BURY INTEGRATED CARE PARTNERSHIP

Agenda

Locality Board – Meeting in Public (on Teams)

Date: 2nd March 2026

Time: 4.00 pm – 6.00 pm

Venue: Microsoft Teams

Chair: Cllr O'Brien

Item No.	Time	Duration	Subject	Paper Verbal	For Approval Discussion Information	By Whom
1.0	4.00 – 4.10	10 mins	Welcome, apologies and quoracy	Verbal	Information	Chair
2.0			Declarations of Interest	Paper	Information	Chair
3.0			Minutes of previous meeting held on 2nd February 2026 and action log	Paper	Approval	Chair
4.0			Public questions	Verbal	Discussion	Chair
Place Based Lead Update						
5.0	4.10 – 4.20	10 mins	Key Issues in Bury	Paper	Discussion	Lynne Ridsdale
6.0	4.20-4.30	10 mins	VCFE Focus - Spectrum Gaming	Verbal	Discussion	Andy Smith
Locality Board Priorities						
7.0	4.30-4.40	10 mins	Maternity Report	Paper	Discussion	Cathy Fines
8.0	4.40-4.50	10 mins	GM Children and Young people Neuro Diverse pathway	Paper	Discussion	Will Blandamer
9.0	4.40-4.55	15 mins	Draft Place Partnership Agreement	Paper	Discussion	Lynne Ridsdale/Will Blandamer
Integrated Delivery Collaborative Update						
10.0	4.55-5.05	10 mins	Integrated Delivery Board Update	Paper	Discussion	Kath Wynne-Jones
11.0	5.05-5.15	10 mins	NCA Organisational Strategy engagement	Paper	Discussion	Lorna Allan

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Updates						
12.0	5.15-5.25	10 mins	Strategic Finance Group	Paper	Discussion	Simon O'Hare
Committee/Meeting updates						
13.0	5.25-5.30	5 mins	PCCC Highlight report	Paper	Information	Adrian Crook
14.0	5.30-5.40	10 mins	Performance & Quality Group update including quarterly Risk report	Paper	Information	Cathy Fines/Kath Wynne-Jones
15.0	5.40-5.45	5 mins	SEND Improvement and Assurance Board Minutes	Paper	Information	Will Blandamer
Closing Items						

16.0	5.45	5 mins	Any Other Business	Verbal
17.0	_____	_____	**Date and time of next meeting in public - Monday, 13th April 2026, 4.00 - 6.00pm in Committee Rooms A and B, Bury Town Hall**	_____

		5 mins	Post Meeting Reflection	Verbal/All

BURY INTEGRATED CARE PARTNERSHIP

Meeting: Locality Board			
Meeting Date	02 March 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 2nd March 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	Bury Council - Councillor	X			Direct	Councillor		Present	As per policy - see details above
				Young Christian Workers - Training & Development	X			Direct	Development Team		Present	
				Labour Party		X		Direct	Member		Present	
				Prestwich Arts College		X		Direct	Governor		Present	
				Bury Corporate Parenting Board		X		Direct	Member		15/01/2025	
				No Barriers Foundation		X		Direct	Trustee		Present	
				CAFOD Salford		X		Direct	Member		Present	
				Caterian Association		X		Direct	Member			
				USDAW		X		Direct	Member			
				Prestwich Methodist Youth		X		Direct	Trustee		Present	
				Unite the Union		X		Direct	Member		Present	
Cllr	Tamoor	Tariq	Executive Member of the Council Adult Care and Health	Bury Council - Councillor	X			Direct	Councillor	May-10	Present	As per policy - see details above
				Health Watch Oldham	X			Direct	Manager	Aug-20	29-Jul-24	
				Pretty Little Thing				Indirect			Present	
				Action Together CIC	X			Direct	Employed		15-Jan-25	
				The Derby High School			X	Direct	Governor	Apr-18	Present	
				St Lukes Primary School		X		Direct	Member		15-Jan-25	
				Unite the Union		X		Direct	Community Member	May-12	Present	
				Labour Party		X		Direct	Member	Jun-07	Present	
Cllr	Smith	Lucy	Executive Member of the Council for Children and Young People	Bury Council	X			Direct	Councillor		Present	As per policy - see details above
				Business in the Community	X			Direct		July 2023	Sep-23	
				The Christie NHS Foundation Trust				Indirect	Related to Spouse		Present	
				Labour Party				Direct	Member		Present	
				Community in the Union				Direct	Member		Present	
				Co-operative Party	X			Direct	Member	Jul-24	Present	
				Socialist Health Association				Direct	Member		Present	
				Good Campaigns Company	X			Direct	Employed	Jul-24	Present	
				Catholics for Labour				Direct	Member		Present	
				GMB Union				Direct	Member		Present	
Dr	Fines	Cathy	Associate Medical Director and Named GP	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	
	Jackson	Catherine	Associate Director of Nursing, Quality & Safeguarding	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)
	O'Hare	Simon	Locality Finance Lead	Simkat Shore Holdings LTD	X			Direct	Director	Apr-19	Present	As per policy - see details above. (Y,Y,Y,Y,Y)
	Kissock	Neil	Director of Finance/Section 151 Officer	None Declared					Nil Interest	Aug-24	Present	
Voting Members (Aligned & Non-Pooled Budget)												
Dr	Howarth	Vicki	Medical Director – Bury Care Organisation, NCA	Unilabs Ltd - Private Histopathology Service	X			Direct	Providing services as Consultant Histopathologist to the	2011	Present	As per policy - see details above (Y,Y,Y,Y,Y)
				Tameside and Glossop Integrated Care NHS Foundation Trust	X			Direct	Bank Consultant Histopathologist performing Coronial Post-	2015	Present	
	Fawcus	Joanna	Director of Operations, NCA	None Declared					Nil Interest	Nov 23	Present	
	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	Trustee at St Leonard's Hospice in York			X	Direct	Trustee	Dec-23	Present	
				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	X			Direct	Medical Director	1994	Present	
				Laserase Bolton - Provider of a range of cosmetic laser and injectable				Indirect	Spouse is a Shareholder	2012	Present	
				Tower Family Health Care - Primary Care General Practice				Indirect	Spouse is a Director	Jul-18	Present	
	Preedy	Sarah	Chief Operating Officer, Pennine Care NHS Foundation Trust	None Declared					Nil Interest	Nov 23	Present	
	Hargreaves	Sophie	Chief Officer, Manchester Foundation Trust	Manchester & Trafford LCO				Indirect	Spouse works as Transformation Manager	Sep-18	Present	As per policy - see details above (Y,N,N,N,N)
	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	Deputy Place Based Lead & Executive Director Health and Adult Care	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
	Bulman	Richard	Director of Nursing, Bury Care Organisation	None Declared					Nil Interest	2025	Present	
	Crook	Adrian	Director of Adult Social Care and Community Services	Bolton Hospice			X	Direct	Trustee	Jul-05	Present	As per policy - see details above (Y,Y,Y,Y,Y)
Non-Voting Members												
	Wynne-Jones	Kath	Chief Officer, Bury Integrated Delivery Collabrative	KWJ Coaching and Consulting	X			Direct	Owner	July 21	Present	As per policy - see details above (Y,Y,Y,Y,Y)
				Roots and Branches CIC	X			Direct	Director	Nov 23	Present	
				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	
	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	Smith	Mike	Attendee of the Locality Board as Leader of Radcliffe First	Angles and Arches	X			Direct	Director	16/1/2009	Present	As per policy - see details above (Y,Y,Y,Y,Y)
				St Philips Community Centre Radcliffe		X		Direct	Member of Sub Committee	Jul-24	Present	
				Anodising Colour		X		Indirect	Spouse is a lab technician	2017	Present	
				Radcliffe First		X		Direct	Leader	2019	Present	
				Radcliffe Market Hall Community Benefit Society		X		Direct	Member	Jul-24	Present	
				Radcliffe Litter Pickers		X		Direct	Member	2019	Present	
				Growing Older Together		X		Direct	Member	2019	Present	
Cllr	Arif	Shahbaz	Cllr Bury Council, Conservative Leader	Conservative Councillor Association		X		Direct	Member	Jun 25	Present	
				Conservative Muslim Forum		X		Direct	Member	June 25	Present	

BURY INTEGRATED CARE PARTNERSHIP

Meeting: Locality Board			
Meeting Date	02 March 2026	Action	Approve
Item No.	3	Confidential	No
Title	Minutes of the Previous Meeting held on 2nd February 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 2nd February 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 - 2nd February 2026

Time: 4.00pm – 6.00pm

Venue: Committee Rooms A & B, Bury Town Hall, Knowsley Street, Bury

Title	**Draft Minutes of the Locality Board**
Author	
Version	0.1
Target Audience	Locality Board
Date Created	2nd February 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**

BURY INTEGRATED CARE PARTNERSHIP

Locality Board

MINUTES OF MEETING
Locality Board Meeting in Public Committee Rooms A & B, Bury Town Hall, Knowsley Street, Bury 2nd February 2026 4.00 pm until 6.00 pm **Chair – Dr Cathy Fines**

ATTENDANCE

Voting Members
Dr Cathy Fines, Senior Clinical Leader in the Borough (Chair) Cllr Eamonn O'Brien, Leader of Bury Council Cllr Tamoor Tariq, Executive Member of the Council for Adult Care and Health Cllr Lucy Smith, 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 Dr Nina Parekh (PhD), Divisional Managing Director Bury Community Services Division Ms Helen Tomlinson, Chief Officer, Bury VCFA (Voluntary, Community, Faith & Social Enterprise) Ms Jeanette Richards, Executive Director of Children and Young People, Bury Council Mr Jon Hobday, Director of Public Health Mr Will Blandamer, Deputy Place Based Lead, Executive Director of Health and Care Mr Adrian Crook, Director of Adult Social Services and Community Commissioning Ms Catherine Jackson, Associate Director for Nursing, NHS Greater Manchester (Bury) Dr Kiran Patel, Medical Director, IDCB Mr Gareth Robinson, Executive Lead, NHS Greater Manchester
Non-Voting Members
Ms Kath Wynne-Jones, Chief Officer, Bury IDC Mr Stuart Richardson, Chief Executive, Bury Hospice
Invited Members and Observers
Mrs Chloe Ashworth, Democratic Services, Bury Council Mrs Emma Kennett, Head of Locality Admin & Governance, NHS Greater Manchester (Bury) Mr Ian Trafford, Head of Programmes, Bury IDC Mr Gary Flanagan, Assistant Director – Mental Health Strategic Commissioning, NHS Greater Manchester (via video link) Ms Ceri Kay, Bury Council Ms Tamara Zatman, NCA Ania Stark-Ketcher, Chief Executive Officer, Bury Age UK

BURY INTEGRATED CARE PARTNERSHIP

MEETING NARRATIVE & OUTCOMES

1.	Welcome, Apologies and Quoracy
1.1	The Chair welcomed all to the meeting. It was reported Mr Gareth Robinson was attending today's Locality Board meeting as the NHS Greater Manchester Executive Member representative.
1.2	Apologies were received from Ms Sarah Preedy, Mr Simon O'Hare and Ms Catherine Wilkinson.
1.3	The meeting was declared quorate.

2.	Declarations Of Interest
2.1	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).
2.2	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.
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 GM (Bury Locality) Corporate Office within 28 days of a change occurring to ensure that the Declarations of Interest register can be updated.
2.8	**There were no new declarations of interest from today's meeting 2nd February 2026 and the previous meeting 1st December 3rd 2025.**

ID	Type	The Locality Board	Owner
D/02/01	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 1st December 2025 were considered as a true and accurate reflection of the meeting.
3.2	The following updates were received in respect of the Action Log: - • A/07/02 – Neighbourhood Communications – Ms Wynne-Jones had been progressing a number of case studies/videos within this area which was referenced as part of the IDC Board update. It was noted that there was a broader risk in relation to communications and engagement from a locality perspective which would need to be worked through. It was noted that this particular action could be closed. • A/09/02 – in relation to the Cancer action, the performance elements would be addressed via the newly established Performance & Quality Group and this could therefore be closed. • A/12/01 – It was highlighted that a discussion had taken place at the GP Engagement Event in relation to the Citizens Advice Bureau and the current service offer as per discussions at the last Locality Board. This action could be closed.

ID	Type	The Locality Board	Owner
D/02/02	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/02/03	Decision	Received the update.	

5.	Place Based Lead Update
5.1	Ms Ridsdale presented the latest Place Based Lead update to the Locality Board. It was reported that: - • Work continued through the SEND Improvement and Assurance Board to improve outcomes for children, young people and families. The Bury SEND Partnership Board was expecting a reinspection at some point before Easter following the judgement in May 2024, and the focal point for the reinspection would be the extent to which Effective Action was being taken by the partnership as a whole against the performance improvement plan previously shared with the Board. • The partnership participated in an Area SEND engagement meeting led by CQC and Ofsted in October 2025 and the report from that meeting was attached for reference in Appendix 1 to this report. The partnership was able to provide assurance on significant action being taken and also recognised areas for further work and refinement. NHS partners would be pleased in the progress being made in waiting times pertaining to the SEND cohort and there were other examples of best practice reference particularly in relation to the SEND HV team in NCA. The context for the improvement work on

	SEND was included within the Bury SEND Strategy and this was attached once again for reference as part of the Locality Board papers as Appendix 2 to this report. • The notes of the Bury SEND improvement and Assurance Board were attached as a paper to the meeting at Agenda Item number 16. The more recent SIAB had a particular focus on the Greater Manchester wide proposed ND pathway, and this was also the subject of consideration at the Health Scrutiny Committee on 28/1/26. Parents and Carers were particularly concerned to see details of the process of implementation of the triage process for the current and future waiting lists. Work was ongoing with partners including NCA, Pennine Care, and First Point who provide the ND hub, to explore opportunities for codesigning the process of triage such that it is undertaken in the full knowledge of the range of support arrangements in the borough. It was recognised that it was essential that all children get support appropriate to their needs. Ms Ridsdale thanked all partners, particularly NCA and Pennine Care for their continued support for this important programme of work. • The transition to the new operating model and new organisational structure for the ICB was progressing rapidly. Last week saw the commencement of the 21-day consultation on structures following publication, and the departure of a number of valued staff under wave 1 redundancy. In Bury, the proposed place-based structure, following the potential aggregation of some functions to pan GM portfolio, focuses on three pillars – neighbourhood working, new models of care, and a smaller place governance and administration function. Ms Ridsdale placed on record her thanks to the 10 staff from the Bury locality team who have left or who are leaving under VR and for their outstanding contribution to the partnership in the borough. • It was noted that the potential to move NHS GM teams to an alternative employer was recognised in the consultation documentation but was not formally part of the consultation. Further work was required with partners on this point, including with organisations in Bury. • Work was progressing to inform the mobilisation of place-based working including the development of a Place Partnership Agreement, Place Outcomes and Place funding. • In relation to the Team Bury Priorities for 2026/2027, each part of the partnership structure in Bury, including for example the Community Safety Partnership and the Bury Business Partnership would be invited to reflect on their own contribution. The Integrated Delivery Board would review and ensure all partners to the Bury Integrated Care Partnership were sighted on the opportunity to make a contribution to the priorities. • In terms of the funding of the Independent Sector provision for routine elective care. Locality Board members were aware of the GM Stakeholder briefing from the ICB relating to information published on the website regarding temporary delays to NHS-funded care delivered by independent hospitals in Greater Manchester. Due to financial pressures and high demand across the system, some independent sector providers of routine planned (elective) care have been asked to pause new routine NHS referrals and the start of new treatment pathways until 31 March 2026. This temporary measure supported fair and clinically appropriate management of waiting lists across Greater Manchester. Further information could be located on the NHS GM website • In relation to the Undertakings and the associated NHS Commitments, it was advised that NHS Greater Manchester had reached an important milestone in its improvement journey, demonstrating real progress across several core areas of system leadership and delivery. NHS England had now confirmed that NHS GM – the Integrated Care Board for the city region – has successfully met the undertakings it set out in July 2024

5.2	relating to governance, performance, quality, leadership, and programme management. These achievements were result of sustained effort across the partnership – including local authorities, NHS providers, primary care, the VCSFE sector, and wider community partners and I a sincere thank you was extended to all partners for their efforts. The following comments/observations were made by Locality Board Members: - • It was important for the Locality Board to express its gratitude to all of the NHS Greater Manchester staff who have departed the organisation under wave 1 of the Voluntary Redundancy scheme. Staff were commended for all of their hard work in recent months and years as part of a farewell get together that took place on the 29th January 2026. Ms Ridsdale, Mr Blandamer and Cllr Tariq were all in attendance to bid farewell.

	Type	The Locality Board	Owner
D/02/04	Decision	Received the update.	
D/02/05	Decision	Expressed its gratitude to all of the NHS Greater Manchester staff who have departed the organisation under wave 1 of the Voluntary Redundancy scheme in the context of all of their hard work in recent months and years	

6.	VCFE focus – Bury Age UK
6.1	Ms Ania Stark-Ketcher was in attendance for the VCFE focus item to provide an overview of Bury Age UK. It was reported that: - • Age UK Bury was formed in 2011 after a merger with Age Concern, which began in 1971. • It was a trusted independent local charity working across the borough of Bury. • It supported people 50+, their families and carers and aimed to help everyone love later life and retirement. • Every penny goes back to the community supporting people 50 and over. • There were 92 volunteers and 26 staff who work for Age UK. • Provided support to people over 50+, offering advice, physical and emotional to improve well-being and reduce isolation • Promoted independence and dignity, helping people remain active, confident and involved in their community. • Combatted loneliness by creating opportunities for social connection, engagement and companionship. • Strengthened community connections. • There were a number of services provided by Age UK including Information and advice, home from hospital, Befriending, Keeping in Touch, Friends Together Hubs and Dumers Lane Community Centre, Handy person, Jubilee café and social events • The Jubilee Centre was situated at Clarence Park overlooking the beautiful location at the lido. The centre was opened on 19th September 1996 and provided a vibrant community hub that brought people together offering a range of services and activities • There were Age UK Charity shops in Bury Town Centre and Ramsbottom.

6.2	The following comments/observations were made by Locality Board Members: - • The VCFE update was a key component of the Locality Board agenda which showcased the excellent work and achievements of the VCFE sector in Bury. • Age UK was an important partner that provided a fantastic service within the borough. • A query as to whether Age UK would be interested in getting involved with the ongoing GM infection control work from an older peoples perspective. Ms Ania Stark-Ketcher commented that she would be happy to discuss this further if Mrs Jackson could forward across some further information outside of the meeting. • The home from hospital work was an excellent example of how strong partnership working and communication can make a difference to people lives. • It would be helpful for Age UK to be invited to attend a future GP webinar and Dr Fines would be in contact in this regard.

ID	Type	The Locality Board	Owner
D/02/06	Decision	Noted the update.	
A/02/01	Action	Email to be sent to Age UK in relation to the opportunity to get involved in the ongoing GM infection control work	Ms Jackson
A/02/02	Action	Age UK to be invited to attend a future GP webinar and Dr Fines would be in contact in this regard.	Dr Fines

7.	Neighbourhood Working
7.1	Ms Wynne-Jones presented a report in relation to Neighbourhood Working. As part of the papers, a summary slide deck outlining the holistic approach to the neighbourhood development in Bury was included.
7.2	It was reported that a working draft of the Greater Manchester neighbourhood planning submission that was due on the 13th February 2026 would be circulated to members for information.
7.3	It was highlighted that following the national neighbourhood pilot, NHS NW have announced a local pilot to support neighbourhood working, which would involve monthly team coaching. The IDC Board have considered this and supported us submitting an expression of interest by the 11th February 2026. The Locality Board were also asked to support this, with a suggestion of a particular focus on bringing together offers for adults, children's and families.
7.4	The following comments/observations were made by Locality Board Members: - • Neighbourhood working was at the heart of the 'Lets Do it Strategy' and there was a need to ensure that the NHS Planning requirements as well as the Council/Social care requirements were all covered off as part of these plans hence was a need to acknowledge the different reporting requirements that exist. • It would be helpful to see further iterations of these neighbourhood slides at future meetings over the Locality Board in the coming months which would enable the locality to challenge itself on progress made. • There was a need to ensure that the neighbourhood work was aligned with the wider public sector reform agenda and that appropriate data stratification is utilised to ensure tangible delivery and outcomes across services.

ID	Type	The Locality Board	Owner
D/02/07	Decision	Noted the update.	
A/02/03	Action	A working draft of the Greater Manchester neighbourhood planning submission that was due on the 13th February 2026 would be circulated to members for information	Ms Wynne-Jones

8.	Greater Manchester Commissioning intentions
8.1	Mr Blandamer submitted a set of slides that outlined the strategic picture ahead for 2026/27 in the context of the Greater Manchester Strategy for 2025 to 2035 and the 10 Year Health Plan 2025-2035. It was reported that: - • The Strategic Commissioning Plan for 2026-2031 would start with the outcomes namely Improved health outcomes, Improved patient experience, Improved effectiveness and Improved efficiency. • The NHS Planning Guidance for 2026/27 set out, for the first time, a requirement for Neighbourhood Health Plans (as set out as part of Agenda Item Number 7). • The Commissioning intentions for 2026-27 were framed in the context of the current ICB Strategic Priorities. NHS Planning Guidance for 26/27 requested that ICBs "set commissioning intentions and outcome-based service specifications to enable providers to undertake effective operational planning aligned to national and local priorities"
8.2	The following comments/observations were made by Locality Board Members: - • It was helpful that the Greater Manchester Strategy and Plan had been shared with the Locality Board at this stage to ensure these is alignment with plan plans/arrangements.

ID	Type	The Locality Board	Owner
D/02/08	Decision	Noted the update.	

9.	Mental Health
9.1	*Mr Trafford and Mr Flanagan (via Video link) was in attendance for this item.*

9.1	Mental Health GAP Analysis
9.2	Mr Blandamer reported that unfortunately Ms Preedy had been unable to attend today's meeting. However he had spoken to a a number of Pennine Care exec Directors and it was agreed the gap analysis would be revisited (and consistently provided to all 5 localities served by Pennine care) in the summer following the implementation of commissioning intentions and contract changes (the subject of the next agenda item), that it would be recognised do address some of the previously identified gaps.

ID	Type	The Locality Board	Owner
D/02/09	Decision	Noted the update.	
A/02/04	Action	Mental Health Gap Analysis to be brought back to future Locality Board meeting.	Ms Preedy/Mr Blandamer

9.3	GMICB Mental Health Commissioning Intentions 2026/2027
9.4	Mr Flanagan submitted a report that sets out the process undertaken for agreeing the Greater Manchester priority programmes for Mental Health and Learning Disabilities and Autism for 2026/27. Mr Flanagan also shared a set of slides in this regard. It was reported that: - • In terms of the Mental Health Investment Standard (MHIS) 2026/27, the Total MHIS financial envelope in 2026/27 was £845.9m based on a forecast 2025/26 outturn with 2.03% uplift applied. • Targeted system development funding identified for NHS Talking Therapies for Anxiety and Depression, Individual Placement and Support (IPS) and Mental Health Support Teams in Schools (MHSTs). • The Integrated Fund was based on a significant reduction in independent sector beds, expected to provide in year benefit with financial plans committed to £8m recurrent in 2026/27 with potential to increase. • Capital funding for transformation was circa. £26m 3-4 years – 'Return to Constitutional Standards/Left Shift' and improve urgent and emergency care performance: • The aim for one Neighbourhood Mental Health Centre in every place by March 2029. • 50% coverage of MH EDs/Crisis Assessment Centres for Type 1 EDs by March 2029 • At least 24 new units of LDA Crisis Accommodation • Capacity management & digitised Mental Health Act (MHA) pathways expected by 2030. • 19 national standards for 2026/27 in MH/LDA of 29 total standards the ICB was assessed against. • In relation to the process to identify priorities for 2026/27 this involved Pre-commitments for services (including those which started part way through 2025/26 and require recurrent full year funding), services which have quality/safety issues which require funding to resolve, National 'Must Dos', Services where there is significant and unwarranted variation in provision across GM, Services/schemes which will deliver funding savings in year – to increase the MH Integrated Fund and enable further reinvestment in community mental health services and other priority areas. • The GM priority programmes and the Bury Locality MH Priorities were described.
9.5	The following comments/observations were made by Locality Board Members: - • The gain share approach adopted in relation to Mental Health reinvestment was positive however the funding uplift was not in line with inflation increases which could prove to be problematic as part of the detailed planning processes going forward. • A query as to whether the commissioning intentions would fully address the mental health gaps previously described at the Locality Board. It was emphasised that it would have been helpful to fully assess the Mental Health gaps in conjunction with this agenda item at today's meeting. Mr Blandamer reported that a full report on the Mental Health Gap analysis would be brought back to the Locality Board in the summer 2026 for further analysis.

	• The need to link some of this work to the Primary Care gap analysis and assess where this is any overlap/ gaps that still exist.		
ID	**Type**	**The Locality Board**	**Owner**
D/02/10	Decision	Noted the update.	

9.6	**Bury Mental Health commissioning priorities/intentions**
9.7	Mr Trafford presented a report in relation to the local high level priorities and commissioning intentions for mental health for 2026/27.
9.8	It was highlighted that in most instances the priorities were local implementation of GMICB priorities and commissioning intentions (see paper AI 9a. NHS GM Planning and Prioritisation for MH and LDA 2026.27) which reflects the GM Mental Health and Wellbeing Strategy 2024 - 2029 as a guiding document and the central role of NHS GM as budget holder and commissioner. It was noted that where priorities are specific to the Bury Locality this is identified in the table.
9.9	It was reported that: - • The Mental Health Programme Board had requested that a revised Mental Health Strategy be developed for Bury. • There was a Becor funding risk associated with the Dementia pathway in relation to the GP Memory offer. A piece of work was therefore required in terms of sustainability within this area. • There were also risks associated with the sustainability of myHappymind/ myMindcoach. It was noted that that this programme was currently operating in all primary schools and 10 high schools. Primary school delivery was part funded by schools and part nonrecurrent. High school provision was currently unfunded. Feedback from teachers, parents and pupils had been excellent. • In relation to Domestic abuse support, a sustainable approach was also required as the Provider was currently out of contract but with funding committed pending outcomes of wider review of domestic abuse services led by Bury Council
9.10	The following comments/observations were made by Locality Board Members: - • Concern raised regarding the long term sustainability of myHappymind/ myMindcoach and the need to urgently review this provision given the importance of mental health support in children and young people. A general discussion took place regarding this matter. It was reported that a meeting involving Mr Blandamer, Ms Richards and the Department for Education was taking place during week commencing 9th February 2026 to explore this area further. • It was important that the Mental Health commissioning intentions were fully joined up with the Live Well strategy. • The need to consider how best to engage with diverse populations within Bury in the development of the Mental Health Strategy. It was noted that there were some targeted funds available from the GMICB within this area with services such as Asian Development Association of Bury (ADAB) which provided culturally sensitive mental health and emotional wellbeing support, focusing on Black, Asian, and Minority Ethnic (BAME) communities, including refugees and asylum seekers in Bury. Further discussions were requires within the Jewish community with links required with Manchester and Salford.

	• The need to ensure that the VCFE and social prescribing was covered as part of this work. • The importance for early intervention was outlined in terms of reducing the amount of people requiring crisis support and having problems in adulthood. • There was an opportunity to review the current number of Section117s for adults in the borough and identify whether any efficiencies can be made that could potentially be reinvented elsewhere within mental health services on a gain share type basis. Mr Crook commented that he would commence the adults piece of work within this area. • There was a need to scale up Mental Health reform within schools linked to both the SEND and inclusion agendas. • There was an emerging risk in relation to Youth Justice in Bury in light of the statutory changes within this area as outlined in the recent paper produced for the Bury cabinet meeting.

ID	Type	The Locality Board	Owner
D/02/11	Decision	Considered the priorities.	
D/02/12	Decision	Approved the high level priorities and commissioning intentions as the basis for more detailed programme planning.	

10	Maternity Report
10.1	Item deferred.

ID	Type	The Locality Board	Owner
D/02/13	Decision	Item deferred.	

11.	Integrated Delivery Board Update
11.1	Ms Wynne-Jones presented the latest Integrated Delivery Board report to the Locality Board. It was reported that: - • The proposals emerging from the ICB were becoming clearer about the formal Place Based Partnership requirements in Localities. These were attached as an appendix for information, and would be the topic of the April Board development session. • Work had commenced to define the programme plan and key milestones from April 2026, based on programmes of work already underway. This would need to shift and change as the 4LP and GM programmes become more clearly defined and the capacity available to us at a Borough level becomes clearer. • Following recent discussions about how the system assures performance, the Bury Performance and Quality Group had met for the first time in January, and would undertake assurance on behalf of the IDC and Locality Board. A bi-monthly highlight report from this meeting will replace the full performance report which will be received every 4 months by the IDC Board and Locality Board • Work on strengthening communication channels had commenced, which included the Creation of the Bury Case Study which included Videos to describe the work of the virtual hospital and the neighbourhoods. The virtual hospital video had now been recorded and could be viewed at:

https://vimeo.com/1146529636?share=copy&fl=sv&fe=ci A Christmas newsletter had also been developed (see attached)

- Work had continued by place partners to design the place element of the NCA Clinical Leadership Model. The ambition was to mobilise the new model from April 26, though a transitional approach has been proposed to manage the transition from Care Organisations to Care Groups in the line with the development of the left shift strategy. Members of the ID Board are involved in the leadership of the NCA place group to support the effective engagement of place in the transitional arrangements, with a further workshop taking place on the 30th January 2026.
- Work continued to progress the front-end review of A&E. The recommendations had now been finalised and work underway on the detailed clinical design and contractual processes with the ICB team and how to change the model of delivery.
- A pilot was due to commence in utilising 3 beds in Elmhust to support earlier discharge for stroke patients from FGH. Clinical pathways and processes are currently being finalised to commence in February 2026.

11.2 The following comments/observations were made by Locality Board Members: -

- A query as to whether the Locality Board would value more data from NHS Greater Manchester at a neighbourhood level as part of the transition into the new Operating model arrangements. Dr Fines commented that the availability of robust local neighbourhood data had been a feature of numerous conversations in recent times and needed to be improved. It was noted that a good example of this could be seen within maternity services where data was only currently available on a provider wide basis and was not specific to the Bury registered population. It was reported that some neighbourhood level data was currently being received in the locality however this was not being required on a regular basis therefore any support that Mr Robinson could provide would be greatly appreciated.

ID	Type	The Locality Board	Owner
D/02/14	Decision	Noted the update.	
A/02/05	Action	A further discussion was required from a Greater Manchester perspective in terms of what information could be provided to localities at a neighbourhood level.	Mr Robinson/Mr Blandamer

12.	Draft NCA Clinical Strategy and update on Clinical Led Model
12.1	Ms Zatman was in attendance to provide partners in Bury with an overview of and key content from the draft of the NCA's new clinical strategy – Our Plan for Transforming Care.
12.2	It was highlighted that the purpose of developing this strategy was to establish a clear, high-level framework that set the future direction, ambitions, and priorities required to support transformed care for patients. One which was reflective of national strategic directives, in particular the NHS 10-year plan and Darzi review, and aligned to regional plans including the GM clinical strategy and the priorities identified in Bury's Locality Plan.
12.3	This strategy was required as the population served was growing, diverse and had unique health challenges related to an ageing population and severe deprivation in some areas. Alongside this, we need to address significant current financial challenges and deliver future sustainability through greater productivity and efficiency.

12.4	The following comments/observations were made by Locality Board Members: - • The importance for this strategy aligning with the direction of travel in terms of the neighbourhood plans was outlined. • The need to consider the projected growth within this area when developing strategies and plans was highlighted including the impact this could have on the future workforce. It was noted that similar challenges could be noted in respect of primary care.

ID	Type	The Locality Board	Owner
D/02/15	Decision	Noted the update.	

13.	Strategic Finance Group update
13.1	Mr Blandamer submitted the latest Strategic Finance Group update in the absence of Mr O'Hare. It was reported that: - • The purpose of this report was to update the locality board on the financial position of all partners, with specific focus upon the budgets delegated to the locality board by NHS Greater Manchester (GM) in 2025/26. • Bury council have reported a quarter 2 forecast out turn overspend of £5.86m (2.45%), with pressures across both Childrens and Adults services. This overspend was intended to be mitigated via increased savings delivery or use of reserves if these increases were not delivered. • Month 8 data was available from NHS GM. At month 8 NHS GM was reporting a £83m deficit versus a planned deficit of £70.2m, giving a £12.8m adverse unplanned variance. This position is driven by pressures in NHS providers, driven mainly by pay pressures associated with industrial action and the 2025/26 pay award. In non provider budgets there are pressures associated with ADHD / ASD assessments, section 117 after care costs and all age continuing care (CHC) but these are currently being offset by underspends in other areas. • Within this position the Bury locality budgets, for which this board is responsible for are £2.67m overspent at m8 and are forecasting to be £2.06m overspent at year end, this position is driven by non recurrent pressures brought forward of £1.7m, plus pressures in CHC, ADHD / ASD assessments and in estates. It should also be highlighted that the forecast out turn for 2025/26, for the same budget lines, is within 0.5% of what the actual 2024/25 out turn was and this represents excellent performance. • The overall efficiency target for NHS GM for 2025/26 was £656m, split £175m non providers and £481m GM providers. As at month 8 providers were £27.3m ahead of the YTD plan with non provider budgets £1.7m behind plan with fully delivery of overall plan of £656m forecast. The CIP delivery plan for the locality delegated budgets was £3.04m, which was full identified and full delivery is forecast, with delivery to month 8 being £2.1m or 69%.

ID	Type	The Locality Board	Owner
D/02/16	Decision	Noted the updates on financial positions for 2025/26	
D/02/17	Decision	Noted the requirements of the deficit recovery plan for the locality	

D/02/18	Decision	Approved the 2025/26 operating cost budget and give delegated authority the Place Based Lead to agree these on behalf of the board	

14.	Population Health and Wellbeing update		
14.1	Mr Hobday submitted an update in relation to Population Health and Wellbeing update.		
ID	**Type**	**The Locality Board**	**Owner**
D/02/19	Decision	Noted the update	

15.	Clinical and Professional Senate update		
15.1	Members received a highlight report from the recent meeting of the Clinical and Professional Senate.		
ID	**Type**	**The Locality Board**	**Owner**
D/02/20	Decision	Noted the update	

16.	SEND Improvement and Assurance Board Minutes		
16.1	Members received minutes from the SEND Improvement and Assurance Board meeting held in November 2025.		
ID	**Type**	**The Locality Board**	**Owner**
D/02/21	Decision	Noted the minutes	

17.	Primary Care Commissioning Committee update		
18.1	Item deferred		
ID	**Type**	**The Locality Board**	**Owner**
D/02/22	Decision	Noted the Performance report.	

18.	Any Other Business		
19.1	There were no items raised.		
ID	**Type**	**The Locality Board**	**Owner**
D/02/23	Decision	Noted the information	

19.	Date and time of next meeting
20.1	**Date and time of next meeting in public - Monday, 2nd March 2026, 4.00 - 6.00pm on Microsoft Teams**

BURY INTEGRATED CARE PARTNERSHIP

Locality Board Action Log – February 2026

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

Date	Reference		Action	Lead	Status	Due Date	Update
2nd February 2026	A/02/01	Action	Email to be sent to Age UK in relation to the opportunity to get involved in the ongoing GM infection control work	Ms Jackson		March 2026	.
2nd February 2026	A/02/02	Action	Age UK to be invited to attend a future GP webinar and Dr Fines would be in contact in this regard.	Dr Fines		March 2026	
2nd February 2026	A/02/03	Action	A working draft of the Greater Manchester neighbourhood planning submission that was due on the 13th February 2026 would be circulated to members for information	Ms Wynne-Jones		February 2026	Email sent to Locality Board members on the 3rd February 2026
2nd February 2026	A/02/04	Action	Mental Health Gap Analysis to be brought back to future Locality Board meeting.	Ms Preedy/Mr Blandamer		June 2026	

2nd February 2026	A/02/05	Action	A further discussion was required from a Greater Manchester perspective in terms of what information could be provided to localities at a neighbourhood level.	Mr Robinson/Mr Blandamer		March 2026	

BURY INTEGRATED CARE PARTNERSHIP

Meeting: **Locality Board**			
Meeting Date	02 March 2026	**Action**	Receive
Item No.	5	**Confidential**	No
Title	Place Based Lead Update - Key Issues in Bury		
Presented By	Lynne Ridsdale – Place Lead, NHS GM (Bury) and Bury Council Chief Executive		
Clinical Lead	Dr Cathy Fines		

Executive Summary
To provide an update on key issues of the Bury Integrated Care Partnership.
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	☒

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:						
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		

1. SEND re-inspection

The Locality Board has received routine updates on the work of the Bury SEND Improvement and Assurance Board since 2024 including receiving the minutes of the meetings. I am grateful for the contribution of all partners to the work.

We have received notification from CQC and Ofsted that the reinspection the Council and NHS GM in relation to the work of the Bury SEND Partnership will take place on 9th-11th March 2026.

I am conscious of the enormous amount of work all partners and sectors have done on this agenda and we very much hope that reinspection recognises the progress. I am also conscious that the reinspection itself is potentially time consuming particularly for NCA colleagues in relation to Speech and Language Therapy, Community Paediatrics and Health Visiting, and for Pennine Care Colleagues in relation to CAMHS and the wider ND pathway programme. Thankyou in advance for the support from partners on this hugely important issue for many Bury residents.

Colleagues will be aware that on the same day our inspection notification was received the White Paper on Schools including substantial reference to proposed changes to SEND systems was available. The GM SEND Board will be looking to understand and interpret the changes in the context of the commitment across GM to improve circumstances for children young people and families with SEND and we will update Locality Board on steps in Bury in due course.

2. Place Mobilisation

In my last report I highlighted a number of aspects of the mobilisation of place based partnership working in the context of the revised operating model of NHS GM in place. This agenda covers two aspects of the mobilisation; the draft place partnership agreement, and as part of the Locality Strategic Finance Group update a paper on a potential place fund.

The draft place partnership agreement was circulated to Locality Board members on 17th February and I hope to discuss in this meeting the opportunities presented by agreement. For my part I think the way this Locality Board, and the Integrated Delivery Board beneath it works in Bury is exemplary and therefore the place partnership agreement is not a significant extension of our current operating model. However, we may consider this an opportunity to pause and reflect on the next steps of our partnership together in Bury, recognising significant organisational turbulence and financial challenges of a number of partners.

NHS GM Bury colleagues continue to engage in the development of other aspects of the place mobilisation including the outcomes framework and the future employment model for NHS staff in places.

3. NHS GM Organisational Change

An update report was sent to Locality Board colleagues on 13/2/26 in relation to the NHS GM Organisational Change. Key aspects of the current position are:

- Consultation on the organisational Structure closed on 27th February
- VR Second wave applications were considered in a panel w/c 23/2/26
- Final Structures will be published 11th March
- Filling of post panels commence 16th March
- V2 second wave leavers leave the organisation 31st March

In addition to the HR consequences work continues with place leads, deputy place leads and NHS GM Chief Officers in identifying a number of areas where further clarity is required on the actual implementation of the operating model, the relative balance of responsibilities, and the importance of sustaining statutory partnerships such as safeguarding in places.

4. GM primary care portal

Last week, NHS GM introduced the Greater Manchester Primary Care Portal – a single, secure hub for all service updates, guidance, templates, contacts and more from GM and the 10 localities.

Whether working in general practice, pharmacy, dentistry or optometry, colleagues now have access to a single repository to find the content they need, right when they need it. It will begin to reduce the number of emails that will be circulated across primary care, particularly through the NHS GM primary care communications mailbox.

Primary care providers across GM are being invited to register to use it throughout this week (9-13 February). You can take a tour of the portal with this video user guide.

NHS GM is keen to make teams who regularly share information with primary care providers aware of a new process for submitting content.

Please submit any items you would like added to the portal using the attached template and send it to the GM Primary Care Team at gmhscp.primarycarecomms@nhs.net. The NHS GM upload team will create and publish your content on the portal once it has been reviewed and approved. They will then share a direct link with you to confirm publication.

5. Leadership Meeting

On behalf of the Leader of the Council I would like to thank a number of leaders from the Health and Care system in Bury for taking the time to meet with us on 26th February. It was a really helpful and constructive exchange of views and perspectives and we will reflect on key outcomes as we move into the next stage of our place partnership.

Lynne Ridsdale
Place Lead NHS GM (Bury)
Chief Executive Bury Council
2/3/26

BURY INTEGRATED CARE PARTNERSHIP

Meeting:			
Meeting Date	02 March 2026	Action	Consider
Item No.	7.0	Confidential	No
Title	Bury Maternity Services Update		
Presented By	Dr Cathy Fines/David Latham		
Author	David Latham		
Clinical Lead	Dr Cathy Fines		

Executive Summary
A presentation in relation to Bury Maternity Services is attached for information. The slides were discussed at the Health Scrutiny Committee on the 28th January 2026
Recommendations
The Locality Board are asked to discuss and note the contents of the presentation.

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

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		

NHS
Greater Manchester
Integrated Care

Bury Overview and Scrutiny Committee
Wednesday 28th January 2026

Bury Maternity Service Update

Dr Cathy Fines - GP
Jon Hobday - Director of Public Health
Trudy Delves - Matron Midwifery Led Services Bolton
David Latham - Programme Manager

Bury Maternity Services Update

NHS
Greater Manchester
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National, GM and Local Priorities

Bury Maternity Services Update

National, GM and Locality Priorities

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National Priorities

Make progress towards the national safety ambition to reduce still birth, neonatal mortality, maternal mortality and serious intrapartum brain injury

- Increase fill rates against funded establishment for maternity staff

GM Priorities

- Lead, via the Greater Manchester Local Maternity and Neonatal System, locality progress towards achievement of National Priorities
- Engagement with National Reviews
- Quality and Safety
- Provider Performance

Locality Priorities

- Choice of Provider
- Continuity of Care
- Early appointment booking
- Pursuing Bury patient level data by provider
- System partner communications
- Link to Maternity Voice Partnership Bury Leads
- Support GM Maternity Network
- Support Midwifery Services Delivered at locations in Bury

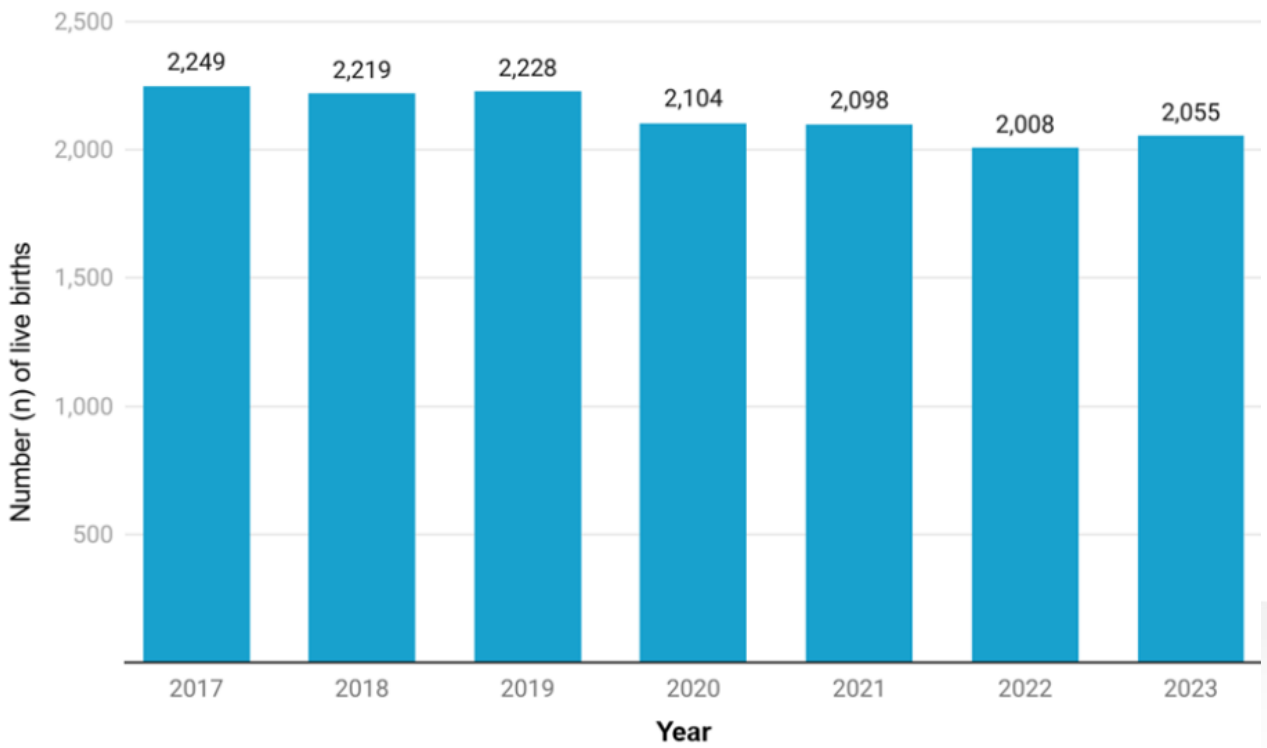
Bury Level Maternity Statistics

Bury Maternity Services Update

Bury Level Maternity Statistics: Number of live births Bury 2017 - 2023

NHS Greater Manchester Integrated Care

Figure 1: Number of live births by area of usual residence, Bury 2017-2023.



Bury Maternity Statistics
(Source Bury JSNA: Pregnancy and Birth | Bury Directory**)**

- Between the years 2017 and 2023, Bury saw a reduction in the number of live births from 2,249 (2017) to 2,055 (2023).
- Year on year figures reduced from 2019 – 2022.
- There was a slight increase of 47 live births in 2023 compared to 2022.

Bury Maternity Services Update

Bury Level Maternity Statistics: Smoking At Time Of Pregnancy 2016-2025

NHS Greater Manchester Integrated Care

Statistics on women's smoking status at time of delivery, England, 2025-26

NHS England

About | SATOD - Time Series | SATOD v2 - Map

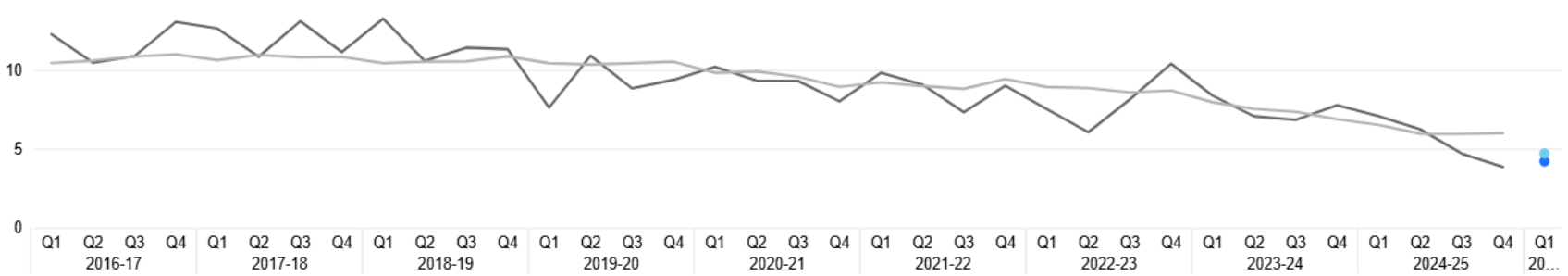
Select Sub-ICB: NHS Greater Manchester ICB - 00V

Select financial year and quarter for table: 2025-26 Quarter 1

Data source changed from Q1 2025-26

Percentage of women that were smokers, by quarter

Click here to view by financial year | Click here to compare data for unknown statuses



Sub-ICB, ICB and national comparisons — 2025-26 Quarter 1

	Maternities (with a known smoking status)	Smokers	% Smokers	Maternities (all)	Unknown statuses	% Unknown statuses
NHS Greater Manchester ICB - 00V	475	20	4.2	490	15	3.1
NHS Greater Manchester Integrated Care Board	7,190	335	4.7	7,560	375	5.0
England	119,795	5,670	4.7	128,595	8,800	6.8

Source: Clinical Outcomes and Indicators, NHS England.

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Bury Maternity Statistics

(Source NHSE: Microsoft Power BI)

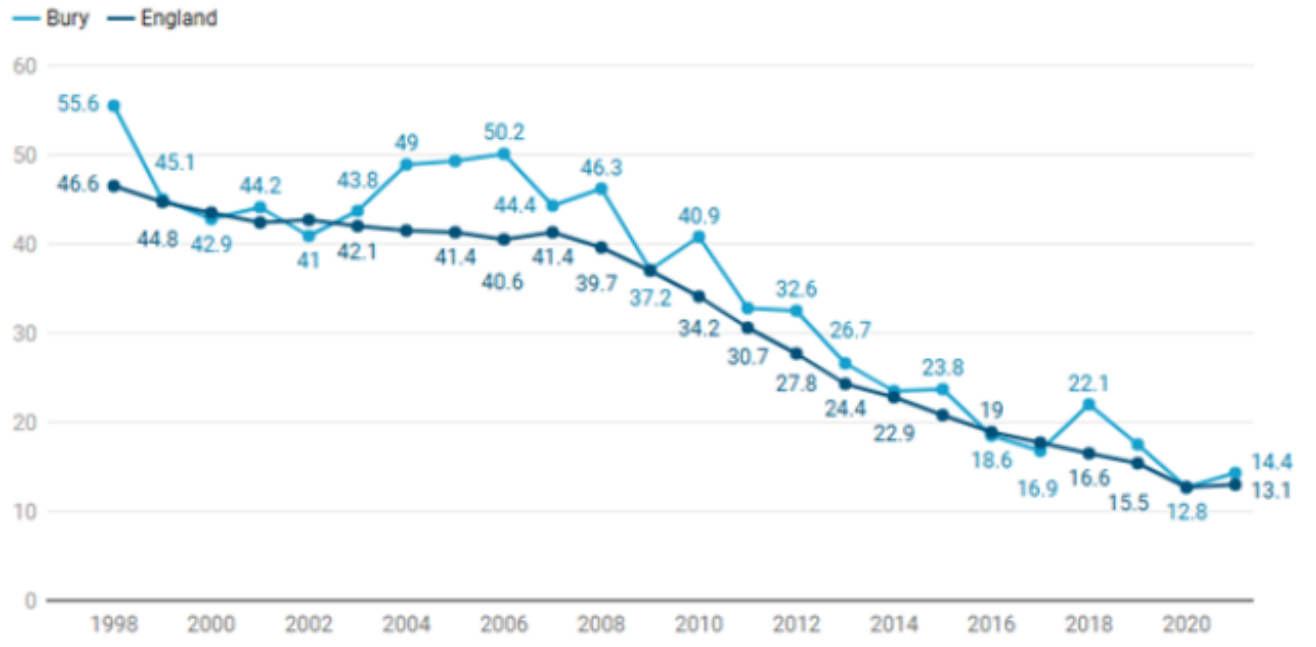
- The National Target was 6% or less by 2022
- From Q1 2025-26 all SATOD statics are taken from the National Maternity Data Set.
- In Q1 2018-19 Bury was recording 13.3% SATOD which was 2.9% behind the national average
- Steady improvement both locally and nationally over the years
- Q1 2025-26 sees Bury at 4.2% ahead of the GM and national performance of 4.7%
- Q1 2025-26 see Bury as the joint 3rd best performing locality in GM.

Bury Maternity Services Update

Bury Level Maternity Statistics: Under 18 Conception Rate 1998 - 2021

NHS Greater Manchester Integrated Care

Figure 4: Conceptions in women aged under 18 per 1,000 females aged 15-17 years for the years 1998 to 2021 for Bury and England (Children and Maternal Health, 2021).



Bury Maternity Statistics

Source (Bury JSNA: Pregnancy and Birth | Bury Directory)

- The infant mortality rate is 60% higher than that of babies born to older women
- Younger woman are at higher risk of adverse pregnancy outcomes.
- The percentages of pregnancy under in under 18's has been declining both nationally and in Bury.
- Most recent figures for the period 2022-23, show 0.5% of pregnancies in Bury were teenage pregnancies (under 18), lower than the national average of 0.6%.

Bury Maternity Services Update

Bury Level Maternity Statistics: Termination of Pregnancy Statistics

NHS Greater Manchester Integrated Care

Central Booking Service Report for: BURY (ICB QOP)
Period: December 2025
Total number of bookings: 30

BPAS British Pregnancy Advisory Service

1. Days to appointment		
Up to 7	28	93%
8 to 14	1	3%
15 to 21	1	3%
Over 21		
Average	2.2	
Median	1	

2. Referrer		
Brook		
FP/CASH		
GP referral		
GUM		
NHS hospital		
Self referral	30	100%
Other		

3. Who called to make the booking		
Client	29	97%
Referrer		
Professional rep		
Personal rep	1	3%
Not recorded		

4. Type of consultation		
Counselling		
Consultation	1	3%
Sameday	4	13%
Telephone	25	83%

5. GP registered		
Yes	30	100%
No		

6. Age at time of call		
Under 16	1	3%
16 to 17	1	3%
18 to 19	3	10%
20 to 24	7	23%
25 to 29	4	13%
30 to 34	10	33%
35 and over	4	13%
Not recorded		

7. Gestation at time of call		
0 to 9 weeks	30	100%
10 to 12 weeks		
13 to 19 weeks		
20 to 23 weeks		
Not recorded		

8. Bookings by provider and provider location

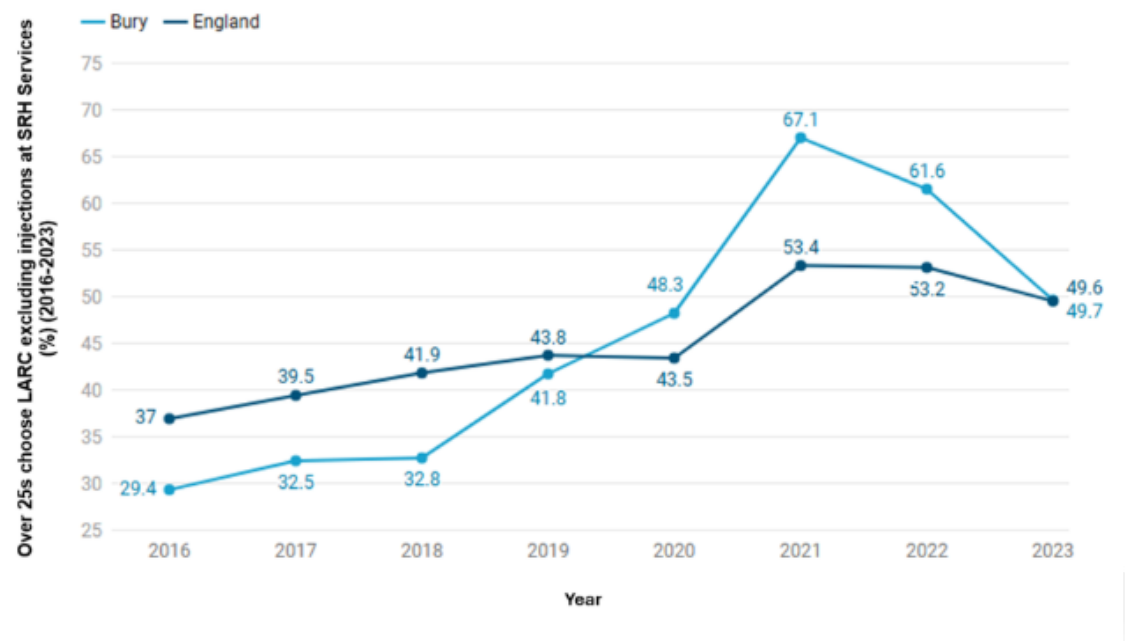
Provider	Location	No. of bookings	% of total	Days to appointment				
				7 or less	8 to 14	15 to 21	Over 21	Average
BPAS	BPAS Telemed Hub (Birmingham)	1	3%	1				0
BPAS	BPAS Telemed Hub (Bournemouth)	1	3%			1		16
BPAS	BPAS Telemed Hub (Doncaster)	1	3%	1				0
MSI	MSI Rochdale EMU	1	3%	1				6
MSI	MSI Telephone Consultations	10	33%	9	1			2.2
NUPAS	NUPAS Bolton	2	7%	2				3.5
NUPAS	NUPAS Manchester	2	7%	2				1.5
NUPAS	NUPAS Telephone Consultations	12	40%	12				1.1

Bury Maternity Services Update

NHS Greater Manchester Integrated Care

Bury Level Maternity Statistics: Over 25s Choosing LARC

Figure 3: Percentage (%) of over 25s choosing LARC excluding injections at SRH Services for the years 2016 to 2023 for Bury and England (Sexual & Reproductive Health Profiles, 2023)



Bury Maternity Statistics
(Source Bury JSNA: Pregnancy and Birth | Bury Directory)

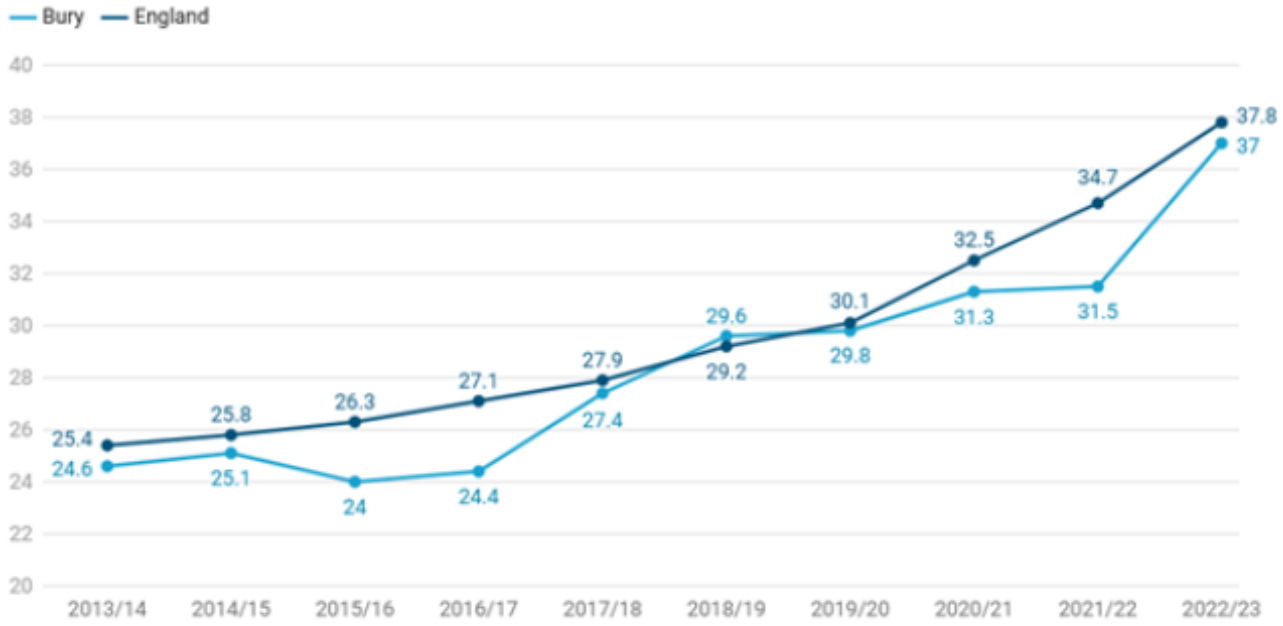
- Long-acting reversible contraceptive (LARC) methods, such as contraceptive injections, implants, the intra-uterine system (IUS) or the intrauterine device (IUD), are highly effective as they do not rely on daily compliance and are more cost effective than condoms and the pill.
- A strategic priority is to ensure access to the full range of contraception is available to all. An increase in the provision of LARC is a proxy measure for wider access to the range of possible contraceptive methods and should also lead to a reduction in rates of unintended pregnancy.
- In the year 2023, 49.7% of ‘over 25s’ chose LARC excluding injections at SRH Services, statistically similar to the figure for England of 49.6%.

Bury Maternity Services Update

Bury Level Maternity Statistics: Percentage of C- Sections

NHS Greater Manchester Integrated Care

Figure 8: Percentage of c-sections during the period 2013/14 to 2022/23 for Bury and England (Children and Maternal Health, 2023).



Bury Maternity Statistics
(Source Bury JSNA: Pregnancy and Birth | Bury Directory**)**

- Caesarean sections (commonly referred to as c-sections) are often required for several maternal and infant reasons. By their nature (i.e. they are used when there are complications) they are likely to be associated with an increased risk of problems.
- The percentage of caesarean sections in Bury was 37% in 2022/23 and statistically similar to England average of 37.8%.

Bury Maternity Services Update

Bury Level Maternity Statistics: Premature Births

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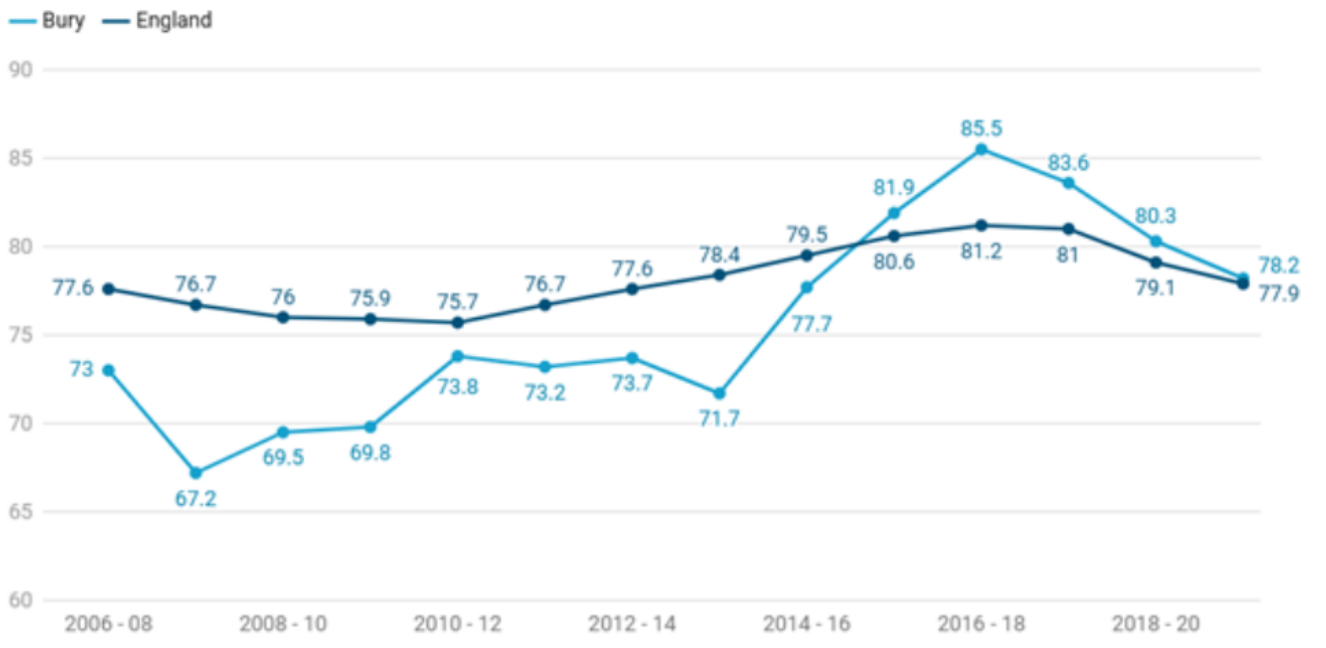
Figure 9: Crude rate of premature live births (gestational age between 24-36 weeks) and all stillbirths per 1,000 live births and stillbirths during the period 2006-08 to 2019-21 for Bury and England (Children and Maternal Health, 2021).



Bury Maternity Statistics
(Source Bury JSNA: Pregnancy and Birth | Bury Directory)

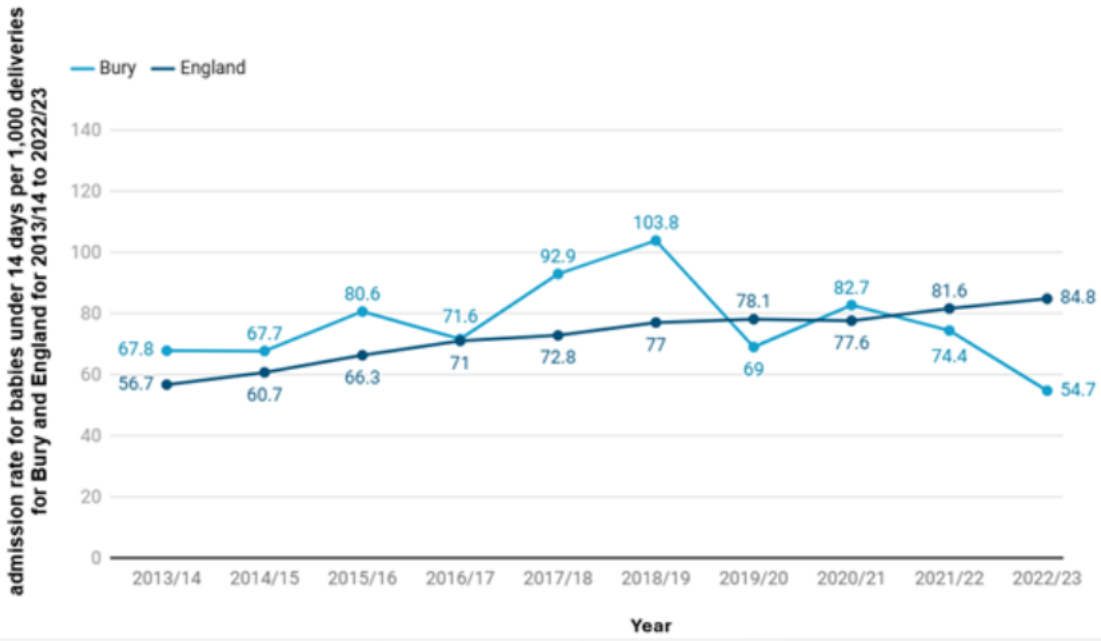
- Premature births are measured in Fingertips as crude rate of premature live births (gestational age between 24-36 weeks) and all stillbirths per 1,000 live births and stillbirths
- From 2015-17 to 2019-21, the rates in Bury were higher than England average but were not statistically significant.
- Premature birth rate in Bury has shown a more rapid increase in recent years than in England, but the most recent data for both areas show a decrease in premature birth rate (Figure 9).

Bury Maternity Services Update

Bury Level Maternity Statistics: Admission Rates

NHS Greater Manchester Integrated Care

Figure 15: Crude admission rate for babies under 14 days per 1,000 deliveries for Bury and England for 2013/14 to 2022/23 (Children and Maternal Health, 2023).



Bury Maternity Statistics
(Source Bury JSNA: Pregnancy and Birth | Bury Directory)

- High admission rates of mothers or infants shortly after birth may indicate problems with the timing or quality of health assessments before the initial transfer or with the postnatal care provided once the mother returns home. Dehydration and jaundice are two common reasons for re-admission of infants and are frequently associated with feeding difficulties.
- Admission rate for babies under 14 days in Bury for the period 2022/23 was 54.7 per 1,000 deliveries.
- The rate in England then increased to its highest rate for the observed time period to 84.8 per 1,000 for 2022/23

Bury Maternity Services Update

Bury Level Maternity Statistics: Low Birth Weight by Bury Ward

NHS Greater Manchester Integrated Care

Table 1: Percentage of low birth weight of live babies in Bury wards, Bury and England (five years pooled data from 2016 to 2020) (Local Health, 2020)

Area	Low birth weight of live babies, five year pooled
Radcliffe North	7.9%
Unsworth	7.9%
Besses	7.8%
Radcliffe West	7.4%
Radcliffe East	7.2%
Elton	7.1%
Redvales	7.1%
East	6.4%
Moorside	6.4%
Tottington	5.8%
Holyrood	5.7%
Church	5.1%
St Mary's	5.0%
Ramsbottom	4.8%
Sedgley	4.8%
Pilkington Park	4.1%
North Manor	3.4%
Bury	6.2%
England	6.8%

Bury Maternity Statistics
(Source Bury JSNA: Pregnancy and Birth | Bury Directory)

- This indicator is defined as percentage of all live births with a recorded birth weight under 2500g as a percentage of all live births with stated birth weight, pooled over five years.
- The percentage of low birth weight of live babies in Bury for the five year pooled data from 2016-20 is 6.2%, slightly lower than England average of 6.8%.
- Examining data by ward, the highest percentages of low birth weight of live babies are in Radcliffe North and Unsworth at 7.9% and Besses at 7.8% in the period 2016-20.
- The lowest percentage during the same time period is in North Manor (3.4%) and Pilkington Park (4.1%) (Table 1)

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Greater Manchester Maternity and Neonatal System

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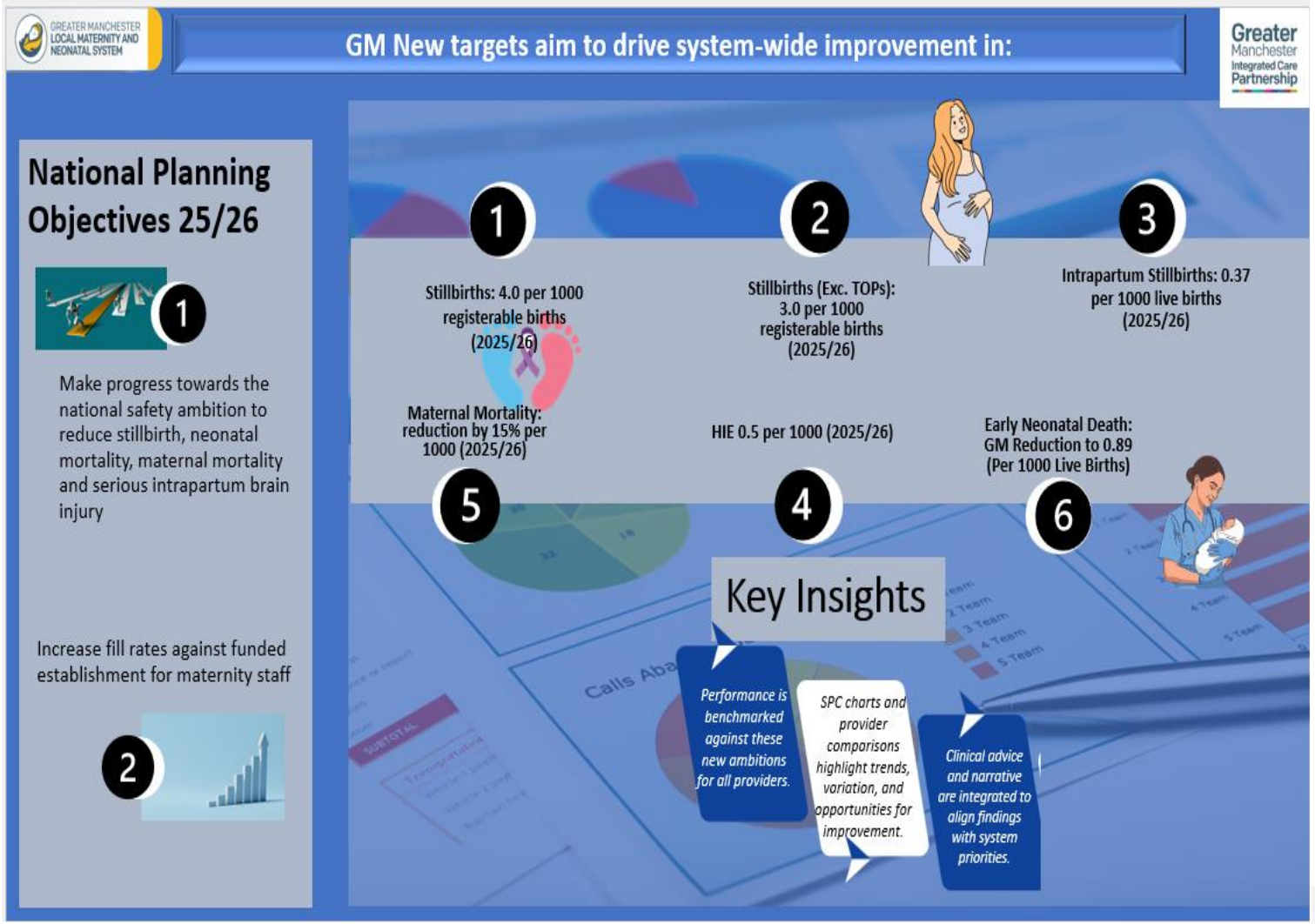

Greater Manchester Local Maternity and Neonatal System 2025/26 Priority Projects

- Improved Safety Outcomes
- High Quality Bereavement Services
- Improved Triage
  - achieve the local standard of 80% of women seen within 15 mins of attendance
  - 95% within 30 mins
- Shared Learning
- Assurance – increase CNST compliance
- Workforce recruitment and improved staff survey results
- Perinatal mental health
- Personalised Care Plan
- Infant Feeding
- Pelvic Health Services
- Continuity of Care
- Community Services
- Gestational diabetes melitus follow up postpartum
- Digital maternity services
- Maternal Medicine information sharing
- Improved data quality
- Early access to antenatal care

Bury Maternity Services Update

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GREATER MANCHESTER LOCAL MATERNITY AND NEONATAL SYSTEM

Summary

Greater Manchester Integrated Care Partnership

Key Escalations to note:

- GM performance against 2025/2026 key performance metrics

Greater Manchester				
Metric	2024 Performance	2025/26 Ambition (per 1,000)	Year to August Rate	Year to October Rate
Stillbirths inc TOP	4.35	4	4.39	4.3
Stillbirths exc TOP	3.35	3	3.44	3.29
Intrapartum Stillbirths	0.4	0.37	0.27	0.18
HIE	0.52	0.5	1.03	1.1
Maternal Deaths (up to 42 days)	0.06	0.5	0.14	0.11
ENND	1.87	0.89	2.6	2.61

- **Below is the provider breakdown driving this data.**

Provider	BOLTON		NORTH MANCHESTER		ORC		WYTHENSHAWE	
Metric	Ambition (per 1,000)	Current (Jan–Oct)	Ambition (per 1,000)	Current (Jan–Oct)	Ambition (per 1,000)	Current (Jan–Oct)	Ambition (per 1,000)	Current (Jan–Oct)
Stillbirths inc TOP	4.54	3.42	3.9	3.7	6.35	5.12	1.9	2.76
Stillbirths exc TOP	3.8	3.42	3.17	3.08	5.04	3.04	1.55	2.26
Intrapartum Stillbirths	0.53	0.24	0	0	0	0	0	0.25
HIE	1.44	2.12	0.65	1.45	0.3	1.27	0.65	1.08
Maternal Deaths (up to 42 days)	1.28	0.25	1.22	0	0.27	0.16	0.26	0.25

Provider	NCA		STOCKPORT		TAMESIDE		WWL	
Metric	Ambition (per 1,000)	Current (Jan–Oct)	Ambition (per 1,000)	Current (Jan–Oct)	Ambition (per 1,000)	Current (Jan–Oct)	Ambition (per 1,000)	Current (Jan–Oct)
Stillbirths inc TOP	3.68	5.46	3.6	3.6	3.37	4.36	2.65	5.95
Stillbirths exc TOP	2.94	4.47	2.95	2.7	1.69	2.72	1.14	4.96
Intrapartum Stillbirths	0.74	0.55	0.65	0.45	2.1	0	0	0
HIE	0.42	0.27	0	1.09	0	0.66	0	0
Maternal Deaths (up to 42 days)	0.37	0	0	0	0	0	0	0

Maternity Pathways

Bury Maternity Services Update

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First contact - information
- nutrition, diet and food hygiene
- lifestyle factors such as smoking, drinking and recreational drug use
- antenatal screening tests, including screening for sickle cell diseases and thalassaemia, the anomaly scan and screening for Down's syndrome, as well as risks, benefits and limits of these tests

8-12 weeks - Booking appointment
- 2 hour appointment at
- information given about antenatal screening, baby's development, maternity benefits
- breastfeeding including workshops, diet nutrition, exercise and pelvic floor
- 1st trimester blood tests

Dating scan – 1st trimester screening (11-14 weeks)
- estimate when baby is due, check the physical development of baby and screen for possible abnormalities.

16 weeks
- review, record and discuss test results
- health checks

Anomaly scan at 18-21 weeks
- check the physical development of the baby

25 weeks – for women having their first baby
- health checks

28 weeks
- health checks
- offer whooping cough vaccine
- offer more screening tests

31 weeks – for women having their first baby
- review, record and discuss any test results
- health checks

34 weeks
- review, record and discuss any test results
- health checks

36 weeks
- information given about breastfeeding, caring for baby, vitamin K and screening for new-born baby, mothers health after the baby is born and post natal depression.
- health checks

Health Visitor antenatal visit
- promotional contact
- information given about infant development, feeding, parenting and the Healthy Start Programme.
- provide contact details and advise how they will/can support following birth

38 weeks
- health checks

40 weeks – for women having their first baby
- health checks
- offer of a membrane sweep

41 weeks
- health checks
- offer a membrane sweep
- discuss the options and choices for induction of labour

Postnatal
- **Discharge plus 1 day** – babies sleep environment, safe sleep messages, feeding support
- **Day 5** – newborn screening
- **Day 10-12 -** discharge and handover to Health Visitor

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Main Provider Level Maternity Infrastructure

Manchester FT (NMGH)

Bolton FT

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Main Provider Level Maternity Infrastructure

Manchester FT (NMGH)

Bury Maternity Services Update

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MFT Midwifery Services – Community Based Maternity Service

- **Locations operational:**
  - Salford, Moston & Blackley, City & New East Manchester, Cheetham, Bury.
- **Bury Team areas:**
  - include BL9, Whitefield and Prestwich.
- **Team Composition:**
  - Band 7 Team Leader with Band 6 community midwives and Maternity Support Workers
- **Services offered face to face:**
  - All community midwifery care is face to face
- **Services offered virtually:**
  - Nil
- **Current service development:**
  - Harmonisation of AN care pathways with AN services across Managed Clinical Services. Introduction of vaccination clinic at Prestwich hub to include flu and pertussis
- **Current Service issues:**
  - 3 x Community clinics currently being held at Fairfield General Hospital due to IT availability in Bury venues.
- **Service Improvements:**
  - Digital platform HIVE now progressing well and teams are more confident when connectivity available. Redvale Hub connectivity remains poor despite refurbishment-have requested room change. Face to Face Antenatal parent education for MFT patients to commence.

Contact details: Bury Fairfield Base 0161 778 3706/ Main NMG base 0161 720 2133
- Rachel Wadkins : Bury Team Leader Rachel.Wadkins@mft.nhs.uk
- Mel Coleman: Community Ward Manager 07977644545 Mel.Coleman@mft.nhs.uk
- Farhana Faruque: Community & Birth Centre Matron (North Manchester site) 07973695232 Farhana.Faruque@mft.nhs.uk

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Main Provider Level Maternity Infrastructure

Bolton FT

Bury Maternity Services Update

Provider Updates: Bolton Foundation Trust Maternity Services – Community

NHS Greater Manchester Integrated Care

- **Locations operational:**
  - Radcliffe Hub, Bury West & North Hub, Farnworth Start Well Centre (for women living in BL4 and M26 1). The team cover the M26, BL2, BL8 and BL0 postcodes of the Bury locality.
- **Team Composition:**
  - 1 WTE Band 7 Team Leader
  - 9.17 WTE Band 6 Registered Midwives.
  - 0.61 WTE Maternity Support Worker (MSW)
- **Services offered face to face:**

  Radcliffe Hub- Clinics Monday- Friday (antenatal bookings, antenatal appointments, post-natal appointments)

  Bury West & North Hub- Clinics Monday- Friday (antenatal bookings, antenatal appointments, post-natal appointments)

  Home post-natal visits (Day 1 and if clinically required)

  All clinics have a Named midwife to provide continuity of care.
- **Services offered virtually:**
  - Nil.
- **Current service development:**

Community review in progress to review services, staffing, processes to highlight any improvements required. Staff under going training for Pregnancy circles to implement across the service as an alternation method of providing care and continuity. Community Team developing Early Pregnancy Information Clinics to provide women with early heath and well-being information, screening information and screening tests. Re-introduction of antenatal face to face sessions. Digital transformation project ongoing at Bolton Maternity services to develop a end to end an maternity system, no completion date at present.

Bury Maternity Services Update

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Provider Updates: Bolton Foundation Trust Maternity Services (cont…)

- **Current service or pathway issues:**
  - Ongoing IT issues within the Bury centres that are causing issues with care. Despite lots of work to improve the IT for 3-5 years we are still having connectivity issues and maintaining connectivity. This is a quality and safety issue and is on our risk register.
  - Fragmented care- Women are choosing to birth with alternative providers and having antenatal care and post natal care provided by Bolton community midwives due to geographical boundaries. Evidence based information highlights this to be a contributor factor in poor outcomes for women and babies with issues of different IT and documentation systems, guidelines, and processes, communication, information sharing, services available, effects on staff.
  - **Contact details for the team (mobile numbers are work phones and only responded to when the staff member is on duty)**

Community Midwives Office at Bolton Hospital (clerical staff only) – 01204 390 023
Nicola Doherty (Team Leader) – 07920182**610**
Email- nicola.doherty@boltonft.nhs.uk
Non urgent information sharing email address (checked daily) –
BFTmidwiferydischarges@boltonft.nhs.uk
Farnworth Start Well Centre (Team base) – 01204 334 955

Bury West & North Children's Centre Midwife Line – 0161 253 7734 (BL8 and BL0)
Linsay Wyatt (deputy) – 07919 598 609, Linsay.Wyatt@boltonft.nhs.uk
Geraldine Wilkes – *07471 522 936*, Geraldine.Wilkes@boltonft.nhs.uk

Enhanced Midwifery Team (safeguarding) –
01204 390390 Ext 4170, email- boh-tr.emt@nhs.net
Nicola Ainsworth (team leader) –07824897295
Email- nicola.ainsworth@boltonft.nhs.uk

Radcliffe Hub Children's Centre Midwife Line – 0161 253 7467
Jessica Robb- 07920182608, Jessica.robb@boltonft.nhs.uk
Eloise Davenport- 07824561184, eloise.davenport@boltonft.nhs.uk

Main Provider Level Maternity Statistics

Manchester FT (NMGH)

Bolton FT

Bury Maternity Services Update

NHS Greater Manchester Integrated Care

GM LMNS Provider Reports – MFT North Manchester

GMEC QSS Toolkit | Quarter comparison | GM Avg Comparison | Quarter Details | 2 Quarter comparison | Data Submission | Surveys | Nursing & Midwifery Survey

Maternity Quality Surveillance

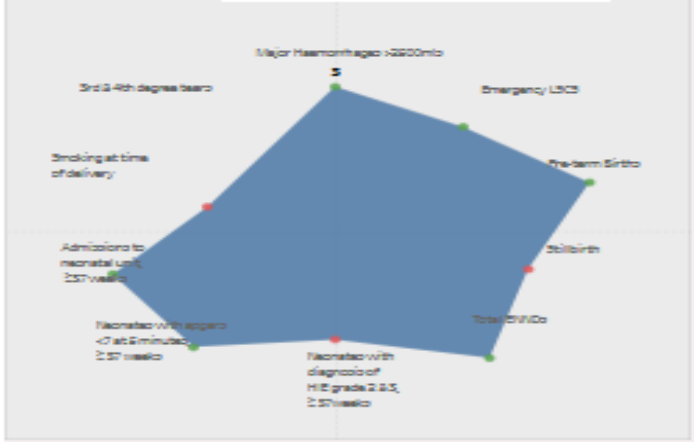
Updated: 31/01/25 (Quarterly update - next update due Apr/May 2025)

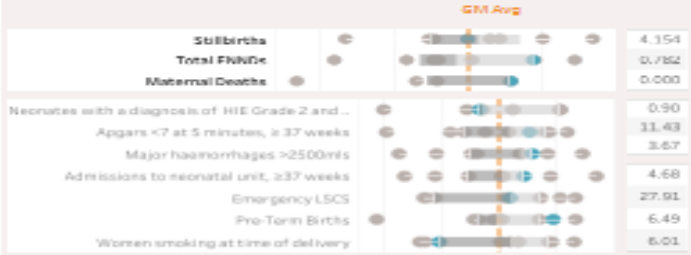
Provider Choice: MFT North Manchester

Lastest 12 months: Oct, 2024 to Sep, 2025

Stillbirth (per 1,000)	Early Neonatal Deaths (per 1,000)	HIE (per 1,000)	Maternal Deaths (per 1,000)
4.170	0.782	0.905	0.000

Further Maternity data available here





% Compliant as of Jan 2024:

Element 1	90%
Element 2	100%
Element 3	100%
Element 4	80%
Element 5	96%
Element 6	100%
All Elements	96%
CNST Met	100%

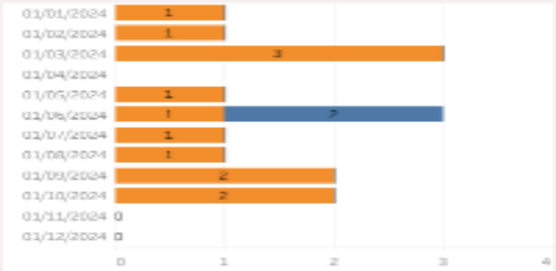
STEIS and Diverts

Total number of diverts

Total number of STEIS excluding diverts

Total	
	2
	13

No. of STEIS/Divert INCIDENTS:



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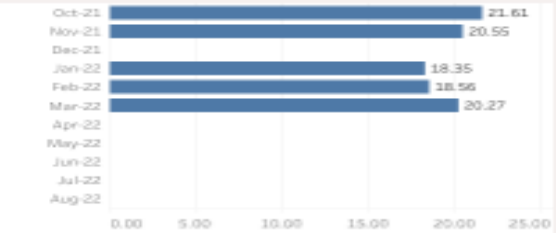


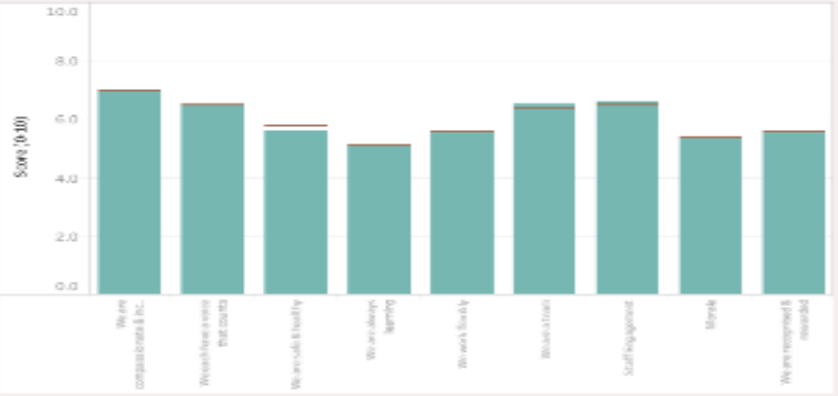
Requires Improvement

CNST MIS Status (Year 6):

SURVEYS

Breakdown | Your Org

Manchester University NHS Foundation Trust: Nursing & Midwifery Registered Score (Breakdown) Vs Unweighted Organisation Average (Your Org)



	We are compassionate & inclusive	We each have a voice that counts	We are safe & healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale	We are recognised & rewarded
Breakdown	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★
Your Org	7.0	6.5	5.8	5.1	5.6	6.4	6.5	5.4	5.6
Responses	742	737	736	707	736	737	743	743	737

GMC National Training Survey (2022) Overall Satisfaction (published March 2023)

60%

GMEC CQC Maternity Survey 2024

Green: > 8 | Amber: 7-7.9 | Red: <7

	Advice at the start of labour	Attending labour	Attention after birth	Care in hospital after the Birth	Clear communication	Delay in discharge	Labour & Birth Overall	Raising concerns	Staff Caring for you Overall	Staff Introduction
Bolton	8.2	8.2	7.1	6.6	3.9	5.8	8	7.4	8.2	8.7
MFT	8.3	8.5	6.7	6.6	3.2	5.5	8	8.3	8.3	9
NCA Oldham	7.5	8.1	5.8	5	3.2	5.6	8	8.3	8.2	8.9
Stockport	8.6	8.7	7	7.4	3.2	5.2	8.1	8.5	8.4	9.2
Tameside	8.3	8.2	6.2	5.9	9	5.3	8.3	8.4	8.2	9.1
Wigan	8.1	8.8	7.9	7	3.6	5.3	7.9	8.2	8.6	9.4

Bury Maternity Services Update

GMEC LMNS Provider Reports - Bolton FT

Greater Manchester Integrated Care

GMEC QSS Toolkit | Quarter comparison | GM Avg Comparison | Quarter Details | 2 Quarter comparison | Data Submission | Surveys | Nursing & Midwifery Survey

Maternity Quality Surveillance

Updated: 31/01/24 (Quarterly update - next update due Apr/May 2024)

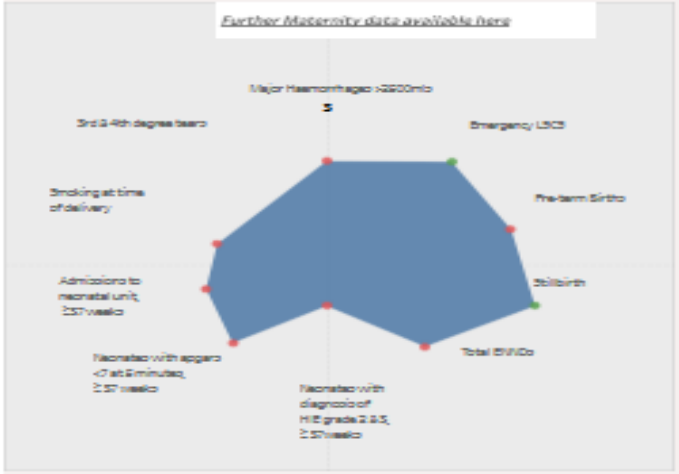
Provider Choice: Bolton

Lastest 12 months | Oct, 2024 to Sep, 2025

Stillbirth (per 1,000)	Early Neonatal Deaths (per 1,000)
3.827	2.630

HIE (per 1,000)	Maternal Deaths (per 1,000)
1.987	0.616

Further Maternity data available here



GM Avg

Stillbirths		3.856
Total ENNDs		2.627
Maternal Deaths		0.673
Neonates with a diagnosis of HIE Grade 2 and ...		1.99
Apgars <7 at 5 minutes, ≥ 37 weeks		17.88
Major haemorrhages >2500mls		5.97
Admissions to neonatal unit, ≥37 weeks		6.34
Emergency LSCS		27.92
Pre-Term Births		8.06
Women smoking at time of delivery		6.24

% Compliant as of Jan 2024:

Element 1	100%	All Elements	99%
Element 2	100%	CNST Met	100%
Element 3	100%		
Element 4	100%		
Element 5	100%		
Element 6	83%		

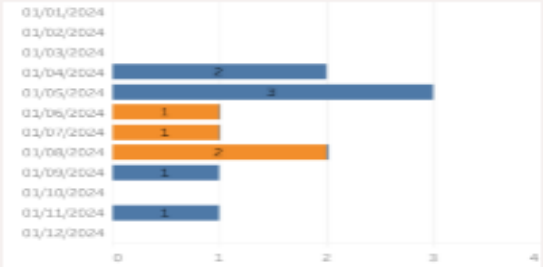
STBIS and Diverts

Total number of diverts

Total number of STBIS excluding diverts

Total	
	7
	4

No. of STBIS/Divert INCIDENTS:



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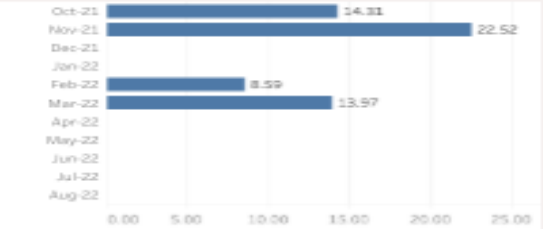


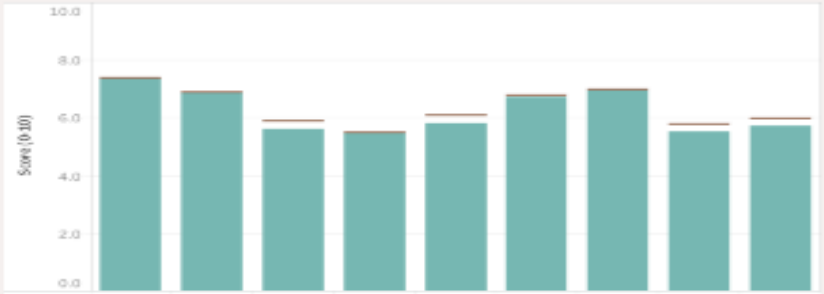
Good

CNST MIS Status (Year 6):

SURVEYS

Breakdown | Your Org

Bolton NHS Trust: Nursing & Midwifery Registered Score (Breakdown) Vs Unweighted Organisation Average (Your Org)



	We are com passionate & inclu...	We each have a voice that counts	We are safe & healthy	We are always learning	We work flexibly	We are a team	Staff Engag ement	Morale	We are recognised & rewarded
Breakdown	*****	*****	*****	*****	*****	*****	*****	*****	*****
Your Org	7.4	6.9	5.9	5.5	6.1	6.8	7.0	5.8	6.0
Responses	676	660	673	650	660	675	676	676	662

GMC National Training Survey (2022) Overall Satisfaction (published March 2023)

69%

GMEC CQC Maternity Survey 2024

Green: > 8 | Amber: 7-7.9 | Red <7

	Advice at the start of labour	Attending during labour	Attention after birth	Care in hospital after the Birth	Clear communication	Delay in discharge	Labour & Birth Overall	Raising concerns	Staff Caring for you Overall	Staff Introduction
Bolton	8.2	8.2	7.1	6.6	8.9	5.8	8	7.4	8.2	8.7
MFT	8.3	8.5	6.7	6.6	9.1	5.5	8	8.3	8.3	9
NCA Oldham	7.5	8.1	5.8	6	9.2	5.6	8	8.3	8.2	8.9
Stockport	8.6	8.7	7	7.4	9.2	6.2	8.1	8.5	8.4	9.2
Tameside	8.3	8.2	6.2	5.9	9	5.5	8.3	8.4	8.2	9.1
Wigan	8.1	8.8	7.9	7	9.6	5.3	7.9	8.2	8.6	9.4

Bury Maternity Services Update

NHS
Greater Manchester
Integrated Care

Provider Performance

Data for all Measures Table format

		2017		2018		2019		2020		2021		2022		2023		2024		2025	
Provider Sit..	Metric Desc	GMEC %	Rates	GMEC %	Rates	GMEC %	Rates	GMEC %	Rates	GMEC %	Rates	GMEC %	Rates	GMEC %	Rates	GMEC %	Rates	GMEC %	Rates
Bolton	3rd & 4th Degree Tears	2.9%	3.3%	2.6%	3.5%	2.6%	2.8%	2.9%	4.1%	2.8%	3.3%	2.7%	3.3%	2.8%	3.7%	3.0%	2.8%	3.2%	2.8%
	Admissions to neonatal u..	5.7%	4.4%	5.1%	4.9%	5.2%	4.6%	5.9%	6.5%	5.4%	6.4%	5.4%	6.0%	5.6%	6.1%	5.4%	6.0%	5.2%	6.2%
	Emergency LSCS	17.0%	18.1%	17.3%	17.9%	17.2%	17.9%	18.3%	19.5%	19.5%	21.0%	21.9%	23.0%	25.9%	24.7%	27.8%	28.3%	28.4%	27.6%
	Inductions	35.2%	36.4%	37.5%	40.1%	37.8%	40.4%	37.4%	39.1%	34.6%	36.8%	35.1%	36.5%	34.9%	36.0%	36.8%	33.4%	37.0%	35.6%
	Major haemorrhages >25..	0.5%	0.3%	0.4%	0.2%	0.4%	0.5%	0.4%	0.2%	0.4%	0.4%	0.5%	0.5%	0.5%	0.4%	0.5%	0.5%	0.6%	0.7%
	Neonates with a diagnosi..	0.1%	0.2%	0.1%	0.2%	0.1%	0.1%	0.2%	0.2%	0.1%	0.0%	0.1%	0.0%	0.1%	0.1%	0.1%	0.2%	0.1%	0.2%
	Neonates with apgars <7 ..	0.9%	1.3%	0.9%	0.9%	1.0%	1.3%	1.0%	1.1%	1.1%	1.6%	1.2%	0.9%	1.3%	1.2%	1.2%	1.4%	1.4%	1.8%
	Pre-Term Births	11.1%	9.2%	9.2%	8.8%	8.9%	9.2%	8.6%	7.9%	8.9%	8.6%	10.1%	8.7%	9.6%	9.5%	8.8%	3.3%		
	Stillbirths	0.4%	0.5%	0.4%	0.3%	0.4%	0.4%	0.5%	0.5%	0.5%	0.4%	0.4%	0.3%	0.5%	0.4%	0.4%	0.5%	0.4%	0.3%
	Total ENNDs	0.2%	0.2%	0.2%	0.3%	0.2%	0.2%	0.2%	0.1%	0.2%	0.1%	0.2%	0.1%	0.2%	0.1%	0.2%	0.1%		
	Women initiating breastf..	65.7%	33.2%	66.0%	32.1%	66.0%	32.6%	68.3%	30.9%	66.1%	32.3%	50.9%	34.3%	53.7%	30.8%	64.5%	30.5%	65.4%	28.9%
	Women smoking at time o..	12.9%	14.8%	11.9%	13.8%	11.0%	13.1%	10.1%	12.3%	8.8%	10.4%	8.1%	10.0%	6.7%	9.6%	5.8%	7.3%	5.0%	6.1%
MFT - North Manchester	3rd & 4th Degree Tears	2.9%	2.9%	2.6%	2.9%	2.6%	2.7%	2.9%	2.2%	2.8%	2.5%	2.7%	1.7%	2.8%	2.0%	3.0%	2.1%	3.2%	2.5%
	Admissions to neonatal u..	5.7%	2.0%	5.1%	1.7%	5.2%	2.0%	5.9%	1.7%	5.4%	3.0%	5.4%	5.6%	5.6%	6.0%	5.4%	4.5%	5.2%	4.7%
	Emergency LSCS	17.0%	19.4%	17.3%	18.6%	17.2%	18.4%	18.3%	18.7%	19.5%	20.2%	21.9%	20.9%	25.9%	25.6%	27.8%	25.6%	28.4%	28.3%
	Inductions	35.2%	39.1%	37.5%	42.0%	37.8%	42.6%	37.4%	40.9%	34.6%	38.0%	35.1%	37.7%	34.9%	39.5%	36.8%	43.1%	37.0%	42.8%
	Major haemorrhages >25..	0.5%	0.4%	0.4%	0.2%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.5%	0.4%	0.5%	0.7%	0.5%	0.4%	0.6%	0.5%
	Neonates with a diagnosi..	0.1%	0.1%	0.1%	0.0%	0.1%	0.1%	0.2%	0.2%	0.1%	0.2%	0.1%	0.2%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
	Neonates with apgars <7 ..	0.9%	0.7%	0.9%	1.1%	1.0%	0.8%	1.0%	1.0%	1.1%	0.9%	1.2%	1.0%	1.3%	1.4%	1.2%	0.9%	1.4%	1.1%
	Pre-Term Births	11.1%	7.8%	9.2%	8.0%	8.9%	8.0%	8.6%	8.0%	8.9%	7.3%	10.1%	9.9%	9.6%	8.1%	8.8%	6.2%		
	Stillbirths	0.4%	0.2%	0.4%	0.4%	0.4%	0.3%	0.5%	0.3%	0.5%	0.6%	0.4%	0.6%	0.5%	0.4%	0.4%	0.4%	0.4%	0.4%
	Total ENNDs	0.2%	0.3%	0.2%	0.1%	0.2%	0.1%	0.2%	0.1%	0.2%	0.1%	0.2%	0.1%	0.2%	0.2%	0.2%	0.1%		
	Women initiating breastf..	65.7%	33.9%	66.0%	33.8%	66.0%	33.5%	68.3%	30.9%	66.1%	34.5%	50.9%	63.3%	53.7%	57.4%	64.5%	47.4%	65.4%	44.5%
	Women smoking at time o..	12.9%	15.9%	11.9%	15.5%	11.0%	14.8%	10.1%	13.7%	8.8%	13.5%	8.1%	8.3%	6.7%	7.9%	5.8%	7.9%	5.0%	5.7%

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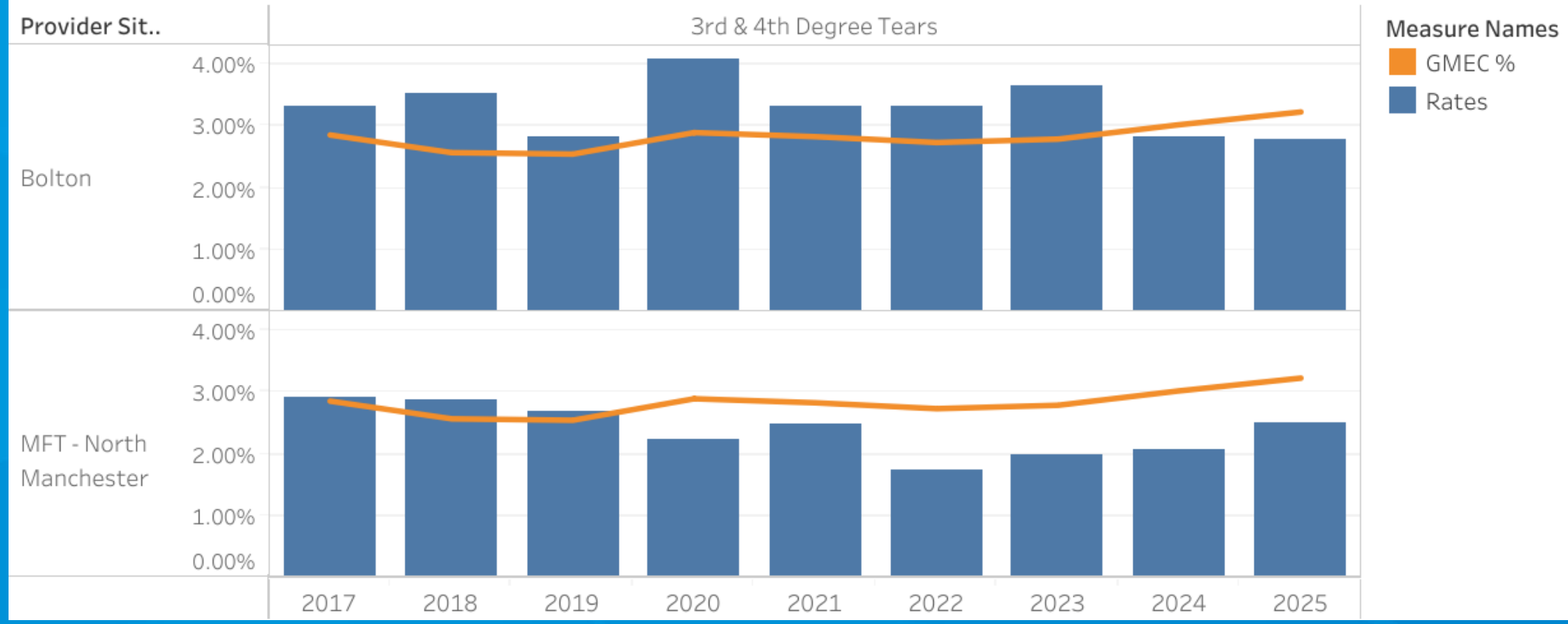
Integrated Care

3rd & 4th Degree Tears



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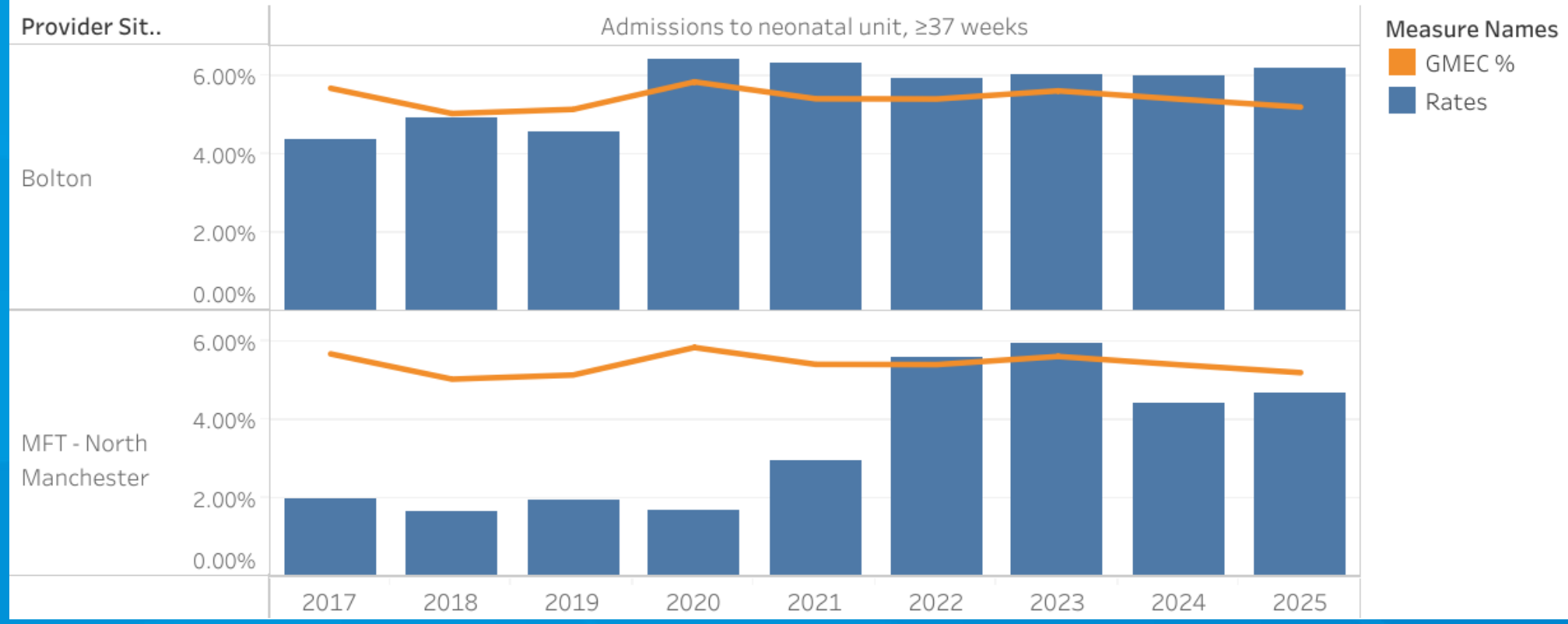
Admissions to neonatal unit



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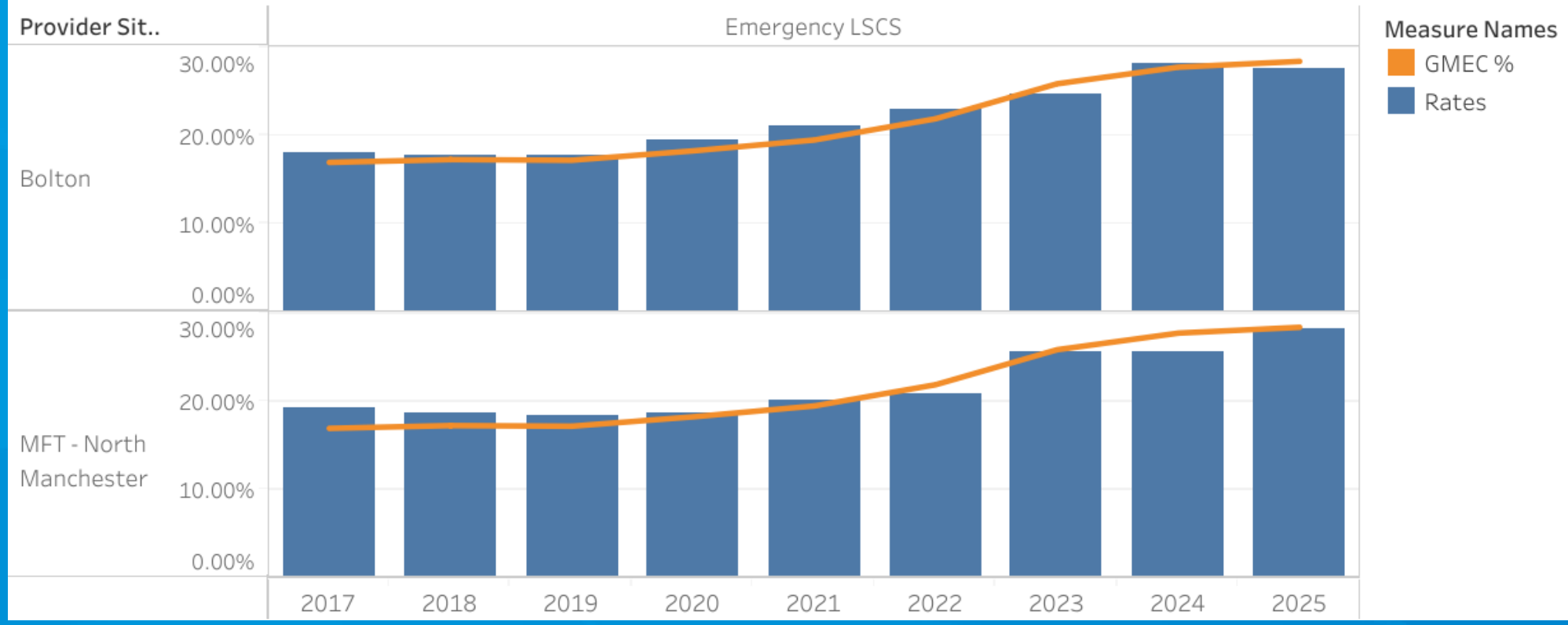
Emergency LSCS



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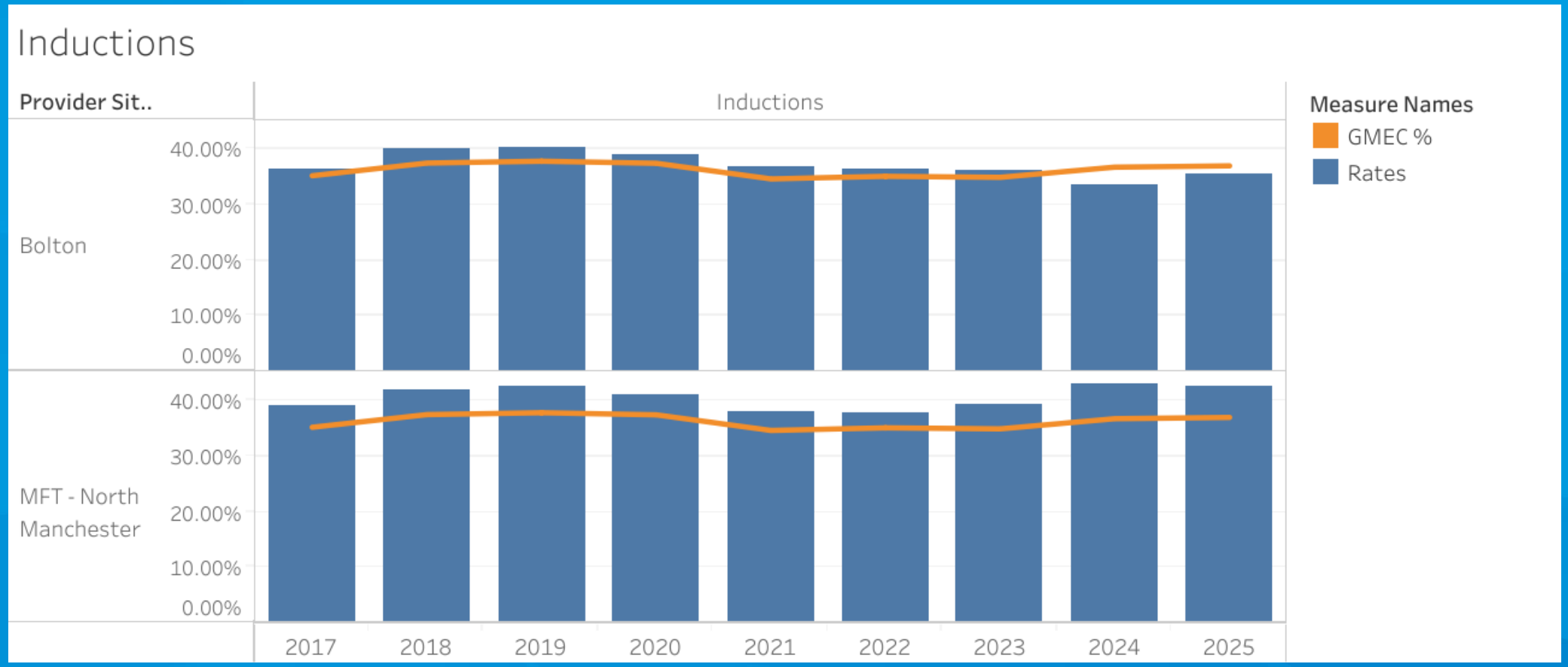

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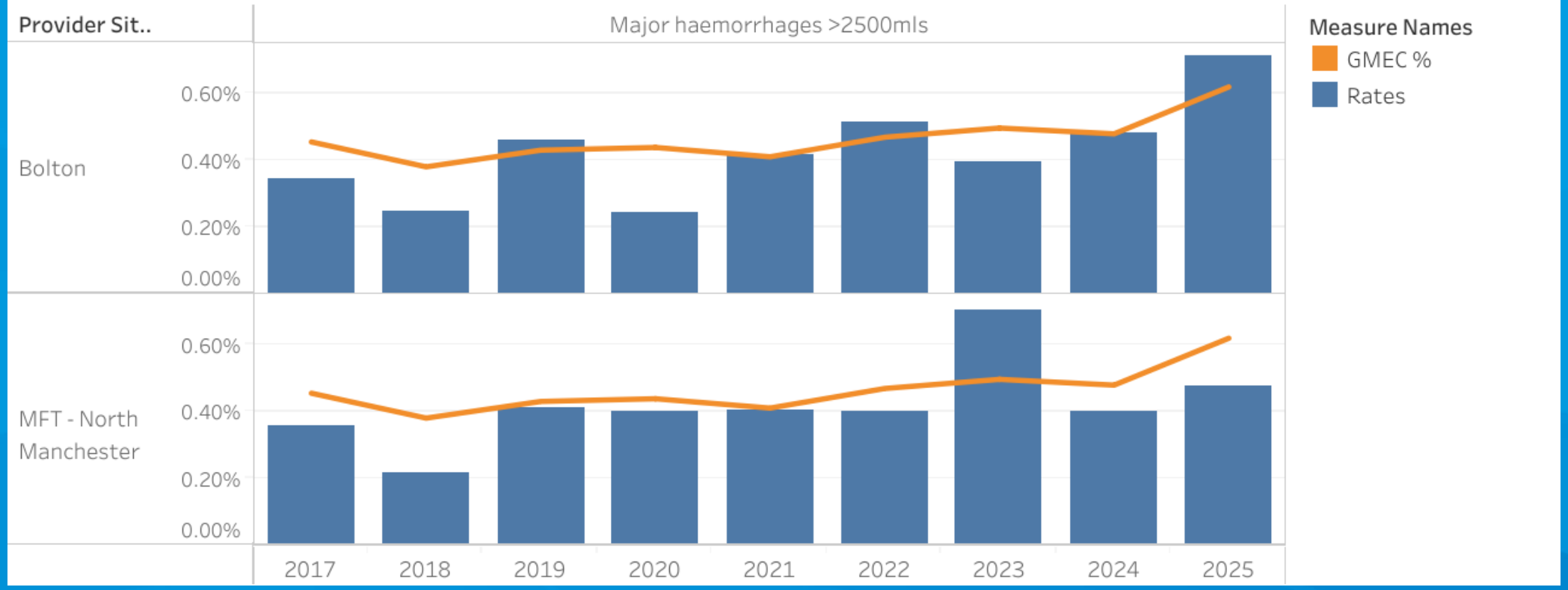
Major Hemorrhages



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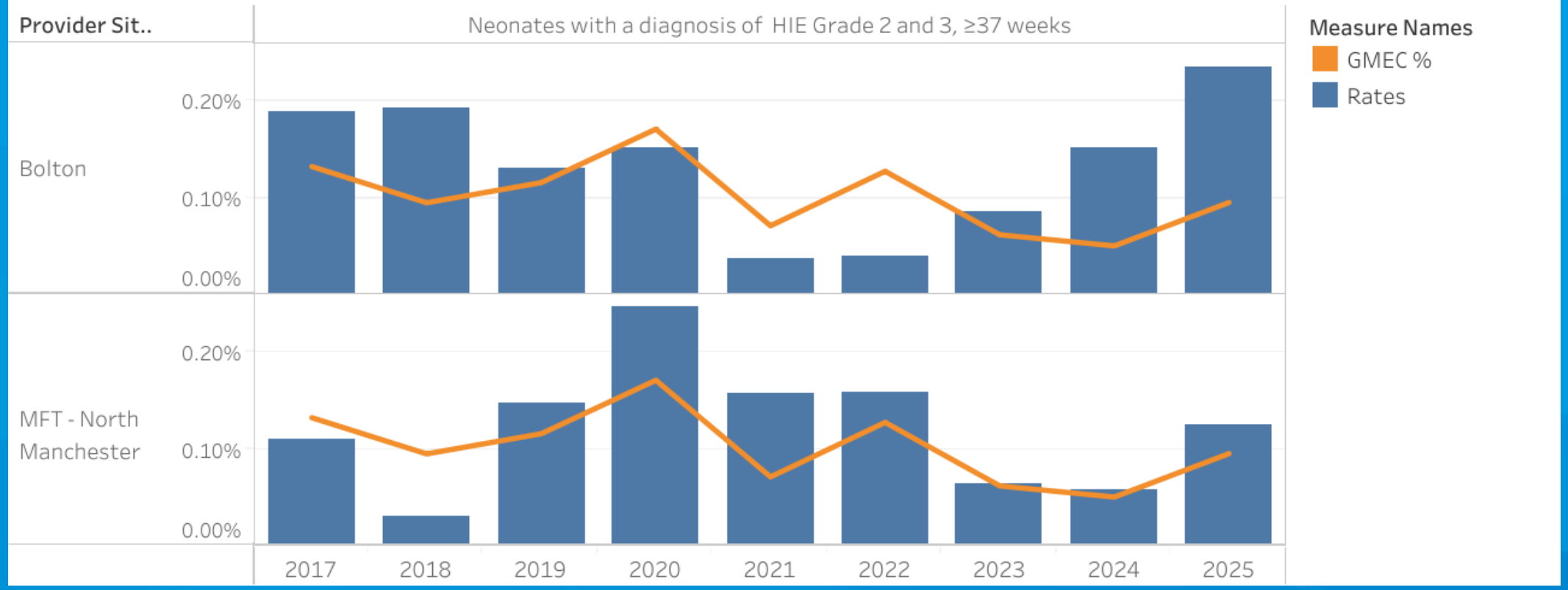
Neonates with a diag of HE Grade 2 &3



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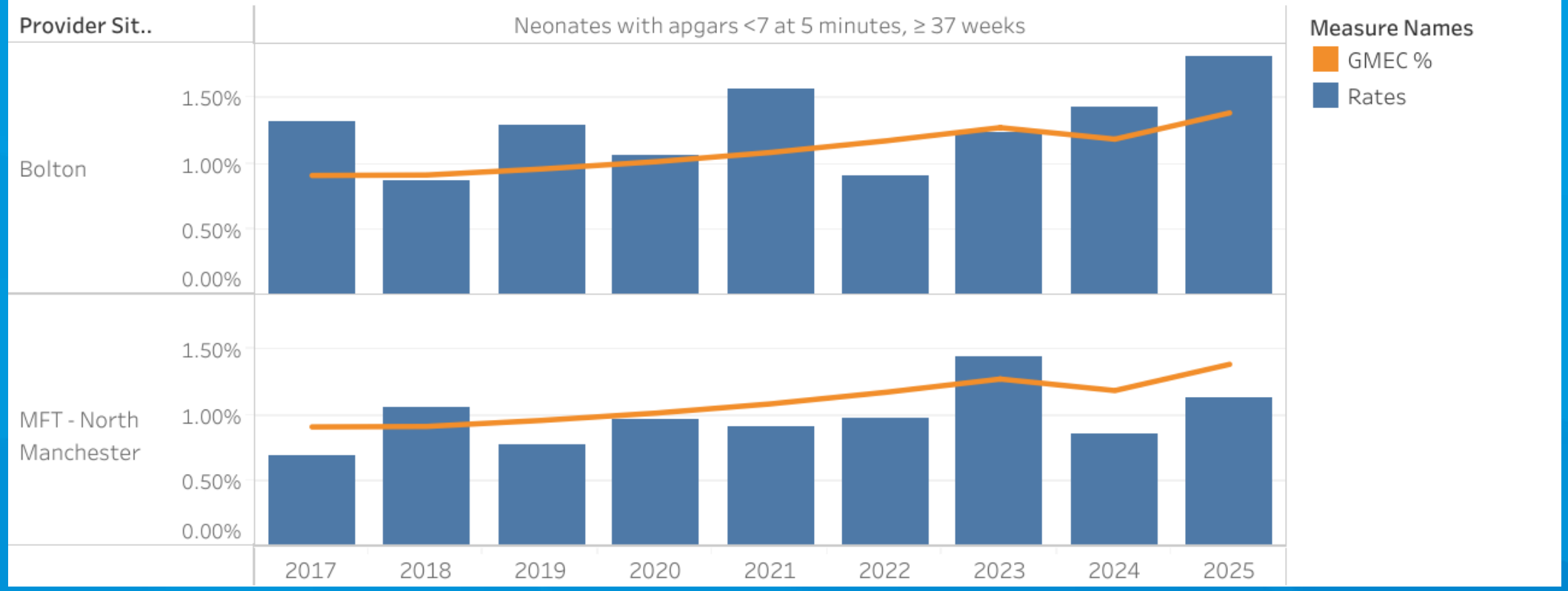
Neonates with apgars



Quality and Safety Assurance

Bury Maternity Services Update

NHS
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Integrated Care

The LMNS currently oversees all maternity providers; including review of LFPSE and any StEIS, SPEN, MBRRACE.

They are all reviewed by Sarah Owen, Associate Director of Quality and Karen Clough, Safety Lead Midwife, GM SCN and colleagues. All serious events are brought to the LMNS MDT Safety Assurance Panel (chaired by Sarah) and all relevant learning from **any** event is presented monthly at the GM Safety Special Interest Group (chaired by Karen).

The LMNS will be reporting at our System Group meeting in February that we anticipate:

- Both providers will achieve compliance with the Maternity & Neonatal 3-Year Delivery Plan, due for completion March 2026.
- MFT & Bolton are both on track to achieve 10/10, full compliance with CNST, Maternity Incentive Scheme Year 7

A series of Quality Assurance visits across GM took place recently, a summary of findings are described on slide 39. All reports available on request.

Overall - taken together, the thematic findings indicate a system that is improving, learning and increasingly aligned, with strong foundations in safety, equity and leadership. The consistent quality lens applied across providers enables comparability and shared learning, supporting ongoing assurance and continuous improvement at system level.

Quality Improvement; During Q3 2025 NHS GM and the LMNS undertook a series of provider-level quality assurance visits across ICB footprint.

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Safety and learning culture - Providers consistently demonstrate strong awareness of safety risks and outcomes, supported by effective use of data, audit and learning from incidents. There is increasing confidence in escalation processes, safety huddles and structured learning responses, reflecting a shift towards a more open, learning-focused approach. While approaches vary, the overall direction of travel is towards greater transparency, shared learning and system-based improvement.

Clinical effectiveness and improvement - Care across providers is clearly evidence-based, with sustained Quality Improvement activity visible in priority areas such as foetal surveillance, perinatal optimisation, maternity triage and neonatal outcomes. Strong maternity–neonatal integration is a recurring strength, supporting more coordinated decision-making and safer pathways. The use of data, including Statistical Process Control, is increasingly embedded to monitor performance and demonstrate improvement over time.

Experience and personalised care - Women's and families' experiences are generally positive, with consistent reports of compassionate, respectful and family-centred care. Personalised Care Support Planning and continuity-focused models are increasingly embedded, supported by active engagement with Maternity and Neonatal Voices Partnerships. Providers demonstrate growing confidence in using feedback to inform service improvement, with further opportunity to strengthen consistency of experience across pathways and settings.

Equity and population health - Providers demonstrate a strong understanding of their local populations and are using demographic intelligence, targeted continuity models and community partnerships to address health inequalities. There is evidence of equity considerations being embedded within governance, incident review and service redesign, with a system-wide commitment to reducing unwarranted variation in outcomes.

Leadership and culture - Leadership across services is increasingly visible, reflective and improvement-focused. Culture is widely recognised as a key enabler of quality, with growing emphasis on psychological safety, multidisciplinary team working and openness to challenge. While cultural maturity varies, providers demonstrate insight into their own cultural strengths and areas for development and are actively engaging in improvement.

Students, trainees and future workforce - Learning environments are generally supportive, particularly for midwifery students, with positive educational cultures evident across providers. Trainee feedback is increasingly used to inform improvements in supervision, leadership visibility and feedback mechanisms, supporting workforce sustainability and retention.

Sustainability and resilience - Providers show responsible stewardship of resources, with workforce growth, specialist role development, estates improvements and digital transformation supporting resilience. Capacity pressures remain, but there is strong evidence of proactive planning and system collaboration to support long-term sustainability.

Provider Safety Profile – Manchester University Foundation Trust

GREATER MANCHESTER LOCAL MATERNITY AND NEONATAL SYSTEM

CQC	Date of visit	Date Report Published	Rating Overall Maternity Services	Safe	Effective	Caring	Responsive	Well-led	Link to report			
ORC	7.3.23-9.3.23	28.7.23	Requires Improvement	Inadequate				Requires Improvement	St Marys CQC Report			
NMGH	7.3.23-9.3.23	28.7.23	Requires Improvement	Inadequate				Requires Improvement	North Manchester CQC Report			
Wythenshawe	7.3.23-9.3.23	28.7.23	Requires Improvement	Inadequate				Requires Improvement	Wythenshawe CQC Report			
Ockenden Compliance April 2025	IEA1 - Enhanced Safety	IEA2 - Listening to women & families	IEA3 - Staff training & working together	IEA4 - Managing Complex Pregnancy	IEA5 - Risk Assess throughout pregnancy	IEA6 - Monitoring fetal wellbeing	IEA7 - Informed consent	Workforce				
CNST Year 6	S.A.1 - PMRT	S.A.2 - MSDS	S.A.3 - TC	S.A.4 - Clinical Workforce	S.A.5 - Midwifery Workforce	S.A.6 - SBL	S.A.7 - MNVP	S.A.8 - Local training	S.A.9 - Board	S.A.10 - MNSI / EN	**Achieved 10/10**	
MPOP – 3yr Plan Progress As of Year 3 Quarter 2	**Objective 1** Blue – 1 Green - 5 *- Are Personalised care audits being undertaken regularly* *- Is the trust in a position to roll out MCoC* *- Number of Teams (planned & Current)* *- Has the trust achieved UNICEF BFI accreditation?*	**Objective 2** Blue – 1 Green – 1 *- Is data collected and disaggregated based on population groups?*	**Objective 3** Green – 1 *- Are service users involved in quality, governance, and co-production when planning the design and delivery of maternity and neonatal services*	**Objective 4** Blue – 10 Green – 2 *- Planned date of next BR+* *- Bi-Annual workforce plan for maternity and neonates including obstetrics in place?*	**Objective 5** Blue – 6 Green – 1 *- Do the trust have a mechanism to identify and address issues highlighted in student and trainee feedback surveys?*	**Objective 6** Blue – 2 Green – 1 *- Do junior and SAS obstetricians and neonatal medical staff meet RCOG and BAPM guidance for clinical and support supervision?*	**Objective 7** Blue – 4 Green – 2 *- Does the trust board support the plan to improve and sustain culture* *- Is there a clear and structured route for the escalation of clinical concerns*	**Objective 8** Blue – 5 Green – 1 *- Is the organisation sensitive to culture, ethnicity, and language when responding to incidents?*	**Objective 9** Blue – 5 Green -2 *- Does the organisation regularly review the quality of services* *- Are MNVPs involved in the quality, safety and surveillance group*	**Objective 10** Green – 3 Amber – 1 *- Is the organisation on track to adopt the national MEWS and NEWTT-2* *- Has the organisation implemented V3 SBL* *- Does the organisation regularly review and act on local outcomes*	**Objective 11** Blue – 2 Green – 1 *- Does the organisation have a process for reviewing available data which draws out themes and trends and identifies and addresses areas of concern including consideration of the impact of inequalities*	**Objective 12** Blue - 3
LMNS/ICB Oversight	**ICB Enhanced Oversight (NOF 25/26 Segment 3)**											
Date of next Annual												

Provider Safety Profile - Bolton

GREATER MANCHESTER LOCAL MATERNITY AND NEONATAL SYSTEM

CQC	Date of visit	Date Report Published	Rating Overall Maternity Services	Safe	Effective	Caring	Responsive	Well-led	Link to report			
	24.11.24	3.3.23	Requires Improvement	Requires Improvement				Requires Improvement	Royal Bolton Hopsital			
Ockenden Compliance April 2025	IEA1 - Enhanced Safety	IEA2 - Listening to women & families	IEA3 - Staff training & working together	IEA4 - Managing Complex Pregnancy	IEA5 - Risk Assess throughout pregnancy	IEA6 - Monitoring fetal wellbeing	IEA7 - Informed consent	Workforce				
CNST Year 6	S.A.1 - PMRT	S.A.2 - MSDS	S.A.3 - TC	S.A.4 - Clinical Workforce	S.A.5 - Midwifery Workforce	S.A.6 - SBL	S.A.7 - MNVP	S.A.8 - Local training	S.A.9 - Board	S.A.10 - MNSI / EN	**Achieved 10/10**	
MPOP – 3yr Plan Progress As of Year 3 Quarter 2	**Objective 1** Blue – 1 Green – 5 *- Personalised care audits undertaken regularly* *- Is the trust in a position to roll out MCoC* *- Number of Teams (planned & Current)* *- Has the trust achieved UNICEF BFI accreditation*	**Objective 2** Blue - 1 Green – 1 *- Does the trust provide access to interpreter services, which adheres to the Accessible Information Standard?*	**Objective 3** Green – 1 *- Are service users involved in quality, governance, and co-production when planning the design and delivery of maternity and neonatal services*	**Objective 4** Blue – 7 Green – 5 *- Bi-Annual workforce plan for maternity and neonates including obstetrics in place* *- Does the annual workforce plan include support for newly qualified staff and midwives who wish to return to practice*	**Objective 5** Blue – 5 Green – 2 *- Do the trust offer newly appointed Band 7 and 8 midwives support with a mentor* *- Does the trust have a leadership succession plan which reflects the ethnic background of the wider workforce*	**Objective 6** Blue – 1 Green – 2 *- Does the trust's TNA align with the core competency framework* *- Do junior and SAS obstetricians and neonatal medical staff meet RCOG and BAPM*	**Objective 7** Blue – 4 Green – 2 *- Do maternity and neonatal leads have time within their job plan to access training and development* *- Does the trust board support the implementation of a focused plan to improve and sustain maternity and neonatal culture*	**Objective 8** Blue – 4 Green – 2 *- Is the organisation sensitive to culture, ethnicity, and language when responding to incidents* *- Is there a process of triangulation of outcomes data, staff, and MNVP feedback*	**Objective 9** Blue – 5 Green –2 *- Are MNVPs involved in the development of the organisations complaints process* *- Are MNVPs involved in the quality, safety and surveillance group*	**Objective 10** Blue – 3 Green – 1 *- Has the organisation implemented version 3 of the Saving Babies' Lives Care Bundle*	**Objective 11** Blue – 3	**Objective 12** Blue – 2 Green -1 *- Does the organisation have an EPR system that complies with national specifications and standards*
LMNS/ICB Oversight	**ICB Routine Oversight (NOF 25/26 Segment 3)**											
Date of next Annual GM/LMNS Assurance visit	2025 Visit completed on 14-Oct-25											

Maternity Voices Partnership

Bury Maternity Services Update

NHS
Greater Manchester
Integrated Care

National Maternity and Neonatal Voices Partnership

- National Maternity Voices is the association of Maternity & Neonatal Voices Partnership leaders that aims to network, support and represent Maternity & Neonatal Voices Partnerships (MVPs) in England.
- Purpose and values are to champion the voices of women, birthing people and their families in the development of maternity services in England. Read about National Maternity Voices guiding principles, how we work and our vision.

Greater Manchester and Eastern Cheshire Maternity Voices Partnership

- MVP network co-chairs are Cathy Brewster & Natalie Qureshi. They sit on the Greater Manchester & Eastern Cheshire Maternity Transformation Board to represent the views of service users.
  - Bolton MVP – Chaired by Amy Rohwell
  - North Manchester MVP – Chaired by Ashleigh Reed
- Our MVPs are linked together via the Greater Manchester & Eastern Cheshire Maternity Voices Partnership network. Every month the chairs of all the MVPs meet via Zoom with our network co-chairs to discuss local feedback, share our challenges and successes and work together on Local Maternity System-wide projects
- An MNVP listens to the experiences of women and families, and brings together service users, staff and other stakeholders to plan, review and improve maternity and neonatal care.
- MNVPs ensure that service users' voices are at the heart of decision-making in maternity and neonatal services by being embedded within the leadership of provider trusts and feeding into the LMNS (which in turn feeds into ICB decision-making).
- This influences improvements in the safety, quality, and experience of maternity and neonatal care.

GREATER MANCHESTER & EASTERN CHESHIRE
Maternity Voices
Networking Maternity Voices Partnerships in GMEC

BURY INTEGRATED CARE PARTNERSHIP

Meeting:			
Meeting Date	02 March 2026	Action	Receive
Item No.	8	Confidential	No
Title	GM ND Pathway Update		
Presented By	Will Blandamer		
Author	Will Blandamer		
Clinical Lead	Dr Cathy Fines		

Executive Summary

This paper updates the Locality Board on:

- The proposed ND pathway changes – Appendix 1
- The guidance note that has been circulated to Children Young people and families (updated February 2026) – Appendix 2
- A guidance note to providers on the intended triage process
- An update on the work in Bury to provide strengthened advise and support to children young people and families, with particular reference to the establishment of the ND Hub in Bury.

Recommendations

The Locality Board is invited to:

1) Note the update on development and implementation of the revised ND pathway
2) Note the engagement and co-design in place
3) Support the work to develop the triage process on multi-disciplinary basis including First Point

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** ☐		

BURY INTEGRATED CARE PARTNERSHIP

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

BURY INTEGRATED CARE PARTNERSHIP

Governance and Reporting		
Meeting	**Date**	**Outcome**

BURY INTEGRATED CARE PARTNERSHIP

NHS GM ND Pathway Development – Update to Bury Locality Board

1. Introduction

Locality Board colleagues have been updated on the work of the Bury SEND Improvement and Assurance Board since its establishment following the receipt by the Bury SEND Partnership of a judgement of "widespread and systemic failings" by CQC and Ofsted published May 2024.

One component of the NHS contribution to the SIAB Performance and Improvement plan relates to the work required to reduce waiting times for treatment and to provide support for CYP and families whilst waiting.

Locality Board will recognise that progress is being made by partners in addressing some waiting times through capacity and through transformation, for example in Speech and Language therapy, Community Paediatrics and Community Physio provision by NCA, and for core CAMHs services provided by Pennine Care

However waiting times for CYP waiting for ADHD and Autism assessment and potential diagnosis remain excessively high for both CAMHS services from Pennine and community paediatrics for NCA.

This is not a problem unique to Bury, or Greater Manchester, or indeed nationally, but the consequences are felt by children and young people in Bury.

The Bury SEND Improvement and Assurance Board has been updated on the work of NHS Greater Manchester on transforming the ND pathway for children and young people.

This paper updates the Locality Board on:

- The proposed ND pathway changes – Appendix 1
- The guidance note that has been circulated to Children Young people and families (updated February 2026) – Appendix 2
- A guidance note to providers on the intended triage process
- An update on the work in Bury to provide strengthened advise and support to children young people and families, with particular reference to the establishment of the ND Hub in Bury.

2. Update on progress

2.1 Proposal

The proposed pathway is attached as Appendix 1 and was considered by the Bury SIAB and the Bury Heath Scrutiny Committee in January.

2.2 Engagement

It is recognised that these changes, along with uncertainty for parents and carers in the delayed arrival of the schools whitepaper including SEND creates anxiety and concern.

- At a GM level the pathway document itself identifies points of engagement and co-production, including the engagement of the GM Parent Care Forum network.
- In Bury We have update and engaged the SEND Improvement and Assurance Board, including our Parent Carer forum Bury2gether.
- We have engaged with Changemakers group – the voice of CYP to the SEND Improvement and Assurance Board.
- We have discussed the pathway and hub at the Health Scrutiny Committee attended by Childrens Srutin Committee members.
- The provider of our ND Hub – First Point, are working with Children, parents and carers to co-design the implementation of the ND hub following the initial pilot phase of working
- Bury Healthwatch have launched Bury Youthwatch and have selected Neurodiversity as the first topic and are working with children and families
- We have commissioned a review of our commissioning arrangements for the ND hub and are implementing agreed actions on the next stage of implementation.
- Deputy place lead is attending a workshop led by the MP for Bury North on 28th Feb to discuss with parents and stakeholders

We commit as a Bury SEND partnership to continue to work with, co-design and co-produce our response to this pathway development

2.3 Triage

The guidance to NHS providers on the triage process is attached as appendix B. We are working with NCA and Pennine Care in the expectation that we will develop together the operation of the Triage process and that it will be informed by the engagement of First Point as our ND hub provider. This will ensure triage is sighed on the range of support, guidance and information in the community, including that of the ND hub.

This work is in progress and can be informed by other localities who have piloted the process - including Manchester and HMR.

2.4 Bury ND Hub

Work is on going to comprehensively described the range of support and guidance available to CYP and families in Bury, including an update on the work of the Bury ND hub. A paper describing the progress of the ND hub is attached as Appendix 4.

3. Recommendations

3.1 The Locality Board is invited to:

4) Note the update on development and implementation of the revised ND pathway
5) Note the engagement and co-design in place
6) Support the work to develop the triage process on multi-disciplinary basis including First Point

Will Blandamer
Deputy Place Lead
w.blandamer@bury.gov
March 26.

NHS
Greater Manchester

New Model of Care for Greater Manchester Neurodivergent Children and Young People

Part of Greater Manchester Integrated Care Partnership

Presented by:
Date:

NHS
Greater Manchester

Rationale for new model of care

- Over the last few years, demand for diagnostic assessments for ADHD and Autism for children and young people has continued to increase significantly nationally. This has resulted in a large growth in waiting times and numbers of people waiting. Existing funding and workforce is not able to meet demand.
- We are not able to deliver a timely service for our children and young people and their families who have the highest needs, which can lead to poorer outcomes.
- The current model is medicalised and focused on diagnosis rather than support.
- To address these challenges, NHS GM has launched an Autism and ADHD Transformation Programme aimed at creating a more sustainable, needs-led system.
- This work aligns with objectives of the recently agreed National Independent review into mental health conditions, ADHD and autism Independent review terms of reference - GOV.UK.

NHS Greater Manchester

National direction of travel

- Report of the Children's Commissioner for England 2024- called for a shift towards needs led working. Accessible here: CYP Commissioner for England Waiting Times Report 2024
- National ADHD taskforce have recently published initial findings stating that:
  - There is robust evidence that **ADHD is not the remit of health alone**. Policies, budgets, spending, service plans and the collection of routine data need to span departments and agencies across all levels from government to locality.
  - **Support for ADHD and neurodivergence should begin early.** This should be needs-led, begin in preschool or school and not rely on or require clinician provided diagnosis.
  - **An entirely specialist, single diagnosis model is not sustainable, or evidence informed.** Given the established adverse outcomes and costs of unsupported ADHD, there is an urgent need to address early determinants of adverse outcomes and reduce waiting times in cost-effective, evidence-supported ways. Neurodevelopmental assessment NHS waiting times will continue to escalate, so cannot be ignored. We recommend a holistic, stepped, joined-up, generalist approach, with adequately-resourced primary care and secondary health care, local authorities and the voluntary/community sector to enable both initial needs-led holistic support and the fast-tracking of those with most clinical need or whose functioning does not improve with first-line non-pharmacological intervention to high-quality clinical diagnostic assessment and medication.

GM Public Engagement: What people told us which has informed the new Model of Care

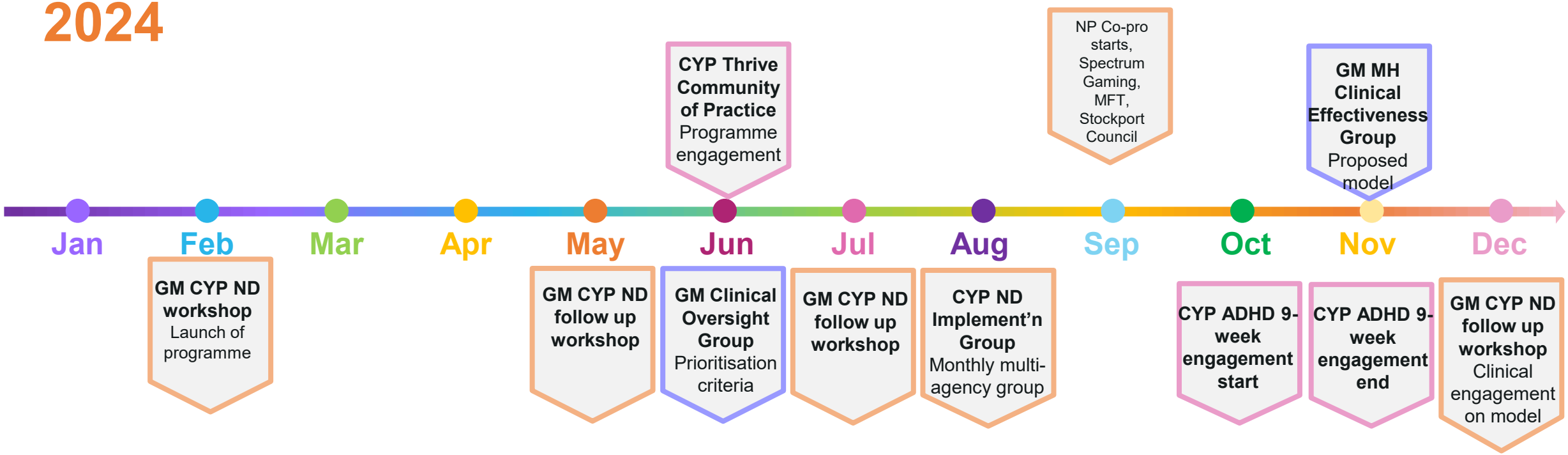
NHS Greater Manchester

- People are experiencing very long waiting times, and this is making the symptoms worse, and the service needs to change.
- People feel there is a lack of support whilst on waiting lists and they need earlier intervention/access to support.
- There is generally a lack of communication at all points in the journey.
- People need a diagnosis to access support.
- Schools have huge role to play in supporting children but are sometimes seen as gatekeepers. Schools need more help and training to support neurodiverse children
- Lack of integration between services, as well as issues with access, right to choose, acceptance of private diagnosis and shared care.
- Medication should not be the only support on offer and doesn't work for many. Currently there is no other option Post diagnosis support is key, this is a lifelong condition, just having a diagnosis is not enough..
- The impact on the family and family history both need more prominence and consideration.
- Every is child is unique, and the services aren't responsive to that.
- People are generally supportive of prioritisation to ensure CYP with the highest level of need are seen quickly
- There are inequalities in terms of access and experience. This is related to geography and some characteristics including age, gender and families on low incomes.

Programme engagement and co-production timeline

NHS Greater Manchester

2024



Co-production Engagement Governance

Programme engagement and co-production timeline

NHS Greater Manchester

2025

Jan
- **ND VCSE Collective Event** Engagement on new model

Feb
- **Health Overview & Scrutiny Committee** Findings from engagement & new model
- **Engagement report published**

Mar
- **GM MH Clinical Effectiveness Group (CEG)** Business case approval

Apr
- **GM MH CEG** Proposal to implement triage and clinical criteria

May
- **GMYN ADHD Lived Experience Group (LEG)** Co-pro of needs-led model
- **ND VCSE Collective Event** Engagement on new model
- **Healthwatch** Engagement on new model

Jun

Jul
- **GM Finance Committee** Approval of business case

Aug

Sep
- **CYP ND workshop** Co-pro of triage & assessment model
- **ND VCSE Collective Event** Engagement on new model
- **Stakeholder briefing** Update on new model
- **CYP ND Parent/Carer Survey - Bury**

Oct
- **CYP ND follow-up workshop** Co-pro of triage & assessment model
- **GM Parent/Carer Forum Cluster meeting** Co-pro of triage and assessment model
- **Community paediatrics** Review CYP ND clinical criteria
- **GMYN ADHD LEG / Bee Heard** Co-pro of triage & assessment model
- **CYP ND Engagement Survey -Wigan**

Dec
- **Autism Consortium** Engagement on new model
- **GM CEG / GM MH CEG** Approval of triage & criteria

Co-production | Engagement | Governance

NHS
Greater Manchester

GM ND transformation workstreams

1. Development of new locality services providing needs-led support in each of the 10 localities underpinned with key pan GM offers

2. Development of a system approach to assessing need which dovetails with locality needs-led support offers and provides onward agreed referral for person-centred assessment

3. Review of CAMHS specification to focus on those with co-occurring mental health and complex needs to ensure that those with the highest need receive timely and specialist support

4. Review of children's community autism and ADHD pathways and specification to ensure consistent commissioning and service offer across GM (including Right to Choose providers)

5. Review of CYP on existing waiting lists to ensure those most in need receive a personalised offer of support

Aligned to the Thrive Graduated Model

NHS Greater Manchester

Provision of easily accessible early information based self help and guidance – available universally

System navigation and access to evidence-based needs led support offers (available at all times without the need for a diagnosis)

Risk management and therapeutic management/ interventions for CYP with complex needs

Relevant diagnostic assessment and post diagnostic care for those in need

GETTING ADVICE:

- Access to online resources providing support, information, and access to services
- GM Autism website
- Advice and guidance support from Specialist ND navigator roles
- Online webinars (coming early 26)
- PADLETS Supporting-your-neurodiverse-child-padlet
- Portage https://www.portage.org.uk/support/resources/resources-parents
- Digital messaging support delivered by Barnardo's (coming early 26)
- Documentation outlining ordinarily available provisions and SEND reasonable adjustments (Ordinarily available provision)

GETTING HELP:

- Evidence based group support for behaviour (pre-school and school age)
  Riding the Rapids (Riding the Rapids info)
- The Hub offer – thematic sessions and support, navigator posts
- Neuro-developmental Profiling tools (going live soon)
- Sensory toolkit, workshops and consultations
- Evidence based communication interventions . E.g PACT (PACT) Can DO The Home of Can Do .
- Family Peer support via Navigators
- Young peoples support - Spectrum Gaming
- Tailored mental health support via MHSTs
- Neurodiversity in education programme (Autism in Schools and PINs) training and support into schools
- CAMHS
- Respect for All Counselling offer

GETTING RISK SUPPORT:

- Access to Rapid Response and Home Treatment Teams for Mental Health
- Dynamic Support Register (DSR)
- Key worker via DSR
- Access to CETR process
- Intensive Specialist Support Teams + Alternatives to Admission

GETTING MORE HELP:

- Relevant assessment / diagnostic pathway
- Prescribing/shared care
- Provision of neuro-affirmative assessment report
- Individualised Post-Diagnostic Support Care Packages

NHS Greater Manchester

ND locality early help services

Co-produced, needs-led model to deliver consistent early ND family support across GM

Early access to “Getting Advice” and “Getting Help” support – diagnosis not required

Universal ND offer: online resources, webinars, chat messaging and digital support

Direct self-referral to local ND specialists for advice and guidance

Short term evidence-based interventions workshops (i.e. PACT and Riding The Rapids)

Mobilisation of a GM wide early help support offer from October 2025: ND website, sensory toolkit, sleep support offer, chat messaging, parent workshops on ND related topics

All ten GM localities have been allocated funding to implement the GM core offer locally

All local ND models approved; mobilisation Oct 2025–Mar 2026

GM Workforce training offer: Neuro profiling, PACT, Riding The Rapids, Haven, sensory

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Greater Manchester

Development of a system approach to understanding and assessing need

A dynamic triage and assessment process

NHS Greater Manchester

A standardised process has been designed to assess the needs of children and young people referred for suspected ADHD and Autism, through a multi-agency approach. This has been approved through NHS GM governance. This ensures

- A consistent, person centered and fair process to assessing individual need across GM
- A multi-agency approach to understanding and deciding the right type and level of support based on an individual's need.
- CYP who are most in need are supported quickly and appropriately to minimise potential risk and harm
- Not all CYP will meet the criteria for an NHS assessment, but everyone will receive a personalised offer of support through our new needs-led services.
- The best use of limited system resources and workforce
- Alignment to NICE guidelines

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Greater Manchester

Consistent approach

- Triage teams to be established, comprising of senior members with extensive knowledge and experience in ND assessment, e.g. CAMHS, Paediatric clinicians (with aspirations for the inclusion of social care and education professionals as the model develops)
- Referrals to include the minimum data requirements, ensuring that the CYP meets the clinical criteria for assessment (as defined in ICD11)
- Appropriate support to be determined inline with the Thrive Framework, based on the urgency and level of need. Decision making will be guided by standardised clinical criteria and a holistic understanding of the individual's needs.
- Diagnostics assessments to take place within relevant local pathways, with CAMHS leading assessment for CYP who have co-existing moderate to severe mental health needs, in collaboration with relevant professionals

Needs-led offer

NHS Greater Manchester

Referrer

- Identifies need
- Connects family to needs led offer
- If the child is in education, considers if appropriate ordinarily available provision and SEN supports are in place
- Considers if the child has presentation indicative of ICD-11 criteria.
- Considers if the child is over 10: the young person is requesting the assessment
- If the young person is under 10: the parent/carer is requesting the assessment

Multi Agency ND Triage

Multi-agency team review referral

- Check ICD 11 criteria
- Consider level of need

Prioritise referral, make informed clinical decision based on:

- mental health
- risk of home/placement breakdown
- risk of education placement breakdown where a clear needs led plan has been tried and reviewed
- significant social factors (including cared for children)
- age at time of referral
- YOS involvement
- CYP who would significantly benefit from medication for treatment of ADHD
- language delay or no speech
- awaiting gender services.

Outcome if ICD-11 Criteria Met

1. Child/young person with very high level of need and are requiring an ND assessment will be seen urgently.
2. Child/young person has significant needs and requires an ND assessment will be added to the wait list.
3. Child/young person may meet ICD 11 criteria, but needs are not considered significant enough to warrant an NHS ND assessment, signpost to support hubs.

ND Assessment

If moderate or severe co-occurring mental health condition or moderate to severe functional impairment due to mental health distress is present, ND assessment by CAMHS

If no or mild co-occurring mental health condition, ND assessment by community.

Outcome communicated to family, young person, GP and referrer

Outcomes if ICD11 Criteria not met OR ICD 11 criteria are met but levels of impairment are low / level of functioning is not affected

Social Care

Education

Mental Health

Community Health

Outcome communicated to family, young person, GP and referrer

NHS
Greater Manchester

CAMHS and Paediatric Services Specification Refresh to support shift to Needs-led Model

ND and CAMHS in GM

NHS Greater Manchester

In Greater Manchester, neurodevelopmental assessments for children and young people are primarily provided through CAMHS and Community Paediatric Services, with variations in service delivery across localities.

Autism and ADHD are neurodevelopmental conditions, not mental health disorders.

Although CAMHS is not designed or funded to meet the increasing demand for neurodevelopmental assessments, in some areas it has taken on cases of ADHD and Autism where there is no primary mental health need. The lack of MDT approach in some localities has led to long waiting times, limited support, and over stretched resources, with funding ringfenced for mental health treatment.

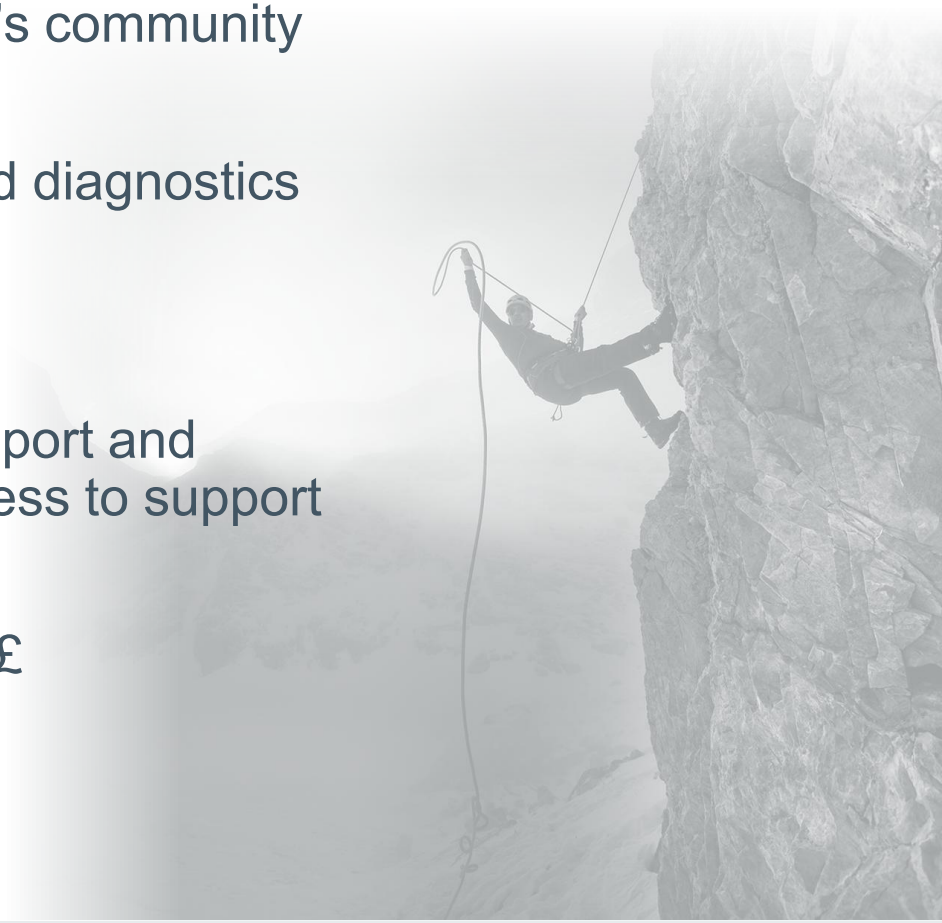
Reversely, in some localities, Community Paediatrics provide the whole service, including where the child or young person has a comorbid mental health need. In this case, it is important to recognise the role of CAMHS in supporting this cohort.

GM CAMHS have a key role in the assessment, diagnosis, and treatment of neurodevelopmental conditions, as per NICE concordant assessment criteria for Autism and ADHD. However, CAMHS should not be seen as a standalone service for diagnosis but are key to service provision where the CYP also has a moderate to severe mental health need

NHS Greater Manchester

Key challenges requiring system focus

- Consistent implementation of the triage and assessment model required from January 2026 but there are recognised gaps in children's community health teams to undertake MDT triage across all localities
- Inconsistent children's community health ND assessment and diagnostics across GM
- Significant waiting lists numbers and waiting times
- Current diagnostic culture that overlooks early needs-led support and holistic support with over-reliance on diagnosis for wider access to support (especially through educational settings)
- Significant impact of Right to Choose on best use of the GM £



Solutions

NHS Greater Manchester

- Phased approach to implementation of the full MDT triage model – starting with existing providers and expanding as capacity and capability are aligned
- In areas where community children's health teams are not currently able to undertake ADHD/Autism assessments, for CYP who meet the clinical criteria for a diagnostic assessment but do not have a moderate to severe co-existing mental health condition, CAMHs will continue to work flexibly to undertake the assessments to ensure all CYP are supported safely (this is for a maximum period of time whilst children's community ND services are mobilised)
- Business case developed for non-recurrent funding to review all CYP on existing waiting lists against the same clinical criteria and prioritise those most in need and/or those who have been on the waiting list for a significant period of time (especially if at a key transition stage)
- Development of new service specification for children's community health services (for ND assessments) with assessment of demand and capacity requirements at locality level
- System-wide communication to share the learning from the MFT Early Years Model pathway which has evidenced that integrated intervention and assessment services produce better outcomes for families than stand alone assessment teams and are a more effective use of workforce and resources.
- All localities have received funding for locality offers of early help and support in place (alongside GM wide offers). Families will be able to go directly to these services for advice, guidance, signposting and access to interventions.
- Ensure consistent communication that diagnosis is not required for access to many support interventions
- Further development of support for other recognised areas including sleep (working to evidence-based practice and aligned to early help/support)

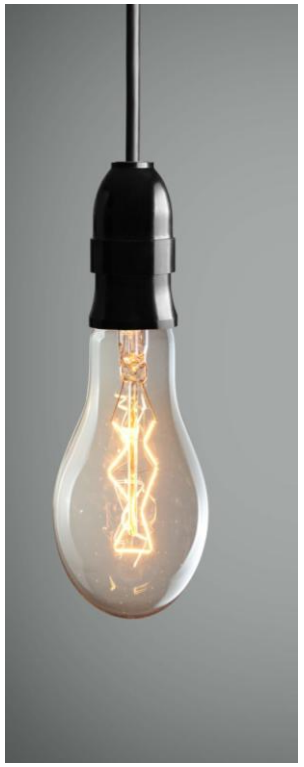
Solutions
Review of Children's Neurodiversity Community Health Services

NHS Greater Manchester

- Review of the children's community health service specification December 2025 – February 2026
- Focus on autism and ADHD pathways within the specification
- Capacity and demand analysis to be undertaken as part of the review
- Development of gap analysis and proposed options for consideration

Solutions
Focus on support in educational settings

NHS Greater Manchester



- NHS Greater Manchester has delivered the Neurodiversity in schools project (formerly Autism in schools) since 2021/22 working into over 100 schools. We have also taken part in a national pilot of the Partnership for the Inclusion of Neurodiversity in Schools (PINS) project since 2024-5 working in 75 schools. Both projects are active in all 10 GM localities.
- Both are focused on delivering a whole school approach to improving the school experience for neurodivergent learners. These 2 projects are delivered as 1 programme of work with a co-produced suite of training modules delivered into all participating schools to improve staff confidence in supporting neurodivergent young people. The projects also deliver:
  - Support to schools to review policies and practices to ensure inclusivity with a focus on a culture of practical reasonable adjustments and changes to the school environment
  - Bespoke commissioned support drawing on the expertise of a range of health, social care/educational and VCSE services
  - Parent Carer Forum support to parents and youth voice participation to ensure change is driven by the needs of young people
- We will be looking at how we can disseminate the learning, training and resources developed as part of these projects more widely to reach more GM schools. Future info on PINS funding is due from NHSE/DofE in the early new year 2026.

Solutions
Focus on support in educational settings

NHS Greater Manchester

- Mental Health Support Teams (MHSTs) are a national initiative designed to embed high-quality mental health support within education settings across England. They play a central role in transforming children and young people's mental health provision, ensuring every school and college can access expert support, early intervention, and whole-school approaches to wellbeing. They have 3 key functions
  - **Deliver evidence-based interventions** for children and young people with common mental health needs
  - **Support senior mental health leads** in education settings to develop and deliver a whole school/college approach to mental health
  - **Provide timely advice** to education staff and liaise with external specialist services to ensure children and young people get the right support and stay in education
- In Greater Manchester, MHSTs are currently operating in 433 education settings (covering 53% of all settings), with plans to expand and achieve the national ambition of reaching 100% coverage by December 2029
- They play a key role in supporting neurodiverse children and young people by working in close partnership with education settings to deliver adapted interventions and make reasonable adjustments. Teams collaborate with specialist services and families to develop care plans and support transitions, drawing on practitioners trained to recognise and respond to neurodevelopmental needs. Assessments and care plans are tailored including preferred communication approaches and adjustments to the learning environment. Practical strategies for classrooms and wider school life are co-planned with staff to promote participation and attendance. MHSTs also help schools embed whole-setting approaches to mental health, incorporating ND-informed policies and staff training.

Solutions
Focus on support in educational settings

Hearing Accepting Valuing Every Neurotype

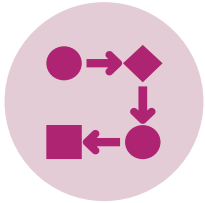
- HAVEN stands for **Hearing, Valuing, Accepting Every Neurotype**, and is a programme providing training for educational setting to create positive social groups in secondary schools, where students can be supported to have positive social experiences and naturally build friendships. Positive social connections are important for physical and mental well-being. We also know that neurodivergent young people may make connections in different ways.
- HAVEN groups aim for neurodivergent young people to feel safe, accepted and supported which may lead to increased confidence, engagement and positive interactions and relationships within the school environment.
- This approach was developed through coproduction by a team of Speech and Language Therapists, with input from autistic young adults, educational psychologists and occupational therapists, researchers from the University of Manchester.
- NHS GM have funded 150 training places to be delivered between October 25 and June 2026 for staff in GM secondary schools.

Solutions
Waiting Lists

NHS Greater Manchester

NHS GM Clinical Effectiveness Group has confirmed and endorsed the clinical criteria for children's neurodevelopmental pathways across Greater Manchester. Further to this it has been agreed to implement a programme of work to utilise the clinical triage criteria to triage the current waiting lists held within trusts for neurodevelopmental assessments, so that we do not have a two-tiered system.

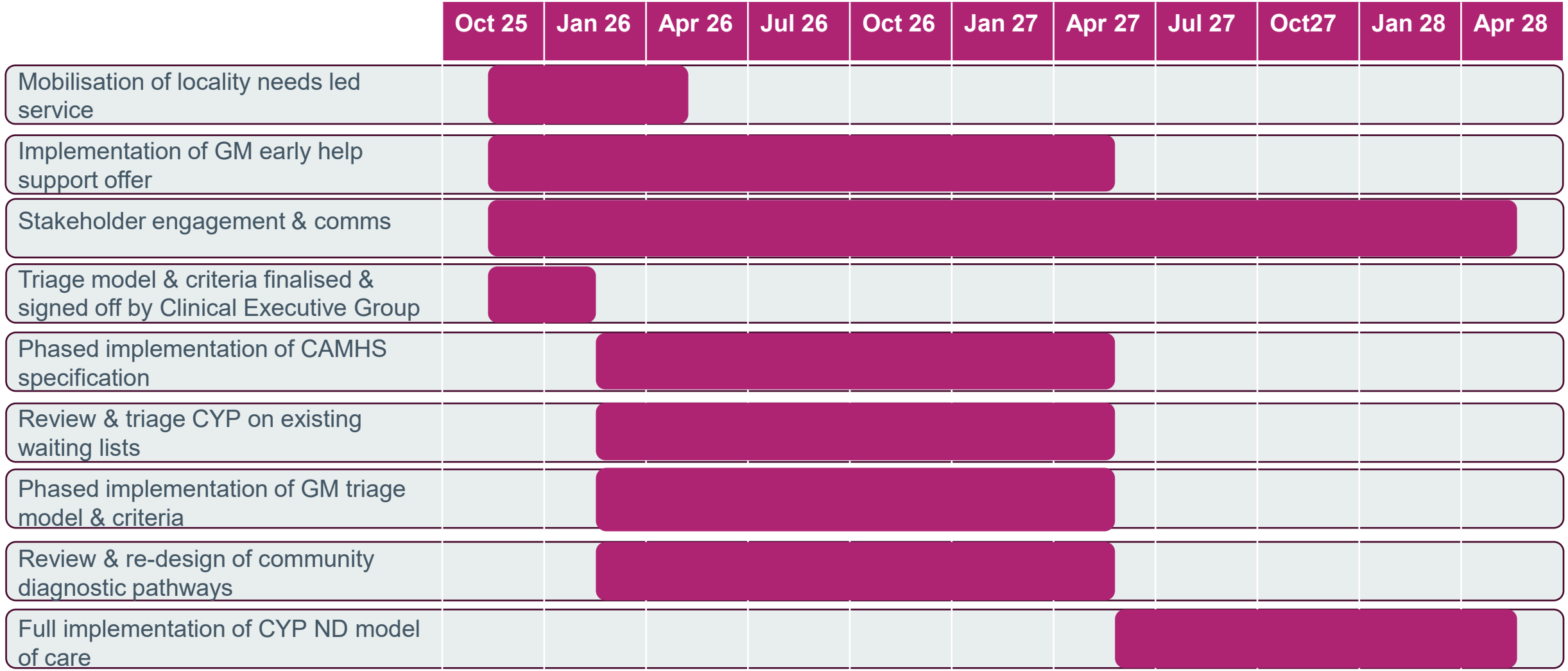
A funding formula has been developed (based on the number of CYP in waiting lists at each provider)which will ensure additional funds to all CAMHS and Community paediatric pathways for this endeavour



We will expect that 100% of the waiting lists to be appropriately prioritised over 12-24 months

Next steps and timelines

NHS Greater Manchester



NHS
Greater Manchester

Right to Choose

Ensuring an equitable offer for all Children and Young People across all providers of ADHD and Autism services

Right to Choose (RTC)

NHS Greater Manchester

Spending on ADHD and Autism assessments through Right to Choose (RTC) for adults and children and young people has grown from £5 million in 2022 to a projected £33 million in 2025. At this time, there are no national plans to increase funding allocations for ADHD and Autism.

While RTC providers often have shorter waits, this has created inequity of access and placed unsustainable pressure on the NHS budget.

To ensure fairness and best use of resources, NHS GM has introduced the following measures:

Urgent referrals already on provider waiting lists will continue to be prioritised and seen.

New non-urgent assessment appointments will be temporarily held across all Right to Choose providers It is expected that these services will resume from April 2026, and patients will retain their original referral date.

Existing booked assessments, ongoing assessments, and treatment reviews will continue as planned.

RTC providers are required to follow the same clinical prioritisation and safety standards as NHS providers.

Quality and Safety Oversight

All Autism and ADHD service specifications (adults and children and young people) have been updated to strengthen clinical safety and ensure consistent quality. Key changes include:

- The need to provide face-to-face appointments within reasonable travel distance.
- Mandatory in-person physical health reviews for patients prescribed ADHD medication, in line with national safety guidance.
- An accreditation process is being established to monitor compliance and maintain standards across all providers.
- These changes respond to findings from recent quality reviews, including a learning from death report, highlighting the importance of robust physical health monitoring.

NHS GM ADHD and Autism Assessments info

Changes in How Children and Young People are Reviewed and Assessed for Autism and ADHD in Greater Manchester

February 2026

NHS Greater Manchester (GM) is making changes to the way children and young people aged 0 to 18 are reviewed and assessed for suspected autism and ADHD. This is to make sure support is offered earlier based on a child or young person's individual need, and that those with highest need can be seen sooner. These changes are an important step to help manage unsustainable demand in GM for autism and ADHD assessments due to limited availability of financial resource and clinical workforce, which means families are currently waiting too long to be seen without access to support.

Who has been involved in developing the new process for reviewing requests for assessment?

NHS GM designed the new process through a series of in-person and on-line workshops, meetings, and surveys. These involved clinicians, service providers, commissioners, parents, carers, people with lived experience and young people.

What are the benefits of this new process?

The new process makes sure requests for assessments are reviewed in the same way across GM and will benefit children and young people and their families, by prioritising those with the highest levels of need for earlier assessment. It will also mean all children and young people with autism and ADHD related symptoms can access the support they need when they need it, with or without a diagnosis.

When is the new process being implemented?

Plans for introducing the new process for reviewing requests for assessment are being put in place from January 2026. They will be introduced step by step across services that support children and young people with autism and ADHD related needs. Introducing changes gradually is important to make sure children and young people are supported safely during the transition.

How will the process work?

The new process will bring together experienced professionals from different services. First this will include Child and Adolescent Mental Health Services (CAMHS) and paediatric clinicians. The longer-term plan is for social care and education to be included, so that care is more joined up for families. They will work together to decide the right type and level of support for each child or young person based on their needs. Their decisions will be guided by newly developed clinically agreed criteria, so that decisions are fair and equal across GM.

Will all children and young people get an assessment?
Not every child or young person will meet the clinical criteria for an assessment after the initial review. Not every child or young person will have the level of need or complexity for an NHS funded assessment. However, every child and family will still receive a personalised offer of support through the new needs-led services. Needs-led means that support is based on what a child or young person needs, rather than whether they have a diagnosis. Children and young people with the highest needs will be prioritised for earlier assessment. Children and young people who are eligible for an NHS assessment based on the new criteria but have less urgent needs than others will wait longer for an assessment.

Will everyone get an offer of support?
All children and young people will receive an offer of support from within their own borough where they live. This support will be based on an individual's need with or without a diagnosis

What is the new early support offer and when will it be available?
The new early support offer will be available in phases from January 2026. It is designed to help children with autism and ADHD related needs and their families, by providing them with access to specialists and proven, research-based support.

- Neurodevelopmental roles –
  Professionals trained in how autism and ADHD affect thinking, attention, behaviour, and social skills. They assess your child's strengths and challenges and give advice tailored to your child or young person's needs.
- Professionals trained to deliver evidence-based interventions, which means the methods and strategies they use are proven by research to help children and young people.
- Neuro-profiling tool –
  Helps identify a child or young person's learning style, strengths, and needs, and provides strategies which support them at home and school.
- Workshops –
  Parent workshops on topics such as behaviour, communication, and coping strategies available on-line and in-person.
- A new website
  A new GM neurodevelopmental website is launching soon, which will include, easy to read information and dedicated sections for parents and carers, young people and professionals, self-help resources and toolkits, recorded webinars on important topics, online mental health support, and a new chat messaging service.

Who will do the assessment and what will it involve?
Senior CAMHS and paediatric clinicians will look at information from parents, schools, and other professionals to decide what support is needed and how quickly. They will use clinically agreed

criteria to guide their decisions. This means children and young people are directed to the right service at the right time based on their levels of need.

Assessments will continue to take place locally in either CAMHS or community paediatric services, depending on the borough. CAMHS will focus on assessments for children and young people who have moderate to severe mental health needs or those with moderate to severe functional impairment due to distress.

My child has been on a waiting list for a long time, what will happen now?
We know many families have been waiting a long time for assessment and support. Experienced CAMHS and paediatric clinicians will review all children and young people currently waiting for an assessment using the new process and criteria. Where children and young people have been waiting a long-time, services will contact the family to ensure they are reviewing the most up to date information.

Not every child or young person on the waiting list will meet the clinical criteria for an assessment. Not every child or young person will have the level of need or complexity for an NHS funded assessment. This will mean that some children and young people will not remain on the neurodevelopmental waiting list, but all children and young people will receive a needs-led offer of support. This will mean children and young people receive the right level of support to meet their individual needs.

What happens if my child's needs change?
If your child or young person's needs change over time, they can be re-referred to local services either by their GP, school or other professional, dependant on the borough, to request an assessment.

NHS
Greater Manchester

NHS GM Implementation of CYP ND Triage and Assessment Model Guidance

Recap:

- New Pan GM triage and assessment process developed for reviewing CYP autism and ADHD assessment requests
- Clinical criteria developed by ICB clinical leads with input from commissioners, localities, parents, carers and CYP
- Model and criteria approved through ICB clinical governance November 2025
- Provides a standardised approach to reviewing requests for assessment across GM
- Addresses unsustainable demand and long waiting times by moving away from a medicalised model that has resulted in unacceptable delays and avoidable harm
- Prioritises NHS resources and assessment for those with the highest needs whilst ensuring all CYP receive an offer of support regardless of diagnostic status

Clinical Criteria

Needs-led offer

NHS Greater Manchester

Referrer

- Identifies need
- Connects family to needs led offer
- If the child is in education, considers if appropriate ordinarily available provision and SEN supports are in place
- Considers if the child has presentation indicative of ICD-11 criteria.
- Considers if the child is over 10: the young person is requesting the assessment
- If the young person is under 10: the parent/carer is requesting the assessment

Multi Agency ND Triage

Multi-agency team review referral

- Check ICD 11 criteria
- Consider level of need

Prioritise referral, make informed clinical decision based on:

- mental health
- risk of home/placement breakdown
- risk of education placement breakdown where a clear needs led plan has been tried and reviewed
- significant social factors (including cared for children)
- age at time of referral
- YOS involvement
- CYP who would significantly benefit from medication for treatment of ADHD
- language delay or no speech
- awaiting gender services.

Outcome if ICD-11 Criteria Met

1. Child/young person with very high level of need and are requiring an ND assessment will be seen urgently.
2. Child/young person has significant needs and requires an ND assessment will be added to the wait list.
3. Child/young person may meet ICD 11 criteria, but needs are not considered significant enough to warrant an NHS ND assessment, signpost to support hubs.

ND Assessment

If moderate or severe co-occurring mental health condition or moderate to severe functional impairment due to mental health distress is present, ND assessment by CAMHS

If no or mild co-occurring mental health condition, ND assessment by community.

Outcome communicated to family, young person, GP and referrer

Outcomes if ICD11 Criteria not met OR ICD 11 criteria are met but levels of impairment are low / level of functioning is not affected

- **Social Care**
- **Education**
- **Mental Health**
- **Community Health**

Outcome communicated to family, young person, GP and referrer

New Referrals

- Providers have been issued the clinical criteria and asked to start planning for implementation from January 2026
- In the first instance, triage may be undertaken by the provider without any external partners.
- Multiagency triage panels are expected to be mobilised over time with attendance from all commissioned assessment providers and where possible education and social care leads
- Using the clinical triage criteria, providers are asked to continue to accept and support CYP referred into their services with needs identified as warranting an assessment (outcome 1 and 2):
  - OUTCOME 1: Child/young person with very high level of need and are requiring an ND assessment will be seen urgently.
  - OUTCOME 2: Child/young person has significant needs and requires an ND assessment will be added to the wait list.
  - OUTCOME 3: Child/young person does not meet criteria for ICD 11; or child and young person seems to meet criteria for ICD but needs are not high enough for an NHS assessment - child will not receive an NHS assessment
- All families will need to be notified of the outcome and signposted to available local or GM support.

Manchester Pilot

- Multiagency triage panel set up in North Manchester
- Consultant Paediatrician, Consultant Psychiatrist, lead for Autism pathway, senior education lead, manager Early Help Team, lead for disability Social Work team, Admin
- All new referrals for Autism or ADHD assessments – reviewed for risk, then being asked to consent to multi agency triage
- Under 5 referrals receive pre screen – some referrals e.g. those where there is regression of language highlighted as likely to need assessment
- Panel receives names in advance – meets face to face for one 3 hour session

Manchester Pilot - Triage

- All members have access to their own EPR
- Referral reviewed and each panel member discusses relevant information from own system
- Enables panel to have much more holistic overview of a CYP and their needs and for more co-ordinated plan to be offered
- Triage documentation has been developed to capture
  - Evidence being reviewed
  - Discussion
  - Outcome decision
  - Plan/recommendations of supprt

Manchester Pilot - Outcomes

- From reviewing community health, CAMHS, social care and education records together it is easier to see if there is enough evidence of an ICD 11 presentation of Autism or ADHD and/or if there is an alternative formulation
- Alternative formulations highlighted include; trauma, learning disabilities, FASD
- From using this multiagency approach 58% of referrals that would have been accepted onto the pathway have been redirected to other agencies/support

Manchester Pilot

	Autism	ADHD	Both	
Comm paeds wlist	12	8	1	**21**
CAMHS list	1	2		**3**
Urgent Community Paeds	2			**2**
Not enough evidence of ICD 11 criteria	12	6	1	**19**
Alternative formulation	9	3		**12**
Not enough evidence that NHS assessment eligibility criteria met	3	2		**5**
Total	39	21	2	**62**

Lessons Learnt

- It would be helpful if pathways started with a multiagency meeting around children schools or families are worried about – as a more co-ordinated needs led offer could be put in place at this point and inappropriate referral to ND pathways avoided
- Having all partners around the table together is invaluable in making better informed decisions – and has largely been welcomed by parents who feedback that they want services to talk to each other
- Referrals are often very complex and require senior staff to review and advise.
- Keeping clear documentation is key as there are likely to be challenges and complaints
- This is a large time commitment but the outcomes for CYP are likely to be better and the triage system will ultimately change the referral culture
- Supports identification of gaps in service provision and identifies services facing most demand

Waiting List

Existing waiting lists now also need to be triaged with the agreed clinical criteria using the same process. Non-recurrent funding has been identified to support this activity, proportionate to the size of existing waiting lists and population served.

- Funding must be used to:
- 1. Triage and screen the existing Autism and ADHD assessment waiting list using the new criteria developed and signed off by NHS GM.
- 2. Activity will need to start with the longest waiters first, contacting families/referrers to check that the information is up to date and an assessment is still requested.
- 3. Those not eligible for assessment due to not meeting the clinical criteria will need to be notified of this and signposted to local GM support offers.
- 4. Undertake assessments for those waiting who meet the clinical criteria, in clinical priority and chronological order

Develop a high-level indicative activity plan to demonstrate implementation of the triage criteria across new referrals and existing waiting lists including assessments. This should demonstrate how waiting list triage and assessment activity will be delivered over and above business as usual activity within services using the funding. The plan should cover Q4 25/26 and the financial year 2026/27.

For new referrals and waiting list activity:

It is expected that each Provider will retain their current assessment responsibilities in this interim period (after application of the new clinical triage criteria). Until a set of commissioning recommendations has been developed to address any gaps in the provision of assessment services for CYP meeting the criteria for an assessment (specifically for children's community health services)

Reporting Requirements

- On a quarterly basis, commencing in January 2026 we will request activity data for new referrals and waiting list activity
- Important to support the development of commissioning recommendations to address gaps in autism and ADHD assessment services relating to implementation of the new CAMHS specification
- On a quarterly basis, commencing in January 2026 we will request activity data and arrange a check in meeting with named leads. This will include:
  - Evidence of spend and activity against the waiting list plan
  - How many CYP on the waiting list and new referrals have been triaged and the outcome
  - Numbers of CYP who are triaged as requiring an assessment that would fall within gaps between commissioned services on individual provider footprints based on current commissioned provision.
  - Agencies involved in triage
  - Detail of additional waiting list assessment activity planned or undertaken.
  - Any other information relating to delivery of your waiting list plan and any mitigating activity.

Centralised Supporting Documentation

- Triage guidance
- Triage outcome letter detailing specific locality support offers for CYP and their families
- Standardised referral documentation
- Communications brief for affected families
- Escalation panel for families appealing the triage process (based on the application of triage information and not the clinical decision)
- Reporting framework
- Equality and quality impact assessments

Next Steps….

- Providers to submit activity plan to demonstrate implementation of the triage criteria across new referrals and existing waiting lists
- Initial meeting to agree plan and release of funding on a quarterly basis
- Collation and submission of quarterly/monthly data to ICB for review in quarterly meetings
- Development of Commissiong recommendations which address gaps and support full implementation of the multi agency triage and CAMHS specification
- Save the date - CYP ND Triage Community of Practice – 23rd February 2026 – details to be confirmed

Q&A

Bury Neuro Hub update

Locality Board – 2nd March 2026

BURY
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PARTNERSHIP

Part of Greater Manchester
Integrated Care Partnership

Ian Trafford

ian.trafford2@nca.nhs.uk

Developing offer across Greater Manchester & Bury

Getting Advice

- **GM Autism website -** My Area – Bury - GMAC
- **Bury ND Hub - Advice and guidance support from specialist navigators**
- **Online webinars – *in development – available from Jan 2026***
- **Bury PADLETS -** Supporting-your-neurodiverse-child-padlet **and other online advice e.g. Sleep advice**
- **Bury Portage service -** https://www.portage.org.uk/support/resources/resources-parents
- **Digital messaging support delivered by Barnardo's - *in the new year***
- **Documentation outlining ordinarily available provisions and SEND reasonable adjustments -** gm-oaip-2025-2026.pdf
- **Bury SEND Local Offer web pages -** Bury SEND Local Offer - Bury Council
- **myHappymind / myMindcoach – inc SEND specific resources** Bury EOY Report 2025 / Online Flipbook
- **First Point workshops and seminars**
- **Bury2Gether resources and workshops -** https://www.bury2gether.co.uk/about

Getting Help

- **Evidence based group support for behaviour (pre-school and school age) Riding the Rapids** Riding The Rapids - GMAC
- **Bury ND Hub offer – thematic sessions and support – *in development***
- **Neuro-developmental Profiling tools - *going live soon***
- **Sensory toolkit, workshops and consultations -** Sensory Toolkit & Sensory support padlet
- **Sleep workshops and consultations – *GM commission coming next financial year***
- **Evidence based communication interventions - PACT** (PACT) **Can DO** (The Home of Can Do) . **Ibasis** (iBasis)
- **Needs led support via Navigators (in ND Hub)**
- **Tailored mental health support via MHSTs**
- **HAVEN group-based support being developed - 13 Bury staff trained representing 5 different schools**
  - **Neuro-diversity in education programme (Autism in Schools and PINs)**
    - **Peer support through Spectrum Gaming -** Home | Spectrum Gaming
    - **RISE at Early Break – open access MH support**

Getting Risk Support

- **Access to Rapid Response and Home Treatment Teams for Mental Health**
- **Access to CETR process**
- **Intensive Specialist Support Teams**

Getting More Help

- **Redesigned Assessment / diagnostic pathways - *in development***
- **Prescribing / shared care for ADHD through CAMHS**
- **Provision of neuro-affirmative assessment report – *in development***
- **Individualised Post-Diagnostic Support Care Packages**
- **Key worker support via DSR – *ongoing discussions to widen criteria to include more proactive approach***

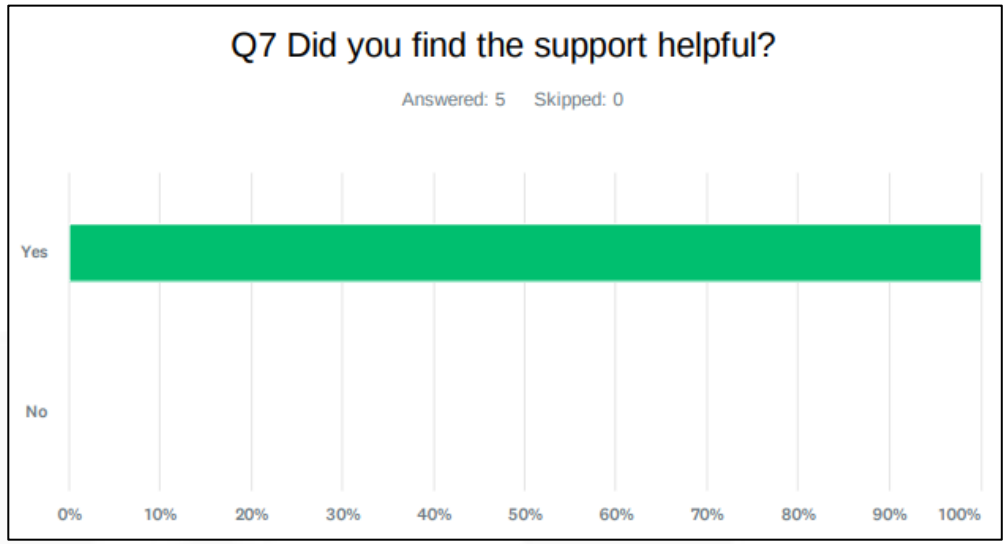
Bury Neuro Hub - delivery update

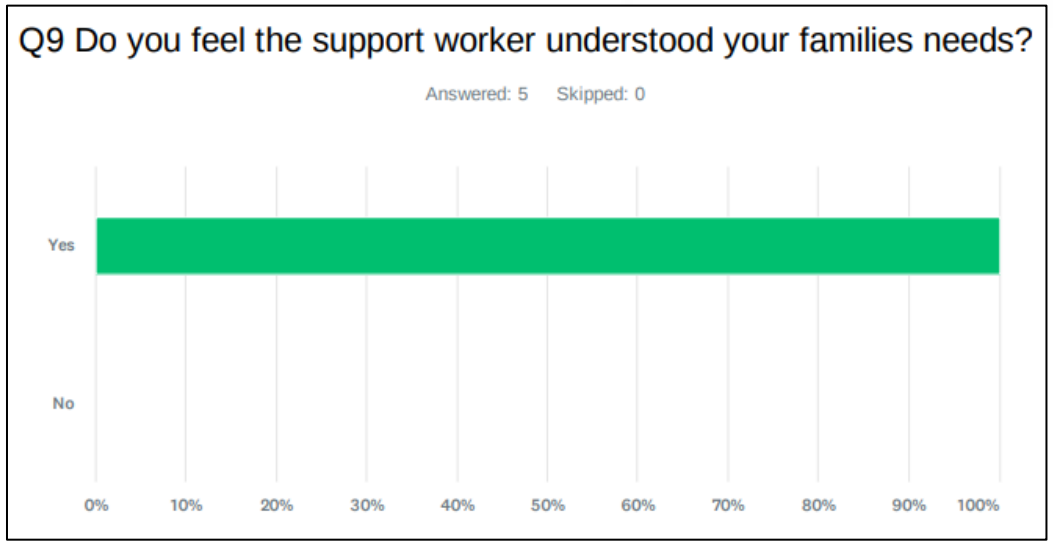
BURY
INTEGRATED CARE
PARTNERSHIP

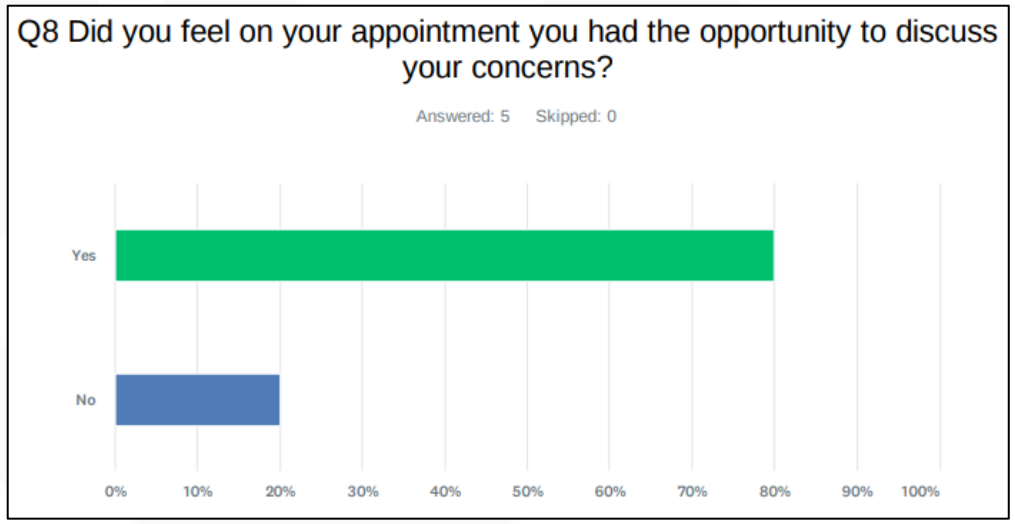
- Recruitment: Co-ordinator, 1x Navigator, admin support in post. 2nd Navigator appointed.
- 6 x Drop ins delivered – further intelligence gathering from parents and carers about their needs and experience.
- 42 Families have attended.
- Initial referral / signposting from Portage and SEND Health Visitor team and more recently Early Help have ten places allocated per session.
- Navigator building up a caseload for individual family support. 21 families identified as requiring Navigator support. 8 Families have received a 4-week support intervention so far.
- Agreement that parents and carers will be signposted to the Hub from ND triage to simplify the pathway.
- First Neuro Hub focus group sessions launched - consulting with parents and carers about what they want from the Hub.
- Gradual expansion planned - March hub opening one day a week then in April two days a week.

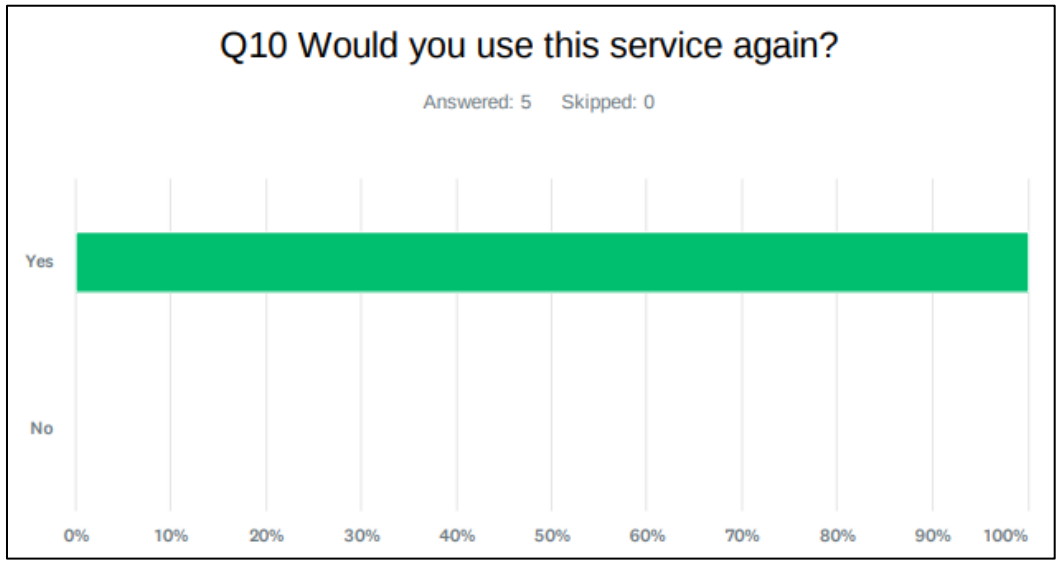
Bury Neuro Hub – early feedback from families attending the drop-in

BURY INTEGRATED CARE PARTNERSHIP









Engagement work

BURY INTEGRATED CARE PARTNERSHIP

- Links established with:
  - Bury Autism Co-production Network
  - Bury Youthwatch
- Commencement of First Point focus group sessions to inform Hub development.
- First Point engagement with Changemakers and Bury2Gether to finalise design of the Hub name, logo and strapline.
- First Point meeting with Community Paediatrics.
- Joint Children's & Health Scrutiny Committee (28th Jan) – engagement with elected members and public questions taken.
- 4 public *listening events* held to inform development of refreshed Bury mental health strategy & survey launched.

PLANNED:

- Meeting with Changemakers – 10th March.
- Triage design workshop - TBC

Logo & strap line

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Bury Neuro Hub

Tailored support for families of children / young people with Neurodiverse needs (with or without a diagnosis)

BURY INTEGRATED CARE PARTNERSHIP

Meeting:			
Meeting Date	02 March 2026	Action	Receive
Item No.	9	Confidential	No
Title	Draft Place Partnership Agreement		
Presented By	Will Blandamer		
Author	Will Blandamer		
Clinical Lead	Dr Cathy Fines		

Executive Summary

Locality Board has been updated on the NHS GM operating model and the establishment of a consistent framework to support the work of each of 10 place partnerships. A draft partnership agreement is included here for the consideration of the Bury Locality Board. This draft is being tested in all 10 parts of Greater Manchester.

Recommendations

The Locality Board is invited to review the draft Partnership Agreement and consider any amendments to it.

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	☒

BURY INTEGRATED CARE PARTNERSHIP

Links to Locality Plan priorities	
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:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☒	N/A	☐

Governance and Reporting		
Meeting	Date	Outcome

BURY INTEGRATED CARE PARTNERSHIP

Draft Place Partnership Agreement.

1. Introduction

1.1. The Locality Board was advised in the February meeting on a number of elements in mobilising the model of place based partnership work as described in the revised NHS GM operating model. These elements include:

- A **Place Partnership Agreement** describing the objectives of place partnership work and describing the duties of partners to the place partnership
- An **outcomes framework**, that will describe the expectation of NHS GM in the work of the place partnership in improving outcomes and health and care system performance for Bury residents
- The establishment of a **Place Based leadership Team**
- A **financial framework** providing clarity on the operation of a pooled budget to deployed by the agreement of the place partnership
- Clarity on the **future employment model of NHS GM** staff in places.

2. Background

2.1. This paper provides as Appendix the currently draft partnership agreement. It is being considered by all 10 parts of Greater Manchester in the month of March. Localities are invited to provide comments on amendments on the agreement.

3. Recommendations

4.1 The Bury Locality Board is invited to consider the Draft Place Partnership Agreement and make comments for consideration.

Will Blandamer
Deputy Place Lead
w.blandamer@bury.gov
March 26.

XXXXX

PLACE PARTNERSHIP AGREEMENT FOR THE OPERATION OF THE LOCAL HEALTH AND CARE SYSTEM

0. Definitions and Glossary

This section provides definitions for key terms used throughout the Place Partnership Agreement. These definitions are intended to support clarity, consistency and shared understanding across all Partners. Where terms are defined in national legislation or Greater Manchester (GM) policy, those definitions will apply unless otherwise stated.

"Agreement"

This Place Partnership Agreement, including all schedules and formally agreed variations.

"Best for [Place]"

The principle that decisions should be made in the interests of improving outcomes, reducing inequalities and supporting the wellbeing of residents in [Place], even where this may not align with individual organisational preferences.

"Best for GM"

The principle that Place decisions should align with and contribute to the wider ambitions, missions and operating model of Greater Manchester.

"Delivery Board"

The operational leadership forum responsible for overseeing delivery of the Place Business Plan, managing performance, quality and risk, and ensuring alignment with the Place Outcomes Framework. This may take the form of an Local Care Organisation (LCO) Board, Provider Collaborative Board or other forum(s) as agreed by the Partnership

."GM Operating Model"

The agreed framework that sets out how NHS GM, Places and neighbourhoods work together, including delegated functions, governance, financial arrangements and system responsibilities.

"GM Strategy"

The overarching strategy for Greater Manchester, including the GM Integrated Care Partnership Strategy and the GM missions.

"Integrated Neighbourhood Team (INT)"

A multi-disciplinary team operating at neighbourhood level, bringing together health, care, community and voluntary sector professionals to provide coordinated, person-centred support.

“Local Care Organisation (LCO) / Provider Collaborative”

The partnership of providers responsible for the design and delivery of integrated health and care services at Place, operating in line with the GM Operating Model.

“Neighbourhood Plan”

The locally agreed plan that sets out priorities, delivery arrangements and outcomes for neighbourhood-level working within [Place].

“Outcomes Framework” or “Place Outcomes Framework”

The shared framework adopted by Partners that sets out the population health, model of care and system outcomes to be achieved at Place, and the measures used to track progress.

“Partner” or “Partners”

The organisations that are signatories to this Agreement and any additional organisations admitted by mutual agreement.

“Partnership Board”

The strategic leadership forum for the Place Partnership, responsible for setting direction, agreeing priorities, overseeing the Place Neighbourhood Plan and ensuring alignment with GM strategy.

“Place”

The defined geographical area covered by this Agreement, corresponding to the local authority footprint of [Place].

“Place Business Plan”

The annual plan that sets out the priorities, programmes, resource deployment and delivery arrangements for the Place Partnership.

“Place Funding Framework”

The agreed approach to aligning, coordinating and stewarding financial resources at Place, including NHS, local authority, VCFSE and wider public service contributions.

“Population Health Management”

An approach that uses data, intelligence and insight to understand population needs, target interventions, and improve outcomes at population, cohort and individual levels.

“Reserved Matters”

Decisions or responsibilities that remain solely within the statutory authority of individual Partners and cannot be delegated or determined collectively.

“Sovereign Organisation”

A Partner that retains its own statutory duties, legal responsibilities, governance arrangements and decision-making authority.

“VCFSE”

Voluntary, Community, Faith and Social Enterprise organisations contributing to health, wellbeing and community resilience within [Place].

1. Purpose, Parties and Status of the Agreement

1.1 Context and Purpose

Greater Manchester's approach to integrated care is founded on the principle that the conditions for good health are created locally, in neighbourhoods, communities, and the relationships between the organisations that serve them, through a strong focus on population health improvement and reduced inequality.

This Agreement provides the shared foundation for how Partners in [Place] will work together to improve outcomes, reduce inequalities, and create the conditions for people to live well.

It sets out the commitments, behaviours and governance arrangements that underpin our partnership, while recognising the statutory responsibilities and sovereign status of each organisation. It is intended to bring clarity, stability and shared purpose to the way we collaborate, ensuring that our collective efforts are aligned to the needs and aspirations of our residents.

1.2 Parties

This Agreement is made between the following Partners:

- NHS Greater Manchester (NHS GM)
- [Name] Council
- [Acute Provider(s)]
- [Mental Health Provider(s)]
- [Community Provider(s) / LCO / Provider Collaborative]
- Primary Care Networks in [Place]
- Voluntary, Community, Faith and Social Enterprise (VCFSE) partners
- Healthwatch [Place]
- Any additional organisations admitted by mutual agreement

1.3 Status of the Agreement

- The Partnership is not a legal entity and cannot bind Partners or enter into contracts.
- This Agreement is not an NHS Contract, but it is a formally adopted, binding expression of shared intent.
- Each Partner remains a sovereign organisation, retaining statutory duties, accountabilities and decision-making powers.
- The Agreement supplements and aligns with:
    - NHS GM strategic commissioning plans
    - Place Neighbourhood Plans
    - Section 75 agreements
    - Services contracts
    - Partnership Board and LCO / Provider Collaborative Terms of Reference
    - The GM Integrated Care Partnership Strategy

1.4 Principles of Partnership

Partners commit to work together on a Best for [Place] and Best for GM basis, recognising that:

- collaboration is essential to improving outcomes;
- no Partner may be required to act unlawfully or contrary to statutory duties;
- decisions should be made collectively wherever possible;
- trust, transparency and shared accountability are essential to success.

2. Commencement and Term

2.1 Context

The Place Partnership operates within a dynamic environment where responsibilities, statutory frameworks and system priorities continue to evolve.

This Agreement is therefore designed to provide a stable and coherent foundation for joint working, while remaining sufficiently flexible to adapt as our system matures, national policy develops, and new opportunities or challenges emerge.

Partners recognise that maintaining the relevance, integrity and effectiveness of this Agreement is a shared responsibility. The commitments in this section ensure that the Agreement remains a living framework, actively stewarded, regularly reviewed, and updated in a way that strengthens collaboration rather than diluting it.

2.2 Term

- The Agreement takes effect from [date] and continues until [date] ("the Term").
- The Agreement will undergo a formal annual review, ensuring it remains aligned with the Place Outcomes Framework, the GM Operating Model, GM Live Well Strategy and the needs of residents and communities.
- Partners will consider renewal, extension or variation no later than six months before the end of the Term, allowing sufficient time for internal governance processes across all sovereign organisations.
- The Agreement may be updated at any time to reflect:
    - changes in legislation or statutory responsibilities;
    - developments in GM strategy, governance or delegated functions;
    - material changes in the scope, ambition or operating model of the Place Partnership.
- Any updates or variations will be agreed collectively through the Partnership Board and approved through each Partner's internal governance arrangements as necessary.

3. Shared Vision, Purpose and Strategic Context

3.1 Why this matters

A shared vision provides the anchor for all partnership activity. It ensures that decisions, resources and leadership are aligned to a common purpose, and that the work of the partnership is coherent with both local aspirations and GM-wide ambitions.

3.2 Greater Manchester Strategic Context

This Agreement contributes to the overarching goal of the NHS Greater Manchester Strategy:

“People in Greater Manchester live in good health for longer, and we reduce the gap in healthy life years between our communities.”

It also supports the wider Greater Manchester Combined Authority vision:

“A thriving city region where everyone can live a good life.”

3.3 Place Vision

[Insert Place vision — e.g. “to create a place we can all take pride in, where everyone can live a good life now and in the future.”]

3.4 Purpose of the Agreement

The Agreement exists to:

- align partners around a shared set of outcomes;
- strengthen collaboration and shared accountability;
- support the shift towards prevention, early intervention and neighbourhood-based delivery;
- ensure coherence between Place and GM strategic ambitions;
- provide clarity on roles, responsibilities and governance.

4. Strategic Priorities and Outcomes Framework

4.1 Context

Strategic priorities provide the focus for collective action. They ensure that the partnership directs its energy and resources towards the areas that will make the greatest difference to residents' lives. The Place Outcomes Framework provides the mechanism for measuring progress and holding ourselves to account.

4.2 Strategic Priorities

Partners agree to work collectively to deliver the following priorities, aligned to the GM missions and adapted for local context:

- Strengthening our communities
- Helping people get into, and stay, in good work
- Recovering and improving core NHS and care services
- Helping people stay well and detecting illness earlier
- Supporting our workforce and carers
- Achieving financial sustainability

4.3 Outcomes Framework

The Partners adopt a shared Place Outcomes Framework (Schedule 1), which includes:

- **A narrowing of the healthy life expectancy gap between the most and least advantaged communities, alongside a general uplift for all residents,** measuring this through locally meaningful indicators of inequality, prevention, and early years development, anchored in what matters to people, such as "I feel supported to live a healthier life where I live.", and also ensuring the future sustainability of the NHS and support economic growth.

- **Increased proportion of care delivered in neighbourhood settings,** reducing health inequalities, reliance on emergency services and enabling earlier support**.**

- **Improved staff wellbeing and retention across sectors**, as a marker of a compassionate, sustainable and inclusive local system.

- **More effective use of local partners' collective resource to achieve shared outcomes**; evaluating impact and taking an approach of continuous improvement.

4.4 How the Outcomes Framework will be used

The Place Outcomes Framework will provide the mechanism through which partners translate strategic priorities into coordinated delivery. It will guide how programmes

are planned and sequenced, ensuring that activity across organisations is aligned to the outcomes we have collectively agreed.

The Framework will also inform decisions about the deployment of resources, supporting partners to target investment where it can have the greatest impact.

It will underpin our shared approach to assurance and improvement, offering a consistent basis for monitoring progress, identifying variation, and supporting collective problem-solving.

Through clear and transparent reporting, the Framework will strengthen accountability to residents and partners, demonstrating how Place activity is contributing to improved outcomes.

The Framework will also ensure alignment with the wider Greater Manchester outcomes architecture, enabling coherence across the system while maintaining a strong focus on local priorities and context.

5. System Characteristics, Leadership and Culture

5.1 Context

Our Place Partnerships are built on relationships, behaviours and shared purpose as much as on structures or formal governance. The effectiveness of the Place Partnership depends on how well we work together, how we lead, how we communicate, how we solve problems, and how we draw on the strengths of each organisation.

This section sets out the characteristics that define the "way we do things here" in [Place]. It describes the leadership behaviours, cultural expectations and ways of working that enable a Place Team to function as a coherent, collaborative system, even though we remain sovereign organisations. It also reflects the commitment to matrix working, where people, skills and capabilities flow across organisational boundaries to support shared priorities.

The Place Partnership for health and care also provides a point of focus and engagement for other important partnerships in the local place with whom the health and care system need to work together to deliver the strategy for local people, for example the community safety partnership, and the business leadership group or equivalent.

5.2 Leadership Characteristics

Partners commit to leadership behaviours that:

- **Embed system ways of working** across organisations, ensuring decisions and actions reflect shared priorities rather than organisational silos.
- **Promote innovation, integration and shared problem-solving**, enabling teams to work flexibly and creatively across boundaries.
- **Demonstrate compassion, empathy and respect**, recognising the pressures faced by residents, communities and the workforce.
- **Model collaborative behaviours and shared accountability**, reinforcing that success at Place is a collective endeavour.
- **Enable and empower the Place Team**, supporting staff to work in matrix arrangements and contribute their expertise wherever it adds most value.
- **Champion prevention, equity and community-led approaches**, ensuring leadership decisions reflect the needs and voices of residents.

5.3 Cultural Characteristics

Partners will foster a culture that:

- **Places outcomes and tackling inequalities at the centre of decision-making**, ensuring all actions contribute to improved health, wellbeing and equity.

- **Recognises and addresses wider social, economic and commercial determinants of health**, working with partners beyond traditional health and care boundaries.
- **Uses shared data, intelligence and insight** to drive improvement, learning and prioritisation.
- **Engages residents and communities meaningfully**, ensuring lived experience shapes design, delivery and evaluation.
- **Communicates clearly, inclusively and transparently**, supporting trust, alignment and shared understanding.
- **Values the strengths of each Partner**, recognising that the diversity of organisations, skills and perspectives is a core asset of the Place Partnership.
- **Supports matrix working**, enabling staff to collaborate across organisational lines with clarity, purpose and mutual respect.

5.4 The Place Team

The Place Partnership will operate through a Place Team; a virtual, multi-disciplinary team drawn from across all Partners. The Place Team:

- brings together skills, expertise and capacity from across organisations;
- works in a matrix model, with individuals contributing to shared priorities while remaining employed by their sovereign organisations;
- supports the development and delivery of the Place Business Plan;
- provides leadership, analytical capability, programme management and operational support to the partnership;
- enables integrated neighbourhood delivery by connecting system priorities with local action;
- embodies the behaviours and cultural characteristics set out in this section.

The Place Team is not a new organisation, it is the practical expression of how we work together.

5.5 Application

These characteristics will be reflected in:

- **Leadership development**, ensuring leaders at all levels understand and model system behaviours.
- **Organisational objectives**, aligning internal priorities with the Place Outcomes Framework.
- **Partnership behaviours**, including how we meet, make decisions, resolve issues and support one another.
- **Programme design and delivery**, ensuring transformation and improvement work is collaborative, evidence-based and aligned with shared outcomes.
- **Workforce development**, supporting staff to work confidently in matrix arrangements and across organisational boundaries.
- **The operation of the Place Team**, ensuring it has the clarity, support and capability required to drive system change.

6. Roles, Responsibilities and Collective Capability

6.1 Context

Delivering meaningful change at Place requires more than alignment of vision and governance. It depends on the ability of Partners to bring together their collective resources, capabilities, expertise and infrastructure in a coordinated and purposeful way. This section sets out how Partners will combine their strengths to drive improvement, innovation and transformation across [Place].

6.2 Shared Responsibilities of All Partners

All Partners will:

- act on a Best for [Place] basis;
- comply with all relevant laws, guidance and constitutional standards;
- contribute to the delivery of the Place Outcomes Framework;
- share information appropriately and lawfully;
- participate in governance, planning and review processes;
- support integrated delivery at neighbourhood level;
- contribute to the development of the Place Business Plan.

6.3 Collective Resource and Capability Commitments

Partners agree that the Place Partnership is the primary forum through which we will:

- **Develop a consistent and shared understanding** of what is meant by neighbourhood team working.
- **Align and coordinate resources** including financial, workforce, estates, digital and community assets to support shared priorities.
- **Deploy capabilities and expertise** from across organisations to support integrated delivery, transformation and improvement.
- **Share skills and leadership capacity**, recognising that no single organisation holds all the capabilities required to deliver population-level change.
- **Develop joint teams and shared functions** where appropriate, particularly in areas such as neighbourhood delivery, analytics, transformation, programme management and community engagement.
- **Support workforce mobility and integration**, enabling staff to work across organisational boundaries where lawful and appropriate.
- **Maximise the contribution of the VCFSE sector**, recognising its unique reach, trust and insight within communities.
- **Strengthen analytical and improvement capability**, using shared data, intelligence and evaluation to drive decision-making.

6.4 Operationalising Shared Capability

To make this real, Partners will:

- Establish shared transformation and improvement capacity at Place, drawing staff and expertise from across organisations.
- Develop a joint analytical and population health intelligence function, aligned with GM standards.
- Support the development of Integrated Neighbourhood Teams, ensuring they have access to the right skills, leadership and community assets.
- Identify opportunities for shared roles, joint appointments and integrated teams where this strengthens delivery.
- Use the Place Business Plan to set out annual priorities for shared resource deployment, ensuring transparency and alignment with outcomes.
- Participate in cross-GM learning and capability-building, ensuring Place benefits from system-wide expertise.

6.5 Commitment to Continuous Development

Partners recognise that the capability required to deliver integrated care will evolve over time. We therefore commit to:

- Regularly reviewing the skills, capacity and capability required to deliver the Place Outcomes Framework.
- Identifying gaps and agreeing how these will be addressed collectively.
- Investing in leadership development and system behaviours.
- Supporting the development of a shared culture of improvement, where learning is openly shared and used to strengthen practice.

7. Place Funding

7.1 Context

Place Funding is a core enabler of integrated care. It provides the financial framework through which Partners can align resources, support shared priorities, and ensure that investment decisions are guided by outcomes, prevention and neighbourhood-based delivery.

7.2 The Place Funding Framework

Partners agree to operate within a shared Place Funding Framework, which:

- allows Partners to develop a shared understanding of the resources currently deployed within the Place, including NHS, local authority, VCFSE and wider public service contributions;
- improves visibility of how these resources are used, enabling clearer identification of duplication, unmet need, and opportunities to maximise collective impact;
- aligns financial planning with the Place Outcomes Framework and broader GM Strategy missions;
- supports the shift towards prevention, early intervention and community-led models of care;
- enables transparent, collective stewardship of resources;
- subject to local governance and mutual agreement, allows Partners to explore options for aligned investment, joint commissioning, or pooled funding arrangements where these add value and support improved outcomes for communities.

7.3 Principles of Place Funding

The Place Funding Framework is underpinned by the following principles:

- **Outcome-driven investment:** Resources are deployed to maximise impact on population health outcomes and reduce inequalities.
- **Transparency:** Partners share information on budgets, expenditure and financial risks to support collective decision-making.
- **Flexibility:** Funding arrangements support innovation, integrated delivery and neighbourhood-based models.
- **Collective stewardship:** Partners take shared responsibility for financial sustainability and risk management.
- **Alignment with GM:** Place Funding arrangements operate within the wider GM financial framework, ensuring consistency and coherence.

7.4 Application

The Place Funding Framework will be used to:

- inform the development of the Place Neighbourhood Plan;

- support joint planning and prioritisation;
- enable pooled or aligned budgets where appropriate;
- support investment in prevention, community assets and neighbourhood delivery;
- monitor financial performance and risk at Place level.

The Place Funding Framework is included in Schedule 2.

8. Governance and Decision-Making

8.1 Context

Effective governance is essential to the success of the Place Partnership. It provides the structure through which Partners exercise shared leadership, make collective decisions, and hold themselves to account for delivering improved outcomes for residents. Governance must be clear, transparent and proportionate, enabling timely decision-making while respecting the statutory duties and sovereign responsibilities of each Partner.

The governance arrangements set out in this section ensure that the Partnership operates with discipline, clarity and shared purpose. They also ensure alignment with the Greater Manchester Operating Model and wider system governance, creating a coherent framework from neighbourhood to GM level.

8.2 Governance Structure

The governance model for the Place Partnership is based on shared leadership, distributed accountability and clear lines of sight between strategy, delivery and neighbourhood-level practice. Each Place operates with the following core components:

- **A Partnership Board**
  The strategic leadership forum responsible for setting direction, agreeing priorities, overseeing the Place Business Plan, and ensuring alignment with GM strategy and the Place Outcomes Framework.
- **A Delivery Board** (e.g. LCO Board / Provider Collaborative Board)
  The operational leadership forum responsible for delivery of the Place Business Plan, management of performance, quality and risk, and coordination of integrated delivery across providers.
- **Supporting groups**
  Thematic groups for finance, quality, workforce, neighbourhoods, transformation and other functions as required, providing assurance, insight and operational coordination.

These components operate as a single, coherent governance system. The detailed governance diagram, membership, reporting lines and operating model will be set out in Schedule 4.

8.3 Decision-Making

Partners agree that decision-making within the Place Partnership will be grounded in shared purpose, transparency and respect for statutory responsibilities. To support this:

- **Consensus is the default**
  Decisions will be made by consensus wherever possible, reflecting the shared

commitment to act in the best interests of residents and the system as a whole.

- **Best for [Place] principle**
  Partners will act in accordance with the Best for [Place] principle, ensuring that decisions are guided by outcomes, equity and the needs of communities.
- **Respect for statutory duties**
  No Partner may be required to act unlawfully, contrary to statutory duties, or in a way that compromises its organisational responsibilities.
- **Reserved matters**
  Certain decisions remain the responsibility of individual sovereign organisations. These Reserved Matters will be respected and handled transparently within the governance process.
- **Clarity of escalation**
  Where consensus cannot be reached, issues will be escalated in line with the dispute resolution process set out in Section 10.

8.4 Accountability

Accountability within the Place Partnership is shared, but not diluted. Partners agree that:

- **The Partnership Board is collectively accountable**
  The Partnership Board is accountable to all Partners for the delivery of the Place Outcomes Framework, the Place Business Plan and the effective stewardship of resources.
- **Sovereign accountability remains unchanged**
  Each Partner remains accountable to its own Board or Cabinet for the discharge of its statutory duties, financial responsibilities and organisational performance.
- **Mutual assurance**
  Partners will provide assurance to one another through transparent reporting, shared intelligence and open dialogue, ensuring that risks, issues and performance concerns are surfaced early and addressed collectively.

9. Transparency, Information and Learning

9.1 Context

Effective partnership working depends on openness, trust and a shared understanding of the system we operate within. Transparency is not simply an administrative requirement, it is a foundational behaviour that enables collective decision-making, supports accountability, and ensures that actions taken at Place are grounded in evidence and insight.

Equally, continuous learning is essential in a complex and evolving system. Partners must be willing to share data, experience and learning in a way that strengthens practice, supports improvement, and enables the partnership to respond to challenges with agility and confidence.

This section sets out the commitments that underpin our approach to information-sharing, transparency and learning, recognising the statutory responsibilities and legal obligations of each Partner.

9.2 Commitments

Partners agree that transparency and learning will be embedded in all aspects of the partnership. To achieve this, Partners will:

- **Share information openly and proactively**
  Provide each other with timely, accurate and relevant information required to deliver the Place Outcomes Framework, monitor performance, manage risk and support effective planning.
- **Ensure compliance with legal and regulatory requirements**
  Handle all information in accordance with data protection legislation, information governance standards, Freedom of Information requirements, and competition law.
- **Protect commercially sensitive information**
  Identify and manage commercially sensitive information appropriately, ensuring it is shared only where necessary, with suitable safeguards, and in a manner that does not compromise legal or competitive obligations.
- **Promote a culture of learning and improvement**
  Foster an environment where learning is openly shared, mistakes are used constructively, and insights from residents, staff and partners inform continuous improvement.
- **Use shared data and intelligence to drive decision-making**
  Work collaboratively to develop and maintain shared analytical capability, ensuring that decisions are informed by robust evidence, population health insight and real-time system intelligence.
- **Support joint review and reflective practice**
  Participate in joint reviews, after-action learning, peer support and cross-organisational improvement activity, recognising that shared reflection strengthens system resilience.

- **Communicate transparently with stakeholders and communities**
  Ensure that information about performance, outcomes and progress is communicated clearly and accessibly to residents, staff and partners, supporting accountability and trust.

9.3 Safeguards and Responsibilities

Partners acknowledge that:

- No Partner will be required to disclose information where doing so would breach legal, regulatory or contractual obligations.
- Each Partner remains responsible for ensuring the security, integrity and lawful handling of information within its control.
- Where information cannot be shared, the Partner concerned will explain the reason and work with others to identify alternative ways to support decision-making.

9.4 Commitment to System Learning

Partners will work together to identify themes, trends and opportunities for improvement across the system. This includes:

- learning from performance data, quality reviews and resident feedback;
- sharing innovation, best practice and improvement methodologies;
- participating in GM-wide learning networks and capability-building programmes.

10. Problem Resolution and Escalation

10.1 Context

In a system of sovereign organisations working collaboratively, differences of view are both inevitable and legitimate. What matters is that such issues are surfaced early, handled constructively, and resolved in a way that protects relationships, maintains trust, and ensures continuity of services for residents. This section sets out a clear, fair and proportionate approach to resolving disagreements, recognising the statutory duties and accountabilities of each Partner.

Partners agree that disputes should be approached in a spirit of openness, transparency and good faith, with a shared commitment to resolving issues at the earliest possible stage and at the most appropriate level.

10.2 Principles

When managing disagreements, Partners will:

- act in accordance with the Best for [Place] principle;
- seek to resolve issues informally and promptly, avoiding unnecessary escalation;
- ensure that discussions are timely, evidence-based and respectful;
- recognise that no Partner may be required to act unlawfully or contrary to statutory duties;
- ensure that escalation is used only when necessary, and in a way that supports resolution rather than blame;
- maintain continuity of services and minimise disruption to residents.

10.3 Approach

If a disagreement arises between Partners:

1. **Local Resolution**
    - Partners will first seek to resolve the issue informally between the individuals or teams directly involved.
    - Where appropriate, this may include facilitated discussion, joint review of evidence, or clarification of roles and responsibilities.
2. **Escalation to Operational Leadership**
    - If the issue cannot be resolved informally, it will be escalated to the relevant operational leads or senior managers within the organisations concerned.
    - These leaders will work together to agree a resolution, ensuring that all relevant information is shared transparently.
3. **Escalation to Partnership Governance**
    - If operational resolution is not possible, the matter may be escalated to:
        - the Delivery Board (for operational, performance or delivery issues);

        - the Partnership Board (for strategic, financial or system-wide issues).
    - The Board will consider the matter in line with the Partnership's principles, statutory duties and agreed priorities.
4. **Escalation to Statutory Bodies**
    - Where the issue relates to statutory responsibilities, legal obligations, or matters that cannot be resolved within Place governance, the matter may be escalated through existing governance routes within:
        - NHS GM;
        - [Name] Council;
        - or other relevant statutory bodies.
    - Partners will notify each other in writing if such escalation is required.
5. **Formal Dispute Resolution**
    - If the issue remains unresolved after the above steps, the formal dispute resolution process will apply.
    - This may include mediation, independent facilitation, or other agreed mechanisms.

10.4 Commitment to Learning

Partners agree that disputes will be reviewed periodically to identify themes, strengthen partnership working, and improve future practice. The aim is not only to resolve issues, but to learn from them and reduce the likelihood of recurrence.

11. Review, Variation and Evolution

11.1 Context

Place partnerships operate in a complex and continually changing environment. Legislation evolves, responsibilities shift, and new opportunities emerge as our system matures. To remain effective, this Agreement must be treated as a living framework, actively stewarded, regularly reviewed, and adapted in a way that strengthens collaboration rather than diluting it.

Partners recognise that maintaining the relevance and integrity of this Agreement is a shared responsibility. Reviews and variations must therefore be undertaken with the same commitment to transparency, trust and collective purpose that underpin the wider partnership.

11.2 Commitments

Partners agree that:

- **Regular review:**
  The Agreement will undergo a formal review at least annually, ensuring it remains aligned with the Place Outcomes Framework, the GM Operating Model, and the evolving needs of residents and communities.
- **Trigger-based review:**
  In addition to the annual review, the Agreement may be reviewed earlier where:
  - significant changes occur in legislation, national policy or GM Strategy arrangements;
  - material changes arise in delegated functions, governance or funding;
  - a Partner identifies a substantive issue that affects the operation or intent of the Agreement.
- **Variation process:**
  Variations may be proposed by any Partner. All proposed changes will be:
  - considered through the Partnership Board;
  - subject to transparent discussion and assessment of impact;
  - approved through each Partner's internal governance processes;
  - recorded formally and appended to the Agreement.
- **Collective stewardship:**
  No variation will be made that:
  - compromises the statutory duties of any Partner;
  - undermines the shared purpose or principles of the partnership;
  - materially alters the balance of responsibilities without explicit agreement.
- **Evolution over time:**
  The Agreement is intended to evolve as Place arrangements mature. This includes the potential to:
  - strengthen shared functions or capabilities;
  - reflect new models of delivery or governance;

- incorporate new schedules (e.g., funding, outcomes, operating models) as they are agreed;
- adapt to changes in the scope or ambition of the partnership.

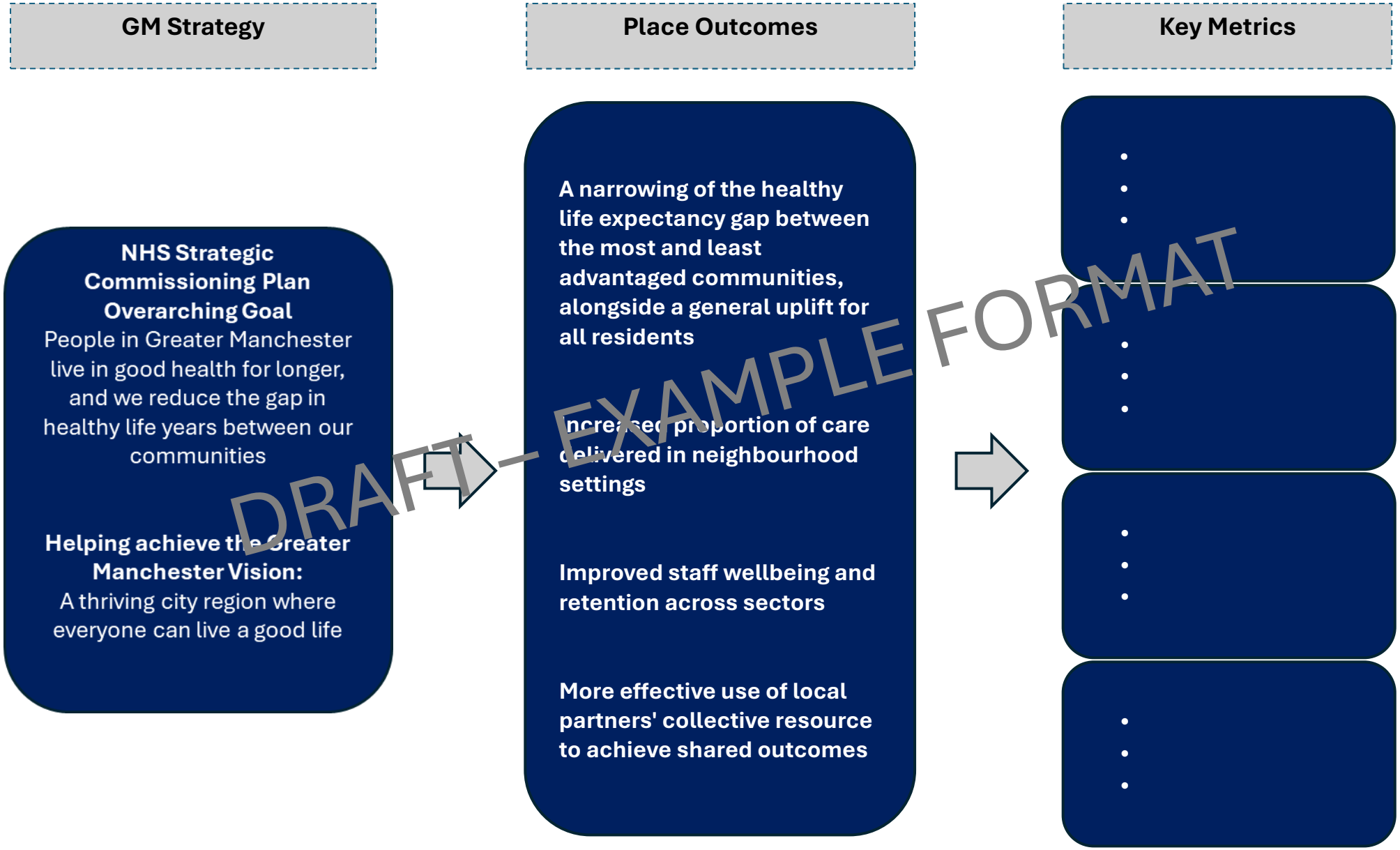
11.3 Transparency and communication

Any agreed changes will be communicated clearly to all Partners, stakeholders and relevant teams to ensure consistent understanding and implementation across the system.

12. Signatures

(Signature blocks adapted for each Place.)

Schedule 1 - Place Outcomes Framework



DRAFT – EXAMPLE FORMAT

Schedule 2 - Place Funding Framework

Schedule 3 – Greater Manchester Health and Care Responsibilities Matrix

Responsibility Matrix - xxxx

System-wide ownership with teams accountable for delivery relevant to their role and organisation

NHS Greater Manchester Integrated Care

Work Area	NHS GM - Place	NHS GM - Central	Local Govt (PH, ASC & Children's)	VCFSE	Primary Care	NHS Trusts (acute & MH)	System Programme

DRAFT – EXAMPLE FORMAT
TO BE COMPLETED TO COVER FUNCTIONAL AREAS

Note: Please include where clinical leadership responsibility lies
Note: You may wish to include on a separate slide any areas of work that are stopping

Schedule 4 – DRAFT Place Partnership Terms of Reference

Healthier Wigan
better care for you and your family

Terms of Reference on a page
Helps provide focus and clarity around roles

NHS Greater Manchester

Purpose

The purpose of the Healthier Wigan Partnership (HWP) Board is to bring together senior leaders from all sectors of the Locality.

Its role as a committee of the ICB is to enable and oversee the locality to use its collective assets, resources and powers to deliver the Locality Plan. Focus on the shared priorities agreed with Partners and those articulated through NHS Greater Manchester.
By working together, the Board will endeavour to improve health, wellbeing, and care for the population of Wigan Borough.

The Board is also a joint committee of the ICB and the Local authority regarding the Section 75 agreement and will make decisions and obtain assurance in relation to that agreement.

Key duties performed as a committee of NHS GM ICB

- **Strategy:**
  - Approve the Locality Plan (including allocation of resources) and the Locality Strategic Risk Register.
- **Oversight:**
  - Obtain assurance regarding operation of locality oversight arrangements for delegated functions, including financial performance and the continuous improvement of service.
- **Section 75 agreement**
  - Approve allocation of resources.
  - Obtain assurance that the s75 agreement is operating effectively
  - Approve BCF Quarterly Submissions

Key duties performed as a Locality Board

- **Strategy:**
  - Approve supporting locality strategies (e.g. population health, quality, finance, people)
  - Oversee the review of the locality plan (including operating model, leadership, culture and ways of working).
- **Locality Commissioning:**
  - Approve proposals to commission and transform services to deliver outcomes and monitor their implementation.
  - Approve proposals to decommission services and to ensure there is no adverse effect on the population of Wigan Borough.
- **Oversight**
  - Delivery of the Locality Plan - provision and outcomes.
  - Maintain oversight of performance issues which impact on the local population and agree locality responses.
- **Governance:**
  - Approve the locality governance arrangements and evaluate their effectiveness.
  - Obtain assurance that strategic risks are being effectively managed.

Membership

Voting membership - two named representatives from each of the following partners:

- NHS Wrightington Wigan and Leigh Teaching Hospitals NHS Foundation Trust
- Greater Manchester Mental Health NHS Foundation Trust
- General Practice / Primary Care Networks
- Wigan Council (one to be the Co-chair or their named deputy)*
- VCFSE Sector
- NHS Greater Manchester (one to be the Place-based Lead or HWP Delivery Director and the other to be the NHS Greater Manchester Executive representative)*

Quoracy = two thirds of members present

In attendance and without voting rights:

- Independent adviser to the HWP System Board
- Locality Finance Lead
- Co-chairs of the Integrated Delivery Board
- Healthwatch

* Voting members for Section 75 Committee

DRAFT – EXAMPLE FORMAT TO BE COMPLETED TO COVER FUNCTIONAL AREAS

BURY INTEGRATED CARE PARTNERSHIP

Meeting:			
Meeting Date	02 March 2026	Action	Consider
Item No.	11	Confidential	No
Title	NCA Organisational Strategy Partner Engagement		
Presented By	Lorna Allan		
Author	NCA		
Clinical Lead			

Executive Summary

The Northern Care Alliance (NCA) is inviting people across Greater Manchester and the communities it serves to help shape its new 10-year organisational strategy.

The engagement programme — Shape Tomorrow Together — asks patients, service users, carers, families, partners, local residents and community organisations to share one bold idea or goal they believe should guide the future of health and care across the region.

A phased approach is being taken in the development of the strategy with Phase one planned to conclude at the end of March 2026. Feedback received will be used to develop a draft vision, mission and objectives, which will then be tested with colleagues, patients and key stakeholders, before being finalised by our Board in the early Summer 2026.

We have already had hundreds of responses from colleagues, service users and the public sharing their 'Big Ideas' for the future of the NCA.

We will engage widely with system partners to ensure that their views are represented. We have initially commenced with conversations via existing forums including professional groups and 1:1 conversations, led by our senior leadership team. At a later date we plan to continue the discussion by sharing the initial feedback with partners and our thoughts on what this means for our future strategy. We have also launched a QR code with questions specifically tailored for system partners to allow contributions from as wide an audience as possible

All system partner views are important to the NCA. If you or your colleagues would like to get involved, you can do this via:

- 1:1 conversation with senior NCA colleagues – these are currently being arranged but if you have not been approached and wish to contribute please contact ncastrategy@nca.nhs.uk who will be able to coordinate a discussion
- Complete our online engagement form, QR code on the next page – and share within your organisation and networks
- Look out for an invite to one of our partner engagement conversations to test the draft vision, mission and objectives in Spring 2026.

BURY INTEGRATED CARE PARTNERSHIP

Recommendations
The Locality Board are asked to contribute towards/note the ongoing engagement process in relation to the new 10-year organisational strategy.

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	☒

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:						
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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Help shape our future.

Share your big idea

We're creating a new 10-year NCA organisational strategy and we want you to be part of it.

Tell us your bold, ambitious idea that matters most to you and the communities that we serve.

Scan me!

BURY INTEGRATED CARE PARTNERSHIP

Meeting:			
Meeting Date	02 March 2026	Action	Receive
Item No.	12	Confidential	No
Title	System Finance Group Update – March 2026		
Presented By	Simon O'Hare - Locality Finance Lead – NHS GM (Bury and HMR Localities)		
Author	Simon O'Hare - Locality Finance Lead – NHS GM (Bury and HMR Localities)		
Clinical Lead			

Executive Summary

The purpose of this report is to update the locality board on the planned changes that this board will be responsible for in 2026/27 and both the positives and the risks of this approach, both to the NHS within the locality and to partners.

Since the inception of NHS Greater Manchester (GM), locality budget discussions and conversations have been dominated by the costs associated with individual packages of care in CHC and Mental Health, alongside ADHD and these escalating versus a static budget. This has not allowed the locality to work strategically and understand the cost drivers of all health and care expenditure and develop a strategic response to these.

The proposal for 2026/27 is to transfer funding for proactive and preventative care, starting with the Better Care Fund (BCF), through a section 75 agreement, as has been the case in the locality for a number of years. The intention is to build up on this in future years, with a commonality of budgets transferred to all localities, such as out of hospital services, voluntary sector services, capacity funds.

As part of this there will be a streamlining of NHS GM governance, with transactions taking place within the receiving organization and subject to their governance. The host organisation acts solely as the administrative and financial vehicle for the monies. Hosting does not confer ownership, control, or unilateral decision-making rights over the monies. The monies remains a ring-fenced system resource, and all decisions on its use are determined collectively through the Place Partnership Agreement.

At this time it is expected that this transfer will not take place at 1st April 2026, due to NHS reform and also to allow the finer detail to be worked through to the satisfaction of all parties, and will more likely take place at the beginning by quarter 3 (October).

It is not intended at this stage that this arrangement will involved any funding for staff, and the host organisation does not automatically host staff. Any decisions on this will be taken separately via the employment model workstream and taken through appropriate governance, including this committee.

The benefits of this approach are:

- Focus upon strategic use of resources and what the locality priorities should be to support the over arching NHS GM aims, and also those set locally, the LETS strategy.

- Focus upon prevention, proactive care and neighbourhood delivery
- Removing volatile and high cost case budgets from locality responsibility, where unavoidable costs can lead to overspends, with little that can be done to mitigate this expenditure.

The risks of the approach are:

- Reduction in the scope of the section 75 agreements and ability for system leaders to work collaboratively on specific risks
- Removal of current joint funding arrangements for packages of care and influence of current system leaders upon these budgets, which could lead to existing arrangements being unpicked, which in turn could destabilise both the strength of our integration locally and partner financial positions, which could upset the status quo and ultimately services to residents / patients.
- Left shift / prevention funding only becomes available when savings are made and costs are removed, which is challenging, particularly in the current, very challenging financial climate for all partners.
- This does not appear to tackle historic funding deficits and the mechanism and basis for transferring non BCF budgets is not yet clear.

Recommendations

Locality board members are asked to:

- Note the contents of this paper and the changes to the budgets to be held by the Locality Board from 2026/27

Note the benefits and risks and provide comments for the Place Based Lead and Deputy Place Based Lead to escalate in NHS GM forums.

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:						
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

System Finance Group Update – March 2026

1. Introduction

1.1. The purpose of this report is to update the locality board on the planned changes that this board will be responsible for in 2026/27 and both the positives and the risks of this approach, both to the NHS within the locality and to partners.

2. Background

2.1 Since the inception of NHS Greater Manchester (GM), locality budget discussions and conversations have been dominated by the costs associated with individual packages of care in CHC and Mental Health, alongside ADHD and these escalating versus a static budget.

2.2 This has not allowed the locality to work as strategically as our remit is, understand the cost drivers of all health and care expenditure, develop a strategic response to these, implement this and monitor the impact. Essentially we have not been able to act as a strategic commissioner, pulling the whole system together to tackle our challenges.

3 Proposal

3.1 The proposal for 2026/27 is to transfer funding for proactive and preventative care, starting with the Better Care Fund (BCF), through a section 75 agreement, as has been the case in the locality for a number of years.

3.2 The intention is to build up on this in future years, with a commonality of budgets transferred to all localities, such as out of hospital services, voluntary sector services, capacity funds and so on.

3.3 As part of this there will be a streamlining of NHS GM governance, with transactions taking place within the receiving organization and subject to their governance. The host organisation acts solely as the administrative and financial vehicle for the monies. It is not expected that this will encompass a significant number of transactions or an administrative burden upon the host.

3.4 Hosting does not confer ownership, control, or unilateral decision-making rights over the monies. The monies remains a ring-fenced system resource, and all decisions on its use are determined collectively through the Place Partnership Agreement.

3.5 As part of this there will be a streamlining of NHS GM governance, with transactions taking place within the receiving organization and subject to their governance. The host organisation acts solely as the administrative and financial vehicle for the monies. Hosting does not confer ownership, control, or unilateral decision-making rights over the monies. The monies remains a ring-fenced system resource, and all decisions on its use are determined collectively through the Place Partnership Agreement.

3.6 At this time it is expected that this transfer will not take place at 1st April 2026, due to NHS reform and also to allow the finer detail to be worked through to the satisfaction of all parties, and will more likely take place at the beginning by quarter 3 (October).

3.7 It is not intended at this stage that this arrangement will involved any funding for staff, and the host organisation does not automatically host staff. Any decisions on this will be taken separately via the employment model workstream and taken through appropriate governance, including this committee.

4 Benefits and Risks

4.1 The benefits of this approach are:

- Focus upon strategic use of resources and what the locality priorities should be to support the over arching NHS GM aims, and also those set locally, the LETS strategy.
- Focus upon prevention, proactive care and neighbourhood delivery
- Removing volatile and high cost case budgets from locality responsibility, where unavoidable costs can lead to overspends, with little that can be done to mitigate this expenditure.

4.2 The risks of the approach are:

- Reduction in the scope of the section 75 agreements and ability for system leaders to work collaboratively on specific risks
- Removal of current joint funding arrangements for packages of care and influence of current system leaders upon these budgets, which could lead to existing arrangements being unpicked, which in turn could destabilise both the strength of our integration locally and partner financial positions, which could upset the status quo and ultimately services to residents / patients.
- Left shift / prevention funding only becomes available when savings are made and costs are removed, which is challenging, particularly in the current, very challenging financial climate for all partners.
- This does not appear to tackle historic funding deficits and the mechanism and basis for transferring non BCF budgets is not yet clear

5.0 Conclusion

5.1 Locality board members are asked to:

- Note the contents of this paper and the changes to the budgets to be held by the Locality Board from 2026/27
- Note the benefits and risks and provide comments for the Place Based Lead and Deputy Place Based Lead to escalate in NHS GM forums.

Simon O'Hare
Locality Finance Lead – NHS GM (Bury and HMR Localities)
s.ohare@nhs.net
March 2026

BURY INTEGRATED CARE PARTNERSHIP

Meeting: Locality Board			
Meeting Date	02 March 2026	**Action**	Receive
Item No.	13	**Confidential**	No
Title	Primary Care Commissioning Committee update		
Presented By	Adrian Crook, Director of Adult Social Services and Community Commissioning		
Author	Zoe Alderson, Head of Primary Care (Bury)		
Clinical Lead			

Executive Summary
The Primary Care Commissioning update is provided as a highlight report from the meeting held on the 26th January 2026.
Recommendations
The Locality Board is asked to note the highlight report from the last Primary Care Commissioning Committee.

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**
Primary Care Commissioning Committee	26/01/2026	Highlight report attached.

Bury Primary Care Commissioning Committee (PCCC) Highlight Report

Chair: Adrian Crook
Reporting period: January 2026
Attendance: ~~Excellent~~ / Acceptable / ~~Unacceptable~~

This report updates / informs the NHS Greater Manchester PCCC on the Bury PCCC work to date. It also provides an opportunity to raise any issues and inform of any changes that may affect the progression of work.

OOH Contracting – The committee received performance reporting against the OOH contract and recommended several actions in support of ensuring appropriate utilisation.
Primary Care Programme – A high-level overview of progress against the GP Strategy programmes was presented to the committee. The highlight report contained several performance indicators being used to monitor delivery against the programme.
Quarter 3 contracting – A full and comprehensive assurance report was presented to the committee.
BeCCoR 26/27 – The committee received the latest update against the programme along with anticipated finances for retained services (defined by GM). The committee discussed concerns regarding the local impact both in terms of Pillar 1 but also Pillar 6 given the progress already made within our neighbourhood teams. The committee was aware that if funding was changed then services would need to stop which would require consultation.
Workforce Strategy – The committee received a draft strategy aimed at supporting and enabling practices to recruit, develop and retain staff in Bury. A detailed delivery plan will be worked on over the course of the coming months, against which regular reporting will be made.

Priority actions in coming period:
BeCCoR 26/27
- Awaiting the board decision regarding Scenario 1.
- Development of a Scenario 2 offering

Bury General Practice Strategy – a review and refresh in line with the new 10year plan
PCNs - Ongoing work to improve Enhanced Access utilisation and ensure maximum ARRS spend
MOT – Continue to roll out patient led ordering in addition to supporting CIP delivery

Decisions made:

- **Contracting** - The committee were supportive of the commissioning recommendations for 26/27 though mindful that this would be subject to sufficient funding being received (specifically Paediatric Phlebotomy, Special Allocation Scheme and the Respiratory Diagnostic Service
- **BeCCoR** – The committee discussed several concerns regarding programme timings and associated funding which is to be formally raised with central GM colleagues on the committee's behalf by the Deputy Place based lead, Associate Director of Finance and Head of Primary Care.

Top 3 Risks:

Risk Identified	Mitigating Actions	Likelihood	Impact	Score
IF: the apportionment of delegated PC monies is insufficient to cover local elements unique to Bury (such as dementia, ring pessaries, bloods etc) THEN: services may need to be stopped limiting what gps support/deliver LEADING TO: Wider provider pathway pressures which cost more & may lead to poorer outcomes for patients	1. Ongoing discussions via phase 3 BeCCoR to secure equitable/sufficient funding from 26/27 onwards 2. System partners fully aware of position and risks associated	4	4	16
IF: the NCA proceeds with the intended roll out of LIMS on the 9th of February THEN: Practices will be limited as to what phlebotomy they can undertake at a crucial time within the year LEADING TO: Harder to reach patients not being followed up for key reviews, clinics being cancelled rescheduled due to short notice. Patient safety and practice targets/income potentially being affected.	1. Concerns have been lodged with the NCA LIMS team 2. Wider attendance at LIMS board meeting agreed in order to continue to discuss concerns and agree a way forward	4	4	16
IF: The locality does not have a clear roadmap for increasing community self-referral pathways as per NHS England's Delivery plan for recovering access to primary care THEN: practices ability to triage and deflect/direct appropriately to other more appropriate services will be limited LEADING TO: delays in patients being seen by the appropriate service, more general impact on GP access and potentially poorer outcomes for everyone as a result.	1. Repeated attempts have been made to engage with the Community Services Provider 2. It has been agreed that a workshop will be arranged but no date as yet.	4	3	12

Any other information:

Key escalations for NHS Greater Manchester PCCC: The funding currently earmarked to be retained for local service delivery as part of Pillar 1 is insufficient to continue with all transactional requirements of the Bury LCS. This has been flagged with finance colleagues, and if not rectified either partially or fully, services will need to cease, and sufficient engagement has not taken place to enable this to happen by 31st March 2026.

BURY INTEGRATED CARE PARTNERSHIP

Meeting: Locality Board			
Meeting Date	02 March 2026	**Action**	Receive
Item No.	14	**Confidential**	No
Title	**Report from the Performance & Quality Meeting – including** Chief Officers Performance Report (Feb 2026) Quarterly Risk Report (Quarter 4)		
Presented By	Kath Wynne-Jones Catherine Jackson		
Author	Kath Wynne-Jones Catherine Jackson		
Clinical Lead	Cathy Fines Kiran Patel Catherine Jackson		

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.

The risk paper details the locality strategic and programme risks set by the locality Risk and Scrutiny Group as scored12 and above using the strategic risk descriptors detailed in section 3 of this report. The risks are described in summary and high-level mitigating actions are included. Further detailed information on the risk mitigations is discussed and actioned through the transformation/programme boards and workstreams.

The Quality Risk Register has been closed with risks transferring where appropriate to this register.

Recommendations

The Board is asked to discuss and consider the risks and make recommendations to the Risk and Scrutiny Group to ensure robust transparency, oversight and mitigation of locality strategic and performance risks.

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.	☒

BURY INTEGRATED CARE PARTNERSHIP

Links to Locality Plan priorities	
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:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☒	N/A	☐

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

Bury Integrated Delivery Collaborative Performance Report

1. Context

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

2. Performance – January 2026

2.1 Requires improvement

Autism average wait in weeks from referral to first assessment MH patients – In November 2025, average waiting time for autism assessments, measured from referral to first assessment, was 107 weeks. This represents a decrease compared to Oct 2025, when figures show patients were waiting 119 weeks.

ADHD average wait in weeks from referral to first assessment – MH patients - In Nov 2025, the average waiting time for ADHD assessments, measured from referral to first assessment, was 92 weeks. This represents an increase compared to Oct 2025, when figures show 90 weeks.

Talking Therapies 6 Week Waits: In Nov 2025, 58.3% of patients waited six weeks or less from referral to starting IAPT treatment, marking an improvement from 50% the previous month. This is also a decline compared to Nov 2024, when the performance was 93.9%. Bury's current performance falls below both the Greater Manchester (GM) average of 79.3% and the national target of 75%. While Bury did not meet the national target of 75%, Greater Manchester succeeded in achieving it.

Access to community mental health services for adults and older adults with severe mental illness - In Nov 2025, a total of 2,335 Bury-registered patients with severe mental illness had two or more interactions with adult mental health services. This marks an increase from 1,665 contacts noted in Nov 2024, and an increase from Oct 2025, which recorded 2,310 contacts. Bury currently reports 14.0 contacts per 1,000 population, positioning it as the second lowest rate among the Greater Manchester (GM) localities.

Talking Therapies Recovery Rate - Nov 25 data shows a Talking Therapies recovery rate with 54.0%, an improvement on the previous month. This is above than the performance in the same period last year, which was 50.0%.

% of people with SMI to receive all six physical health checks in the preceding 12 months – MH Patients - Published data indicates that, as of Dec 2025, 54.7% of individuals registered in Bury with a serious mental illness (SMI) had completed all six recommended physical health checks within the preceding 12 months. This equates to 1,124 out of 2,054 eligible patients. In comparison, the Greater Manchester (GM) average for the same period was 60.6%, indicating that Bury is currently performing below the GM average.

Percentage of CYP receiving ADHD assessment within 18 weeks of referral - In Nov 2025, 0% of CYP receiving an ADHD assessment within 18 weeks of referral, down from 8.8% the previous month. Please note: Figures may be different to those reported locally due to differences in methodology between NHS England and local providers. A paper is being drafted to explore solutions.

Talking Therapies Access Rate - In Nov 2025, there were 280 recorded accesses to NHS Talking Therapies by Bury-registered patients, slightly higher than the same period the previous year (275).

Bury currently reports an access rate of 1.3 per 1,000 population, which ranks as the 2nd lowest among the Greater Manchester (GM) localities.

Percentage of CYP receiving Autism Assessment within 18 weeks of referral - In Nov 2025, 0% of CYP received an autism assessment within 18 weeks of referral, matching the previous month. Please note: Figures may be different to those reported locally due to differences in methodology between NHS England and local providers. A paper is being drafted to explore solutions

Talking Therapies Second Treatment Waits - In Nov 2025, 45.5% of patients in Bury attended their second appointment within 90 days of their first, reflecting an increase since Oct 2025 (43.3%). This performance is above the Greater Manchester (GM) average of 38.9%. Bury currently ranks the 7th lowest among all GM localities for this measure. Both Bury and GM remain above the national target of 10%

Percentage of Patients aged 14+ with a completed LD health check - The performance metrics for LD health checks have been reset for the 2025/2026 reporting period, accounting for the significant decline observed in the latest data. In Nov 2025, 48.9% of patients aged 14 and above completed an LD health check, showing an improvement compared to 40.7% in Oct 2025 and 48.9% in Nov 2024. The Bury locality currently reports a rate below the Greater Manchester (GM) average of 51.9%, ranking it 8th among GM localities.

28-day wait from referral to faster diagnosis (all patients) – In Nov 2025, 75.5% of patients in Bury received their cancer diagnosis outcome within 28 days following a two-week wait (2WW) referral. This marks a decrease from 77.2% in Oct 2025, as also a decrease from 78.6% in Nov 2024. Bury is currently ranked as the 8th highest performing area within Greater Manchester (GM) for this indicator. The GM average for Nov 2025 is 78.8%, which remains below the national target of 80%. Consequently, both Bury and the wider GM regions (excluding Bolton, Stockport, Trafford and Salford) are operating below the national standard for the timely communication of cancer diagnoses.

Females, 25-64 attending cervical screening within target period (3.5 or 5.5 year coverages %) - The GM Cancer Screening Dashboard, shows cervical screening coverage for Bury patients in Dec 2025 was 68% among individuals aged 24 to 49 years, and 74.6% among those aged 50 to 64 years. Both figures fall below the efficiency target of 80%.

A&E 4-Hour Performance – In Dec 2025, Bury achieved a 4-hour emergency care performance rate of 67.8%, a slight reduction from Nov 25 when performance rate was recorded at 68.7%.
This reflects an increase compared to 61.2% in Dec 2024. Bury's performance is currently below the Greater Manchester (GM) average of 68%, ranking as the 5th highest among GM localities.

Diagnostics Waiting 6 weeks + - In Nov 2025, 8.2% of patients in Bury were waiting more than six weeks for a diagnostic test. This represents an increase from 7.5 % in Oct 2025 but a decrease from Nov 2024 which represented 11.3%. Bury's performance is better than the Greater Manchester (GM) average, which is 13.7%. Bury and GM are both above the less than 1% target.

2.2 Average/ maintained Performance

Talking Therapies 18 Weeks Wait - In Nov 2025, there were 97.2% of patients that waited 18 weeks or less from referral to entering IAPT treatment. This represents a slight improvement from 97.1% in Oct 2025. Bury's performance remains above the national target of 95% and is also higher than the Greater Manchester (GM) average of 96.2%. Bury ranks as the 5th highest among the GM localities.

Access to individual placement and support services – Mental Health Patients - The number of individuals accessing Individual Placement and Support (IPS) Services rose to 230 in Nov 2025, compared to 210 in Oct 2025 and 85 in Nov 2024. Bury presently records an access rate of 1.09 per 1,000 population, placing it 5th among the localities within Greater Manchester.

Access to Children and Young People MH Services - In November 2025, a total of 3,595 attendances were recorded for Children and Young People's Mental Health Services by patients registered in Bury. This represents an increase from 3,530 attendances in October 2025 and is also higher than the 3,560 attendances reported in November 2024. Bury currently reports an access rate of 79.9 per 1,000 population, placing it fourth highest among the Greater Manchester localities in terms of access rate per 1,000 population.

RTT Incomplete 65+ weeks Waits – As of Nov 2025, there were 4 patients from Bury experiencing waits of 65 weeks or more, matching the figure from Oct 2025 when there were also 4 patients. This also reflects a reduction when compared to Nov 2024, when 34 patients were recorded. Bury currently holds the position of having the 4th lowest number of 65+ week waits among the Greater Manchester (GM) localities.

A&E Attendances – In Dec 2025, there were 7,446 A&E attendances recorded for Bury-registered patients. This represents an increase from 7,256 in Nov 2025 and is also an increase from 7,040 in Dec 2024.
Bury currently reports an attendance rate of 35.1 per 1,000 population, ranking as the 5th lowest among the Greater Manchester (GM) localities.

2.4 Good performance

Community Response (UCR) first care contacts - In Nov 2025, 98.3% of Urgent Community Response (UCR) referrals for Bury-registered patients received a response within the two-hour standard. This represents a slight decrease from 98.8% in Oct 2025. Bury currently holds the highest performance among the Greater Manchester (GM) localities and exceeds the national target of 70%.

Total number of specific acute non elective spells – in Dec 2025, there were 2,076 specific acute non-elective spells recorded for Bury-registered patients. This reflects a decrease from both 2,028 spells in Nov 2025 and a decrease from 2,099 spells in Dec 2024. Bury currently ranks as having the 7th lowest rate of specific acute non elective spells among the GM Localities.

Length of stay for adults (60+days) mental health patients - In Nov 2025, 23.1% of MH Patient discharges in Bury involved a long length of stay (LOS), a decrease from 25% recorded in Nov 2024. Bury currently has the 3rd lowest proportion of long LOS discharges among the Greater Manchester (GM) localities. The GM average for the same period is 28.4%.
Both Bury and GM exceed the national target, which is set at 0%.

Percentage of MH Patients with no criteria to reside – In Dec 2025, the number of mental health patients with NCTR in Bury was 7, marking a decrease from the previous month. Bury presently reports 0.033 NCTR patients per 1,000 people, which is lower than the Greater Manchester (GM) average of 0.043. Within GM areas, Bury has the lowest reported rate

Dementia: Diagnosis Rate (aged 65+) - As of Nov 2025, 76.7% of patients aged 65 and over in Bury have received a dementia diagnosis. Bury's diagnosis rate is higher than the Greater Manchester (GM) average, which stands at 75.2%, and ranks 4th highest among the GM localities.
Both Bury and GM exceed the national target for dementia diagnosis, which is set at 66.7%.

Number of MH Patients with no criteria to reside - As of Dec 2025, 9.5% of mental health patients in Bury with no criteria to reside (NCTR), representing a decrease from 16.2% in Nov 2025 and a decrease from 14.8% in Dec 2024. Bury's current percentage is lower than the Greater Manchester (GM) average, which stands at 13.1%. Among the GM localities, Bury ranks as having the 2nd lowest NCTR percentage.

Percentage of Patients with no criteria to reside as % of occupied beds – In Dec 2025, the NCTR percentage for Bury was 16.2%, reflecting a decrease from 17.0% in Nov 2025, but an increase compared to 13.8% in Nov 2024. Bury's rate remains above the Greater Manchester (GM) average of 13.4% and currently ranks as the 9th lowest percentage among GM localities.

Percentage of Care Homes Rated Good or Outstanding - In Dec 2025, 84.6% of care homes received ratings of 'Good' or 'Outstanding', matching the previous month. Bury holds the position of fourth highest among the Greater Manchester areas for this indicator.

Women Accessing Specialist Community Perinatal Mental Health Services - During the 12-month period ending in Nov 2025, 215 women registered in Bury accessed Perinatal Mental Health Services. This represents an increase from 200 accesses recorded in the equivalent period ending Nov 2024. Bury currently reports an access rate of 5.2 per 1,000 population, which is the 2nd highest rate among all Greater Manchester (GM) localities.

E.Coli blood stream infections - In the 12-month period ending Nov 2025, 126 cases of E. Coli bloodstream infections were recorded among Bury-registered patients. This is a decrease from Oct 25 when 133 cases were reported, and below the 152 cases in Nov 2024. Bury currently reports an infection rate of 0.59 per 1,000 population, ranking as the 3rd lowest rate among the Greater Manchester (GM) localities.

Seasonal Flu vaccine Uptake 65 years an over - The uptake of the seasonal Flu Vaccine 65 years and over rose to 69.9% in Nov 2025 an increase from Oct 2025. It is also an improvement from Nov 2024 when performance was reported as 69.7%

3. Recommendations

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

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February2026

BURY INTEGRATED CARE PARTNERSHIP

Bury ICP Strategic Risk Report

1. Introduction

1.1. This report updates the Locality Board on the key strategic risks to the delivery of the Locality Plan and Board priorities.

1.2. This report updates the Locality Board on the risks considered 12 or greater by the workstreams of the IDCB.

1.3. Risks are managed by the relevant IDCB workstreams and this report providers an overview to inform Locality Board members of high risks but does not contain those judged to be under 12 or all the actions that are ongoing in mitigation.

1.4 There is a locality Risk and Scrutiny Group who consider all the borough level risks, seeks assurance from the Transformation/Programme Boards and workstreams to advise on the elements of managing, scoring and escalation processes.

1.5 There is currently no electronic system for risk management for the borough whilst an agreement is made across the GM ICP and no locality risk manager.

2. Risk Descriptors

			Likelihood				
			1	2	3	4	5
			Rare	Unlikely	Possible	Likely	Almost certain
Consequence	5	Catastrophic	5	10	15	20	25
	4	Major	4	8	12	16	20
	3	Moderate	3	6	9	12	15
	2	Minor	2	4	6	8	10
	1	Negligible	1	2	3	4	5

KEY

Static rating

Reduced rating

Increased rating

BURY INTEGRATED CARE PARTNERSHIP

No	Theme	Risk description	Initial score							Risk movement	Risk target	Assurance
			2024.25				2025.26					
			Q1	Q2	Q3	Q4	Q1	Q2	Q3			
~~1~~	Strategy and transformational change Further change anticipated due to national policy affecting NHSE and ICBs during 2025-26. CLOSE	BECAUSE of the partnership-wide, organisational and GM ICP breadth of transformational ambition, THEN there is a risk that there is insufficient finance, capacity and focus to deliver health and care strategic change locally.	16	16	16	16	16			↔	8	Local governance structures reflect ICB governance. Generic Communications and Engagement Strategy which supports the public messages and campaigns. Finalised locality budget annually. Locality Board operation agreed by GM March 2023 with relevant delegated authority. Operational planning guidance received in February for 2025-26. Bury 2030 'Let's Do It' strategy embedded and refreshed regularly. Scrutiny on delivery in place at Strategic Finance Committee, System Assurance Committee, IDCB and Locality Board. Relevant prioritised workstreams with programme leadership in place.
1	NHS Reform Programme disruption of core ICB business service delivery.	There is a risk that the NHS Reform Programme could disrupt delivery of core ICB business due to restructure and staffing reductions. This will result in core ICB business being disrupted during the transition. Included in this risk is quality oversight of							16	New	4	GM Transition Programme Team oversees management and updates of the risks for all component programme areas. Transition Operational Delivery Group holds oversight on all the risks within the transition programme and component workstreams. Transition Risk Group to have a grip and oversight over all programme risks. This group will

		commissioned services.										monitor controls, actions and ensure that all work is being done to lower the risk. Chief Officers meeting gives exec level assurance and approval of BAF risks and other high-level risks within the transition needed to be escalated. They will provide periodic updates to ensure progress on mitigations. Executive Committee has exec level assurance and approval of BAF risks and other high-level risks within the transition needed to be escalated. They will provide periodic updates to ensure progress on mitigations. NEDs/Execs Meeting assurance of the high-level risks within the transition programme with monitoring to ensure the risks are correctly being mitigated periodically. NHSE Oversight Meetings report on progress of the reform and any risks that need to be escalated.
2	Finance: System Finance Position	BECAUSE of the risk that the financial position of all partners and the statutory requirement to achieve a break-even position versus budgets set and deliver in year savings / CIP targets THEN there is a risk that this challenges the model of partnership working in the Bury Integrated Care	16	16	16	16	16	16	16	↔	8	Commissioning oversight through Commissioning Oversight Group (COP). Commissioning intentions developed for GMICB for 2025-26. Locality Finance and Scrutiny committee oversight. Saving planning meetings in place. QIPP management and oversight. Improvement work carried out since last quarter means that there is

		Partnership by inducing actions that effectively cost shunt within the system.										vastly improved clarity on budgets. PwC support across range budgets.
3a	Finance: Locality Healthcare budgets *25/26 only*	BECAUSE 2025/26 delegated budget are over £2m less than 2024/25 actual expenditure (due to the significant locality overspend in 2024/25), including 4% CIP and the underlying drivers remain, and the overall NHS GM position and that of statutory partners in Bury being very challenged THEN there is a high risk that financial balance will not be achieved.	16	16	15	15	15	15	15	↔	8	1.Bury System Finance Group. 2. Monthly Locality assurance meetings with NHS GM. 4.Weekly finance and complex care meetings. 5. Projects to drive down costs. 6.Saving planning meetings. 7.QIPP management and oversight. 8.Programme leads in place, monthly formal scrutiny. 9.Programme leads active management CIP targets. 10. Finance Locality Assurance Meetings (LAMs) monthly.
3b	Finance: Locality Healthcare budgets *Recurrent position*	BECAUSE 2025/26 delegated budget are over £2m less than 2024/25 actual expenditure (due to the significant locality overspend in 2024/25), including 4% CIP and the underlying drivers remain, and the overall NHS GM position and that of statutory partners in Bury being very challenged, leaving little opportunity for transformatory change to reduce system wide costs THEN there is a high risk	16	16	16	16	16	16	16	↔	8	1.Bury System Finance Group. 2.System wide workshops being set up. 3.Monthly Locality assurance meetings with NHS GM. 4.Weekly finance and complex care meetings. 5. 7 Projects to drive down costs. 6. Saving planning meetings. 7. QIPP management and oversight. 8. Programme leads in place, monthly formal scrutiny. 9. Programme leads active management CIP targets. 10. Finance Locality Assurance Meetings (LAMs) monthly.

		that financial balance will not be achieved										
4	Finance: Locality Operating costs budgets	The RBMS funding situation has now been resolved with the removal of the savings target of £120k therefore this can be closed.	16	16	16	16	8	8	8	↔	8	1. Escalated to NHS GM re RBMS and dialogue remains ongoing 2. Saving planning meetings. 3. QIPP management and oversight. 4. Work to reconcile the RBMS function and costs.
~~5~~	Data, insight and intelligence (DII) CLOSE	BECAUSE of a loss of locality analytics and data sharing solutions since the formation of the ICB, THEN there is a risk that data and insights are not adequately shared and used across all partners and sectors, resulting in a lack of ability to make real time and longer-term changes and improvements for the benefit of our communities.	16	16	16	16	16			↔	4	Working with GM ICB analytics team on some projects to gain insights. Using data from Tableau and other sources where available. Local data sharing work rounds in place between NCA and ICB. Datasets now more readily available and shared informing programmes of accurate timely data. Futures platform developing.
5	Urgent and Emergency Care	BECAUSE of limited flow of patients out of the ED and hospital, the number of patients in ED can be greater than the staff's capacity to manage within targets, THEN there is a risk that this could lead to a compromised quality of care given to patients. Also, IF the number of patients on the Days Kept	16	16	16	16	16	16	16	↔	8	FGH failed the 4-hour target in 2024-25. However, the site is on an improvement trajectory and has seen improved performance month on month since December 2024. This improvement is currently set to continue in May 2025. Further work continues into 2025 -26 including: • Front door streaming review • Re launch of Bury Patient Flow

		Away from Home (DKAFH) list do not reduce, THEN patients will be kept in hospital unnecessarily leading to potential increased harm for those patients (e.g. increased risk of infection, deconditioning) and for other patients attending the emergency department and requiring admission to an acute bed (e.g. reduced ED capacity, trolley waits in ED).										Collaborative • Avoiding needless in patient/emergency care" Deflection from ED • Stroke Rehab -Right Place, Right Time • 7 Day Working More People Home Same Day • Understanding Length of Stay Wards Why not home? why not today? • Increase opening hours on SDEC Staffing review • Consultant Community in reach for Frailty and Dementia • Relaunch Activity rooms on Ward 18 & Ward 8 • Understand Blockers to be able to Discharge before 10am • Review of services that we can left shift to the community • Implementation booking system to bring patients back the following day for SDEC/UTC June/July 25 • Fall Pilot in the Community • Rochdale Pathways • Weekend SDEC Frailty • Implementation of Hot Clinics • Roll out of Call before your conveyance starting 19th May 25 • Review of a 24-hour Assessment area

6	Elective Care and Community Care	BECAUSE of the waiting times created by the pandemic and on-going staffing challenges, including junior doctors' industrial action, THEN there is a risk that patients have delayed treatment, are at risk of harm and have a poor experience which could affect their health and wellbeing.	16	16	12	12	12	12	12	↔	4	GM ICB programme boards in place. Bury Elective & Community Board in place. 2025-26 operational planning guidance sets out waiting list reduction expectations. Current NHS GM Programmes of work to reduce waiting times e.g. implementation of advice and guidance and the implementation of the GM Dermatology MOC. Overall numbers of Bury patients waiting has been reducing and the number of log waits has also been on a downward trend.
7	Services for Children, including SEND	BECAUSE the Bury system is not delivering in-line with the SEND national framework expectations, THEN there is a risk that the children, young people, families, and carers do not get the right support from health services, Children's Social Care and Education to ensure they reach as good outcomes as all children. The increase in requests for ND assessments is being felt nationally and locally.	16	16	16	16	16	12	12	↔	8	Children's Improvement Board in place. Work continues on an improvement journey to strengthen the support for children, young people. and families in the borough. External support from national team. Independently chairing a SEND improvement board. Refreshed action plan underway. Committed £300k investment in the HV service delivered by NCA. mobilised in increasing SEND HV team. Investment into Early Years team. Developing - GM Investment (£200k) in the Neurodevelopmental offer, with the progress of a new model of care pathway. Offering early help to families – this should be fully mobilised by October 25. GM ADHD consultation on adult

												pathway changes is ongoing. Developing (GM) work is ongoing to address reduction in CAMHS waiting lists. Locally focus activity continues to address aspects of the pathway that are under significant pressure. Pathway mapping of the first 1001 days, and the potential roll-out of family hubs. Launch parenting strategy and early years proposition with oversight by the Children's Strategic Partnership Board. February 2025 – feedback following monitoring visit, positive improvements evidenced.
8	Local Implementation of Families First Partnership	There is a risk that the GM ICB will be unable to fulfill the statutory requirements of the Families First Partnership due to a lack of available funds to sustain the health workforce elements of the programme, following the initial allocation of grant monies in year one. Cause - Each of the 10 localities across the GM ICB footprint has a unique starting position both financially from the FFP grant and with the existing workforce within Provider Safeguarding Teams. Impact - This presents risk							16	New		Planned workshops in place since 2025. Submission made to national team. Submission has included a proposed model for NCA health to support Lead Professional and Muli Agency Child Protection Teams. Further bi-weekly planning session with all partners in place. JDs under development. Further meetings with NCA in place. Further work with GM ICB on a standardised model to be commenced.

		that the Multi Agency Protection Teams will not have sufficient input from health to be able to ensure a true multi-agency response to child protection concerns.										
9	Lack of a Plan for Managing the Dynamic Support Register for LDA Children	Dynamic support registers (DSRs) and Care (Education) and Treatment Reviews (C(E)TRs) are essential elements of the pathway providing people with a learning disability and autistic people with appropriate support and care at the right time. There is a risk due to the GM ICB reforms that the staff member responsible locally (DSO) will no longer carry out this function and there will be a gap in this function.							12	New		Locally the Designated Clinical Officer (DSO) for SEND has responsibility for this function. Reform discussion underway with regard to having a centralised GM DSO team with fewer staff. Discussions with GM ICB on the role and responsibilities of the DSO ongoing. Adult DSR managed in Complex Care - no capacity in the team to pick this work up. Support from Complex Care team member to stream line process. No current identified landing place post ICB reforms for the DSR .
10	Safeguarding workforce	There is a risk that the proposed GM ICB Safeguarding Team will be unable to fulfil all of its statutory obligations due to insufficient capacity within the team. Requirements for Named and Designated professionals who have delegated responsibility from the ICB to carry out							12	New		Across GM there are gaps in staff in key safeguarding positions, additionally GM ICB have agreed further VR posts which will create more gaps. Locally the borough has statutory posts filled at the current time. Work on-going with GM ICB on the new proposed model. JDs and responsibilities being developed at GM level without local

		safeguarding duties on behalf of the organisation may not comply with statutory guidance. Impact - Insufficient capacity to deliver the level of assurance and oversight required by the GM delivery model Inability to meet required levels of audit and oversight within the multi-agency strategic safeguarding partnership. Reduced ability to engage fully in the GM workstreams. Insufficient links with Primary care, Insufficient ability to support GP's with safeguarding work. Inability to gather assurance that learning is adequately embedded across the health economy										input into the design. Mutual aid will be offered where able to as requested.
11	Sustainable General Practice	IF: the apportionment of delegated PC monies is not sufficient enough to cover local elements unique to Bury (such as dementia diagnosis, ring pessaries, bloods etc) THEN: services may need to be stopped limiting what general practice	16	16	16	16	12	12	12	↔	12	Additional investment supported by GM Board for 25/26 and whilst this hasn't fully addressed the variability goes some way to increasing investment and therefore service delivery/improvement over a phased period. Several services including Dementia Diagnosis are funded through LCS

		support/deliver LEADING TO: Wider provider pathway pressures which cost more and possible poorer outcomes for the patients of Bury										investment. Depending on the financial value attributed to further GM standardisation 1st April 2026 these locality specific services may be at risk. This has been flagged through various committees both locally and centrally in GM.
12	The delivery of the Uplands practice estate solution Awaiting update	BEAUSE an affordable scheme cannot be achieved to enable move of Uplands practice from current premises, THEN there is a risk that patients will have a poor experience of healthcare due to the condition of the estates. The current facility is becoming increasingly difficult to maintain to an acceptable level and is already impacting on patient experience and staff within the practice.	16	16	16	12	12	12		↔	8	Work continues to secure a variable alternative Health Centre. Financial and contractual discussions are progressing well with all parties. National approval has been secured for capital to deliver the scheme on the ex-library site – work now progressing to tender construction works and secure planning approval. Current estimates propose start on site September 2025 with new facility operational around 12-18 months later depending on tendered construction period.
13	Mental health programme	If patient flow is not improved in MH inpatient wards this will lead to delayed discharge of patients to more appropriate placements, drive demand for inappropriate Out of Area Placements and increase the risk of 12-hour breaches in ED	16	16	16	16	16	12	12	↔	8	Risk score reduced due in Q2 due to progress made. Bury has consistently had an average if between 0 and 1 inappropriate out of area placement and Month on month since April 2025 the number of bed days occupied on acute MH wards by Bury Patients who are clinically ready for discharge has been below target. The YTD position in the last reported month (October) was 817 bed days lost against a maximum

												target of 1113. LOS for adults and older adults have been on a downward trajectory since the start of the financial year and the number of 12 hour breaches has been consistently below the peak in December 2024. GM, PFT and locality level improvement plan in place. Weekly locality and GM MADE meetings to support flow in MH wards. GM crisis programme to increase / improve community-based crisis provision and pathways. Actively monitored through Bury MH Programme Board.
~~12~~	Mental health programme CLOSE	If Bury (and the other NES localities) are unable to commission a provider of adult ASD assessment and ADHD assessment and treatment (2025.26) there will be complete reliance on the right to choose pathway resulting in: • inability to implement a managed pathways of care. • reliance on right to choose with the	16	16	16	16	16	8 Closed		↓	8	Risk closed as target score reached. Contract with Optimise now in place for 2025.26.

		associated inequality in access and cost pressures. • ongoing reputational impact.										
14	Mental health programme	If the number of referrals for adult neurodevelopmental assessments via the right to choose pathways continues to increase this will lead to potentially inequitable provision and significant financial pressures on the locality budget.	16	16	16	16	16	16	16	↔	8	Expenditure is significantly up on the same period last year with significant overspend projected. Budgets for ADHD / ASD provision are being centralised by GMICB and GMICB has taken the decision to suspend funding for new assessments by so called right to choose providers until at least April 2026 to control costs. Expenditure is being closely monitored. Standard service specifications for ASD assessment and ADHD assessment and treatment have been developed and will be implemented with all contracted and right to choose providers in 2026 which should support greater consistency in terms of quality. Plans to implement a triage gateway for adult ADHD assessments have been approved by the GMICB following a public consultation and this will ultimately limit the number of assessment referrals. There has been in principle agreement with GMICB exec to

												recommission Optimise Healthcare to provide shared care oversight and ADHD / ASD assessment for in 2026.27. This will provide a commissioned alternative to right to choose for patients requiring an ADHD or ASC assessment. The transformation of adult ADHD pathways is overseen by the GM Adult ADHD Steering Group with Bury Commissioner representation.
15	Mental health programme	If demand and waiting times for CYP neurodevelopmental assessments are not reduced this will lead to continued delays in diagnosis and follow up treatment and support for children and families, and risk of further poor OFSTED / CQC inspection outcomes.	16	16	16	16	16	16	16	↔	8	Waiting times remain long – further work required to ensure standard routine reporting of waiting times. Progress monitored as part of the SEND improvement programme with regular reporting to SIAB PCFT CAMHS have implemented: - routine check-ins with families on waiting lists. - waiting list initiatives. GM triage / prioritisation criteria for ADHD / ASD assessments due to be implemented within CAMHS and community pediatrics as part of a wider neurodevelopment transformation programme from Jan 2026. CYP with the greatest needs / risks will be prioritised for assessment. The Bury ND Hub has been established to provider early help

												and needs based support without the need for a diagnosis. This together with other early help initiatives will provide needs led support to children and families and may reduce demand for full assessment in the longer term.
16	Mental health programme	If Bury (and the other NES localities) are unable to commission a provider of adult ASD assessment and ADHD assessment and treatment (2025.26) there will be complete reliance on the right to choose pathway for new assessments and risk to the continuity of care for patients on medication resulting in: • Inability to implement managed pathways of care e.g., for CYP transition to an adult service. • Potential disruption to prescribing to patients. • Increased potential for GPs to refuse to enter into shared care agreements. • Reliance on right to choose with the associated inequality in access and cost pressures.						16	12	↓	8	There has been in principle agreement with GMICB exec to recommission Optimise Healthcare to provide shared care oversight and ADHD / ASD assessment for in 2026.27. The STAR form has been submitted. The Process of seeking approval from the GM procurement team is in process. CAMHS teams have been notified that they can continue to transition young people on ADHD medication to Optimise. GMICB has taken the decision to suspend funding for new assessments by so called right to choose providers until at least April 2026 to control costs. NES commissioners continue to meet fortnightly to monitor the situation and progress commissioning arrangements for 2026.27.

		Ongoing reputational impact.										

4 Recommendations

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

5 Actions Required

5.1 The Locality Board is asked to note the contents of the report and to raise any issues for the IDCB and Risk, Performance and Scrutiny Group.

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BURY
INTEGRATED CARE
PARTNERSHIP

Locality Performance Report Jan 2026

Part of Greater Manchester Integrated Care Partnership

Presentation by:

Bury - Oversight Metrics

Show Definitions

Domain	Code	Measure	Frequency	Date	Latest	Previous	Change	Target/Median	Numerator	Denominator	Quartile
Mental Health & Learning Disabilities	N/A	Adult inpatients with autism only	Monthly	Nov 25	2	2	→	2	N/A	N/A	N/A
	N/A	Adult inpatients with LD and LDA	Monthly	Nov 25	4	4	→	3	N/A	N/A	N/A
	S030a	% of patients aged 14+ with a completed LD health check	Monthly	Nov 25	48.9%	40.7%	↗	75.%	580	1,187	Inter
	EH09	Access to Children and Young Peoples Mental Health Services	Monthly	Nov 25	3,595	3,530	↗	5,735	N/A	N/A	Lower
	EAS01	Dementia: Diagnosis Rate (Aged 65+)	Monthly	Nov 25	76.7%	76.8%	↘	66.7%	1,898	2,475	Upper
	S086a	Inappropriate adult acute mental health Out of Area Placement (OAP) bed days (rolling 3 month total)	Monthly	Nov 25	3,265	3,290	↘	0	N/A	N/A	Lower
	N/A	Number of MH patients with no criteria to reside - number of beds occupied by mental health patients who are ready to be discharged	Monthly	Dec 25	7	12	↘	N/A	N/A	N/A	Inter
	N/A	Percentage of MH patients with no criteria to reside (NCTR)	Monthly	Dec 25	9.5%	16.2%	↘	N/A	7	74	Inter
	S110a	Overall Access to Community MH Services for Adults and Older Adults with Severe Mental Illnesses	Monthly	Nov 25	2,335	2,310	↗	4,470	N/A	N/A	Inter
	S081a	Talking Therapies: Access Rate	Monthly	Nov 25	280	305	↘	N/A	N/A	N/A	Lower
	S131a	Women Accessing Specialist Community Perinatal Mental Health Services	Quarterly	Nov 25	215	220	↘	N/A	N/A	N/A	Lower
	S125a	Long length of stay for adults (60+ days)	Monthly	Nov 25	23.1%	21.4%	↗	0.%	15	65	Inter
	N/A	Proportion of routine eating disorder referrals cases entering treatment within four weeks, aged 0-18	Monthly	May 25	78.0%	78.0%	↘	N/A	78	N/A	Inter
Cancer	N/A	Cancers Diagnosed at an Early Stage (12-month rolling): All Tumours Staged within RCRD	Monthly	Sep 25	58.6%	58.9%	↘	N/A	439	749	Lower
Primary Care	S053b	% of hypertension patients who are treated to target as per NICE guidance	Annual	Mar 25	70.6%	69.6%	↗	77.%	22,781	32,267	Inter
	S053c	% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins	Quarterly	Jun 25	64.3%	64.2%	↗	63.7%	7,005	10,890	Inter
	S129a	GP appointments - percentage of regular appointments within 14 days	Monthly	Nov 25	76.6%	71.2%	↗	81.0%	60,819	79,436	Lower
Quality	S042a	E. coli blood stream infections	Monthly	Nov 25	126	133	↘	N/A	N/A	N/A	Upper
	S044a	Antimicrobial resistance: total prescribing of antibiotics in primary care	Monthly	Jun 25	68.9%	69.8%	↘	87.1%	N/A	N/A	Upper
	S044b	Antimicrobial resistance: proportion of broad-spectrum antibiotic prescribing in primary care	Monthly	Jun 25	5.6%	5.6%	↗	10.%	5,314	95,172	Upper
	S037A	% of patients describing the overall experience of their GP practice as good	Annual	Mar 23	71.4%		→	73.9%	N/A	N/A	N/A

Bury

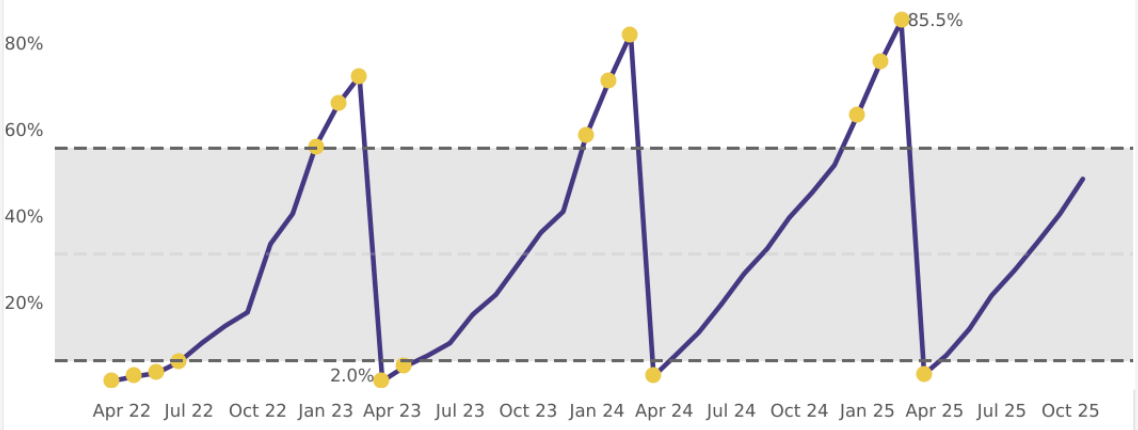
% of patients aged 14+ with a completed LD health check

The % of people on the QOF Learning Disability Register who received an annual health check between the start of the financial year and the end of the reporting period

Source: Learning Disabilities Health Check Scheme (Monthly)

48.9%	40.7%	31/106	75.%
November 2025	October 2025	National Rank Inter Quartile	National Target

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	2.0%	3.1%	3.9%	6.5%	10.9%	14.8%	18.0%	33.8%	40.8%	56.4%	66.4%	72.7%
2023-24	2.0%	5.4%	7.9%	10.8%	17.5%	22.0%	29.1%	36.5%	41.3%	58.9%	71.7%	82.5%
2024-25	3.2%	8.1%	13.3%	19.8%	26.9%	32.7%	39.9%	45.8%	52.1%	63.7%	75.9%	85.5%
2025-26	3.6%	8.0%	14.1%	21.9%	27.7%	34.2%	40.7%	48.9%				

Selected measure at November 2025 has continuously increased for 7 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities

1	Trafford	62.4%
5	Stockport	55.5%
6	Salford	55.2%
10	Wigan	53.8%
17	Manchester	52.2%
23	Bolton	50.7%
29	Tameside	49.9%
31	Bury	48.9%
40	Rochdale	47.2%
56	Oldham	44.5%
3	NHS Greater Manchester Integrated Care Board	51.9%

Narrative

- The performance metrics for LD health checks have been reset for the 2025/2026 reporting period, accounting for the significant decline observed in the latest data.
- In Nov 2025, 48.9% of patients aged 14 and above completed an LD health check, showing an improvement compared to 40.7% in Oct 2025 and 48.9% in Nov 2024.
- The Bury locality currently reports a rate below the Greater Manchester (GM) average of 51.9%, ranking it 8th among GM localities.
- Please note this this is an annual check and Bury undertakes them in the last quarter and thus are on track for usual high performance

Bury

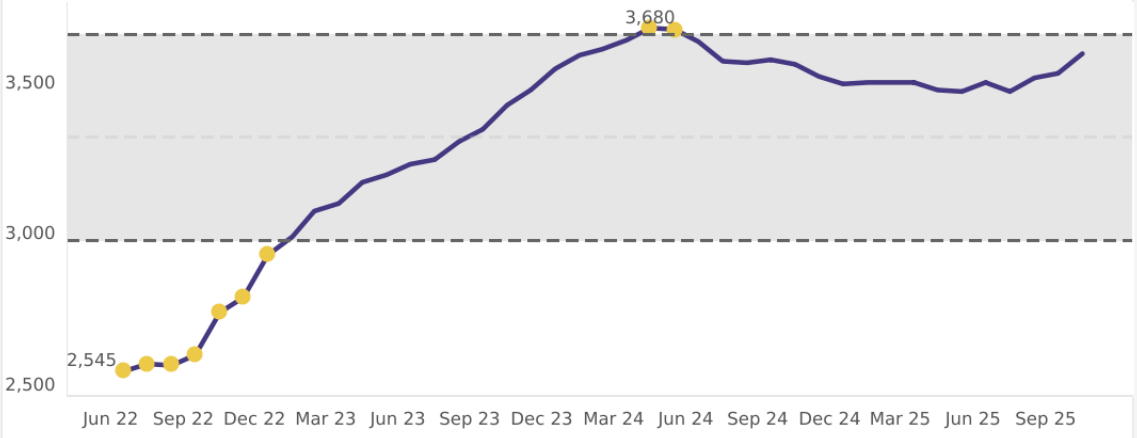
Access to Children and Young Peoples Mental Health Services

Access to Children and Young Peoples Mental Health Services

Source: Published MHSDS (Monthly)

3,595	3,530	93/115	5,735
November 2025	October 2025	National Rank Lower Quartile	National Median

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23				2,545	2,570	2,565	2,600	2,740	2,790	2,930	2,990	3,075
2023-24	3,100	3,170	3,195	3,230	3,245	3,305	3,345	3,425	3,475	3,545	3,590	3,610
2024-25	3,640	3,680	3,675	3,635	3,570	3,565	3,575	3,560	3,520	3,495	3,500	3,500
2025-26	3,500	3,475	3,470	3,500	3,470	3,515	3,530	3,595				

Selected measure at November 2025 has continuously increased for 3 period(s) of time

Latest Value GM Benchmarking

Rate per 1000 | Count (National Rank based on count)

Manchester	108.4	15,965 (20)
Tameside	101.9	4,900 (71)
Trafford	90.9	4,890 (72)
Bury	79.9	3,595 (93)
Rochdale	79.5	4,660 (76)
Salford	74.6	4,925 (69)
Stockport	64.4	4,320 (81)
Oldham	61.7	3,915 (88)
Wigan	61.3	4,320 (81)
Bolton	55.0	4,235 (83)

The rate is calculated using the 0-17 registered population figure for each locality | Bury: 45,310

Narrative

- In November 2025, a total of 3,595 attendances were recorded for Children and Young People's Mental Health Services by patients registered in Bury. This represents an increase from 3,530 attendances in October 2025 and is also higher than the 3,560 attendances reported in November 2024
- Bury currently reports an access rate of 79.9 per 1,000 population, placing it fourth highest among the Greater Manchester localities in terms of access rate per 1,000 population.

Bury

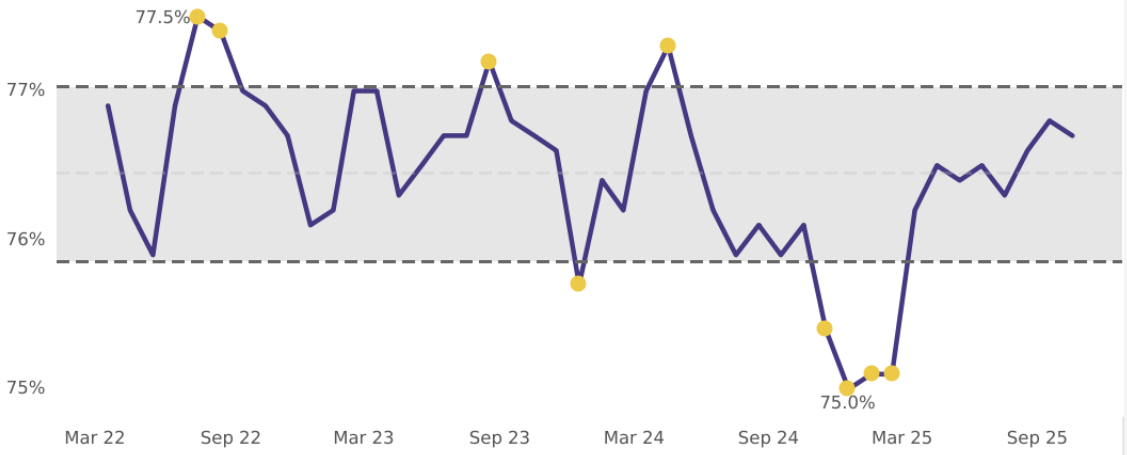
Dementia: Diagnosis Rate (Aged 65+)

Diagnosis rate for people aged 65 and over, with a diagnosis of dementia recorded in primary care, expressed as a percentage of the estimated prevalence based on GP registered populations.

Source: Primary Care Dementia Data (Monthly)

76.7%	76.8%	9/106	66.7%
November 2025	October 2025	National Rank Upper Quartile	National Target

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	76.9%	76.2%	75.9%	76.9%	77.5%	77.4%	77.0%	76.9%	76.7%	76.1%	76.2%	77.0%
2023-24	77.0%	76.3%	76.5%	76.7%	76.7%	77.2%	76.8%	76.7%	76.6%	75.7%	76.4%	76.2%
2024-25	77.0%	77.3%	76.7%	76.2%	75.9%	76.1%	75.9%	76.1%	75.4%	75.0%	75.1%	75.1%
2025-26	76.2%	76.5%	76.4%	76.5%	76.3%	76.6%	76.8%	76.7%				

Selected measure at November 2025 has continuously **decreased** for **1** period(s) of time

Latest Value GM Benchmarking

National Rank against other localities

4	Salford	78.8%
6	Rochdale	77.9%
7	Manchester	77.3%
9	Bury	76.7%
11	Stockport	76.5%
13	Oldham	76.0%
23	Wigan	74.0%
25	Tameside	73.7%
33	Bolton	71.6%
37	Trafford	70.3%
2	NHS Greater Manchester Integrated Care Board	75.2%

Narrative

- As of Nov 2025, 76.7% of patients aged 65 and over in Bury have received a dementia diagnosis.
- Bury's diagnosis rate is higher than the Greater Manchester (GM) average, which stands at 75.2%, and ranks 4th highest among the GM localities.
- Both Bury and GM exceed the national target for dementia diagnosis, which is set at 66.7%.

Bury

Percentage of MH patients with no criteria to reside (NCTR)

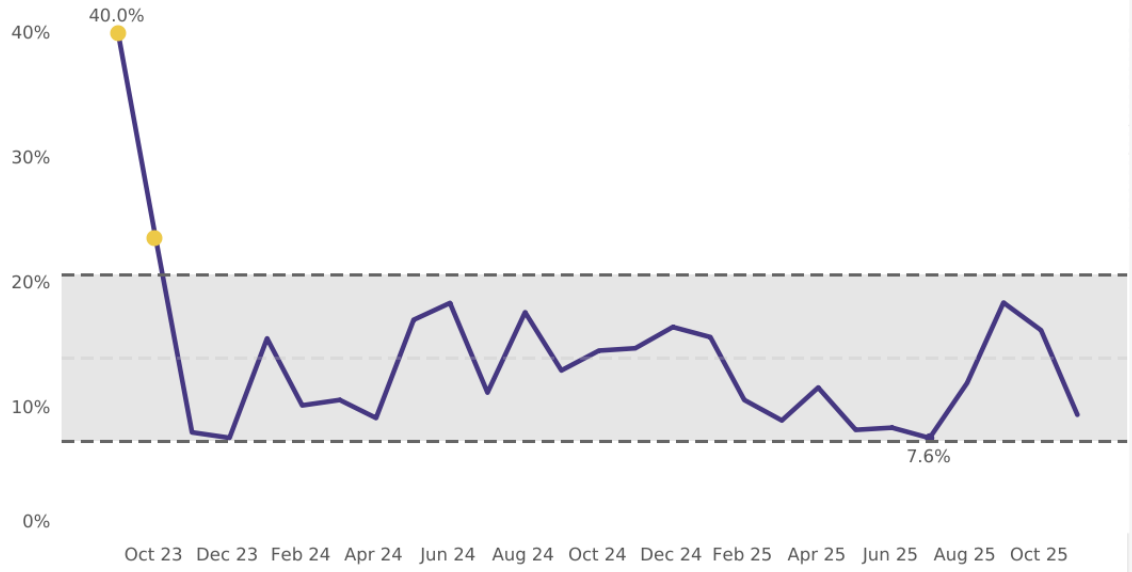
Percentage of beds occupied by MH patients who are ready to be discharged

Source: GM Admissions - Local (Monthly)

9.5%
December 2025

16.2%
November 2025

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023-24							40.0%	23.6%	8.0%	7.6%	15.6%	10.2%
2024-25	10.6%	9.2%	17.0%	18.4%	11.2%	17.6%	13.0%	14.6%	14.8%	16.5%	15.7%	10.6%
2025-26	9.0%	11.6%	8.2%	8.4%	7.6%	12.0%	18.4%	16.2%	9.5%			

Selected measure at December 2025 has continuously decreased for **2** period(s) of time

Latest Value GM Benchmarking

Narrative

- As of Dec 2025, 9.5% of mental health patients in Bury with no criteria to reside (NCTR), representing a decrease from 16.2% in Nov 2025 and a decrease from 14.8% in Dec 2024.
- Bury's current percentage is lower than the Greater Manchester (GM) average, which stands at 13.1%.
- Among the GM localities, Bury ranks as having the 2nd lowest NCTR percentage.

Bury

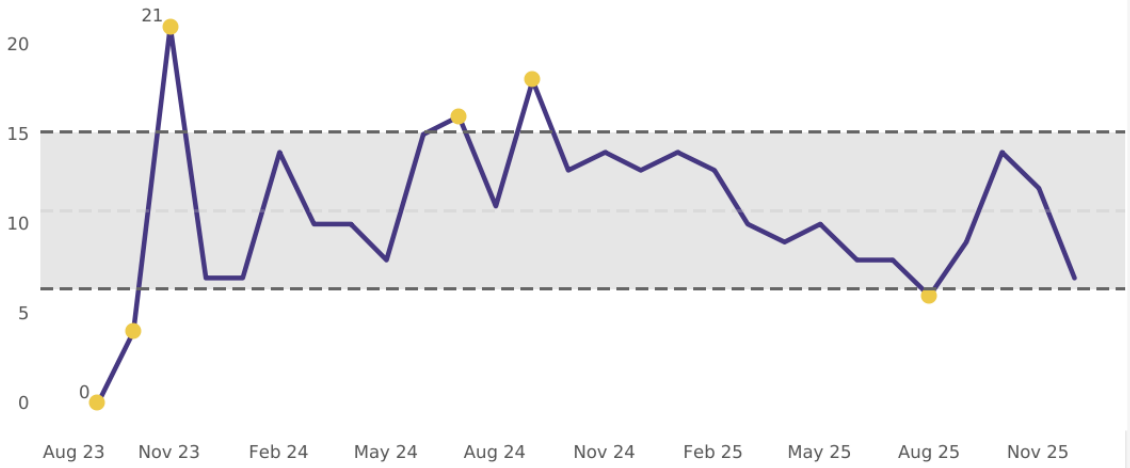
Number of MH patients with no criteria to reside (NCTR)
Number of beds occupied by MH patients who are ready to be discharged

Source: GM Admissions - Local (Monthly)

7
December 2025

12
November 2025

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023-24						0	4	21	7	7	14	10
2024-25	10	8	15	16	11	18	13	14	13	14	13	10
2025-26	9	10	8	8	6	9	14	12	7			

Selected measure at December 2025 has continuously decreased for 2 period(s) of time

Latest Value GM Benchmarking
Rate per 1000 | Count

Bury	0.033	7
Rochdale	0.028	7
Tameside	0.031	7
Trafford	0.032	8
Oldham	0.033	9
Wigan	0.028	10
Bolton	0.042	14
Stockport	0.048	16
Salford	0.055	18
Manchester	0.062	47
NHS Greater Manchester Integrated Care Board	0.043	143

The rate is calculated using the registered population figure for each locality | Bury: 212,439

Narrative

- This metric is monitored on a daily basis to ensure timely oversight and responsiveness.
- In Dec 2025, the number of mental health patients with NCTR in Bury was 7, marking a decrease from the previous month.
- Bury presently reports 0.033 NCTR patients per 1,000 people, which is higher than the Greater Manchester (GM) average of 0.043. Within GM areas, Bury has the lowest reported rate.

Bury

Overall Access to Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses

Number of people who receive two or more contacts from NHS or NHS commissioned community mental health services (in transformed and non-transformed PCNs) for adults and older adults with severe mental illnesses, in a rolling 12 month period

Source: Published MHSDS (Monthly)

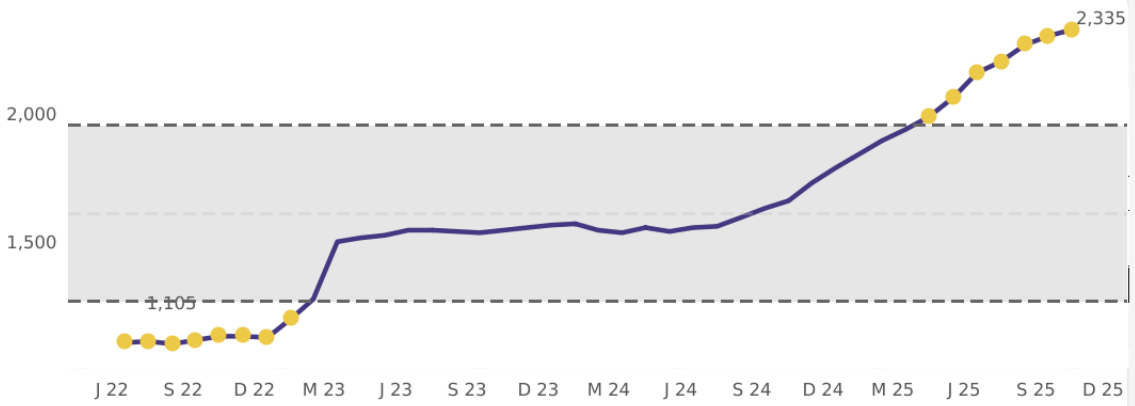
2,335
November 2025

2,310
October 2025

85/115
National Rank
Inter Quartile

4,470
National Median

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23				1,110	1,115	1,105	1,120	1,135	1,135	1,130	1,205	1,280
2023-24	1,505	1,520	1,530	1,550	1,550	1,545	1,540	1,550	1,560	1,570	1,575	1,550
2024-25	1,540	1,560	1,545	1,560	1,565	1,600	1,635	1,665	1,735	1,795	1,850	1,900
2025-26	1,945	1,995	2,070	2,165	2,210	2,275	2,310	2,335				

Selected measure at November 2025 has continuously increased for 17 period(s) of time

Latest Value GM Benchmarking
Rate per 1000 | Count (National Rank)

1	Salford	18.5	4,820 (53)
2	Bury	14.0	2,335 (85)
3	Manchester	13.5	8,255 (37)
4	Trafford	12.8	2,485 (81)
5	Tameside	12.6	2,280 (87)
6	Wigan	12.2	3,440 (68)
7	Bolton	10.8	2,785 (78)
8	Rochdale	10.3	2,005 (94)
9	Oldham	9.1	1,860 (96)
10	Stockport	6.9	1,825 (97)

The rate is calculated using the 18+ registered population figure for each locality | Bury: 167,113

Narrative

- In Nov 2025, a total of 2,335 Bury-registered patients with severe mental illness had two or more interactions with adult mental health services. This marks an increase from 1,665 contacts noted in Nov 2024, and an increase from Oct 2025, which recorded 2,310 contacts.
- Bury currently reports 14.0 contacts per 1,000 population, positioning it as the second lowest rate among the Greater Manchester (GM) localities.

Bury

Talking Therapies: Access Rate

This indicator tracks our ambition to expand Improving Access to Psychological Therapies (IAPT) services, also known as NHS Talking Therapies. The primary purpose of this indicator is to measure improvements in access to psychological therapy (via IAPT) for people with depression and/or anxiety disorders.

Source: Improving Access to Psychological Therapies Data Set (Monthly)

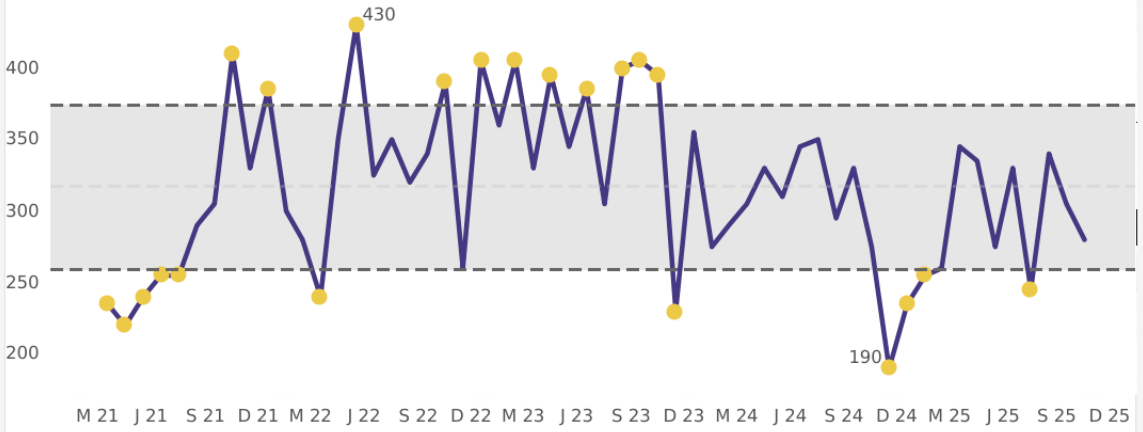
280
November 2025

305
October 2025

94/110
National Rank
Lower Quartile

No Target

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	235	220	240	255	255	290	305	410	330	385	300	280
2022-23	240	350	430	325	350	320	340	390	260	405	360	405
2023-24	330	395	345	385	305	400	405	395	230	355	275	290
2024-25	305	330	310	345	350	295	330	275	190	235	255	260
2025-26	345	335	275	330	245	340	305	280				

Selected measure at November 2025 has continuously decreased for 2 period(s) of time

Latest Value GM Benchmarking
Rate per 1000 | Count (National rank)

1	Salford	2.6	860 (41)
2	Manchester	2.4	1,845 (17)
3	Bolton	1.6	520 (61)
4	Oldham	1.5	405 (78)
5	Trafford	1.5	365 (83)
6	Tameside	1.4	325 (89)
7	Wigan	1.4	500 (64)
8	Stockport	1.4	460 (69)
9	Bury	1.3	280 (94)
10	Rochdale	1.0	265 (97)

The rate is calculated using the registered population figure for each locality | Bury: 212,439

Narrative

- In Nov 2025, there were 280 recorded accesses to NHS Talking Therapies by Bury-registered patients, slightly higher than the same period the previous year (275).
- Bury currently reports an access rate of 1.3 per 1,000 population, which ranks as the 2nd lowest among the Greater Manchester (GM) localities.

Bury

Women Accessing Specialist Community Perinatal Mental Health Services

Women Accessing Specialist Community Perinatal Mental Health Services (Rolling 12 mths)

Source: Published MHSDS (Quarterly)

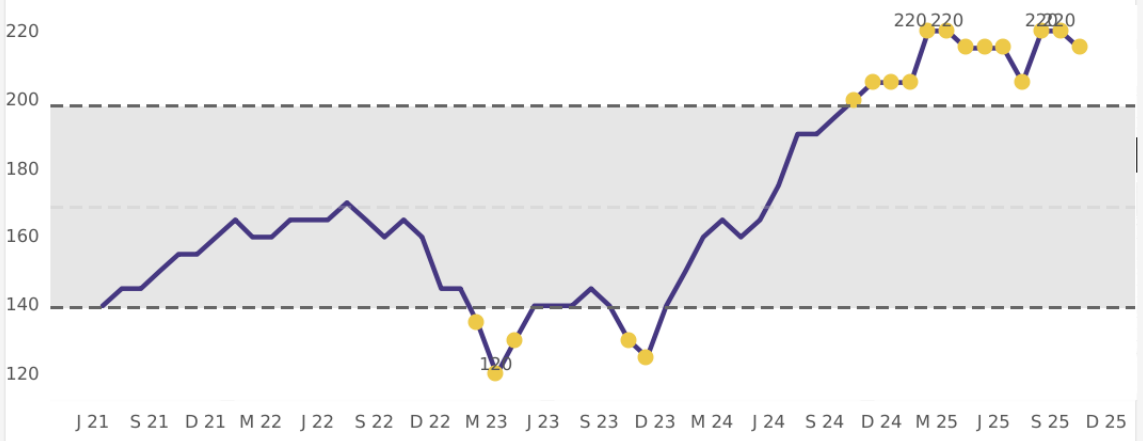
215
November 2025

220
October 2025

87/107
National Rank
Lower Quartile

No Target

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22				140	145	145	150	155	155	160	165	160
2022-23	160	165	165	165	170	165	160	165	160	145	145	135
2023-24	120	130	140	140	140	145	140	130	125	140	150	160
2024-25	165	160	165	175	190	190	195	200	205	205	205	220
2025-26	220	215	215	215	205	220	220	215				

Selected measure at November 2025 has continuously **decreased** for **1** period(s) of time

Latest Value GM Benchmarking
Rate per 1000 | Count (National Rank)

1	Stockport	5.3	335 (60)
2	Bury	5.2	215 (87)
3	Tameside	4.8	220 (86)
4	Rochdale	4.5	230 (82)
5	Oldham	4.2	230 (82)
6	Trafford	3.9	185 (94)
7	Wigan	3.9	260 (78)
8	Bolton	3.4	225 (84)
9	Salford	3.1	245 (80)
10	Manchester	2.6	515 (44)

The rate is calculated using the 15-44 female population figure for each locality | Bury 41,131

Narrative

- During the 12-month period ending in Nov 2025, 215 women registered in Bury accessed Perinatal Mental Health Services. This represents an increase from 200 accesses recorded in the equivalent period ending Nov 2024.
- Bury currently reports an access rate of 5.2 per 1,000 population, which is the 2nd highest rate among all Greater Manchester (GM) localities.

Bury

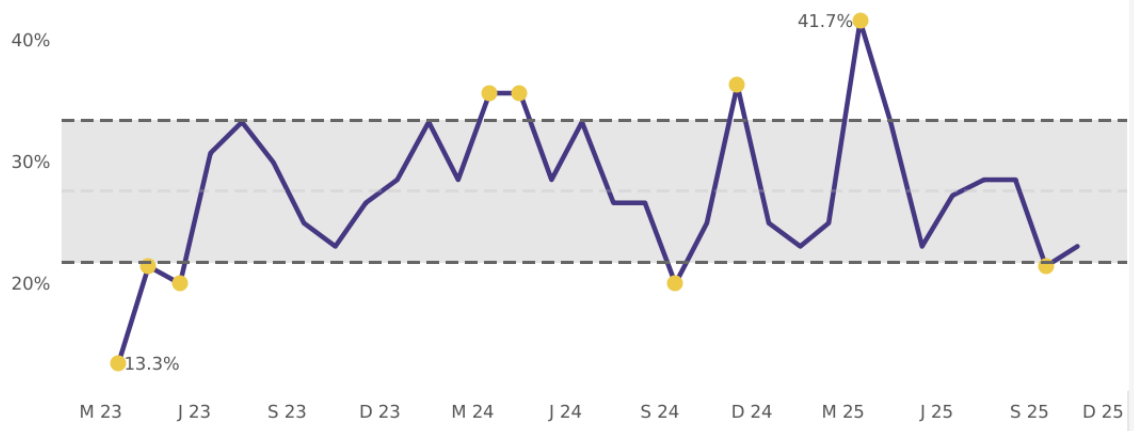
Long length of stay for adults (60+ days) - Mental Health Patients

Proportion of all discharges from adult acute and older adult acute beds, with a length of stay of over 60 days

Source: Published MHSDS (Monthly)

23.1%	21.4%	44/102	0.%
November 2025	October 2025	National Rank Inter Quartile	National Target

Outliers more than 1 standard deviation from the mean

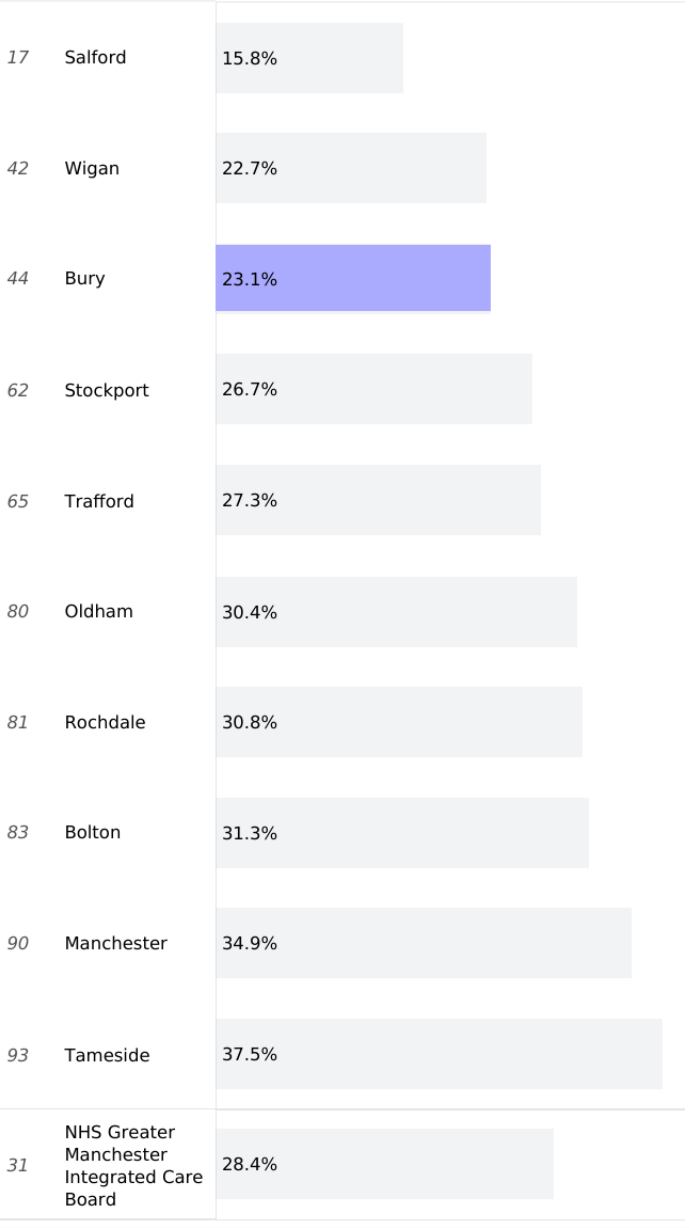


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023-24	13.3%	21.4%	20.0%	30.8%	33.3%	30.0%	25.0%	23.1%	26.7%	28.6%	33.3%	28.6%
2024-25	35.7%	35.7%	28.6%	33.3%	26.7%	26.7%	20.0%	25.0%	36.4%	25.0%	23.1%	25.0%
2025-26	41.7%	33.3%	23.1%	27.3%	28.6%	28.6%	21.4%	23.1%				

Selected measure at November 2025 has continuously increased for 1 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities



Narrative

- In Nov 2025, 23.1% of MH Patient discharges in Bury involved a long length of stay (LOS), a decrease from 25% recorded in Nov 2024.
- Bury currently has the 3rd lowest proportion of long LOS discharges among the Greater Manchester (GM) localities. The GM average for the same period is 28.4%.
- Both Bury and GM exceed the national target, which is set at 0%.

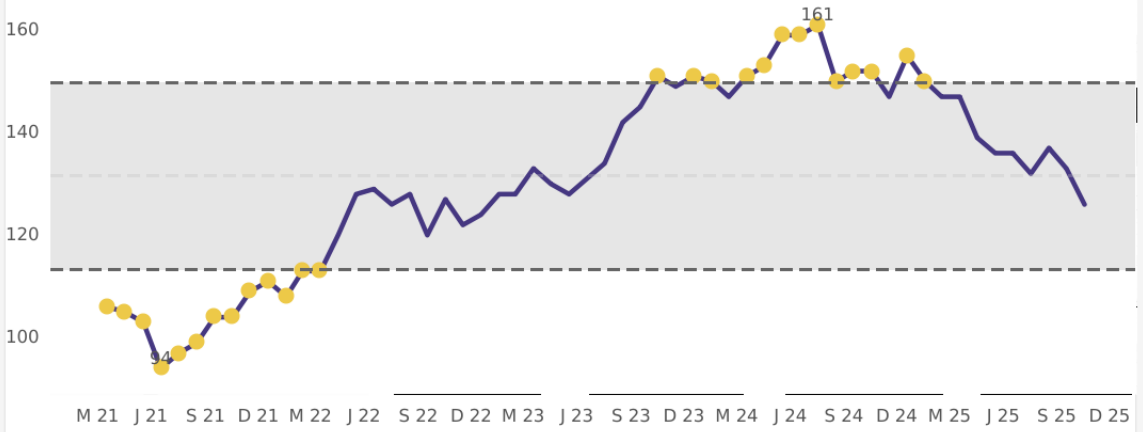
Bury

E. coli blood stream infections
12-month rolling counts of E. coli blood stream infections

Source: National Statistics: E. coli bacteraemia: monthly data by location of onset (Monthly)

126	133	12/107	No Target
November 2025	October 2025	National Rank Upper Quartile	

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	106	105	103	94	97	99	104	104	109	111	108	113
2022-23	113	120	128	129	126	128	120	127	122	124	128	128
2023-24	133	130	128		134	142	145	151	149	151	150	147
2024-25	151	153	159	159	161	150	152	152	147	155	150	147
2025-26	147	139	136	136	132	137	133	126				

Selected measure at November 2025 has continuously decreased for 2 period(s) of time

Latest Value GM Benchmarking
Rate per 1000 | Count (National Rank)

Salford	0.48	158.0 (21)
Wigan	0.52	182.0 (27)
Bury	0.59	126.0 (12)
Bolton	0.59	198.0 (32)
Manchester	0.60	457.0 (67)
Rochdale	0.64	163.0 (22)
Oldham	0.69	185.0 (29)
Trafford	0.71	177.0 (26)
Stockport	0.80	265.0 (48)
Tameside	0.93	214.0 (35)

The rate is calculated using the registered population figure for each locality | Bury: 212,439

Narrative

- In the 12-month period ending Nov 2025, 126 cases of E. Coli bloodstream infections were recorded among Bury-registered patients. This is a decrease from Oct 25 when 133 cases were reported, and below the 152 cases in Nov 2024.
- Bury currently reports an infection rate of 0.59 per 1,000 population, ranking as the 3rd lowest rate among the Greater Manchester (GM) localities.

Bury

Antimicrobial resistance: total prescribing of antibiotics in primary care

The number of antibiotic (antibacterial) items prescribed in primary care, divided by the item-based Specific Therapeutic group Age-Sex related Prescribing Unit STAR-PU

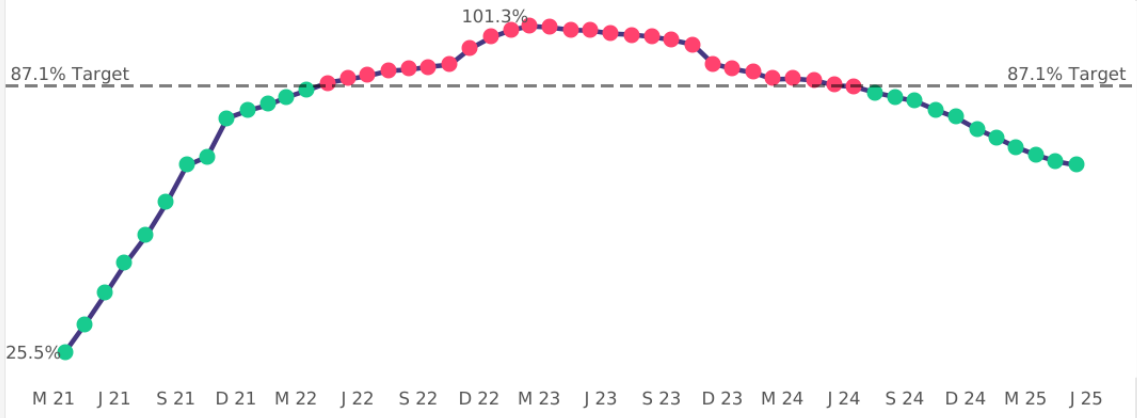
Source: EPACT Prescribing Data (Monthly)

68.9%
June 2025

69.8%
May 2025

87.1%
National Target

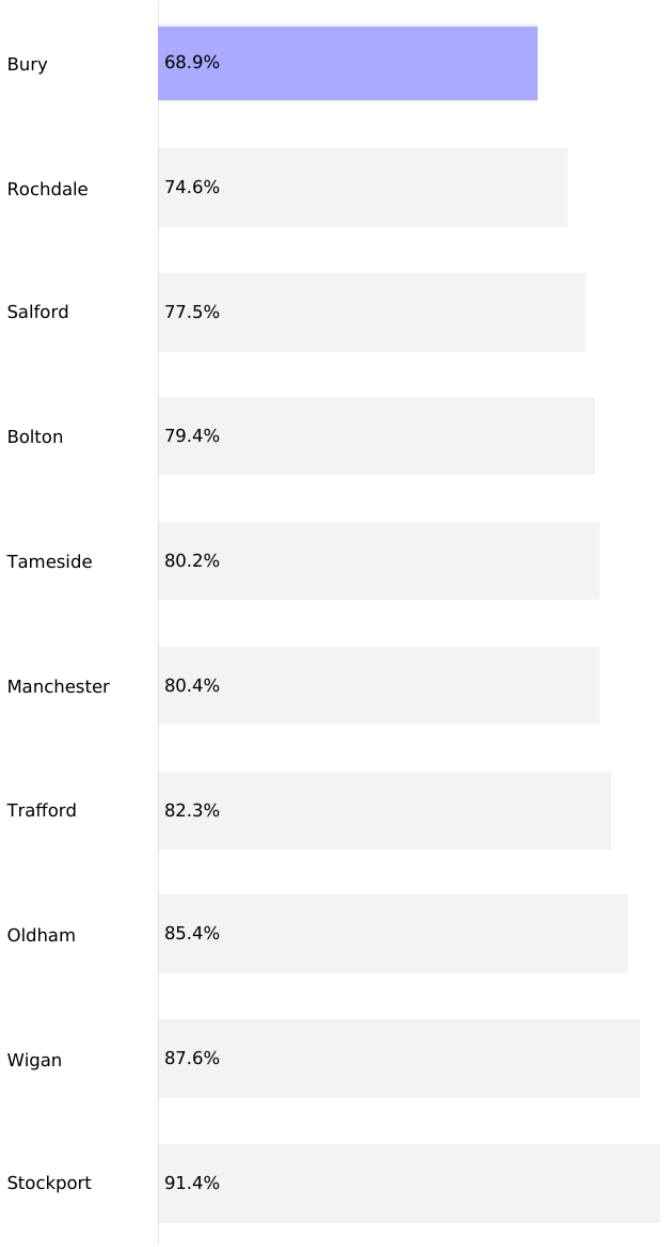
Performance Against National Target of 87.1%



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	25.5%	31.9%	39.0%	46.1%	52.5%	60.2%	68.8%	70.9%	79.9%	81.6%	83.0%	84.8%
2022-23	86.4%	88.1%	88.9%	89.7%	90.9%	91.1%	91.8%	92.3%	96.0%	98.6%	100.3%	101.3%
2023-24	100.9%	100.4%	100.2%	99.5%	99.3%	98.8%	98.0%	97.0%	92.5%	91.3%	90.4%	88.9%
2024-25	89.0%	88.7%	87.5%	87.2%	85.8%	84.7%	83.8%	81.7%	80.0%	77.3%	75.2%	73.1%
2025-26	71.3%	69.8%	68.9%									

Selected measure at June 2025 has continuously decreased for **14** period(s) of time

Latest Value GM Benchmarking



Narrative

- In June 2025, 68.9% of total antibiotic prescribing in primary care for the Bury population met the relevant criteria. This reflects a significant improvement compared to 87.5% in June 2024.
- Bury currently reports the lowest percentage among the Greater Manchester (GM) localities and has successfully achieved the national target of below 87.1%.

Bury

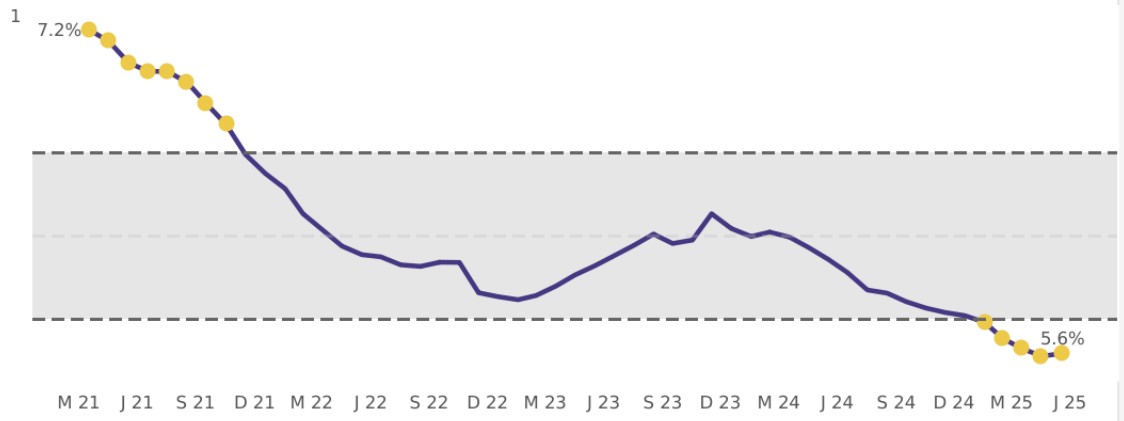
Antimicrobial resistance: proportion of broad-spectrum antibiotic prescribing in primary care

The number of broad-spectrum antibiotic (antibacterials) items from co-amoxiclav, cephalosporin class and fluoroquinolone class drugs as a percentage of the total number of antibacterial items prescribed in primary care.

Source: EPACT Prescribing Data (Monthly)

5.6%	5.6%	15/113	10.%
June 2025	May 2025	National Rank Upper Quartile	National Target

Outliers more than 1 standard deviation from the mean

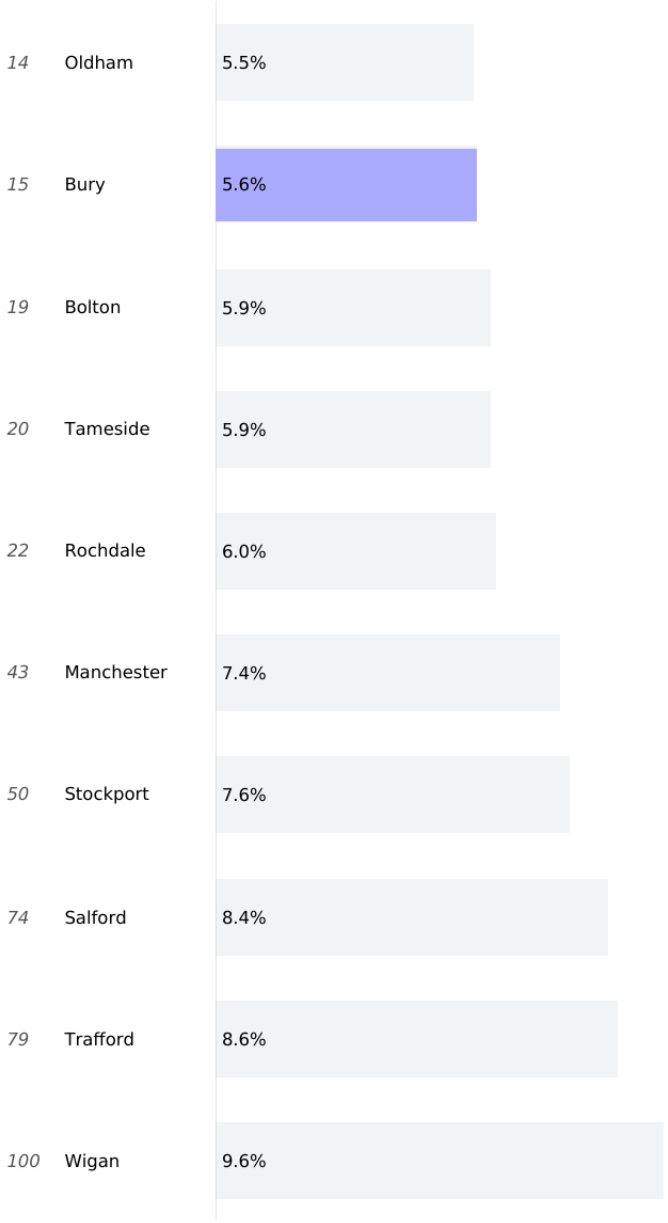


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	7.2%	7.1%	7.0%	7.0%	7.0%	6.9%	6.8%	6.7%	6.6%	6.5%	6.4%	6.3%
2022-23	6.2%	6.1%	6.1%	6.1%	6.0%	6.0%	6.0%	6.0%	5.9%	5.9%	5.9%	5.9%
2023-24	5.9%	6.0%	6.0%	6.1%	6.1%	6.2%	6.1%	6.2%	6.3%	6.2%	6.2%	6.2%
2024-25	6.2%	6.1%	6.1%	6.0%	5.9%	5.9%	5.8%	5.8%	5.8%	5.8%	5.7%	5.7%
2025-26	5.6%	5.6%	5.6%									

Selected measure at June 2025 has continuously increased for 1 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities



Narrative

- Bury's rate of broad-spectrum antibiotic prescribing in June 2025 is 5.6%, the same as the previous month.
- The chart shows that the selected measure has decreased continuously over the past 15 reporting periods, highlighting sustained improvement.
- Bury currently reports the 2nd lowest percentage of broad-spectrum prescribing among the Greater Manchester (GM) localities.
- This performance is within the national target threshold of less than 10%.

Bury - Sight Metrics

Domain	Code	Measure	Frequency	Date	Latest	Previous	Change	Target/Median	Numerator	Denominator	
Urgent Care	N/A	A&E 4 hour performance	Monthly	Dec 25	67.8%	68.7%	↘	78.0%	5,052	7,446	N/A
	N/A	A&E Attendances	Monthly	Dec 25	7,446.0	7,256.0	↗	N/A	7,446	N/A	N/A
	N/A	No Reason/Criteria To Reside patients (NCTR) as % of occupied beds	Monthly	Dec 25	16.2%	17.0%	↘	N/A	1,672	10,295	N/A
	EM11	Total number of specific acute non-elective spells	Monthly	Dec 25	2,076.0	2,028.0	↗	N/A	2,076	N/A	Inter
Elective Care	EB28	Diagnostic 6ww: All	Monthly	Nov 25	8.2%	7.5%	↗	1.%	426	5,197	Upper
	EB20	RTT incomplete: 65+ week waits	Monthly	Nov 25	4.000	4.0	→	0.	4	N/A	Upper
Cancer	S012a	28 Day Wait from Referral to Faster Diagnosis (Monthly): All Patients	Monthly	Nov 25	75.5%	77.2%	↘	80.%	775	1,026	Inter
Maternity	S104a	Number of neonatal deaths per 1,000 total live births	Annual	Dec 23	1.5	0.0	↗	1.4	3	2,049	Inter
	S022a	Number of stillbirths per 1,000 total births	Annual	Dec 23	5.4	4.0	↗	3.1	11	2,049	Lower
Screening and Immunisations	S049a	Breast screening coverage, females aged 53-70, screened in last 36 months	Annual	Dec 24	73.3%	69.2%	↗	N/A	16,305	22,244	Inter
	S046a	COVER immunisation: MMR2 Uptake at 5 years old	Quarterly	Sep 25	87.6%	85.3%	↗	95.%	546	623	Inter
	S050a	Females, 25-64, attending cervical screening within target period (3.5 or 5.5 year coverage, %)	Quarterly	Jun 24	70.3%	70.6%	↘	80.%	37,935	53,940	Inter
	S047A	Seasonal Flu Vaccine Uptake: 65 years and over	Monthly	Nov 25	69.9%	60.5%	↗	85.%	25,712	36,796	Inter
Community	N/A	% 2-hour Urgent Community Response (UCR) first care contacts	Monthly	Nov 25	98.3%	98.8%	↘	N/A	231	235	N/A

Bury - Sight Metrics

The below metrics are currently missing from the report due to lack of locality level reporting or the measure is currently being built.

Theme	Indicator	
Cancer	Total patients waiting over 62 days to begin cancer treatment vs target	Build in progress
LD and Autism	Inpatients with a learning disability and/or autism per million head of population	Build in progress
Primary Care and Community Services	Proportion of Urgent Community Response referrals reached within two hours	Currently available in the scorecard at trust level but not locality
	Proportion of virtual ward beds occupied	Currently unavailable at locality level due to inaccurate reporting
	Units of Dental Activity delivered as a proportion of all Units of Dental Activity contracted	Build in progress
Screening and immunisation	Bowel screening, aged 60-74, screened in the last 30 months	DQ issues
Urgent and Emergency Care	Reduce adult general and acute bed occupancy below 92%	Currently available in the scorecard at trust level but not locality

Bury

A&E 4 hour performance

Number of attendances at A&E departments, and of these, the number of attendances where the patient spent less than 4 hours from time of arrival to time of admission, or discharge, or transfer.

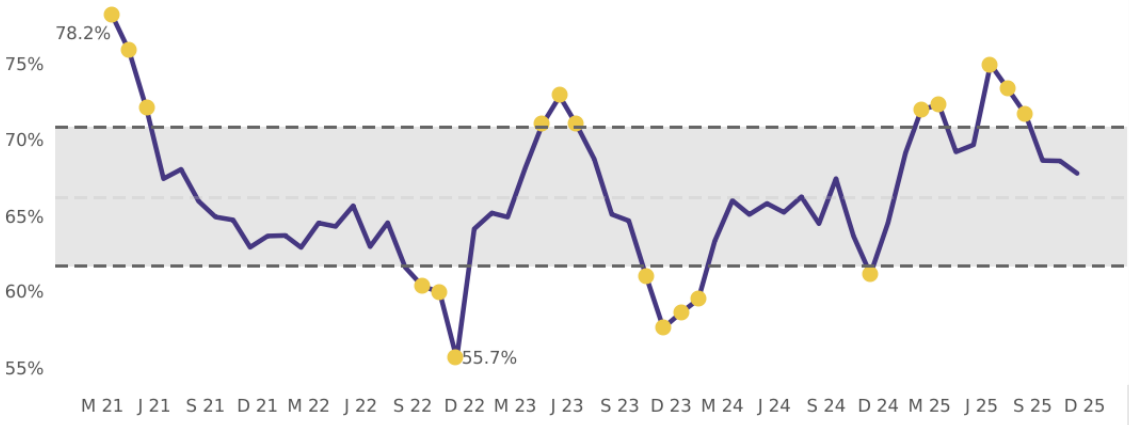
Source: Emergency Care Dataset (ECDS) (Monthly)

67.8%
December 2025

68.7%
November 2025

78.0%
National Target

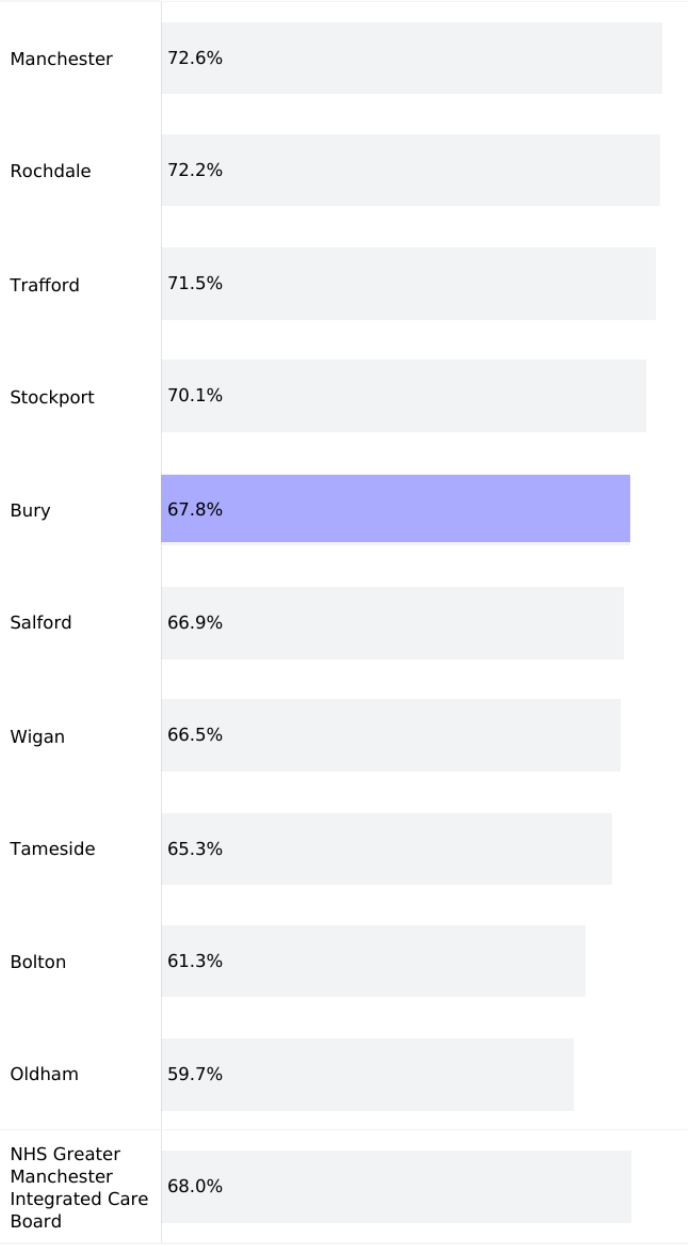
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	78.2%	75.9%	72.1%	67.5%	68.1%	66.0%	65.0%	64.8%	63.0%	63.7%	63.8%	63.0%
2022-23	64.6%	64.4%	65.7%	63.0%	64.6%	61.7%	60.5%	60.0%	55.7%	64.2%	65.2%	65.0%
2023-24	68.2%	71.0%	72.9%	71.0%	68.8%	65.2%	64.7%	61.1%	57.7%	58.7%	59.6%	63.4%
2024-25	66.1%	65.1%	65.9%	65.3%	66.3%	64.5%	67.5%	63.7%	61.2%	64.6%	69.2%	72.0%
2025-26	72.3%	69.3%	69.7%	75.0%	73.4%	71.7%	68.7%	68.7%	67.8%			

Selected measure at December 2025 has continuously **decreased** for **5** period(s) of time

Latest Value GM Benchmarking



Narrative

- This metric is monitored on a daily basis to support timely performance oversight.
- In Dec 2025, Bury achieved a 4-hour emergency care performance rate of 67.8%, a slight reduction from Nov 25 when performance rate was recorded at 68.7%.
- This reflects an increase compared to 61.2% in Dec 2024.
- Bury's performance is currently below the Greater Manchester (GM) average of 68%, ranking as the 5th highest among GM localities.

Bury

A&E Attendances

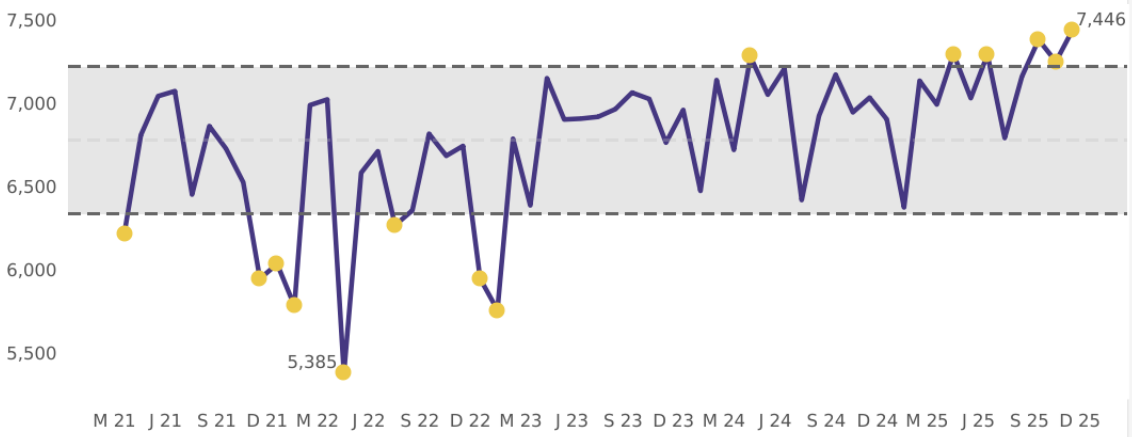
Number of attendances at A&E departments

Source: Emergency Care Dataset (ECDS) (Monthly)

7,446
December 2025

7,256
November 2025

Outliers more than 1 standard deviation from the mean

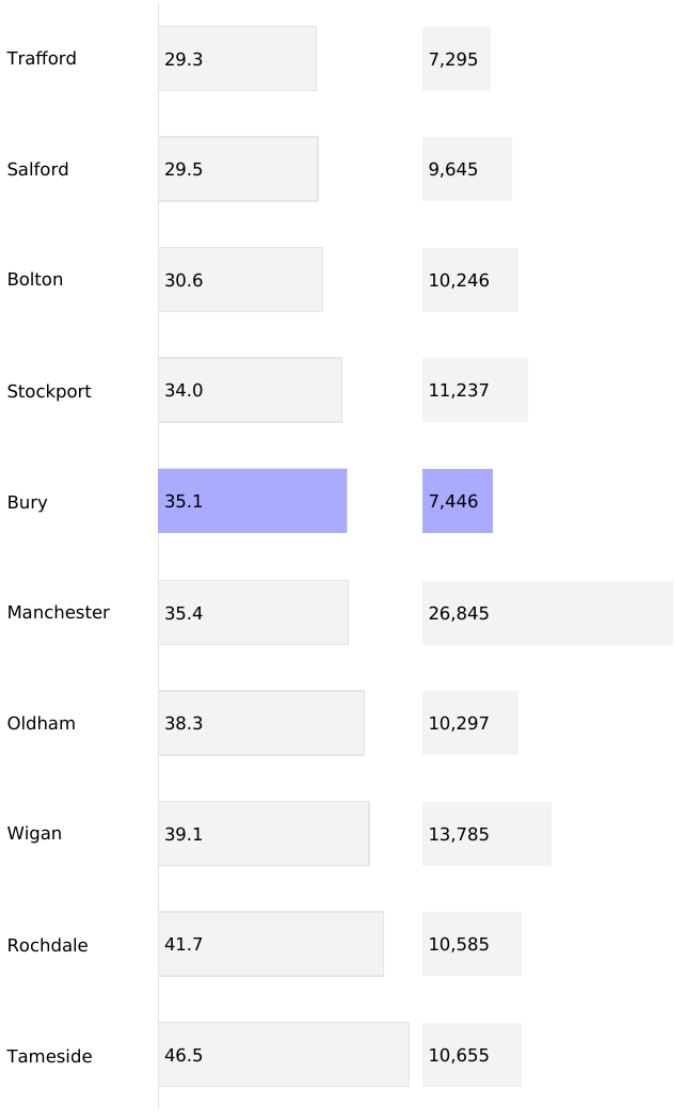


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	6,220	6,816	7,049	7,079	6,459	6,869	6,734	6,532	5,954	6,042	5,791	6,995
2022-23	7,029	5,385	6,589	6,718	6,275	6,363	6,823	6,691	6,750	5,953	5,766	6,793
2023-24	6,394	7,156	6,909	6,914	6,925	6,971	7,070	7,032	6,770	6,966	6,481	7,145
2024-25	6,727	7,285	7,058	7,214	6,426	6,930	7,178	6,952	7,040	6,910	6,382	7,141
2025-26	6,999	7,302	7,037	7,298	6,798	7,167	7,387	7,256	7,446			

Selected measure at December 2025 has continuously increased for 1 period(s) of time

Latest Value GM Benchmarking

Attendances Rate per 1000 population & Count



The rate is calculated using the registered population figure for each locality | Bury: 212,439

Narrative

- In Dec 2025, there were 7,446 A&E attendances recorded for Bury-registered patients. This represents an increase from 7,256 in Nov 2025 and is also an increase from 7,040 in Dec 2024.
- Bury currently reports an attendance rate of 35.1 per 1,000 population, ranking as the 5th lowest among the Greater Manchester (GM) localities.

Bury

No Reason/Criteria To Reside patients (NCTR) as % of occupied beds

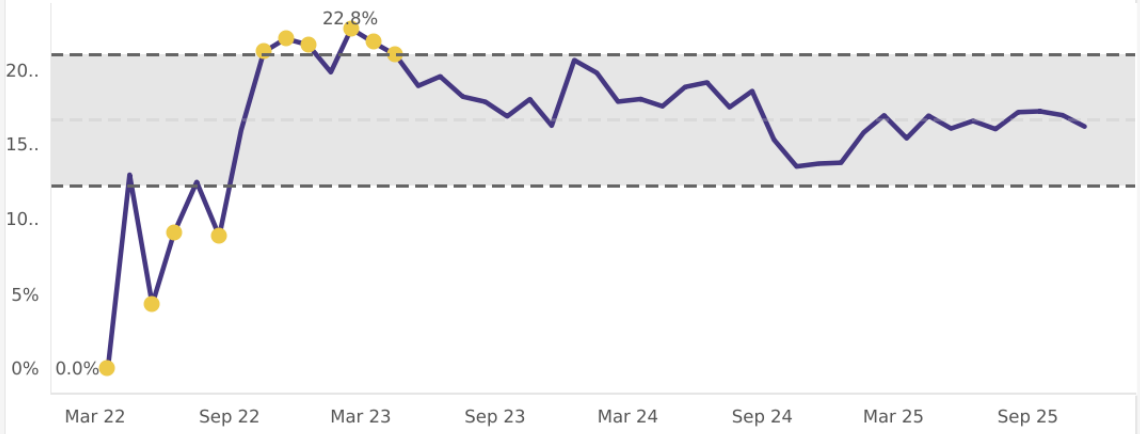
Total occupied beds, and of these, the number of patients who are fit for discharge and have no need to reside in a hospital bed

Source: GM Admissions - Local (Monthly)

16.2%
December 2025

17.0%
November 2025

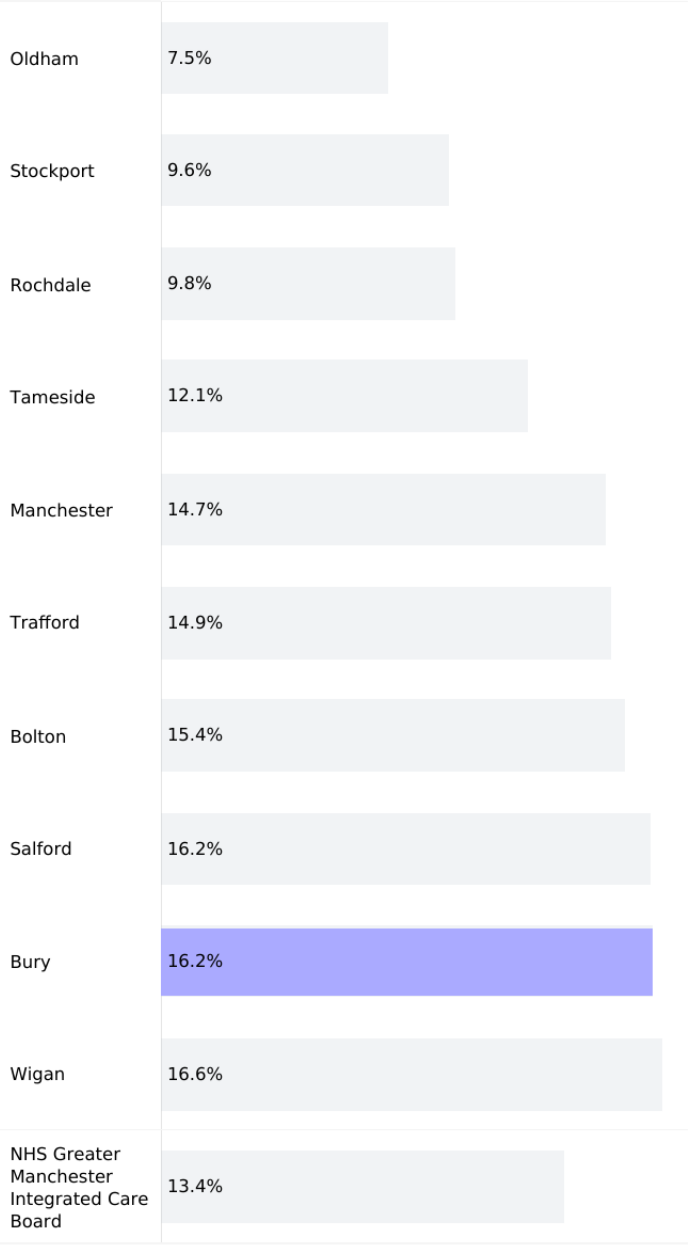
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	0.0%	13.0%	4.3%	9.1%	12.5%	8.9%	16.0%	21.2%	22.1%	21.7%	19.9%	22.8%
2023-24	21.8%	21.0%	19.0%	19.6%	18.2%	17.9%	16.9%	18.1%	16.3%	20.7%	19.8%	17.9%
2024-25	18.1%	17.6%	18.9%	19.2%	17.5%	18.6%	15.4%	13.6%	13.8%	13.8%	15.8%	17.0%
2025-26	15.5%	17.0%	16.1%	16.6%	16.1%	17.2%	17.3%	17.0%	16.2%			

Selected measure at December 2025 has continuously decreased for 2 period(s) of time

Latest Value GM Benchmarking



Narrative

- This metric is monitored daily to support ongoing performance oversight.
- In Dec 2025, the NCTR percentage for Bury was 16.2%, reflecting a decrease from 17.0% in Nov 2025, but an increase compared to 13.8% in Nov 2024.
- Bury's rate remains above the Greater Manchester (GM) average of 13.4% and currently ranks as the 9th lowest percentage among GM localities.

Bury

Total number of specific acute non-elective spells

Number of specific acute non-elective spells in the period (auto-calculated sum of E.M.11a and E.M.11b)

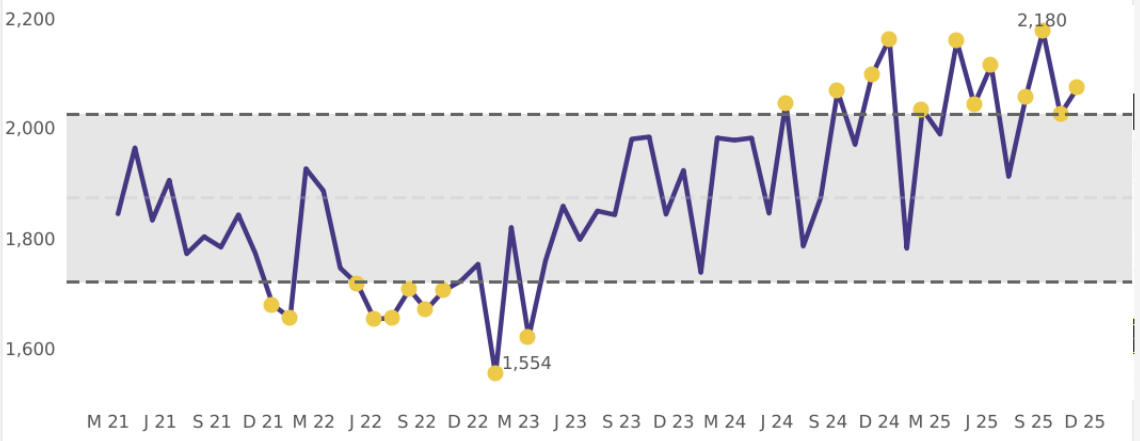
Source: National Flows APC (Monthly)

2,076
December 2025

2,028
November 2025

3/10
GM Rank

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	1,847	1,967	1,835	1,908	1,774	1,805	1,786	1,845	1,775	1,681	1,657	1,929
2022-23	1,889	1,748	1,718	1,654	1,658	1,709	1,672	1,707	1,724	1,755	1,554	1,822
2023-24	1,622	1,762	1,861	1,800	1,852	1,845	1,983	1,987	1,846	1,926	1,740	1,985
2024-25	1,981	1,985	1,848	2,049	1,788	1,876	2,070	1,973	2,099	2,166	1,784	2,037
2025-26	1,992	2,161	2,046	2,117	1,915	2,061	2,180	2,028	2,076			

Selected measure at December 2025 has continuously increased for 1 period(s) of time

Latest Value GM Benchmarking
Count & Rate Per 1000 Population

The rate is calculated using the registered population figure for each locality | Bury: 212,439

Narrative

- In Dec 2025, there were 2,076 specific acute non-elective spells recorded for Bury-registered patients. This reflects a decrease from both 2,028 spells in Nov 2025 and a decrease from 2,099 spells in Dec 2024.
- Bury currently ranks as having the 7th lowest rate of specific acute non-elective spells among the Greater Manchester (GM) localities.

Bury

Diagnostic 6ww: All

% of Patients waiting over 6 weeks for a diagnostic test or procedure

Source: Monthly Diagnostics Waiting Times and Activity Return - DM01 (Monthly)

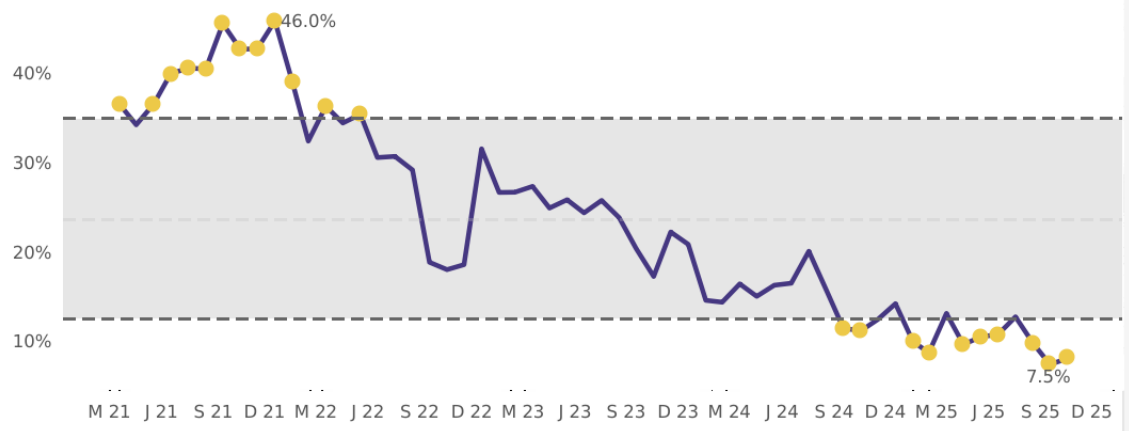
8.2%
November 2025

7.5%
October 2025

17/107
National Rank
Upper Quartile

1.%
National Target

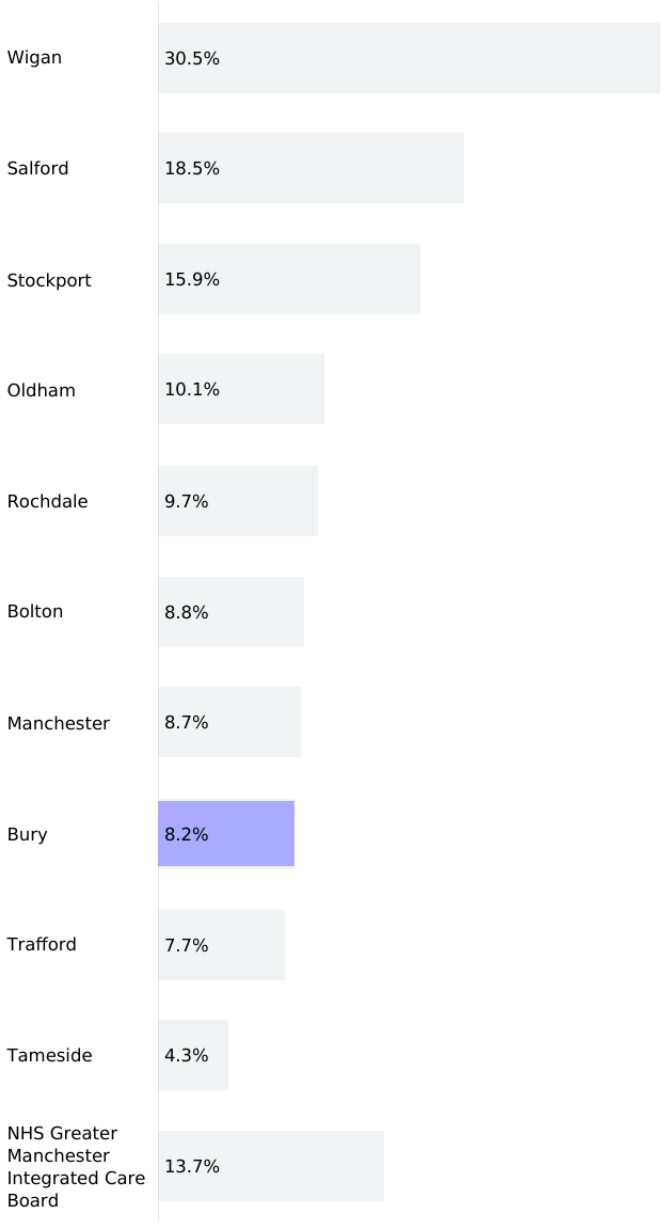
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	36.7%	34.4%	36.7%	40.1%	40.7%	40.6%	45.7%	42.8%	42.9%	46.0%	39.1%	32.5%
2022-23	36.4%	34.6%	35.5%	30.7%	30.8%	29.3%	19.0%	18.1%	18.7%	31.7%	26.8%	26.8%
2023-24	27.5%	25.0%	26.0%	24.5%	25.9%	24.0%	20.5%	17.4%	22.3%	21.0%	14.7%	14.5%
2024-25	16.5%	15.1%	16.4%	16.6%	20.2%	15.8%	11.6%	11.3%	12.6%	14.3%	10.1%	8.8%
2025-26	13.2%	9.7%	10.6%	10.9%	12.8%	9.9%	7.5%	8.2%				

Selected measure at November 2025 has continuously increased for 1 period(s) of time

Latest Value GM Benchmarking
National Rank against other localities



Narrative

- In Nov 2025, 8.2% of patients in Bury were waiting more than six weeks for a diagnostic test. This represents an increase from 7.5 % in Oct 2025 but a decrease from Nov 2024 which represented 11.3%.
- Bury's performance is better than the Greater Manchester (GM) average, which is 13.7%.
- Bury and GM are both above the less than 1% target.

Bury

RTT incomplete: 65+ week waits

"The number of 65+ week incomplete RTT pathways based on data provided by NHS and independent sector organisations and reviewed by NHS commissioners via SDCS.
The definitions that apply for RTT waiting times, as well as guidance on recording and reporting RTT data, can be found on the NHS England and NHS Improvement Consultant-led referral to treatment waiting times rules and guidance webpage."

Source: Consultant-led RTT Waiting Times data collection (National Statistics). (Monthly)

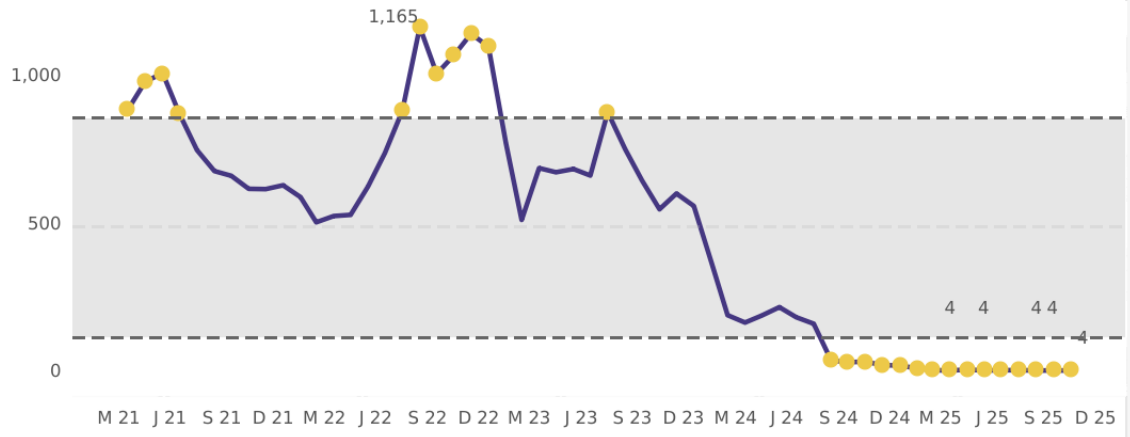
4.000
November 2025

4
October 2025

5/121
National Rank
Upper Quartile

0.
National Target

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	888	980	1,009	871	749	678	662	618	617	630	590	505
2022-23	526	530	626	739	882	1,165	1,007	1,070	1,142	1,099	773	513
2023-24	688	674	685	663	877	752	646	549	602	560	371	191
2024-25	166	190	218	184	162	38	32	34	22	21	11	5
2025-26	4	7	4	5	5	4	4	4				

Selected measure at November 2025 has continuously for **2** period(s) of time

Latest Value GM Benchmarking
National Rank against other localities

Narrative

- As of Nov 2025, there were 4 patients from Bury experiencing waits of 65 weeks or more, matching the figure from Oct 2025 when there were also 4 patients.
- This also reflects a reduction when compared to Nov 2024, when 34 patients were recorded.
- Bury currently holds the position of having the 4th lowest number of 65+ week waits among the Greater Manchester (GM) localities.

Bury

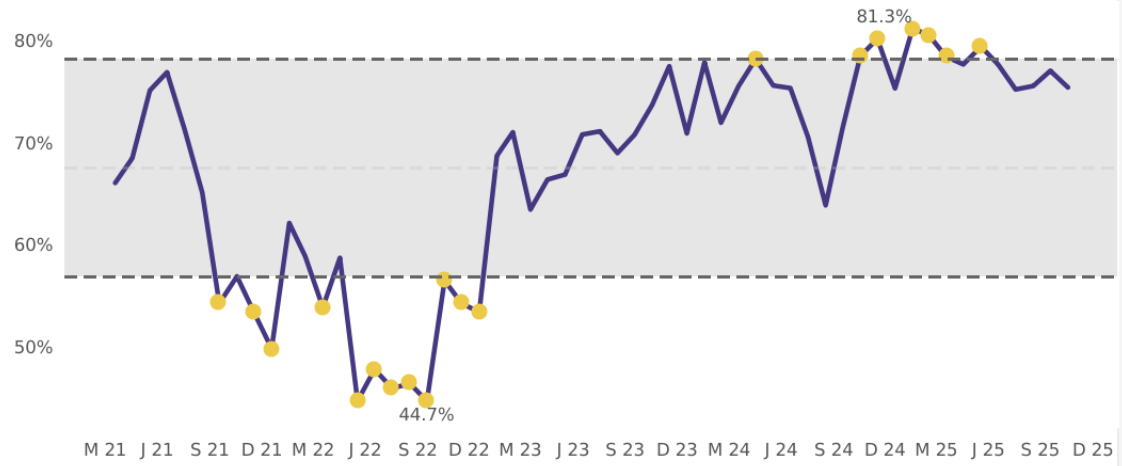
28 Day Wait from Referral to Faster Diagnosis (Monthly): All Patients

Proportion of patients told cancer diagnosis outcome within 28 days of their urgent referral for suspected cancer, referral for breast symptoms, or urgent screening referral

Source: National Cancer Waiting Times Monitoring Data Set (CWT) (Monthly)

75.5%	77.2%	64/106	80.%
November 2025	October 2025	National Rank Inter Quartile	National Target

Outliers more than 1 standard deviation from the mean

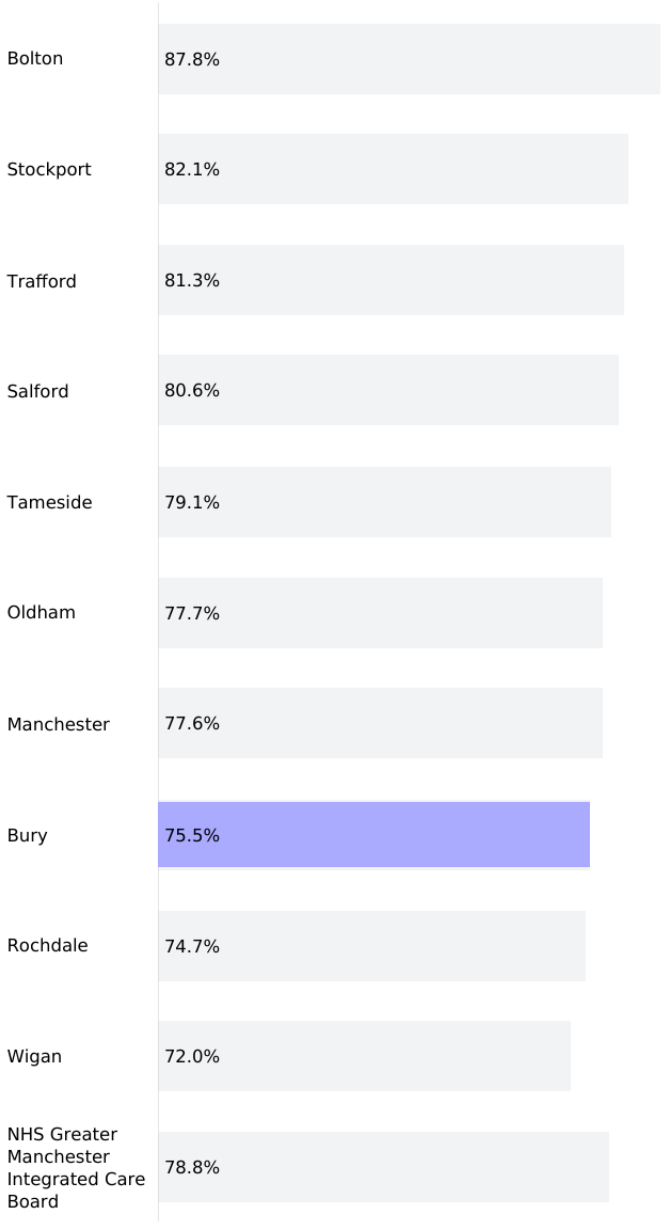


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	66.2%	68.6%	75.2%	77.0%	71.4%	65.2%	54.3%	57.0%	53.4%	49.9%	62.2%	58.9%
2022-23	53.9%	58.8%	44.7%	47.8%	46.0%	46.4%	44.7%	56.6%	54.3%	53.5%	68.8%	71.1%
2023-24	63.5%	66.5%	67.0%	70.9%	71.2%	69.1%	70.9%	73.8%	77.6%	71.0%	78.0%	72.1%
2024-25	75.7%	78.3%	75.7%	75.5%	70.7%	64.0%	71.6%	78.6%	80.3%	75.4%	81.3%	80.7%
2025-26	78.6%	77.8%	79.5%	77.8%	75.3%	75.7%	77.2%	75.5%				

Selected measure at November 2025 has continuously decreased for 1 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities



Narrative

- In Nov 2025, 75.5% of patients in Bury received their cancer diagnosis outcome within 28 days following a two-week wait (2WW) referral. This marks a decrease from 77.2% in Oct 2025, as also a decrease from 78.6% in Nov 2024.
- Bury is currently ranked as the 8th highest performing area within Greater Manchester (GM) for this indicator.
- The GM average for Nov 2025 is 78.8%, which remains below the national target of 80%.
- Consequently, both Bury and the wider GM regions (excluding Bolton, Stockport, Trafford and Salford) are operating below the national standard for the timely communication of cancer diagnoses.

Bury

COVER immunisation: MMR2 Uptake at 5 years old

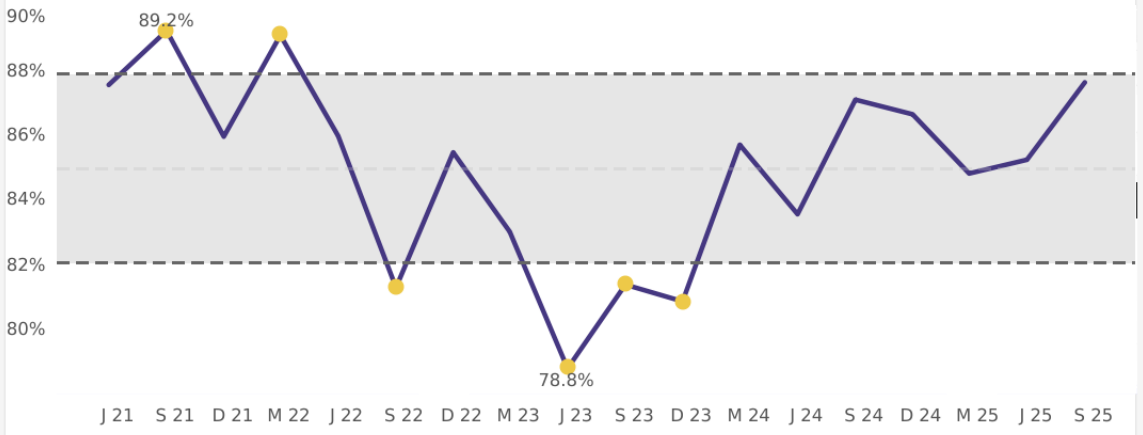
Population vaccination coverage – MMR for two doses (5 years old)

Source: Cover of vaccination evaluated rapidly (COVER) programme (Quarterly)

87.6%
September 2025

95.%
National Target

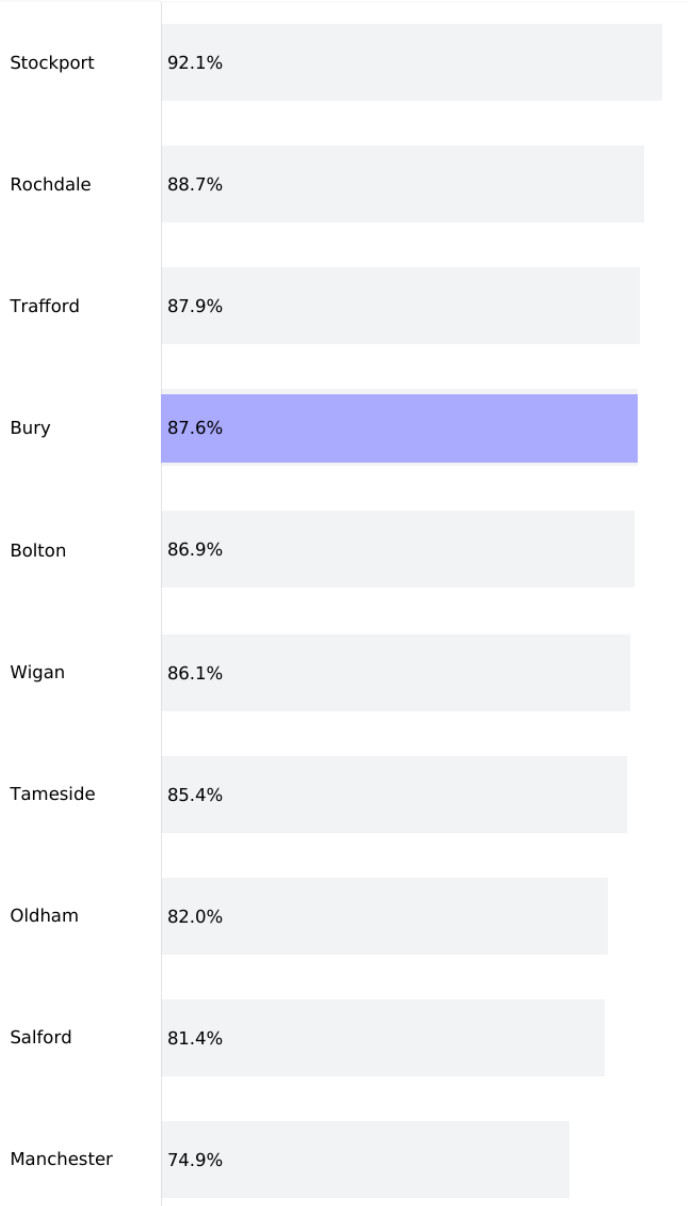
Outliers more than 1 standard deviation from the mean



	Jun	Sep	Dec	Mar
2021-22	87.6%	89.2%	86.0%	89.1%
2022-23	86.0%	81.3%	85.5%	83.0%
2023-24	78.8%	81.4%	80.9%	85.7%
2024-25	83.6%	87.1%	86.7%	84.8%
2025-26	85.3%	87.6%		

Selected measure at September 2025 has continuously increased for 2 period(s) of time

Latest Value GM Benchmarking
National Rank against other localities



Narrative

- As of Sept 2025, the MMR2 uptake rate at age five years in Bury stands at 87.6%, representing an increase from 85.3% in June 2025.
- Among the GM localities, Bury ranks fourth.
- However, both Bury, and all other GM localities remain below the national target of 95%.

Bury

Females, 25-64, attending cervical screening within target period (3.5 or 5.5 year coverage, %)

The overall cervical screening coverage: the number of women screened adequately in the previous 42 months (if aged 24-49) or 66 months (if aged 50-64) divided by the number of eligible women on last day of review period.

Source: Cervical Screening Programme - Coverage Statistics [Management Information] (Quarterly)

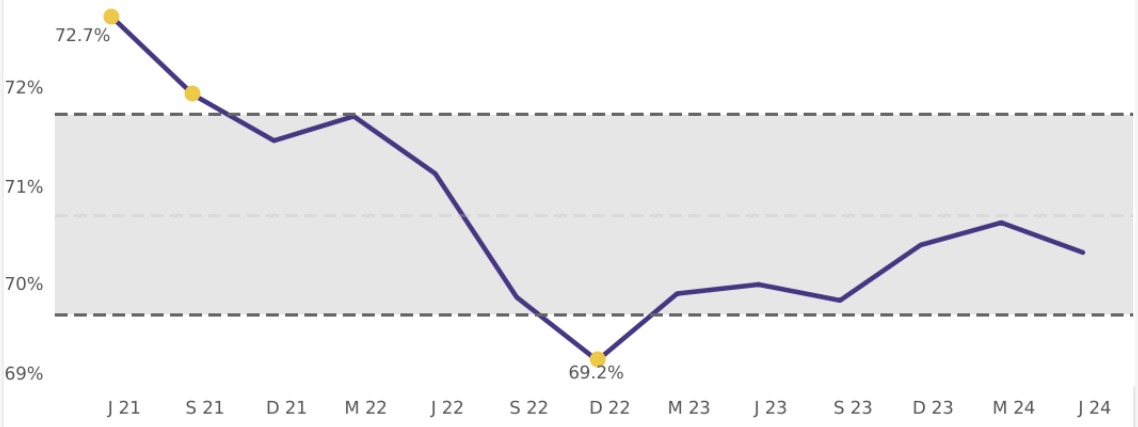
70.3%
June 2024

70.6%
March 2024

68/106
National Rank
Inter Quartile

80.%
National Target

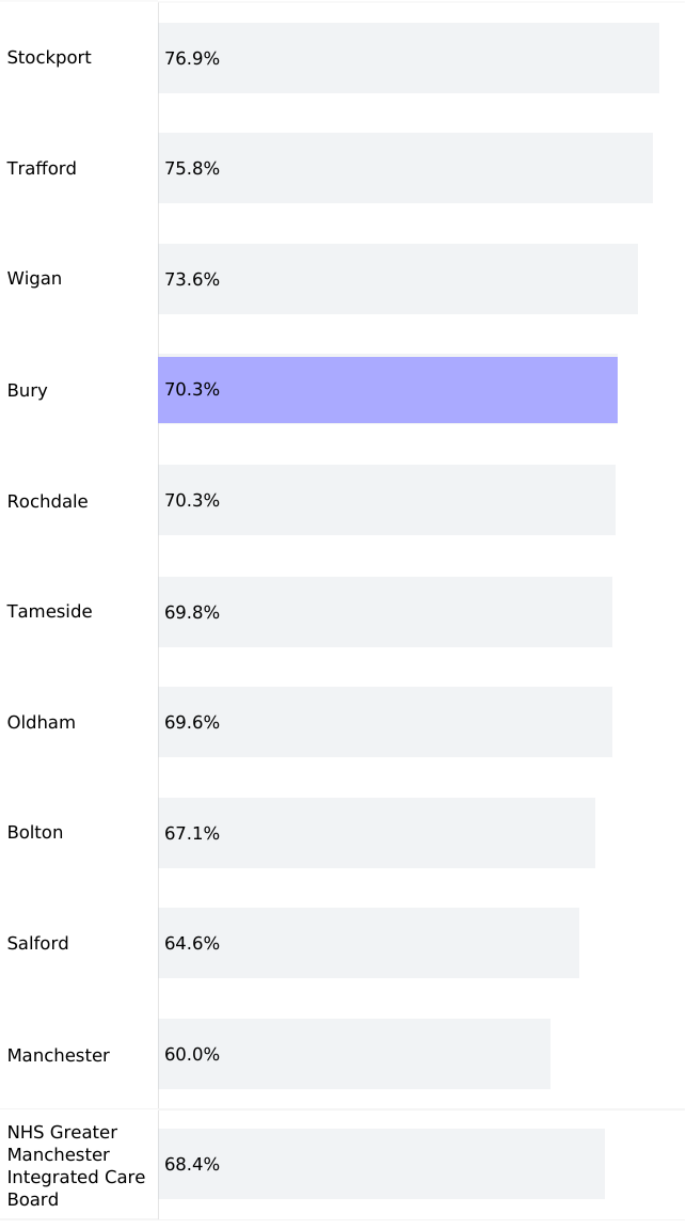
Outliers more than 1 standard deviation from the mean



	Jun	Sep	Dec	Mar
2021-22	72.7%	71.9%	71.5%	71.7%
2022-23	71.1%	69.9%	69.2%	69.9%
2023-24	70.0%	69.8%	70.4%	70.6%
2024-25	70.3%			

Selected measure at June 2024 has continuously decreased for 1 period(s) of time

Latest Value GM Benchmarking
National Rank against other localities



Narrative

- The GM Cancer Screening Dashboard, shows cervical screening coverage for Bury patients in Dec 2025 was 68% among individuals aged 24 to 49 years, and 74.6% among those aged 50 to 64 years.
- Both figures fall below the efficiency target of 80%.

Bury

Seasonal Flu Vaccine Uptake: 65 years and over

The uptake of seasonal influenza vaccination among those aged 65 and over

Source: Seasonal influenza vaccine uptake in GP patients: monthly data, 2022 to 2023 (Monthly)

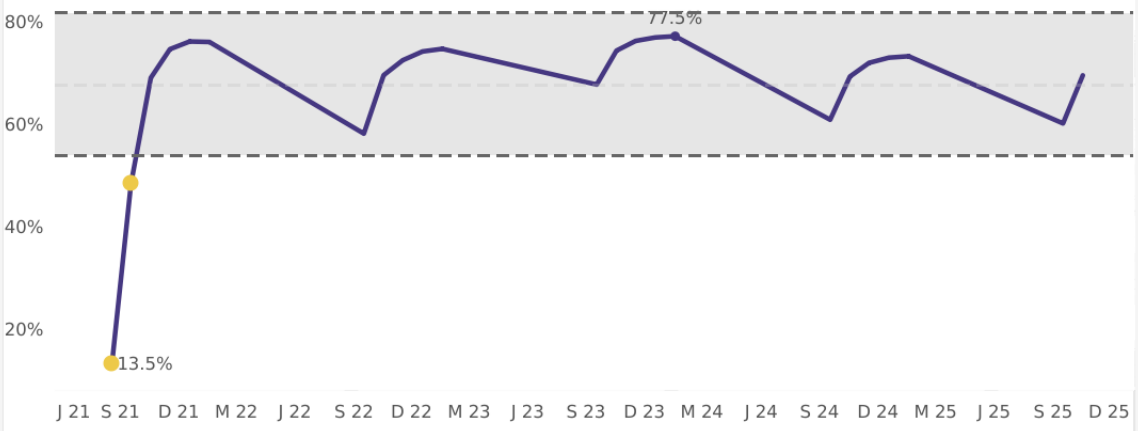
69.9%
November 2025

60.5%
October 2025

74/106
National Rank
Inter Quartile

85.%
National Target

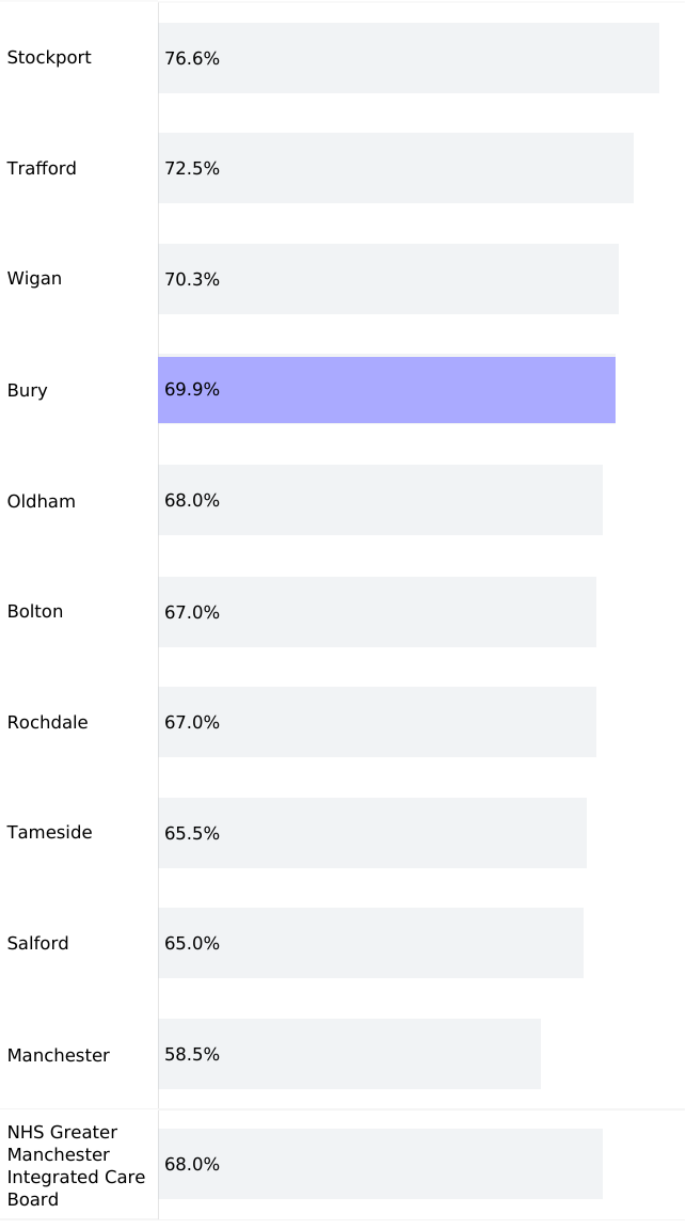
Outliers more than 1 standard deviation from the mean



	Sep	Oct	Nov	Dec	Jan	Feb
2021-22	13.5%	48.8%	69.4%	75.0%	76.5%	76.4%
2022-23		58.5%	69.9%	72.8%	74.6%	75.1%
2023-24		68.1%	74.7%	76.6%	77.3%	77.5%
2024-25		61.2%	69.7%	72.3%	73.3%	73.6%
2025-26		60.5%	69.9%			

Selected measure at November 2025 has continuously increased for 1 period(s) of time

Latest Value GM Benchmarking
National Rank against other localities



Narrative

The uptake of the seasonal Flu Vaccine 65 years and over rose to 69.9% in Nov 2025 an increase from Oct 2025. It is also an improvement from Nov 2024 when performance was reported as 69.7%

Bury

% 2-hour Urgent Community Response (UCR) first care contacts

Percentage of 2-hour UCR referrals subject to the 2-hour response standard (as specified in the UCR technical guidance), with an RTT end date in reporting month, that achieved the 2-hour response standards

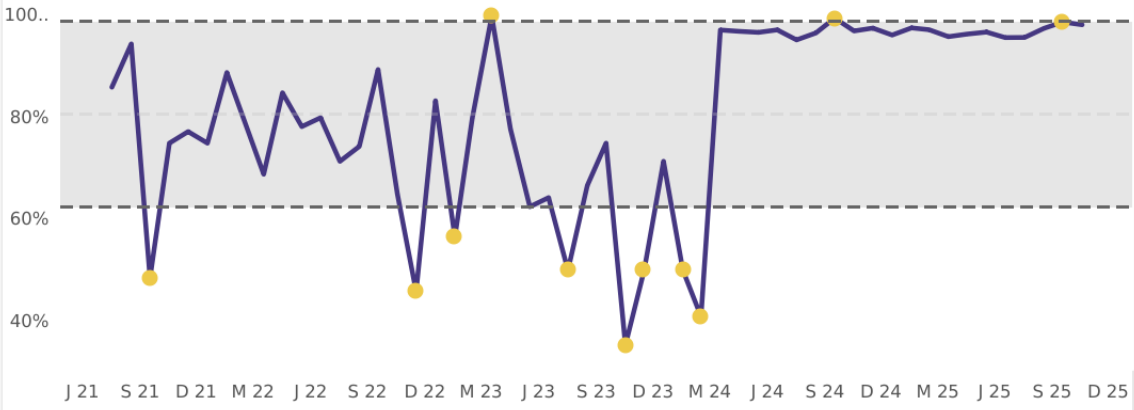
Source: Community Services Data Set (CSDS) (Monthly)

98.3%
November 2025

98.8%
October 2025

70%
National Target

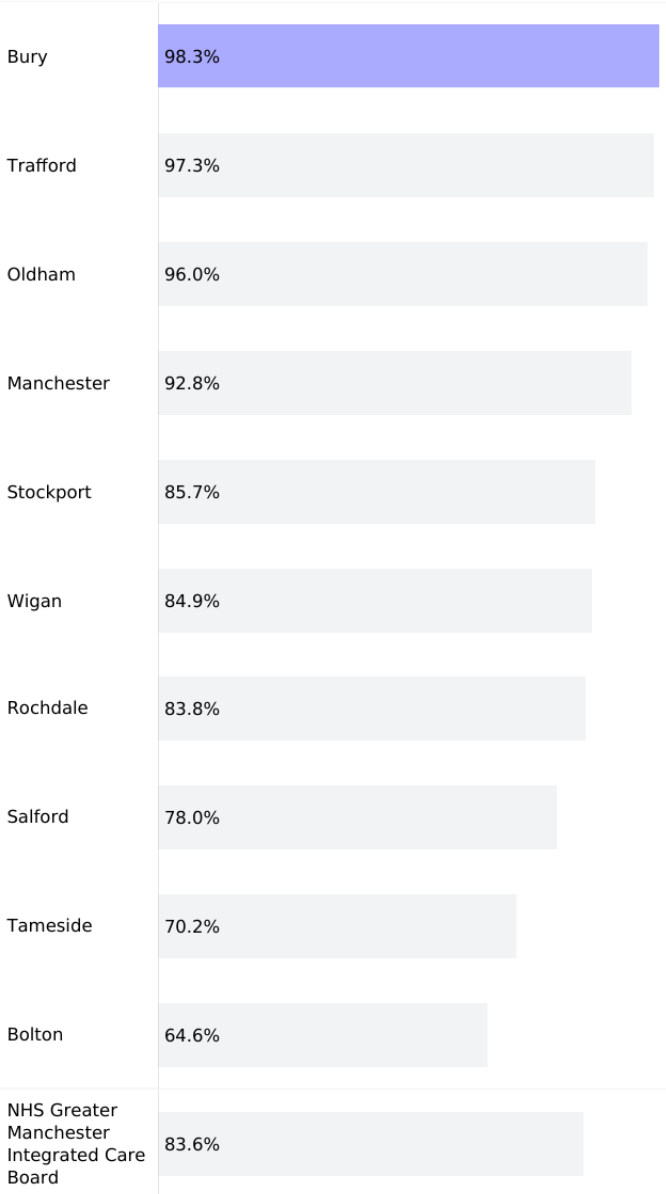
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22					86.0%	94.5%	48.5%	75.0%	77.3%	75.0%	88.9%	79.4%
2022-23	68.9%	84.9%	78.3%	80.0%	71.4%	74.4%	89.5%	65.0%	45.8%	83.3%	56.5%	80.0%
2023-24	100.0%	77.8%	62.5%	64.3%	50.0%	66.7%	75.0%	35.3%	50.0%	71.4%	50.0%	40.9%
2024-25	97.3%	97.0%	96.8%	97.3%	95.3%	96.7%	99.6%	97.1%	97.6%	96.3%	97.7%	97.3%
2025-26	96.0%	96.5%	96.9%	95.8%	95.8%	97.6%	98.8%	98.3%				

Selected measure at November 2025 has continuously decreased for 1 period(s) of time

Latest Value GM Benchmarking



Narrative

- In Nov 2025, 98.3% of Urgent Community Response (UCR) referrals for Bury-registered patients received a response within the two-hour standard. This represents a slight decrease from 98.8% in Oct 2025.
- Bury currently holds the highest performance among the Greater Manchester (GM) localities and exceeds the national target of 70%.

Oversight Metrics Glossary

Domain	Code	Measure	Description	Data Source	Frequency	Latest	Updated	RAG rated against	Desired Direc
Cancer	N/A	Cancers Diagnosed at an Early Stage (12-month rolling): All Tumours Staged within RCRD	12-month rolling count of cancers diagnosed at stages 1 and 2 divided by 12-month rolling count of cancers diagnosed at stages 1, 2, 3, and 4	Rapid Cancer Registration Data (RCRD) at Tumour Level	Monthly	Sep 25	2nd Thursday	National Target	Increase
	S086a	Inappropriate adult acute mental health Out of Area Placement (OAP) bed days	Inappropriate Out of Area Placements	Out of Area Placements in Mental Health Services Official Statistics	Monthly	Nov 25	2nd Thursday	National Target	Decrease
	S081a	Talking Therapies: Access Rate	Number of people accessing first treatment	Improving Access to Psychological Therapies Data Set	Monthly	Nov 25	2nd Thursday	No Target	Increase
	EAS01	Dementia: Diagnosis Rate (Aged 65+)	Dementia: Diagnosis Rate (Aged 65+)	Primary Care Dementia Data	Monthly	Nov 25	2nd Thursday	National Target	Increase
	S030a	% of patients aged 14+ with a completed LD health check	% of patients aged 14+ with a completed LD health check	Learning Disabilities Health Check Scheme	Monthly	Nov 25	2nd Thursday	National Target	Increase
	S110a	Overall Access to Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses	Number of people who receive two or more contacts from NHS or NHS commissioned community mental health services (in transformed and non-transformed PCNs) for adults and older adults wit..	Published MHSDS	Monthly	Nov 25	2nd Thursday	National Median	Increase
	S125a	Long length of stay for adults (60+ days)	Number of people for a given CCG discharged from an adult acute inpatient bed with a hospital spell over 60 days (calculated from the point of admission to the point of discharge)	Published MHSDS	Monthly	Nov 25	2nd Thursday	National Target	Decrease
	EH09	Access to Children and Young Peoples Mental Health Services	Number of CYP aged 0-17 supported through NHS funded mental health services receiving at least one contact.	Published MHSDS	Monthly	Nov 25	2nd Thursday	National Median	Increase
	S131a	Women Accessing Specialist Community Perinatal Mental Health Services	Number of women accessing specialist community PMH and MMHS services in the reporting period	Published MHSDS	Quarterly	Nov 25	2nd Thursday	No Target	Increase
	N/A	Number of MH patients with no criteria to reside (NCTR)	Number of MH patients with no criteria to reside	GM Admissions - Local	Monthly	Dec 25	1st	No Target	Decrease
	N/A	Percentage of MH patients with no criteria to reside (NCTR)	Percentage of MH patients with no criteria to reside	GM Admissions - Local	Monthly	Dec 25	1st	No Target	Decrease
	N/A	Proportion of routine eating disorder referrals cases entering treatment within four weeks, aged 0-18	Proportion of referrals with eating disorders categorized as routine cases entering treatment within four weeks in RP, aged 0-18	Published MHSDS	Monthly	May 25	2nd Thursday	National Target	Increase
Primary Care	S053b	% of hypertension patients who are treated to target as per NICE guidance		NHS Quality Outcome Framework	Annual	Mar 25	2nd Thursday	National Target	Increase
	S129a	GP appointments - percentage of regular appointments within 14 days	Percentage of appointments where the time between booking and appointment was 'Same day', '1 day', '2 to 7 days' or '8 to 14 days'	Appointments in General Practice	Monthly	Nov 25	Last Thursday	National Median	Increase
	S053c	% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins	% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins	CVD Prevent	Quarterly	Jun 25	2nd Thursday	National Median	Increase
Quality	S037A	% of patients describing the overall experience of their GP practice as good	The weighted percentage of people who report through the GP Patient Survey their overall experience of their GP practice as 'very good' or 'fairly good'	GP Patient Survey	Annual	Mar 23	2nd Thursday	National Median	Increase
	S042a	E. coli blood stream infections	12-month rolling counts of E. coli	National Statistics: E. coli bacteraemia: monthly data by loc..	Monthly	Nov 25	1st Wednesday	No Target	Decrease
	S044b	Antimicrobial resistance: proportion of broad-spectrum antibiotic prescribing in primary care	The proportion of broad-spectrum antibiotic prescribing in primary care	EPACT Prescribing Data	Monthly	Jun 25	2nd Thursday	National Target	Decrease
	S044a	Antimicrobial resistance: total prescribing of antibiotics in primary care	The proportion of antibiotic prescribing in primary care	EPACT Prescribing Data	Monthly	Jun 25	2nd Thursday	National Target	Decrease

Sight Metrics Glossary

Domain	Code	Measure	Description	Data Source	Frequency	Latest	RAG rated against	Target/National
Elective Care	EB20	RTT incomplete: 65+ week waits		Consultant-led RTT Waiting Times data collection (National Statistics).	Monthly	Nov 25	National Target	0.
	EB28	Diagnostic 6ww: All	% of Patients waiting over 6 weeks for a diagnostic test or procedure	Monthly Diagnostics Waiting Times and Activity Return - DM01	Monthly	Nov 25	National Target	1.%
Cancer	S012a	28 Day Wait from Referral to Faster Diagnosis (Monthly): All Patients	Count of patients told cancer diagnosis outcome within 28 days divided by total count of patients told cancer diagnosis outcome following their urgent referral for suspected cancer, referral for breast symptoms, or urgent screening referral	National Cancer Waiting Times Monitoring Data Set (CWT)	Monthly	Nov 25	National Target	80.%
Materni..	S022a	Number of stillbirths per 1,000 total births	Count of cancers diagnosed at stages 1 and 2 divided by count of cancers diagnosed at stages 1, 2, 3, and 4	MBRRACE-UK - Perinatal Mortality Surveillance Report	Annual	Dec 23	National Median	3
	S104a	Number of neonatal deaths per 1,000 total live births	Number of neonatal deaths per 1,000 total live births	MBRRACE-UK - Perinatal Mortality Surveillance Report	Annual	Dec 23	National Median	1
Screening and Immunisations	S047A	Seasonal Flu Vaccine Uptake: 65 years and over	number of people over 65 who received the seasonal influenza vaccination divided by the number of eligible people who are aged 65 and over	Seasonal influenza vaccine uptake in GP patients: monthly data, 2022 to 2023	Monthly	Nov 25	National Target	85.%
	S046a	COVER immunisation: MMR2 Uptake at 5 years old	% children whose fifth birthday falls within the time period who have received two doses of MMR vaccination	Cover of vaccination evaluated rapidly (COVER) programme	Quarterly	Sep 25	National Target	95.%
	S050a	Females, 25-64, attending cervical screening within target period (3.5 or 5.5 year coverage, %)	% of females, age 25-64 yrs, attending cervical screening within target period (3.5 yrs if aged 24-49 or 5.5 yrs if aged 50-64)	Cervical Screening Programme - Coverage Statistics [Management Information]	Quarterly	Jun 24	National Target	80.%
	S049a	Breast screening coverage, females aged 53-70, screened in last 36 months	% women eligible for screening who have had a test with a recorded result at least once in the previous 36 months	Fingertips, Public Health Data, Public Health Outcomes Framework	Annual	Dec 24	No Target	
Commu..	N/A	% 2-hour Urgent Community Response (UCR) first care contacts	Percentage of 2-hour Urgent Community Response referrals subject to the 2-hour standard where care was provided within two hours	Community Services Data Set (CSDS)	Monthly	Nov 25	National Target	

Bury

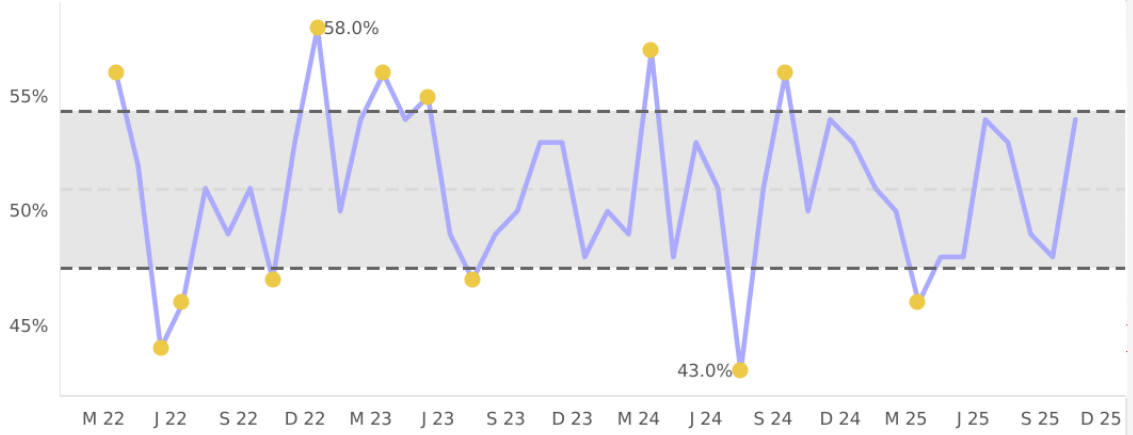
Talking Therapies: Recovery Rate

The proportion of people who complete treatment who are moving to recovery

Source: Improving Access to Psychological Therapies Data Set (Monthly)

54.0%	48.0%	19/110	50.%
November 2025	October 2025	National Rank Upper Quartile	National Target

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	56.0%	52.0%	44.0%	46.0%	51.0%	49.0%	51.0%	47.0%	53.0%	58.0%	50.0%	54.0%
2023-24	56.0%	54.0%	55.0%	49.0%	47.0%	49.0%	50.0%	53.0%	53.0%	48.0%	50.0%	49.0%
2024-25	57.0%	48.0%	53.0%	51.0%	43.0%	51.0%	56.0%	50.0%	54.0%	53.0%	51.0%	50.0%
2025-26	46.0%	48.0%	48.0%	54.0%	53.0%	49.0%	48.0%	54.0%				

Selected measure at November 2025 has continuously increased for 1 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities

Narrative

- Nov 25 data shows a Talking Therapies recovery rate with 54.0%, an improvement on the previous month.
- This is above than the performance in the same period last year, which was 50.0%.
- Currently, Bury ranks as the Manchester (GM) localities in terms of Talking Therapies recovery rate.

Bury

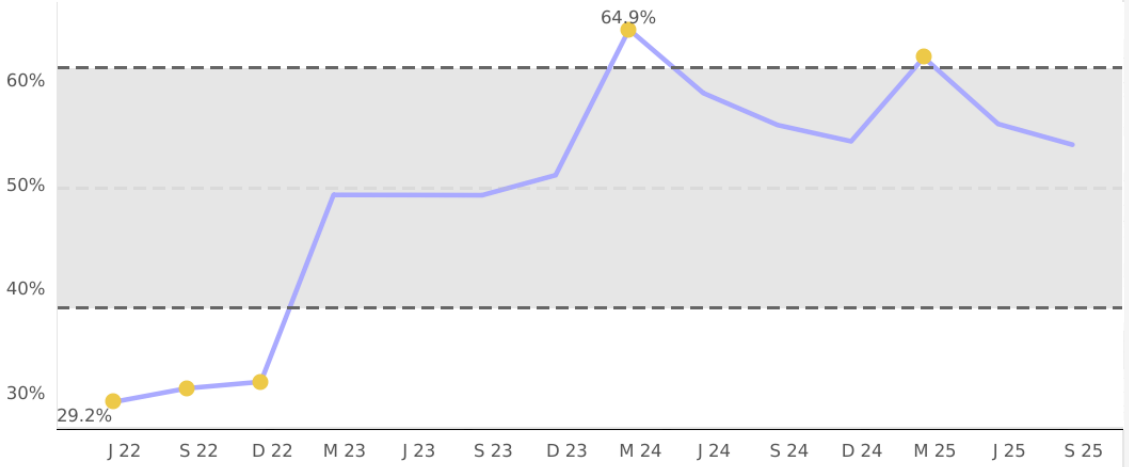
% of people with SMI to receive all six physical health checks in the preceding 12 months. - Mental Health Patients

People with severe mental illness receiving a full annual physical health check and follow up interventions

Source: Physical Health Checks for people with Severe Mental Illness (Quarterly)

53.9%	55.9%	82/106	60.%
September 2025	June 2025	National Rank Lower Quartile	National Target

Outliers more than 1 standard deviation from the mean



	Jun	Sep	Dec	Mar
2022-23	29.2%	30.5%	31.1%	49.1%
2023-24	49.0%	49.0%	50.9%	64.9%
2024-25	58.8%	55.8%	54.2%	62.2%
2025-26	55.9%	53.9%		

Selected measure at September 2025 has continuously **decreased** for **2** period(s) of time

Latest Value GM Benchmarking

National Rank against other localities

16	Salford	65.1%
19	Wigan	63.4%
26	Oldham	62.7%
31	Stockport	62.0%
35	Trafford	61.6%
38	Rochdale	60.9%
43	Bolton	60.5%
67	Manchester	55.9%
81	Tameside	54.3%
82	Bury	53.9%
15	NHS Greater Manchester Integrated Care Board	59.7%

Narrative

- Published data indicates that, as of Dec 2025, 54.7% of individuals registered in Bury with a serious mental illness (SMI) had completed all six recommended physical health checks within the preceding 12 months. This equates to 1,124 out of 2,054 eligible patients.
- In comparison, the Greater Manchester (GM) average for the same period was 60.6%, indicating that Bury is currently performing below the GM average.

Bury

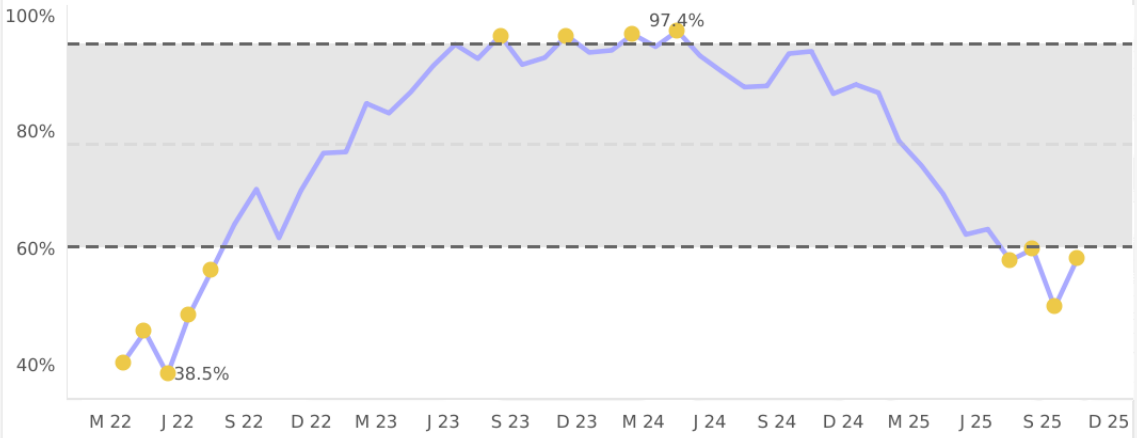
Talking Therapies: 6 Week Waits

The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period.

Source: Improving Access to Psychological Therapies Data Set (Monthly)

58.3%	50.0%	105/110	75.%
November 2025	October 2025	National Rank Lower Quartile	National Target

Outliers more than 1 standard deviation from the mean

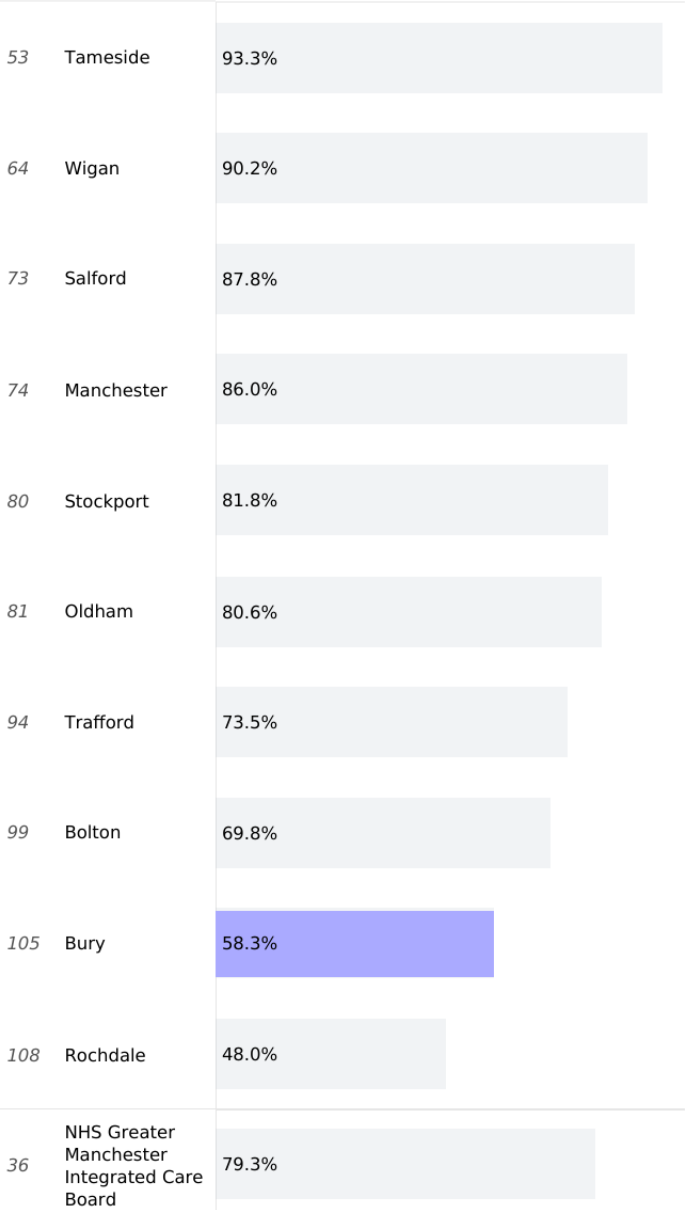


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	40.5%	45.8%	38.5%	48.7%	56.4%	64.3%	70.3%	61.9%	70.0%	76.5%	76.7%	85.0%
2023-24	83.3%	87.0%	91.5%	95.1%	92.7%	96.7%	91.7%	92.9%	96.7%	93.8%	94.1%	96.9%
2024-25	94.7%	97.4%	93.2%	90.5%	87.8%	88.0%	93.5%	93.9%	86.7%	88.2%	86.8%	78.6%
2025-26	74.4%	69.4%	62.5%	63.4%	58.1%	60.0%	50.0%	58.3%				

Selected measure at November 2025 has continuously increased for 1 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities



Narrative

- In Nov 2025, 58.3% of patients waited six weeks or less from referral to starting IAPT treatment, marking an improvement from 50% the previous month. This is also a decline compared to Nov 2024, when the performance was 93.9%.
- Bury's current performance falls below both the Greater Manchester (GM) average of 79.3% and the national target of 75%.
- While Bury did not meet the national target of 75%, Greater Manchester succeeded in achieving it.

Bury

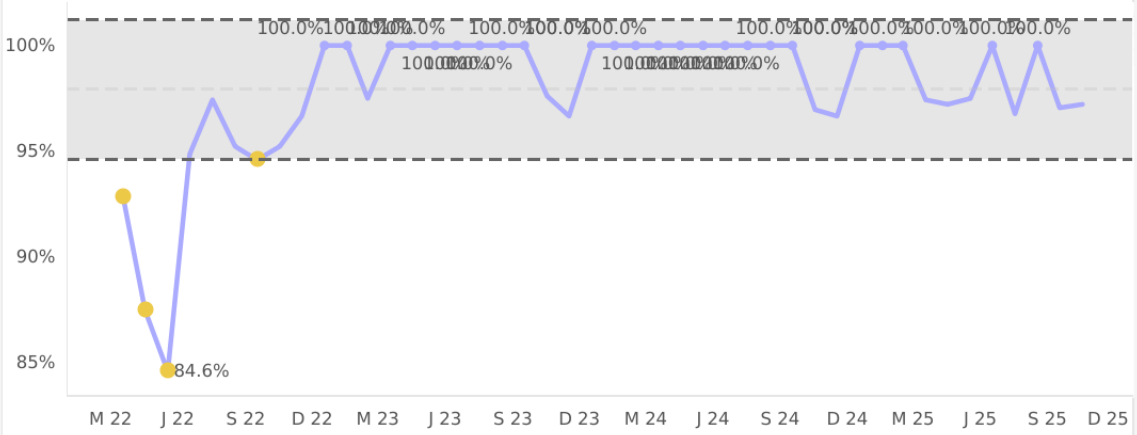
Talking Therapies: 18 Week Waits

The proportion of people that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period.

Source: Improving Access to Psychological Therapies Data Set (Monthly)

97.2%	97.1%	87/110	95.%
November 2025	October 2025	National Rank Lower Quartile	National Target

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	92.9%	87.5%	84.6%	94.9%	97.4%	95.2%	94.6%	95.2%	96.7%	100.0%	100.0%	97.5%
2023-24	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.6%	96.7%	100.0%	100.0%	100.0%
2024-25	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.0%	96.7%	100.0%	100.0%	100.0%
2025-26	97.4%	97.2%	97.5%	100.0%	96.8%	100.0%	97.1%	97.2%				

Selected measure at November 2025 has continuously increased for 1 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities

3	Salford	100.0%
	Tameside	100.0%
83	Manchester	98.0%
84	Stockport	97.7%
87	Bury	97.2%
	Oldham	97.2%
89	Trafford	97.1%
97	Rochdale	96.0%
98	Wigan	95.1%
108	Bolton	85.7%
37	NHS Greater Manchester Integrated Care Board	96.2%

Narrative

- In Nov 2025, there were 97.2% of patients that waited 18 weeks or less from referral to entering IAPT treatment. This represents a slight improvement from 97.1% in Oct 2025.
- Bury's performance remains above the national target of 95% and is also higher than the Greater Manchester (GM) average of 96.2%.
- Bury ranks as the 5th highest among the GM localities.

Bury

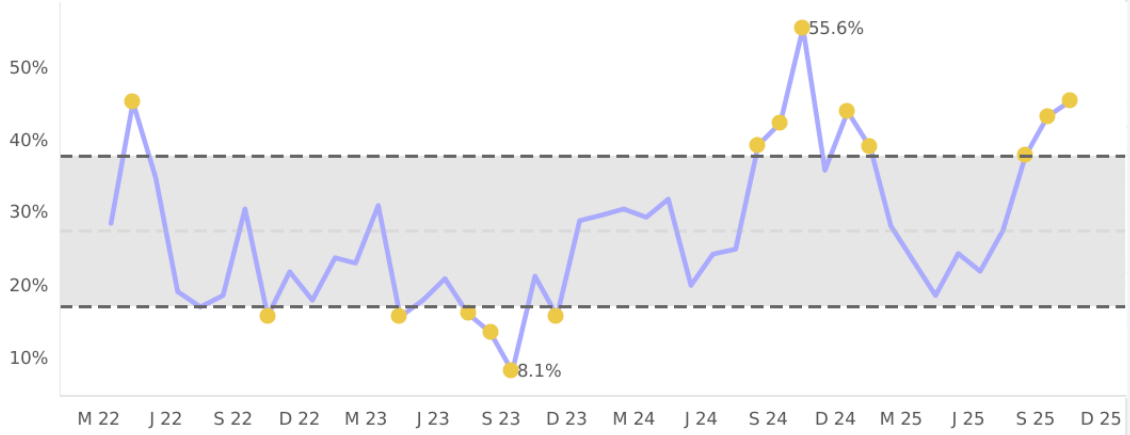
Talking Therapies: Second Treatment Waits

The proportion of people that waited more than 90 days from their first treatment appointment to their second treatment appointment.

Source: Improving Access to Psychological Therapies Data Set (Monthly)

45.5%	43.3%	90/104	10.%
November 2025	October 2025	National Rank Lower Quartile	National Target

Outliers more than 1 standard deviation from the mean

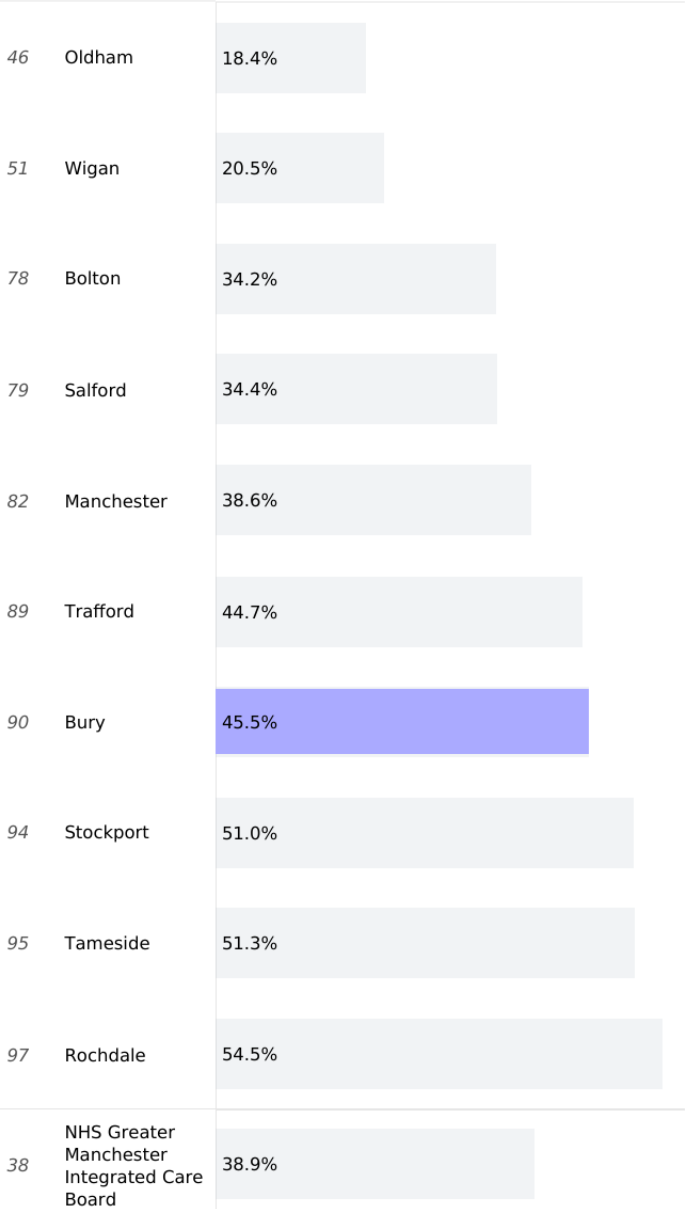


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	28.6%	45.3%	34.9%	19.1%	17.0%	18.6%	30.6%	15.8%	21.9%	17.9%	23.8%	23.1%
2023-24	31.0%	15.7%	17.9%	20.9%	16.1%	13.5%	8.1%	21.3%	15.8%	28.9%	29.7%	30.6%
2024-25	29.4%	31.9%	20.0%	24.3%	25.0%	39.4%	42.4%	55.6%	35.9%	44.0%	39.0%	28.2%
2025-26	23.3%	18.6%	24.4%	22.0%	27.6%	37.9%	43.3%	45.5%				

Selected measure at November 2025 has continuously increased for 4 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities



Narrative

- In Nov 2025, 45.5% of patients in Bury attended their second appointment within 90 days of their first, reflecting an increase since Oct 2025 (43.3%).
- This performance is above the Greater Manchester (GM) average of 38.9%. Bury currently ranks the 7th lowest among all GM localities for this measure.
- Both Bury and GM remain above the national target of 10%

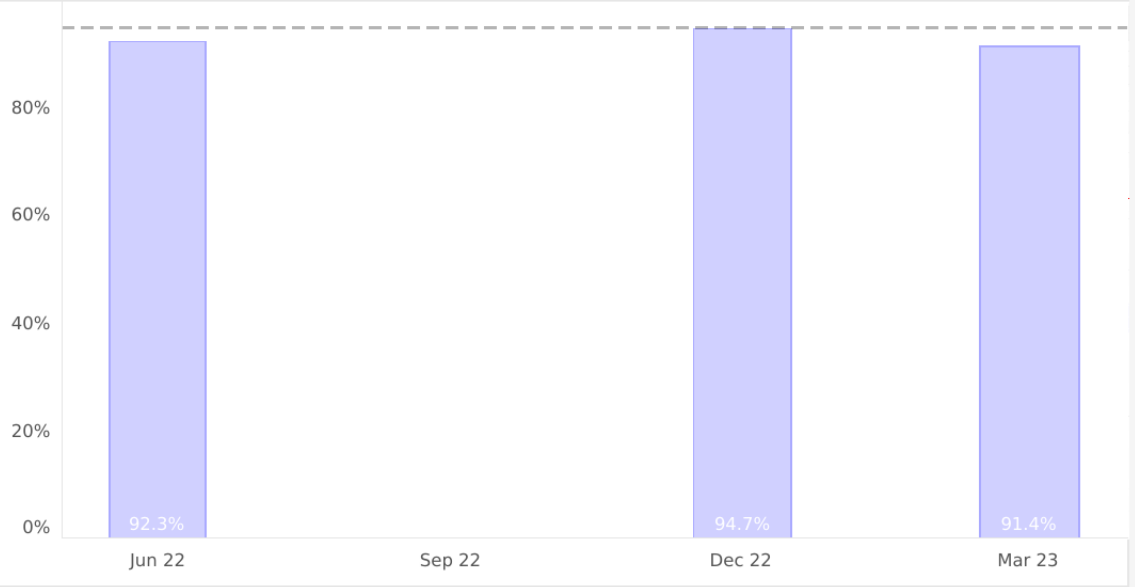
Bury

CYP Eating Disorders: Routine - % within 4 weeks

C&YP Routine Eating Disorders: 4 Week Waits (Rolling 12 mths)

Source: Children and Young People with an Eating Disorder: Waiting Times. (Quarterly)

91.4%	94.7%	47/107	95.%
March 2023	December 2022	National Rank Inter Quartile	National Target



	Jun	Dec	Mar
2022-23	92.3%	94.7%	91.4%

Selected measure at March 2023 has continuously **decreased** for **1** period(s) of time

Latest Value GM Benchmarking

National Rank against other localities

18	Salford	100.0%
28	Trafford	98.5%
30	Manchester	97.7%
34	Rochdale	96.3%
39	Stockport	94.5%
45	Oldham	92.0%
47	Bury	91.4%
51	Bolton	89.5%
52	Wigan	89.4%
56	Tameside	84.6%
11	NHS Greater Manchester Integrated Care Board	94.7%

Narrative

- Data taken from the Greater Manchester Eating Disorder Dashboard, shows 50% of patients with routine eating disorders in the Children and Young People (CYP) category were seen within four weeks during Oct 2025. Specifically, 2 out of 4 patients received care within the four-week target timeframe.

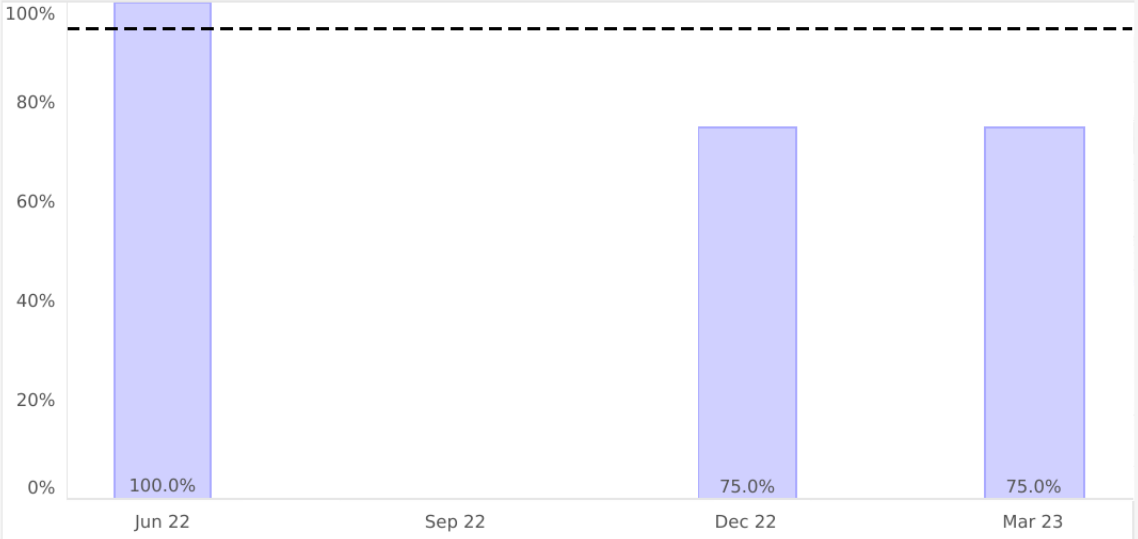
Bury

CYP Eating Disorders: Urgent - % within 1 week

C&YP Urgent Eating Disorders: 1 Week Waits (Rolling 12 mths)

Source: Children and Young People with an Eating Disorder: Waiting Times. (Quarterly)

75.0%	75.0%	75/107	95.%
March 2023	December 2022	National Rank Inter Quartile	National Target

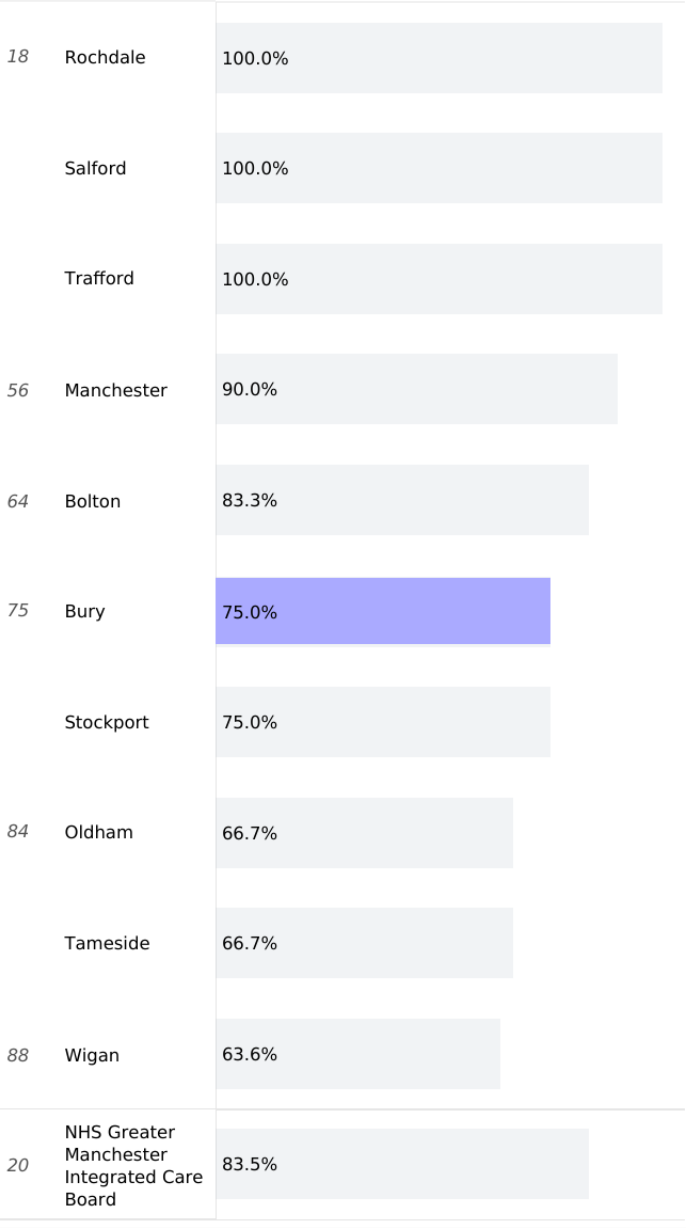


	Jun	Dec	Mar
2022-23	100.0%	75.0%	75.0%

Selected measure at March 2023 has continuously for **1** period(s) of time

Latest Value GM Benchmarking

National Rank against other localities



Narrative

- Data from the GM Eating Disorder Dashboard indicates that there were no Children and Young People (CYP) with an urgent eating disorder requirement in Oct 2025.

Bury

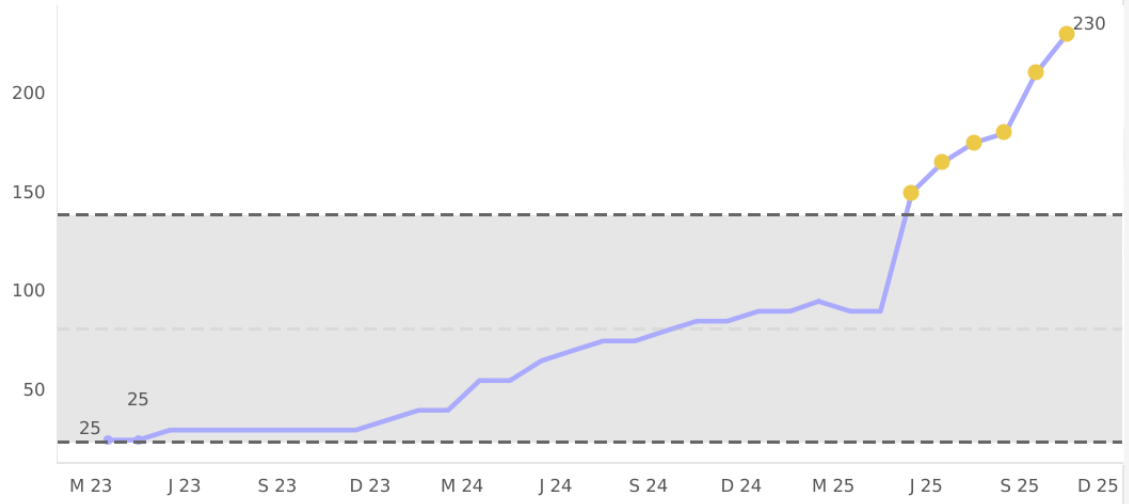
Access to Individual Placement and Support Services - Mental Health Patients

Access to Individual Placement and Support Services

Source: Published MHSDS (Monthly)

230	210	66/106	290.0
November 2025	October 2025	National Rank Inter Quartile	National Median

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023-24	25	25	30	30	30	30	30	30	30	35	40	40
2024-25	55	55	65	70	75	75	80	85	85	90	90	95
2025-26	90	90	150	165	175	180	210	230				

Selected measure at November 2025 has continuously increased for **6** period(s) of time

Latest Value GM Benchmarking

Rate Per 1000 | Count (National Rank)

Salford	1.74	550 (27)
Tameside	1.16	260 (62)
Stockport	1.13	370 (44)
Rochdale	1.10	275 (56)
Bury	1.09	230 (66)
Trafford	1.09	270 (58)
Wigan	1.06	370 (44)
Manchester	0.99	725 (16)
Oldham	0.88	235 (64)
Bolton	0.85	280 (54)

Narrative

- The number of individuals accessing Individual Placement and Support (IPS) Services rose to 230 in Nov 2025, compared to 210 in Oct 2025 and 85 in Nov 2024.
- Bury presently records an access rate of 1.09 per 1,000 population, placing it 5th among the localities within Greater Manchester.

Bury

Percentage of CYP receiving Autism assessment within 18 weeks of referral

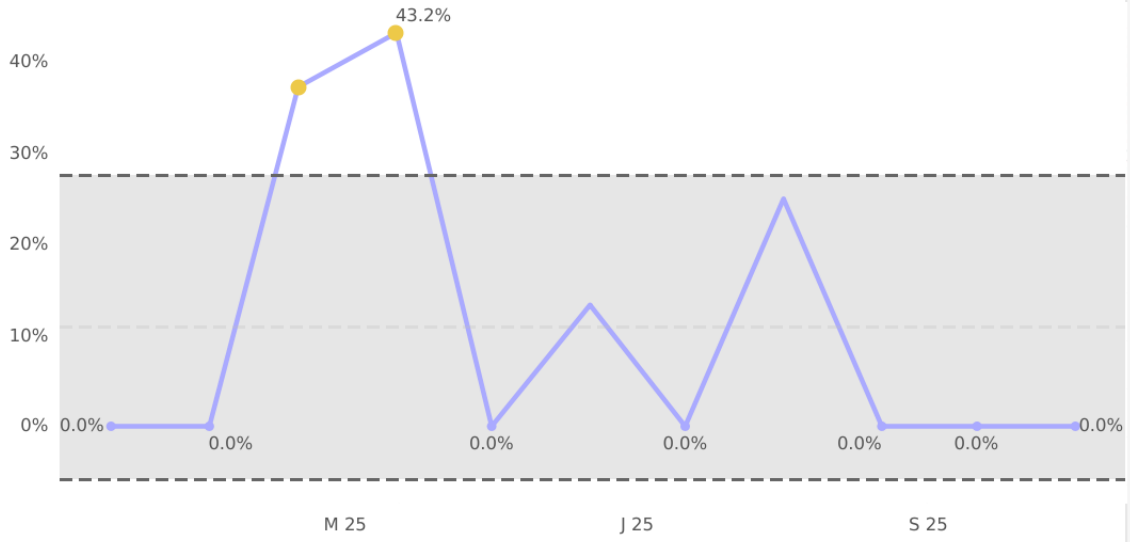
Percentage of CYP receiving Autism assessment within 18 weeks of referral

Source: Local Autism_ADHD Submission (Monthly)

0.0%
November 2025

0.0%
September 2025

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Jan	Feb	Mar
2023-24											
2024-25									0.0%	0.0%	37.3%
2025-26	43.2%	0.0%	13.3%	0.0%	25.0%	0.0%	0.0%	0.0%			

Selected measure at November 2025 has continuously for **2** period(s) of time

Latest Value GM Benchmarking

Narrative

- In Nov 2025, 0% of CYP received an autism assessment within 18 weeks of referral, matching the previous month.
- Please note: Figures may be different to those reported locally due to differences in methodology between NHS England and local providers. A paper is being drafted to explore solutions.

Bury

Percentage of CYP receiving ADHD assessment within 18 weeks of referral

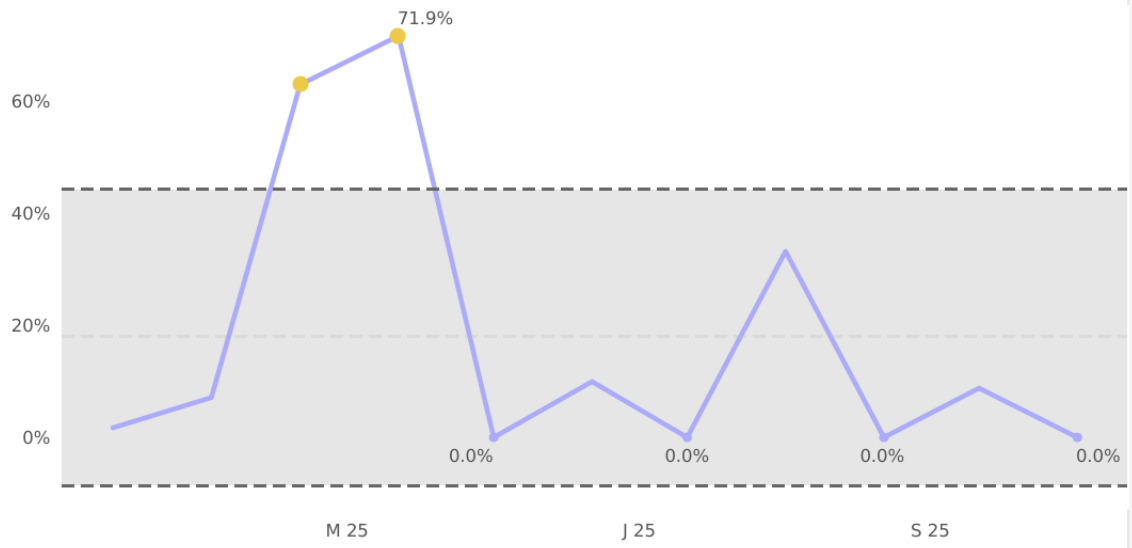
Percentage of CYP receiving ADHD assessment within 18 weeks of referral

Source: Local Autism_ADHD Submission (Monthly)

0.0%
November 2025

8.8%
September 2025

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Jan	Feb	Mar
2023-24											
2024-25									1.7%	7.1%	63.2%
2025-26	71.9%	0.0%	10.0%	0.0%	33.3%	0.0%	8.8%	0.0%			

Selected measure at November 2025 has continuously decreased for 1 period(s) of time

Latest Value GM Benchmarking

Wigan	75.0%
Oldham	66.7%
Manchester	29.4%
Trafford	15.8%
Salford	12.5%
Bolton	0.0%
Bury	0.0%
Rochdale	0.0%
Stockport	0.0%
Tameside	0.0%
NHS Greater Manchester Integrated Care Board	20.2%

Narrative

- In Nov 2025, 0% of CYP receiving an ADHD assessment within 18 weeks of referral, down from 8.8% the previous month.
- Please note: Figures may be different to those reported locally due to differences in methodology between NHS England and local providers. A paper is being drafted to explore solutions.

Bury

Autism average wait in weeks from referral to first assessment - Mental Health Patients

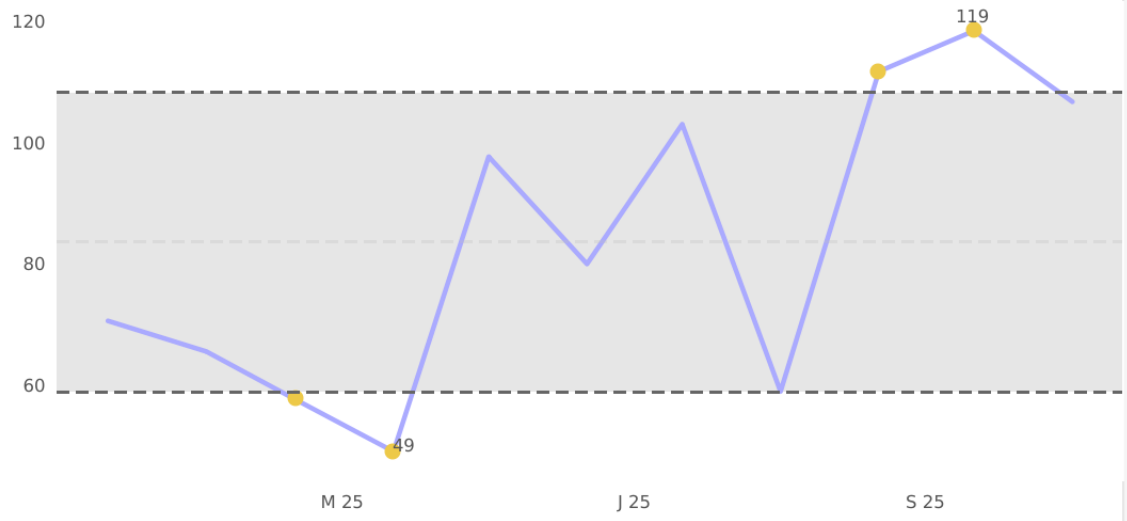
Autism average wait in weeks from referral to first assessment

Source: Local Autism_ADHD Submission (Monthly)

107
November 2025

119
September 2025

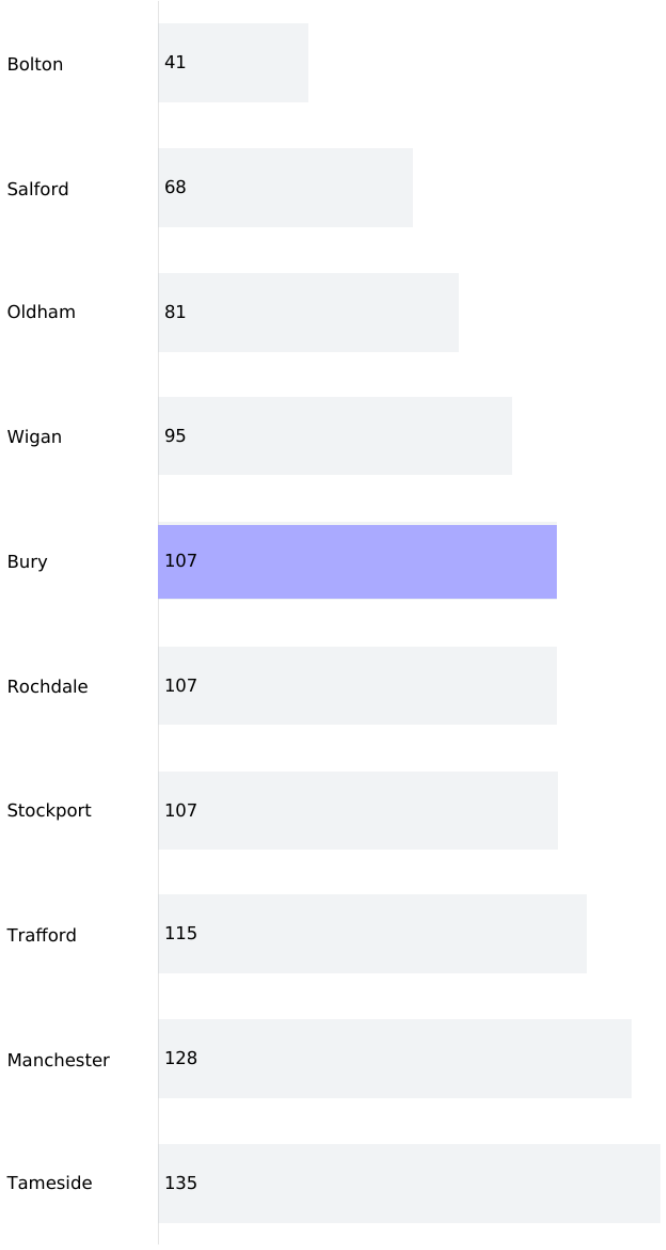
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Jan	Feb	Mar
2023-24											
2024-25									71	66	58
2025-26	49	98	80	103	59	112	119	107			

Selected measure at November 2025 has continuously decreased for 1 period(s) of time

Latest Value GM Benchmarking



Narrative

- In Nov 2025, the average waiting time for autism assessments, measured from referral to first assessment, was 107 weeks. This represents a decrease compared to Oct 2025, when figures show patients were waiting 119 weeks.

- Please note: Figures may be different to those reported locally due to differences in methodology between NHS England and local providers. A paper is being drafted to explore solutions.

Bury

ADHD average wait in weeks from referral to first assessment - Mental Health Patients

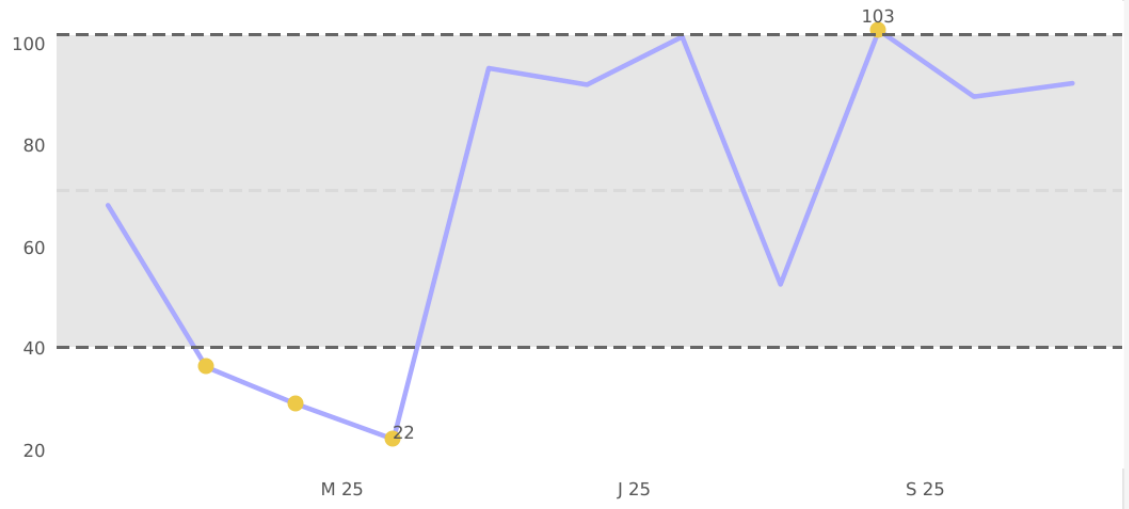
ADHD average wait in weeks from referral to first assessment

Source: Local Autism_ADHD Submission (Monthly)

92
November 2025

90
September 2025

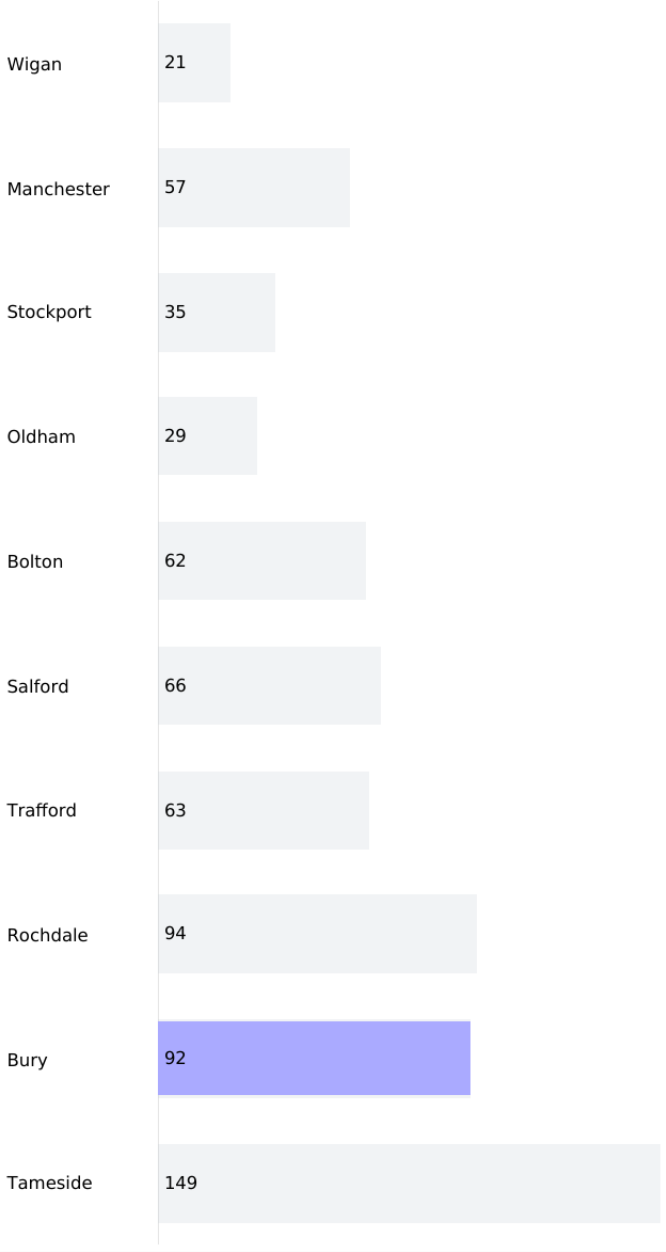
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Jan	Feb	Mar
2023-24											
2024-25									68	37	29
2025-26	22	95	92	102	53	103	90	92			

Selected measure at November 2025 has continuously increased for 1 period(s) of time

Latest Value GM Benchmarking



Narrative

- In Nov 2025, the average waiting time for ADHD assessments, measured from referral to first assessment, was 92weeks. This represents an increase compared to Oct 2025, when figures show 90 weeks.
- Please note: Figures may be different to those reported locally due to differences in methodology between NHS England and local providers. A paper is being drafted to explore solutions.

Bury

% of CHC referrals completed within 28 days

Percentage of referrals completed (including discounted referrals) within 28 Days

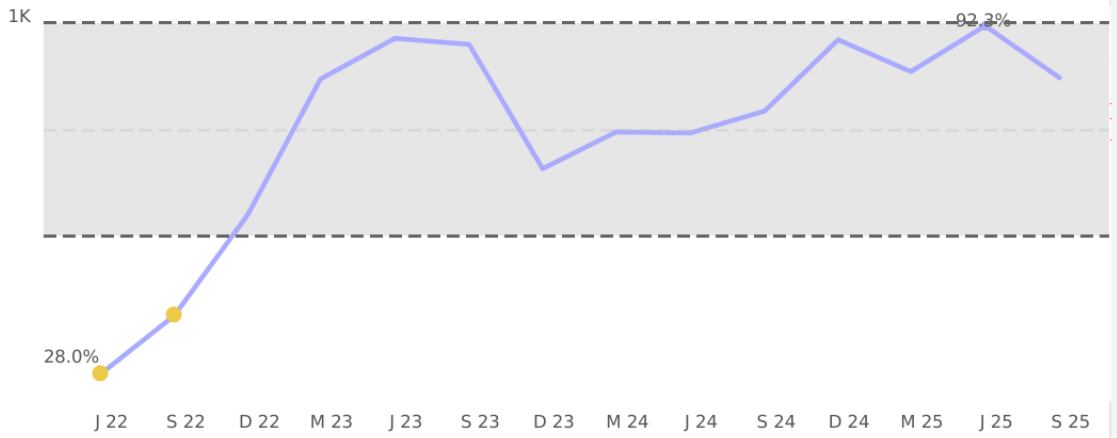
Source: Continuing Healthcare and NHS-funded Nursing Care quarterly published figures (Quarterly)

82.8%
September 2025

92.3%
June 2025

56/106
National Rank
Inter Quartile

Outliers more than 1 standard deviation from the mean



	Jun	Sep	Dec	Mar
2022-23	28.0%	38.9%	57.5%	82.5%
2023-24	90.0%	88.9%	66.0%	72.7%
2024-25	72.5%	76.6%	89.7%	83.9%
2025-26	92.3%	82.8%		

Selected measure at September 2025 has continuously **decreased** for **1** period(s) of time

Latest Value GM Benchmarking
National Rank against other localities

1	Tameside	100.0%
14	Rochdale	96.2%
19	Bolton	94.5%
20	Salford	94.5%
28	Trafford	91.8%
50	Oldham	84.6%
56	Bury	82.8%
58	Wigan	81.8%
60	Manchester	81.7%
63	Stockport	81.4%

Narrative

- The % CHC referrals completed within 28 days for Sept 2025 is 82.8%, this is a decrease from June 2025 when the figure shows 92.3%.
- Bury is currently ranked 7th among the GM localities.

Bury

Number of prescriptions dispensed per 1000 patients

Number of prescriptions dispensed per 1000 patients

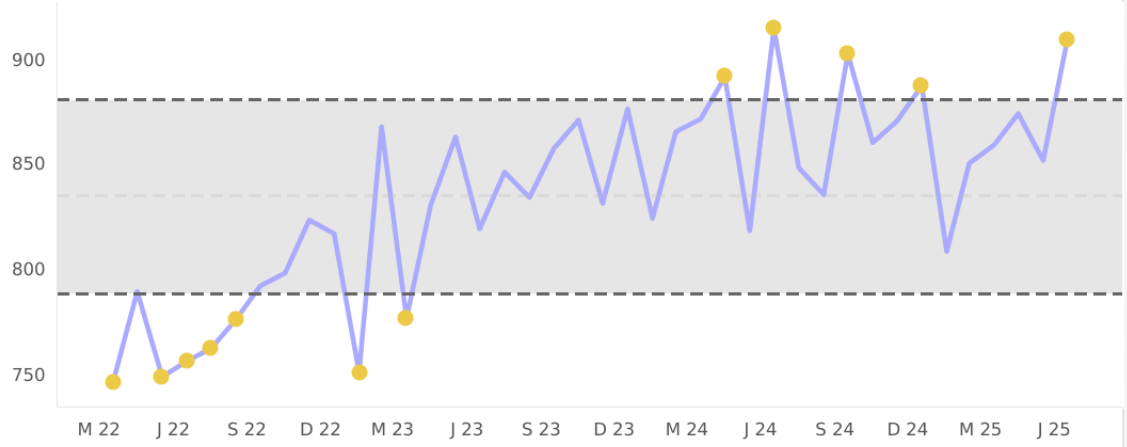
Source: Patient Level Prescribing Data (Monthly)

909.5
July 2025

852.2
May 2025

110/117
National Rank
Lower Quartile

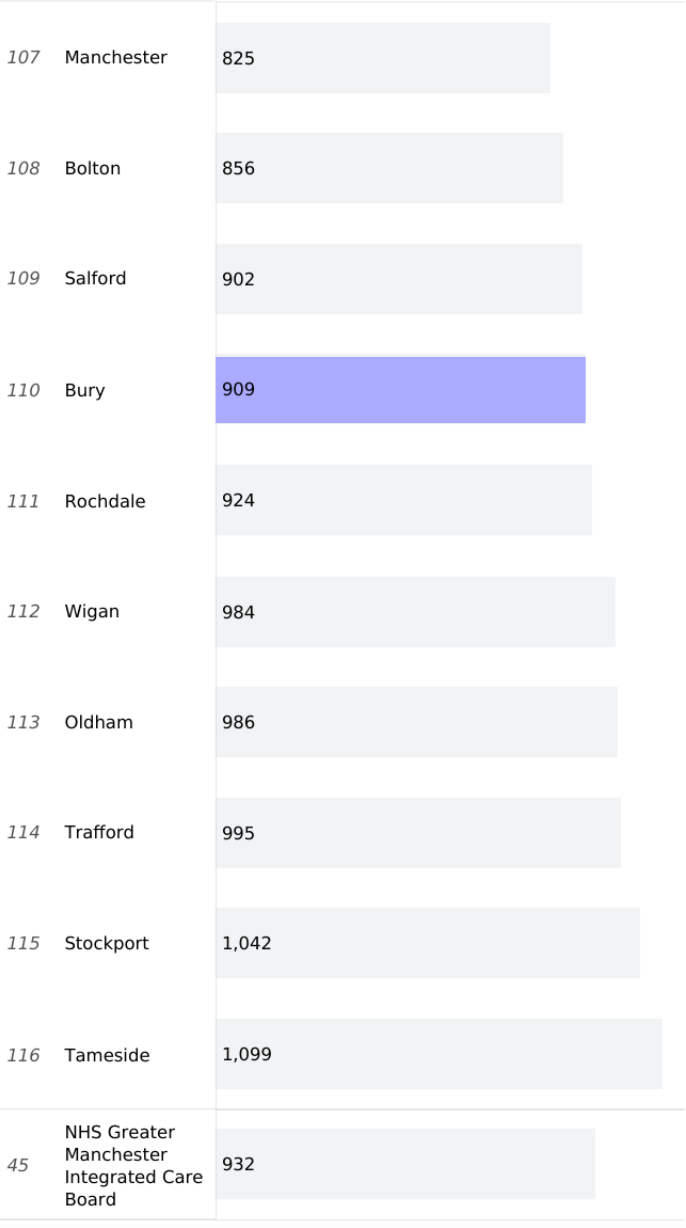
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	746.7	789.8	749.2	756.5	762.9	776.6	792.5	798.6	823.8	817.4	751.3	868.2
2023-24	777.0	830.8	863.4	819.6	846.6	834.6	857.7	871.4	831.8	876.7	824.7	865.8
2024-25	871.9	891.9	818.8	915.0	848.7	835.9	903.0	860.7	870.8	887.7	808.9	850.8
2025-26	859.6	874.4	852.2	909.5								

Selected measure at July 2025 has continuously increased for 1 period(s) of time

Latest Value GM Benchmarking
National Rank against other localities



Narrative

- In July 2025, the number of prescriptions issued per 1,000 patients was 909.5, representing an increase from May 2025, when the rate was 852.2.
- However, this reflects an increase compared to July 2024, when the figure stood at 915.0.
- Bury currently ranks fourth among the Greater Manchester localities and remains below the Greater Manchester average of 932.

Bury

Percentage of Care Homes rated Good or Outstanding

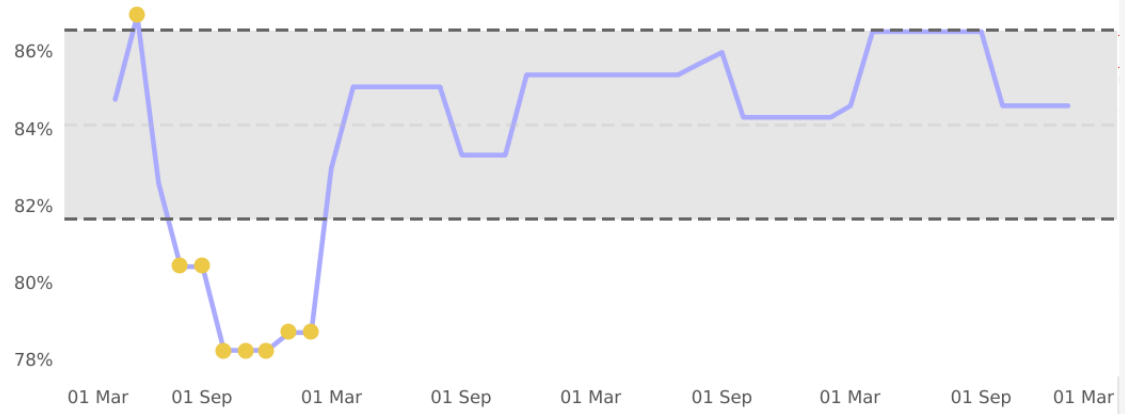
The % of Care Homes rated Good or Outstanding at the end of the period

Source: CQC (Monthly)

84.6%
Dec 25

84.6%
Nov 25

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23												
2023-24												
2024-25												
2025-26												

Latest Value GM Benchmarking
Rank against other localities

1	Wigan	92.5%
2	Trafford	88.5%
3	Bolton	85.5%
4	Bury	84.6%
5	Oldham	82.9%
6	Manchester	82.4%
7	Salford	80.0%
8	Stockport	75.0%
9	Tameside	70.6%
10	Rochdale	67.9%

Narrative

- In Dec 2025, 84.6% of care homes received ratings of 'Good' or 'Outstanding', matching the previous month.
- Bury holds the position of fourth highest among the Greater Manchester areas for this indicator.

Bury

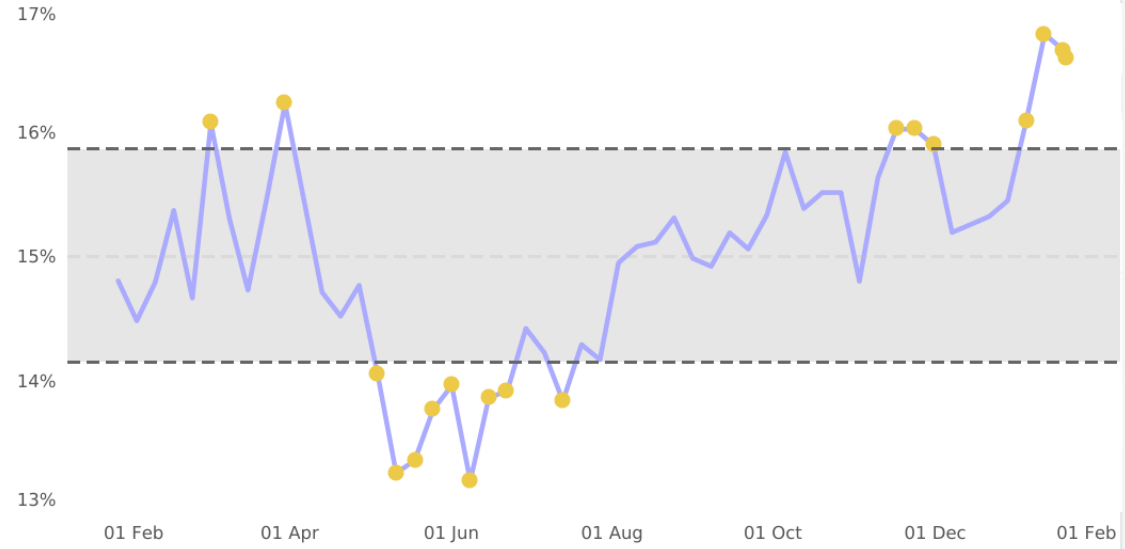
Care home beds vacancy rate
% of care home beds that are vacant

Source: NECS Capacity Tracker (Weekly)

16.6%
19 Jan

16.7%
18 Jan

Outliers more than 1 standard deviation from the mean



02 Nov	09 Nov	16 Nov	23 Nov	30 Nov	07 Dec	14 Dec	21 Dec	28 Dec	04 Jan	11 Jan	18 Jan	19 Jan
14.8%	15.6%	16.0%	16.0%	15.9%	15.2%	15.3%	15.3%	15.5%	16.1%	16.8%	16.7%	16.6%

Latest Value GM Benchmarking
Rank against other localities

1	Bury	16.6%
2	Manchester	13.4%
3	Trafford	13.2%
4	Rochdale	12.1%
5	Oldham	11.2%
6	Stockport	11.1%
7	Salford	11.0%
8	Wigan	10.8%
9	Bolton	9.7%
10	Tameside	9.0%
1	NHS Greater Manchester Integrated Care Board	11.8%

Narrative

- In the week commencing 19th Jan 26, 16.6% of care home beds were reported as vacant, consistent with the figure from the prior week.
- Bury presently records the highest care home vacancy rate within the Greater Manchester area, surpassing the Greater Manchester average of 11.%.8

Areas of Good Performance

CYP Mental Health Access

- 79.9 per 1,000, 4th highest in GM – *Slide 4*

Dementia Diagnosis

- 76.7%, above GM and national target – *Slide 5*

Mental Health – Delayed Discharges (NCTR %)

- Strong reduction to 9.5% and 2nd lowest in GM – *Slide 6*

Perinatal Mental Health Access

- 5.2 per 1,000, 2nd highest in GM – *Slide 10*

E. coli Bloodstream Infections

- 0.59 per 1,000, 3rd lowest in GM – *Slide 12*

Broad-spectrum Antibiotic Prescribing

- Sustained long-term improvement, 5.6%, 2nd lowest in GM – *Slide 14*

Urgent Community Response

- 98.3% within 2 hours, highest in GM – *Slide 27*

IAPT 18-Week Standard

- 97.2%, above GM average and national target – *Slide 33*

Care Home CQC Ratings

- 84.6% Good/Outstanding, 4th highest in GM – *Slide 44*

Areas for Attention

Talking Therapies – Access

- 1.3 per 1,000, 2nd lowest in GM – *Slide 9*

Diagnostics – 6 Week Wait

- 8.2%, above national <1% target – *Slide 21*

Screening – Cervical & MMR2

- MMR2: 87.6% – *Slide 24*
- Cervical: 68% / 74.6% – *Slide 25*
  All below national thresholds.

SMI Physical Health Checks

- 54.7%, below GM 60.6% – *Slide 31*

IAPT 6-Week Standard

- 58.3%, below GM and national target – *Slide 32*

CYP Autism/ADHD Timeliness

- Autism: 0% within 18 weeks – *Slide 38*
- ADHD: 0% within 18 weeks – *Slide 39*
- Long waits (107 and 92 weeks) – *Slides 40 & 41*

Emerging Concerns / Deteriorating Trends

A&E 4-Hour Performance

- 67.8%, slight drop & below GM – *Slide 17*

Non-Elective Spells (NEL)

- Slight decrease in Dec but remaining above normal range – *Slide 20*

CHC Completion Within 28 Days

- Decline from 92.3% → 82.8% – *Slide 42*

Prescribing Volumes

- Uptick to 909.5 per 1,000 – *Slide 43*
  (Still below GM average but rising trend.)

Care Home Vacancy Rate

- 16.6%, highest in GM – *Slide 45*

BURY INTEGRATED CARE PARTNERSHIP

Meeting: Locality Board			
Meeting Date	02 March 2026	Action	Receive
Item No.	15	Confidential	No
Title	SEND Improvement and Assurance Board Minutes – 13th January 2026		
Presented By	Will Blandamer, Deputy Place Based Lead		
Author			
Clinical Lead	N/A		

Executive Summary
The minutes from the SEND Improvement and Assurance Board held on the 13th January 2026 are attached for information.
Recommendations
It is recommended that the Locality Board note the minutes.

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

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 Council
Department of Children & Young People

Bury Council

NHS Greater Manchester Integrated Care

Minutes (Anonymised)

SEND Improvement & Assurance Board Meeting
13th January 2026

1	**WELCOME & INTRODUCTIONS**
	The Chair welcomed a new Vice-Chair to the group and thanked the previous Vice-Chair for their time and support. The Chair also welcomed a returning Board member who will be assisting with their team in the transition of administrative support to the Board. The Chair introduced a new member, who welcomed the Board to Bury College. They highlighted some of Bury College's provisions for Young People and Adult learners, including • Their focus on needs not diagnosis • A whole college approach, with SEND at the forefront • The resources and staff needed to support at-risk students, including training measures to prevent anyone from slipping through the cracks • The College's Multi-Agency panel meets weekly with advisors and managers to review at-risk students and identify any additional support required. The member expressed that they are keen to work with the SIAB and advised that they are happy for their email address to be circulated to the group for future contact.
2	**MINUTES FROM THE PREVIOUS MEETING**
	The Chair reviewed the minutes from the previous meeting, held on 16th December, and asked the Board if any amendments were required. An attendee requested a correction for Page 4, 2nd Paragraph, 2nd Sentence, advising the letter to the ICB was intended to raise concerns about both the Neuro Development Pathway and the Neuro-Hub, not only the Neuro-Hub. The Chair referenced an update regarding Page 12, about areas that are in intervention. No further amendments were requested, following amendment, the Board accepted the minutes as an accurate record of the previous meeting.

3	**ACTIONS AND RISKS LOG**
	The Chair asked to review the action log with a specific focus on upcoming/due actions. • **Action 292** – Provide updates on timeframes for Comms work (including Instagram, requested by the Changemakers), for Board prioritisation assurance – now due 9th February The action owner advised that a new Instagram account with robust safeguards in place will be rolled out at the next Changemakers meeting. The Chair welcomed this and discussed ongoing work to the Local Offer including a mapping exercise to index the Local Offer. Copies of communications distributed in the past four months were passed out to remind the group of recent outputs. Pointing out that these updates are shared through the Local Offer and posted on multiple social media platforms. The Chair asked for an update on Changemakers' events across schools and confirmed Changemakers' representatives were aware of this. The action owner advised that they were currently waiting for some further information before this can be completed. • **Action 192 -** Develop the next stages of alignment of the model to Neighbourhood delivery – now due 9th February The action owner added that to explore the opportunity to broaden the Early Help offer and a broadening of the SEND offer and the Families First programme. They added there were ongoing conversations around an early help focused SEND offer. • **Action 194 –** Next set of actions working with providers on reducing the waiting times – now due 9th February The action owner updated on waiting times, advising that the health department now routinely report data. • **Action 195** – Ensure parents understand the support available, keep them informed on changes and manage expectations – now due 9th February The action owner advised that this is ongoing work, there is a newer action which is to be clear about the increasing support available on the Neurodevelopment Pathway. • **Action 266 –** Arrange and confirm dates for initial co-production engagement sessions with key stakeholders – now due 9th February One of the action's owners updated that the corporate side of this action was done as discussed at the last meeting, with the council's 'Together' month and the co-production masterclass launch was completed as a part of that, which has since been adapted into the 'Manager Essentials' programme. The

	remaining SEND specific work will be progressed at the upcoming Data and Communications groups. Another owner provided an update on the Co-production Charter and explained that future sessions have been mapped out. On 3rd March there will be a Strategy to sign off, and on 17th March, there will be a session to formally review. It was confirmed that there will be a Bury2Gether member in attendance for this. The Chair highlighted co-production, emphasising the need to work collaboratively with others rather than imposing work on them. She stated that it is to integrate this approach into everyday professional practices. The remaining actions were acknowledged but concerns raised about how slowly risks are updated in the log. The Chair recommended this is investigated with the Data Sub-Group and an update will be provided on Risks at the next Board. **Action points:** 1. An update on risks to be provided at the next Board on 16th February 2026.
4	**CONTRIBUTIONS FROM, AND ENGAGEMENT WITH, CHILDREN AND YOUNG PEOPLE**
	The Chair asked the Bury College students in attendance for an update, also attending with the students was a Bury College Jobs Coach. A presentation was made to the Board, the presentation provided stories of students' 'reasonable adjustments', with particular attention to changing adjustments whilst progressing through educational settings. Before inviting students to share their experiences, the coach emphasised Bury College's commitment to making adjustments. Students noted that Bury College is very accommodating. They highlighted the helpful presence of dedicated job coaches who support students in transitioning to employment after college by assisting with placements and job readiness. The availability of quiet rooms, offering a relaxing and safe space at any time, was also mentioned. Additionally, students described exam adjustments such as the use of coloured paper and extra time. Other adjustments mentioned were the use of laptops. One student said that a scribe had been made available: a person who the student can dictate too and can then write on the student's behalf. Students can work in reduced group sizes aimed to reduce social anxiety, which has enabled some of the students to work closely together and to develop lasting friendships. The College encourages the students to widen their social 'bubbles'. The coach asked the students if they had struggled with reasonable adjustments at work placements, speaking to the students' positive impact in the workplace.

One student spoke of their desire to work in a particular industry and Bury College had collaborated with an employer to facilitate reasonable adjustments to allow the student to acclimate to working life in their desired industry.

Discussion continued around the need to find working opportunity for students with additional needs. The Chair asked the Board to consider how the offer can be improved to better offer opportunities to young people when leaving Education. The Chair asked for this to be communicated to communicate this, with an attendee adding that employers are missing out if they do not offer reasonable adjustments and suggested this should be highlighted in the communication.

The potential for work experience opportunities to be widened within Health and at GP Practices was discussed, The Chair suggested this could be an action for the Changemakers in relation to 'You said, we're doing.'

An attendee mentioned meeting with representatives from Bury College and commended the college's principle of providing every Bury learner with a college place.

An attendee then reiterated the eagerness of young people with additional needs and their fantastic work ethic, emphasising that creating working opportunities for such people can only be a positive.

The college also updated on the work to support young people into work experience and employment, and they confirmed they work with BEST (the Bury Employment Services Team) to facilitate opportunities for some.

Another member added that many students with additional needs leave the College with great qualifications for working life, only needing additional support when bridging into employment opportunities.

The Chair urged Board members to consider employment opportunities for young people with additional needs in their own departments, asking each member to update at the next Board with information relating to opportunities available.

The Chair asked for an update on the training the Changemakers have created and are going to deliver. It was confirmed that there is a delay due to ongoing internal discussions but spoke of an upcoming discussion where a trial-run will take place, with members of the Communications and Education teams taking part.

An attendee spoke in relation to the need for a medical diagnosis for reasonable adjustments, asking another attendee if following discussions in previous Board meetings, they had any update after speaking with the Changemakers group. They declared intentions to take concerns to School Leaders, adding that the important thing for Leaders to note, is that common sense should prevail if a diagnosis is not present.

Another member added that it was refreshing to hear the aspirations of the Young People in attendance.

The Chair highlighted that it is important that the Board prioritise the actions from this Board to improve outcomes for young people including those in the care of the Local Authority.
The Board was advised that there is a planned meeting about supported employment coming up, between representatives from Bury's Skills team and GPs.

Action points:

2. All Board members to update on work opportunities explored for SEND students, and to provide information on what has been done to improve this – due 16th February
3. Changemakers representatives to liaise with Health on work experience opportunities in relation to 'You said, we're doing' ahead of the next Board – due 9th February
4. A communication is to be made on the positive impact of reasonable adjustments in the workplace ahead of the next Board – due 9th February

5 **STATUTORY DUTIES**

Input was provided on the Statutory Duties Refresher. The Chair thanked Board members that had helped to put this together.

Another attendee clarified that there are ongoing changes to ICBs for Greater Manchester, advising there is no gap in accountabile officers, despite the changes.

The Chair asked the group to consider the presentation, and that everything that 'must' be done is being done. And asked what confidence the Board has that the 'musts' are being done.
The Chair asked the room for input, one member advised that this would be a good topic to discuss with teams.
An attendee added that a piece of work for the 'must, should and could' would be of benefit, The Chair highlighted that this would be a piece of work that could reassure the Board at the next meeting.

The presentation continued, discussing EHCPs and advised that there are national issues with EHCP delivery. With failure to complete EHCPs within agreed timescales being a particular issue.

An attendee highlighted that when 'musts' have been missed, the expectations of what 'should' be delivered are raised, increasing the likelihood of poor outcomes.

The Chair addressed historic issues and reminded the group that the SEND Code of Practice is still aspirational and emphasised the need to bring the partnership together.

An attendee added that currently there is a tendency for money to be spent on the system rather than on children directly, adding that there is an ongoing shift in the priority of spending, to ensure the focus is on children.

	One member asked another about EHCP compliance as the data pack suggests Bury are in a good place, versus national averages. The member in question confirmed that there is very good performance against timely plans being completed and that they are working to demonstrate improved quality as well with initial positive progress being seen in the audit of plans. The Chair asked the group to remain focused on the task at hand, recognising the 'must, should and could' areas of the current environment need to be address even in the face of upcoming changes. The Chair suggested that it would be useful for Board members to refresh themselves with the SEND Code of Practice. The member then added that a simpler document exists which summarises the Code of Practice, this document is to be uploaded to the Local Offer and would be useful for this exercise and would be a useful resource for parents. Another attendee added that the wording of certain elements of the Code of Practice suggest EHCP plans are outside of mainstream settings, as if the two are opposing, rather than extensions of one another. It was suggested that this shows the age of the document and the development of the work going into support for additional needs. The Chair agreed that the need for increased specialism has never gone away. It was suggested that there are historical inconsistencies with Annual Reviews of the document, feeling this could have been done more and should be a focus going forward, suggesting that certain recommendations are not fulfilled. An attendee added that there has been a long-standing backlog of Annual Reviews. But the reviewing duties have improved over the last 12 months, with more than a half of children with Education, Health & Care plans now having an annual review completed in the last 12 months. There are now reports which can help to improve the speed of the process, identifying areas of need earlier. One member pointed out that earlier in the service there were historic issues, and a decision was made to prioritise securing a plan. Adding that achieving some level of compliance was a positive indicator of progress being made. **Action points:** **5.** A piece of work on 'Must, Could, Should' for statutory duties to be done – due 9th February 6. All Board members to review the SEND Code of Practice – due 24th March
6	**THEME 2 PAPER REVIEW**
	The Chair requested an update regarding the Theme 2 report. It was explained that the report combined three main components of the priority impact plan: PIP2, PIP3, and section 6.1. These cover early intervention and Graduated Approach, support whilst waiting, and the education, and health and care plans.

It was added that efforts have centred on further developing the Communities of Practice and the Graduated Approach, so that these are now clearly understood throughout the system. Key highlights being the Graduated Approach Champions, who have been working evidently in the area.

The attendee continued that there is now a need to step forward and show how much our families understand and welcome the offer. Engagement sessions are particularly well supported in Primary and Secondary sectors, with a high percentage of the secondary sector now engaging in sessions.

They advised that over the coming weeks, parent engagement sessions and drop-in sessions will also be incorporated. There is strong evidence that the Graduated Approach is now much better understood. They continued to discuss the national view and how it is important to note how that is landing and being communicated.

Speaking of the improvement from November 2024 to December 2025, demonstrating a positive trajectory of improvement. There was mention to the auditing process and the monthly multi-agency termly audit, which identified strengths and areas of improvement, suggesting this is where focus should shift to ensure continued improvement.

Another attendee updated on the report from an NHS perspective. They commended the positive progress on waiting times generally, with mention of several areas of concern which will need to be monitored and addressed. They specifically addressed waiting times for Community and Paediatric Health and for Autism and ADHD assessments.

They concluded that another key area of focus was the SEND Health Visiting team, which has shown significant progress. Notably, the agenda pack contained a case study on the very positive impact of the SEND HV team for one family.

The Chair opened the discussion to the Board, and one attendee spoke on the Graduated Approach and suggested a communication piece around it to highlight this success.

Another member asked if we are capturing all the PVI (Private, Voluntary and Independent Sector) involvement. Another added that working with in tandem with other Board members, there is a need to share best practice across early years and family hubs. Highlighting that Primary settings need to feedback on where children are not ready and practice could be improved. The member confirmed that this an action from a previous meeting was to ensure this is done effectively moving forward.

A different attendee added that there is more work to be done, for example with ‘Ages and Stages’ questionnaires and questions, to investigate if children are accessing provisions.

The reduction of waiting times presented earlier was welcomed, but an attendee spoke about issues surrounding re-referral and the importance of

	diagnosis for family support and the financial burdens that accompany longer waiting times. The Board was asked about culture change in schools and meeting the needs of children at the first run of the Graduated Approach. Suggested that those not involved with the meetings may be those with the most need. One member pointed to the Communities of Practice and how the model will help to close this gap. The need to track which schools are engaging in these events was then raised.
7	**PROGRAMME PERFORMANCE AND OUTCOME REVIEW (INCLUDING THE MOST RECENT DATA PACK)**
	An attendee stated intent to bring the overview of all themes to each Board and added that it is an evidence based in approach. Adding that it would make sense for each section of the data pack to have an owner for accountability going forward. The next step would be for the Delivery Group to work through the pack, slide by slide to ensure it remains on track. A presentation was shared which displayed progress made, highlighting the percentages of standards across multiple ratings. The Chair thanked the group for their help and welcomed the use of data to evidence progress. The presenter added that going forward the introduction of Communications to the Data group would also ensure that the impact of this insight will also support how the system works with children, young people and parents. On the back of the feedback, a member added that teams have been able to review the advice offered but recognise that advice from the wider services has been less robust and new arrangements have been made to improve Social Care.
8	**NEW MODEL OF CARE FOR GREATER MANCHESTER NEURODIVERGENT CHILDREN AND YOUNG PEOPLE**
	The Chair handed asked for an update on waiting times and highlighted that some wait times are unacceptable, referencing the data pack. This has been validated by surveys carried out by Bury2Gether. An attendee updated, listing several excessive waiting times before suggesting a standardised process, to ensure the children who are most in need are supported quickly. The importance of ensuring families feel confident in the range of services available to them was raised and it was stressed that the focus should remain on assessing need. They referenced the proposal for implementing a triage system and establishing processes to invite current providers to collaboratively address the existing waiting list. Funding will be allocated to support these assessment activities.

They ended by stating there is currently an untenable situation in regard to demand on the Neuro Development Pathways and appreciated the implications on families that are not getting assessments in a timely manner. There is a need to ensure the model can be amended over time, and we need to listen to children, parents and carers.

The Chair asked if there was a Risk Register in place about it, and the attendee confirmed there is.

An attendee representing Bury2Gether added that there are issues. Firstly, with co-production not taking place soon enough, adding that the timeline of co-production had a large gap of over 12 months from inception to instigation (February 2024 to October 2025), making families feel this is being done 'to' them rather than 'with' them.
They questioned if the current offer is the only solution, pointing out that information is not being relayed to families fast enough. The language used in reporting was also highlighted, further suggesting a lack of co-production. With regards to the Neuro-hubs, Bury2Gether do not agree that the diagnosis option can be removed until it is evident there are services available and no gaps.

They asked what is being done to mitigate risks and believes there is a need for reflection on whether this has been co-produced correctly.

The Chair agreed with this concern around risks and suggested this may be something that should be put in writing to address these concerns to the GM ICB. And that this could be done as a response to the letter from GM ICB following the escalation of concerns from the Chair previously.

Another member added that children and young people feel similarly, where many were distressed by the prospect of this, feeling the changes were affecting them personally. They added that more appropriate communication is needed to keep children updated and that she is struggling to effectively communicate some of the messages from the Board to young people.

The Joint Council for Qualifications was discussed by another member; they also added that an early diagnosis impacts the entire process and the need for a smoother process to take place.

Another attendee reasoned that currently there is not an effective service, and that difficult choices will likely need to be made to improve the service.

Another member added, NHS GM changes and asked if we could look toward other areas and asked if this will be an early version of a wider National issue. The Chair agreed that this is a wider issue but suggested that as GM ICB is at the forefront of this decision it is important to ensure effective learning is done to minimise the risks involved.

An attendee explained that they understood a number of ICBs nationally were progressing similar proposals to that proposed by NHS GM in response to the very challenging demand pressures from services.

	The Chair asked the Board what it believed is the best response to the concerns, to effectively progress the work. It was added that there is a scale of need that unfortunately the systems are not set up to manage, highlighting a need to help those that need it most, whilst understanding the risks and issues associated with that moving on. The importance of getting answers to Parent and Carer Forums quickly was noted, adding that there is widespread opposition to this proposition so far. Following discussion, it was surmised that members had a difference in opinion on the level of co-production in Greater Manchester. One member added that Parent Carer Forums across the GM ICB footprint (10 in total) will likely be putting the concerns in writing. The Chair added that the feeling of a lack of co-production is there and that consultation is not the same as co-production. The Board were asked for thoughts on a letter to the ICB. Another attendee added that it may be beneficial if the three colleagues identified have a discussion suggesting this may be the appropriate and considered thing to do, following which a decision might better be made. A second attendee agreed with this suggestion, adding the more pressing issue may be the anxiety of children, parents and carers and ensuring that the community understand what it is we are going to do with the information available to us now. She suggested a multi-agency approach, having focused conversations and providing additional support to affected families, which fits in with the commitment to the Graduated Approach. It was noted that the offer of support whilst waiting can mean a great deal to families. An attendee mentioned that plans have been made and communications will be developed together with parent and carer forums, these updates will be distributed. The Chair ended the conversation due to time constraints and asked members to request more time for this discussion at future Board meetings.
9	**TERMS OF REFERENCE REVIEW & TRANSITIONING TO LONG-TERM PARTNERSHIP**
	It was confirmed that the Terms of Reference had been updated and for Board members. There were two items in the Terms of Reference that members of the Board were asked to consider: • Have all Board members met with the Changemakers • Who from the voluntary sector would be a good addition to the Board **Action points:** 7. All Board members to confirm they have met with the Changemakers to be confirmed at the next Board - due 16th February.

	8. All Board members to consider and suggest candidates from the voluntary sector as an addition to the Board, to be followed up at the next Board - due 16th February.
10	**ALTERNATIVE PROVISION STRATEGY UPDATE**
	It was confirmed that the updates from the previous Boards had been included. The Board agreed to sign the strategy of with one very small addition. **Action points:** 9. Amend page 8 of the Alternative Provision Strategy to refer to SIAB as the SEND Improvement and Assurance Board, not the SEND Partnership Board – due 9th February
11	**SUMMARY OF KEY MESSAGES FROM TODAY'S MEETING**
	• Introduction of the new Vice-Chair. • Upcoming monitoring inspection appears imminent. • Board members to review terms of reference, and the code of practice. • Reasonable adjustments, how do we extend the reach of good practice. • Is the updated graduated approach taking hold? Gather insight and a case study. Board members are to review these take aways then cascade and discuss with practice groups and stakeholder groups as discussed at the meeting.
12	**AOB**
	Action points: 10. An update is required on Project Safety Valve for March's SIAB meeting – due 17th March 11. A self-evaluation is to be prepared and presented at the February Board - due 16th February The Chair flagged the likelihood of the Monitoring Inspection soon and asked the Board to keep this in mind.
13	**UPCOMING MEETING DATES**
	- 16th February 10.00 – 13.00 Town Hall - 24th March 10.00 – 13.00 Town Hall - 14th April 10.00 – 13.00 Town Hall - 12th May 10.00 – 13.00 Town Hall - 23rd June 10.00 – 13.00 Town Hall - 14th July 10.00 – 13.00 Town Hall