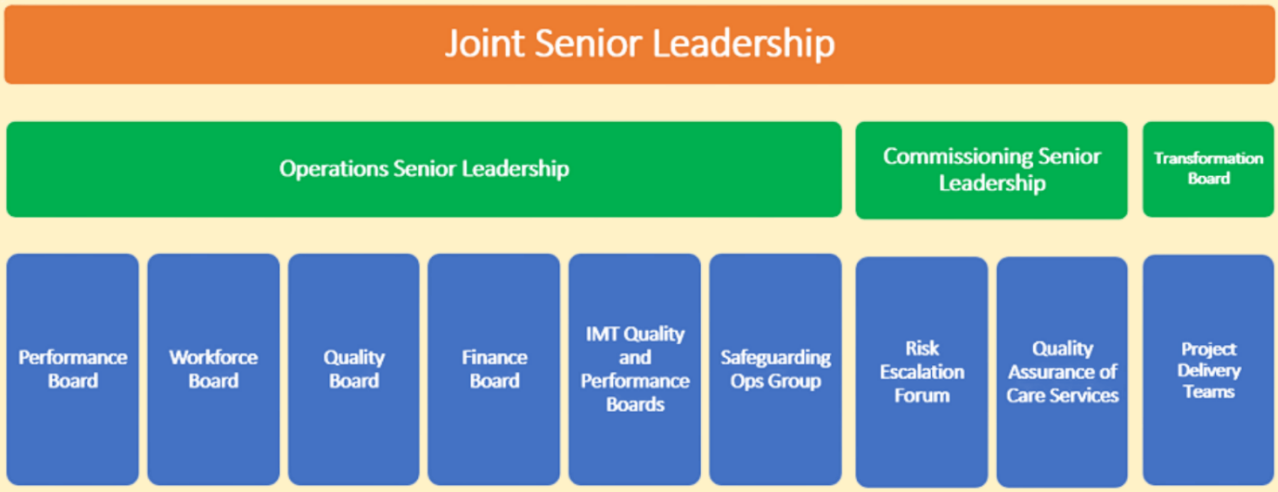
- Access to local authority-arranged care or funded users by age and setting (nursing, residential and community) per 100,000 adults.
- Proportion of staff in the formal care workforce leaving their role in the past 12 months.
- Overall satisfaction of people who use services with their care and support.
- Overall satisfaction of carers with social services (for them and the person they care for).
- Proportion of section 42 safeguarding enquiries where a risk was identified, and the reported outcome was that the risk was reduced or removed - Corporate Plan Metric.
- Adults aged 18 or over in receipt of care and receiving direct payments.
- Median number of days from the start of a request to the beginning of the response from the local authority.
- Median number of days from the start of a request to the start of the first service.
- Proportion of people who receive long-term support who are enabled to live in their home or with family.
- Proportion of people who received reablement during the year, who previously were not receiving services, where no further request was made for ongoing support - Strategic Plan Corporate Plan Metric.
- Proportion of people aged 65 and over discharged from hospital into reablement and who remained in the community within 12 weeks of discharge.
- Number of adults whose long-term support needs are met by admission to residential and nursing care homes, split by age (aged 18 to 64 or 65 and over) per 100,000 population.
- Emergency admissions to hospital for people aged over 65 per 100,000 population.
- Average length of discharge delay for all acute adult patients.

Governance and Assurance

Our assurance governance, rooted in the principles of business and practice assurance, includes boards for Performance, Quality, Workforce and Finance. A Legal Gateway Panel has also been introduced. This enables oversight and feedback to senior leadership but also embeds ownership and understanding of Adult Social Care strategic and statutory requirements.

Our governance arrangements enable the monitoring of performance and assurance across all areas of service delivery. This enables our department to identify themes and trends using data, monthly assurance reporting and robust escalation enables the early identification of issues impacting service quality and provision for action planning and escalation to address.

An annual delivery plan is prepared with regular performance reporting in place. A quarterly report for Members provides a public overview of performance across Adult Social Care in Bury, supported by relevant datasets.



Bury
Council

ADULT SOCIAL CARE DELIVERY PRIORITIES 2026-2029, June 2026

Theme	Reach	Priority	Baseline position	KPIs / Success Measures	Financial impact	SLT Lead/s	Outputs/products	Assurance	Q1 milestones	Q2 milestones	Q3 milestones	Q4 milestones	RAG Status
Promoting Independence	Significant financial or performance impact	Embed strengths-based practice in social work		% increase of people who say they have achieved their goal % reduction in mean number of hours of care at home % increase of tech or VCFA provision % increase number of practitioner recorded as a provision in the Support Plan % increase in number of people after review have a decrease in long term support % increase in number of risk assessments used to support decision making in support plans?		Emma Massey	ASC Principles SOPs LAS health-check audit New LAS forms SBP KPI dashboard	Senior Leadership Team	Completed reviewed SOPs with standardized template across all teams. Embed quality assurance tools as BAU. Complete the 7 Principles which will include feedback from our working groups. Complete MLMW and Support Plan Workshops and produce final documents	Staff handbook completed. Review of audit from System-C and Planned work agreed with resources. Huddle Rollout to additional teams started with 8 week content agreed. Staff Training program started and delivered	Completed Liquid Logic changes. KPI dashboard fully functional. Go live with Liquid Logic changes following Testing and process mapping.	Continued embedding with new post in place to deliver support from PSW Team. QA check on system at 3/6 month review to reflect on work completed.	ON TRACK
Promoting Independence	Significant financial or performance impact	Care at Home - retender - reduce residential - proportional response to needs to support delivery of the Ageing Well Strategy 2025-2030	Our providers are keen to offer reablement and want to be a trusted assessor Over-provisioning Cautious risk appetites New Brokerage Manager - future service offer Highest spender per person in the NW	Optimised care packages "Everybody with a care package has been through reablement" % Increase in reablement from completion of a care act 4x % decrease in commissioned package of care after completion of a care act 4x after reablement % increase in referrals for tenancy related support (Housing)	Reduction in average cost of package of care Reduction in overall cost of Care at Home	Deb Yates	New contract awarded and implemented October 2026	Ageing Well Partnership Board Senior Leadership Team	Tender live on the Chest May 2026	Tender Evaluations	Report to Cabinet Contract Awarded October 2026 Implementation	Business as Usual Continued Provider Performance monitored Customer Survey (Annual)	ON TRACK
Promoting Independence	Significant financial or performance impact	Embed strengths-based occupational therapy practice	No therapies practice framework currently in place: therapy expectations vary across teams, with strengths based practice not consistently embedded , evidenced or assured.	% of cases where therapy input supports proportionate care planning (reduced reliance on care following therapy input) % of therapy assessments and interventions audited as strengths based, proportionate and outcome focused	Indirect - supports reduced escalation and more proportionate care planning, contributing to improved value for money across adult social care pathways.	Fauve Syers	A. Agreed Therapies Practice Framework in place which sets clear expectations for strengths-based, person-centred and proportionate OT practice. B. Defined practice standards and principles for therapy, linking therapy assessment and intervention to independence outcomes and prevention of escalation. C. Embedded quality assurance and audit framework D. Baseline assurance report completed, evidencing current practice, variation and development priorities.	IMT Quality Board	Scope, purpose and governance for the Therapies Practice Framework agreed, including alignment with supervision and quality assurance.	Therapies Practice Framework developed and agreed including standards, principles and audit approach.	Therapies Practice Framework embedded within supervision and quality assurance arrangements.	Baseline assurance established through audit and supervision review, with development priorities identified.	NOT STARTED
Promoting Independence	Significant financial or performance impact	Embed Occupational Therapy within Social Work Pathways	Occupational Therapy input is available to social work teams but it is not yet consistently embedded at the earliest point of assessment and review. This limits the ability to shape care decisions early, support proportionate care planning, and prevent escalation into higher-cost commissioned care.	% of social work cases where OT input is provided early in the assessment or review process % of cases where OT input contributes to reduced or avoided care package escalation Reduction in average commissioned care hours following OT-supported reviews Improved timeliness of OT input within social work pathways Evidence of avoided escalation into long-term or higher-cost care, supported by case review and audit	Mixed impact. Some cashable savings through reduced commissioned care hours. alongside avoided escalation into higher-cost care through more proportionate and preventative interventions.	Fauve Syers	A. Embedded OT presence within priority social work pathways (assessment, review and care optimisation) B. Clear referral routes and decision-making points and expectations for OT involvement C. Agreed model for OT contribution to care reviews and complex decision-making D. Improved joint working between OT and social work, supported by shared learning and case discussion E. Evidence of impact demonstrating reduced or avoided care package escalation. By year end, OT input is embedded within social work pathways, shaping care decisions earlier and contributing to smaller or avoided care packages.	Senior Leadership Team	Agree priority social work pathways for embedded OT input and define referral points and expectations.	Targeted OT availability model developed and piloted within agreed social work pathways.	OT input embedded within pathways, with performance data and case review collected to evidence impact on care decisions and escalation. .	Review effectiveness of embedded OT model and evidence impact on care decisions and escalation. Agree next-phase expansion or refinement.	NOT STARTED
Promoting Independence	ASC system	Re-design the adult social care front door (CAD)		Conversion rate from calls to allocation Number of enquiries resulting in referrals to the third sector Customer satisfaction / user feedback		Paul Carr	Discover, Design and Develop a redesigned Front Door based on a preventative offer for social care. This needs to include review of function of CAD and Living Well, alongside information, prevention and advice including the digital offer	Performance Board and Quality Board	Discovery phase: Work with CAD operations manager and partners to review what is working in our region. Living data and information for other CQC assessment and knowledge from staff Develop/coproduce the project plan encompassing the outputs/products with VCFA, partners and those with lived experience	Continue design phase of transformation project Develop the place that the transformation will take place Share the designed transformation programme with SLT (keeping in mind the need to prevention and budgetary control)	Deliver the transformation project when it has been defined, reporting back/escalating to SLT on a regular basis. Review milestones for Q3 depending on development of transformation programme	Continue Delivery of transformation project Review and report back to SLT to feed into 27/28 strategic plan	NOT STARTED
Promoting Independence	Service delivery (BAU) or improvement	Deliver a commissioning strategy for supported living with the aim of ensuring sufficiency, reducing demand and improving cost effectiveness	Provision has increased over recent years. 60 over-50s currently in supported living. Supported Living Budget is overspent by over £3.6million 294 people living in supported living Currently we spend £173 on average per person than the GM average We have few people place out of borough but those that are place are expensive currently 56 OOB costing £2.7million	Less voids in supported living placements Reduction of care package in own home vs supported living cost Increased number of people moving on from Supported living to more independent living.	A reduction in the supported living budget Supported living Budget used more effectively (voids maximised in a timely way)	Ahmed Ajmi/ Anna Jenkins	Supported Living Allocation Framework Detailed projections for future changes in demand based on known population Plan for new schemes included financial impact A programme of reviews to maximise hours in supported living and promote independence	Finance Board	Supported Living Allocation Framework Developed and implemented. Including panel to prioritise referrals and allocate supported living placements. Data collated on current and future demand. Phase 1 of targeted reviews complete - highlight report shared with SLT.	Phase 2 targeted reviews complete - highlight report shared with SLT. Scope and plan developed for OOB reviews. Plan to allocate flats at William Kemp Heaton and Fletcher Fold approved and all people allocated to start the planning.	Phase 3 targeted reviews completed - highlight report shared with SLT. Ongoing coordination of William Kemp Heaton and Fletcher Fold moves.	Phase 4 targeted reviews complete Review of Supported Living Allocation Framework William Kemp Heaton and Fletcher Fold open Scope and plan delivery plan for 2027/28	ON TRACK
Promoting Independence	Significant financial or performance impact	Development of a transformation programme that addresses use of residential care for older adults including for hospital discharge	33% are supported in residential care. Falling below stat neighbours for supporting people at home.	% Reduction in avoidable admissions to long-term residential care % Decrease in short term placements via Integrated Discharge Team More people supported at Home (Home First)		Deb Yates	% Reduction in avoidable admissions to long-term residential care Replace 'residential by default' hospital discharge decisions with Home First, strengths-based pathways Grow alternative community-based services including reablement, home care, intermediate care and voluntary sector support. Improve flow through hospital discharge pathways, reducing delays and long-term placements made from acute settings. Strengthen early intervention and prevention to avoid crisis that drive the use of residential care Improve capacity and resilience of the community workforce and provider market. Ensure better outcomes for older adults in line with what matters to them.	Ageing Well Partnership Board Senior Leadership Team	Data analysis completed Project Initiation Document done Programme Delivery Group established	Progress Highlight Report shared with Commissioning Savings Group Determine Strength Based Pathways to be used by Integrated Discharge Team		Reduction in avoidable admissions to Residential Care Aligned to the transformation of Home Based Reablement, new pathways adopted	ON TRACK
Promoting Independence	Significant financial or performance impact	Deliver our autism strategy and design services for autism	The number of adults supported by Bury Council with Autism is unknown. There is a limited specialist offer for adults with Autism.	10% increase to 25-26 baseline for people involved in autism peer networks.	Not known currently as autism is not recorded on information systems as a PSR	Helen Dawson	Autism strategy published, including feedback from coproduction network	Transformation Board LD & Autism Partnership Board	Held Provider event to build relationships with autism-specific Providers (20+ Providers attended)	Highlight report from "Respect for All" about their engagement events and outcomes. Case tracking excercise complete to determine operations pathways and 'what good looks like' operations.	Audit of Care Providers and their skills Delivery of 3 year training plan Options Apraisal Community Crisis offer	Autism Partnership Board Designed	ON TRACK
Promoting Independence	Significant financial or performance impact	Development of a transformation programme 18-65 year olds	Bury - along with GM - supports more people 18-64 than England average. Managing LD activity and spend is important (volume) - but fastest growth areas are phys dis and MH support	KPIs (ref: Use of Resources report recommendations): Volumes and waiting lists of reviews are on target (Ops) Increase in investment in "other" support ie tech and signposting non traditional services/self care (Tec and other) Ratio of suitably qualified staff receiving strengths based training (Emma) No. of working age adults accessing enablement/reablement support		Anna Jenkins	This is an overarching programme linked to the following strtegic objectives and their out puts: Supported Living Strategy Autism Strategy Mental Health Strategy PFA Standards and Dashboard Review of Employability Services Review of Community enablement offer for working age adults	Senior Leadership Team	Discovery phase	Design Pahse	Development Phase	Delivery Phase	NOT STARTED
Promoting Independence	Significant financial or performance impact	Transform our reablement services		% of people completing reablement with no onward long-term commissioned care % reduction in escalation from reablement into residential or nursing care Improvement in functional independence outcomes at reablement end Reduced length of reablement episodes where appropriate Improved flow through reablement pathways (referral-to-start / completion)		Dill Hawley	New operating model. Increased capacity. Referral to start time reduced. Improved outcomes	Performance Board, Reablement Board and Senior Leadership Team	Design the future operating model. Define eligibility and referral criteria. Review and implement areas of test of change. Define workforce roles.	Develop strength-based and asset-based training. Formulating processes Review job description and supervision structures Implement new model of working	Introduce clear referral pathways. Develop discharge planning and review points. Monitor outcomes and staff feedback. Refine the model based on learning.	Setting goals for 2027 Evaluation of impact reduce long-term home care packages. Fester hospital discharges. Higher user satisfaction. Improved staff confidence in strengths-based practice.	ON TRACK
Promoting Independence	Service delivery (BAU) or improvement	Collaborate with young people and their families on preparing for adulthood		All young people likely to be eligible for ASC at age 18 will have access to a named PfA Social Worker by age 15. Voice of the young person is obtained and fed into service delivery and reporting. PfA dashboard/tracker measures.	Reduction in costs against savings targets	Linda Prescott	Finalised PfA pathway standards Agreed PfA dashboard tracker measures End of Year PfA performance and impact report	Senior Leadership Team Childrens SLT	Full review of COP and legal work along with case allocations focused on getting the team back on track. Regular attendances of TM at both Adults and Childrens Legal gateway Recruitment to vacant posts Review PfA eligibility and early-identification criteria Establish baseline position for PfA allocations, including cohort aged 14–15 and current allocation gaps. Finalise PfA pathway standards, including requirements for capturing the voice of the young person. Review and agree PfA dashboard / tracker measures, reporting frequency and governance arrangements to produce a highlight report.	Implement allocation model to ensure early identification and access to a named PfA Social Worker by age 15. Begin phased rollout of named PfA Social Worker allocation for identified cohorts. Embed consistent practice for recording the voice of the young person within PfA assessments and planning. PfA dashboard / tracker goes live with monthly reporting to Adults SLT.	Majority of young people aged 15 likely to be eligible for ASC allocated a named PfA Social Worker. Quality assurance activity completed to review consistency, completeness and impact of young person voice. PfA dashboard used routinely to monitor demand, performance, outcomes and cost avoidance. Interim review of savings and cost-avoidance delivered through PfA intervention.	All young people likely to be eligible for ASC at age 18 allocated a named PfA Social Worker by age 15. Demonstrable evidence that the voice of the young person informs service delivery, planning and reporting. End-of-year PfA performance and impact report produced, including outcomes and financial impact. Delivery against savings targets confirmed and priorities for the next delivery year agreed.	NOT STARTED
Promoting Independence	Significant financial or performance impact	Review of employability services.	We currently have ex people in Persona's day care services - Provider (Persona) are supporting 16 people to move from day care services into employment 26/27 and 27-28.	16 people in paid employment by March 28	Reduction in number of day care placements: £50k 26/27 £90k 27/28	Helen Dawson	Review of progress and options for service redesign.	LD & Autism Partnership Board Highlight report	Reporting requirements established.	Establish 5 year trajectory for demand. Highlight report received	Review of activity and project to date with any recommendations	Activity for 26/27 delivered against plan. Delivery plan available to achieve 27/28 plans	NOT STARTED

Promoting Independence	Service delivery (BAU) or improvement	Coproduce and publish a Young Adult Carers offer	There is no clear offer for Young Adult Carers which take into account their needs and support to help their loved ones.	Clear Young Adult Carers Charter that provides pledges from the council and partners how they will be supported in their important role in the community,		Ahmed Ajmi	Publish Young Adult Carers Charter Documented themes and priorities from young adult carers Evidence of inclusive participation Commitment to ongoing co production, not a "one off" exercise	Senior Leadership Team	Confirm purpose and scope for the Youn	Begin engagement with young adult carers using multiple ways: 1:1 conversations Small group sessions Creative or informal engagement Digital / written input Provide clear information on what a Charter is and how it will be used Explore lived experience priorities (support gaps, transitions, education, employment, health, information) Actively reach underrepresented groups and communities Capture insight in accessible and inclusive ways	Co design sessions with young adult carers to: Test priorities Agree what commitments matter most Shape language and tone of the Charter Draft the Young Adult Carers Charter collaboratively Sense check feasibility with partners (without compromising carers' voice) Share draft Charter back with young adult carers for approval and refinement	Finalise Charter with young adult carers Agree ownership, accountability and monitoring arrangements Secure formal endorsement through agreed governance routes Publish the Charter in accessible formats Promote across Team Bury, commissioned services, education, health and partners Begin embedding commitments into: Commissioning intentions Service expectations Partnership working Agree review cycle with young adult carers	ON TRACK
Best Services Ever	Significant financial or performance impact	Review our community enablement for adults with learning disabilities and mental health needs	Currently no enablement services available to adults with LD or MH needs.	% achieving ≥75% of goals within 8–12 weeks Improvement between start & discharge (using validated tool) % exiting with no or reduced package vs baseline % reporting improved independence & control	Reduction in LD and MH budget	Anna Jenkins	Review of current Bury offer & demand Development of business case (included costed options) for new offer Commission new service	Senior Leadership Team Mental Health & LD & Autism Partnership Boards	Review of current Bury offer & demand	Engagement events with people with lived experience to inform review	Business case for new service (included costed options) to SLT	Commission or mobilise new service (depending on option chosen)	NOT STARTED
Best Services Ever	Significant financial or performance impact	Brokerage service redesign	Our current Brokerage function operates across multiple referral pathways, with processes that are largely manual and fragmented. Referrals are received from	Full adoption of a single e-Brokerage platform Improved speed, consistency, and transparency Stronger financial grip and market management	Deliver annual financial savings Strengthen financial control and sustainability	Saheed Lawal	The output is a modern, data-driven brokerage function that delivers both better outcomes for residents and significant financial benefits for the Council.	Commissioning Leadership Meeting Highlight Report	Consultation ongoing with IESE and Surrey Council	Establishment of a clear Brokerage Workplan and clear end-to-end workflow.	Review of the plan against target which would inform next steps	Delivery of agreed e-Brokerage function with target date 2026/2027	NOT STARTED
Best Services Ever	Service delivery (BAU) or improvement	Develop and deliver a social care performance improvement programme	Community Care budget expenditure	Deflection Uptake in universal service Care act and OT assessments timeliness Overdue reviews Caseload management Legal literacy Fewer Care Act Assessments		Sue Massel, Darren Pegram	Improvement Programme	Performance Board	Agree programme scope and benchmarks for 'fundamentals' across Social Work, Therapy and Commissioning (Care Act & OT assessment timeliness, overdue reviews, caseload, managementand deflection). Establish baseline position and data definitions for each	Implement core improvement package (assessment, support plan, review) Minimum case recording standards and compliance/audit cycle. Confirm escalation routes for non-compliance	Embed performance grip, monthly team performance reporting, exception reporting and operational recovery plans for any team off-track. Start to evidence early outcome shifts (reduced overdue reviews, improved timeliness, improved deflection)	Demonstrate sustained improvement and reduced variation across teams. Complete year-end evaluation and lessons learned. Agree 2027 priorities and refresh targets.	NOT STARTED
Best Services Ever	Service delivery (BAU) or improvement	Bed-based services improvement programme	Length of stay average 40 days, people waiting over 7 days for bedded IMC admission and therefore, hospital sending people into short term residential care.	Reduce length of stay to 30 days Improved independence at point of discharge	A reduction in short term care from hospital and an increase in people going through IMT services	Louise Palmer	Clear process for key worker to plan discharge from point of admission with clear goals and discharge destination.	IMT Performance Board	Review current process and commence key worker process with Discharge Planning meeting within 2 weeks from admission, for all new customers admitted to Killelea.	Review process of all customers in service (Killelea and Elmhurst) and audit estimated date of discharge and date DPM took place.	Audit length of stay, implement DPM within 1 week of admission at bed base	Review impact and confirm next step improvements.	ON TRACK
Best Services Ever	Significant financial or performance impact	Transform our Mental Health services (transformation programme)	900 people on the 117 register for Bury, last review of 117 after care eligibility took place in 2014. Referral pathways to the LD and MH Teams are not clearly defined. There are limited options for an alternative to mental health hospital.	No. 117 reviews No. 117 responsibility ending Reduction in care and support for those in reciept of 117	Reduction in 117 budget Bury and ICB	Anna Jenkins	Review Mental health and LD referral pathways 117 Aftercare Review Review/Design MH Crisis Bed/Step Down offer Mental Health Strategy	Mental Health Programe Board, Senior Leadership Team and Pennine Care Community Transformation Board.	Review criteria and screening tool for each service. Review results of the Mental Health Neighbourhood Pilot Days away From Home Hospital Discharge Pilot 117 review procedure and plan for 117 reviews agreed. Establish a Mental Health Partermship Board	Workshop with wider partners to develop pathways to and from the mental health teams. Analysis of DAFH Pilot and proposal for future practice model. Gap analysis of MH Aftercare services. 117 Reviews Progress Report MH User Involvement group meeting to have taken place	Mental Health Hospital Discharge Framework &Performance Dashboard 117 Reviews Progress report Horizon Scan and consider options appraisal Crisis bed/MH Step down offer	117 aftercare framework agreed for long term implementation. QA Approach to 117 aftercare defined. Options Appraisal MH Crisis Bed/Step Down Service Design MH Partership Board and governance structure.	ON TRACK
Best Services Ever	ASC system	Improve the customer journey for people who need care and support (safe systems)				Emma Massey		Performance Board	Discovery phase including definition of the project for 12 months and requirements- develop a plan to mapping pathways and communication touch points.	Mapping and evaluation. Recommendation for improvement plan.	Implementation		NOT STARTED
Best Services Ever	Service delivery (BAU) or improvement	Implementing forthcoming Mental Health reforms and DoLs/LPS		Ensure the Supervisory Body is strategically prepared for the future implementation of the Liberty Protection Safeguards		Paul Carr	Practice and Policy is aligned to forth coming changes in legislation. Opportunities and risks reviewed regularly and maximised and mitigated.	Senior Leadership Team	Deliver BIA training for social work staff Keep up to date with the Department of Health's implementation plan for the Mental Health Act - this has not been published yet.	Contribute to NWADASS DoLS Leads Response to the Government consultation			NOT STARTED
Best Services Ever	Service delivery (BAU) or improvement	Ensure fit for purpose business systems (LAS and Controcc)	Lack of confidence in forecasting. Lack of training. Inability to evidence impact. End-to-end. (Including referrals into the system, online portals/referral forms etc) Create a full list of issues. We don't know what we don't know. No governance in place.	Reduction in use of spreadsheets outside controcc and LAS Implementation of digital self-service % increase in use of signposting to digital offer Use for customer invoicing Customer satisfaction		Darren Pegram	LAS Health Check audit Business Systems governance for change control Online Financial Assessment Portal Customer Finance Portal AI opportunities assessment DDoT capacity review	Senior Leadership Team	Appointment of Digital Programme Manager. Set up delivery governance joint ASC/DDoT/Performance/Improvement Steering Group. Define future state requirements.	Map priority ASC pathways. Confirm delivery plan and resourcing. Interface and integration design (Liquid Logic to Controcc). Prioritise LAS workflows (i.e. front door/ triage, assessment, support plan) Cleanse data and migration planning	Build in system amendments. Assurance and controls testing commenced.	Go live and stabilisation continues with plans in place for 2027 continuation of delivery.	NOT STARTED
Best Services Ever	Service delivery (BAU) or improvement	Deliver timely advice and accessible digital services	Lack of knowledge and accessibility of universal services means that more people are accessing later, most costly interventions.	% of people receiving first contact/advice of enquiry (phone, web or email). % of enquiries that start and complete through digital routes (web forms, chat, portal) Average time from digital referral/enquiry to advice outcome/signposting provided Average satisfaction score for advice and digital journey, plus % who say information was easy to understand % of users reporting advice helped them take the next step and reduced need for repeat contact Usage rates of digital services by key cohorts compared with overall service users (to identify and reduce digital exclusion gaps)	Less costly interventions by preventing escalation of needs and crisis management.	Ahmed Ajmi	Clear, prevention focused digital advice offer that is useable, inclusive and joined up with the Adult Social Care website and the Bury directory.	Senior Leadership Team	Confirm scope of "timely advice" in line with Prevention and Wellbeing priorities (early help, prevention, independence) Map existing digital and non-digital advice routes (e.g. Adult Social Care website, Bury Directory) Identify priority life events and trigger points where advice is most needed (e.g. caring roles, hospital discharge, housing issues) Agree design principles for accessibility, usability and inclusion (plain language, mobile friendly, assisted digital) Align delivery with voluntary, community and faith sector partners already supporting prevention and wellbeing	Improve navigation and content on the Adult Social Care website to support informed decision making Test content with residents and frontline staff to ensure clarity and accessibility Begin training frontline staff to use the digital offer to provide proactive advice at key life events Ensure strong links to VCFA services, social prescribing and neighbourhood support		Formally launch the digital advice offer as part of the Prevention and Wellbeing programme Promote the offer to residents, partners and staff, emphasising prevention and independence Monitor usage, access and outcomes to assess contribution to prevention aims Gather feedback from residents and practitioners Agree ongoing review and improvement cycle aligned to Prevention and Wellbeing governance	ON TRACK
Best Services Ever	Significant financial or performance impact	DFG and major and minor adaptations review		% of DFG cases progressing within agreed timescales (baseline established in Q1 and improvement demonstrated over the year) % of approved DFG cases completed within target timescales, with reduction in long-running cases by Q4 % of DFG recommendations assessed as necessary, appropriate and proportionate, evidenced through audit % of cases where timely adaptations prevent escalation into increased care packages or long-term care, evidenced through case review and audit	Some cashable savings, alongside avoided escalation into higher-cost care and improved value-for-money from DFG use	Fauve Syers	1. Refreshed Housing Assistance Policy and guidance 2. Regular performance oversight of the DFG pipeline (demand, delays, blockages) 3. Agreed Minor and Major Adaptations Framework, setting out clear criteria, OT decision-making, funding routes (DFG / RRO), and pathways for delivery, aligned across OT, Housing and Commissioning. 4. Improved DFG budget oversight and governance, with clear visibility of demand, pipeline and pressures through existing Housing and ASC finance governance. 5. Evidence of impact, including case examples, audit findings and performance data. 6. By year end, DFG decisions are made faster, long-running cases are reduced, and adaptations are more consistently preventing escalation into higher-cost care.	Senior Leadership Team	Using Foundations review and existing performance data, agree a defined and prioritised set of DFG, minor and major adaptations improvement actions for 2026/27, including governance, ownership and scope across OT, Housing and Commissioning.	Translate agreed Foundations recommendations into a clear DFG and adaptations improvement plan Develop and agree the Minor and Major Adaptations Framework, building on Foundations findings. Agree required updates to the Housing Assistance Policy / RRO, informed by the Foundations review.	Implement agreed changes to DFG and adaptations pathways. Embed the Minor and Major Adaptations Framework into OT and Housing practice. Strengthen performance and financial oversight for DFG delivery, in line with Foundations recommendations.	Review impact of DFG and adaptations improvements on, timeliness, consistency, escalation, into higher-cost care. Demonstrate progress against Foundations recommendations. Agree any further improvement actions for 2027/28.	ON TRACK
Best Services Ever	Service delivery (BAU) or improvement	Strengthen our Disability Services Occupational Therapy offer	The Disability Services OT Service provides specialist functional assessments, equipment and adaptations, but demand pressures and pathway complexity limit early and consistent intervention to support independence and prevent escalation into commissioned care.	Reduction in waiting times for Disability Services OT assessment % of cases where OT intervention supports independence at home, evidenced through reduced escalation into commissioned care % of cases receiving timely equipment or adaptation provision, supporting functional independence Reduction in care package escalation following Disability Services OT involvement Reduced delays and long-running cases within Disability Services OT pathways	Mixed impact. Some cashable savings through reduced care package escalation and reductions in commissioned hours, alongside avoided escalation into higher-cost care through timely intervention.	Fauve Syers	A. Strengthened Disability Services OT operating model, improving access and prioritisation B. Updated OT Equipment and Adaptations criteria guidance, aligned to Foundations recommendations D. Evidence of impact on prevention and independence E. Refreshed quality and performance oversight for Disability Services OT F. Updated Disability Services OT performance dashboard By year end, people are waiting less time for Disability Services OT assessment and equipment, and a greater proportion of cases are resolved without increases to commissioned care.	IMT Quality Board IMT Performance Board	Confirm baseline using existing performance report Agree scope of OT Equipment & Adaptations guidance update in response to Foundations. Agree refreshed Disability Services OT performance dashboard requirements	Update and re-issue OT Equipment & Adaptations Criteria Develop refreshed dashboard (building on existing data)	Embed updated guidance and dashboard into practice. Use refreshed data to evidence outcomes and variation	Review impact and confirm next step improvements.	NOT STARTED

Best Services Ever	Service delivery (BAU) or improvement	Review Short-Term Placements being discharged from the Integrated Discharge Team (to support delivery of the Intermediate Tier Strategy 2025/2030)		% Decrease in short term placements via Integrated Discharge Team More people supported at Home (Home First)		Deb Yates	% Reduction in short term placements Replace 'residential by default' hospital discharge decisions with Home First, strengths-based pathways Grow alternative community-based services including reablement, home care, intermediate care and voluntary sector support. Strengthen early intervention and prevention to avoid crisis that drive the use of residential care Improve capacity and resilience of the community workforce and provider market. Ensure better outcomes for older adults in line with what matters to them.	Ageing Well Partnership Board Senior Leadership Team	Data analysis completed Project Initiation Document done Programme Delivery Group established	Progress Highlight Report shared with Commissioning Savings Group Determine Strength Based Pathways to be used by Integrated Discharge Team		Reduction in short term admissions to Residential Care Aligned to the transformation of Home Based Reablement, new pathways adopted	ON TRACK
Best Services Ever	Service delivery (BAU) or improvement	Deliver the Carers Strategy and strengthen our approach to supporting unpaid carers in Bury	Carers assessment need to be more holistic. Carers need to have a clear pathway to access support, both by ASC and the community.	Timeliness of carers assessments % increase in carers ax with community and universal service offer % increase in referrals and feedback from Carers Hub Increase in referrals and feedback from universal services?		Ahmed Ajmi	Review of carers direct payment process/offer. Review pathways for Carers assessment Understand what prevents carers accessing community based services.	Senior Leadership Team	Confirm KPI definitions, baselines and targets (including what counts as an assessment completed on time, what qualifies as community/universal support, what qualifies as a referral and feedback). Agree operational pathway for carers assessments, including priority and escalation routes. Set up routine performance reporting and a monthly improvement arrangements (INTs, Carers Hub, CAD). Launch a referral-and-feedback drive: refresh referral forms, scripts and feedback capture for Carers Hub Workforce briefing: carer identification and "offer" message for all front doors and accessible services.	Improve carers assessment timeliness: implement triage, caseload controls and standard appointment/assessment templates. Increase community/universal offer uptake: make "supported without formal assessment" options visible at first contact and within reviews. Carers Hub referral uplift: targeted outreach to priority teams/PCNs and weekly monitoring of referral volumes. Universal services referral uplift: implement simple referral routes from universal services (e.g., libraries, housing, community connectors) and ensure feedback loop back to referrers. Capture carer feedback regular to update via performance reporting.	Deep-dive on assessment timeliness: identify bottlenecks by team/cohort and implement targeted fixes Strengthen community offer- expand pathways for carers to access support groups wellbeing and practical help. Embed Carers Hub referrals across the ASC and VCFA system in the borough. Co-production role and carer feedback to improve quality, service changes and visible 'you said, we did', communications. Nominate champions, refresh carer awareness session.	Sustain and standardise improvements, confirm business as usual processes for assessment timeliness and referral routes. Complete end of year performance review against all KPIs and identify what drove change. Refresh targets and improvement priorities for next year (including commissioning, monitoring, front door function) Publish a summary for Carers and partners and confirm how feedback will be captured and acted on going forward. Plan next year engagement/co-production schedule with carers, Carers Hub and partners to maintain referral rates.	NOT STARTED
Best Services Ever	Service delivery (BAU) or improvement	Review of complex care packages	A need for a clearly defined Floating Support service (non-regulated/regulated, complex/non-complex) to maximise utilisation, simplify pathways, standardise outcomes reporting, and create a single point of accountability for delivery and performance.	Service model and delivery- ability to deliver a range of packages of support at scale, response times, locality coverage, delivery hours, flexibility, including evenings/weekends of required. Pathway integration- working with MHLD teams, housing, hospital	Prevent costly packages of care, by shortar intervention and utilising universal services.	Ahmed Ajmi	Recommissioned service for people with complex care needs.	Senior Leadership Team	Review of current position of care packages. Understand care package profile which includes number of people, average	Commissioning design (if approved): finalise service specification, KPIs, pricing mechanism and mobilisation requirements	Run commissioning exercise for one provider: publish, clarify, evaluate, moderate, and award (subject to route-to-market).	Mobilise awarded provider (or contract variation): staffing, IT, policies, SLAs and reporting dashboard live. Implement transition plan for existing	NOT STARTED
Best Services Ever	Service delivery (BAU) or improvement	Advocacy referrals	Review the CQC report first - waiting times 1 year contract extension We currently have to pay for advocates separately (Anna)			Emma Massey		Senior Leadership Team	Discovery phase. Gather evidence and baseline response times alongside statutory duties.	Development of implementation plan for all departmental areas.	Implementation		NOT STARTED
Best Services Ever	Significant financial or performance impact	Implement Beam Notes			Reduce the number of crisis	Emma Massey		Quality Board Performance Board	implementation across the Social Work Teams aligned to SBP implementation	Secure funding for next year. Embed into practice Embed into performance reporting	Review and refine usage of Beam notes.	Full review and exploration of all AI tool on the market that support social work practice	ON TRACK
Best Services Ever	Service delivery (BAU) or improvement	Deliver and embed our outcome focused safeguarding process		Reduction of S.42 enquiries to under 85 days Renewal of safeguarding case record/assessment documentation CAD/prevention/front door project discovered and defined Digital offer reviewed and defined Internal review/learning system embedded Increase in internal BIA's		Paul Carr	A. SAFEGUARDING PATHWAYS AND PROCESSES B. GOVERNANCE AND TRAINING C. DoLS (LPS) D. PREVENTION INFORMATION AND ADVICE E. ELECTRONIC SYSTEM REVIEW (LAS) F. REDUCE S.42 ENQUIRY LENGTH TO UNDER <85 DAYS AVERAGE	Safeguarding Ops Group Quality Board Senior Leadership Team	A1. Bring Hospital Safeguarding into Safeguarding Team A2. Comms to all staff/Safeguarding Adults Board regarding new Pathway/process for Adult Safeguarding B1. Finalise placement and launch of safeguarding awareness module B2. Modify Safeguarding Operation Group to include Connect and Direct C1. Develop SoP/ToR for DoLs C2. Develop guidance for CoP work D1. Link in with CAD and commissioning and develop awareness of what Bury prevention/information/advice (including digital) offer is. D2. Develop plan alongside commissioning and CAD to bring to SLT regarding prevention information and advice E1. Develop with front line new safeguarding module/forms on LAS E2. Review DoLS recording and archiving system. F1. Work with business intelligence to develop additional data set around S.42 enquiry length	A3. Develop new processes where needed with partner agencies (MAPPA/MARAC etc) A4. Formalise Commissioning/Safeguarding links A5. Develop and sign off standardised letters for individuals under safeguarding B3. Finalise and launch internal learning/review system B4. Ensure that feedback is linked into Safeguarding Operation Group and Audits are linked into Quality Assurance Board D3. Start work on developed plan for Prevention/information and advice with CAD and Commissiong	B7. Develop 'you said/we did' on safeguarding documentation and link into governance B8. Develop shared risk management documentation to support positive risk taking in safeguarding practice. B9. Develop feedback forms for VCFA/community groups around safeguarding/DoLS D.4 Continue work on Prevention/Information and Advice with CAD and commissioning	B5. Further embedding of CoP/DoLS training and awareness B6. Continue process of developing Internal BIA's C3. Continued awareness regarding LPS and consultation as it develops REVIEW OUTCOMES OF SAFEGUARDING TRANSFORMATION PROGRAMME AND REPORT TO SLT	ON TRACK
Great Place to Work	Enabler	Deliver a refreshed Adult Social Care workforce strategy for the Department				Emma Massey		Workforce Boards	Discovery phase - develop a to support 'Best place to Work' Development of implementation plan for all departmental areas.	Sign off and start implementation in July	Workforce strategy fully implemented across services, including delivery of key initiatives (recruitment, retention, development and wellbeing), with progress actively monitored and adjustments made through ongoing feedback and performance data.	Review workforce metrics (turnover, absence, agency usage) and demonstrate improvement.	ON TRACK
Great Place to Work	Enabler	Deliver our Provider Workforce Strategy and Bury Care Academy	Workforce support in Bury is currently fragmented, with no fully embedded Provider Workforce Strategy. While the Bury Care Academy has been established, it is at an early stage and not yet fully functioning as a coordinated system-wide workforce solution.	A single, coordinated Provider Workforce Strategy A fully operational Care Academy acting as the system hub A stable, skilled workforce with clear career pathways Improved provider performance and CQC outcomes Better value for money, social value indication and reduced system pressure	The outcome is likely going to reduce pressure on the Council budget which originates from staff turnover. Having a stable workforce leads to cost avoidance re: job advert, training, induction etc for new constant staff changes	Saheed Lawal	Bury Care Academy Provider Excellence Programme Leadership Development Programme College to Care pathway	Senior Leadership Team Highlight Report	Gather feedback from staff and managers to inform development project plan for Q2 2-4	Bury Care Academy established Together towards outstanding started. Care providers vacancy reduced across all care setting	Champions initiative established with collaboration with IPC colleagues	Maintain reduction of vacancies across all care settings to a manageable level. Encouragement of local workforce to avpid over reliance on International Sponsored workforce (COS)	NOT STARTED
Great Place to Work	Enabler	Review our Training Partnership	Current training partnership arrangements exist but are fragmented across providers and internal teams Limited alignment between: workforce development commissioning intentions provider quality improvement Variation in provider training standards, access, and uptake	minimum 95% mandatory training compliance across all ASC services 100% standardised training framework and system adoption ≥90% utilisation of external training funding Measurable reduction in quality issues (complaints, safeguarding, CQC concerns) linked to workforce improvement ≥80% provider engagement in Training Partnership / Care Academy model. minimum 95% staff satisfaction target	£120,000-127,000 for 2026/2027 subject to consultation with colleagues	Saheed Lawal	Standardised ASC Training Framework and Compliance Dashboard Fully implemented Training System (LMS) and reporting model Training Partnership / Care Academy offer for providers Training Impact and Quality Improvement reporting (linked to QAF/CQC) 3-year Training Investment and Cost Avoidance plan	Senior Leadership Team Highlight Report	Agreed to fund an Apprentice position by Emma M's service for the first 2 years then we review. Recruitment to follow	Advertise for the role and commence recruitment	Employment checks done and an Apprentice start in post	Clear plan to ensure ASC mandatory training are booked for frontline staff and others	NOT STARTED
Great Place to Work	Enabler	Create a workforce that reflects the diversity of our communities by identifying and removing barriers to equality and discrimination.				Emma Massey	Fully implemented Training System (LMS) and reporting model	Inclusion Board Senior Leadership Team	Review existing workforce equality data Analyse protected characteristic data gaps Review staff survey results, complaints, grievances and exit feedback for equality themes Conduct listening activity with staff networks, ASC steering group and frontline teams Agree priority focus areas for the year (e.g. recruitment biases, progression, inclusive leadership)	Review and revise recruitment processes (inclusive job adverts, diverse panels, anonymised shortlisting where possible) Improve data capture for protected characteristics Explore mentoring programmes to develop and retain staff.	Roll out inclusive leadership expectations into performance reviews Embed EDI responsibilities into job descriptions and objectives Support ASC steering group to influence policy and service design	Re-analyse workforce data against Q1 baseline Evaluate training, recruitment changes and progression initiatives Publish and annual ASC workforce EDI report Refresh EDI priorities and workplan for 2027/28 Celebrate diversity of the Health and Adult Care department	ON TRACK
Great Place to Work	Enabler	Develop Provider workforce skills to support people to live independently.	Movement to outcomes-based contract for LD Providers (supported living). Providers need to shift culture from 'support' to enabling people to live more independently	% of people achieving outcomes in care plan [contract specification will have specific target - tbc]		Helen Dawson	Training Partnership / Care Academy offer for providers	Senior Leadership Team Highlight Report	Design phase completed.	Deliver Business case with recommendation	Engage Bury care Academy to mobilise offer (subject to funding)	Offer is "live" for Providers - uptake rates to be monitored	ON TRACK

Coproduction	Enabler	Establish, embed, and evidence meaningful coproduction with people who draw on adult social care, unpaid carers, and community partners across Bury so that service design, delivery, and improvement are shaped by lived experience.	Improve co-production in ASC in Bury to ensure services are shaped with people and carers, leading to better outcomes and trust.	Ensure co-production runs through the culture of the department. Ensure commissioning of services use co-production approaches in development and reviewing.		Ahmed Ajmi	Training Impact and Quality Improvement reporting (linked to QAF/CQC)	Senior Leadership Team	Agree a shared definition of coproduction, aims, and "what good looks like" for adult social care in Bury Map stakeholders and existing groups; identify gaps (e.g., seldom-heard communities, carers, self-funders, people with communication needs). Co-design and publish departmental Co-production Charter: recruitment routes, role descriptions, accessibility, safeguarding, data privacy, and feedback commitments. Select 2–3 priority workstreams to pilot coproduction (e.g. assessment pathway, carers support, commissioning/service review).	Introduce routine "you said, we did" reporting for each workstream. Strengthen inclusion: targeted outreach and partnerships to support participation from seldom-heard communities; provide interpreters, Easy Read, and alternative methods (online/offline/1:1). Set up ways for wider involvement opportunities (mailing list, intranet/website, referral routes via practitioners/VCFA). Agree information governance approach for coproduction activity (consent, confidentiality, use of feedback).	Embed coproduction into business-as-usual: project initiation documents, commissioning cycles, service change approvals, and quality assurance. Co-produce and publish an accessible Coproduction Framework & Toolkit for Bury ASC (including case studies and minimum standards).	Co-produce and publish an annual impact report. Review governance effectiveness and refresh membership to maintain diversity Set next-year priorities aligned to statutory duties and ASC strategies.	NOT STARTED
Inclusion	Enabler	Strengthen our approach to Equality, Diversity and inclusion in Adult Social Care	Need to improve inclusion in ASC in Bury so that operational pathways, neighbourhood working and commissioning decisions reflect diverse voices and reduce inequality in access and experience	Embed inclusion across the department with robust governance to ensure accountability and impact. Address and reduce inequalities in care and support by ensuring services meet the diverse needs of all communities.		Emma Massey/Ahmed Ajmi		Inclusion Board Senior Leadership Team	Strengthen the ASC Inclusion Board aligned to Bury Council Inclusion Strategy and LET's Principles Map where inclusion risks sit across ASC functions Analyse ASC data to identify inequalities	Review commissioning practices around EDI and co-productions activities Introduce routine equality impact prompts in ASC decision making Co-design improvements with people who use services and carers Improve accessibility- information in community languages, people with sensory needs, flexible assessment approaches, better use of interpreters and advocates	Monitor workforce indicators and intervene when disparities persist Support ASC services to test and share inclusive practice improvements Strengthen cultural competence in frontline practice Review equality requirements into commissioning specifications and contract monitoring quality assurance	Reassess ASC workforce data against Q1 Capture qualitative feedback from ASC steering group Share learning across corporate and VCFA partners Evaluate service changes, commissioning interventions and provider performance. Gather qualitative feedback from people drawing on care and support	ON TRACK
Inclusion	Service delivery (BAU) or improvement	Deliver Bury ASC Sensory Impairment Strategy	Accessibility and pathways of services for people with sensory impairments need to improve, both in the council and community services.	Sensory Partnership established and active: partnership terms of reference agreed, named leads in place, and meetings held at least quarterly with published actions. Accessible information offer in place: a single, agreed set of sensory advice and signposting content available in multiple formats Digital access improvements delivered: key ASC web pages/journeys updated for sensory accessibility Front-door advice is "right first time": reduction in repeat contacts from people with sensory impairment for the same query and improved satisfaction with information/advice Better intelligence- improved completeness of sensory impairment data		Ahmed Ajmi	**3-year Training Investment and Cost Avoidance plan** Sensory Impairment Partnership established and operational Clearer, more accessible information and advice offer Improved early identification and referral pathways Evidence of co production and lived experience feedback shaping delivery Sensory aware practice embedded across key pathways Stronger links between statutory and community provision Clear understanding of gaps and commissioning implications	Inclusion Board Senior Leadership Team	Establish the Sensory Impairment Partnership, as set out in the Strategy, with clear terms of reference and named leads Confirm Year One priorities from the Strategy's implementation and commissioning intentions Map existing sensory impairment services, pathways and community assets across hearing loss, sight loss and dual sensory loss Agree how the Strategy aligns with wider transformation programmes (e.g. prevention, neighbourhoods, Ageing Well) Confirm engagement routes with people with lived experience, carers and specialist partners (e.g. Bury Blind Society and others)	Review and improve accessibility of Adult Social Care information for people with sensory impairment (formats, language, navigation) Strengthen referral routes into sensory support at earlier points, supporting prevention and independence Work with specialist partners (e.g. hearing and sight loss organisations) to clarify roles, pathways and offers Begin workforce development activity to improve awareness and confidence in supporting people with sensory impairment, in line with the Strategy's strength based approach Test changes with people with lived experience and carers	Embed sensory aware, strength based approaches within assessment, support planning and review processes Strengthen links between sensory impairment services and community based support that promotes independence and wellbeing Support partners to develop or adapt provision that builds independent living skills Identify and address gaps in local provision through commissioning or service development activity, where required Monitor early impact and emerging learning through the Sensory Impairment Partnership	Review progress against Year One priorities through the Sensory Impairment Partnership Gather feedback from people with sensory impairment, carers and partners on what has changed Identify measurable outcomes and learning from Year One delivery Refresh the implementation plan to reflect learning, policy changes and emerging needs Agree Year Two priorities, including any commissioning or transformation activity	NOT STARTED
Quality Assurance	Enabler	We plan to embed a Departmental Quality Assurance Framework that provides evidence of how the council is performing against achieving outcomes and experiences for residents.				Adrian Crook	Delivery of a quarterly assurance framework report	Senior Leadership Team	Research available data sets and other authorities reports for outcomes. Research current experience collection in the department and external	Draft format and test if collection can be timely. Engage and seek feedback from users on content. Design and embed feedback collection methods	Prepare a draft	Produce as business as usual	NOT STARTED

BURY INTEGRATED CARE PARTNERSHIP

Meeting: Locality Board			
Meeting Date	05 October 2026	Action	Approve
Item No.	10	Confidential	No
Title	Mental health commissioning intentions		
Presented By	Ian Trafford / Will Blandamer		
Author	Ian Trafford		
Clinical Lead	Dr Cathy Fines		

Executive Summary
One mental health contract is currently out of contract and three VCSE mental health contracts expire in March 2027. The paper summarises the current position and makes recommendations about future commissioning intentions for consideration by the Board.
Recommendations
The Board is asked to approve the recommendations with respect to the specific provider contracts detailed in the paper.

OUTCOME REQUIRED *(Please Indicate)*	**Approval** ☒	**Assurance** ☐	**Discussion** ☐	**Information** ☐
APPROVAL ONLY; (please indicate) whether this is required from the pooled (S75) budget or non-pooled budget	**Pooled Budget** ☐	**Non-Pooled Budget** ☐		

Links to Locality Plan priorities	
Scale our work on Population Health Management - Improve population health and reduce health inequality of those in the most disadvantaged areas	☐
Drive prevention, reducing prevalence and proactive care – supporting Demand Reduction through primary intervention, secondary preventions and tertiary prevention	☒
Transforming Community Care in Neighbourhoods - fully realising the benefit of neighbourhood team working with a focus on the assets of residents and communities and providing proactive care	☒
Optimise Care in institutional settings and prioritising the key characteristics of reform.	☐

BURY INTEGRATED CARE PARTNERSHIP

Links to Locality Plan priorities	

Implications						
Are the risks already included on the Locality Risk Register?	Yes	☐	No	☐	N/A	☒
Are there any risks of 15 and above that need to be considered for escalation via an NHS GM Statutory Committee or Board in line with the Risk Escalation process ?	Yes	☐	No	☒	N/A	☐
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☐	N/A	☒
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☒	N/A	☐
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☒	N/A	☐
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☒	N/A	☐
Are there any financial Implications?	Yes	☐	No	☒	N/A	☐
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☒
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
If yes, please give details below:						
Finance – all NHS budgets are now held centrally with NHS GM. None of the services are commissioned from locality budgets.						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
The proposal is to recommission on a more or less like for like basis with no substantial changes to the services commissioned.						
Are there any associated risks including Conflicts of Interest?	Yes	☒	No	☐	N/A	☐
There are risks in relation to the Sensory Service and VCSE element of the Neighbourhood Mental Health Team. These are referenced briefly in the paper for information and fully articulated in the Mental Health programme risk register. The risks are monitored through the Bury Mental Health Programme Board and reported to the Bury Locality Board where the score is 12+. There are no conflicts of interest on the part of the author or any NHS GM or Bury Council officer involved in making the recommendations.						

Governance and Reporting		
Meeting	**Date**	**Outcome**
N/A		

BURY INTEGRATED CARE PARTNERSHIP

Mental health commissioning intentions

1. Introduction

One mental health contract is currently out of contract and three VCSE mental health contracts expire in March 2027.

The paper summarises the current position and makes recommendations about future commissioning intentions for consideration by the Board.

2. Background

In previous years some elements of the budget for Mental Health Commissioning were allocated to localities. In relation to provider contracts the budget related mainly to the commissioning of locality specific provider commissioning [largely from the VSCE]. Over the course of the last year almost all commissioning budgets have been centralised. As in previous years the contracts are between NHS Greater Manchester and the commissioned provider.

While financial governance arrangements therefore don't necessarily require formal approval from Locality Boards or their equivalent the purpose is to ensure that the Bury Locality Board has the opportunity to be sighted on and approve specific commissioning intentions in relation to the services provided to Bury residents.

In all cases final approval to recommission will be subject to NHS GM financial and procurement governance processes and compliance with procurement regulations.

3. The services

3.1 Peer Led Crisis Service (VCSE provider: BIG in Mental Health]

This service provides community based support to adults experiencing a mental health crisis. The service is provided through bookable appointments and drop-ins both during the day and in the evenings. The workforce is made up of people with lived experience of mental ill-health who provide crisis support and follow up along with signposting and referral to NHS and a wider range of other community based support services. The service is well established and is highly integrated with NHS crisis services and our Neighbourhood Mental Health Team. It forms part of a wider GM model of VCSE led crisis response services operating as part of an integrated pathway with NHS mental health trusts.

Contract type: NHS standard contract.

Contract expiry date: 31st March 2027

Annual contract value: c£416,098

Recommendation: recommission for two further years on a like for like basis.

Rationale:

- The service is meeting all contractual requirements in relation to quality and performance.

BURY INTEGRATED CARE PARTNERSHIP

- Positive feedback from service users.
- The service is integral to local mental health crisis pathways and contributes to national requirements to provide 24/7 crisis response.
- The service demonstrates value for money in diverting patients from presenting to A&E.

3.2 **Community based mental health and wellbeing support (VCSE provider: the Creative Living Centre)**
The service provides person-centred, holistic support to adults experiencing mental or emotional distress to enable them to better understand and manage their mental wellbeing. It aims to increase understanding of mental and emotional health in the wider community**.** The service provides a range of individual group and activity-based support as well as access to counselling.

Contract type: Grant agreement.

Annual grant value: c£144,390

Grant agreement expiry date: 31st March 2027

Recommendation: recommission for two further years on a like for like basis.

Rationale:
- The service is meeting all grant requirements in relation to quality and performance.
- Positive feedback from service users.
- The service provides a valuable range self-referral mental health and wellbeing services in the borough.
- Value for money is demonstrated through reducing demand on NHS services.

3.3 **VCSE element of the Bury Neighbourhood Mental Health Service (VCSE providers: BIG in Mental Health and the Creative Living Centre with additional input from Early Break).**
The service provides the VCSE element of the adult Living Well / Neighbourhood Mental Health Service. Living Well is an innovative approach to helping people achieve good mental health in community settings and it underpins the NHS Community Mental Health Framework vision.
The VCSE team support people to achieve their personal goals and connect them with wider community support as appropriate. The team offer a combination of in person and remote interventions and the model aligns to the GM Living Well Handbook.

The VCSE team work closely with the clinical practitioners from PCFT to provide the Neighbourhood Mental Health Service. They attend weekly Huddles which are established in line with the Bury neighbourhood model and a weekly MDT led by a PCFT Consultant. There is strong evidence of a positive and collaborative working environment with effective structures of support and supervision and retaining a strong focus on Living Well's principles.

Contract type: Bury Council Contracts.

Annual contract value: c£299,397

Contract expiry date: 31st March 2027

BURY INTEGRATED CARE PARTNERSHIP

Recommendation: recommission for two further years on a like for like basis.

Rationale:

- The service is meeting all contractual requirements in relation to quality and performance.
- Positive feedback from service users.
- The service forms an integral part of the Bury Neighbourhood Mental Health Service working in partnership with PCFT.

Risks and issues:

It should be noted that there is a financial risk in relation to the sustainability of this service. The service was originally commissioned on a budget that incorporated a recurrent allocation plus an underspend that was accumulated due to Bury being among the last localities in Greater Manchester to go live with the Living Well model. This was done in order to commission the most viable possible model. As a consequence, there is s shortfall in recurrent funding of c£138,000 per annum from April 2027. Discussions are underway with NHS Greater Manchester commissioning and finance leads to seek to identify the additional funding required to commission on a minimum like for like basis.

In addition, the existing budget falls well short of that required to deliver the full workforce model as set out in the GM Living Well Handbook. The Bury Mental Health Strategy recognises this and one of our key priorities over the next three years is to expand the capacity and skill mix of the Bury Neighbourhood Mental Health Service across both the clinical and VCSE elements.

The service is funded by NHS Greater Manchester but the service was initially contracted through Bury Council. The preferred approach is to recommission the service through NHS GM on an NHS standard contract. This will bring Bury into line with the approach in other localities. Discussions are in progress with NHS Greater Manchester commissioning and finance leads to agree a commissioning approach which is compliant procurement regulations.

3.4 **Bury Sensory Service (Provider: First Point Family Support Services Ltd with the direct service provision subcontracted to Rehabilitation for Independence)**

The service is commissioned to provide specialist assessment for children who present with sensory processing needs, parental workshops and system workforce sensory processing training. Sensory processing difficulties are commonly present in children with neuro developmental disorders such as autism.

During 2024.25 the pathway was redesigned in response to learning from the pilot and subsequent delivery to better manage the level of demand using triage and a graduated approach in response to presenting need and complexity.

Contract type: NHS Standard Contract

Annual contract value: c£240,089

Contract expiry date: 31st March 2026 [currently operating on an implied contract]

Recommendation 2026.27: recommission on a like for like basis.

BURY INTEGRATED CARE PARTNERSHIP

Recommendation for subsequent years: review followed by procurement based on the recommendations.

Rationale:

- We know that there is a high demand for sensory processing support to children and families and especially for children with neuro-developmental disorders as well as an ongoing need to specialist consultancy and support to the children's workforce including health visitors, SENCOs and early years staff.
- The service is relatively well integrated with wider children's services and schools and further work is happening to improve pathways.
- There is positive feedback from families both in relation to the sensory seminars and individual specialist assessment and consultation provided and positive feedback from children's professionals in response to the training provided.
- There is a need to ensure that the service is operating under an up to date NHS contract for the current year.
- It is timely to review service model required in the context of wider changes, notably the Greater Manchester CYP neurodevelopment transformation programme and the Bury SEND reform plan to ensure that we have the most appropriate model in future years.

Risks and issues:

- There have been some challenges mobilising the new graduated approach and embedding the use of the Sensory Toolkit as and work is underway to try and ensure that more children and families get the right level of support in a timely way.
- The timescale for service review and a full procurement exercise to have a new service in place for April 2026 is very tight. There is a risk that this can not be achieved in the time available.
- Discussions will be undertaken with locality partners and NHS Greater Manchester contracts and procurement teams to identify options for mitigating the risk of a gap in provision.

4 Recommendations

4.1 The service specific recommendations are set out above. The Bury Locality Board is asked to approve the recommendations.

5 Actions Required

5.1 The next steps will be to progress the require service reviews where these are outstanding and take the required evidence and forms through NHS Greater Manchester finance and governance processes.

Ian Trafford
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October 2026

BURY INTEGRATED CARE PARTNERSHIP

Meeting: Locality Board			
Meeting Date	05 October 2026	**Action**	Receive
Item No.	11	**Confidential**	No
Title	Population Health update		
Presented By	Jon Hobday – Director of Public Health		
Author	Jon Hobday – Director of Public Health		
Clinical Lead	N/A		

Executive Summary
An overview of the work discussed and planned in key population health/public health meetings.
Recommendations
To note the work being discussed.

OUTCOME REQUIRED *(Please Indicate)*	**Approval** ☐	**Assurance** ☐	**Discussion** ☐	**Information** ☒
APPROVAL ONLY; (please indicate) whether this is required from the pooled (S75) budget or non-pooled budget	**Pooled Budget** ☐	**Non-Pooled Budget** ☐		

Links to Locality Plan outcomes	
To support a local population that is living healthier for longer and where healthy expectancy matches or exceeds the national average by 2025.	☒
To achieve a reduction in inequalities (including health inequality) in Bury, that is greater than the national rate of reduction.	☒
To deliver a local health and social care system that provides high quality services which are financially sustainable and clinically safe.	☐
To ensure that a greater proportion of local people are playing an active role in managing their own health and supporting those around them.	☒

BURY INTEGRATED CARE PARTNERSHIP

Implications						
Are the risks already included on the Locality Risk Register?	Yes	☐	No	☐	N/A	☒
Are there any risks of 15 and above that need to be considered for escalation via an NHS GM Statutory Committee or Board in line with the Risk Escalation process ?	Yes	☐	No	☐	N/A	☒
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☐	N/A	☒
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☐	N/A	☒
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☐	N/A	☒
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☐	N/A	☒
Are there any financial Implications?	Yes	☐	No	☐	N/A	☒
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☒
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☒

Governance and Reporting		
Meeting	**Date**	**Outcome**
N/A		

BURY INTEGRATED CARE PARTNERSHIP

Population Health and Wellbeing update

1. Introduction

1.1. This paper sets out recent population health updates from the Bury Health and Wellbeing Board.

2. Bury Health and Wellbeing Board

2.1 The Bury Health and Wellbeing Board met on 3 September. The agenda included discussions on community safety, neighbourhood working, health and wellbeing data, and childhood obesity.

2.2 Community Safety

- An update was received on community safety priorities, including serious violence, domestic abuse, safeguarding children, inclusive communities, safer places and counter-extremism activity. It was highlighted that Bury continues to have lower violence rates than the Greater Manchester average, with targeted work underway on knife crime hotspots and repeat domestic abuse. In addition, learning from the Southport Inquiry is being incorporated into local safeguarding and risk management arrangements.

2.3 Neighbourhood working

- Progress was reported on neighbourhood working across Bury's five neighbourhoods, strengthening integrated working between health, social care, housing, police, VCSE and wider partners. Focus remains on prevention, demand reduction, Live Well implementation, neighbourhood leadership teams and family hub development. Whitefield Live Well Centre opening was discussed, along with further locality-based development planned across the borough.

2.4 Health and Wellbeing data

- A verbal update was received on health and wellbeing data and trends, supporting ongoing monitoring of population health outcomes
- The key positive findings are that smoking rates continue to fall, children’s levels of physical activity are improving, community wellbeing remains string with lower levels of crime.
- The key areas of concern are increasing child poverty and economic inactivity, mental health pressures (particularly in young people), obesity and unhealthy weight continues to get worse despite all the work being done one the agenda.

2.5 Childhood obesity

- The Board considered rising levels of excess weight among children, particularly in more deprived communities. Members endorsed the whole-system approach being led through the Obesity Alliance, recognising obesity as an inequalities issue linked to wider determinants such as poverty, food environments and opportunities for physical activity. Further work will focus on healthy environments, schools, neighbourhood approaches and active travel.

2.6 Overall Themes

- Continued emphasis on prevention, neighbourhood-based working, reducing inequalities and strengthening community assets.

BURY INTEGRATED CARE PARTNERSHIP

- Opportunities for localities to support targeted obesity prevention, Live Well delivery, safeguarding, domestic abuse prevention and early intervention.
- Greater integration of health, care, VCSE and community safety partners through neighbourhood teams and Public Service Leadership Teams

Jon Hobday
Director of Public Health
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October 2026