Agenda

Locality Board – Meeting in Public

Date: 2nd November 2026

Time: 4.00 pm – 6.00 pm

Venue: Microsoft Teams

Chair: Dr Cathy Fines

Item No.	Time	Duration	Subject	Paper Verbal	For Approval Discussion Information	By Whom
1.0	4.00 – 4.05	5 mins	Welcome, apologies and quoracy	Verbal	Information	Chair
2.0			Declarations of Interest	Paper	Information	Chair
3.0			Minutes of previous meeting held on 5th October 2026 and action log	Paper	Approval	Chair
4.0			Public questions	Verbal	Discussion	Chair
Place Based Lead Update						
5.0	4.05 – 4.10	5 mins	Key Issues in Bury	Verbal	Discussion	Lynne Ridsdale
6.0	4.10-4.20	10 mins	Place Partnership documentation	Paper	Approval	Will Blandamer
7.1	4.20-4.40	20 mins	NCA Improvement Plan update	Paper to follow	Discussion	Lorna Allan/ Alistair Craig
7.2			Fairfield General Hospital CQC Improvement Plan	Verbal	Discussion	Claire Stott
Integrated Delivery Update						
8.0	4.40-4.50	10 mins	Integrated Delivery Collaborative Update	Paper	Discussion	Kath Wynne Jones
9.0	4.50-5.05	15 mins	NHS GM Commissioning Framework	Paper	Discussion	Will Blandamer
10.0	5.05-5.15	10 mins	Update on progress of the VCSE/Public Sector MoU –	Paper	Discussion	Helen Tomlinson/ Jordan Fahy
11.0	5.15-5.30	15 mins	Neighbourhood update – Whitefield	Paper	Discussion	Jane Wilson

12.0	5.30-5.40	10 mins	Winter planning	Paper	Discussion	Kath Wynne Jones/David Latham
Committee/Meeting updates						
13.0	5.40-5.50	10 mins	Performance report	Paper	Information	Kath Wynne-Jones/Catherine Downes
Closing Items						
14.0	5.50	5 mins	Any Other Business		Verbal	
	_____	_____	**Date and time of next meeting in public - Monday, 7th December 2026, 4.00 - 6.00pm in Committee Rooms A and B, Bury Town Hall**		_____	
15.0		5 mins	Post Meeting Reflection		Verbal/All	

Meeting: Locality Board			
Meeting Date	02 November 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 November 2026 and

- 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	☒

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

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

Committees and Sub-Committees

Locality Board

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

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

Cllr	Rydeheard	Jack	Attendee of the Locality Board as Reform UK Councillor	Association of Reform Councillors (ARC)		x		Direct	Member		Present	
				Royal British Legion			x	Direct	Member		Present	
				Conservative and Unionist Party		x		Direct			Present	
Cllr	Walmsley	Sandra	Attendee of the Locality Board as Labour Councillor	GMB Union		x		Direct	Member		Present	
				Bury North Constituency Labour Party		x		Direct	Chair		Present	
				Labour Party		x		Direct	Member		Present	
				LGBT (Labour)		x		Direct	Member		Present	
				Labour Women's Network		x		Direct	Member		Present	
				Moorside Branch Labour Party		x		Direct	Vice Chair		Present	
				Bury Local Government Committee		x		Direct	Member		Present	
				Voluntary Trustee at the Fusilier Museum (Bury)		x		Direct	Trustee		Present	

Meeting: Locality Board			
Meeting Date	02 November 2026	**Action**	Approve
Item No.	3	**Confidential**	No
Title	Minutes of the Previous Meeting held on 5th October 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 5th October 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	
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Optimise Care in institutional settings and prioritising the key characteristics of reform.	☒

Implications						
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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		

Draft Minutes

Date: Locality Board – Meeting in Public – 5th October 2026

Time: 4.00pm – 6.00pm

Venue: Microsoft Teams

Title	**Draft Minutes of the Locality Board**
Author	Emma Kennett
Version	0.1
Target Audience	Locality Board
Date Created	5th October 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**

Locality Board

MINUTES OF MEETING
Locality Board Meeting in Public Committee Rooms A and B, Bury Town Hall 5th October 2026 4.00 pm until 6.00 pm **Chair – Dr Cathy Fines**

ATTENDANCE

Voting Members
Dr Cathy Fines, Senior Clinical Leader for 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 Sandra Walmsley, Executive Member of the Council for Children and Young People Mrs Catherine Downes, Associate Clinical Director (Bury) Ms Lynne Ridsdale, Place Based Lead Ms Lorna Allan, Chief Digital and Information Officer, NCA Ms Sarah Preedy, Chief Operating Officer, Pennine Care Foundation Trust Ms Helen Tomlinson, Bury VCFA (Voluntary, Community, Faith & Social Enterprise) Mr Will Blandamer, Deputy Place Based Lead, Executive Director of Health and Care (for part) Mr Adrian Crook, Director of Adult Social Services and Community Commissioning Mr Jon Hobday, Director of Public Health, Bury Council Dr Manisha Kumar, 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
Cllr Carol Birchmore, Leader, Radcliffe First Mr Ian Trafford, Head of Programmes, Bury Integrated Delivery Collaborative Mrs Emma Kennett, Place Partnership Lead, NHS Greater Manchester (Bury) Ms Chloe Ashworth, Democratic Services, Bury Council

MEETING NARRATIVE & OUTCOMES

1.	Welcome, Apologies and Quoracy
1.1	The Chair welcomed all to the meeting.
1.2	Apologies were received from: - • Ms Jeanette Richards, Executive Director of Children and Young People, Bury Council • Ms Karen Kennedy, Director of Strategy, Manchester Foundation Trust • Ms Ruth Passman, Chair, Bury Healthwatch
1.3	The meeting was declared quorate.

2.	Declarations Of Interest
2.1	NHS Greater Manchester has responsibilities in relation to declarations of interest as part of their governance arrangements (details of which can be found outlined in the NHS Greater Manchester Integrated Care Conflict of Interest Policy version 1.2).
2.2	NHS Greater Manchester (Bury Locality) therefore, has a requirement to keep, maintain and make available a register of declarations of interest for all employees and for a number of boards and committees.
2.3	The Local Authority has statutory responsibilities detailed as part of Sections 29 to 31 of the Localism Act 2011 and the Relevant Authorities (Disclosable Pecuniary Interests) Regulations 2012. For other partners and providers, we understand that conflicts of interest are recorded locally and processed within their respective (employing) NHS and other organisations as part of their own governance and statutory arrangements too.
2.4	Taking into consideration the above, a register of Interests has been included detailing Declaration of Interests for the Locality Board.
2.5	In terms of agreed protocol, the Locality Board members should ensure that they declare any relevant interests as part of the Declaration of Interest Standing item on the meeting agenda or as soon as a potential conflict becomes apparent as part of meeting discussions.
2.6	The specific management action required as a result of a conflict of interest being declared will be determined by the Chair of the Locality Board with an accurate record of the action being taken captured as part of the meeting minutes.
2.7	There is a need for the Locality Board members to ensure that any changes to their existing conflicts of interest are notified to NHS Greater Manchester (Bury Locality) Corporate Office within 28 days of a change occurring to ensure that the Declarations of Interest register can be updated.

ID	Type	The Locality Board	Owner
D/10/01	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 7th September 2026 were considered as a true and accurate reflection of the meeting.
3.2	Updates were received in respect of the Action Log and the log was updated.

ID	Type	The Locality Board	Owner
D/10/03	Decision	Accepted the minutes from the previous meeting as a true and accurate reflection of the meeting and noted the updates in respect of the actions from the last meeting.	

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

ID	Type	The Locality Board	Owner
D/10/04	Decision	Received the update.	

5.	Key Issues in Bury
5.1	Ms Ridsdale presented the latest Place Based Lead update to the Locality Board. It was reported that: - • NHS GM's Commissioning Framework for 2027/28 was published on Friday and had been shared with NHS providers. The framework presented an ambitious and exciting programme of work to support delivery of the ambitions set out in our Five-Year Strategic Commissioning Plan. The commissioning framework was attached as an Appendix to this report and would be discussed in greater detail at the November Locality Board meeting. • An NHS Greater Manchester Staff event with around 1000 staff took place on the 30th September 2026. • There had been a GM wide event on frailty led informed by a keynote presentation from Professor Tom Downes, National Clinical Director for Frailty at NHS England. Professor Downes delivered an excellent presentation highlighting the significant challenges facing the NHS. It was highlighted that approximately 1.4 million people in England were living with moderate or severe frailty, representing around 2.4% of the population but accounting for 66% of non-elective bed days. Bury was repeatedly referenced as an exemplar across a number of areas which reflected the strength of partnership working and the progress being made collectively across the borough. Work on frailty in Bury has been led by Clare Hunter, Adrian Crook, Dr Jason Raw, and Dr Emma Vardy. Whilst the outstanding relative progress in this area was noted, the team were committed to further improvement and would be visiting a national exemplar of best practice in Walsall to identify further opportunities. • Ms Jackson had recently got married and members congratulated 'Mrs Downes' in this regard. • A NHSE NW Winter planning event had taken place last month which tested system readiness with a number of scenarios, and some lessons were learnt for Bury around further preparation, communication and clarification of opel 4 arrangements. A key theme for the event was an invitation to reflect on the performance of the system going

	into the winter period. In this the Bury system felt confident to go into winter with the 2nd best RSV vaccination rates in GM and an expectation that Covid and flu vaccination would once again perform strongly. A step change improvement had been sustained in relation to 4hr and 12hr waits and corridor care in Fairfield General Hospital. There was also a step change improvement in mental health waiting times thanks to some great partnership working between Pennine care and NCA. NHS Greater Manchester was convening a winter planning evening on 5th November 2026 and invitations would be sent to colleagues shortly.
5.2	.The following comments/observations were made by Locality Board members: - • In relation to the step change improvement in relation to 4hr and 12hr waits and corridor care in Fairfield General Hospital, it was reported that the Trust was stiving to make improvements month on month regardless of winter planning timescales and was important to consider that summer planning was also as important from a health perspective. • The need to look at different vaccination approaches when targeting different age groups and utilising the voluntary sector where possible. It was noted that the Vaccination and Assurance Group had recently had a similar discussion. • It would be helpful to have a more detailed discussion in relation to Winter Planning at the next Locality Board meeting however there was a need to check on the timescales as to whether the December 2026 meeting may work better. Ms Wynne-Jones agreed to speak to Mr Latham about the winter planning timescales and bring back an update to either the November or December Locality Board meeting. It was noted that NHS Greater Manchester had produced a Communication Plan within this area and Dr Kumar agreed to circulate this to members.

	Type	The Locality Board	Owner
D/10/05	Decision	Received the update.	
A/10/01	Action	Ms Wynne-Jones to speak to Mr Latham about the winter planning timescales and bring back an update to either the November or December Locality Board meeting.	Ms Wynne-Jones
A/10/02	Action	Communication plan in relation to winter planning to be shared with members.	Dr Kumar

5.	Place Partnership documentation update
5.3	Mr Blandamer presented an update report in relation to the Place Partnership documentation. It was reported that: - • The Bury Locality Board had reviewed draft iterations of the Place Health and Care Partnership (PHCP) document suite at its meetings in recent months. • The latest document suite was presented and was broadly supported at the Greater Manchester Chief Officers during w/c 28th September 2026 and the final version would be shared with partners in the coming weeks. • It was anticipated that the final document suite would be available in time for the November Locality Board meeting and a number of update reports were being shared today to ensure the Board were being kept up-to-date on the latest developments.

5.4	The following updates were included with the report: - • Engagement feedback outcome reports (short read slide deck and long read paper) • Updated PHCP Document Suite summary slide deck • A timeline which showed key steps and changes from now until 1st April 2027.
5.5	The following comments/observations were made by Locality Board members: - • A query as to when the first cut of the data to support the planning in the context of the new Outcomes Framework would be available. Dr Kumar agreed to clarify the timescales for this data being made available at the Executive Leadership Team meeting tomorrow. • A question around the role of the ICP/ICB going forward and how localities would still be engaged/have the ability to collaborate in relation to local priorities. A general discussion took place regarding this issue including the role of Beccor. • A query around the Bury Integrated Partnership logo contained within the documentation and whether this aligned with other locality logos. Ms Wynne-Jones agreed to look at this.

ID	Type	The Locality Board noted	Owner
D/10/06	Decision	The Engagement feedback outcome reports (short read slide deck and long read paper).	
D/10/07	Decision	Updated PHCP Document Suite summary slide deck	
D/10/08	Decision	A timeline which shows key steps and changes from now until 1st April 2027	
D/10/09	Decision	The intention to share the final Place Health and Care Partnership (PHCP) document suite at the November Locality Board meeting.	
A/10/03	Action	Dr Kumar agreed to clarify the timescales for this data being made available at the Executive Leadership Team meeting tomorrow.	Dr Kumar
A/10/04	Action	Ms Wynne-Jones to review the Bury Integrated Partnership logo included as part of this documentation.	Ms Wynne-Jones

6.	NCA Improvement Plan Update
6.1	Ms Allan provided a verbal update in relation to the NCA Improvement Plan developments. It was reported that: - • The first Board to Board meeting between the NCA, ICB and NHS England had taken place. There had been an open conversation in relation to the current position in relation to waiting lists sustainability and patient safety which had been both helpful and supportive. The Board-to-Board meetings would take place every 6 months. • The System Assurance meeting had now met twice and received an initial draft of the NCA Improvement Plan at its meeting today. The plan covered 6 core themes and 17

	programmes and was some further work to do on the plan prior to be shared wider. A briefing would be issued to stakeholders in due course in relation to the main discussions at the meeting. The System Assurance meeting would continue to meet on a monthly basis to ensure that all the concerns were being addressed as part of the Improvement Plan. • A Quality meeting was being held every 2 weeks to review in detail the quality aspects of the process. • The new Chief executive of the NCA had commenced this week and there was a need to ensure that the plan had been reviewed from that perspective.
6.2	The following comments/observations were made by Locality Board members: - • The appointment of the new Chief Executive at the NCA was a positive leadership appointment given the current organisational position/challenges. • A query as to whether the governance arrangements at the NCA were going to be reviewed as part of this process. It was reported that the Good Governance Institute had been working with the Trust over the course of the last year to review the governance arrangements. It was noted that as a result of this review, the Quality Committee had been changed. • A comment made around some of the issues previously reported in the press 7/8 years ago in terms of HR qualification checks on clinicians and how these issues could have contributed to the current Trust wide position and what learning had taken place as a result of these cases. • There was a need to consider how best to communicate the NCA issues to the public. It was noted that the Trust had brought in an independent communications specialist who had developed a comprehensive Communications Plan. • A query as to whether the Single Improvement Plan would cover all of the 4LP priorities. It was reported that various themes linked to the plan were currently being reviewed. • Patient experience was a key part of the Improvement Plan process and there was a question as to whether Healthwatch and the VCFA were being linked into discussions within this area. Ms Allan agreed to check on this element. • There was a need to build public confidence as part of the NCA improvements going forward. • The need to continually make improvements in relation to corridor care. It was noted that there was a national target that needed to be achieved by 2028 however the NCA were looking to expedite progress within this area ahead of this date. • There was a need to be clear on the governance and reporting arrangements in relation to the NCA Improvement Plan going forward in terms of there being a more formal written report being submitted via the Locality Board and other key meetings such as the Scrutiny Committee. Ms Allan would pick this point up ahead of the next Locality Board meeting.

ID	Type	The Locality Board	Owner
D/10/07	Decision	Noted the contents of this report.	
A/10/05	Action	Ms Allan to check whether Healthwatch and the VCFA are being linked into discussions in relation to the NCA Improvement Plan.	Ms Allan

A/10/06	Action	A written report in relation to the NCA Improvement Plan to be brought back to the Locality Board in November 2026.	Ms Allan

7.	Bury Estates Update
7.1	Ms Postlethwaite was in attendance to present a report in relation to Bury estates in the context of neighbourhood working. It was reported that: - • The ageing estate across many parts of the locality risked being an obstacle to service change and expansion. It was noted that the ability of the estates solution to sufficiently respond to service need was particular challenging due to the economic and financial constraints that existed both within the locality and across Greater Manchester more widely. • The Locality Board was last updated in October 2025 and over recent months, significant work had been progressed to ensure that, despite financial and economic constraints, the locality estate plans were sufficiently developed to ensure that the local estates solution continued to be a key enabler to the delivery of service and place-based change within the borough. • Recognising the current financial climate across all areas of public service, recent work had focused on the ability of innovative work at partnership level to ensure that focused estates solutions could still be found. The focus of the work remained to ensure that the estate enabled neighbourhood working and also provided the accommodation necessary to enable left-shift service discussions. • This report provided an update of key estates development work over recent months and also aimed to articulate the priority areas moving forward for the locality. • This report also outlined the importance of the estate in the delivery of the neighbourhood working proposals across Bury and provided a specific update on some assets identified as tail estate to ensure that the Board was updated on the current position. • Strategic estates work over the past twelve months has also focused on defining a solution in each borough of Bury that enabled the Integrated Team in each borough to be based within the locality in which they work. This work was now well developed with the strategic direction in each borough of Bury now better understood. • In East Bury, the solution focused around existing estate, potentially New Kershaw Centre. In North Bury, the solution focused around Tottington and Ramsbottom health centres and Ramsbottom library linking to wider regeneration proposals within the town centre. Plus outreach provision in some areas of borough. In Whitefield, establishment of the Live Well Centre, Whitefield. In West Bury, there were solutions working across Radcliffe Hub and Radcliffe Primary Care Centre. In Prestwich, the was a Prestwich Health Centre solution linked to wider regeneration of Town Centre • In terms of project Developments, the identified site of the Uplands Project redevelopment (Whitefield) was purchased by NHS Property Services in July 2025, with a planning consent achieved in July 2026 - alongside a related tender process for the construction contract for this scheme. After many months of work on the current scheme, in August 2026 confirmation from NHS England was received to approve the additional funds required to progress this project. On this basis, a contract award has now been made with a start on site being planned towards the end of November 2026/early December 2026 (subject to the necessary pre-planning conditions being met.) Tenders received estimate a construction period of circa ten months hence, a

	new facility is now expected to be ready for occupation around September/October 2027. • Detailed discussions continued to secure a solution in Prestwich, whilst aspirations to achieve a joint service solution for Prestwich remained - currently a solution on the existing health centre site may offer the most deliverable solution hence, the site had been reclassified as core estate to aid in discussions to this regard. Since the last update to the Locality Board, Prestwich had been identified by NHS Greater Manchester as a key strategic scheme noted with strategic capital allocated to the scheme on this basis. This securing of capital funds has enabled more specific and advanced discussions to be progressed by locality partners and NHS Property Services to identify the most appropriate and achievable solution for this site. • Further to previous Locality Board approval to dispose of the Sunnybank Clinic site, once the site had been vacated in full, it was noted that the site was sold at auction in July 2026 and this money would be reinvested.
7.2	The following comments/observations were made by Locality Board members: - • It was clear that were very few community spaces available in Radcliffe and East Bury and may be a need to look at other options available. It was suggested that buildings such as Moorgate should be looked to support services in east Bury as well as considering health on the High Street options. Mr Blandamer reported that early discussions had taken place in relation to Health on the High street options in terms of what services could possibly be provided. It was noted that a report would be shared with the Locality Board at a later stage to describe how this would operate. • Further discussions in relation to the Prestwich funding/opportunities would be helpful to establish what is possible. • The need for Councillors to be linked in with estates discussions at the appropriate time so residents can be updated on key developments.

ID	Type	The Locality Board	Owner
D/10/08	Decision	Noted the content of the report and in particular the key role of partnership working in continuing to strive for aspirational and innovative estates solution across the locality.	
D/10/09	Decision	Noted the importance of estate as an enabler to establishment strong neighbourhood working arrangements in each borough.	
D/10/10	Decision	Noted in particular the progress made in a number of areas and also the updated position with regard to some tail assets within the locality.	
D/10/11	Decision	Noted the continued focus of the partnerships established in Bury to continue to strive for a locality estate that enables service change across the borough.	

8.	Integrated Delivery Collaborative Update
11.1	Ms Wynne-Jones presented the latest Integrated Delivery Collaborative update to the Locality Board. It was reported that: - • The Locality Plan, the Delivery Plan and the BECCOR plans have now been signed off by the Integrated Delivery and Locality Boards and submitted to Greater Manchester. • The delivery arrangements for our Integrated Neighbourhood Teams were being reviewed. It was noted that given the CLM changes at the NCA and statutory requirements of the council, there had been a need to relook at the single line management arrangements that are in Place. • An outline of the 4LP programme of work with the NCA had now been agreed and the process of scoping the content of these programmes was underway. • Planning for Falls Prevention Week was underway which was being supported by local team initiatives. • There had been a significant improvement in cancer performance with Bury having exceeded the 3% improvement target set by Greater Manchester for 2025/26 and moved above the Greater Manchester average. Performance in April 2025 was 56.7% (8th position in Greater Manchester) with an improvement seen in March 2026 to 62.0% (4th position in Greater Manchester). This represented an improvement of 5.3% over the year and a rise of 4 places within the Greater Manchester ranking, reflecting the positive impact of the work undertaken to support earlier cancer diagnosis across the system. • The Bury community based 24/7 Crisis Resolution Service launched at the end of September 2026. Communications had been produced for stakeholders including Primary Care. Updates had been provided for the Mental Health Programme Board and the Bury Primary & Secondary Care Interface meeting in September 2026. This service would be communicated as part of the GP Webinar process.
11.2	The following comments/observations were made by Locality Board members: - • The frailty report was an excellent read and demonstrated improvements that could be made.

ID	Type	The Locality Board	Owner
D/10/12	Decision	Noted the update.	

12.	3 Year Development Plan for Adult Social Care
12.1	Mr Crook submitted a report in relation to the 3 year business plan for the Adult Social Care Department in Bury. It was reported that: - • The priorities were to promote independence, deliver best ever services and to make Bury a great place to work. • Bury faced significant challenges in relation to rising demand for a range of services across the council creating unsustainable pressures on council services and budget which has been identified as part of the Corporate Risk Register. This also included demand pressures via the NHS which affected the Council's demand profile.

	• There had been a number of achievements made to date including improved independence and outcomes for our learning-disabled residents evidenced by our spending on younger adults only increasing by 23% compared to 37% nationally.
12.2	The following comments/observations were made by Locality Board members: - • A comment made around the importance of supporting the transition of young people into adulthood to ensure people are not feeling isolated and are confidence with independent living. • A query in relation to NHS dental care available to vulnerable adults in a care home setting. Mr Crook commented that this was not part of this particular plan as this was an NHS commissioning area. Dr Kumar agreed to raise this issue via the Primary Care Commissioning Committee and was agreed that Cllr Walmsley should Email some further details about the issue. • This was an excellent plan and there was a lot of learning that could be taken into health from an empowerment perspective. •

ID	Type	The Locality Board	Owner
D/10/12	Decision	Noted the update.	
A/10/07	Action	Dr Kumar to raise the issue of availability of NHS dental care for vulnerable adults in a care home setting via the Primary Care Commissioning Committee.	Dr Kumar

13.	Mental Health Commissioning Intentions
13.1	Mr Trafford presented a report in relation to the Mental health commissioning intentions.
13.2	It was reported that: - • one mental health contract was currently out of contract and three VCSE mental health contracts were due to expire in March 2027. • The paper summarised the current position and made recommendations about future commissioning intentions for consideration by the Board. • In previous years some elements of the budget for Mental Health Commissioning were allocated to localities. In relation to provider contracts the budget related mainly to the commissioning of locality specific provider commissioning [largely from the VSCE]. Over the course of the last year almost all commissioning budgets have been centralised. As in previous years the contracts are between NHS Greater Manchester and the commissioned provider. • Whilst financial governance arrangements therefore don't necessarily require formal approval from Locality Boards or their equivalent the purpose is to ensure that the Bury Locality Board has the opportunity to be sighted on and approve specific commissioning intentions in relation to the services provided to Bury residents. • In all cases final approval to recommission would be subject to NHS GM financial and procurement governance processes and compliance with procurement regulations. • Section 3 of the report provided further detail in relation to the four contracts.

	• In relation to the VCSE element of the Bury Neighbourhood Mental Health Service (VCSE providers: BIG in Mental Health and the Creative Living Centre with additional input from Early Break). It was noted that there was a financial risk in relation to the sustainability of this service. The service was originally commissioned on a budget that incorporated a recurrent allocation plus an underspend that was accumulated due to Bury being among the last localities in Greater Manchester to go live with the Living Well model. This was done in order to commission the most viable possible model. As a consequence, there was a shortfall in recurrent funding of c£138,000 per annum from April 2027. Discussions were underway with NHS Greater Manchester commissioning and finance leads to seek to identify the additional funding required to commission on a minimum like for like basis. Dr Kumar commented that she would be happy to pick up a conversation with Mr Trafford if required regarding the outcomes that may need to be demonstrated to support additional funding within this area. Dr Kumar agreed to circulate the early life well data with Locality Board members.

ID	Type	The Locality Board	Owner
D/10/13	Decision	Noted the update.	
A/10/08	Action	Early life well data to be shared with Locality Board members	Dr Kumar

14.	Population Health and Wellbeing update
14.1	Mr Hobday presented the latest Population Health and Wellbeing update. It was reported that: - • The Bury Health and Wellbeing Board met on 3 September 2026. The agenda included discussions on community safety, neighbourhood working, health and wellbeing data, and childhood obesity. • Progress was reported on neighbourhood working across Bury's five neighbourhoods, strengthening integrated working between health, social care, housing, police, VCSE and wider partners. Focus remained on prevention, demand reduction, Live Well implementation, neighbourhood leadership teams and family hub development. Whitefield Live Well Centre opening was discussed, along with further locality-based development planned across the borough.
14.2	The following comments/observations were made by Locality Board members: - • A children's workshop had taken place last week and emotional wellbeing was discussed in terms of the neighbourhood priorities.

ID	Type	The Locality Board	Owner
D/10/14	Decision	Noted the report.	

15.	Any Other Business
15.1	There were no items raised.

ID	Type	The Locality Board	Owner
D/10/15	Decision	Noted the information	

17.	Date and time of next meeting
17.1	**Date and time of next meeting in public - Monday, 2nd November 2026, 4.00 - 6.00pm On Microsoft Teams**

BURY INTEGRATED CARE PARTNERSHIP

Locality Board Action Log – October 2026

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

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

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

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

13th April 2026/6th July 2026	A/04/01	Action	A further update/items for approval on the Place Partnership arrangements to be provided to the Locality Board in June 2026.The specific governance arrangements would need to be agreed given the timing of the June meeting.	Mr Blandamer		November 2026	Included on the agenda for June 2026. Final version to be brought back to the Locality Board in November 2026
7th Sept 2026	A/09/02	Action	An update on CAMHS to be provided to a future meeting of the Locality Board	Ms Preedy		November 2026	
7th Sept 2026	A/09/03	Action	MFT to share how the locality can connect into the OP transformation programme in terms of the SPOA/tier 2 work	Ms Kennedy		October 2026	September 2026 - Ms Wynne-Jones to follow this up with Ms Kennedy
5th October 2026	A/10/01	Action	Ms Wynne-Jones to speak to Mr Latham about the winter planning timescales and bring back an update to either the November or December Locality Board meeting.	Ms Wynne-Jones		October 2026	Included on agenda for Locality Board in November 2026
5th October 2026	A/10/02	Action	Communication plan in relation to winter planning to be shared with members.	Dr Kumar		October 2026	

5th October 2026	A/10/03	Action	Dr Kumar agreed to clarify via the Executive Leadership Team meeting – the timescales for the data to support the Outcomes Framework being made available	Dr Kumar			
5th October 2026	A/10/04	Action	Ms Wynne-Jones to review the Bury Integrated Partnership logo included as part of this documentation.	Ms Wynne-Jones			
5th October 2026	A/10/05	Action	Ms Allan to check whether Healthwatch and the VCFA are being linked into discussions in relation to the NCA Improvement Plan.	Ms Allan			
5th October 2026	A/10/06	Action	A written report in relation to the NCA Improvement Plan to be brought back to the Locality Board in November 2026.	Ms Allan			
5th October 2026	A/10/07	Action	Dr Kumar to raise the issue of availability of NHS dental care for vulnerable adults in a care home setting via the Primary Care	Dr Kumar			

			Commissioning Committee.				
5th October 2026	A/10/08	Action	Early live well data to be shared with Locality Board members	Dr Kumar			

Meeting: Locality Board			
Meeting Date	02 November 2026	**Action**	Consider
Item No.	6	**Confidential**	No
Title	Place Documentation update		
Presented By	Will Blandamer, Place Partnership Director - NHS GM (Bury)		
Author	Will Blandamer, Place Partnership Director - NHS GM (Bury)		
Clinical Lead	Dr Cathy Fines, Place Clinical Director - NHS GM (Bury)		

Executive Summary
Further to previous updates, the Place Partnership document suite is now being presented to the Locality Board for approval. Individual organisations may also wish to consider the suite through their own governance arrangements. As the Northern Care Alliance and Pennine Care operate across multiple boroughs, they may choose to undertake a single approval process on behalf of the four relevant places.
Recommendations
The Locality Board are asked to approve the Place Partnership document suite.

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	☒

Links to Locality Plan priorities	
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		

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Place Health and Care Partnership Document Suite

Summary Slides

Part of Greater Manchester Integrated Care Partnership

About This Document and Contents

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

1. **Executive Summary and Introduction:** Summarises how PHCPs enable Greater Manchester to deliver reform through prevention, neighbourhood care and system-wide collaboration.
2. **Partnership Agreement:** Sets the shared intent, principles, governance and mutual accountability for how Place partners work together.
3. **Place Outcomes Framework:** Defines the outcomes PHCPs seek to improve and the shared basis for measuring progress and collective assurance.
4. **Place Fund:** Sets out the 2026/27 Better Care Fund scope, financial stewardship, accountability and decision-making arrangements.
5. **Place Team and Hosting Arrangements** Defines the Place Delivery & Integration Service, the wider multidisciplinary Place Team and the arrangements that support workforce integration and neighbourhood working.
6. **Governance, Accountability, Oversight and Assurance Framework:** Sets the common three-layer architecture, retained accountabilities and approach to Place assurance and improvement.

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Executive Summary and Introduction

Part of Greater Manchester
Integrated Care Partnership

Foreword

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

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

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

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

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

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

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

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

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

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



Professor Colin Scales
Acting Chief Executive
NHS Greater Manchester



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

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

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System Convenor – to enable delivery of the ICP strategy

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

Strategic Commissioner

Needs Assessment & Outcomes Setting

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

Strategy and Planning

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

Contracting & Evaluating Impact of System

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

Clear Accountability and Trust

Ten Integrated Place Partnerships

Local Insight-led Planning

Develop priorities and plans to address:

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

Integrated Delivery at Place

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

Aligning Partnership Incentives & Resource

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

Enablers: portfolio/s to encompass all of these functions

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

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

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

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



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

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

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Introducing the PHCP Document Suite

How the core operating-model documents work together

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Partnership Agreement

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

Place Fund

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

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

Place Outcomes Framework

Defines the outcomes the partnership is collectively seeking to improve.

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

Place Delivery & Integration Service

Dedicated hosted capacity supporting the Partnership and neighbourhood delivery.

Forms part of the wider multidisciplinary Place Team.

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

Governance, Accountability, Oversight & Assurance

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

Sets a consistent GM core with local flexibility.

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

Logic Model - Place Delivery

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Inputs

Governance inputs:
- Partnership Agreement
- Place Fund
- Place Team
- Place Governance

Investments into:
- Place Delivery & Integration Service
- Place Grants
- Neighbourhood services through contracts

Key Activities

Activity in Live Well Centres and Spaces

Primary Care activity

Integrated Neighbourhood Team Activity

Demand Management Initiatives

Community Services Activity and Access

Metrics and Outcomes

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

Delivery Measures: Uniform across the 10 localities

Place Specific

Supported by measures to show demand reduction and cost avoidance

Contributing to GM Strategy

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

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

Leading to Change in Place and System

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

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Partnership Agreement

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Integrated Care Partnership

Partnership Agreement

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

Partnership Agreement: Structure by section

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

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

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

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

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

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

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

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

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

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

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

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

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Place Outcomes Framework

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Place Outcomes Framework

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



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



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



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



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

Place Outcomes Framework – Linking delivery measures to outcomes

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Outcome 1
Keeping people healthy and preventing ill health

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

Outcome 3
Supporting staff wellbeing and retention

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

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

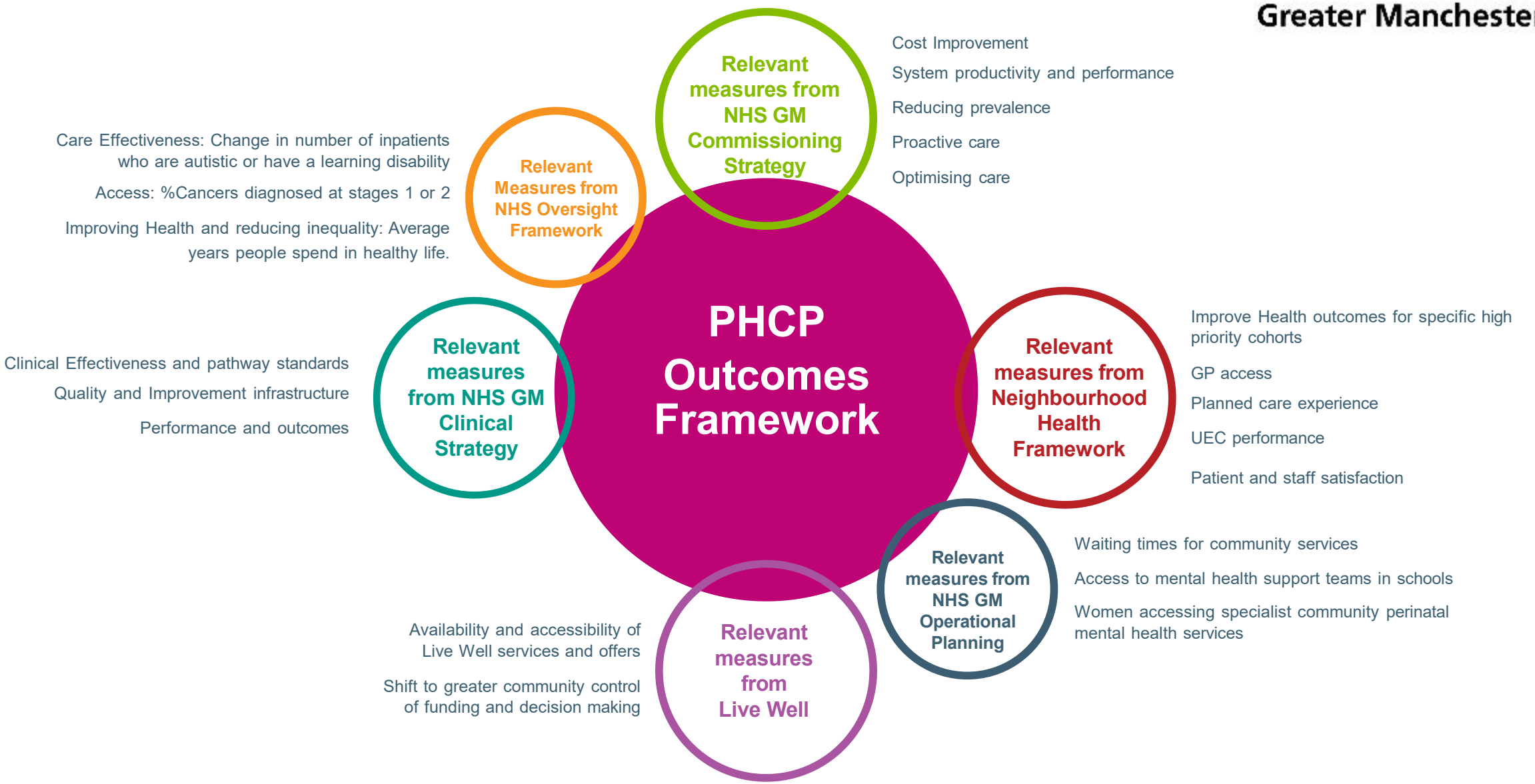
Uniform across all 10 PHCPs

Delivery measures

PHCP Specific

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

Outcomes Framework composition



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Place Fund

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Place Fund

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

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

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

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

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

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

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

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

What is included in the Place Fund?

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2026/27 Place Fund – agreed scope

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

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

Aligned expenditure – outside the Fund

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

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

Potential future additions

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

Before inclusion it must define:

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

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

Place Fund: How this works in 2026/27

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2026/27: Shadow Year for the Place Fund

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

“Shadow year” does not confer delegated financial authority.

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

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

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

Learning and Development In-Year

During 2026/27 partners may use learning to:

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

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

Strengthen reporting, assurance and record keeping

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

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Place Team

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

Part of Greater Manchester Integrated Care Partnership

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

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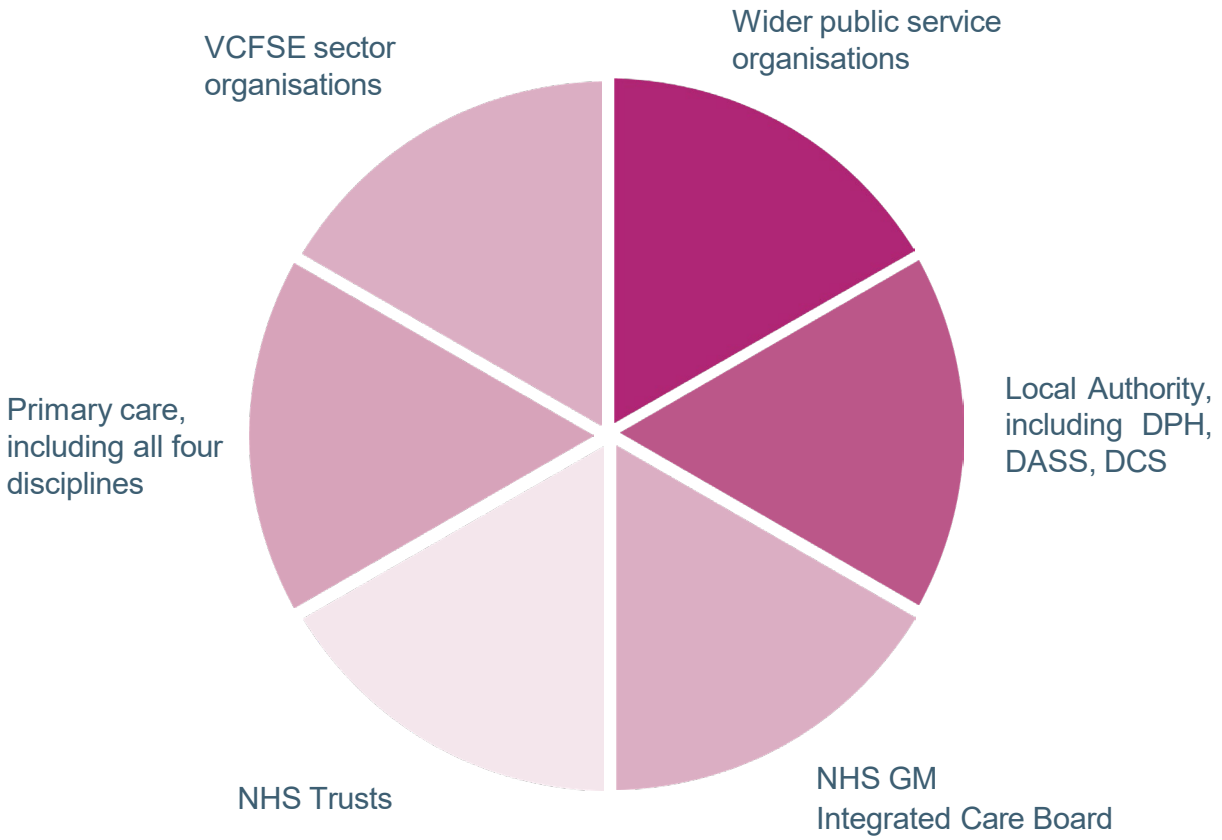

Creating success through:

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

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

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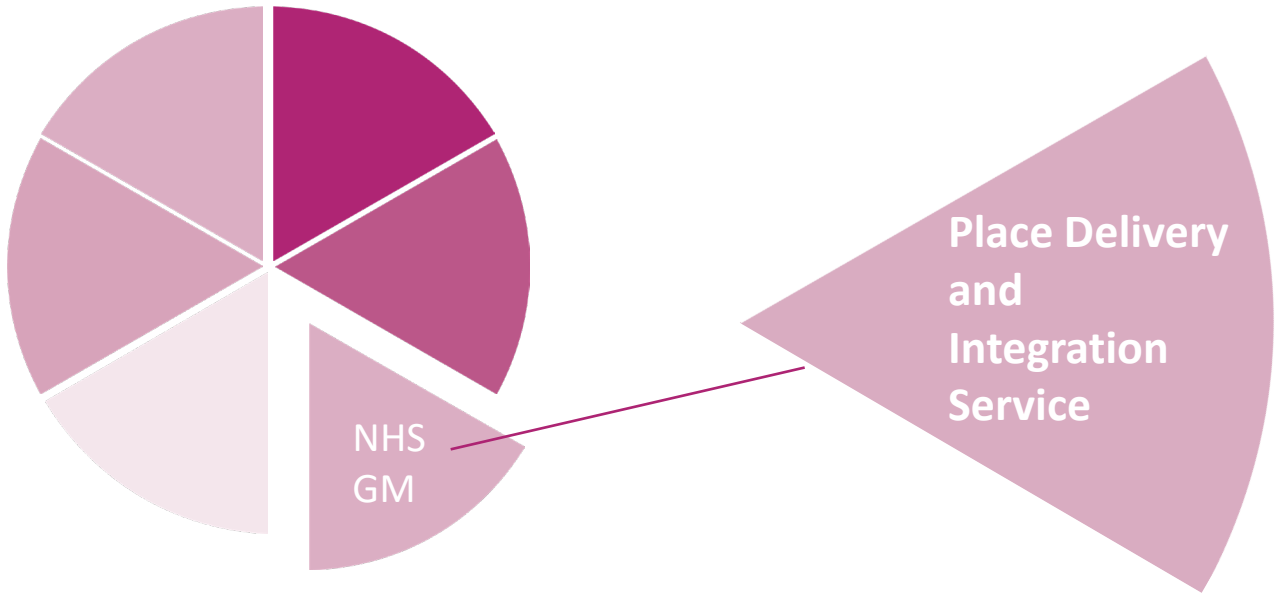
NHS GM contributes alongside all partners

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

Components of the NHS GM Model Place Team



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

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

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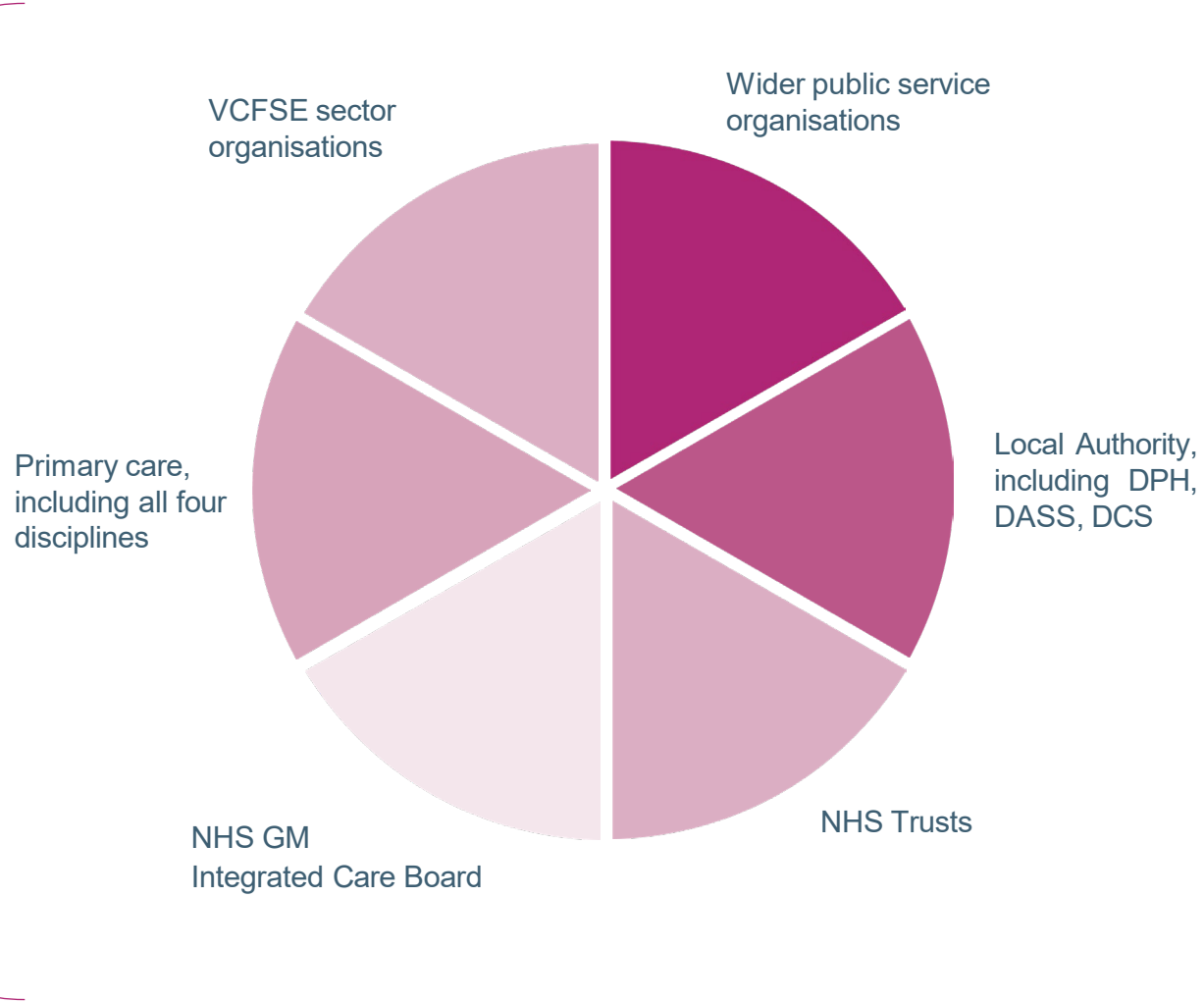
A series of potential scenarios is featured below:

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



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Governance

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Governance, Accountability, Oversight and Assurance Framework

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

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

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

Layer 3 turns shared outcomes into accountable action

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

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

ACCOUNTABILITY AND DECISION RIGHTS

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

REPORTING AND RECENT ACTIVITY

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

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Place Partnership Agreement for the operation of the local health and care system

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Narrative Overview: Place Partnership Agreement

This is the Place Health and Care Partnership Agreement, a core component of the Place Health and Care Partnerships (PHCP) document suite as referenced in the overarching slide deck. It sets out the shared framework through which Partners will work together at Place, defining the vision, principles, governance and ways of working required to deliver improved outcomes for local populations. It establishes the collective commitments, roles and responsibilities of Partners, while recognising the statutory duties and sovereignty of each organisation within the PHCP.

Together with the wider Place Mobilisation components, including the Place Outcomes Framework, Place Governance, Accountability, Oversight and Assurance Framework, Place Team and Place Fund documents, this Agreement provides a coherent foundation for collaborative working. It supports Partners to align resources, make joint decisions, and operate on a “Best for Place” basis to improve health outcomes, reduce inequalities, and deliver sustainable, locally responsive health and care services.

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Definitions and Glossary

This section provides definitions for key terms used throughout the Place Health and Care 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.

"Accountability"

The requirement for Partners to own and report on decisions and performance. Statutory accountability remains with sovereign organisations; shared accountability applies to collective commitments.

"Agreement"

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

"Best for Place"

Partners will make decisions that contribute to improved outcomes, reduced inequalities and the wellbeing of residents in Place. This includes working collaboratively to balance Place-level priorities with organisational responsibilities, ensuring that solutions are sustainable for all Partners involved.

"Best for GM"

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

"Commissioning Organisation"

The organisation holding statutory or delegated responsibility for commissioning functions relevant to this Agreement (e.g. NHS GM or the local authority).

"Delivery Board"

The operational leadership forum responsible for overseeing delivery of the Place Neighbourhood Plan(s), managing performance, quality and risk, and ensuring alignment with the Place Outcomes Framework. This may take the form of a 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.

"Greater Manchester (GM) Strategy"

The overarching strategy for Health and Care in 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"

A defined local area within Place. It is the footprint for Integrated Neighbourhood Teams, where primary care, community services, social care, mental health and VCFSE partners work together to deliver coordinated, person-centred support rooted in local communities.

"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 PHCP, responsible for setting direction, agreeing priorities, overseeing the Place Neighbourhood Plan and ensuring alignment with the GM Strategy.

"Partnership Board Terms of Reference"

means the terms of reference for the Partnership Board, drawn up in accordance with section 8 of this Agreement, an initial example of which is at Schedule 4, as may be amended from time to time.

"Place"

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

"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.

"Place Neighbourhood Plan(s)"

The annual plan that sets out the priorities, programmes, resource deployment and delivery arrangements for neighbourhood level working within the Place Health and Care Partnership.

"Place Health and Care Partnership or PHCP"

The Partners working together in accordance with this Agreement.

"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.

"Primary Care in Place"

Primary Care in Place, represented by an agreed mechanism determined locally (e.g., PCN Clinical Directors, GP Federation, Pharmacist, Optometrist or Dentist, or a democratically appointed representative(s)).

The representative(s) acts on behalf of the primary care sector, not solely their employing organisation, and holds a mandate defined in the Partnership Board Terms of Reference.

“Reserved Matters”

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

“Responsibility”

The specific duties or functions a Partner is expected to lead, deliver or support, as set out in this Agreement.

“VCFSE”

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

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1. Purpose, Parties and Status of the Agreement

1.1 Context and Purpose

Greater Manchester's model of integrated care recognises that the conditions for good health are created locally, in neighbourhoods, in communities, and through the relationships between the organisations that support them. These local partnerships provide the strongest platform for improving population health and reducing inequality.

This Agreement sets out how Partners will work together to realise that ambition through a shared focus on collaboration, prevention, tackling inequalities and the needs of our residents.

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 in Place]
- Voluntary, Community, Faith and Social Enterprise (VCFSE) partners
- Healthwatch [name]

Any additional organisations admitted by mutual agreement of all existing Partners.

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1.3 Principles of Partnership

Partners will 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;
- representatives hold a formal right of objection to decisions that would create an unfunded transfer of workload or financial liability to their organisation/sector, without their explicit agreement; and
- trust, transparency and shared accountability are essential to success.

1.4 Status of the Agreement

The PHCP is not a legal partnership or a legal entity and cannot bind Partners or enter into contracts.

This Agreement is not an NHS Contract, nor is it a legal binding contract. However, the Partners do intend for it to be formally adopted as a clear expression of shared intent, setting out the commitments, behaviours and governance arrangements that all Partners agree to follow in exercising their respective roles within the PHCP.

Being a signatory to this Agreement does not create legal or financial liability beyond existing statutory responsibilities. Signatories commit to active participation, transparency, and stewardship of shared priorities.

Each Partner remains a sovereign organisation, retaining its own statutory duties, legal responsibilities, accountabilities, governance arrangements and decision-making authority.

Where any collective decision, recommendation or position of the PHCP conflicts with a Partner's statutory, contractual, fiduciary or governance responsibilities, the Partner's sovereign responsibilities shall take precedence. Partners will explain the basis of any such conflict and work collaboratively to identify alternative solutions that remain lawful and deliverable.

Decisions of the Partnership Board are advisory and influential rather than legally binding. Partners will give due regard to collective decisions but retain full authority

to determine whether and how such decisions are implemented within their own organisations.

This Agreement supplements and aligns with but does not replace or supersede:

- Greater Manchester Strategy
- NHS GM Strategic Commissioning Strategy
- NHS GM Clinical Strategy
- Place Neighbourhood Plan(s)
- Services contracts
- Section 75 agreements
- Partnership Board and LCO / Provider Collaborative Terms of Reference

1.5 Inclusion of New Parties

New parties may join the PHCP where this strengthens the delivery of Place priorities and aligns with the principles set out in this Agreement.

Requests for membership will be considered by the Partnership Board, which will assess the organisation's role, contribution and alignment with the Partnership's purpose and ways of working.

Where the Partnership Board supports the request, a recommendation will be made to all Partners for approval in line with the decision-making arrangements in Section 8. Once approved, the new party will be added to this Agreement and the Partnership Board Terms of Reference updated accordingly.

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2. Commencement and Term

2.1 Context

The PHCP 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, periodically 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"), unless terminated earlier by agreement of all the Partners.
- The Agreement will be reviewed periodically, ensuring it remains aligned with the Place Outcomes Framework, the GM Operating Model, Greater Manchester Strategy (GMS) 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 Partners, as sovereign organisations.
- The Agreement may be updated at any time to reflect:
- changes in legislation or statutory responsibilities;
- developments in strategy, governance or delegated functions;
- material changes in the scope, ambition or operating model of the Place Health and Care Partnership.
- Any updates or variations will be agreed collectively through the Partnership Board and approved through each Partner's internal governance arrangements as necessary.
- Variations to this Agreement require:
- recommendation by the Partnership Board;

- approval through each Partner's sovereign governance;
- publication of an updated version and change log.

2.3 Withdrawal

A Partner may withdraw from this Agreement by giving a minimum of 6 months written notice to the Partnership Board, unless agreed otherwise by the Partnership Board. The transition arrangements will be agreed collectively by the Partnership Board to ensure continuity of Place responsibilities and avoid operational disruption.

3. Shared Vision, Purpose and Strategic Context

3.1 Why this matters

A shared vision provides the anchor for all PHCP activity. It ensures that decisions, resources and leadership are aligned to a common purpose, and that the work of the PHCP 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

This 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.

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4. Strategic Priorities and Place Outcomes Framework

4.1 Context

Strategic priorities provide the focus for collective action. They ensure that the PHCP directs its energy and resources towards the areas that will make the greatest difference to residents' lives. The Place Outcomes Framework sets out the shared outcomes for Place and provides the mechanism for measuring progress and holding ourselves to account in order to achieve those outcomes.

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
- Ensuring the best start in life for children and young people

4.3 Place Outcomes Framework

The Partners agree to adopt the shared Place Outcomes Framework in Schedule 1, with a view to achieving the following shared outcomes:

- **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, including giving children and young people the best start in life 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 crisis 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 Partners' collective resource to achieve shared outcomes**; evaluating impact and taking an approach of continuous improvement.

4.4 How the Place 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.

- inform decisions about the deployment of resources, supporting Partners to target investment where it can have the greatest impact.

- 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, strengthen accountability to residents and Partners, demonstrating how Place activity is contributing to improved outcomes.

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

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4.5 Place Outcomes Framework Principles

The Place Outcomes Framework will be underpinned by a set of consistent principles across GM:

- a unified framework to encourage GM wide consistency while addressing place specific priorities
- a broader approach than NHS alone - PHCPs, including NHS GM, local authorities, and voluntary sectors, will share responsibility for outcomes, with collectively agreed metrics reflecting this shared accountability
- a decision-making tool, for example, linking neighbourhood plans with activity and financial changes
- a means to identify areas requiring in-depth analysis related to challenging issues
- a platform for sharing best practices
- subject to quarterly review at Oversight and Outcome meetings - ensuring a collective understanding of issues, holding parties accountable for delivery, and maintaining a focus on solutions
- focused on the contribution of Neighbourhoods to overall delivery
- complementary to, and not replacing, existing accountability arrangements for individual organisations, which will continue to be held accountable through formal processes such as contract meetings
- inclusive of, but not limited to, national mandatory metrics
- agreed collectively, with flexibility for Places to set varying levels of ambition based on current performance and delivery methods
- limited in terms of the number of oversight metrics, with other Data Insight and Intelligence products supporting Place teams
- centred on metrics that demonstrate overall system performance
- providing one version of the truth via a balanced scorecard

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4.6 Place Outcomes Framework Structure

OUTCOMES: longer term impact measures, consistent across the 10 Places with varying levels of ambition based on starting point.

1. **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.

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

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

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

Delivery Measures: Uniform across the 10 Places

- Feature the consistent themes from the 10 Place plans
- Data generated at a minimum on a quarterly basis
- Include subject matter experts in metric design, such as elective demand management supported by the elective program team
- Establish ambitions and plans for ongoing monitoring
- Incorporate certain national requirements alongside GM strategic goals

Delivery Measures: Place Specific

- Focussed on how the individual Place will deliver the outcomes based on their specific neighbourhood plans
- Data produced at least quarterly
- Establish ambitions and plans for ongoing monitoring
- May include some national must dos and GM strategic ambitions
- Over time be monitored on a neighbourhood footprint

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5. System Characteristics, Leadership and Culture

5.1 Context

Our PHCP is built on relationships, behaviours and shared purpose as much as on structures or formal governance. The effectiveness of the PHCP 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 the Place Team to function as a coherent, collaborative system, even though Partners 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 PHCP also provides a point of focus and engagement for other important partnerships in the 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 will adopt 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.

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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 PHCP.
- **Values an equal balance of influence across sectors,** ensuring that acute, community, mental health, primary care, VCFSE and commissioner partners contribute equitably to decision-making.
- **Recognise where organisational priorities may compete**, they will utilise the Best for Place, Best for GM principles to identify shared solutions and avoid unilateral decisions that undermine collective outcomes.
- **Supports matrix working**, enabling staff to collaborate across organisational lines with clarity, purpose and mutual respect.

5.4 The Place Team

The PHCP 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 Partners;
- **works in a matrix model**, with individuals from Partners contributing to shared priorities while remaining employed by that Partner, as a sovereign organisation;
- supports the development and delivery of the Place Neighbourhood Plan(s);

- provides leadership, analytical capability, programme management and operational support to the PHCP;
- 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 Hosted and Ringfenced Roles

In order to strengthen delivery at Place, Partners may agree that specific roles, functions or capacity are formally assigned to, or deployed within, the PHCP to support agreed priorities.

These roles may:

- be hosted by a Partner organisation, including NHS Greater Manchester, the Local Authority or other Partners;
- remain employed by that organisation on existing contractual terms unless otherwise agreed;
- be ringfenced, in whole or in part, to support the work of the PHCP; and/or
- operate as part of the Place Team, contributing to shared priorities, programmes and outcomes.

Where roles are designated as ringfenced, Partners will ensure that:

- sufficient clarity exists regarding the purpose, scope and expected contribution of the role at Place;
- the individual is able to focus on agreed Place priorities without competing organisational demands, where appropriate; and
- reporting arrangements support effective integration into Place governance and delivery structures.

These arrangements are intended to strengthen collective capacity and enable more coherent system working. They do not, in themselves, create a new employing entity or alter the underlying employment relationship unless separate arrangements are formally agreed.

The detailed approaches to hosted, assigned and ringfenced roles will be set out in the Place Team Approach (Schedule 3) and kept under review as the PHCP evolves.

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5.6 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.

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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.

This Agreement strengthens neighbourhood integration, shared planning, and coordinated delivery. It is not intended to alter contractual obligations but provides a framework for joint working, shared intelligence, and aligned resource deployment.

6.2 Place Lead

The Place Lead provides visible, system-wide leadership for the development and delivery of the PHCP, acting as a unifying presence across NHS, Primary Care, Local Authority, VCFSE and community partners.

They help shape the shared vision for Place, ensure that priorities, resources and delivery models align, supporting coordinated implementation through neighbourhood and service-level teams.

The role ensures that governance, assurance and the effective use of resources operate well at Place, enabling the Partners to meet shared outcomes around population health, inequalities, quality and value.

Working alongside the wider Place Team, the Place Lead contributes to the collective flow of insight, risk, performance and local priorities into GM-wide decision-making, and supports the translation of system expectations into coherent, joined-up action across the Place.

6.3 Collective Resource and Capability Commitments

Partners agree that the PHCP is the primary forum through which the Partners 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 where appropriate and/or possible.
- **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 and/or possible, 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 Hosted, Assigned and Ringfenced Workforce Arrangements

To support the delivery of shared priorities, Partners may agree arrangements through which workforce capacity is hosted, assigned or ringfenced to the PHCP.

These arrangements are intended to provide practical mechanisms for aligning resources with Place priorities and may include:

- roles that are formally hosted by one Partner on behalf of the PHCP;
- staff who are assigned, seconded or functionally aligned to Place delivery while remaining employed by their substantive organisation;
- capacity that is ringfenced, in full or in part, to support agreed Place programmes or functions; and/or
- the establishment of joint teams or shared functions, drawing on staff from across multiple organisations.

In all cases:

- individuals will remain employees of their host organisation, unless separate arrangements are formally agreed;
- host organisations will retain responsibility for contractual employment matters, including HR processes, professional standards and line management, unless explicitly varied;
- day-to-day work priorities, objectives and delivery will be aligned to Place priorities, and overseen through Place governance arrangements where appropriate; and
- Partners will ensure that arrangements are clear, transparent and understood by all parties, including the individual concerned.

Where roles are ringfenced to Place, Partners will work collectively to:

- agree the intended contribution and outcomes associated with the role;
- ensure alignment with the Place Outcomes Framework and Place Neighbourhood Plan(s);

- review the effectiveness of the arrangement as part of ongoing performance and capability discussions; and
- adjust deployment over time in response to changing needs.

These arrangements will be reflected in, and supported by, the Collaboration Matrix (section 6.8) and the Place Team Approach (Schedule 3), which together provide clarity on how roles, functions and responsibilities are exercised across the Place.

6.6 Commitment to Continuous Development

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

- Regularly review the skills, capacity and capability required to deliver the Place Outcomes Framework.
- Identify gaps and agree how these will be addressed collectively.
- Invest in leadership development and system behaviours.
- Support the development of a shared culture of improvement, where learning is openly shared and used to strengthen practice.

6.7 Collaboration Matrix

The PHCP will be supported by a clear and consistently applied Collaboration Matrix, which provides a shared understanding of how functions, duties and activities are distributed across the system. The matrix is a practical tool that translates the principles of shared accountability into an operational framework, ensuring that all Partners understand their respective roles.

- Clarifies who leads, who supports and who assures each functional area, enabling transparency and reducing ambiguity in day-to-day working.
- Reflects the sovereign duties of each Partner, ensuring that statutory responsibilities remain with the appropriate organisation while enabling coordinated system delivery.
- Supports integrated neighbourhood delivery, by showing how responsibilities flow from GM-level frameworks through Place and into Neighbourhoods,

consistent with the commitment to “support integrated delivery at neighbourhood level.”

- Enables effective planning and prioritisation, ensuring that the right capabilities are aligned to the right functions, and that shared resources are deployed where they add most value.
- Provides a single reference point for understanding how functions are exercised across NHS GM, the Local Authority, Providers, Primary Care and the VCFSE sector.
- Strengthens accountability, supporting the Partnership Board and Delivery Board to oversee delivery, monitor progress and identify gaps or overlaps in responsibilities.
- Supports continuous development, enabling the Partnership to review and adapt responsibilities as the system matures, in line with the commitment to “regularly reviewing the skills, capacity and capability required to deliver the Place Outcomes Framework.”

The Collaboration Matrix is not a static document. It will be reviewed periodically to ensure it remains aligned with the GM Operating Model, delegated functions, and the evolving needs of residents and communities. Updates will be agreed collectively through the PHCP’s governance arrangements and reflected in the Partnership Board Terms of Reference.

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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 the shared Place Funding Framework (Schedule 2), 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 oversight of resources;
- subject to the statutory duties and sovereign governance of each Partner 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 oversight:** 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(s);
- support joint planning and prioritisation;
- enable pooled or aligned budgets where appropriate/possible;
- support investment in prevention, community assets and neighbourhood delivery;
- monitor financial performance and risk at Place level.

7.5 Decision-making

Decision-making relating to the Place funding will follow the shared governance principles set out in this Agreement, as described in Section 8.

In practice, decisions on the use, deployment and adjustment of Place-level resources will be taken collectively through the PHCP, informed by agreed priorities, evidence, and the Outcomes Framework. Partners are expected to contribute to decisions in line with their statutory duties, delegated authority and agreed roles within the Place governance model.

Where funds are hosted by a Partner organisation, the host will administer the funds but will not supersede the authority of the Partnership Board in determining their use, subject to statutory constraints, contractual or reserved matters.

Where decisions relate to the allocation or reallocation of funding, the PHCP will operate on the basis of transparency, shared intelligence and early engagement, ensuring that proposals are developed collaboratively and tested for impact on outcomes, equality, equity and financial sustainability.

Risk-sharing arrangements will be agreed collectively, including how financial pressures, overspends or savings are managed across Partners.

Any matters requiring escalation, arbitration or formal approval will follow the routes and thresholds set out in Section 8, ensuring consistency, clarity and a single approach across all Place-based decisions.

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8. Governance and Decision-Making

8.1 Context

Effective governance is essential to the success of the PHCP. 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 8 ensure that the PHCP 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 PHCP is based on shared leadership, distributed accountability and clear lines of sight between strategy, delivery and neighbourhood-level practice. Place operates with the following core components:

- **A Partnership Board**
  The strategic leadership forum responsible for setting direction, agreeing priorities, overseeing the Place Neighbourhood Plan(s), and ensuring alignment with the 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 the appropriate Terms of Reference.

8.3 Health and Wellbeing Board

The PHCP will work in close alignment with the local Health and Wellbeing Board, recognising its statutory role in setting the strategic direction for population health and tackling inequalities.

The PHCP will ensure regular two-way communication, shared insight and coordinated planning so that priorities, outcomes and delivery activity remain connected and mutually reinforcing.

This relationship is intended to strengthen collective leadership across the system, avoid duplication, and ensure that neighbourhood and place-level work is fully anchored in the ambitions of the local Health and Wellbeing Strategy.

8.4 Decision-Making

Partners agree that decision-making within the PHCP 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. Consensus means that no voting Partner formally objects to the proposed decision after reasonable discussion.
- **Best for Place, Best for GM principle**
  Partners will act in accordance with the Best for Place, Best for GM principle, ensuring that decisions are guided by outcomes, equity and the needs of communities.
- **Respect for statutory duties**
  No Partner will be required to act unlawfully, contrary to statutory duties, or in a way that compromises its organisational responsibilities. Where any collective decision, recommendation or position of the PHCP conflicts with a Partner's statutory, contractual, fiduciary or governance responsibilities, the Partner's sovereign responsibilities shall take precedence. Partners will

explain the basis of any such conflict and work collaboratively to identify alternative solutions that remain lawful and deliverable.

- **Organisational sovereignty**

  Decisions of the Partnership Board are advisory and influential rather than legally binding. Partners commit to giving due regard to collective decisions, but retain full authority to determine whether and how such decisions are implemented within their own organisations.

- **Reserved matters**
  Certain decisions remain the responsibility of individual Partners, as sovereign organisations. These Reserved Matters will be respected and handled transparently within the governance process, documented with the Partnership Terms of Reference.
- **Conflicts of interest**
- All actual or potential conflicts of interest will be declared and managed in accordance with the PHCP's agreed process, ensuring impartiality and protecting the integrity of decision-making.
- **Disagreements**
- Where a Partner does not support a collective decision, they will set out their rationale, including any statutory or operational constraints, and work with Partners to mitigate impacts on shared priorities.
- **Clarity of escalation**
  Where consensus cannot be reached, issues will be escalated in line with the dispute resolution process set out in Section 11.

8.5 Accountability

Accountability within the PHCP 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 Neighbourhood Plan(s), and the effective oversight 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.
- **Accountability for hosted and ringfenced roles**
  Where staff or functions are hosted by a Partner or ringfenced to support Place delivery, Partners agree that:
    - statutory and organisational accountability remains with the employing organisation, unless explicitly varied through formal arrangements;
    - individuals may operate to Place-aligned objectives and priorities, agreed through the Partnership's governance structures;
    - governance arrangements will ensure clarity of reporting, decision-making and escalation routes, avoiding duplication or ambiguity; and
    - no arrangement under this Agreement shall be interpreted as transferring statutory duties, legal accountability or employer liability between Partners, unless separate arrangements are formally agreed.

- **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.

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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.

Partners will operate a shared data-sharing protocol, in accordance with applicable data protection legislation and relevant guidance, covering what data is shared, how often, for what purpose, and under what safeguards.

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 PHCP. To achieve this, Partners will:

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

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 other Partners 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.

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10. Clinical Strategy

10.1 Clinical Governance

The PHCP will operate in full alignment with:

- The NHS GM Clinical Strategy, including its ambitions for clinical leadership, clinical quality, safety, outcomes, and reducing unwarranted variation.
- The NHS GM Clinical Governance Framework, including requirements for assurance, clinical risk oversight, escalation, learning, and system-wide quality improvement.
- The GM Strategic Commissioning Plan, ensuring Place-level work supports the delivery of clinical priorities, transformation programmes, and population health improvement ambitions.

Partners agree to work together to:

- Ensure that Place priorities, service developments, INTs and neighbourhood models are clinically safe, professionally supported, and aligned with GM-wide frameworks.
- Strengthen the visibility of clinical quality and safety issues that span organisational boundaries (e.g., interface issues, medicines safety, transitions of care, pathway redesign).
- Support early identification of clinical risk, enabling timely escalation through existing Partner clinical governance routes.
- Enable shared learning, cross-organisational quality improvement, and wider adoption of evidence-based practice consistent with the NHS GM Clinical Strategy.

Clinical governance at Place will focus on:

- Supporting the delivery of the GM Clinical Strategy at neighbourhood and Place level.
- Facilitating multi-professional clinical leadership and engagement in the development of pathways, redesign work and preventative models.
- Ensuring clinical quality, safety and learning are embedded in transformation and commissioning decisions.

Supporting INTs with structured clinical input and clear professional leadership connections to provider and NHS GM governance.

Partners, as sovereign organisations, retain full statutory accountability for clinical governance, patient safety and quality within their services. The PHCP will therefore:

- Not duplicate provider clinical governance committees or NHS GM governance structures.
- Provide a shared space for coordination, visibility and joint action on cross-system clinical issues.
- Ensure a coherent two-way link with NHS GM's Clinical Governance Framework to support escalation, learning, risk management and clinical leadership.

The PHCP will actively contribute to the delivery of the GM Clinical Strategy by:

- Supporting consistent clinical pathways and minimising variation.
- Embedding prevention and population health management approaches.
- Strengthening cross-sector clinical collaboration (including mental health, community, primary care and acute).
- Ensuring clinical voices shape commissioning priorities, service redesign and resource deployment.

10.2 Quality Oversight & Assurance

Quality oversight at Place will operate as a coordinating and collaborative function, supporting Partners to share intelligence, identify cross-system risks, and take joint action where issues span organisational boundaries.

- Place quality arrangements will be fully aligned with:
- NHS GM Clinical Governance Framework (assurance requirements, risk escalation, quality surveillance, and learning systems)
- NHS GM Clinical Strategy (priority areas for quality, safety, outcomes, and clinical variation)
- GM Strategic Commissioning Plan (quality as a core system enabler and outcome, prevention, sustainability, system productivity, and community based care)

The PHCP will support quality by:

- Providing a shared space to triangulate data, intelligence and feedback from across primary care, community, acute, mental health, VCFSE and social care.
- Enabling early escalation of cross-system quality risks through existing NHS GM and provider governance routes.
- Promoting joint learning and improvement where themes affect multiple partners (e.g., interface safety issues, safeguarding learning, transitions of care, medicines-related harm).
- Ensuring quality is embedded in commissioning, transformation and service redesign decisions at Place.

Partners, as sovereign organisations, retain statutory responsibilities for quality, patient safety and regulatory compliance. Place-level arrangements therefore:

- Do not replace provider Quality Committees, Local Authority governance or ICB statutory quality functions.
- Focus instead on coordination, visibility and proactive improvement of issues that require cooperation across organisational lines.

Quality insight will be routinely fed into Place governance structures and used to inform priority-setting for INTs, Neighbourhood delivery, pathway redesign and resource allocation.

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11. Problem Resolution and Escalation

11.1 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.

11.2 Principles

When managing disagreements, Partners will:

- 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; and
- not cause unnecessary delay and will seek to complete the relevant stage of dispute resolution as promptly as is reasonably possible.

11.3 Place 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 relevant Board will consider the matter in line with the PHCP's principles 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;
     - [INSERT 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 matter may be escalated through the formal dispute resolution process as follows:

     a. Independent Facilitator

     The Partners may select an independent facilitator to assist with resolving the issue. The independent facilitator shall:

- subject to the provisions of this Agreement, be provided with any information they request about the issue;
- assist the Collaborative Board to work towards a consensus decision in respect of the issue;
- regulate its own procedure and, subject to the terms of this Agreement, the procedure of the Partners at such discussions;
- determine the number of facilitated discussions, provided that there will be not less than three and not more than six facilitated discussions, which must take place within 30 days of the independent facilitator being appointed; and
- have its costs and disbursements met by the Providers involved in the issue equally or in such other proportions as the independent facilitator shall direct.

b. Mediation

If the independent facilitator cannot resolve the issue, the Partners may submit the issue to mediation by CEDR or other independent body of organisation agreed between the Partners in all other cases.
The mediation will follow the mediation process of CEDR or other independent body as may be agreed between the Parties.

c. Exit, termination or non-resolution

If, after taking the steps in this formal dispute resolution process, the issue cannot be resolved, the Partners may agree:

- that the Partner(s) involved in the dispute can withdraw from the PHCP;
- to terminate this Agreement in whole or in part; or
- that the issue need not be resolved.

11.4 Commissioning Level Disputes

Where a Commissioning Organisation is both:

- a Partner within the PHCP; and
- a statutory commissioner with corporate responsibilities that may, at times, require decisions that are separate from its role within the PHCP; and

the Commissioning Organisation, acting corporately, proposes or adopts a commissioning policy, decision or change that the Partnership Board considers is:

- materially detrimental to the delivery of the Place Outcomes Framework;
- inconsistent with the Place Neighbourhood Plan;
- misaligned with GM strategy or delegated functions; or
- likely to undermine neighbourhood delivery or worsen inequalities,

the Partnership Board may, without needing agreement from the Commissioning Organisation, raise a formal statement of concern with the Commissioning Organisation, setting out:

- the nature of the concern
- the anticipated impact on outcomes, inequalities or delivery;
- the areas of misalignment with agreed Place or GM priorities; and
- any proposed mitigations or alternatives.

11.5 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.

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12. Review, Variation and Evolution

12.1 Context

The PHCP operates 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.

12.2 Commitments

Partners agree that:

- **Regular review:**
  The Agreement will be formally reviewed on a periodic basis, ensuring it remains aligned with the Place Outcomes Framework, the GM Operating Model, and the evolving needs of residents and communities.
- **Trigger-based review:**
  The Agreement may also be reviewed earlier where:
  - significant changes occur in legislation, national policy or GM Strategy arrangements;
  - material changes arise in delegated functions, governance or funding; and/or
  - 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; and
  - recorded formally and appended to the Agreement.

- **Collective oversight:**
  No variation will be made that:
  - compromises the statutory duties of any Partner;
  - undermines the shared purpose or principles of the PHCP; and/or
  - materially alters the balance of responsibilities without explicit agreement.
- **Evolution over time:**
  This 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; and
  - adapt to changes in the scope or ambition of the PHCP.

12.3 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.

13. Signatures

(Signature blocks adapted for each Place.)

NHS Greater Manchester

Schedule 1 - Place Outcomes Framework

NHS Greater Manchester

Schedule 2 - Place Funding Framework

NHS Greater Manchester

Schedule 3 - Place Team Approach

NHS Greater Manchester

Schedule 4 -Example Terms of Reference for Partnership Board

Terms of Reference

[Place] Partnership Board

PROPOSED REVISED TEMPLATE

Template status: This document is a template Terms of Reference. Each Place must complete the locally variable provisions and secure approval through the governance arrangements of all Partners before adoption.

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1. Introduction

These are the Terms of Reference for the [Place] Partnership Board (the Board), which is the strategic leadership forum for the [Place] Place Health and Care Partnership (PHCP).

Unless otherwise stated, capitalised terms used in these Terms of Reference have the meanings given to them in the [Place] Place Health and Care Partnership Agreement (the Agreement).

These Terms of Reference set out the purpose, accountabilities, responsibilities, membership and decision-making arrangements required to enable the PHCP to work together to improve health and care for residents of [Place].

These Terms of Reference are aligned with the Agreement, the Place Fund, the Place Outcomes Framework, the Place Neighbourhood Plan(s), the GM Operating Model and any applicable Section 75 agreements.

2. Status and authority of the Board

The Board is not a separate legal entity and cannot bind a Partner, enter into contracts or exercise a Partner's statutory authority unless that authority has been expressly and lawfully delegated through a separate formal arrangement.

Decisions of the Board are advisory and influential rather than legally binding, except to the extent that a specific decision-making function has been expressly and lawfully delegated to the Board. Partners will give due regard to collective decisions while retaining authority over implementation within their own organisations.

Each Partner remains a sovereign organisation and retains its own statutory duties, legal responsibilities, accountabilities, contractual and fiduciary obligations, governance arrangements and decision-making authority. Where a collective decision conflicts with those responsibilities, the Partner's sovereign responsibilities take precedence.

Any formal delegation to the Board must be recorded in Appendix 3, including the delegating body, scope, financial limit, conditions, duration and reporting route. No delegation will be inferred from participation in the PHCP or from these Terms of Reference alone.

3. Purpose

Integrated health and care within local and Neighbourhood footprints provides a foundation for improving outcomes for communities and residents.

The PHCP is collectively responsible for improving outcomes, reducing inequalities and creating the conditions for people to live well.

The Board will set the strategic direction for health and care in [Place], agree priorities, oversee the Place Neighbourhood Plan(s), and support alignment with the Greater Manchester strategy for health and care and the Place Outcomes Framework.

The PHCP and the Board will promote equally shared leadership, distributed accountability and clear lines of sight between strategy, delivery and work undertaken at neighbourhood level.

4. Accountabilities

The PHCP is collectively responsible for coordinating the design and delivery of the Place Neighbourhood Plan(s), stewardship of Place-level resources and pursuit of the Place Outcomes Framework, subject to each Partner's statutory duties, contractual obligations, governance arrangements and decision-making authority.

The PHCP is accountable to all Partner organisations. Each Partner remains accountable through its own sovereign governance arrangements.

The Board is accountable for:

- aligning Partners around a shared set of outcomes;
- strengthening collaboration and shared accountability;
- ensuring children and young people are explicitly considered in strategy, priority-setting, outcomes and service planning;
- providing oversight and making decisions in relation to budgets only where shared financial authority has been expressly and lawfully delegated;
- overseeing the delivery of outcomes and any responsibilities expressly delegated to the Board under a documented and lawfully approved delegation;
- leading and influencing the shift towards prevention, early intervention and neighbourhood-based delivery;

- ensuring coherence between [Place] priorities and the strategic ambitions for Greater Manchester;
- providing clear and transparent reporting across Partners, with a focus on delegated accountabilities and responsibilities; and
- respecting each Partner's statutory duties, sovereign governance and Reserved Matters.

5. Responsibilities and duties

The Board will lead, monitor and track delivery of the PHCP's responsibilities, whether established through formal delegations or agreed by all Partners.

The Board is responsible for:

- setting the strategic direction of the PHCP;
- ensuring local communities can influence strategy and local service provision;
- ensuring the voices and needs of children, young people, families and carers inform strategy, delivery and evaluation;
- agreeing health and care-related strategies and plans for [Place], where these fall within the Board's authority;
- collective stewardship of financial sustainability and the PHCP's governance and risk management processes;
- overseeing any agreed arrangements for underspends, overspends, risks and gains, subject to the relevant legal and financial framework;
- modelling collaborative behaviours and integrated working;
- sharing best practice and supporting continuous learning and improvement;
- agreeing [Place]-specific metrics for Neighbourhoods and hyper-local areas within the flexibility permitted by the Place Outcomes Framework;
- using data, analysis and appropriate decision-making tools to support resilience, improvement and prioritisation;
- ensuring approaches extend beyond the NHS and social care alone;
- maintaining the relevance, integrity and effectiveness of the Agreement; and
- providing assurance to Partners, delegating bodies and other relevant parties.

6. Membership and chairing

Membership will comprise nominated strategic representatives of the Partners, including NHS Greater Manchester, the Local Authority, acute, mental health and community providers, Primary Care in Place, VCFSE Partners and Healthwatch, together with any additional Partners admitted in accordance with the Agreement.

The membership table below must distinguish between Partners, who are signatories to the Agreement, and any stakeholders or additional participants who attend but are not Partners.

Partner or sector	Nominated member	Approved substitute	Voting entitlement	Term
[Insert]	[Insert]	[Insert]	[Insert]	[Insert]
[Insert]	[Insert]	[Insert]	[Insert]	[Insert]
[Insert]	[Insert]	[Insert]	[Insert]	[Insert]

Primary Care in Place will be represented through the locally agreed mechanism. The representative will act with the mandate described in these Terms of Reference and will not be treated as having authority to bind individual practices or contractors unless expressly authorised.

The Chair and Deputy Chair will be appointed by [insert appointing body/process] for a term of [insert term]. [Insert whether the Chair and Deputy Chair have a vote and whether any casting vote applies]. If the Chair is absent or has a conflict of interest, the Deputy Chair or another member agreed by the Board will chair the relevant meeting or item.

7. Quoracy and decision-making

The Board will be quorate where at least two-thirds of voting members are present, including representation from [insert required Partners or sectors]. Approved substitutes count towards quoracy. A member who cannot participate in an item because of a conflict of interest will not count towards quoracy for that item.

Consensus is the preferred basis for decision-making. Consensus means that no voting Partner formally objects to the proposed decision after reasonable discussion. Abstention does not constitute agreement.

Where consensus is not achieved, and the matter is within the Board's authority and is not a Reserved Matter, it may be put to a vote. A decision will require two thirds of voting Partners present and entitled to vote. Each Partner will have one vote, as set out below.

Partner	Number of votes	Special conditions
VCFSE	1	[Insert]
Primary Care	1	[Insert]
Local Authority	1	[Insert]
Community & acute NHS Trust	1	[Insert]
Mental Health NHS Trust	1	[Insert]
NHS GM	1	[Insert]
Other – where relevant	1	[Insert]

Reserved Matters are listed in Appendix 2. They are outside the Board's authority and must be referred to the relevant Partner's sovereign governance arrangements. Appendix 2 will also identify any matters requiring unanimous approval by all Partners.

A representative may formally object to a proposed decision that would create an unfunded transfer of workload or financial liability to their organisation or sector without explicit agreement. The objection and supporting rationale will be recorded in the minutes. The proposed decision will not take effect for the objecting Partner unless expressly approved through that Partner's governance arrangements. The Board will consider mitigations or an alternative proposal.

Where consensus cannot be reached, the disagreement, rationale and any statutory, contractual, financial or operational constraints will be recorded and escalated through the problem resolution process in the Agreement. Pending resolution, no Partner will be committed to the disputed proposal, without prejudice to any existing statutory, contractual or regulatory duty.

All members will seek decisions that improve outcomes, reduce inequalities and support the wellbeing of residents in [Place], balancing Place priorities with organisational responsibilities and the ambitions and operating model of Greater Manchester.

8. Funding, Section 75 agreements and the Better Care Fund

Where the Board has a role in relation to the Place Funding Framework, a Section 75 agreement or the Better Care Fund, that role will be exercised only within the authority, financial limits, conditions, contractual requirements, Reserved Matters and governance arrangements expressly set out in the relevant agreement or formal delegation.

The Board will not be treated as having authority to allocate, reallocate or commit funds solely because a funding arrangement is referenced in these Terms of Reference.

Any locally applicable financial decision-making arrangements, risk and gain-sharing provisions, approval thresholds and reporting requirements must be recorded in Appendix 3 or cross-referenced to the relevant formal agreement.

9. Frequency and operation

The Board will meet no fewer than six times each year. Additional meetings may be convened by the Chair where required.

Agendas and papers will normally be circulated at least five working days before the meeting. Urgent or late business may be accepted by the Chair where necessary, with the reason recorded in the minutes.

Meetings will be held in public except where confidential, personal, commercially sensitive or legally privileged business requires an item to be considered in private. Each Place will ensure this approach aligns with the governance requirements of any statutory body through which the Board reports.

The Board will work in close alignment with the local Health and Wellbeing Board, recognising its statutory role in setting the strategic direction for population health and tackling inequalities. Local arrangements must specify whether the Board is a formal subgroup, an advisory forum or a separate partnership body, together with the reporting and escalation route.

[Insert arrangements for decisions outside meetings, including circulation, response period, required threshold and subsequent recording.]

10. Reporting and information sharing

Partners will provide assurance to one another through transparent reporting, shared intelligence and open dialogue, ensuring risks, issues and performance concerns are surfaced early and addressed collectively.

Appendix 4 will specify reporting to Partner organisations, delegating bodies, the Health and Wellbeing Board and any relevant Section 75 governance, including frequency, information required, escalation thresholds and the responsible officer.

The Board will support lawful and proportionate information sharing through the PHCP's agreed data-sharing protocol. These Terms of Reference do not create a separate lawful basis for sharing personal, confidential or commercially sensitive information.

Draft minutes, decisions and actions will be prepared within ten working days and made available to Board members. Agreed records may be used by members to report through their own statutory or organisational governance processes.

11. Confidentiality and conflicts of interest

Effective partnership working depends on transparency, openness and trust, supported by appropriate confidentiality and information governance arrangements.

All Board members and participants are expected to act professionally and with integrity, having regard to their own codes of conduct and confidentiality obligations.

All actual, potential and perceived conflicts of interest will be declared, recorded and managed under the PHCP's agreed conflicts-of-interest process and, where applicable, the relevant Partner's policy. The Chair will determine appropriate management action, including withdrawal from discussion or decision-making. Where the Chair is conflicted, the Deputy Chair or another non-conflicted member will determine the action.

A register of interests and the management action taken will be maintained by the secretariat.

12. Administration and support

The PHCP will designate [insert lead organisation or shared secretariat arrangement] to coordinate agenda planning, papers, minutes, decision records, action tracking, publication and maintenance of the conflicts-of-interest register.

Where staff or functions are hosted, assigned or ringfenced to support Place delivery, governance arrangements will provide clear reporting, decision-making and escalation routes without transferring statutory duties, legal accountability or employer liability between Partners unless separate formal arrangements provide otherwise.

Partners will contribute proportionately and equitably to the administration and support of the Board, as agreed locally.

13. Review and effectiveness

These Terms of Reference will be reviewed at least every 12 months and earlier where there is a material change to legislation, delegations, governance, funding arrangements or the Agreement.

The Board will undertake an effectiveness review every 12 to 18 months, either as a focused review of these Terms of Reference or as part of a wider system governance review.

Any amendment must be approved through the same governance arrangements used to approve these Terms of Reference and recorded in a version-controlled change log.

Appendix 1: Document approval and version control

Field	Detail
Place	[Insert]
Version	0.3 proposed revised template
Approval body/bodies	[Insert]
Approval date	[Insert]
Effective date	[Insert]
Review date	[Insert]
Document owner	[Insert]

Appendix 2: Reserved Matters

Each Place must complete this appendix before adoption. Reserved Matters are decisions or responsibilities that remain solely within the statutory or sovereign authority of an individual Partner and cannot be delegated or determined collectively by the Board.

Reserved Matter	Responsible Partner/governance body	Required approval	Notes
[Insert]	[Insert]	[Insert]	[Insert]
[Insert]	[Insert]	[Insert]	[Insert]
[Insert]	[Insert]	[Insert]	[Insert]

Appendix 3: Delegations and financial authority

Delegating body	Delegated function or decision	Financial limit	Conditions and Reserved Matters	Duration	Reporting route
[Insert]	[Insert]	[Insert]	[Insert]	[Insert]	[Insert]
[Insert]	[Insert]	[Insert]	[Insert]	[Insert]	[Insert]

Appendix 4: Reporting and assurance schedule

Recipient/body	Report or assurance required	Frequency	Escalation threshold	Responsible officer
[Insert]	[Insert]	[Insert]	[Insert]	[Insert]
[Insert]	[Insert]	[Insert]	[Insert]	[Insert]

Appendix 5: Change log

Version	Date	Summary of change	Approved by
0.3	17 September 2026	Proposed amendments following review comments on the Partnership Agreement, including clarification of status, definitions, sovereignty, delegations, consensus, voting, Reserved Matters, financial authority, reporting and conflicts of interest.	Draft for review

Outcomes Framework: Narrative Introduction

This is the Place Outcomes Framework document, a core underpinning component of the Place Health and Care Partnerships (PHCP) document suite as referenced in the overarching slide deck. It sets out the shared outcomes, priorities and measures that partners will collectively work towards at place, providing a consistent framework for aligning activity, resources and decision making to improve population health and reduce inequalities.

Together with the wider Place Mobilisation components, including the Place Partnership Agreement, Place Governance Framework, Place Team arrangements and Place Funding Framework, this framework establishes a clear basis for shared accountability and performance. It supports partners to translate strategic ambition into coordinated delivery, enabling a collective focus on prevention, neighbourhood based care, and sustainable improvement in outcomes for residents.

1. 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.

Metric Ref	National framework/GM framework/ICB team	Metric Description	Rationale	Metric Type
		Reduce inequality		
Live Well/EX1	Live Well	% residents who feel confident in knowing where to go in their local area to access support for everyday needs	Deliver equity of access	Annual Oversight
PH2	ICB Team	Reduce smoking rates for adults: a rate of less than 5% by 2030 compared to the 2023 level of 12.5%	Healthy life for longer (relative to England as a whole) and we will reduce the gap in healthy life between the richest and poorest communities	Annual Oversight
LW2	Live Well	Reduce the percentage of adults who are obese	Healthy life for longer (relative to England as a whole) and we will reduce the gap in healthy life between the richest and poorest communities	Annual Oversight
PH1	ICB Team	Reduction in gap between lowest and highest IMDs for age of onset of multiple long term conditions (currently 15yr gap in gm)	To address health inequalities	Annual Oversight
OV8	Strategic Commissioning Plan	To improve Healthy Life Expectancy (HLE) (male/female/all) in GM so that it at least matches the NW of England by 2030	To address health inequalities	Annual Oversight
OV9	Strategic Commissioning Plan	To reduce the gap in HLE between most and least advantaged areas in GM in line with a 10-year ambition to at least halve that gap by 2035 (10 Year Health Plan ambition)	To address health inequalities	Annual Oversight
OF2073	NOF 26/27	Deprivation and ethnicity gap in pre-term births	To address health inequalities	Annual Oversight
OF0117	NOF 26/27	Deprivation gap in lipid and hypertension management	To address health inequalities	Annual Oversight
OF2056	NOF 26/27	% of eligible people supported by obesity prevention programmes	To address health inequalities	Annual Oversight
		Children and Young People		
EX5.1	Live Well	% young people who, through #BeeWell schools survey, agree they have hope and feel optimistic about their future.	Improve health outcomes with specific focus on children and young people as a high-priority cohort	Annual Oversight
E.A.6	Op Plan	Expand coverage of mental health support teams (MHSTs) in schools and colleges (including teams in training)	Improve health outcomes with specific focus on children and young people as a high-priority cohort	Delivery Metric - consistent across place
EH15	Op Plan	Number of women accessing Specialist Community Perinatal Mental Health Services (12-month rolling metric)	Improve health outcomes with specific focus on children and young people as a high-priority cohort	Delivery Metric - consistent across place
Chil1	ICB Team	Reduction in dental extractions in children due to dental cavities	Improve health outcomes with specific focus on children and young people as a high-priority cohort	Annual Oversight
Chil2	ICB Team	Reduction in high/very high unmet need for children with asthma (beccor)	Improve health outcomes with specific focus on children and young people as a high-priority cohort	Annual Oversight
Chil3	ICB Team	Reduction in smoking in pregnancy rates	Improve health outcomes with specific focus on children and young people as a high-priority cohort	Annual Oversight
LW8	Early Years Foundation Stage	School readiness as measured by the proportion of children achieving a GLD	Improve health outcomes with specific focus on children and young people as a high-priority cohort	Annual Oversight
LW2	Live Well	Reduce the percentage of children who are obese	Healthy life for longer (relative to England as a whole) and we will reduce the gap in healthy life between the richest and poorest communities	Annual Oversight
Live Well/AD4	Live Well	(a) No. of children re-referred into children’s social care within 12 months (b) No. of children stepped up from Early Help to Social Care*	A successful LW approach will strengthen and enrich existing approaches to early and targeted family help, providing early intervention for families experiencing challenges, helping children thrive within their own homes and reducing the need for intensive social care interventions. Measures reflect success in	Delivery Metric - consistent across place
		Cancer		
OF0009	NHSOF	Percentage of all cancers diagnosed that are diagnosed at stage 1 or 2	Improve health outcomes for people with cancer through early diagnosis and treatment	Delivery Metric -
Can1	ICB Team	Cancer Screening rates	Improve health outcomes for people with cancer through early diagnosis and treatment	Delivery Metric -
		Long Term Conditions		
LiveWell/AD2	Live Well	% patients with long-term conditions repeatedly not taking up offers of support who are then identified and helped (“Missingness” positively addressed)	Improve health outcomes for people long term conditions - Initial phases focused of cardio-vascular disease, diabetes and respiratory conditions. Scope for wider expansion to a range of other long-term	Delivery Metric - consistent across place
OF0054	NHSOF	Percentage of patients with GP recorded CVD who have their cholesterol levels managed to NICE guidance	Improve health outcomes for people with CVD through improved diagnosis and treatment	Delivery Metric - consistent across place
OF0053	NHSOF	Percentage of hypertension patients treated to target	Improve health outcomes for people with hypertension through improved diagnosis and treatment	Delivery Metric - consistent across place
LD/SMI1	ICB Team	Increasing the proportion of people with Learning Disabilities (aged 14 and over) who receive an annual health check and personalised care plan	Improve health outcomes for people with Learning Disabilities through improved access to annual health checks and personalised care plans	Delivery Metric - consistent across place
SMI1	ICB Team	Increasing the proportion of people with SMI (aged 18 and over) who receive an annual health check and personalised care plan	Improve health outcomes for people with SMI through improved access to annual health checks and personalised care plans	Delivery Metric - consistent across place
		Imms		
Imms2	ICB Team	Childhood vaccinations	Improve health outcomes with specific focus on children and young people as a high-priority cohort	Delivery Metric -
Imms3	ICB Team	Winter illness vaccination rates	Improve health outcomes by prioritising individuals who benefit from vaccination as a key cohort	Delivery Metric -

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

National framework/GM framework/ICB team	Metric Description	Rationale	Metric Type
	Access to General Practice		
Live Well	% residents who say it is easy to contact their GP practice (GP Patient Survey)	Improve access to general practice so people can see their GP in a timely, high-quality way	Delivery Metric - consistent across place
National Neighbourhood Framework	90% of clinically urgent patients on the same day by March 2027	Improve access to general practice so people can see their GP in a timely, high-quality way	Delivery Metric - consistent across place
	CHC		
NHSOF	Percentage of continuing healthcare referrals completed in 28 days	Better co-ordination of care for high-priority cohorts	Delivery Metric - consistent across place
	Children and Young People		
National Neighbourhood Framework	Reduce acute outpatient appointments for children under the age of 16 by 10%	Improve quality and access to care for children and young people by enhancing paediatric expertise across the pathway, including primary care	Delivery Metric - consistent across place
National Neighbourhood Framework	Reduction of community waits for children, as part of delivering Medium Term Planning Framework success measures	Improve quality and access to care for children and young people by enhancing paediatric expertise across the pathway, including primary care	Delivery Metric - consistent across place
	Community		
National Neighbourhood Framework / NHSOF	For those adult patients not discharged on their DRD, the average (mean) number of days from the DRD to discharge	Ensure there is better co-ordination of discharge process and capacity planning across health and care services, enabling patients to be discharged efficiently and effectively. Contribute to an improvement in the average length of discharge delay	Delivery Metric - consistent across place
National Neighbourhood Framework	The proportion of adult patients discharged from acute hospitals on their discharge ready date (DRD)	Ensure there is better co-ordination of discharge process and capacity planning across health and care services, enabling patients to be discharged efficiently and effectively. Contribute to an improvement in the average length of discharge delay	Delivery Metric - consistent across place
Op Plan	Increased utilisation of Pharmacy First, Hypertension Case Finding, Contraception services	Better access in community and reduce reliance on others services	Delivery Metric - consistent across place
Op Plan	Reduction of community waits for adults, as part of delivering Medium Term Planning Framework success measures	Better access in community	Delivery Metric - consistent across place
	Elective		
ICB Team	A&G: deliver a 10% increase in requests for Advice & Guidance over 25/26 baseline in 2026/27	Improve experiences of planned care and support delivery of the referral to treatment (RTT) standard	Delivery Metric - consistent across place
ICB Team	Community: work with elective programme and local trust to design and implement a local community / Tier 2 provision for ENT and Gynaecology specialties in 2026/27 [Suggested Change to expand scope and longevity - Work with Elective programme and Trust to implement community/Tier 2 provision through 2026/27]	Deliver more follow-up outpatient care in neighbourhoods	Delivery Metric - consistent across place
ICB Team	Referral rates: reduce referrals by 5% across 10 specialties in 2026/27 vs 2025/26 baseline, in line with BeCCoR EQIS scheme	Improve experiences of planned care and support delivery of the referral to treatment (RTT) standard	Delivery Metric - consistent across place
National Neighbourhood Framework	Follow-up appointments: work with local Trust to redesign outpatient model to support reduction in follow-up appointments by at least 10% by March 2027	Improve experiences of planned care and support delivery of the referral to treatment (RTT) standard	Delivery Metric - consistent across place
	End of Life		
National Neighbourhood Framework	Better identify people coming to the end of life and improve access to services so people can die in a place of their choosing by increasing the number of people identified as approaching end of life by 10%	Better identify people coming to the end of life and improve access to services so people can die in a place of their choosing	Delivery Metric - consistent across place
National Neighbourhood Framework	Reduce non-elective admissions and bed days of one day or over by 10% for the end of life cohort by March 2029	Better identify people coming to the end of life and improve access to services so people can die in a place of their choosing	Delivery Metric - consistent across place
	Harm		
ICB Team	Reduction in medicines related harm through neighbourhood approaches	Improve safety of care	Delivery Metric - consistent across place
	Long Term Conditions		
National Neighbourhood Framework	Improvement of at least 10% in evidence-based clinical outcomes, measured through quality and outcomes framework standards for CVD, diabetes, COPD, mental health conditions and dementia	Better diagnosis and treatment for people with long-term conditions	Delivery Metric - consistent across place
ICB Team	Reduction in those with high/very high unmet need (CVD, Diabetes, Asthma, COPD) through neighbourhood approaches (beccor)	Improve health outcomes for people with long term conditions	Delivery Metric - consistent across place
NHSOF / National	Percentage of diabetes patients to receive all eight care processes	Better diagnosis and treatment for people with long-term conditions	Delivery Metric - consistent across place
Op Plan	Reducing the number of admissions to inpatient settings and reducing length of stay for people with learning disability and/or autism	Improved provision and co-ordination of care people with mental illness. Ensure there is better co-ordination of discharge process and capacity planning across health and care services, enabling patients to be discharged efficiently and effectively.	Delivery Metric - consistent across place
NHSOF	Percentage change in the number of inpatients who are autistic or have a learning disability	Improving lives of those with LD and/or autism	Delivery Metric - consistent across place
Op Plan	Reduce admission rates to mental health hospitals for people with a learning disability and autistic people	Improving lives of those with LD and/or autism	Delivery Metric - consistent across place
	Mental Health		
SCGCSINAWG	Average LOS (physical and mental health) to be improved	Improved provision and co-ordination of care people with mental illness. Ensure there is better co-ordination of discharge process and capacity planning across health and care services, enabling patients to be discharged efficiently and effectively.	Delivery Metric - consistent across place
ICB Team	Reducing the number of people presenting to A&E in mental health crisis (all age)	Improved provision and co-ordination of care people with mental illness. Ensure there is better co-ordination of discharge process and capacity planning across health and care services, enabling patients to be discharged efficiently and effectively.	Delivery Metric - consistent across place

ICB Team	Reduction in CRFD for adults, older adults and rehab patients in MH inpatient settings	Improved provision and co-ordination of care people with mental illness. Ensure there is better co-ordination of discharge process and capacity planning across health and care services, enabling patients to be discharged efficiently and effectively.	Delivery Metric - consistent across place
	UEC		
National Neighbourhood Framework	Reduce category 3 and 4 ambulance conveyances in high-priority cohorts (those with mid to severe frailty, in a care home or housebound and end of life) by March 2029	Have fewer ambulance call-outs for the least urgent cases, with appropriate diversion to relevant urgent care provision in the community.	Delivery Metric - consistent across place
National Neighbourhood Framework	Reduce non-elective admissions and bed days of one day or over by 10% for people with mild to severe frailty, in a care home or housebound by March 2029	Help people with mid to severe frailty, in a care home or housebound, to stay healthier, manage escalating conditions and maintain greater independence for longer.	Delivery Metric - consistent across place
National Neighbourhood Framework	Keep growth flat and work towards an overall reduction in non-elective admissions for high priority cohorts	Better co-ordination of reactive care for high-priority cohorts (those with mid to severe frailty, in a care home or housebound and end of life), increasing use of urgent care provision in the community. For example, by making	Delivery Metric - consistent across place
National Neighbourhood Framework	Contribute to an overall reduction in type 1 ED attendances for high priority cohorts	Better co-ordination of reactive care for high-priority cohorts (those with mid to severe frailty, in a care home or housebound and end of life), increasing use of urgent care provision in the community. For example, by making	Delivery Metric - consistent across place
	Live Well infrastructure		
Live Well	% of neighbourhoods in each locality with a Live Well access point (Centres and Spaces) % LW centres offering: I. Employment support pathway II. Housing support and advice **III. Mental health & wellbeing support** **IV. Primary care** V. Debt advice & income support*	The ambition through LW is for residents to be able to access support in their local area, with “priority offers” available through their local access points. The metric reflects the five proposed priority offers at the time of writing	GMS Implementation monitoring

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

Metric Ref	National framework/GM framework/ICB team	Metric Description	Rationale	Metric Type
		Workforce		
Live Well/WOW 3	Live Well	% of frontline workers in Live Well roles reporting feeling fully integrated into the wider health, care and other public services in their area	Improve staff satisfaction	Delivery Metric - consistent across place
OF0082	NHSOF	Staff sickness rate	Improve staff satisfaction - drawn from across the entire partnership from several inputs to provide the most accurate picture	Delivery Metric - consistent across place
OF0061	NHSOF	Staff survey – raising concerns sub-score	Improve staff satisfaction - drawn from across the entire partnership from several inputs to provide the most accurate picture	Delivery Metric - consistent across
OF0084	NHSOF	Staff survey engagement theme score	Improve staff satisfaction - drawn from across the entire partnership from several inputs to provide the most accurate picture	Annual Oversight
Ref TBC	NHSOF	Staff survey - We are compassionate and inclusive headline metric score	Improve staff satisfaction, wellbeing and retention drawn from across the entire partnership from several inputs to provide the most accurate	Annual Oversight
Ref TBC	WRES	WRES indicator 5 - %staff experiencing harrassment, bullying or abuse from patients/relatives/public	GM agreement via the ICP to combat racism and support staff and communities.	Annual Oversight
Ref TBC	WRES	WRES indicator 6 - %staff experiencing harrassment, bullying or abuse from colleagues, managers	GM agreement via the ICP to combat racism and support staff and communities.	Annual Oversight
Ref TBC	WRES	WRES indicator 8 - %staff experiencing discrimination at work from managers, team leaders, colleagues	GM agreement via the ICP to combat racism and support staff and communities.	Annual Oversight
Ref TBC	NHSOF	Staff mix - agency spend as % of total temporary staffing/ Bank vs agency spend split	Improve staff retention	

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

Metric Ref	National framework/GM framework/ICB team	Metric Description	Rationale	Metric Type
		Experience		
Nat20B	National Neighbourhood Framework	By 2027 95% of people with complex needs will have an agreed care plan	Take a proactive approach, where the patient feels in control of their care	Delivery Metric - consistent across place
OV12	Hospital experience scores to be improved	Hospital experience scores to be improved	Improve patient satisfaction with NHS services	Annual Oversight
Nat10	National Neighbourhood Framework	Improve patient satisfaction with GP access	Improve access to general practice so people can see their GP in a timely, high-quality way	Annual Oversight
ICB Team	Local	Improve shared decision making	Improve satisfaction with NHS services	Annual Oversight
OV13	Strategic Commissioning Plan	Mental Health services experience scores to be improved	Improve patient satisfaction with NHS services	Annual Oversight
		Financial stability and productivity		
ICB Team	ICB Team	Place delivers a level of financial efficiency, which a minimum will be the national efficiency requirement (set annually)	To deliver financial stability	Delivery Metric - consistent across place
ICB Team	ICB Team	Place delivers an improvement in productivity and accessibility for the services within the scope of the Place Fund – specific metrics TBC	To deliver financial stability	Delivery Metric - consistent across place
ICB Team	ICB Team	Place delivers at least a balance position with the funding available via the Place Fund (set annually)	To deliver financial stability	Delivery Metric - consistent across place
ICB Team	ICB Team	Place delivers non-financial savings through demand management initiatives - specific metrics TBC	To deliver financial stability	Delivery Metric - consistent across place
NEW	ICB Team/Place Partnership	Clearly identified opportunities to increase and deliver more through the Place Fund).	Over time, and subject to agreed processes, additional budgets may be aligned into the Place Fund using a consistent GM-wide methodology. This aligns with the Strategic Financial Framework's emphasis on:	Delivery Metric - consistent across place
LW /WOW4	Live Well	Shift to greater community control of funding and participation in decision-making around how public money is spent Share of implementation support funding to VCFSE	A further key pillar of LW is: "a resilient VCFSE ecosystem" – creating the conditions for a resilient and connected VCFSE sector resourced to respond to what matters to people, with community-led approaches at its heart. This metric speaks to the central ambition of LW to promote a shift to greater control of funding.	GMS Delivery Monitoring
		Quality		
IMPR1	ICB Team	Increase in QI capabilities (as evidenced by QI skills question on staff survey)	Embed quality improvement methodology	Annual Oversight

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Place Fund

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Place Fund: Narrative Overview

This is the Place Fund document, an underpinning document in the Place Health and Care Partnerships (PHCP) document suite as referred to in slides 20-23 in the overarching summary slide deck.

The Place Fund document sets out the current scope and operation of the Place Fund, including financial stewardship, accountability and decision-making. It should be read alongside the Place Partnership Agreement and the accountability, governance and assurance documentation.

The Place Fund is only one component of the overall funding spent in each Place. The expectation is that Place partnerships have visibility of the total spend in each Place through the “Jigsaw” and play a fundamental role in influencing how funding is spent, such as through urgent care demand management.

The framework builds on partners’ shared commitment to strong financial stewardship. It supports clear, connected accountability and collective oversight, while preserving the formal statutory, financial and contractual responsibilities of the organisations that hold and transact funding.

Background and Strategic Context

Greater Manchester’s strategic direction creates an opportunity to evolve investment and delivery models over time, with greater emphasis on community services, prevention and neighbourhood-based support. The current Place Fund provides a firm foundation through the agreed Better Care Fund arrangements. Partners are committed to developing proposals for potential future additions, including left shift and VCSFE funding. Any resource shift beyond the current arrangements will be assessed and considered separately through the appropriate governance and approval processes.

Future changes can be developed collaboratively through the appropriate governance arrangements. In the context of significant operational and financial pressures, proposals will balance immediate constraints, service stability and affordability with the opportunity for medium-term transformation.

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The Financial Opportunity

The GM Integrated Care Board (ICB) is responsible for managing approximately £9bn of public funding on behalf of GM residents. How these resources are spent in each Place is reflected in the "Jigsaw", with a recognition that the Jigsaw needs to evolve to more accurately reflect appropriately weighted spend, what funding would be available on a "needs" basis and the outcomes being delivered for the funding available i.e. the value for money.

The Place Fund seeks to bring disparate spend together so that Place partners have full visibility of spend, such as Intermediate Care, rather than this being reported in acute, community and independent sector spend. By having this full visibility, Place partners can make holistic decisions and drive much better value than the current arrangements. In addition, Place partners can explore economies of scale where providers have multiple commissioners.

The Place Fund is just one component of the overall spend in each Place. The Place Partnership Board will have visibility of all relevant expenditure in its Place, so health and social care, the impact this is having, the opportunities to drive the left shift in spend and deliver better outcomes from the funding available.

The Place Fund

The Place Fund is an important element of the Greater Manchester operating model. For 2026/27, it brings together the agreed Better Care Fund scope through the existing Section 75 and Better Care Fund arrangements. The Place Partnership Board provides partnership oversight and influence, while formal financial authority remains with the relevant statutory decision-makers.

The Place Fund is just one component of the overall resources in each Place over which Place partners will have visibility and can influence. For 2026/27, the Place Fund comprises the agreed Better Care Fund scope, which was revised to include ten categories of expenditure to ensure each Place Fund started on a broadly consistent basis. Partners are committed to developing proposals for potential future additions to the Place Fund, such as left shift, VCSFE and capacity funding. Any addition will be subject to assessment, stakeholder agreement and the relevant governance and approval processes.

The ten agreed categories of BCF spend applied consistently across all Places are:

Community equipment, including telehealth, digital solutions and wheelchairs	Intermediate care, including bed-based and home-based provision	Integrated Neighbourhood Teams (NHS services) recognising local variation in terminology	Reablement services	Protection of adult social care
Care co-ordination	Support for Carers	Hospices	Community Nursing	Discharge to Assess

Place partners will provide joint oversight and shape proposals within the agreed arrangements, with formal decisions taken by the relevant authorised ICB or local authority decision-maker as partners to the Better Care Fund. Recommendations made by the Place Partnership Board will be given due consideration by the relevant authorised decision-makers. Where a recommendation is not approved, the relevant decision-maker will provide clear reasons and identify any further action or escalation required.

As part of this standardisation, certain areas of spend have been moved from the BCF into other ICB budget lines. These include:

- Primary care, including GP out-of-hours services
- Adult Continuing Healthcare
- Children's social care
- Mental health IAPT services
- Mental health and learning disability placements
- End-of-life care (excluding hospices), with further review planned
- Non-NHS community services, pending further contract rationalisation

The reclassification changes how funding is classified but does not remove funding or discontinue services. The expenditure remains visible to Place partners through the Jigsaw.

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Place Resources

As noted above, the Place Fund is just one component of the overall resources being spent in each Place. All relevant health and social care expenditure in each Place will be visible to Place partners. For example, this includes spend on A&E attendances, outpatient appointments, primary care, continuing healthcare packages and mental health services. The health elements are captured within the Jigsaw that is provided by the ICB, and the expectation is that Place partners bring financial information to the Place Partnership Board. For example, the Place Partnership Board should be central to discussions regarding the deployment of the Live Well funding.

Financial decision-making, governance and assurance

The existing Better Care Fund and Section 75 governance arrangements will continue during the 2026/27 shadow year. The following arrangements will be developed and confirmed for the Place Fund from 2027/28:

- The Place Partnership Board provides joint oversight and influence, helping partners shape priorities and recommendations, while formal financial authority remains with the relevant statutory decision-makers.
- Within the agreed Better Care Fund scope, partners can develop proposals and recommendations for approval by the relevant authorised decision-maker or decision-makers, in line with the existing Better Care Fund and Section 75 arrangements.
- Regular reporting will cover expenditure against plan, forecast position, delivery, outcomes, risks, mitigations and matters requiring escalation.

As opportunities for future additions emerge, partners will confirm and approve the appropriate governance before funding or services are included, reflecting the nature of the funding and the mechanism used to transact it.

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Draft Finances

	2025/26			2026/27			Year on Year Change		
Locality	NHS Minimum Contribution	Additional NHS Contribution	Total	NHS Minimum Contribution	Additional NHS Contribution	Total	NHS Minimum Contribution	Additional NHS Contribution	Total
Bolton	£ 31,600,519	£ 4,899,747	£ 36,500,266	£ 32,671,355	£ 23,587,038	£ 56,258,393	£ 1,070,836	£ 18,687,291	£ 19,758,127
Bury	£ 19,577,112	£ 2,136,317	£ 21,713,429	£ 20,235,161	£ 9,956,165	£ 30,191,326	£ 658,049	£ 7,819,848	£ 8,477,897
HMR	£ 25,006,338		£ 25,006,338	£ 25,839,000	£ 11,821,977	£ 37,660,977	£ 832,662	£ 11,821,977	£ 12,654,639
Manchester	£ 61,951,118	£ 2,919,654	£ 64,870,772	£ 63,739,285		£ 63,739,285	£ 1,788,167	-£ 2,919,654	-£ 1,131,487
Oldham	£ 26,466,246		£ 26,466,246	£ 27,008,093	£ 8,771,406	£ 35,779,499	£ 541,847	£ 8,771,406	£ 9,313,253
Salford	£ 30,535,029	£55,155,918	£ 85,690,947	£ 31,629,403	£ 31,284,995	£ 62,914,398	£ 1,094,374	-£ 23,870,923	-£ 22,776,549
Stockport	£ 30,621,034		£ 30,621,034	£ 31,548,357	£ 22,033,708	£ 53,582,065	£ 927,323	£ 22,033,708	£ 22,961,031
Tameside	£ 24,530,503		£ 24,530,503	£ 25,326,410	£ 13,074,248	£ 38,400,658	£ 795,907	£ 13,074,248	£ 13,870,155
Trafford	£ 22,721,698		£ 22,721,698	£ 23,389,589	£ 4,516,367	£ 27,905,956	£ 667,891	£ 4,516,367	£ 5,184,258
Wigan	£ 35,917,248		£ 35,917,248	£ 37,201,259	£ 11,297,527	£ 48,498,786	£ 1,284,011	£ 11,297,527	£ 12,581,538
Grand Total	£308,926,847	£65,111,636	£374,038,482	£318,587,912	£136,343,431	£454,931,343	£ 9,661,065	£ 71,231,795	£ 80,892,861

The draft financial position reflects the application of the agreed Better Care Fund categorisation and provides the baseline for the 2026/27 Place Fund.

While two categories of Place expenditure have reduced as part of this reclassification, the Better Care Fund in each Place remains above the national minimum contribution requirements. The overall position demonstrates increased coherence and transparency in how resources supporting community, intermediate care and neighbourhood services are identified and managed.

This position reflects the agreed 2026/27 scope. Any proposal to add services or funding from 2027/28 will be considered consistently across Greater Manchester, agreed with key stakeholders and approved through the governance arrangements relevant to the funding and transaction mechanism before inclusion.

Importantly, no funding has been withdrawn from frontline activity as a result of this exercise. As mentioned earlier, where spend has moved out of the BCF, it has been repositioned into more appropriate ICB budget lines to better reflect commissioning responsibilities and contractual structures. Services continue to be funded, with changes focused on improving clarity, consistency and alignment rather than reducing investment.

Overall, the draft finances provide a clearer baseline for managing the agreed 2026/27 Better Care Fund services and for financial oversight in each Place within the existing statutory and organisational accountabilities.

Shadow Year

During 2026/27, the Place Fund will bring together the agreed Better Care Fund services through the existing Section 75 and Better Care Fund arrangements. The

"shadow year" provides a practical opportunity for partners to learn, strengthen ways of working and inform future choices. Formal financial authority remains unchanged, and any future delegation would be considered and agreed separately.

During 2026/27, partners may use learning from operation of the Place Fund to inform future proposals. This includes:

- Confirm and document the operating arrangements, governance and controls for the agreed 2026/27 Better Care Fund scope
- Develop and test neighbourhood investment and left shift mechanisms, including risk and gain-share approaches
- Strengthen reporting, assurance and record keeping for the services within the Place Fund
- Use learning from the Place Health and Care Partnership work to inform future partnership and financial arrangements

The current operating model will be described clearly across this document, the Place Partnership Agreement and the accountability, governance and assurance documentation. Learning from 2026/27 will help partners co-design any future operating model, with agreement in place before additional funding or services are included.

Future Planning

The Place Fund provides a platform for the wider ambition to increase investment in neighbourhood and community-based services over time. For 2026/27, it operates within the agreed Better Care Fund scope, while creating learning that can inform future proposals for resource alignment.

From 2027/28, partners are committed to developing and considering proposals for additional areas of expenditure to be included in the Place Fund, alongside evolving the Jigsaw to provide more granular information. Any addition will be subject to assessment, stakeholder agreement and the relevant governance and approval processes. Partners may also explore opportunities to align budgets, strengthen risk and gain-sharing arrangements, reduce fragmentation in contracting and manage risks collectively to unlock future investment.

Future proposals will be designed to support the stability and sustainability of acute, primary care, mental health and local authority services. The timing, scale and destination of any resource change will be assessed with partners and progressed through the appropriate approval routes.

This document will be reviewed as the Greater Manchester operating model, national policy and the Place Fund arrangements develop. Any substantive change to scope, authority or governance will be subject to stakeholder engagement and the appropriate organisational approvals.

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Place Team Framework

V3

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Purpose and status

This document describes the role and operation of the wider multidisciplinary Place Team within each Greater Manchester Place Health and Care Partnership. It should be read alongside the Place Partnership Agreement, Place Outcomes Framework, Place Fund, Governance, Accountability, Oversight and Assurance Framework, relevant Section 75 arrangements, and the Place Service and Hosting Contract.

The model distinguishes between:

- The **wider Place Team**, comprising capacity contributed by NHS Greater Manchester, local authorities, NHS providers, primary care, voluntary, community, faith and social enterprise organisations, and other Partners.
- The **Place Delivery and Integration Service**, which is the dedicated NHS Greater Manchester-funded service supporting Place leadership, strategic planning, programme delivery, transformation, partnership development, governance, integration and enabling activity.
- The **provider organisation**, which will become the substantive employer of the transferring workforce and provide employment and organisational infrastructure.
- The **Place Health and Care Partnership**, which agrees local priorities and outcomes and oversees delivery through its partnership arrangements.
- **NHS Greater Manchester**, which remains the commissioner and funder of the Place Delivery and Integration Service and retains its statutory, financial, contractual, quality and strategic commissioning accountabilities.
- All Partners are expected to identify, agree and maintain a proportionate contribution to the wider Place Team. Participation in the wider Place Team does not, of itself, alter an organisation's statutory responsibilities or an individual's employer, contractual terms, professional accountability or formal line-management arrangements.

These arrangements are intended to protect and strengthen Place-based working while enabling NHS Greater Manchester to operate as a more focused strategic commissioner.

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Strategic context

Place is central to the Greater Manchester operating model and provides the connection between strategic commissioning, neighbourhood working and integrated local delivery. It supports the shift from hospital to community, from treatment to prevention, and towards shared leadership and delivery with communities and Partners.

Place Health and Care Partnerships bring together the NHS, local government, primary care, the voluntary, community, faith and social enterprise sector, and wider public services to improve population health, reduce inequalities and coordinate services around local needs.

Health and Wellbeing Boards retain their statutory role. Place arrangements complement, rather than replace, the legal responsibilities and decision-making authority of individual partner organisations.

A common Greater Manchester framework will provide consistency in purpose, outcomes, governance, assurance and hosting arrangements. Local flexibility will remain important because each Place has different relationships, delivery arrangements, capabilities and levels of maturity.

The model depends on active contribution from all Partners. The Place Delivery and Integration Service provides a funded and stable core, but it does not constitute the whole Place Team or carry sole responsibility for delivering the full breadth of Place activity.

Purpose of the Place Team

The Place Team enables the Place Health and Care Partnership to turn shared priorities into coordinated action. It provides the leadership, relationships, capacity and technical expertise required to:

- Develop and deliver Place strategies, plans and transformation programmes.
- Support integrated neighbourhood working and the Live Well approach.
- Coordinate delivery across organisational and professional boundaries.

- Use population health intelligence, evidence and lived experience to identify priorities.
- Support prevention, early intervention and action on health inequalities.
- Develop integrated services and pathways that respond to local need.
- Align resources and influence investment towards agreed outcomes.
- Support clear governance, performance oversight, risk management and assurance.
- Engage residents, patients, carers and communities in service design and improvement.
- Escalate risks or concerns where action is required by NHS Greater Manchester or another organisation holding statutory or contractual accountability.

The Place Team is not a separate legal entity, statutory commissioner or contract holder. It operates through the authority and governance of the organisations participating in the Place Health and Care Partnership.

Relationship between the wider Place Team and the Place Delivery and Integration Service

For the purposes of this framework, the Place Team is the collective, multi-organisational capacity brought together by Partners to deliver agreed Place priorities. It is not a separate organisation, employing entity or joint employer. It includes the Place Delivery and Integration Service, together with leadership, workforce, expertise, assets and other capacity contributed by local authorities, NHS providers, primary care, the VCFSE sector and other Partners through substantive, hosted, seconded, joint, assigned, ringfenced or matrix arrangements.

The Place Delivery and Integration Service is the identifiable service currently delivered by NHS Greater Manchester to provide dedicated leadership, strategic planning, programme management, transformation, partnership development, governance, integration and enabling capacity in support of the relevant Place Health and Care Partnership. Its purpose is to enable the Place Health and Care Partnership to agree and deliver shared priorities, support neighbourhood working, coordinate resources and improvement across organisational boundaries, and provide assurance to NHS Greater Manchester and Place governance.

The transfer and hosting of that Service, including employees assigned to it, is a distinct service and employment process governed through the relevant contract and schedules, workforce consultation and applicable TUPE protections. The wider Place Team is the collaborative operating model within which the Service will work; it is not itself the service being transferred.

Wider Partner contributions supplement the Service and do not, of themselves, change its identity, continuity or scope. Staff contributed by other Partners remain employed by their substantive organisations and retain their existing employment and line-management arrangements unless a separate arrangement is expressly agreed and documented. Hosting the Service does not make the Host the employer of the wider Place Team or accountable for all Place functions and outcomes.

The Place Delivery and Integration Service

The Place Delivery and Integration Service is the identifiable service currently delivered by NHS Greater Manchester to provide dedicated leadership, strategic planning, programme management, transformation, partnership development, governance, integration and enabling capacity for the relevant Place Health and Care Partnership.

The purpose of the service is to enable the Place Health and Care Partnership to:

- Deliver agreed Place priorities and outcomes.
- Improve population health and reduce health inequalities.
- Support the integration of health, care and wider public services.
- Develop neighbourhood working.
- Coordinate delivery across Partner organisations.
- Provide a stable core around which wider Partner capacity can be aligned.

The service comprises an established and continuing set of activities, functions and responsibilities delivered through dedicated resources and an organised workforce.

Responsibility for delivering the service is intended to transfer from NHS Greater Manchester to a designated NHS Trust or Foundation Trust host. Following transfer, the host will employ and support the workforce and provide the agreed employment, digital, estates and corporate infrastructure.

The service will remain dedicated to the Place Health and Care Partnership. It must not be absorbed into the host organisation's general workforce, service priorities, cost-improvement programme or establishment except where this is expressly agreed through the contractual and governance arrangements.

The transfer is being progressed on the working assumption that Transfer of Undertakings (Protection of Employment) Regulations (TUPE) applies. The employees assigned to the Place Delivery and Integration Service and therefore in scope of transfer will be confirmed through the formal assignment assessment, consultation, due diligence and legal advice.

Hosting organisation and employment responsibilities

Hosting provides the legal and organisational framework through which the Place Delivery and Integration Service and its dedicated workforce will operate following transfer. The designated NHS Trust or Foundation Trust will act as the host organisation and become the substantive employer of employees transferring from NHS Greater Manchester. NHS Greater Manchester will remain the commissioner and funder of the service, while the Place Health and Care Partnership will continue to agree local priorities and oversee delivery through its governance arrangements.

The purpose of hosting is to provide a stable employment home and the corporate infrastructure required to support the workforce, while preserving the identity, purpose and integrity of the Place Delivery and Integration Service. The hosted workforce will remain a defined and ring-fenced Place resource. It must not be absorbed into the host organisation's wider establishment, redirected to unrelated organisational priorities or included in cost-improvement activity unless this has been expressly agreed through the relevant Place governance, contractual change-control and workforce processes.

Responsibilities of the host organisation

As substantive employer and contracted provider of the Place Delivery and Integration Service, the host organisation will:

- Employ the transferring workforce and discharge all statutory, contractual and regulatory employer responsibilities.
- Provide employment contracts, payroll, Electronic Staff Record administration, pension administration and workforce records.
- Apply its employment policies and procedures, while preserving continuity of employment and contractual rights protected through the applicable transfer arrangements.
- Provide human resources advice, employee relations support, occupational health, employee assistance, wellbeing services, workforce development and access to staff networks on the same basis as other employees, subject to the agreed arrangements.
- Maintain safe systems of work and fulfil its responsibilities for health and safety, equality, safeguarding, professional standards, statutory checks and regulatory compliance.
- Provide or arrange the agreed digital, information governance, estates, equipment and corporate support required for the workforce to deliver its Place responsibilities, taking account of the NHS Greater Manchester corporate offer set out in Appendix B and the detailed arrangements agreed through the Place Service and Hosting Contract
- Maintain ring-fenced financial and workforce records for the service and provide agreed reporting, assurance and reconciliation information.
- Implement recruitment, organisational change and formal employment processes within the agreed Place establishment, funding envelope and governance arrangements.
- Identify a senior host officer and appropriate corporate leads to support employer assurance, mobilisation and ongoing operation of the service.
- Manage risks within its control as employer and service provider, escalating issues through the agreed Place and contractual routes.

Place leadership and day-to-day management

The Place Partnership Director will lead the Place Delivery and Integration Service and coordinate the wider multidisciplinary Place Team. The Place Lead and Place governance arrangements will set strategic priorities, objectives and expected

outcomes. Day-to-day deployment and delivery will be managed through the Place leadership arrangements, while the host will retain responsibility for employment decisions and statutory employer duties. The detailed division of authority will be set out in the agreed governance and employment arrangements.

Where the Place Lead is employed by another organisation, the host and the Place Lead's employing organisation will maintain an appropriate assurance relationship with the Place Partnership Director. This will support the discharge of statutory duties and formal employment decisions but will not give the host unilateral authority to determine Place strategy, service priorities, workforce establishment or deployment.

The host's legal responsibilities as employer must be respected. Where a proposed Place decision creates an employment, legal, regulatory, financial or safety concern, the host may require the matter to be reviewed through the agreed governance and escalation arrangements before implementation.

Employment responsibilities and workforce change

Following transfer, employees will use the host organisation's employment infrastructure and, where agreed, its core systems and policies. The detailed arrangements will be confirmed through formal consultation, due diligence and local mobilisation.

The employment arrangements will include:

- Confirmation of the employees and funded posts transferring as part of the service.
- Treatment of vacancies, live recruitment activity and temporary workforce arrangements.
- Transfer of payroll, pension, Electronic Staff Record and relevant employment records.
- Management of live employee-relations cases, reasonable adjustments, occupational health requirements and statutory checks.
- Identification and consultation on any proposed measures arising from the transfer.
- Confirmation of line-management, professional accountability and appraisal arrangements.

- Arrangements for learning and development, mandatory training, wellbeing and staff engagement.
- Place-specific arrangements for work bases, hybrid working, information technology access, email, systems and equipment.
- Agreed processes for future recruitment, restructuring, redeployment, redundancy or other material workforce change.

Any material change to the purpose, structure, establishment, deployment or funding of the hosted workforce must follow the agreed Place governance, employer decision-making, contractual change-control and consultation processes. Neither the host nor the Place Health and Care Partnership may unilaterally implement a change that exceeds its authority or leaves another party with an unapproved liability.

Scope and safeguards

Hosting applies only to the defined Place Delivery and Integration Service and its hosted workforce. It does not make the host the employer of the wider multidisciplinary Place Team. Staff contributed by local authorities, NHS providers, primary care or other Partners will remain employed and professionally accountable to their substantive organisations unless a separate arrangement is expressly agreed.

Hosting does not transfer NHS Greater Manchester's statutory or strategic commissioning responsibilities to the host. It also does not, by itself, make the host responsible for managing the Section 75 Place Fund or delivering all Place Health and Care Partnership and neighbourhood outcomes. Any responsibilities allocated to the host through a separate agreement will be governed by that agreement. Other responsibilities will remain with the organisations and governance arrangements identified in the Place Partnership Agreement, Section 75 arrangements, Place Fund and accountability framework.

The Place Service and Hosting Contract will set out the detailed service scope, funded establishment, contract price, employment and corporate support requirements, performance standards, reporting, risk allocation, liabilities, indemnities, change control, escalation, dispute resolution and exit arrangements. These provisions remain subject to final legal, workforce, financial, commercial, tax, pensions and information-governance review.

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Membership of the wider Place Team

The wider Place Team is multi-organisational and may include capacity from:

- Local authorities, including public health, adult social care and children's services.
- NHS acute, community, mental health and ambulance providers.
- Primary care, including general practice and the wider primary care disciplines.
- NHS Greater Manchester.
- Voluntary, community, faith and social enterprise organisations.
- Housing, education, leisure, employment and wider public services.
- Independent and commissioned Partners where relevant.

Residents, people who use services, unpaid carers and communities should influence priorities, improvement and service design through proportionate and accessible participation arrangements.

Membership should be purposeful and workable. Core, advisory and co-opted participation routes may be used, recognising that some organisations operate across several Places and cannot duplicate capacity within every local structure.

Core capabilities

The Place Team requires access to a broad set of capabilities. These may be provided through dedicated Place roles, Partner contributions, footprint-based services or Greater Manchester-wide functions.

Core capabilities include:

- Place leadership and partnership integration.
- Population health management, intelligence and evaluation.
- Live Well and neighbourhood health and care development.
- Clinical and professional leadership.
- Programme, project and transformation management.
- Pathway development and demand management.
- Strategic planning and service redesign.
- Commissioning support and contract interface.

- Finance, resource planning and benefits management.
- Governance, risk management, administration and assurance.
- Quality, safety, safeguarding and equality support.
- Engagement, communications, co-production and community development.
- People, organisational development and workforce planning.
- Digital, data, information governance and estates support.

Not every capability needs to be permanently located within each Place. The enabling offer and interfaces must be sufficiently clear to avoid unfunded expectations, gaps in support or duplication. The NHS Greater Manchester corporate offer available to support Place is set out in Appendix B.

Governance and accountability

The governance model separates but connects three areas:

1. **Place Health and Care Partnership governance** — collective leadership, priority setting, delivery oversight, performance review, risk management and stewardship of Place outcomes.
2. **Resource and hosting arrangements** — management of the dedicated workforce and resources supporting Place, including the Place Delivery and Integration Service.
3. **Strategic commissioning, accountability and assurance** — oversight by NHS Greater Manchester and other sovereign organisations of their statutory functions, resources, contracts, quality responsibilities and agreed outcomes.

The Place Health and Care Partnership is not a contracting party or legal employer. Partnership decisions must operate within the authority delegated or retained by the relevant legal organisations.

The host organisation:

- Is the substantive employer of the hosted workforce.
- Provides employment administration and agreed corporate infrastructure.
- Retains legal and regulatory employer responsibilities.
- Does not gain additional partnership decision rights by virtue of being the host.

- Must maintain the Place workforce and resources as a defined and ring-fenced service.

The Place Partnership Director provides leadership for the Place Delivery and Integration Service and supports the wider Place Health and Care Partnership to coordinate delivery. The detailed decision rights, reporting arrangements and workforce responsibilities will be set out through the partnership, contractual and local governance documents.

NHS Greater Manchester retains responsibility for its statutory functions, strategic commissioning duties, financial controls, contractual relationships, quality oversight and assurance. Where an issue cannot be resolved through partnership action, it must be escalated to the organisation holding the relevant authority or accountability.

Wider Place Health and Care Partnership risks should be owned by the organisation best placed to manage them or shared where appropriate. Risks should be overseen through Place governance, with material matters escalated through the locality assurance framework.

Place Fund and resources

For 2026/27, the Place Fund comprises agreed Better Care Fund services operating through existing Section 75 and Better Care Fund arrangements. It supports joint oversight, influence and financial stewardship; it is not automatically a delegated budget.

NHS Greater Manchester remains responsible for ensuring appropriate financial governance and controls while future arrangements are finalised. The developing framework will clarify:

- Budget-holder responsibilities.
- Delegated authority.
- Financial reporting.
- Decision-making and escalation routes.
- Section 75 arrangements.
- The relationship between the Place Fund and the Place Delivery and Integration Service.

- Treatment of workforce, pay, infrastructure and directly attributable hosting costs.

The hosted Place workforce will be funded through a defined contractual arrangement. The detailed treatment of liabilities, indemnities, overheads, vacancies, inflation and future changes remains subject to final legal, financial and commercial agreement.

Existing voluntary, community, faith and social enterprise budgets within the Place Fund should be managed in support of agreed outcomes. Partners also have a wider responsibility to maximise the impact of all available resources rather than focusing only on budgets formally labelled as Place funding.

How the Place Team will operate

Each Place will agree a limited number of priorities and outcomes through its Place Health and Care Partnership governance. Delivery arrangements should be supported by:

- Clear leadership and decision-making.
- Defined Partner contributions.
- Delivery plans with milestones, measures, risks and dependencies.
- Outcome and experience measures that extend beyond NHS activity.
- Neighbourhood and population-group insight.
- Transparent escalation routes.
- Shared learning and continuous improvement.
- Effective interfaces with Greater Manchester-wide and footprint-based support.

The Place Delivery and Integration Service provides the stable core of the model. Wider Partner capacity may be assigned, ring-fenced or offered into Place priorities while remaining employed and professionally accountable within the relevant Partner organisation.

Matrix working must be intentional and supported by clear objectives, agreed contributions, appropriate authority and disciplined governance.

NHS Greater Manchester

Workforce, identity and ways of working

The receiving organisation will provide the substantive employment home for transferring employees. The workforce will continue to work on behalf of the wider Place Health and Care Partnership, rather than solely for the interests of the host.

Local arrangements should maintain a clear Place identity through:

- Communications and stakeholder messaging.
- Email signatures and team descriptions.
- Leadership and reporting arrangements.
- Place Health and Care Partnership governance.
- Ring-fenced workforce and budget controls.
- Visible connection to agreed Place priorities and outcomes.

Employees are expected ultimately to use the host organisation's core employment and technology infrastructure. However, continuing access to NHS Greater Manchester and Partner systems, data and collaboration tools may be required.

Each Place mobilisation group must agree arrangements covering:

- Information technology systems, devices and licences.
- Shared drives, Microsoft Teams sites and shared mailboxes.
- Data migration, retention and ownership.
- Access to Partner systems and information.
- Information governance, cyber security and data protection.
- Records management and business continuity.
- Premises, equipment and agile working arrangements.
- Employment policies, payroll, pensions and workforce systems.

Solutions may differ between Places, but they must support safe and effective cross-organisational working.

Approach to configuration

The current model is based on a defined Place Delivery and Integration Service hosted by an identified NHS Trust or Foundation Trust. This replaces the earlier

position in which several employment configurations were presented as equally available options for the transferring NHS Greater Manchester workforce.

The wider multidisciplinary Place Team may still operate through a combination of:

- A hosted core workforce.
- Partner-contributed capacity.
- Matrix working.
- Time-limited specialist contributions.
- Footprint-based or Greater Manchester-wide enabling support.

Local design should therefore focus on how Partner capacity is aligned around the hosted core, rather than reconsidering the substantive employment model for the transferring workforce.

The principles are:

- Place priorities and outcomes drive deployment.
- The host provides employment infrastructure but does not control Place Health and Care Partnership purpose.
- Resources remain dedicated and ring-fenced to Place.
- Partner contributions are explicit and transparent.
- Statutory and professional accountabilities remain clear.
- Local flexibility operates within a consistent Greater Manchester framework.
- Change is subject to agreed governance, contractual controls and workforce processes.
- Strategic support including DII, Strategic Commissioning and Population Health support will be provided by the ICB, as set out in Appendix B.

NHS Greater Manchester

Appendix A - Roles and Responsibilities of the Place Delivery and Integration Service Overview

The Place Delivery and Integration Service shall provide strategic leadership, clinical leadership, programme delivery, operational management, partnership development and administrative support to enable the effective planning, commissioning, transformation and delivery of integrated health and care services within the Place.

The service shall operate on behalf of NHS Greater Manchester and its partners to support the achievement of agreed Place outcomes, statutory duties and strategic priorities.

Strategic Leadership and System Development

The Provider shall:

- Lead and support the development and delivery of Place-based strategies, plans and transformation programmes.
- Contribute to the delivery of the NHS Greater Manchester Integrated Care Strategy and associated Place priorities.
- Provide leadership for system transformation, service redesign and continuous improvement.
- Support the development of integrated models of care and collaborative approaches across organisational boundaries.
- Ensure alignment between Place priorities, Greater Manchester objectives and relevant national policy requirements.
- Promote innovation and good practice to improve outcomes, reduce inequalities and maximise value from public resources.

Partnership and Stakeholder Management

The Provider shall:

- Develop and maintain effective working relationships across NHS organisations, local authorities, primary care, voluntary, community, faith and social enterprise organisations, provider collaboratives and wider public sector partners.

- Facilitate collaborative decision-making and shared ownership of Place priorities.
- Support meaningful engagement with residents, patients, carers and communities to ensure services respond to local needs.
- Represent the Place within relevant system governance groups, networks and programme boards.
- Promote partnership working that supports integration, prevention and improved population health outcomes.

Programme and Transformation Delivery

The Provider shall:

- Establish and maintain effective programme and project management arrangements for agreed Place priorities.
- Develop and maintain delivery plans, milestones, benefits realisation arrangements and performance measures.
- Coordinate multi-agency programmes and workstreams to support delivery against agreed objectives.
- Support the development of business cases, options appraisals, implementation plans and service improvement proposals.
- Monitor programme performance and provide timely reporting, escalation and assurance to relevant governance bodies.
- Identify, share and apply learning, innovation and good practice across the Place system.

Clinical Leadership and Professional Advice

The Provider shall:

- Inform strategic planning, service redesign and transformation programmes through appropriate clinical and professional leadership.
- Provide expert clinical advice to governance forums and decision-making bodies.
- Promote evidence-based practice, quality improvement and innovation.
- Support the delivery of safe, effective and high-quality services.

- Enable clinical engagement across primary care, community services, mental health, acute services and social care.
- Champion population health approaches and interventions that improve outcomes and reduce health inequalities.

Governance, Risk and Assurance

The Provider shall:

- Operate within the governance framework established by NHS Greater Manchester and relevant Place governance arrangements.
- Maintain effective systems of internal control, assurance and accountability.
- Identify, assess, manage and escalate risks in accordance with agreed policies and procedures.
- Support audit, assurance and regulatory compliance requirements.
- Maintain appropriate records management, information governance and decision-making processes.
- Provide regular performance, financial and risk information to relevant governance bodies.

Performance, Intelligence and Planning

The Provider shall:

- Collect, analyse and interpret quantitative and qualitative information to support planning, decision-making and service improvement.
- Use population health, epidemiological and service utilisation information to inform priorities and delivery.
- Develop and maintain performance monitoring arrangements for agreed Place outcomes and priorities.
- Produce reports, dashboards and intelligence products to support governance and performance oversight.
- Support evidence-based prioritisation, investment decisions and resource allocation.

Workforce, Leadership and Organisational Development

The Provider shall:

- Maintain an appropriately skilled and competent workforce capable of delivering the requirements of this service specification.
- Promote leadership development, continuous professional development and succession planning.
- Support a positive organisational culture that promotes collaboration, inclusion, accountability and continuous improvement.
- Ensure compliance with relevant NHS workforce policies, employment legislation and professional standards.
- Support system-wide workforce planning and organisational development activity where required.

Business Support and Operational Delivery

The Provider shall:

- Deliver professional business support and operational management functions necessary to support Place governance, leadership and programme delivery.
- Coordinate meetings, governance arrangements, reporting cycles and decision-making processes.
- Maintain effective document management, information management and administrative processes.
- Support communication, engagement and coordination across partner organisations.
- Ensure the efficient and effective operation of the Place Delivery and Integration Service.

Equality, Quality and Population Health

The Provider shall:

- Ensure all activities are undertaken in accordance with the Public Sector Equality Duty and relevant NHS equality commitments.
- Promote equitable access, improved outcomes and the reduction of health inequalities.
- Embed quality improvement principles within service planning and delivery.

- Support safeguarding responsibilities and the delivery of safe services.
- Ensure population health, prevention and community engagement principles are reflected throughout service delivery and decision-making.

Expected Service Outcomes

The Place Delivery and Integration Service shall contribute to the achievement of the following outcomes:

- Effective delivery of agreed Place priorities, strategies and transformation programmes.
- Improved population health outcomes and reduced health inequalities.
- Strong and sustainable partnership arrangements across the Place.
- Improved quality, safety and experience of health and care services.
- Effective governance, assurance and risk management.
- Delivery of agreed programme benefits and value for money.
- Increased integration of services and collaborative working across organisational boundaries.
- Enhanced capability to respond to local population needs through evidence-based planning and decision-making.

Appendix B – Proposed Corporate offer for Place

Corporate service	Core offer
Comms and Engagement	• Stakeholder communications • Media and reputation management • Crisis communications • Social media management • Website development and maintenance • Brand management • Lived experience engagement • Service change consultation and engagement • Digital engagement • Accessible communications • Statutory duties and legislative guidance advice • Project management • Agency liaison • System convening • Strategic advice
Corporate Services	• Requires further clarification. But will include: • Responding to FOI requests • Access to legal advice policy and processes • Collation and submission of ICB Annual Report • FOI management and response • Patient Services (Complaints) • Freedom to Speak Up Arrangements and Processes
DII	• Requires further clarification. But will include: • Access to the suite of dashboards with local and national indicators • Access to population health intelligence • Performance and Outcomes Reporting
IT	• To be described in the schedules within the Hosting Contract.
Estates	• Coordination, development and oversight of the Estates Infrastructure Strategy • Coordinate interface between and strategic engagement with NHS GM, GMCA, NHSE/Region, NHS PS and CHP • Strategic leadership of the Estates utilisation and efficiencies workstream where pan-GM input is required • Managing access to Estates data and dashboards to support decision making at Place – e.g. STRATA • System assurance for Primary Care premises focused on statutory responsibilities including VfM oversight on new

Corporate service	Core offer
	leases, renewals and variations – currently subcontracted to NHS Property Services • Town Planning Services – securing funding from new developments to mitigate their impact. Currently sub-contracted to NHS PS and responses signed off by Place Estates Leads • Coordinate Pan-GM Estates input into wider organisational strategies and plans • Strategic oversight of LIFT estate and options as leases expire, supporting Place Teams • MP enquiries, FOI's etc. where pan-GM team is best placed to respond. • Some of the detail relating to the estates offer is still being worked through.

Appendix C: Place Service and Hosting Contract – Overview

Status and Purpose of the document

This document is a practical working aide to support mobilisation discussions and planning. It provides a high-level description of the intended hosting contract and the proposed operating model. It does not reproduce, summarise in full, or incorporate the contract's clauses, schedules or detailed content, and it should not be relied upon as a contractual or legal document. The contract remains subject to legal, information-governance and Partnership approval processes. If this working aide differs from the final signed contract, the signed contract will take precedence.

Executive summary

The hosting contract sets out how a designated NHS organisation (receiving organisation) will host and employ the dedicated Place Delivery and Integration Service workforce. NHS Greater Manchester will continue to commission and fund the service, while the Place Health and Care Partnership will continue to agree local priorities and oversee delivery through its governance arrangements.

- The host (receiving organisation) will provide the legal employment home, payroll, workforce systems and agreed corporate support.
- The hosted workforce will remain a defined and dedicated place resource rather than becoming part of the host's general workforce.
- Place leadership will set priorities and direct day-to-day delivery within agreed authority.
- The host (receiving organisation) will retain the formal duties and decisions that come with being the employer and service provider.
- NHS Greater Manchester will retain its statutory commissioning, funding, contract-management and assurance responsibilities.
- Material changes will require formal governance, affordability checks, workforce processes and contractual approval.

Why the contract is needed

- It gives the hosted service and workforce a clear legal and operational framework.
- It separates the roles of commissioner, funder, host employer and Place partnership.
- It defines the service's purpose, resources and Place identity.
- It sets consistent expectations for governance, performance, funding, risk management, development and change
- It supports a common Greater Manchester approach while allowing appropriate local detail to be agreed for each Place.

How the model works

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NHS Greater Manchester will commission and fund the service, define the overall outcomes and funding envelope, manage the contract and obtain proportionate assurance. It will not normally undertake day-to-day line management or replace local Place governance.

Host (receiving organisation)

The host (receiving organisation) will become the substantive employer of the defined workforce and provide employment administration, workforce support, systems, management infrastructure and other agreed corporate services. It will remain responsible for formal employer, regulatory, safety and operational duties within its control.

Place Health and Care Partnership

The Place partnership will agree local priorities and oversee delivery through its established governance arrangements. It is not created as a separate legal body by the contract, and its decisions remain subject to the lawful authority and approval requirements of the organisations involved.

Place leadership

The Place Partnership Director will lead the service and coordinate delivery against agreed Place priorities. The host's (receiving organisation's) nominated senior officer will provide the formal employer and corporate interface. This is intended to preserve clear Place leadership while ensuring the host can meet its legal duties.

Key safeguards and boundaries

- **Dedicated workforce:** The funded workforce and service remain dedicated to Place and should not be redirected, absorbed or restructured for unrelated host (receiving organisation) priorities without formal agreement.
- **Clear authority:** Place governance sets strategic and delivery priorities; the host (receiving organisation) retains formal employer and organisational duties.
- **No transfer of statutory functions:** Each organisation keeps its existing statutory, regulatory and professional responsibilities unless these are changed through a separate lawful arrangement.
- **Controlled change:** Material changes to service scope, funding, workforce, structures or deployment, the agreed governance and contract-change process.
- **Local separation:** Where one host (receiving organisation) supports more than one Place, each Place's resources and responsibilities are intended to remain separately identifiable.
- **Continuity:** Mobilisation and any employment transfer will be planned to ensure continuity for employees' information, systems access and service delivery.

Workforce and employment

- The host (receiving organisation) will become the substantive employer for the workforce identified in the final schedules.
- Any employee transfer will follow applicable law (TUPE), due diligence, formal consultation and agreed mobilisation arrangements.
- Individual employment rights, collective agreements and professional accountabilities will continue to apply.

- Formal employment matters will sit with the host (receiving organisation), informed by Place leadership and the agreed governance process.
- Employees contributed by other partner organisations will remain employed and managed by those organisations unless separately agreed.

Funding, performance and risk

- NHS Greater Manchester will fund the agreed service and workforce through the contract, aligned with the wider Place funding framework where relevant.
- The final schedules will define the service scope, funded establishment, support requirements, outcomes and reporting arrangements.
- Performance will be reviewed through proportionate reporting, Place oversight and NHS Greater Manchester contract assurance.
- Risk will sit with the organisation best placed and authorised to manage it: the host for matters within its employer and operational control, and NHS Greater Manchester for its commissioning and funding responsibilities.
- Additional costs or liabilities arising from an agreed material change will require prior agreement.

Change, escalation and exit

- Routine operational decisions will be taken at Place within delegated authority.
- Material service, workforce or financial changes will follow formal discussion and agreement and contract variation as appropriate.
- Concerns will be managed through agreed escalation and dispute-resolution routes before formal remedies are considered.

What the contract does not do

- It does not create a new legal organisation or partnership body.
- It does not make the host (receiving organisation) responsible for the whole multidisciplinary Place Team, all Place outcomes or every partner contribution.
- It does not transfer NHS Greater Manchester's statutory commissioning responsibilities.
- It does not automatically transfer or delegate the Place Fund or responsibilities governed by Section 75 arrangements.

- It does not allow one organisation to direct another outside agreed legal authority.
- It does not remove the need for formal workforce consultation, organisational approvals or local mobilisation planning.

Executive takeaways

- The model changes the employment and hosting arrangements, not the purpose of the Place Delivery and Integration Service.
- The host (receiving organisation) provides the employment home and infrastructure; Place leadership retains strategic and operational direction within agreed governance.
- NHS Greater Manchester remains commissioner and funder and retains its statutory accountabilities.
- The hosted service and workforce are intended to remain dedicated to and identifiable as Place capacity.
- Material change cannot be made informally; it requires governance, workforce, financial and contractual discussion and agreement
- The current draft is not ready for execution until legal and technical reviews, local schedules, due diligence and pan organisational agreements are complete.

Details still to be confirmed

The final position will depend on completion of the contract schedules and Place-specific mobilisation work. This working aide should be used to help identify, discuss and coordinate the practical actions needed for mobilisation; it is not intended to replicate contractual wording or contain the detailed provisions that will sit within the contract and its schedules. Matters still to be confirmed include local reporting and governance interfaces, corporate support arrangements, funding and cost treatment, information and systems access, risk and liability allocation and performance measures. These matters remain subject to the relevant reviews, due diligence and approvals.

PLACE GOVERNANCE, ACCOUNTABILITY, OVERSIGHT AND ASSURANCE FRAMEWORK

NHS Greater Manchester

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1. Purpose and status

This framework describes the governance, accountability, oversight and assurance arrangements for Greater Manchester Place Health and Care Partnerships (PHCP).

The framework supports place-based delivery while maintaining appropriate accountability for public resources, outcomes, and retained organisational duties. It should be read with the Place Partnership Agreement, Partnership Board Terms of Reference, Place Outcomes Framework, Place Fund, Section 75 arrangements, Place Team and workforce-hosting documents, and relevant partner governance.

The framework does not itself transfer statutory functions or create authority for one partner to direct another outside agreed delegations. Detailed delegations, approval routes, contractual obligations, change control and dispute-resolution arrangements sit in the relevant Place Partnership Agreement, Terms of Reference, Section 75 and hosting agreements.

2. What is being proposed

- A three-layer operating model linking partnership governance, resources and hosting, and assurance on delivery of outcomes together.
- A Place Partnership Agreement as the principal framework for each PHCP, alongside a Place Partnership Board and appropriate delivery of governance.
- Place Teams and the Place Fund deployed on behalf of the PHCP to deliver agreed priorities.
- A Place-led accountability, assurance and improvement approach based on governed evidence, expert interpretation, a shared Place narrative and judgement, accountable action, support or recovery, escalation and de-escalation.
- Retention of each organisation’s statutory, contractual, financial, quality, clinical, professional, safeguarding, employment and regulatory accountabilities.
- A consistent Greater Manchester core with local flexibility in the detailed governance architecture.

3. The three-layer model

Layer 1

Place Health and Care Partnership Governance

How partners come together, set priorities, exercise agreed authority and oversee delivery.

Layer 2

Resources and Hosting

How Place resources are transferred, hosted, protected and managed on behalf of the PHCP.

Layer 3

Accountability, Oversight and Assurance of Outcomes

How collective accountability, Place assurance, improvement, support and system oversight operate.

How the layers connect

The Place Partnership Board sets shared priorities and agrees the deployment of the Place Fund and Place Teams within delegated authority. Delivery governance, Place Teams, services and Neighbourhood arrangements deliver those priorities. Outcomes and intelligence inform the Layer 3 accountability, assurance and improvement cycle, with learning, support and recovery feeding back into priorities and resource deployment. Governance interfaces and retained organisational accountabilities operate in parallel throughout.

4. Common design principles

Place-led: Place governance and routine assurance begin locally through the PHCP.

Collective and reciprocal: partners are accountable for their agreed contribution and may seek assurance, support and constructive challenge from one another, including NHS Greater Manchester.

Local accountability with Greater Manchester visibility: local ownership is retained while material themes, exceptions and learning are visible through agreed system routes.

One governed evidence base, different lenses: forums use consistent definitions and sources, with measures, depth and narrative tailored to their purpose.

Intelligence-led: governed data is interpreted with qualitative intelligence, local context, lived experience and professional judgement.

Action and improvement focused: governance supports decisions, accountable actions, recovery, learning and measurable impact.

Proportionate and streamlined: existing governance and information are used wherever possible and additional mechanisms are created only where they add value.

Distinct responsibilities: PHCP accountability does not replace statutory, organisational, contractual, professional or employment accountability.

Transparent and iterative: decisions, risks, actions and assurance positions are recorded clearly, and the approach evolves with learning and maturity.

Minimum core with local flexibility: All Places meet common expectations but may design wider local arrangements to fit context, capacity and maturity.

LAYER 1

Partnership Governance

5. Layer 1: Partnership governance

At the centre of the model is the Place Partnership Agreement. It establishes the PHCP purpose, membership, outcomes, decision-making arrangements, accountabilities and relationships between partners and with NHS Greater Manchester.

5.1 Minimum governance expectations

Place Partnership Board. Provides collective leadership, strategic direction, stewardship of resources, accountability and assurance for agreed Place outcomes. It exercises decision-making only within agreed delegations and cannot bind a partner outside that authority.

Delivery Board or equivalent. Oversees delivery of agreed priorities, monitors programme and operational performance, and escalates strategic risks, delivery challenges and recovery requirements to the Place Partnership Board.

Health and Wellbeing Board interface. Health and Wellbeing Boards retain their independently established statutory functions. Each PHCP should locally agree and document how its arrangements interface with the Health and Wellbeing Board, including alignment, information exchange, referral and avoidance of duplication.

5.2 Critical governance interfaces

Place Partnerships should maintain clear relationships with relevant statutory boards, committees, and PHCP forums. These interfaces provide routes for information, assurance, referral and escalation without transferring or duplicating retained responsibilities. They may include:

- GP and primary care governance arrangements.
- Safeguarding Children Partnerships and Safeguarding Adults Boards.
- Community Safety Partnerships and Domestic Abuse Partnership Boards.
- Strategic estates arrangements.
- Overview and scrutiny arrangements.
- Special Educational Needs and Disabilities partnership arrangements.
- Partner organisation and provider governance.

- Other statutory or partnership forums relevant to local priorities.

5.3 Minimum assurance and enabling functions

Each PHCP should demonstrate effective arrangements for advice, insight, assurance and operational coordination across:

- Clinical and professional leadership.
- Primary care and GP governance.
- Quality and safety.
- Finance and value.
- Performance and risk.
- Neighbourhood delivery.
- Workforce.
- Digital.
- Data, insight and intelligence.
- Estates.

These functions may be provided through existing organisational forums, integrated partnership arrangements, dedicated groups, or other locally agreed mechanisms. Places are not required to establish identical structures but must explain how assurance is obtained; relevant matters reach the Place Partnership Board, and duplication is avoided. The documented arrangements must distinguish clearly between: responsibilities retained by NHS Greater Manchester; responsibilities exercised collectively through the PHCP; and responsibilities retained by individual partner organisations.

NHS Greater Manchester participates as a full partner within Place while also retaining its distinct statutory role as strategic commissioner. In that capacity, it contributes to shared priorities and collective accountability and provides the leadership, governance, expertise and assurance required for the functions it retains, including primary care and GP governance, estates, quality, clinical and professional assurance, finance and commissioning. Participation in the PHCP does not transfer those retained responsibilities to the Place Team or to other partners.

Before responsibilities are assigned or changed, partners must confirm the accountable organisation, decision authority, delivery resource, enabling support, funding and assurance route. The proposed arrangements must be deliverable within available Place capacity. Place

should not be expected to absorb additional functions without explicit partner agreement and commensurate resource, expertise and support.

5.4 Clinical, quality and safeguarding role of Place

Place Health and Care Partnerships provide the forum through which partners collectively consider the contribution of quality, clinical effectiveness, safeguarding and professional leadership to shared Place outcomes; identify and escalate concerns; convene collective discussion; and share learning and effective practice. NHS Greater Manchester remains responsible for the statutory, commissioning, primary care, quality and clinical assurance functions that it retains, and should make the relevant expertise and governance routes available to Place. Individual partners remain responsible for their own statutory, clinical, professional, safeguarding, contractual, and regulatory duties. Collective consideration through Place does not transfer or dilute those retained accountabilities.

5.5 Local flexibility and governance review

Beyond the minimum requirements, Places retain discretion to design governance arrangements reflecting local priorities, partnerships, capacity, and maturity. Each Place should periodically review governance below the Place Partnership Board to determine which enabling and thematic forums remain required, can be combined or streamlined, or should be stood down. The review should test whether the model is deliverable with the capacity and capability available across the PHCP, including whether partners have provided the support required for functions expected to operate through Place. It should also examine recent examples of activity progressed outside Place, assess whether this weakened alignment or accountability, and agree any changes needed to governance interfaces, engagement or escalation routes.

LAYER 2

Resources and Hosting Arrangements

6. Layer 2: resources and hosting arrangements

Layer 2 describes the linked arrangements for the Place Fund, Section 75 agreements, and the Place Delivery and Integration Service. Together, these provide the resources and workforce capacity needed to deliver Place priorities while retaining the statutory, financial, employment and contractual responsibilities of the relevant organisations.

Detailed legal and operational requirements sit within the relevant Section 75 agreement, Place Service and Hosting Contract, service specification and supporting schedules. These arrangements do not create a separate legal entity, transfer statutory functions or allow one partner to direct another outside formally agreed authority.

6.1 Place Fund

For 2026/27, the Place Fund comprises the agreed Better Care Fund services administered jointly by NHS Greater Manchester and the relevant local authority through existing Section 75 arrangements. It is not a separately delegated budget. Wider-aligned expenditure may inform the overall Place financial position but does not automatically form part of the Fund.

The Place Fund operates in shadow form during 2026/27 while governance and assurance arrangements are developed. The PHCP shapes priorities and recommendations, but formal decisions are taken by those holding the relevant lawful authority. Any expansion of the Fund is supported by clear scope, funding, governance, risk allocation, and partner approval.

6.2 Section 75 arrangements

The Section 75 agreement remains the legally operative mechanism through which NHS Greater Manchester and the relevant local authority pool or align agreed resources. It sets out the services and contributions in scope, accountable bodies, decision rights, financial controls, reporting, risk allocation, audit, dispute resolution, and termination arrangements.

Existing Section 75 agreements continue for 2026/27 and, for 2027/28 onwards, are reviewed to reflect the PHCP model, including updated decision rights, oversight and escalation arrangements. Place governance supports collective stewardship but does not replace the lawful authority or approvals of the statutory parties.

6.3 Place Delivery and Integration Service (Place Team)

The Place Delivery and Integration Service provides dedicated capacity to support the PHCP, Neighbourhood arrangements and agreed programmes of work. It coordinates delivery, integration, improvement, performance, risk and assurance and supports collaboration between partners.

The hosted service forms part of the wider multidisciplinary Place Team. Place governance sets its priorities and oversees delivery, while colleagues employed by other partners remain accountable to their substantive organisations unless a separate lawful employment arrangement is agreed.

6.4 Service hosting and employment arrangements (Place Team)

The model is for an NHS Trust or NHS Foundation Trust to host the Place Delivery and Integration Service (Place Team) through a standalone contract with NHS Greater Manchester. NHS Greater Manchester remains the commissioner and funder, while the host becomes the substantive employer and provides the necessary workforce, infrastructure and corporate support.

The hosted workforce and funded establishment remain dedicated to Place and must not be redirected towards unrelated host priorities. The host retains its legal and employer duties, while Place governance retains strategic oversight within agreed decision rights. Any workforce transfer or material change follows applicable employment law, formal consultation, agreed governance and contractual change control.

The Place Service and Hosting Contract specify the funded establishment, contract price, workforce costs, infrastructure requirements, payment arrangements and treatment of vacancies, pay awards, liabilities and service changes.

6.5 Risk, liability and accountability

Risk should sit with the organisation best placed and authorised to manage it. The host remains responsible for employer and operational risks within its control; NHS Greater Manchester retains its commissioning responsibilities; Section 75 parties retain the risks allocated through the agreement; and individual partners retain their statutory, contractual and regulatory duties.

6.6 Assurance, change and dispute resolution

The Place Partnership Board provides strategic oversight of the hosted service and collective oversight of resources deployed on behalf of Place. NHS Greater Manchester retains

contractual oversight, while the host provides assurance on its employment, operational and corporate responsibilities.

6.7 Relationship between partnership and legal documents

Document	Principal purpose	Status / relationship
Place Partnership Agreement	PHCP purpose, governance, ways of working and decision architecture.	PHCP documents contain detailed dispute resolution and amendment provisions.
Partnership Board Terms of Reference	Membership, delegated authority, quorum, decisions and reserved matters.	Operates with the Partnership Agreement.
Section 75 / Place Fund arrangements	Lawful pooling, hosting, transactions, financial controls and approvals.	Legally operative subject to execution and approvals.
Hosted-services contract	Service specification, funding, employer responsibilities, workforce governance, and protections.	Legally operative as specified in executed agreements.
This framework	Common architecture, principles, roles and assurance model.	Does not itself transfer functions or replace operative agreements.

LAYER 3

Accountability, Oversight and Assurance of Outcomes

7. Layer 3: Accountability, Oversight and Assurance of Outcomes

7.1 Purpose

Layer 3 sets out how PHCP, NHS Greater Manchester and partner organisations obtain assurance regarding delivery of the Place Outcomes Framework, associated Neighbourhood outcomes and agreed strategic priorities.

It provides the mechanism through which partners understand:

- whether agreed outcomes are improving;
- whether delivery remains on track;
- whether partner contributions are effective;
- whether the Place Partnership is operating effectively in coordinating collective action; and
- what improvement, support, recovery or escalation may be required?

Layer 3 is the Place application of the wider NHS Greater Manchester direction of travel for integrated reporting and assurance. It does not create an additional dashboard, performance framework, or parallel reporting process. Different governance forums draw the assurance they require from a common understanding of outcomes, delivery, risk and recovery.

The Place Partnership Board provides the principal forum for collective accountability and Place assurance. NHS Greater Manchester and individual partner organisations use the same evidence, Place narrative and governance discussion to inform their own assurance responsibilities while retaining their statutory, organisational, contractual and professional accountabilities.

7.2 Relationship to the Place Outcomes Framework

The Place Outcomes Framework is the principal organising framework for Layer 3.

The Place Outcomes Framework defines the outcomes that PHCP and partners are collectively seeking to improve. It connects Greater Manchester strategic commissioning intentions, Place priorities and Neighbourhood outcomes and provides the basis against which progress, delivery confidence and partner contributions are considered.

The Place Outcomes Framework provides:

- the agreed outcomes against which Place progress and impact are assessed;
- the structure for connecting Greater Manchester, Place and Neighbourhood outcomes;
- the basis for collective accountability and assurance discussions;
- the starting point for identifying the evidence, intelligence and delivery information required;
- the structure for the Place narrative and assurance judgement; and
- the means through which partners assess whether collective action is improving outcomes for residents and communities.

Layer 3 does not create a separate outcomes or performance framework. It provides the governance, accountability, assurance and improvement approach through which partners interpret, understand and act on the evidence relating to the Place Outcomes Framework.

The relationship can be summarised as:

- The Place Outcomes Framework describes the outcomes the PHCP is seeking to achieve.
- Delivery plans, Neighbourhood plans and partner contributions describe how those outcomes will be achieved.
- Layer 3 describes how partners collectively understand progress, reach an assurance judgement, agree action and respond where delivery is off track.

The evidence used through Layer 3 should therefore include both:

- the agreed measures and indicators within the Place Outcomes Framework; and
- the delivery, operational, qualitative, and Neighbourhood intelligence needed to explain the outcome position and support effective action.

7.3 What Layer 3 assures

Layer 3 provides assurance regarding:

- Progress against the outcomes and ambitions set out in the Place Outcomes Framework.
- Delivery of associated Place and Neighbourhood priorities.
- Progress against delivery plans, improvement actions, and recovery trajectories.
- The contribution made by partners towards agreed outcomes.
- The effectiveness of the PHCP in coordinating delivery and collective action.
- The effective stewardship of shared resources.
- Inequalities and Neighbourhood variation, where these affect the interpretation of outcomes or delivery.

- Risks, dependencies, and barriers that may affect delivery of agreed outcomes.
- The credibility of improvement and recovery arrangements where delivery is off track.

Assurance should consider outcomes and impact for residents and communities, rather than relying solely on activity or high-level indicators.

Partnership risk oversight focuses on risks to delivery of shared Place outcomes. It does not replace organisational oversight of statutory duties, clinical and professional governance, safeguarding, operational delivery, finance, quality, contracts, or regulation.

7.4 How accountability, assurance and improvement work

Stage	Lead mechanism	How it works	Output
1. Governed evidence	Data, Insight and Intelligence, relevant reporting domains and partners	Place Outcomes Framework measures, Neighbourhood outcomes measures, delivery information, operational intelligence and qualitative insight are brought together from governed sources. The evidence should include, as appropriate, agreed outcome measures and trajectories; Neighbourhood variation; inequalities; delivery milestones; financial and workforce information; quality and experience; partner contributions; risks and dependencies; recovery progress; and lived experience and professional intelligence.	A consistent and governed evidence base for Place, partner and Greater Manchester use.
2. Interpretation	An appropriate multidisciplinary interpretation process	The evidence is interpreted to understand what has changed; why it has changed; what the change means for delivery of the Place Outcomes Framework; whether inequalities or	A considered draft Place narrative, supported by selected

		Neighbourhood variation affect the assessment; what risks, dependencies or opportunities are present; whether partner contributions remain effective; whether delivery remains credible; and whether improvement or recovery arrangements are likely to achieve the intended outcomes. The process supports constructive challenge but is not an additional governance layer.	measures and evidence.
3. Place narrative and judgement	Place Partnership Board	The Board considers and tests the draft Place narrative and reaches a rounded collective judgement regarding delivery of the Place Outcomes Framework, including the current outcome position, direction and pace of change, delivery confidence, inequalities, risks, partner contributions, PHCP effectiveness, recovery credibility and support required.	A single Place narrative, an agreed collective assurance position and clear decisions.
4. Action, improvement and recovery	Named delivery and executive leads, operating through existing governance routes	The Board agrees accountable owners, the issue being addressed, improvement or recovery action, milestones, support, review points, escalation where necessary and criteria for returning to routine oversight. The relevant operational or executive lead owns any time-bound recovery plan.	Accountable actions, measurable improvement and a clear recovery trajectory.
5. System assurance and learning	Strategic Commissioning Committee and NHS Greater	Material Place narratives, cross-cutting themes, strategic risks, support requirements and learning are consolidated into the Greater	Strategic assurance, system action, escalation

	Manchester Board through the agreed governance route	Manchester view, using the evidence already considered through Place governance wherever possible.	where required and shared learning.

7.5 The Place narrative

The principal shared output of Layer 3 is a concise, decision-focused Place narrative describing progress against the Place Outcomes Framework, the effectiveness of delivery arrangements, the contribution of partners, the level of risk and the actions required to improve outcomes.

The Place narrative is not a single dashboard intended to serve every purpose. It allows different governance forums to understand the same underlying position while applying the lens appropriate to their responsibilities.

The Place narrative should cover:

- the overall assurance assessment and material change since the previous review;
- progress against the Place Outcomes Framework;
- what is improving, what is off track and why;
- inequalities and Neighbourhood variation where these affect interpretation;
- delivery confidence and the effectiveness of delivery arrangements;
- partner contributions and PHCP effectiveness;
- material dependencies and risks;
- agreed actions and accountable owners;
- improvement or recovery milestones and review points;
- support or enabling action required from NHS Greater Manchester or other partners;
- recommendations for deeper review, system action or escalation; and
- learning and effective practice for wider sharing.
    - The Place narrative should be proportionate and focused on matters requiring collective understanding, decision or action. It should draw from information already used through Place and partner governance wherever possible.

7.6 Assurance relationships

The same Place Outcomes Framework evidence, Place narrative and governance discussion support several assurance relationships without creating separate reporting processes. Assurance is explicitly reciprocal and bi-directional: Place provides assurance, intelligence and challenge to NHS Greater Manchester, and NHS Greater Manchester provides assurance, transparency, support and a clear response to Place. The relationship is not an additional upward reporting route; it is a two-way partnership mechanism for understanding impact, resolving barriers and improving decisions affecting Place outcomes.

Assurance relationship	Purpose
Place Partnership Board to partners	Provides the principal collective judgement on delivery of agreed Place outcomes, shared risks, partner contributions and PHCP effectiveness.
Partners to one another	Provides assurance on agreed contributions, commitments and actions, with reciprocal support, challenge and accountability.
Place to NHS Greater Manchester	Provides assurance on delivery of agreed outcomes, use of delegated resources and contribution to NHS Greater Manchester strategic commissioning intentions; shares local population intelligence, identifies barriers and dependencies, challenges proposals where Place outcomes may be affected, and sets out the support or response required from NHS Greater Manchester.
NHS Greater Manchester to Place	Provides assurance on strategic direction, commissioning intent, retained functions and system actions affecting Place; listens to and consults Place when developing commissioning intentions; demonstrates how local population needs and Place intelligence have informed decisions; responds transparently to Place challenge or assurance; and takes enabling action on barriers or dependencies outside Place control.
Reciprocal response and influence	Requires both parties to record the intelligence or challenge received, the response and action agreed, and how the matter influenced commissioning, delivery or assurance decisions. Where Place advice is not adopted, NHS Greater Manchester or the relevant partner explains the

	rationale and any mitigating action through the agreed governance route.
Individual organisations	Enables each organisation to use the shared evidence and Place narrative within its own governance while retaining responsibility for its statutory, contractual, financial, quality, professional, safeguarding, regulatory and employment duties.

7.7 Assurance positions and proportionate response

Position	Meaning	Typical response
Assured	Delivery is broadly on trajectory against the Place Outcomes Framework. Risks are understood and controlled, partner contributions are effective and PHCP arrangements support delivery.	Continue routine Place Partnership Board oversight, maintain agreed actions and share learning and effective practice.
Partially assured	Material gaps or emerging risks are present, but the causes are understood and a credible improvement or recovery approach is in place.	Agree targeted support, accountable actions and a time-bound review. Use a focused deep dive or peer input to strengthen understanding and recovery.
Not assured	There is material or sustained risk to delivery of the Place Outcomes Framework, risk of harm, unclear accountability, ineffective recovery or unresolved partner contribution.	Agree formal recovery arrangements, increased oversight and escalation through the route relevant to the nature of the issue, with clear review and de-escalation criteria.

The assurance position is a rounded collective judgement. It should be informed by evidence and agreed lines of inquiry but should not be reduced to a rigid numerical score.

It does not replace statutory, contractual, regulatory, quality or performance judgements made through other governance routes.

7.8 Escalation, difference of view and dispute resolution

Where delivery of the Place Outcomes Framework is off track, the relevant operational or executive lead owns a time-bound recovery plan with milestones, support requirements, review arrangements and de-escalation criteria.

The Place Partnership Board normally determines whether collective support, further review or escalation is required. NHS Greater Manchester or another partner may also seek further assurance or action where required to discharge its own statutory, organisational or contractual responsibilities.

Escalation should follow the route appropriate to the nature of the issue. This may include:

- Place delivery or outcome oversight;
- NHS Greater Manchester strategic commissioning governance;
- provider performance or contractual arrangements;
- quality, clinical or safeguarding governance;
- financial governance;
- corporate risk arrangements; or
- the sovereign governance of a partner organisation.

A difference in assurance judgement should be recorded transparently, including the evidence, reasons, action sought and governance route through which the matter will be considered.

Detailed dispute-resolution arrangements are specified in the Place Partnership Agreement and are not repeated in this framework.

7.9 System assurance and wider reporting alignment

The Place Partnership Board provides the principal local assurance conclusion regarding delivery of the Place Outcomes Framework.

Material Place narratives, cross-cutting themes and significant exceptions are consolidated for the Strategic Commissioning Committee and, through the agreed route, the NHS Greater Manchester Board.

Where a Place delivery risk meets organisational risk criteria, it is considered through the relevant corporate risk route. Where an issue relates to a retained statutory, quality, safeguarding, contractual, financial or regulatory accountability, it is also considered through the relevant existing governance route.

Layer 3 aligns with the wider NHS Greater Manchester direction of travel towards:

- one governed evidence base, with different views for different responsibilities;
- a shared narrative connecting outcomes, delivery, risk and recovery;
- clear ownership of interpretation, actions and improvement;
- information produced once and reused through existing governance wherever possible; and
- governance discussions focused on understanding, decision-making and improvement rather than debating competing data or producing reports as an end in themselves.

The objective is not to create an additional reporting product. It is to provide a consistent accountability, management and assurance approach through which PHCP, partners and NHS Greater Manchester understand progress against the Place Outcomes Framework, agree action and improve outcomes for residents and communities.

ACCOUNTABILITY SCHEDULE

High-level Responsibilities, Decision-making and Assurance

8. High-level accountability, decision-making and assurance schedule

This schedule describes the framework position. It is not a detailed delegation instrument and does not override formal organisational approvals or operative agreements. Detailed authority, delegations, approval routes, change control and dispute resolution are specified in the Place Partnership Agreement, Terms of Reference, Section 75 and hosting arrangements.

Area	NHS Greater Manchester	Place Partnership Board	Place Lead / Place leadership	Delivery governance	Partner and host organisations
Shared outcomes	Sets or agrees relevant GM strategic commissioning signals and draws assurance through agreed routes.	Owns collective oversight and the Place assurance judgement for agreed outcomes.	Coordinates priorities, delivery and the shared narrative; connects Place and GM.	Maintains delivery grip, actions, dependencies and recovery.	Agree and deliver contributions; retain accountability for own functions.
Decision-making	Retains statutory ICB decisions and acts through formal delegation	Makes or recommends decisions only within delegated authority and	Exercises documented Place Lead and delegated authority	Makes operational decisions within agreed remit and escalates	Take sovereign decisions and approvals required by law or internal

Area	NHS Greater Manchester	Place Partnership Board	Place Lead / Place leadership	Delivery governance	Partner and host organisations
	where agreed.	Terms of Reference.	cannot bind a partner outside it.	reserved matters.	governance.
Place Fund	Provides NHS resources to the pooled or aligned fund through s75 with the relevant local authority	Takes responsibilities formerly held by Locality Board Committees for prioritisation, decision making and oversight of the S75.	Supports implementation and stewardship; identifies risks and formal approvals required.	Monitors delivery and resource use.	Local authority host and partners discharge Section 75, finance and contribution responsibilities.
Place Team / hosted service	Commissioner and funder as set out in the hosted service contract.	Provides strategic oversight of the hosted service on behalf of the PHCP.	Provides strategic and functional leadership, priorities and performance oversight within agreed rights.	Coordinates day-to-day delivery through the Place Partnership Director or equivalent.	Host remains employer and provides lawful employment, infrastructure and corporate assurance; partners contribute agreed capacity.
Quality, clinical	Retains its duties and	Considers implications for	Ensures clinical and	Monitors delivery	Providers, local

Area	NHS Greater Manchester	Place Partnership Board	Place Lead / Place leadership	Delivery governance	Partner and host organisations
leadership and safeguarding	provides system quality and clinical routes.	outcomes, convenes discussion, identifies concerns and shares learning.	professional advice informs Place decisions and concerns reach the correct route.	impacts and actions within remit.	authorities, regional and other bodies retain statutory, professional and safeguarding accountabilities.
Assurance	Receives and responds to Place assurance, intelligence and challenge; provides reciprocal assurance, support and enabling action; explains how Place input has informed decisions;	Owns the collective Place assurance position; seeks assurance and action from NHS Greater Manchester and partners where decisions, retained functions or dependencies affect Place outcomes.	Coordinates evidence, narrative, action and links to GM routes.	Supplies delivery evidence and monitors actions.	Provide accurate evidence, assurance on contributions and use shared intelligence in own governance.

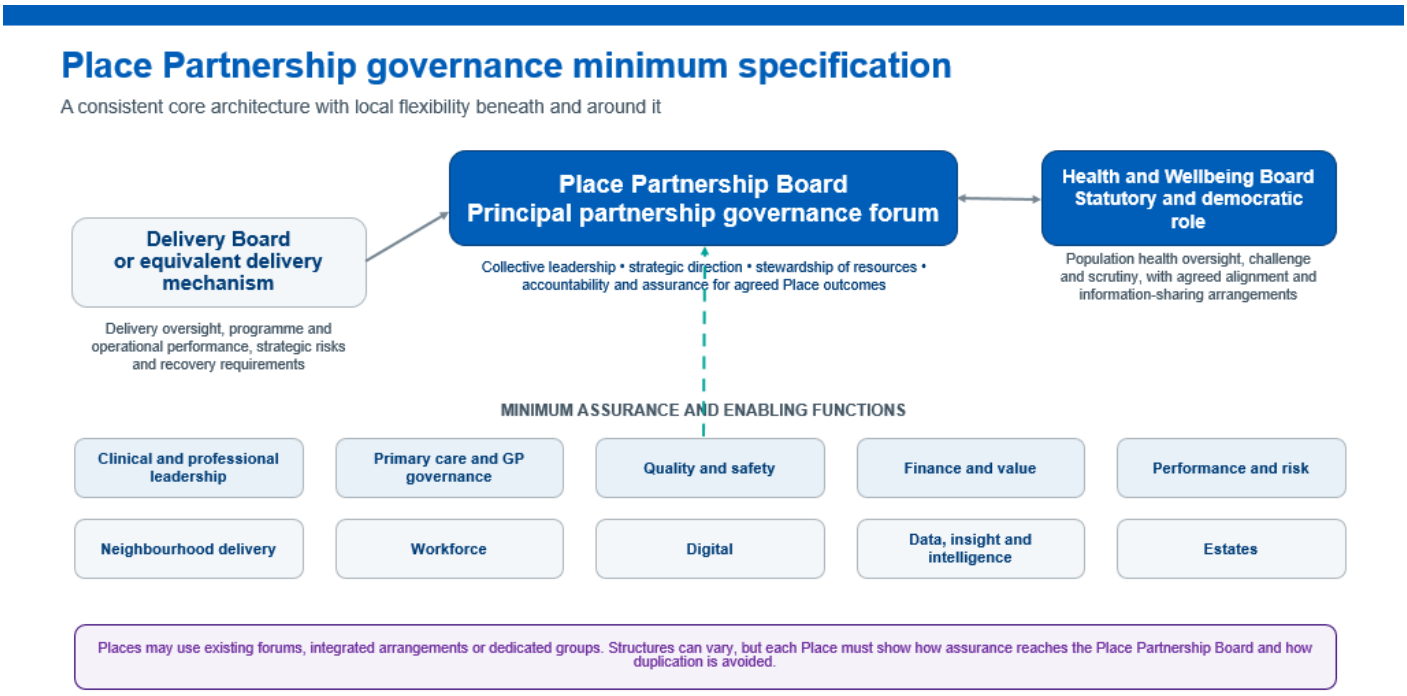
Area	NHS Greater Manchester	Place Partnership Board	Place Lead / Place leadership	Delivery governance	Partner and host organisations
	and consolidates material themes.				
Recovery and escalation	Provides support, enabling action or intervention where within authority or required by retained duty.	Agrees collective support, recovery and escalation position.	Coordinates recovery and makes barriers visible.	Named leads deliver recovery plan and report progress.	Deliver assigned actions and use retained performance, contractual, statutory or risk routes as applicable.
Governance interfaces	Sets relevant GM governance and system assurance routes; engages and consults Place on commissioning intentions and decisions affecting local outcomes;	Determine Place specific governance outside of minimum specification. Maintains appropriate connections without replacing statutory bodies.	Supports alignment, referral and information flow.	Maintains operational links to thematic and Neighbourhood arrangements.	Maintain own governance and statutory partnerships; agree local interfaces.

Area	NHS Greater Manchester	Place Partnership Board	Place Lead / Place leadership	Delivery governance	Partner and host organisations
	and provides clear feedback on the response to Place intelligence and challenge.				
Primary care, GP governance and estates	Retains and discharges relevant statutory and commissioning responsibilities, provides access to expertise and governance routes, and assures Place on decisions and actions affecting local delivery.	Considers the implications for shared outcomes, provides local intelligence and challenge, and agrees collective priorities or recommendations within delegated authority.	Connects NHS Greater Manchester, Place and partner routes; ensures responsibilities, support and escalation are explicit.	Coordinates agreed delivery activity and escalates issues outside its remit or capacity.	Retain their own legal, operational, professional and estates responsibilities and contribute agreed expertise, capacity, and assurance.

PLACE-SPECIFIC GOVERNANCE MAP

Minimum Specification

9. Place Health and Care Partnership governance minimum specification

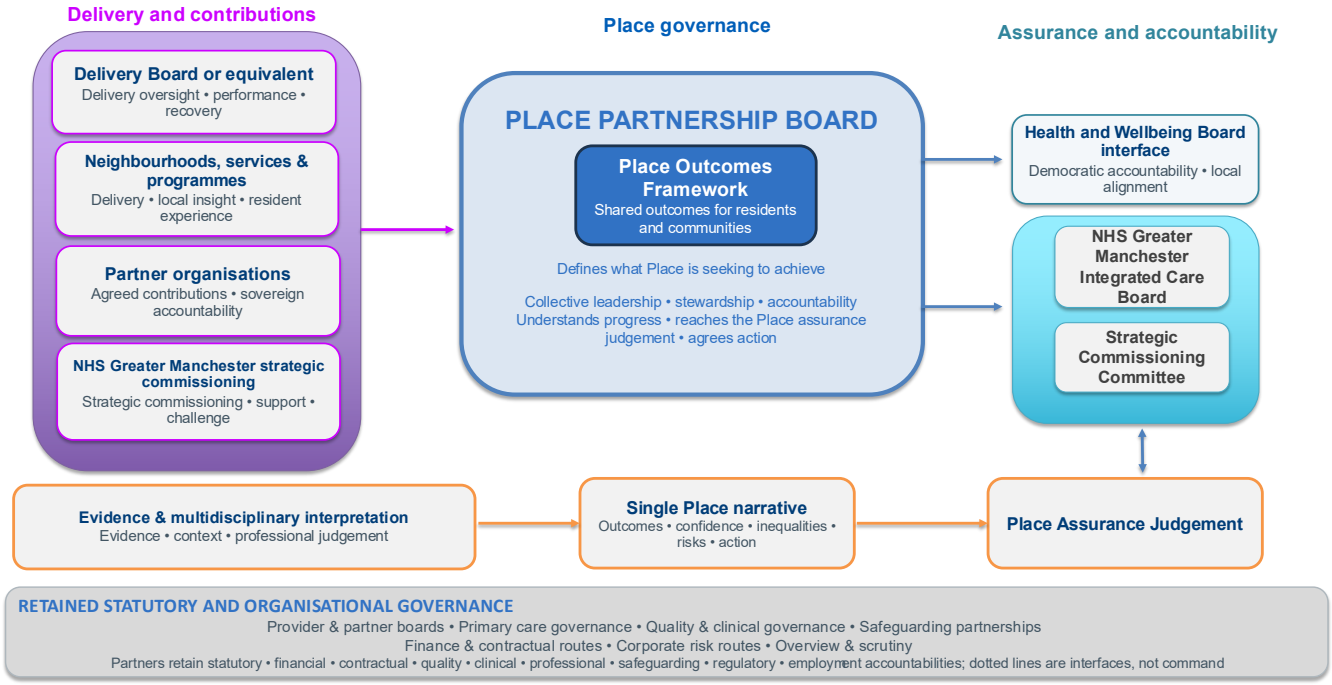


PLACE AND SYSTEM GOVERNANCE MAP

How governance, accountability and assurance connect

10. Governance, accountability and assurance connector map

How Place governance, accountability and assurance connect



Meeting: Locality Board			
Meeting Date	02 November 2026	**Action**	Consider
Item No.	7.1	**Confidential**	No
Title	NCA Improvement Plan update		
Presented By	Lorna Allan/ Alistair Craig		
Author			
Clinical Lead	N/A		

Executive Summary

The NCA Improvement Plan update comprises of the following components: -

- A report setting out the NCA commitment to communicating openly and consistently, together with a timeline for engagement on the Integrated Improvement Plan.
- The draft engagement strategy.
- The draft Integrated Improvement Plan being submitted to the NCA Board meeting on the 4th November 2026.
- An invitation for Bury place to attend the Northern Care Alliance (NCA) Integrated Improvement Board going forward.
- Edition number 2 of the System Improvement Board update.

Recommendations

It is recommended that the Locality Board note and comment on the NCA Improvement Plan update.

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	☒

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**

Northern Care Alliance
NHS Foundation Trust

Meeting	**Locality Boards and Scrutiny Committees**
Paper Title	Arrangements for communicating and engaging with our localities about the Integrated Improvement Plan (IIP).
Prepared by:	Julie Hartley, Director of Communications and Fundraising; Tamara Zatman, Associate Director – Post Transaction Integration; Andrew Hulcoop, Head of Strategy & Four Localities Partnership Programme Director
Presented by:	Relevant NCA executive director
Executive Summary	This paper proposes an approach to ensure our localities receive clear, consistent and timely NCA information about the Integrated Improvement Plan (IIP) through their core meetings. The meetings covered are the locality boards for Oldham, Rochdale, Bury and Salford; the Joint Health Overview and Scrutiny Committee, which covers the four local authority areas; and the Salford Health and Adults Scrutiny Panel.
Recommendations	Locality boards and scrutiny committees are invited to: • note the NCA's approach to providing one core monthly IIP briefing, with relevant local context • consider the proposed timetable and engagement arrangements • use the scheduled November and December meetings to test the plan's priorities, gaps, risks and dependencies, and advise on local outcomes and community involvement

Communicating and engaging with our localities about the Integrated Improvement Plan (IIP)

1. Introduction

The Northern Care Alliance NHS Foundation Trust (NCA) will produce one core monthly briefing on its Integrated Improvement Plan (IIP) for all locality boards and health scrutiny committees. The timing will align with the NCA Board and the System Improvement Board, which oversees progress against the plan. Each briefing will include relevant local context and:

- agreed messages from the latest System Improvement Board meeting
- IIP progress, milestones and next steps
- points for discussion, engagement or local input

The same core briefing will be used at every board and committee, with changes only where local context requires them. It will be checked for accuracy and consistency through the NCA's arrangements for overseeing the IIP. An appropriate NCA representative will present it, supported by improvement programme leads where relevant.

This paper focuses specifically on communication and engagement about the IIP.

2. Scope and limitations

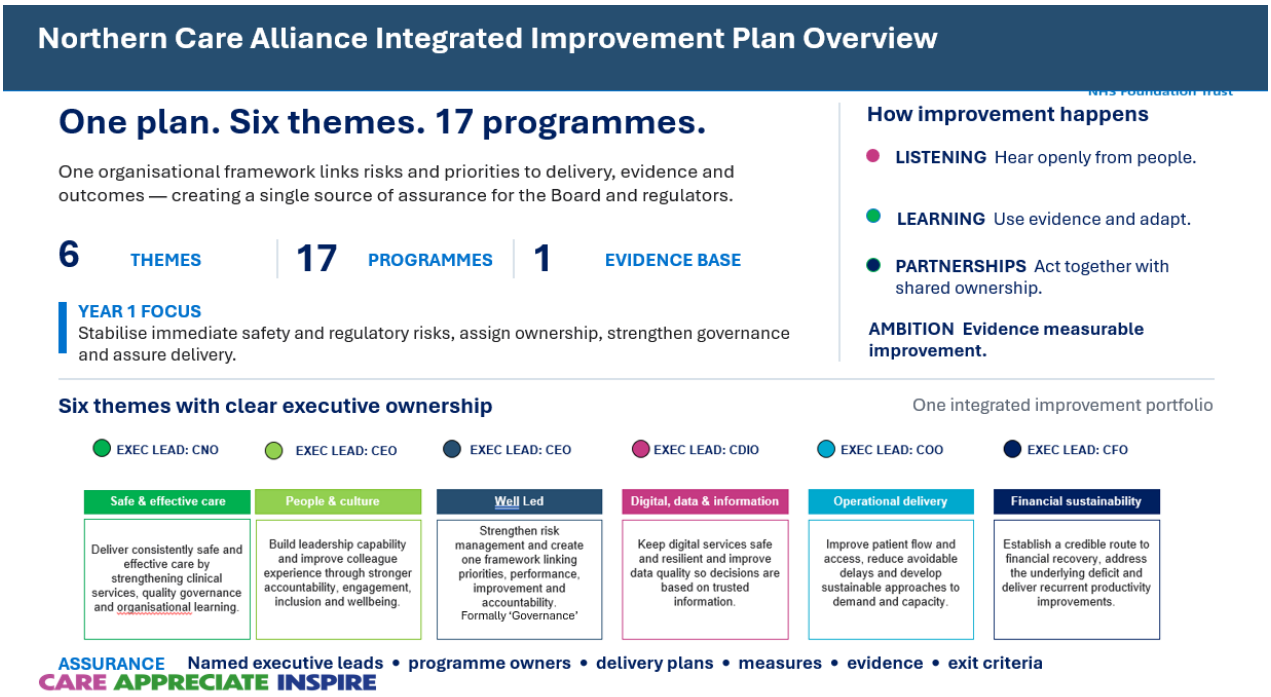
This approach is intended to provide locality boards and scrutiny committees with consistent and timely information about the IIP.

The NCA will coordinate questions and requests arising from meetings and direct them to the relevant clinical service, improvement programme or corporate team. That team will be responsible for providing an accurate and timely response.

3. Integrated Improvement Plan: key messages for October and November 2026

Progress: Development of the IIP started later than intended because of leadership changes, the response to Care Quality Commission findings, the formal warning notice issued under Section 29A of the Health and Social Care Act 2008, and significant external scrutiny. Leadership capacity has since been strengthened and work is progressing at pace.

Purpose and scope: The IIP will bring improvement work into one evidence-based framework covering six themes and 17 programmes: safe and effective care; people and culture; well-led; digital, data and information; operational delivery; and financial sustainability.



NCA Board consideration: The NCA Board will review the working draft, priorities, governance and approach to monitoring progress on 4 November 2026. This will inform further engagement and refinement. Locality boards and scrutiny committees will then help test and strengthen the plan before final approval.

Local engagement: This paper sets out a timeline and approach to be discussed at the following locality boards: Oldham and Salford on 22 October, Rochdale on 27 October and Bury on 2 November.

Engagement approach: The NCA will work with NHS and local authority partners across the four localities to agree a common approach to engagement.

Sharing the draft: The working draft of the IIP will be shared around 28 October, ahead of discussion by the NCA Board in public on 4 November. Structured engagement will then take place at: Rochdale Locality Board on 24 November; Oldham Locality Board on 26 November; Salford Locality Board on 26 November; Salford Health and Adults Scrutiny Panel on 2 December; Bury Locality Board on 7 December; and the Joint Health Overview and Scrutiny Committee on 17 December.

Role of locality boards and scrutiny committees: Boards and committees will test priorities, gaps, risks and dependencies; advise on local outcomes and community involvement; and identify opportunities for partners and communities to help shape and deliver the plan.

Attendance: An appropriate NCA representative will attend, supported where relevant by the senior lead responsible for the IIP or by individual programme leads. Discussion will focus on local priorities, evidence of improvement, partner contributions and progress reporting.

4. Timescales

Proposed timescales and purpose are below.

Date	Activity	Purpose
22 October 2026	Oldham locality engagement	Present the proposed approach and explain the IIP timetable.
22 October 2026	Salford locality engagement	As above
27 October 2026	Rochdale locality engagement	As above
28 October 2026	Working draft of the IIP shared with all four locality boards and scrutiny committees ahead of discussion by the NCA Board in public on 4 November	Provide the working draft
2 November 2026	Bury Locality Board	Present the proposed approach and explain the IIP timetable.
4 November 2026	NCA Board considers the working draft IIP	Review the plan's structure and priorities, how it will be overseen and how progress will be monitored; and support further engagement and refinement.
November–December 2026	Locality engagement and co-production based on the agreed approach Rochdale Locality Board, 24 November; Oldham Locality Board, 26 November; Salford Locality Board, 26 November; Salford Health and Adults Scrutiny Panel, 2 December; Bury Locality Board, 7 December; and the Joint Health Overview and Scrutiny Committee, 17 December.	Test priorities and outcomes, identify local implications and support, and shape delivery and reporting arrangements.

end

Northern Care Alliance NHS Foundation Trust

Integrated Improvement Plan (IIP) Stakeholder Engagement Strategy DRAFT (Indicative timings, subject to confirmation)

Contents

1. Prepare
2. Listen
3. Learn
4. Refine
5. Share

1. Prepare

The Integrated Improvement Plan (IIP) is the NCA's single plan for making services better. It brings together our priorities for quality and safety, colleagues and culture, leadership and governance, digital and data, day-to-day performance and finance. The plan has been shaped with clinical leaders, Board members and partners. It has six main themes and 16 programmes of work.

A plan everyone can understand

We will produce a short and clear version of the Integrated Improvement Plan that anyone can read and comment on. It will not list hundreds of individual actions. Instead, it will explain what we need to improve, why it matters and what patients, colleagues and communities should notice as things get better. We will ask people whether we are focusing on the right things.

This strategy sets out a proportionate approach to engagement from October to December 2026: prepare one accessible version of the plan, listen through existing channels, bring feedback together, refine the plan and share it with all stakeholders. There will be no standalone summit.

We want people to help set the right priorities, describe what better services should look and feel like, identify practical ideas and support, and build shared ownership of the improvements. We will be open about what can and cannot change, make it easy to take part and explain how feedback has shaped the final plan.

What people can help shape

People can help shape the priorities within the six themes, the results we should aim for, what good looks like, what should happen first, how quickly changes should be

made, and how organisations and communities can help. We will be clear about decisions that have already been made and about any legal, regulatory, clinical or financial rules that limit the choices. The NCA Board will approve the revised IIP following engagement.

Making sure everyone can take part

People will be able to take part face to face, online or through local groups they already know and trust. We will work with Healthwatch, staff networks and local partners to reach people who may not attend formal meetings or complete an online survey.

We will make an extra effort to hear from people who face health inequalities, disabled people, people who need information or communication support, people who do not speak English as their first language, carers, children and young people where relevant, and people who cannot easily get online. We will provide information and support in suitable formats. We will check who is taking part and do more to reach any groups that are missing.

How the work will be managed

The executive lead for the Integrated Improvement Plan is responsible for this engagement strategy. The engagement team will organise the work, keep one feedback record and report what people have said, whose views may be missing and any problems that could affect the work. The NCA will consider the feedback and explain how it has been used. Before approving the revised IIP, the NCA Board will check that we have involved the right people and listened properly.

Approval and status

This engagement strategy and proposed timetable are subject to NCA Board approval before engagement begins. All dates are indicative and will be confirmed against approval, existing meetings and available capacity. The executive lead, engagement lead and lead for each activity, accessible materials and feedback routes must be in place before listening starts. Stages may overlap once these requirements are met; dates will move if necessary. Following engagement, the revised IIP and feedback-and-response summary will be submitted to the NCA Board for approval before publication.

What we need to deliver the work

The engagement team will confirm the capacity needed for one accessible plan, a simple feedback route and one feedback record. Existing meetings, colleague channels and trusted partner networks will be the main routes for engagement. Additional conversations and communication support will be arranged where needed to hear missing voices, rather than as a separate events programme.

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How we will know it is working

We will keep participation under review, follow up where important voices are missing, and explain how different views have been considered and what can realistically change.

We will judge engagement by the range and usefulness of views, not event numbers or response quotas. We will check that:

- All stakeholder groups have been offered an accessible opportunity to comment, with reach checked across Oldham, Salford, Bury and Rochdale.
- Important gaps in participation are identified and followed up through suitable routes.
- Clear evidence of how feedback has been considered, what changed and why, including reasons for not making changes to the plan, its priorities, measures or delivery approach.
- A proportionate process for ongoing feedback and progress updates is agreed through existing channels.

How we will look after people's information

We will tell people how their feedback will be used before they take part. Survey responses will be reported without naming individuals unless they have agreed otherwise. Notes from meetings and events will focus on themes rather than attributing comments to named people. Personal information will be kept securely, used only for this work and handled in line with the NCA's information governance and privacy requirements. We will also explain how confidential or sensitive concerns can be raised through the right route.

Who we will involve

This stakeholder list is a checklist for reach, not a requirement for a separate meeting with every group. We will share the same accessible plan and use the most suitable existing route for each audience.

Stakeholder area	Stakeholders
Internal leadership and clinical teams	Trust Leadership Group Clinical Group leadership teams Clinical Service Units Consultants, nurses, allied health professionals (AHPs) and operational leaders
Internal colleagues and representatives	All colleagues Staff networks Freedom to Speak Up Guardians Trade unions and staff-side representatives

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	Governors Volunteers
National, GM system and strategic leadership	NHS England NHS GM Chief Officers NHS GM Board GM Integrated Care Partnership Board GM Mayor GMCA Chief Executive GM MPs
Place and local government	NHS GM Place Leads and Place Partnership Directors Place Clinical Directors Locality Boards Local authorities Councillors and council leaders and health portfolio leads Directors of public health, adult social services and children's services
Scrutiny, patients and communities	GM Joint Health Scrutiny Committee Joint Health and Overview Scrutiny Committee (Bury, Oldham, Rochdale) Healthwatch Salford Health & Adults Scrutiny Panel Patient representatives Patients, carers and communities Voluntary and community networks
Providers, primary care and professional networks	Trust Provider Collaborative Alternative Provider Collaborative Primary Care Provider Board Local Medical Committees (LMCs) Primary care workforce, via the GM Primary Care Portal Care sector partners GM NHS trust and council communications leads

2. Listen

How people can take part

We will share one short, accessible summary of the IIP with all stakeholders and ask the four questions below, using the engagement routes set out in this section.

Four questions for everyone

We will use the same four short questions in conversations and written feedback. Wording and communication support can be adapted to people's needs without adding a separate question set for each audience. Where helpful, prompts will explore what better services should look and feel like, the results people want to see and the pace of change.

- Are we focusing on the right improvements?
- What is missing?
- What should happen first?
- How can you support us?

When someone is representing others

We will be clear whether someone is sharing their own view or speaking for patients, residents, colleagues, communities, professional groups or partner organisations. We will ask whose views they are bringing and whether any important voices are missing.

Ways to take part

- Existing meetings, colleague channels and staff networks, adapting conversations to the audience.
- Through Healthwatch, to share information and hear views.
- One simple written feedback route, with a non-digital option so people can respond without attending a meeting or going online.
- Targeted follow-up conversations where important voices are missing, rather than a fixed programme of new events.

Our aim is to give all stakeholder groups a meaningful opportunity to contribute, rather than promise to reach every individual. The method we use will depend on the audience, the purpose of the conversation and any accessibility or communication needs. The routes below will be confirmed before sharing; they do not require a separate events programme.

How we will reach people

Audience	Practical route to confirm
Colleagues and clinical teams	Share the accessible IIP summary through colleague communications and existing leadership and team briefings. Ask managers to use the four questions in team conversations, with paper feedback available for colleagues who are not regularly online.
Staff representatives, networks, governors and volunteers	Use existing meetings and distribution lists. Invite individual feedback and collective responses where appropriate.

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Patients, carers and communities	Publish the plan and feedback invitation on the NCA website. Use patient-facing information and trusted Healthwatch, voluntary and community networks to share it and support conversations. Provide a clear non-digital response route and suitable communication support.
Local authorities, locality partners, MPs and scrutiny bodies	Send a direct briefing with the accessible IIP summary, four questions and response deadline. Use scheduled meetings where available, with written feedback if meeting dates do not fit.
National and GM NHS partners, providers, primary care and care sector partners	Use direct partner briefings, existing professional networks and the GM Primary Care Portal. Ask contacts to circulate the invitation and offer a coordinated response where useful.

The plan at a glance – indicative 2026 timings, subject to Board approval and confirmation against existing meetings and capacity

Stage	Timing	What we will do	Key output
Prepare	19–30 October	Prepare one accessible IIP summary, four questions, a simple feedback route with a non-digital option, and one feedback record. Confirm named leads, existing channels and Board approval of the engagement strategy before listening starts.	One set of materials, named leads and clear ways to take part.
Listen	26 October–27 November, subject to approval and readiness requirements in section 1; dates will move if necessary.	Share the plan through existing meetings, colleague channels and trusted networks. Invite written feedback and follow up where important views are missing.	A broad evidence base covering all four places, priority stakeholder groups and voices that may otherwise be missed.
Learn	23 November–4 December	Bring feedback together, check reach and gaps, identify common and different views, and carry out focused follow-up where needed.	Updated feedback record and draft findings for the single feedback-and-response summary, including common and different views

			and gaps in participation.
Refine	30 November–11 December	Use feedback to refine the plan and prepare one summary of what we heard, what changed and why.	Revised plan and one feedback-and-response summary for Board consideration.
Share	December 2026, following approval	Share the revised accessible plan and feedback summary with all stakeholders. Agree how ongoing feedback and progress updates will use existing channels.	Shared plan and an agreed, proportionate process for feedback and progress updates.

3. Learn

NCA engagement team will keep one feedback record and bring together the main themes, different views and gaps in participation. The NCA will use this to refine the plan. One short summary will explain what we heard, what changed and why, including where suggestions could not be taken forward.

- One record of all feedback received.
- One feedback-and-response summary covering the main messages, different views, gaps in participation, what changed and why, and reasons for not taking suggestions forward.
- The NCA will consider relevant feedback and record any changes or reasons for not making them.
- An agreed way to continue feedback and share progress through existing channels.

4. Refine

The NCA will review the feedback and propose changes to priorities, measures or delivery. The executive lead will bring the revised plan and feedback summary to the NCA Board for approval. The indicative timetable above will be checked against existing meetings and available capacity; it does not require a separate event or meeting for each stakeholder group.

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5. Share

Following Board approval, we will share the revised accessible plan and one summary of what we heard and our response with all stakeholders, using the checklist in section 1. This will explain the priorities and expected improvements for NCA services in Oldham, Salford, Bury and Rochdale.

We will agree how stakeholders can continue to give feedback, how it will be considered and how often progress will be shared. Named leads will use existing meetings and communication channels wherever possible, keeping the process useful and manageable.

DRAFT

Northern Care Alliance
NHS Foundation Trust

Trust Integrated Improvement Plan (IIP)

Version 1.0

START ▶

CARE APPRECIATE INSPIRE

Draft 26.10.26

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1.

Introduction



1. Introduction

1.1 Overview

The Integrated Improvement Plan (IIP) approach is a strategic initiative designed to enhance the quality, efficiency, and sustainability of healthcare services. It provides a structured framework for driving improvement by bringing together multiple improvement initiatives under one cohesive framework, rather than managing them in isolation, and it is overseen by the Board.

The IIP clearly identifies the key challenges facing an organisation, set out the actions required to address them, and defines measurable outcomes to track progress and impact.

The IIP is a three-year plan made up of six themes with the aim of:

- **Year 1: Stabilising** immediate safety and regulatory risks, strengthen governance and assure delivery.
- **Year 2: Optimising** performance, embed consistent ways of working, strengthen accountability, and deliver measurable improvements across all themes and programmes.
- **Year 3: Transforming** organisational capability, culture and outcomes, embedding sustainable improvement and delivering long-term strategic change.

In Year 1, 16 programmes have been identified under the six themes.

Theme	 Exec Lead: **CNO**	 Exec Lead: **CP&SO**	 Exec Lead: **CEO**	 Exec Lead: **CDIO**	 Exec Lead: **COO**	 Exec Lead: **CFO**
	Safe & Effective Care	**People & Culture**	**Well Led**	**Digital, Date & Information**	**Operational Delivery**	**Financial Sustainability**
Programme	**Gynaecology Services** Exec Sponsor: **Rafik Bedair** SRO: **Jo Humphreys**	**Medical Engagement** Exec Sponsor: **Rafik Bedair** SRO: **Suzy Ning**	**Risk Management & Assurance** Exec Sponsor: **Juliette Cosgrove** SRO: **Caroline Greenhalgh**	**Digital Safety & Infrastructure** Exec Sponsor: **Lorna Allen** SRO: **David Grant, Nicci Hancox**	**Urgent & Emergency Care & Patient Flow** Exec Sponsor: **Leah Robins** SRO: **Kate McKenna**	**Financial Recovery** Exec Sponsor: **Suzanne Robinson** SRO: **Asif Umarji**
	Spinal Services Exec Sponsor: **Rafik Bedair** SRO: **Omar Pathmanaban**	**Culture, Speaking Up & Inclusion** Exec Sponsor: **Gertie NicPhilib** SRO: **Shabana Sadiq**	**Organisational Management & Governance** Exec Sponsor: **Suzanne Robinson** SRO: **TBC**	**Data Quality & Information Management** Exec Sponsor: **Lorna Allen** SRO: **Emma Wright**	**Elective Recovery** Exec Sponsor: **Leah Robins** SRO: **Julia Bridgewater**	**Productivity & Cost Improvement** Exec Sponsor: **Suzanne Robinson** SRO: **Asif Umarji**
	Quality Governance Exec Sponsor: **Juliette Cosgrove** SRO: **Caroline Greenhalgh**	**Colleague Health, Attendance & Wellbeing** Exec Sponsor: **Gertie NicPhilib** SRO: **Amy Goodale**	**Executive & Senior Leadership Effectiveness** Exec Sponsor: **Kevin McGee**			
	Patient Safety, Complaints & Learning Exec Sponsor: **Juliette Cosgrove** SRO: **Caroline Greenhalgh**					

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1.2 Scope

In the first year, the focus is on stabilising the immediate safety and regulatory risks relating to:

- CQC Section 29A – October 2024 (Continuous Flow).
- CQC Section 29A – October 2025 (Salford Surgery).
- NHSE Undertakings – June 2026 (Spinal, Gynaecology, Quality Governance, Reporting & Assurance).
- CQC Well-Led 29A – August 2026 (Risk Management, Patient Safety, Complaints, Freedom to Speak Up, Workforce Wellbeing / EDI).

Given the nature of the regulatory and safety concerns and the need to achieve statutory targets in year the specific programmes that will deliver in the early part of the year are:

- Gynaecology Services.
- Spinal Services.
- Quality Governance.
- Patient Safety, Complaints and Learning.
- Colleague Health, Attendance & Wellbeing (Sickness).
- Digital Safety and Infrastructure.
- Access and waiting time recovery (Elective Recovery).
- Financial Recovery.

There will be progress and delivery across all 6 themes and 16 programmes.

1.3 Governance

An Integrated Improvement Board will be the principal executive-led forum for oversight of the IIP and will focus on delivery confidence, outcome trajectories, risks, dependencies, capacity constraints and corrective action. It will meet monthly and will be chaired by the Chief Executive and comprise Executive Directors, programme Senior Responsible Owners and Subject Matter Experts as required. Its cadence will be aligned to the Northern Care Alliance NHS Foundation Trust (NCA) Board of Directors and System Improvement Board.

It will be underpinned by robust programme architecture to ensure delivery of the programmes of work, including Programme Boards and oversight at an IIP Theme level via existing Executive-led management governance.

Reporting will be standardised, exception-based and principally assurance-focused. It will report delivery progress against defined outcomes, outputs and success measures using evaluation criteria based on assurance (confidence) levels. Reporting will also include position against trajectory, risks, dependencies, corrective action and decisions required. Assurance will flow from operational teams and workstreams, through defined programme governance, to the Integrated Improvement Board. The Integrated Improvement Board will review aggregate assurance, resolve cross-organisational barriers and escalate matters requiring collective executive decision.

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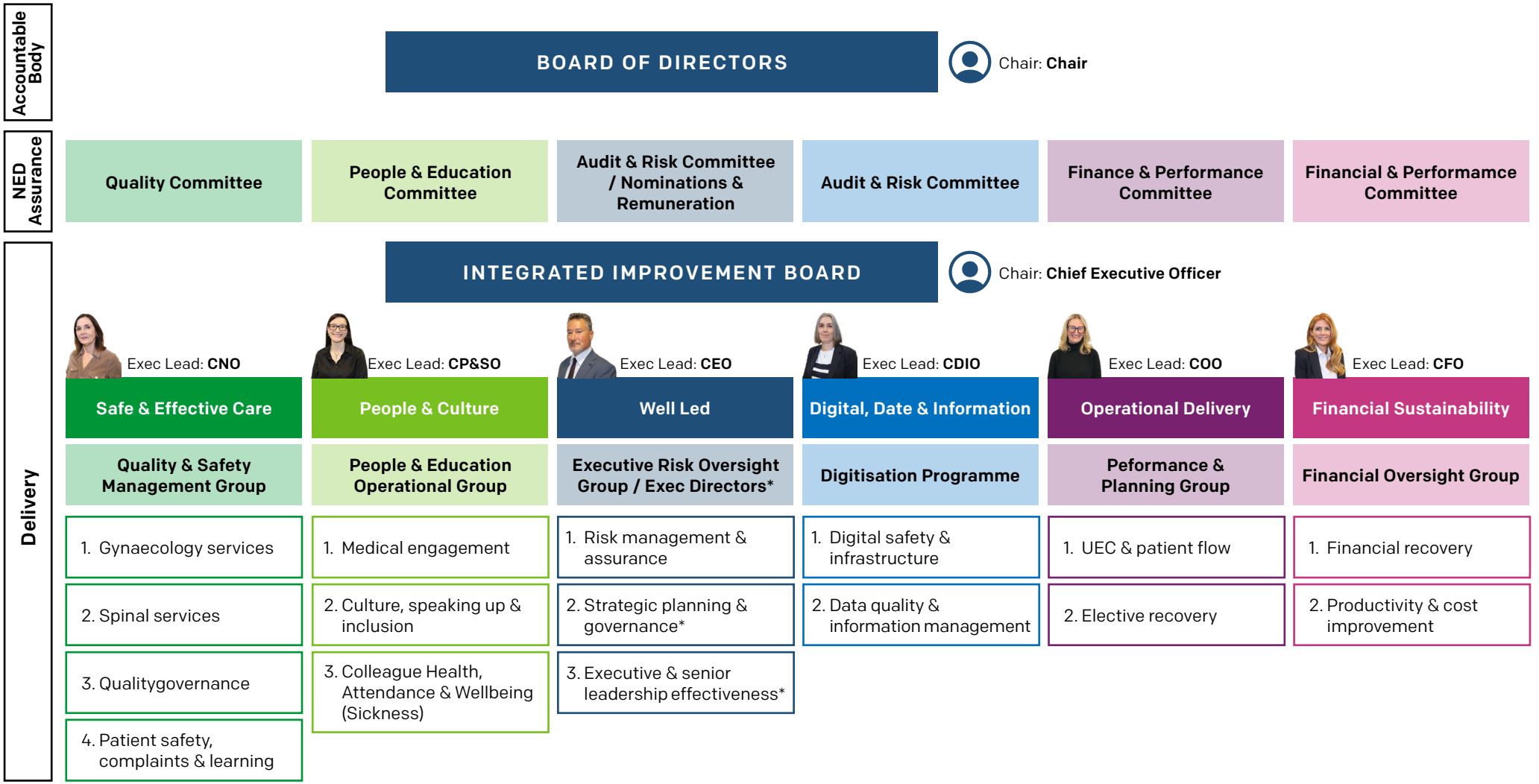
The Board of Directors retains direct oversight and accountability of the IIP with the existing Board Committee structure being utilised for assurance and scrutiny. This is illustrated on the diagram below.



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1.4 Assurance Framework

A structured assurance approach will be utilised to support oversight of the IIP, providing a consistent basis for assessing progress against defined assurance criteria, evidence requirements and success measures.

The Integrated Improvement Assurance Framework establishes a consistent approach for determining whether the IIP is delivering the improvements and outcomes expected by the Board and regulators. Importantly, the framework is designed as an outcome-focused approach which tests whether improvement has actually been achieved, evidenced, embedded and sustained as well as the level of confidence that assurance criteria (outcomes) can be achieved by the target date.

The Integrated Improvement Assurance Framework defines the assurance criteria (outcomes), evidence (outputs) and success / impact measures (SMART KPIs) at a programme and theme level. It also defines the framework for evaluating confidence in delivering outcomes at two complementary levels: Level 1, providing an overall assessment generated by individual programmes, and Level 2, an independent assessment by the NCA's Portfolio Assurance Office. A common assurance scale from Low through to Full Assurance and transfer to business as usual will provide a consistent assessment of both demonstrated improvement and confidence in achieving the required outcomes. Regulatory requirements, including CQC Section 29A Warning Notices, NHS England Undertakings and GGI recommendations, are mapped directly into the relevant IIP programmes so that regulatory compliance forms part of the evidence of successful improvement rather than operating as a separate process.

1.5 Stakeholder Engagement Plan

We are committed to making sure the IIP delivers real, lasting change. The engagement strategy sets out how we will involve all our stakeholders, including colleagues, patients, communities and place partners to create a plan that reflects what matters to them and the improvements they need to see. This means listening to their experiences and ideas, welcoming questions and challenge, and using their feedback to shape both the plan and the action we take.

Through regular conversations, clear updates and local partnership and scrutiny meetings, we will show how people's views have influenced the plan, share progress and be open about the challenges that remain.

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1.6 Risk Management

A consistent and proactive approach to programme risk management will be embedded across all programmes to identify, assess, manage and monitor risks that could impact the successful delivery of the IIP programmes. Each programme will maintain a risk register, with risks assessed using the agreed likelihood and impact.

Risks will be reviewed regularly through programme governance arrangements, with clear ownership assigned and mitigating actions tracked to ensure timely action and decision-making.

This approach will support early identification of emerging issues, strengthen accountability, and enable informed decisions that maximise the likelihood of successful programme delivery and sustainable improvement outcomes. An overarching risk associated with delivery of the IIP has also been included on the Trust's BAF.

Across the programme the following risk areas have been identified that could impact successful delivery and appropriate action is being taken to mitigated these:

- **Stakeholder engagement:**
  Engagement and communications programme in development and being considered across all themes and programmes. This is being integrated into existing forums where possible.
- **Improvement and programme resources and support:**
  Core programme support in place and being reviewed across all programmes to ensure to correct support to enable delivery.
- **Cross-programme and Clinical Group dependencies:**
  Programme team in place and dependencies being mapped across all programmes alongside review of Clinical Group alignment.
- **Governance maturity across the programmes:**
  Core programme support in place and stocktake of governance and reporting across all programmes to ensure consistency.
- **Cultural differences between professional groups:**
  Embed a culture of collaboration and open decision-making across the IIP and programme.
- **Industrial action:**
  We are committed to reaching a fair and sustainable resolution. During periods of industrial action we are doing everything we can to maintain safe care, minimise disruption and keep contingency plans in place.

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2. THEME 1
Safe & Effective Care



2. THEME 1 : Safe & Effective Care



THEME EXECUTIVE LEAD:
Chief Nursing Officer: Juliette Cosgrove

2.1 Theme Overview
2.2 Gynaecology Services
2.3 Spinal Services
2.4 Quality Governance
2.5 Patient Safety, Complaints & Learning

2.1 Theme Overview

Main issues being addressed

Significant concerns about the safety, governance, leadership and delivery of Gynaecology and Spinal services have resulted in regulatory intervention and require both urgent recovery and sustainable improvement.

NCA does not yet consistently bring together quality intelligence to identify emerging risks, escalate concerns, take effective action and ensure that identified actions are followed through, providing reliable assurance from clinical services through to the Board.

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2.2 Gynaecology Services

Programme roles

Executive Sponsor	**Rafik Bedair**
Programme SRO	**Jo Humphreys**
Clinical Lead	**Alana Mitchel**
Operational Lead	**Vic Fox**

Current reality

Significant concerns about the safety, governance, leadership and delivery of Gynaecology services have resulted in regulatory intervention and require both urgent recovery and sustainable improvement.

Programme aim – what we need to achieve

We aim to establish a safe, well-led and sustainable Gynaecology service through strengthened safety systems, governance, culture, operational performance and agile service delivery models.

This will result in improved patient experience and outcomes, staff experience, regulatory compliance and assurance, whilst working with our partners to achieving sustained improvement, evidenced by resolution of the underlying causes.

Assurance criteria, evidence and success measures

Assurance Criteria (Outcomes)
• Improved health outcomes and experience for people / population in the service. • Accountable and sustainable Gynaecology Service able to flex to demands. • Strengthened safety systems.

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Evidence (Outputs)	Date Due
We will have a safe, sustainable, standardised and clinically coherent delivery model for gynaecology across the NCA: • Designed by.	 Nov 2026
We will be assured that the previous Rapid Quality Review (RQR) safety priority actions have been: • Completed and addressed. • The learning identified embedded in practice.	 Oct 2026 Mar 2027
We will have achieved and sustained compliance with colposcopy and external cervical-screening requirements and provided reliable assurance over tracking, reporting and accreditation: • Safety and Quality Assessment for Sustainability (SQAS) actions submitted. • Screening Incident Assessment Form (SIAF) completed / addressed. • Embedded in practice.	 Dec 2026 Mar 2027 Jul 2027
We will have reliable systems for identifying, escalating, investigating and learning from clinical risk and for assuring the quality and safety of the service (completed / addressed).	Jan 2027
We will ensure leadership behaviours, team environment and management arrangements required for safe, collaborative and sustained improvement, whilst ensuring professional concerns, restrictions, consent issues and speaking-up themes are managed consistently, fairly and in a way that produces organisational learning: • Phase 1.	 Dec 2026
We will have reliable clinical and operational controls of patient pathways: • First step completed / addressed.	 Nov 2026

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Success Measures (KPIs) under development to confirm targets	Target:
Reduced locum usage and reduction in vacancy position: • Long term locums. • Vacancies.	 0 0
Improved NHS Staff Survey Response Rate: • Reduction in areas scoring red in NHS Staff Survey.	 50% response 5 reds
Timely completion of overdue incidents in line with NCA Incident Reporting Process and Patient Safety Incident Response Framework (PSIRF) Principles.	TBC
Complete the 58 historical outstanding SIAF actions by 31/10/26.	All completed
All 41 PSII actions to have evidence they are embedded.	All embedded

Regulatory alignment

Aligned Regulatory Action:

- NHSE Undertakings - June 2026 (Gynaecology).

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2.3 Spinal Services

Programme roles

Executive Sponsor	**Rafik Bedair**
Programme SRO	**Omar Pathmanaban**
Clinical Lead	**Kate Bailey**
Operational Lead	**Sam Dickens**

Current reality

Longstanding concerns, multiple reviews and outstanding issues have resulted in uncertainty about safety, accountability and sustainable service delivery.

Programme aim – what we need to achieve

We aim to deliver sustainable improvements in quality, safety, patient experience, culture, and operational performance across the Spinal service, through implementation of a structured improvement programme that will evidence that underlying causes are resolved.

Assurance criteria, evidence and success measures

Assurance Criteria (Outcomes)
• Clear and controlled patient safety position. • Improvement in agreed clinical and service outcomes. • Delivery of regulatory requirements. • Effective and stable leadership and governance. • Evidence that improvements are sustained. • Ability to return safely to routine organisational oversight.

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Evidence (Outputs)	Date Due
We will complete the MDT improvement actions ensuring all appropriate patients receive an MDT.	Mar 2027
We will embed the single spinal governance and morbidity and mortality (M&M) structure across neurospinal and orthopaedic services: • In place by, ongoing audit. • Expand cross-organisation.	 Dec 2026 Mar 2027
We will introduce and embed staff feedback mechanisms and implemented leadership development actions.	Dec 2026
We will maximise high-volume low-complexity (HVLC) activity at Rochdale elective hub and the potential to evaluate opportunitie to move activity across the NCA footprint, including utilising Fairfield General Hospital.	Mar 2027
We will have routine patient experience and feedback collection mechanisms in place and strengthened processes for responding to concerns, complaints and compliments.	Dec 2026
Success Measures (KPIs) – under development to ensure safety and the quality metrics are fully reflected	**Target**
% patients sent to MDT.	100%
% of complex cases discussed in line with agreed MDT standards.	100%
Patient and family satisfaction - patient experience metrics demonstrate sustained improvement.	Over at least three consecutive reporting periods
Emergency back pain admissions with LOS >4 days and no procedure.	≤10% benchmark
Staff survey results.	Year-on-year improvement
Elective hub utilisation – increased HVLC activity.	TBC

Regulatory alignment

Aligned Regulatory Action:

- NHSE Undertakings - June 2026 (Spinal).

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2.4 Quality Governance

Programme roles

Executive Sponsor	**Juliette Cosgrove**
Programme SRO	**Caroline Greenhalgh**
Clinical Lead	**Alistair Craig**
Operational Lead	**Caroline Greenhalgh**

Current reality

NCA does not yet consistently bring together quality intelligence to identify emerging risks, escalate concerns, take effective action and ensure that identified actions are followed through, providing reliable assurance from clinical services through to the Board.

Programme aim – what we need to achieve

We aim to establish a consistent, standardised, intelligence driven and clinically led quality governance framework across the NCA that provides effective 'ward-to-board-to ward' assurance, strengthens accountability, supports organisational learning and enables informed decision-making.

In doing this we will identify risks early and generate the evidence required to assure our patients, regulators and stakeholders that we are complaint across all regulatory standards.

Assurance criteria, evidence and success measures

Assurance Criteria (Outcomes)

- Patients receive safe, effective and high-quality care, with a clear focus on improving outcomes and experience.
- Risks and variation identified early, learning to translate into improvement.
- Leaders to have clear assurance that all internal and regulatory care standards are being achieved and sustained.
- Greater staff satisfaction by creating clarity, shared accountability and a positive culture in which staff feel supported and able to deliver high-quality care.
- Enhance Board assurance, improve regulatory compliance and sustainable improvement across the NCA.

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Evidence (Outputs)	Date Due
We will commission a review which will demonstrate increased quality governance maturity.	Jun 2027
We will have a simplified quality governance and accountability framework, with clear roles from ward/service level through Clinical Groups to Executive and Board.	Feb 2027
We will have an effective Board assurance framework for quality, providing clearer line of sight from frontline care to Board assurance, particularly around patient safety, clinical outcomes and experience.	Apr 2027
We will have a more focused quality reporting framework, with a smaller set of meaningful measures covering outcomes, safety, patient experience, inequalities and workforce, allowing greater focus on trends, variation and improvement.	Mar 2027
We will have a stronger quality and safety culture, where staff understand their responsibilities, feel supported to raise concerns and can see that their input results in action and improvement.	Jun 2027
We will have an improved approach to learning and continuous improvement, demonstrating a clear link between incidents, complaints, audit, patient feedback, staff insight and measurable improvement.	Jun 2027
We will have a greater clarity about quality risks and escalation, including how emerging concerns are identified, triangulated, escalated and sustainably addressed.	Apr 2027
Success Measures (KPIs) – under review to ensure safety and quality metrics are fully reflected	**Target:**
% compliance for significant risks with effective mitigation and evidence of impact.	90%
% compliance for escalated quality and safety concerns being reviewed within agreed timescales.	95%
% compliance for Quality Committee reports being supported by agreed quality intelligence and a KPI framework.	100%

Regulatory alignment

Aligned Regulatory Action:

- CQC S29A - Oct 2024 (Continuous Flow).
- CQC S29A - Oct 2025 (Salford Surgery).
- NHSE Undertakings - Jun 2026 (Spinal, Gynaecology, Quality governance, Reporting & Assurance).
- CQC Well-Led S29A - Aug 2026 (Patient safety, Risk management).

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2.5 Patient Safety, Complaints & Learning

Programme roles

Executive Sponsor	**Juliette Cosgrove**
Programme SRO	**Caroline Greenhalgh**
Clinical Lead	**Alistair Craig**
Operational Lead	**Caroline Greenhalgh**

Current reality

NCA does not consistently demonstrate that patient safety incidents, complaints and other sources of safety intelligence are reviewed and responded to in a timely and reliable way, or that resulting learning and actions lead to changed practice and reduced risk.

Programme aim – what we need to achieve

We will create an integrated and learning-focused approach to patient safety and complaints that ensures the organisation listens, learns and acts when care falls short, translating insight from patients, families and staff into sustained improvements in safety, quality and experience.

Assurance criteria, evidence and success measures

Assurance Criteria (Outcomes)
• Deliver safer care and a better experience for patients and staff by strengthening how the organisation listens, learns and improves following incidents and complaints. • Reduce recurrence of concerns and harm, embed a stronger learning culture and provide greater assurance that insight is consistently translated into measurable and sustained improvement.

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Evidence (Outputs)	Date Due
We will see a reduction in avoidable and recurrent harm.	Apr 2028
We will see fewer recurring themes in incidents and complaints.	Aug 2027
We will have stronger evidence that learning results in sustained improvement through commissioned review of actions.	Aug 2027
We will have an improved patient and family experience when concerns arise.	Jun 2027
We will observe greater staff confidence in raising concerns and learning from them.	Jun 2027
We will have stronger Board assurance that patient safety risks are understood and effectively addressed.	Apr 2027
We will have a stronger quality and safety culture, where staff understand their responsibilities, feel supported to raise concerns and can see that their input results in action and improvement.	Aug 2027
Success Measures (KPIs) – under review to ensure safety and the quality metrics are fully reflected	**Target**
Reduction in serious harm from categories defined in the PSIRF local priorities.	10% reduction
% compliance in the staff survey and Pulse results with staff being confident to speak up.	80%
Reduction in the BAF risk score for Patient Safety and Clinical Quality risks.	No higher than 12
% completion and evidence of actions arising from incidents and complaints	95%

Regulatory alignment

Aligned Regulatory Action:

- CQC S29A - Oct 2024 (Continuous Flow).
- CQC Well-Led S29A - Aug 2026 (Patient safety, Complaints).

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3. THEME 2
People & Culture



3. THEME 2 : People & Culture



THEME EXECUTIVE LEAD:
Chief People & Strategy Officer: Gertie NicPhilib

3.1 Theme Overview

3.2 Medical Engagement

3.3 Culture, Speaking up & Inclusion

3.4 Workforce Health, Attendance & Wellbeing (Sickness)

3.1 Theme Overview

Main issues being addressed

The NCA faces significant challenges with leadership stability, organisational alignment, and workforce culture. Inconsistent leadership and accountability have contributed to fragmented decision-making and slower delivery, while clinical leadership and medical engagement are not yet consistently developed or embedded across the organisation.

Concerns also remain about staff confidence to speak up, fear of reprisal, inequalities in colleague experience, and the effectiveness of staff engagement and partnership arrangements.

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3.2 Medical Engagement

Programme roles

Executive Sponsor	**Rafik Bedair**
Programme SRO	**Suzy Ning**

Current reality

NCA has made important progress in strengthening medical engagement, including through the Clinical Leadership Model, the re-established Medical Staff Committee and continued investment in medical leadership. However, the experience of medical engagement remains variable across the organisation and continues to depend too heavily on individual relationships and local arrangements rather than consistent organisational practice.

NCA already has many of the structures and mechanisms associated with effective medical engagement. The challenge is therefore not primarily to create more opportunities for engagement, but to improve how consistently existing arrangements work together and the quality of the relationship between the organisation and its medical workforce. Medical staff want earlier involvement in significant decisions, greater understanding of organisational priorities, and clearer evidence of how their advice has been considered and influenced organisational thinking.

Effective medical engagement also requires collective organisational ownership. It is shaped by doctors' relationships with operational, corporate and Executive leaders as well as professional medical leadership. The opportunity is therefore to establish medical engagement as an enduring organisational capability, characterised by trust, openness, shared responsibility and constructive partnership, through which medical expertise routinely informs leadership, decision-making and improvement.

Programme aim – what we need to achieve

To strengthen the organisation's capability to work in partnership with its medical workforce, ensuring that medical expertise routinely informs organisational leadership, decision-making and improvement.

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Assurance criteria, evidence and success measures

Assurance Criteria (Outcomes)
• **Medical voice and influence** - Medical expertise routinely informs organisational leadership, governance and decision-making, with clinicians having meaningful opportunities to influence significant decisions before they are finalised and clear evidence of how their advice has been considered. • **Leaders and partnership** - Clinicians, managers and organisational leaders work in effective partnership, characterised by trust, openness, mutual respect, shared responsibility and constructive challenge, with medical engagement experienced consistently rather than being dependent on individual relationships. • **Communication and Organisational Dialogue** - Medical staff understand organisational priorities and significant decisions and experience open, honest and meaningful two-way dialogue with organisational leaders, including clear explanations of how and why decisions have been reached. • **Organisational Listening and Learning** - Medical staff are confident that their expertise, concerns and ideas are heard and responded to, with insight from the medical workforce systematically informing organisational learning, governance, leadership and improvement. • **Partnership in Improvement** - Doctors routinely participate as active partners in the design, delivery and evaluation of organisational improvement, with medical expertise shaping problems, solutions and change and supporting stronger clinical ownership of improvement. Collectively, these outcomes will establish medical engagement as an enduring organisational capability, embedded in the normal way NCA leads, makes decisions and improves, rather than being dependent on individual leaders, local relationships or standalone engagement initiatives.

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Evidence (Outputs)	Date Due
We will set up five-workstream programme architecture, with clear senior ownership and governance.	Dec 2026
We will produce a problem and causal analysis validated with clinicians, Clinical Groups, the Medical Staff Committee and available quantitative and qualitative evidence.	Mar 2027
We will clarify roles and relationships between existing medical engagement arrangements, particularly the Medical Staff Committee, Medical Council, Local Negotiating Committee and organisational governance.	Mar 2027
We will establish consistent arrangements established for early medical input into significant organisational decisions, with evidence of how medical advice has been considered.	Mar 2027
We will set up reliable organisational listening and feedback arrangements, including visible responses to significant themes raised by the medical workforce.	Mar 2027
We will ensure there are regular opportunities for meaningful dialogue between Executive leaders and the medical workforce, supporting visibility, openness and understanding of organisational priorities.	Mar 2027
We will embed medical participation within priority organisational improvement activity, with evidence that clinical expertise has influenced the design, delivery or evaluation of improvement.	Mar 2027
We will set baseline medical engagement measures and agree Year 1 improvement expectations.	Mar 2027

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Success Measures (KPIs) under development to ensure fully reflects evidence and to confirm targets	Target:
Medical Engagement Scale.	TBC
NHS Staff Survey – Medical Workforce.	TBC
GMC National Training Survey.	TBC
Medical Staff Committee participation.	TBC
% of defined significant organisational decisions with documented medical input before the decision is finalised.	TBC
% of defined medical leadership roles with agreed role, accountability and decision-making arrangements in place.	TBC
% of Clinical Groups receiving the agreed minimum standard of Executive-medical workforce dialogue each reporting period.	TBC
% of significant medical workforce themes receiving a documented organisational response within an agreed timeframe.	TBC
% of defined strategic improvement programmes with documented medical involvement from programme initiation / design.	TBC

Regulatory alignment

Aligned Regulatory Action:

- NHSE Undertakings - June 2026 (Spinal, Gynaecology).

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3.3 Culture, Speaking up & Inclusion

Programme roles

Executive Sponsor	**Gertie NicPhilib**
Programme SRO	**Shabana Sadiq**

Current reality

NCA does not yet provide a consistently psychologically safe and inclusive working environment in which colleagues feel able to raise concerns openly and confident that concerns will be acted upon without detriment.

There are significant concerns about high levels of anonymous speaking up, reported fear of reprisals, insufficient oversight of detriment, inequalities in colleague experience, and a lack of organisational oversight and assurance regarding Freedom to Speak Up (FTSU) processes.

Programme aim – what we need to achieve

A positive and inclusive organisational culture in which colleagues feel respected and psychologically safe, are confident to raise concerns and challenge openly, are protected from detriment, and can see that their voice leads to meaningful action and improvement.

Assurance criteria, evidence and success measures

Assurance Criteria (Outcomes)

- Effective organisational oversight and assurance arrangements are in place for FTSU cases, processes, themes and outcomes.
- A respectful, inclusive culture where colleagues can raise concerns and shape improvement.
- Staff feel safe, supported, and confident to raise concerns.
- Reduction in fear of retaliation or negative consequences.
- Improved awareness of speaking-up routes and support available.
- Leaders actively encourage and respond to concerns.
- Psychological safety improves within teams.
- Underrepresented groups have equal confidence and opportunity to raise concerns.
- Barriers to speaking up are identified and addressed.

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Evidence (Outputs)	Date Due
We will mandate FTSU National eLearning and add to Learning Management System.	Dec 2026
We will have a governance and assurance framework to provide organisational oversight of FTSU cases, processes, themes, outcomes, and learning.	Mar 2027
We will have one singly policy for FTSU and Whistleblowing.	Mar 2027
We will develop a process to understand and identify detriment (incl. increasing coms).	Mar 2027
We will work with Comms teams to share positive stories and case studies.	Mar 2027
We will put additional training on to capture leaders who attended leadership training (Foundation Leadership Development Training) who attended the course prior to the introduction of FTSU to the sessions.	Mar 2027
Success Measures (KPIs) – under development to confirm targets	**Target**
% reporting compliance and organisational oversight of FTSU cases, themes, outcomes and learning through agreed governance structures.	100%
NHS Staff Survey FTSU indicators (overall score).	Improvement year-on-year and above NHS acute trust average
Number of concerns raised through FTSU and other appropriate routes.	Sustained increase or maintained reporting levels
Monitor Compliance with National FTSU training (First year of roll out).	TBC
% of staff who know how to raise concerns (Staff Survey or local pulse survey).	Increase by 10%
Response times for FTSU concerns (in line with the FTSU Policy once complete).	TBC

Regulatory alignment

Aligned Regulatory Action:

- CQC Well-Led S29A - Aug 2026 (Organisational oversight, governance, and assurance of Freedom to Speak Up cases and processes, Workforce Wellbeing / EDI).

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3.4 Workforce Health, Attendance & Wellbeing (Sickness)

Programme roles

Executive Sponsor	**Gertie NicPhilib**
Programme SRO	**Amy Goodale**
Clinical Lead	**Karen Coverley**

Current reality

Sickness absence remains high and management practice around attendance, return to work and colleague wellbeing is inconsistent.

Existing processes do not yet consistently support early intervention, effective management or sustainable improvement in attendance and workforce resilience and we do not yet have sufficient confidence that the principal causes, risks and operational impact of sickness absence are being systematically addressed.

Programme aim – what we need to achieve

We aim to create a healthier and more resilient workforce through consistent attendance management; deliver a consistent Board to Ward absence reporting and assurance framework; and strengthen leadership and management capability that delivers sustained reduction in sickness absence, improved colleague experience, safer staffing levels, improved patient experience and financial performance.

Assurance criteria, evidence and success measures

Assurance Criteria (Outcomes)
• Sustained reduction in in-month and rolling 12-month sickness absence. • More timely and effective management of long-term sickness cases. • Reduction in the impact of stress, depression and anxiety-related absence. • Consistent attendance management practice across Clinical Groups and Corporate teams.

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Evidence (Outputs)	Date Due
We will establish executive-led attendance review panels, with systematic review of long-term cases, high-absence areas, barriers and overdue actions.	Sept 2026
We will implement a single, validated attendance dashboard and exception-reporting framework, providing reliable Board to Ward data on absence performance, long-term cases, management actions and Clinical Group variation.	Oct 2026
We will strengthen long-term sickness case management, ensuring cases over 90 days are validated, regularly reviewed and supported by timely Occupational Health (OH) / Human Resources (HR) intervention.	Mar 2027
We will deliver targeted recovery plans for sickness absence hotspots and psychological absence, using deep dives to identify local drivers and implement evidence-based wellbeing, management and operational interventions.	Dec 2026
We will improve management capability and consistent application of attendance processes, through effective planning to ensure effective engagement that embeds the deliverable actions in a sustained way.	Mar 2027
We will deliver and evidence sustained improvement in attendance and workforce resilience, demonstrating reductions in sickness absence alongside improvements in the operational and financial impact of sickness-related temporary staffing.	Mar 2027
Success Measures (KPIs)	**Target**
Rolling 12-month sickness absence rate.	6.2 - 6.4%
In-month sickness absence rate.	5.7 - 5.9%
Long-term sickness cases with a recorded current management plan.	≥ 90%
Welcome Back Conversation compliance.	≥ 90%

Regulatory alignment

Aligned Regulatory Action:

- CQC S29A - Oct 2025 (Salford Surgery).
- CQC Well-Led S29A - Aug 2026 (Workforce Wellbeing / EDI).

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4. THEME 3
Well Led



4. THEME 3 : Well Led



THEME EXECUTIVE LEAD:

Chief Executive Officer: Kevin McGee

4.1 Theme Overview

4.2 Risk Management & Assurance

4.3 Integrated Planning, Performance & Improvement Governance

4.4 Executive & Senior Leadership Effectiveness

4.1 Theme Overview

Main issues being addressed

The NCA does not currently have sufficient assurance that its risk management processes provide an accurate and up-to-date view of key organisational and operational risks. In addition, multiple strategies, plans, programmes, and performance frameworks are not yet integrated into a single management system, creating challenges in setting clear organisational priorities, aligning delivery efforts, and measuring whether improvement activities are achieving the desired outcomes.

Executive leadership instability and capacity constraints have also affected organisational alignment, clarity of accountability and the pace and consistency of delivery. NCA needs stable and effective collective executive leadership, with clear accountabilities and sufficient leadership capacity to provide strategic direction, maintain grip on performance and lead the scale of improvement and transformation required across the organisation.

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4.2 Risk Engagement

Programme roles

Executive Sponsor	**Juliette Cosgrove**
Programme SRO	**Caroline Greenhalgh**
Clinical Lead	**Alistair Craig**
Operational Lead	**Caroline Greenhalgh**

Current reality

NCA cannot currently be confident that its risk management system provides a reliable and current view of its most important organisational and operational risks.

Risk registers contain significant numbers of historic, outdated or poorly maintained risks, with weaknesses in ownership, review, escalation and alignment with organisational policy. This limits the ability of Clinical Groups, Executive leaders and the Board to identify priorities, manage risk effectively and provide reliable assurance.

There is also a risk that risk registers, reporting processes and completion of actions become proxies for effective risk management rather than demonstrating that risks are genuinely controlled and reducing.

Programme aim – what we need to achieve

We aim to strengthen the organisation's approach to risk management and assurance, ensuring that key risks are identified, understood, escalated and effectively managed, with clear accountability and robust assurance enabling the Board to make informed decisions and maintain confidence that risks to the delivery of safe, high-quality and sustainable services are being appropriately mitigated.

Assurance criteria, evidence and success measures

Assurance Criteria (Outcomes)
• A more mature and proactive approach to risk and assurance, enabling earlier identification and effective management of significant risks, clearer accountability and better-informed decision-making. • Greater Board confidence that risks to the delivery of the organisation's strategic objectives and safe, high-quality care are understood, appropriately controlled and subject to effective assurance.

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Evidence (Outputs)	Date Due
We will implement a programme of risk maturity assessment and continuous improvement providing evidence that the new arrangements are embedded and delivering impact. The assessment will evidence:	Jan 2027
A revised Risk Management Framework and Strategy with clear principles, responsibilities, escalation routes and expectations across the organisation.	Timescales to be informed by the assessment
A strengthened Board Assurance Framework (BAF) clearly linking strategic objectives, principal risks, controls, assurances and gaps.	
A clear risk appetite framework, supporting consistent and informed decision-making.	
A standardised risk assessment and scoring approach, improving consistency and quality of risk information.	
Clear risk ownership and accountability, from service and divisional level through to Executive and Board.	
Improved risk escalation and de-escalation arrangements, ensuring significant and emerging risks reach the appropriate level promptly.	
An integrated assurance framework, bringing together clinical, operational, workforce and financial assurance and identifying gaps or duplication.	
Improved Board and Committee risk reporting, focused on trends, movement, effectiveness of controls and areas requiring leadership attention.	
A programme of risk management training and development, strengthening capability and ownership across the organisation.	
Success Measures (KPIs)	**Target**
% of significant risks reviewed on time.	95%
% of significant risks with effective controls and assurance.	95%
% of risk mitigation actions delivered on time.	80%
Number/proportion of risks outside agreed appetite without an approved treatment plan.	0
% of strategic risks with identified assurance gaps and active mitigation.	95%

Regulatory alignment

Aligned Regulatory Action:

- CQC S29A - Oct 2024 (Continuous Flow).
- CQC S29A - Oct 2025 (Salford Surgery).
- NHSE Undertakings - Jun 2026 (Quality governance, Reporting & Assurance).
- CQC Well-Led S29A - Aug 2026 (Risk management).

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4.3 Strategic Planning & Governance

Programme roles

Executive Sponsor	**Suzanne Robinson**

Current reality

NCA has multiple strategies, plans, programmes and performance arrangements that are not yet consistently brought together into a single organisational management system. This can make it difficult to maintain clarity about the organisation's strategic priorities, translate them into a small number of organisational priorities, and understand whether delivery and improvement are changing outcomes.

Programme aim – what we need to achieve

A coherent organisational management system that connects strategy, annual priorities, the IIP, operational performance and Executive accountability.

Assurance criteria, evidence and success measures

Assurance criteria (outcomes)
– evidence and success measure are under development

- Clear organisational priorities.
- Clear Executive accountability.
- Stronger alignment between strategy, improvement and operational delivery.
- Fewer overlapping plans and reporting processes.
- Greater focus on outcomes and impact.
- Earlier identification of areas requiring intervention.
- Improved confidence that organisational priorities are being delivered.

Regulatory alignment

Aligned Regulatory Action:

- NHSE Undertakings - Jun 2026 (Quality Governance, Reporting & Assurance).

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4.4 Executive & Senior Leadership Effectiveness

Programme roles

Executive Sponsor	**Kevin McGee**

Current reality

NCA has experienced significant Executive and senior leadership instability, affecting continuity, organisational alignment and the pace of delivery. Collective leadership, alignment around organisational priorities and clear accountability are not yet consistently embedded.

Differences in approach across portfolios and services can contribute to fragmented decision-making, inconsistent messages and variable delivery of organisational priorities.

The scale and complexity of the organisation's improvement agenda also requires sufficient Executive and leadership capacity to maintain grip on current performance while leading sustained organisational improvement.

Whilst clinical and operational leaders appointed to senior CLM roles have/are attending the advanced development programme there is still more to do to ensure our leaders are engaged in and committed to leading improvement and contributing to organisational performance, transformation and patient outcomes.

Programme aim – what we need to achieve

To establish a stable, effective and collectively accountable Executive leadership team, with the capacity and capability to provide clear organisational direction, align the organisation around shared priorities and lead sustained improvement across NCA.

Senior leaders will work in an inclusive and equitable environment where they are clear on expectations, supported in their development and equipped with the leadership and management skills needed to succeed and deliver high quality care.

Assurance criteria, evidence and success measures

Assurance Criteria (Outcomes)
• Stable and effective Executive leadership with clear collective accountability. • Clear organisational priorities, consistently communicated and understood across NCA. • Timely and consistent delivery of agreed Executive decisions and organisational priorities. • Fair, inclusive and transparent processes for leaders throughout their employment. • Leaders understand what is expected of them in their role and professional practice. • Identify strengths and development needs as leaders and managers and access opportunities to build their skills, confidence and effectiveness.

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Evidence (Outputs)	Date Due
We will have clear Executive roles, accountabilities and decision-making arrangements.	Dec 2026
We will ensure clear and consistently communicated set of NCA organisational priorities.	Nov 2027
We will put in place executive succession and capacity plans for critical leadership roles.	Jan 2027
We will support all leaders to complete foundation leadership development, identifying any further development needs: • For AforC colleagues Band 8d+. • For AforC colleagues Band 8b-8c. • For medical colleagues all Clinical Group leadership roles. • For medical colleagues CSU leadership team roles.	 Jan 2027 Mar 2027 Jan 2027 Mar 2027
Success Measures (KPIs) – under development to confirm targets	**Target**
Executive leadership stability, measured through substantive appointments/vacancy or turnover position.	TBC
Agreed IIP priorities are collectively owned by the Executive team and delivered to agreed milestones.	TBC
% of agreed actions arising from the Executive portfolio review implemented within agreed timescales.	100%
% of leaders completed foundation leadership development.	90%
% of leaders who have had a line manager led development conversation (completed on appointment to a new role and annually thereafter).	95%

Regulatory alignment

Aligned Regulatory Action: N/A

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5. THEME 4
Digital, Data & Information



5. THEME 4 : Digital, Data & Information



THEME EXECUTIVE LEAD:

Chief Digital & Information Officer: Lorna Allan

5.1 Theme Overview

5.2 Digital Safety & Infrastructure

5.3 Data Quality & Information Management

5.1 Theme Overview

Main issues being addressed

Digital systems and infrastructure do not yet provide consistently reliable support for safe and effective care across NCA.

Data quality and confidence in information is variable across NCA. Inconsistent definitions, data entry, validation and ownership can make it difficult to establish a single reliable view of organisational performance, risk and improvement, and can reduce confidence in information used for clinical, operational and organisational decision-making and assurance.

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5.2 Digital Safety & Infrastructure

Programme roles

Executive Sponsor	**Lorna Allan**
Programme SRO	**David Grant & Nicci Hancox**
Clinical Lead	**James Kerr, David Rog & Sarah Webb**

Current reality

Digital systems and infrastructure do not yet provide consistently reliable support for safe and effective care across NCA.

Recent disruption to electronic prescribing has demonstrated the potential patient safety and operational impact when important clinical systems are unavailable or unreliable. Wider concerns about infrastructure resilience have also been identified through external review.

Programme aim – what we need to achieve

We will develop a clear understanding of and method of managing system failure risks, disruption and the impact of ageing technology. This will keep clinical systems and digital infrastructure safe, reliable and recoverable to support safe clinical care; reduce the highest patient-safety, cyber, obsolescence and continuity risks; stabilise today's services while simplifying the estate for future Single Electronic Patient Record (EPR) delivery; and establish a clear EPR roadmap and timeline.

Assurance criteria, evidence and success measures

Assurance Criteria (Outcomes)
• Clinical safety certification for all critical clinical systems. • More resilient services, faster incident recovery and lower cyber exposure evidenced through the Data Security Protection Toolkit (DSPT) certification. • Accountable application ownership with defined lifecycle and investment plans. • A supportable estate ready for Single EPR, underpinned through delivery of an EPR readiness plan.

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Evidence (Outputs)	Date Due
We will have a plan for all high-risk clinical systems to be stabilised and remediated.	Dec 2026
We will have a resilient, secure and modern digital infrastructure delivered (subject to sustained annual investment).	Mar 2028
We will rationalise our clinical applications by 33% each financial year and technical debt reduced through: • Phase 1 – collation of application register and allocated ownership. • Phase 2 – decommission all current redundant applications. • Phase 3 – application roadmap plan and investment strategy towards Single EPR defined.	 Jan 2027 Feb 2027 May 2027
We will strengthen cyber security and access controls, aligned to DSPT "standards met" compliance, recognising the DSPT standards increase year on year.	Mar 2028
We will have an EPR-ready digital architecture specification and roadmap established - pending EPR roadmap confirmation.	May 2027
Success Measures (KPIs)	**Target**
Red systems with approved and funded treatment plans.	100%
Critical systems with clinically owned and validated business continuity plans.	100%
Number of server operating systems and databases at End of Life.	0
Critical Clinical applications entering final support without identified risk mitigation and approved treatment.	0

Regulatory alignment

Aligned Regulatory Action: N/A.

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5.3 Data Quality & Information Management

Programme roles

Executive Sponsor	**Lorna Allan**
Programme SRO	**JEmma Wright & Alex Garbett**
Clinical Lead	**James Kerr, David Rog & Sarah Webb**

Current reality

Data quality and confidence in information is variable across NCA.

Inconsistent definitions, data entry, validation and ownership can make it difficult to establish a single reliable view of organisational performance, risk and improvement, and can reduce confidence in information used for clinical, operational and organisational decision making and assurance.

Programme aim – what we need to achieve

Reliable and consistently understood information, with clear ownership of data quality and appropriate information governance across the organisation.

To enable accurate, consistent and trusted data to support patient care, operational performance, assurance and strategic decision making.

Assurance criteria, evidence and success measures

Assurance Criteria (Outcomes)
• Trusted data for confident decisions. • Consistent assurance from frontline services to Board. • Earlier identification of risk, quality and performance issues. • Better staff access, understanding and use of data. • Improved patient care, performance and strategic planning.

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Evidence (Outputs)	Date Due
We will hold Clinical Group listening events and complete Integrated Improvement Plan data interdependency mapping, leading to: • Prioritised data action plan, including review of support offer for clinical groups.	Dec 2026 Mar 2027
We will analyse and centralise governance of all regulatory data reporting with clear ownership.	Mar 2027
We will have a baseline organisational quality dashboard.	Feb 2027
We will have an approved NCA Data Strategy.	April 2027
Success Measures (KPIs)	**Target**
% of critical datasets that meet agreed data-quality standards.	≥95%
% of senior leaders report confidence in the data used for decision making.	≥90%
% of critical data domains have accountable owners, defined quality measures and active improvement plans.	100%

Regulatory alignment

Aligned Regulatory Action: N/A.

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6. THEME 5
Opetrational Delivery



6. THEME 5 : Operational Delivery



THEME EXECUTIVE LEAD:
Chief Operating Officer: Leah Robins

6.1 Theme Overview

6.2 Urgent and Emergency Care (UEC) & Patient Flow

6.3 Elective Recovery

6.1 Theme Overview

Main issues being addressed

Patient flow across NCA is not consistently reliable, contributing to delays in care, pressure on urgent and emergency services, extended length of stay and reduced capacity to respond effectively to demand. Operational pressures can result in significant organisational effort being focused on managing immediate problems rather than addressing the causes of delay and variation.

Patients are waiting too long for some planned services, with variation in performance, waiting-list management and the ability to match capacity to demand. Backlogs and weaknesses in validation, pathway management and operational grip can make it difficult to maintain an accurate understanding of demand and to target improvement effectively.

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6.2 Urgent and Emergency Care (UEC) & Patient Flow

Programme roles

Executive Sponsor	**Leah Robins**
Programme SRO	**Kate McKenna**
Clinical Lead	**Karen Coverley**
Operational Lead	**Kelly McLellan**

Current reality

Patient flow across NCA is not consistently reliable, contributing to delays in care, pressure on urgent and emergency services, extended length of stay and reduced capacity to respond effectively to demand.

Operational pressures can result in significant organisational effort being focused on managing immediate problems rather than addressing the causes of delay and variation.

Programme aim – what we need to achieve

We will use our capacity effectively across all our services and sites to deliver a coordinated, organisation-wide approach to urgent and emergency care. This will ensure reliable flow whereby patients are admitted, transferred and discharged without unnecessary delay so that patients receive safe, timely care in the right place whilst improving experience and clinical outcomes.

We will strengthen operational grip, expand alternatives to admission, improve discharge and length of stay, align capacity with demand, and eliminate corridor care through sustainable, standardised ways of working.

Assurance criteria, evidence and success measures

Assurance Criteria (Outcomes)

- Improved patient safety, experience and clinical outcomes.
- Timely access to care, reduced delays and corridor care.
- Fewer avoidable admissions, improved patient flow and length of stay.
- More resilient and sustainable urgent and emergency care system.

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Evidence (Outputs)	Date Due
We will mobilise the programme: governance established, workstream leads appointed, baseline metrics agreed, benefits framework approved & delivery plans established.	Oct 2026
We will fully implement the NCA Winter Plan.	Jan 2027
We will embed the new Site Management Operating Model, Discharge Policy, and Full Capacity Policy and implementation of the Site Management Plan.	Mar 2027
We will expand admission avoidance pathways.	Mar 2027
We will have oversight of the delivery plans for Care In the Right Place, Corridor care, Safer Sooner / Los, Bed reconfiguration, GIRFT.	Mar 2027
Success Measures (KPIs)	**Target**
Emergency Department 4-Hour Performance.	82%
Patients Experiencing Corridor Care >45 Minutes.	0
Patients Waiting in ED >12 Hours.	9.90%
UEC (Non elective) average Length of Stay in days (LoS).	9.32

Regulatory alignment

Aligned Regulatory Action:

- CQC S29A - Oct 2024 (Continuous Flow).

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6.3 Elective Recovery

Programme roles

Executive Sponsor	**Leah Robins**
Programme SRO	**Julia Bridgewater**
Clinical Lead	**Graham Nelson**
Operational Lead	**Clinical Group Director of Operations**

Current reality

Patients are waiting too long for some planned services, with variation in performance, waiting-list management and the ability to match capacity to demand.

Backlogs and weaknesses in validation, pathway management and operational grip can make it difficult to maintain an accurate understanding of demand and to target improvement effectively.

Programme aim – what we need to achieve

We aim to deliver a three-year route to restoring and sustaining NHS constitutional standards for RTT elective care, eliminating long waits and creating a productive, equitable and financially sustainable elective operating model. The programme will provide improved and equitable access to planned care, supporting accuracy of waiting lists, sustainable management of demand and capacity leading to reduced waiting times. The aim is to deliver the Trust back to year 1 plan outcomes by March 2027.

Assurance criteria, evidence and success measures

Assurance Criteria (Outcomes)
• Reduce elective waiting times and unwarranted variation. • Improve access and patient experience. • Increase productivity and utilisation of substantive capacity and reduce reliance on non-core activity. • Deliver constitutional standards while establishing a financially sustainable elective operating model.

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Evidence (Outputs)	Date Due
We will have oversight of the implementation of theatre, outpatient and pre-operative improvement plans to increase productivity and right-size core capacity.	Dec 2026
We will mobilise a coordinated non-core value for money additional capacity programme (insourcing, outsourcing, mutual aid and independent sector provision), targeted at reducing long waits and the activity gap.	Dec 2026
We will implement referral optimisation and pathway redesign, including SPOAs, PIFU, and community alternatives.	Jan 2027
We will establish the central RTT validation function and standardised PTL processes, supported by automation, digital reporting and patient administration improvements.	Jan 2027
We will agree and commence implementation of a sustainable elective recovery team workforce plan covering workforce modelling, recruitment, extended roles, productivity and administrative redesign.	Feb 2027
We will develop and approve the Elective Recovery Strategy which will focus on digital innovation, service redesign, estate optimisation and new models of care. Deliver the Future Proofing Programme, prioritising invest to save schemes which create recurrent capacity, improve productivity and reduce reliance on premium additionality.	Mar 2027
Success Measures (KPIs)	**Target**
RTT <18 week wait.	62%
RTT >52-week waits <2%.	2600
Community RTT >52-week waits.	0%
Achieve an overall waiting list size aligned to 62% performance.	129,901
Reduce DM01 waits >6 weeks.	2%
Deliver >100% of agreed elective activity plan .	26-27 Plan

Regulatory alignment

Aligned Regulatory Action: N/A.

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7. THEME 6
Financial Sustainability



7. THEME 6 : Financial Sustainability



THEME EXECUTIVE LEAD:

Chief Finance Officer: Suzanne Robinson

7.1 Theme Overview

7.2 Financial Recovery

7.3 Productivity and Cost Improvement

7.1 Theme Overview

Main issues being addressed

NCA faces a significant financial challenge. Credible financial recovery plans are in place, but these are not yet being consistently translated into operational delivery, workforce change, productivity improvement and sustainable financial benefit.

The challenge is therefore one of execution: strengthening ownership, accountability and delivery so that agreed plans result in measurable operational change and recurrent financial improvement.

Without this stronger line of sight from plan to action to benefit, there is a risk that planned efficiencies and productivity improvements are not realised, leaving the underlying financial position unresolved.

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7.2 Financial Recovery

Programme roles

Executive Sponsor	**Suzanne Robinson**
Programme SRO	**Asif Umarji**
Clinical Lead	**Jay Naisbitt**
Operational Lead	**Steve Leech**

Current reality

NCA has credible financial recovery plans, but delivery is not consistently keeping pace with those plans. There is insufficient translation of agreed financial actions into operational, workforce and productivity change, meaning that planned benefits are not consistently realised or sustained.

Programme aim – what we need to achieve

To translate NCA's agreed financial recovery plans into sustained operational delivery and recurrent financial improvement.

Through clear ownership, accountability, disciplined execution and timely decision-making, we will ensure that planned workforce, productivity and efficiency improvements are delivered and their financial benefits are realised and sustained. This will restore financial stability while protecting patient care and enabling resources to be directed to our priorities.

Assurance criteria, evidence and success measures

Assurance Criteria (Outcomes)

- Financial performance is sustainably improved, with delivery against the agreed recovery trajectory and a demonstrable reduction in the underlying financial deficit.
- Agreed recovery actions are translated into operational, workforce and productivity improvements, with clear ownership and accountability for delivery.
- Planned financial benefits are demonstrably realised, recurrent and sustained, with a clear line of sight from operational improvement to financial impact.
- Workforce plans are affordable and sustainable, with reduced reliance on temporary staffing.
- There is strong financial grip and control, supported by robust governance, accurate forecasting, timely decision-making and effective management of delivery risks.
- Improved financial stability creates organisational resilience and confidence amongst the Board, regulators and system partners, enabling a progressive shift from recovery to sustainable improvement and investment.

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Evidence (Outputs)	Date Due
We will deliver the agreed financial recovery plan to achieve the organisation's annual financial control total and recovery trajectory.	Mar 2027
We will deliver the agreed recovery actions, with clear ownership and evidence of resulting operational, workforce and productivity improvement.	Mar 2027
We will deliver validated, recurrent financial benefits demonstrating a clear line of sight between operational improvement and financial impact.	Mar 2027
We will maintain strong financial grip and control through effective management of pay, non-pay, vacancies, temporary staffing and delegated expenditure.	Mar 2027
We will deliver affordable and sustainable workforce, including reduced reliance on temporary staffing and alignment of workforce, activity and finance.	Mar 2027
Success Measures (KPIs)	**Target**
Two consecutive quarters delivery of financial plan in 2026/27.	To achieve Q3 and Q4
Underlying recurrent deficit reduced in line with the agreed recovery trajectory in 2026/27.	To achieve by Q4
Cash performance maintained in line with the agreed plan in 2026/27.	To achieve by Q4

Regulatory alignment

Aligned Regulatory Action: N/A.

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7.3 Productivity & Cost Improvement

Programme roles

Executive Sponsor	**Suzanne Robinson**
Programme SRO	**Asif Umarji**
Clinical Lead	**Jay Naisbitt**
Operational Lead	**Steve Leech**

Current reality

NCA is not consistently translating cost improvement and productivity opportunities into delivered, recurrent financial benefit. Cost improvement activity can be overly focused on identifying savings rather than delivering sustainable changes to how services operate. Productivity improvement is variable, and there is not yet a consistent line of sight from operational change to realised financial benefit.

Programme aim – what we need to achieve

To deliver sustainable improvements in productivity and cost efficiency by changing the way services operate and making better use of workforce, capacity and resources. We will ensure that productivity improvements and cost reduction plans translate into demonstrable, recurrent financial benefits, reducing the underlying deficit while protecting quality, safety and patient outcomes.

Assurance criteria, evidence and success measures

Assurance Criteria (Outcomes)

- Productivity improves across priority clinical and operational services, with better utilisation of workforce, estate and clinical capacity while maintaining quality and safety.
- Cost improvement is delivered through sustainable changes to how services operate, rather than reliance on non-recurrent measures.
- Productivity and efficiency improvements translate into demonstrable and recurrent financial benefit, with a clear line of sight between operational change and financial impact.
- The recurrent CIP is delivered, supported by robust benefits realisation and clear accountability for delivery.
- Productivity improvement contributes to a sustained reduction in the underlying financial deficit.

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Evidence (Outputs)	Date Due
We will achieve demonstrable improvement in productivity and utilisation across priority services.	Mar 2027
We will increase proportion of CIP delivered recurrently.	Mar 2027
We will achieve sustained improvement in CIP delivery against the agreed recovery trajectory.	Mar 2027
Success Measures (KPIs)	**Target**
Two consecutive quarters of improved CIP delivery against trajectory in 2026/27.	To achieve by Q4
Improvement in agreed productivity measures across priority services for two consecutive quarters in 2026/27.	To achieve by Q4
Increase in recurrent CIP delivery in 2026/27 compared with the current baseline.	To achieve by Q4

Regulatory alignment

Aligned Regulatory Action: N/A.

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8.
Appendices



8. Appendices

8.1 Delivery Team Roles

As a minimum the core delivery team with responsibility with overseeing delivery of the IIP will include the following roles.

Role	Description
Senior Responsible Owner (SRO)	Accountable for overall success of the IIP and reports progress to the Board and regulators.
Programme Director: Delivery Oversight, Mobilisation and Leadership	Leads day-to-day delivery of the IIP. Supports the SRO with delivery, planning and stakeholder management. Manages regulatory relationship and submissions.
Delivery Team / Programme Management Office (PMO) Lead	Oversees reporting, planning, actions, risks and dependencies. Coordinates programmes, assurance submissions and governance papers.
Delivery / PMO Support	Coordinates programme governance and reporting, maintain programme controls and provides assurance and administrative support.
Strategy Lead	Aligns IIP with Trust strategy and organisational priorities. Provides strategic insight and challenge to support decision-making, prioritisation, planning and involvement across localities and partners.
Assurance and Governance Lead	Maintains programme risk framework. Ensures alignment with Trust risk management processes. Oversees assurance.
Communications and Engagement Lead	Develops engagement strategy. Manages staff, stakeholder and partner communications. Supports culture and behavioural change.
OD Lead	Leads change management and adoption activities. Supports leadership and cultural improvement programmes.
BI Lead	Provides expertise on data, success measures as part of assurance framework and connections into the IPR to ensure consistent and accurate reporting.

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8.2 IIP Theme Roles

Theme Role	Description
Theme Executive Lead	Responsible for ensuring that the portfolio of programmes with the IIP Theme are aligned with the organisational and strategic objectives, championing implementation and supporting the team responsible for delivery. This person is responsible for providing updates into the Integrated Improvement Board (IIB).
Theme Improvement Team Senior Lead	Responsible for engaging with the Executive Lead to establish the theme portfolio, supporting programme scoping, development and delivery with Executive Sponsors and SROs. The Senior Lead will oversee the theme governance, documentation including risks and will support identification of current and future resource requirements to deliver sustainable improvement.
Assurance Lead	Responsible for providing independent assurance including monthly assurance reviews. A source of advice and guidance to support successful delivery (based on MSP principles); and promotion of best practice and a standardised approach e.g. sharing of templates.

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8.3 IIP Programme Roles

Programme Role	Description
Executive Sponsor	Responsible for ensuring that the programme is aligned with the organisational and strategic objectives, championing implementation and supporting the team responsible for delivery.
Senior Responsible Owner (SRO)	The single individual with overall responsibility for ensuring that the programme meets its objectives and delivers the projected benefits. This person is responsible for providing updates into the relevant management group and supporting the Executive to provide updates into the Integrated Improvement Board.
Clinical / Quality Lead:	• Advising the Programme team of any potential impact on quality arising from the project. • Assuring the accuracy and validity of the Quality Impact Assessment and Equality Impact Assessment. • Presenting the completed impact assessments to the appropriate person / forum for consideration. • Monitors progress of the programme for any quality issues.
Operational Lead	• Advising the Programme team of any potential operational impact aspects of operational consideration from the project. • Supporting completion of the Quality and Equality Impact Assessments to assure the accuracy and validity of the assessments. • Supports presentation of completed impact assessments to the appropriate person / forum for consideration. • Monitors delivery progress for any operational issues.
Assurance Lead	• Independent programme assurance to the Exec Sponsor, SRO and Programme Board including monthly assurance reviews and periodic Gateway reviews. • Programme advice and guidance to support successful delivery (based on MSP principles); *and* • Promotion of best practice and a standardised approach e.g. sharing of templates.

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8.3 IIP Programme Roles *continued*

Programme Role	Description
Improvement Lead	• Advice to the programme from an improvement perspective (inc. quality and service improvement); • Support to identify, test and assess the impact of interventions / improvements through best practice quality improvement principles and approaches; *and* • Assists in the development of packages of interventions and improvements that are then implemented across the programme.
Project Manager	• Responsible for day-to-day management and delivery of the project(s). • Focuses on the project's deliverables, making sure the project delivers on time and within the budget. • Creates a detailed project plan for the resources, cost, timeliness and delivery. • Monitors and controls project tasks, reporting into appropriate governance.
Subject Matter Expert (SME) leads for Strategy, Procurement, Contracting, HR / OD, Estates, Finance, Digital and Business Intelligence (BI)	• Nominated to bring subject matter expertise to the programmes and to take and deliver such work / actions are required to support delivery, reporting progress into appropriate governance.
Benefits / Business Change Manager	• Drafts benefits map and circulate for stakeholder agreement. • Facilitate agreement of benefits management strategy, realisation plan and profiles. • Consolidates reports on the realisation of benefits. • Works with programme team and other stakeholders to identify, report and monitor emergent benefits.

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8.4 Assurance Framework Definitions

Programme Aim *Why we're doing it*	Programme Outcomes (Assurance Criteria) *What will change*	Programme Outputs (Evidence) *What we'll deliver*	Success Measures *How we'll know we've succeeded*
• The overall strategic purpose or ambition. • High-level statement describing what the programme is trying to accomplish overall.	• The changes, benefits or improvements that result from the programme. • Describes the future state that will exist because the programme has been delivered.	• The products, services, capabilities or deliverables produced by the programme. • Tangible things the programme creates.	• The metrics, indicators and targets used to assess achievement of outcomes and benefits. • Defined as SMART KPIs.

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Northern Care Alliance
NHS Foundation Trust

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27 October 2026

Telephone: 0161 206 5186
Email : kevin.mcgee@nca.nhs.uk

Will Blandamer
Executive Director, Health and Adult Care
Bury Council

Sent via email to : w.blandamer@bury.gov.uk

Dear Will

Re : Northern Care Alliance (NCA) Integrated Improvement Board

I would like to invite you to attend the Northern Care Alliance (NCA) Integrated Improvement Board as a representative of your place, bringing your local perspective to discussions about the delivery of our Integrated Improvement Plan.

The newly formed Board is executive led, including those who are members of place partnership meetings and attend local scrutiny forums. It will therefore also provide an opportunity to connect the updates and discussions taking place through the Board with those happening locally and build a shared understanding across our improvement work and local discussions. We will also invite colleagues leading specific workstreams to provide feedback and assurance on progress.

Your involvement would provide an opportunity to hear first-hand about the work we will undertake, how we are progressing and where further action is needed. We would very much welcome your input into discussions about our priorities, what is required to deliver improvement and how this connects with the needs of your place.

I want this to be a two-way conversation, with space for you to ask questions, offer constructive challenge and share the perspectives of local partners and communities. Your contribution would help us keep our improvement work connected to the places we serve.

I also hope that hearing these discussions directly will help you support informed communications within your place, sharing a clear picture of our plans, progress and the challenges we still need to address, while bringing local questions and feedback back to the Board.

I would very much welcome your involvement. Please let me know whether you would be able to take up this invitation so that we can share the meeting arrangements with you and provide the Terms of Reference.

Thank you for your continued support and partnership.

Yours sincerely



Kevin McGee OBE
Interim Chief Executive Officer

Northern Care Alliance
NHS Foundation Trust

Edition two (monthly) 20th October 2026

A briefing for NCA stakeholders following System Improvement Board 05/10/26

Prepared by NHSE, GM Integrated Care Board and Northen Care Alliance

Please send queries to NCA.questions@nca.nhs.uk

Overview

The creation of the System Improvement Board demonstrates the seriousness with which the Northern Care Alliance NHS FT, NHS Greater Manchester ICB and NHS England North West are treating the challenges facing Northern Care Alliance NHS FT, and their shared commitment to coordinated, pace-driven improvement.

▪ NHS England North West has established a System Improvement Board, supported by NHS Greater Manchester ICB, to provide a formal, structured forum for driving improvement in patient outcomes, staff experience and organisational sustainability at Northern Care Alliance NHS FT.

▪ This is a partnership-based improvement aimed at supporting the Trust in its efforts to make focused, sustained progress.

▪ The Trust Board retains full statutory accountability and sovereignty over decision-making. The System Improvement Board's role is to test and challenge evidence of progress against the Trust's integrated improvement plan and regulatory actions.

▪ The additional layer of oversight provided by the System Improvement Board brings together national, regional, system and Trust leadership so that support is coordinated, avoids duplication, and is targeted where it will have the most impact.

Overall improvement context

The Northern Care Alliance NHS FT is open and transparent about the challenges it faces, and is taking clear, coordinated action to address those issues at pace.

▪ The Trust has brought together a number of separate regulatory actions and improvement requirements into a single integrated improvement plan, built around the principles of listening, learning and partnerships.

▪ The plan spans six strategic themes and 17 programmes of work. Further work is progressing to strengthen alignment between the plan, the assurance framework, evidence requirements and co-produced exit criteria, including measures of sustainability.

▪ The Trust and its regional partners are clear that success will be measured by demonstrable and sustained improvements in patient and staff outcomes.

▪ This work is being carried out against the backdrop of a significant organisational change, with the Trust having introduced a new clinically led operating model on 1 April 2026 following 18 months of preparation, moving from a hospital-group structure to one organised across six clinical domains.

CQC findings and regulatory concerns

The Trust has responded constructively to regulatory feedback and is taking clear, evidenced steps to address the concerns raised.

▪ Following a CQC well-led assessment in July, the Trust received a Section 29A warning notice covering issues related to learning from incidents and complaints, staff listening and speaking up, patient safety, staff wellbeing, and equality, diversity and inclusion.

▪ The Trust is continuing to progress its improvement plan while the CQC Well-Led findings are finalised. The findings will be incorporated into the existing improvement and assurance framework.

▪ Regulatory actions are being explicitly linked to measurable outcomes for patients and staff, creating a clear ‘golden thread’ from action taken to demonstrable impact.

Specific clinical service concerns (spinal, gynaecology, incident learning, contracted services)

Where specific clinical concerns have been identified, the Trust is taking targeted, evidence-based action and ongoing assurance will focus on risks being fully understood and that controls are effective and improvements are sustained.

▪ Regulatory concerns regarding spinal services relate to specific surgical services and not the spinal service as a whole. A new approach to delivering the service is being established.

▪ The gynaecology service, which operates across Bury and Salford Royal, has a developing improvement plan that combines targeted improvements to internal processes with other direct measures, including translating patient complaints directly into service changes.

▪ The Trust has seen improvement in several areas related to learning from incidents and has commissioned specific work to ensure those improvements are embedded, sustained and demonstrably improving outcomes for patients.

▪ Following an incident involving a subcontracted renal dialysis service (where the patient came to no harm) the Trust identified the need to strengthen escalation and quality-assurance arrangements for contracted-out services. The integrated improvement plan will apply the same assurance standards to commissioned services as it does to services provided directly by the Trust.

Industrial action and elective recovery

The Trust is working with system partners to maintain resilience during industrial action and recover elective performance as quickly as possible while prioritising patient safety. The elective recovery plan has been scrutinised through Trust governance, with further work under way with the ICB on additional capacity and system support,

▪ Industrial action affecting theatres has created additional pressure on elective services, with the Trust prioritising trauma and time-critical patients throughout.

▪ The Trust is modelling a range of recovery scenarios, including additional mutual aid from across Greater Manchester, to address the backlog as quickly as possible.

▪ While an accelerated recovery by January remains possible, a return to expected performance levels by March is considered a more realistic timeframe, reflecting a responsible and evidence-based approach to planning rather than over-promising.

▪ Work to distinguish the direct impact of industrial action from overall operational performance will provide a clearer assessment of recovery progress, as well as additional work to address variations in waiting-list management and patients lost to follow up through strengthened data and governance.

Workforce culture and staff wellbeing

The Trust is taking a proactive, evidence-led approach to culture, speaking up and workforce health, recognising that a supported workforce is central to safe, high-quality patient care. Increased executive visibility and engagement with clinical leaders and system partners are now in place. Sickness absence and Freedom to Speak Up remain immediate priorities and the sickness absence management plan is being strengthened.

▪ Monthly, line-by-line reviews are now in place across nursing, allied health professional and wider healthcare teams, with a move towards shared ownership of staff wellbeing across the organisation from this month.

▪ Independent freedom-to-speak-up and safeguarding support is in place to ensure staff have a clear, trusted route to raise concerns.

▪ The Trust is increasing visibility of its senior leaders with staff and supporting clinical leaders to speak openly about both problems and progress, reflecting a genuine culture of listening and learning.

Financial sustainability

The immediate financial priority is to accelerate the development of a single, credible recovery plan, which aligns to operational, workforce, productivity improvements whilst protecting quality.

▪ At month four, the Trust remains broadly in line with its financial plan, supported by non-recurrent measures, though it continues to face pressures from industrial action, inflation and rising demand.

▪ Significant financial governance improvements have been introduced for 2026 to 2027, including revised delegation arrangements, additional training for leaders and strengthened governance meetings that link financial oversight directly to operational recovery planning.

Stakeholder and partner communications

The Trust and its system partners are committed to open, coordinated communication with local representatives, communities and stakeholders throughout the improvement process, including on issues likely to generate significant stakeholder or media interest.

▪ The Trust is committed to communicating openly with local political leaders, MPs and stakeholders about the challenges it faces and the actions being taken to address them.

▪ A stakeholder engagement plan is being finalised covering staff, localities, primary care and clinical partners, ensuring consistent messaging that avoids duplication and reinforces a single, coordinated narrative.

▪ The Trust and its partners operate on a ‘no surprises’ basis, ensuring that emerging risks and incidents are shared transparently and proportionately through appropriate governance channels.

Ends

Meeting: Locality Board			
Meeting Date	02 November 2026	**Action**	Receive
Item No.	8	**Confidential**	No
Title	Chief Officer's Report		
Presented By	Kath Wynne-Jones		
Author	Kath Wynne-Jones		
Clinical Lead	Kiran Patel		

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

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

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

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

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

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

Bury Integrated Delivery Collaborative Update

1. Context

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

2. Programme Delivery

- We continue to define roles and responsibilities in the context of the totality of the resource we have in Place and responsibilities aligned to Place from GM. It should be recognised that the uncertainty for the ICB Teams has not disappeared given the direction of travel of hosting arrangements for Place Based Teams. In our Locality , we do already have a similar arrangement in place with the NCA for the former LCO team, and therefore have some learning to inform the changes.

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

- We have recently completed our self-assessment of the neighbourhood framework against the 100 national standards.. We are currently reviewing these against the existing delivery plans alongside the recently released GM commissioning intentions

- We are in the process of reviewing our delivery arrangements for our Integrated Neighbourhood Teams. Given the CLM changes at the NCA and statutory requirements of the council, we have needed to relook at the single line management arrangements that are in Place, and in the process of Consultation with teams. However the principle of neighbourhood approach will remain at the heart of everything we do. We held a workshop on the 19th October to reset the direction of travel for neighbourhood working for health and care.

- Through the national BCF support team, we have gained some support from PPL to assist with defining our vision for how the pillars of health and care INT's, children's neighbourhood teams , neighbourhood leadership teams and Live Well connect together to inform our governance and engagement of teams.

- An outline of the 4LP programme of work with the NCA has now been agreed. We are in the process of scoping the content of these programmes. The priorities will be the outpatients, community services and primary care / secondary care interface programmes of work.

- There still remain challenges resourcing the primary care / secondary care interface group with the NCA. Discussions are ongoing within the NCA to determine our collective resource to support this programme. We also considered in depth the issue regarding medication details being transferred back to Primary Care following admission to NCA sites due to electronic system changes. This issue is actively being addressed by GM ICB, the Locality and the NCA.

- We are progressing discussions with PCFT with regard to the role and funding of the neighbourhood mental health workers given recent decisions by some PCN'.s We have agreed a way forward regarding data capture and considering recommendations for the model post April 27.. We have also agreed a workshop with PCFT colleagues for neighbourhood teams across the locality to understand the current Mental Health community offer.

- Bury's early cancer diagnosis performance is continuing to improve, with the locality now jointly ranked first across Greater Manchester.

3. IDC Programme Highlights:

3.1 Frailty and Falls

Bury continues to gain national and regional recognition for its frailty programme, demonstrating the impact of strong partnership working and integrated neighbourhood delivery.

- **Recognition as a Greater Manchester exemplar:** At the Greater Manchester Frailty Leadership Event, Bury was repeatedly highlighted as an exemplar locality. Data presented by NHS England identified Bury as one of the strongest performers in Greater Manchester for frailty care, reflecting the collective efforts of partners across the borough.
- **Sharing best practice nationally:** Following Bury's presentation at the event, NHS England has invited local colleagues to deliver a Lunch & Learn session for the Urgent and Emergency Care Learning Improvement Network, providing an opportunity to showcase Bury's innovative approaches and learning on a wider stage.
- **Strengthening care closer to home:** New monthly **Care Home Virtual MDTs**, led by NCA Geriatricians alongside GPs and ACPs, launched in October. The pilot aims to improve clinical decision-making, support advance care planning and deprescribing, enhance connectivity between services, and help avoid unnecessary hospital admissions.
- **Developing proactive post-discharge support:** Work is underway with the Acute Visiting Service to explore community follow-up for people aged 65+ following hospital discharge, with the aim of reducing readmissions and supporting residents to remain well and independent at home.
- **External validation of local services:** The recent GIRFT Frailty and Geriatric Medicine Review recognised Fairfield Hospital's outstanding acute frailty performance, including strong early assessment processes and excellent discharge outcomes, while identifying opportunities to further strengthen the pathway in response to future demand.
- **Supporting winter resilience:** System-wide communications have promoted alternative community-based services to support residents when they become unwell, helping to reduce avoidable ambulance conveyance and hospital attendance while ensuring people receive care in the most appropriate setting.
- **Promoting healthy ageing and falls prevention:** During Falls Prevention Week, partners across Bury delivered a coordinated programme of activity to improve awareness, confidence and access to support for residents, carers and professionals, helping people maintain independence and reduce the risk of falls:



Overall, the programme continues to focus on preventing avoidable hospital admissions, improving outcomes for older people, and delivering person-centred care closer to home, while gaining increasing recognition for its impact across Greater Manchester and beyond.

3.2 Mental Health

Strategic / commissioning:

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

Coping & Thriving:

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

Suicide prevention:

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

Primary & Community:

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

Crisis & inpatient:

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

CYP:

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

Misc:

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

3.3 Neighbourhoods

Programme wide:

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

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

	engagement and completion of high need reviews.
Whitefield	CVD cohort (including hypertension, AF and diabetes). Includes engagement with *hard-to-reach* groups through the Whitefield Live Well Hub and neighbourhood events.
North	CVD Core, CVD Stretch and primary prevention cohorts. Focus on proactive identification and engagement of patients who have historically not attended reviews

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

North:
- East neighbourhood event – Hoyles park.

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

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

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

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

3.4 Cancer

- Bury's early cancer diagnosis performance is continuing to improve, with the locality now jointly ranked first across Greater Manchester.
- Engagement has taken place between NCA Pathway Navigators and Bury Care Coordinators/Cancer Care Coordinators, as part of ongoing work to enhance communication and support more joined-up patient care.

3.5 Neighbourhood Health and Care

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

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

- BeCCoR Scheme 26/27
  - Neighbourhood Plans shared with IDC in August and Locality Board in September
  - MOT met with West NHD, and information re Community Pharmacy NHD offer shared with all NH leads and support officers. Arranging for CPGM (CO rep) to attend NH meetings Sept/Oct
  - AMS & SPN QI plan submissions – all reviewed and feedback complete – three QI plans returned for improvements and 1 accepted with conditions. A/w 2wk review deadline and resubmission by practices. Uplands failed to submit plan due to extenuating circumstances (the team are supporting this appeal).
- Respiratory Diagnostic Hub 26/27 Scheme – Revised specification received and STAR form submitted to GM
- Paediatric Phlebotomy - 26/27 Scheme – agreed through STAR
- Quality Visits – Several visits now in the diary

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

- 90% of clinically urgent appointments to be delivered on the same day
  - Only 4 practices currently achieving requirement
  - NHS E seeking assurance for those under 60% achievement. For Bury this is Greyland, Monarch and Blackford House.
- PCN DES:
  - Q4 25/26 assurance returns outstanding for Bury PCN
  - Q1 26/27 assurance returns outstanding for Bury PCN
  - ARRS
    - 24/25 & 25/26 Bury PCN – Evidence outstanding, significant issue raised with GM Finance team (meeting requested)
    - 26/27 - forecast received for all PCNs outlining intended spend and WTE for each post
    - All PCNS asked for monthly updates re WTE and spend and asked to update NWRS:
      - Bury PCN advised spend and WTE as per submitted forecast for each month to date
      - Horizon - monthly update received for April however, May - August outstanding
      - Prestwich and Whitefield - April - June updates received. July and August outstanding
      - Issues with validating NWRS submissions as tableau is not updating correctly - GM aware and resolution sought
  - Enhanced Access 26/27
    - Utilisation remains a concern across all PCNs
      - July and August data received for Horizon – data shows over offer in hours and increased utilisation

  - July and August data received for Prestwich and Whitefield – data shows an under-offer in hours against contract which has been flagged with the provider for resolution
  - July and August data outstanding for Bury PCN
- Estates – Work continues to improve premises across the borough, both through new developments and reconfigurations
- Patient-led ordering and increase NHS App uptake – Knowsley & Rock meeting on 04/08/26 with Sharon. Monarch/ Radcliffe- agreed for Sept go live. Mile lane not responded. Whittaker Lane, Walmersley Road & Ramsbottom have not engaged – information shared with practice.

GOAL 3 IMPROVE EXPERIENCE OF PLANNED CARE

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

GOAL 4 IMPROVE URGENT AND EMERGENCY CARE PERFORMANCE

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

GOAL 5 IMPROVE PATIENT AND STAFF SATISFACTION

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

OTHER PROGRAMMES

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

3.6 Social Care

Older People and Aging Well & Dementia

Progress and Challenges

- Care at Home tender underway, significant time currently being spent on evaluation of bids.
- Reablement Transformation programme underway, delivery group established and Discovery Phase complete, QA Officer to undertake a 'deep dive' assessment.
- New Food Service for Killilea, good progress with internal Team, existing provider to be given notice.

LD and Autism

Progress & Challenges

- Papers for supported living tender – discussed at Commissioning SLT – positive feedback for specification. Dependency on Cabinet discussion in Oct on RLW.
- More Providers who support complex and challenging behaviour now working in Bury eg Amore. Dedicated Provider Forum/GM Framework/ relationships.
- Commissioning manager post advertised and needed to be readvertised (lack of applicants).

Carers, Prevention and Physical Disabilities

Progress and Challenges

- Co-production Framework approved and published. Team pack prepared.
- Prevention- Information and Advice- 12 weeks of engagement activities progressing through localities.

- Improvement and Adaptation Board established- work streams defined. Foundation commissioned approved for Housing Assistance Policy.

Mental Health
Progress and Challenges

- Tender for Advocacy service approved by July Cabinet- Soft market activity completed.
- Scoping ASC commissioning intentions- aligned with wider Mental Health Strategy

3.7 CVD/Diabetes

CVD/Diabetes

- Work is underway with Bury College to develop a Hybrid Closed Loop (HCL) awareness video, aimed at increasing understanding and uptake of the technology.
- Community Pharmacy have delivered presentations through neighbourhood meetings to increase awareness of hypertension case finding and promote opportunities for earlier identification and management of cardiovascular risk.

3.8 Community and elective

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

3.9 Palliative and End of life

- Roll out of GM Hospices Palliative Care Education Passport - further discussions have taken place but no progress.
- Implementation of the Rapid Discharge checklist for PEoLC patients – awaiting sign off from the Admissions, Discharge & Transfer group for approval. pilot wards continue using document.
- Nurse led DNAR – out standing training for individuals before implementation.
- The Co-location of community specialist team within Bury Hospice is going through a staff engagement and evaluating the financial cost.
- NCA has developed a draft Business Case for 7 day community palliative care service currently going through a NCA Governance process.
- Expanding EPaCCS across other services.

4. Recommendations

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

Kath Wynne-Jones
Chief Officer – Bury Integrated Delivery Collaborative
kath.wynnejones@nca.nhs.uk
October 2026

Meeting: Locality Board			
Meeting Date	02 November 2026	**Action**	Consider
Item No.	9	**Confidential**	No
Title	NHS GM 2027/2028 Commissioning Framework		
Presented By	Will Blandamer, Place Partnership Director - NHS GM (Bury)		
Author	Will Blandamer, Place Partnership Director - NHS GM (Bury)		
Clinical Lead	Dr Cathy Fines, Place Clinical Director - NHS GM (Bury)		

Executive Summary

The Commissioning Framework provides the delivery mechanism for NHS Greater Manchester's Five Year Strategic Commissioning Plan, supporting the implementation of strategic priorities and transformational change during 2026/27. It sets out a system-wide approach to achieving improved population health outcomes through collaborative working across commissioners, providers and the wider workforce, with clinical leadership at the heart of delivery.

Recommendations

The Locality Board are asked to discuss and note the contents of the paper.

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

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

Links to Locality Plan priorities	
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		

NHS Greater Manchester

NHS Greater Manchester's 2027/28 Commissioning Framework

September 2026

Part of Greater Manchester Integrated Care Partnership

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

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

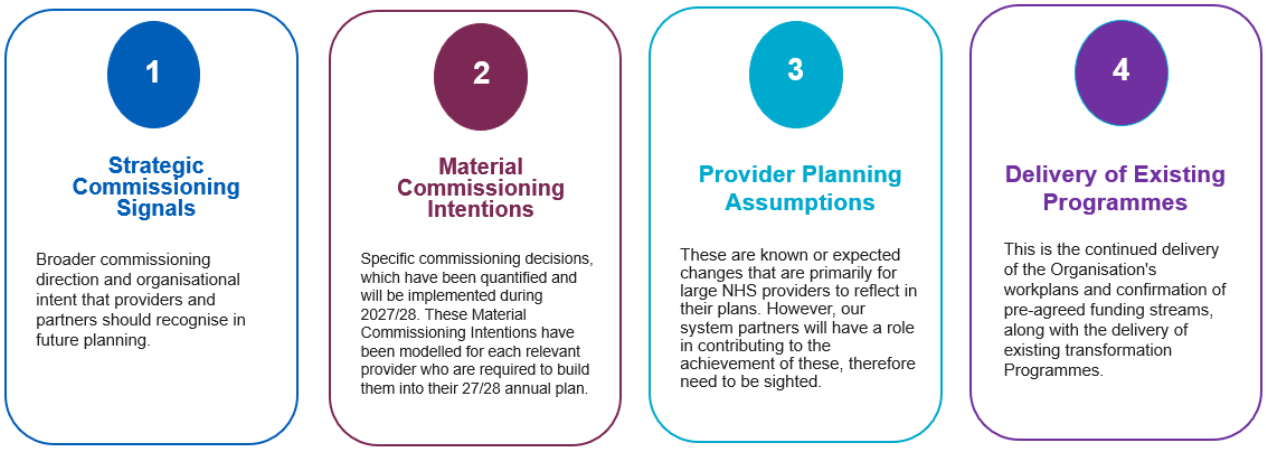
The framework will be our mechanism to embark on our major transformation plans, which are far reaching and require all our Providers and their workforce to be come together to achieve. Everyone has a role to play in the realisation of these ambitions, with clinical leadership at the heart of every part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

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

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

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

The Framework consists of the following 4 components: -



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

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

1 Strategic Commissioning Signals

Neighbourhood Health

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

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

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

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

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

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

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

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

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

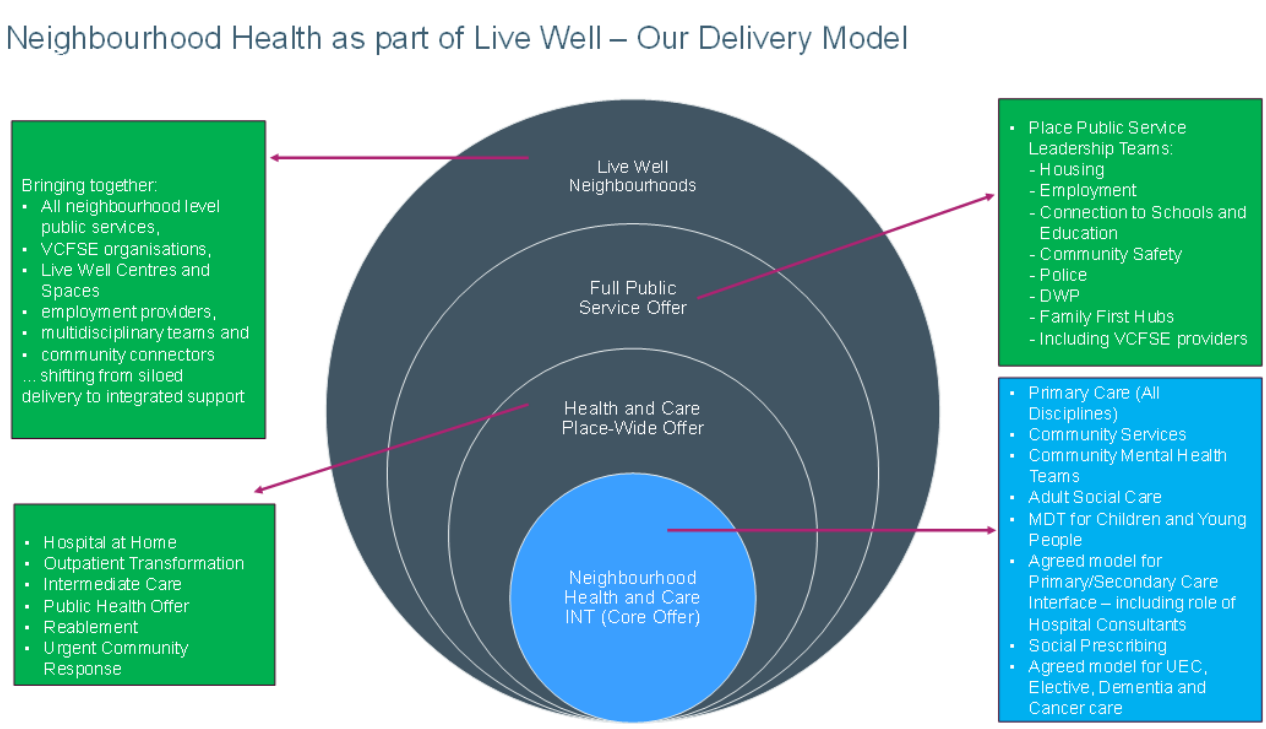
Core Requirements

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

Core Functions

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

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



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

Neighbourhood Profiles

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

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

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

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

Place Outcomes Framework

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

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

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

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

The roles of providers in delivering prosperous Neighbourhood Health.

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

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

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

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

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

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

Children's & Young People's Services

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

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

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

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

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

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

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

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

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

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

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

Elective Care

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

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

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

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

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

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

Urgent & Emergency Care

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

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

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

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

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

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

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

Mental Health Services

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

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

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

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

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

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

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

New Modern Service Frameworks

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

Strategic Commissioning of Medicines

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

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

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

2 NHS Greater Manchester's Material Commissioning Intentions

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

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

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

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

3 Provider Planning Assumptions

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

Urgent and Emergency Care

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

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

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

Elective Care

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

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

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

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

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

Cancer

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

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

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

Mental Health, Learning Disabilities and Autism

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

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

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

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

Long Term Conditions and Prevention

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

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

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

4

Delivery of our Existing Programmes & Strategic Finance

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

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

Closing the Gap

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

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

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

Finance and Contracting Arrangements

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

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

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

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

Deconstruction of the block contracts

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

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

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

As with acute services, we await national guidance on how this work will be used in 2027/28 operational planning.

Work is also in progress for specialised commissioning. This is taking longer than anticipated because of the scale of local tariffs/arrangements, in addition to the added complexity of disaggregating the data by commissioner. The expectation is that all specialised services are within scope (delegated, retained and secure mental health).

Local Financial Planning Assumptions

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

Meeting: Locality Board			
Meeting Date	02 November 2026	**Action**	Receive
Item No.	10	**Confidential**	No
Title	Bury VCSE/Public Sector MoU – one year on		
Presented By	Helen Tomlinson and Jordan Fahy		
Author	Helen Tomlinson		
Clinical Lead	N/A		

Executive Summary

In September 2025, Locality Board formally endorsed and signed the Bury VCSE/Public Sector Memorandum of Understanding (MoU), establishing a shared commitment between public sector partners and the Voluntary, Community and Social Enterprise (VCSE) sector to work differently together in pursuit of improved outcomes for residents.

One year on, partners have reflected on the progress made against the ambitions set out within the MoU and the extent to which its principles have begun to influence how partnership working takes place across Bury. This paper summarises the discussion undertaken by the VCSE Leadership Group regarding progress to date and future priorities.

Evidence suggests the MoU has helped strengthen relationships, increase VCSE influence within strategic decision-making, support greater co-design of programmes and services, and contribute to a more mature partnership culture across the locality.

Examples highlighted by partners include increased VCSE involvement across public sector boards and partnerships, collaborative development of the Bury Live Well Model and Live Well Spaces of Hope and Connection, support for the launch of the Bury Suppliers List, Bury Council commitment to the Bury Fund, volunteer strategy development, and greater engagement between public sector and VCSE leaders through roundtables, prevention conversations and co-design activity.

Whilst there is positive evidence of progress, partners acknowledge that further work is required to ensure that representation consistently translates into influence, that co-production becomes a routine rather than project-specific approach, and that tangible improvements in VCSE financial resilience continue to be developed. The VCSE Leadership Group has therefore identified a number of priorities to shape the next phase of delivery and support ongoing collective ownership of the MoU.

Recommendations

Locality Board members are asked to:

- Note the progress made during the first year following adoption of the Bury VCSE/Public Sector Memorandum of Understanding, acknowledging the contribution of both VCSE and public sector partners in embedding the principles of the MoU across strategic and operational partnerships.

- Reaffirm its collective commitment and joint ownership to the principles and ambitions of the Bury VCSE/Public Sector MoU.
- Identify specific actions that each partner organisation can take over the next 12 months to strengthen partnership working, co-production and VCSE influence within decision-making.
- Receive a further annual progress review in 12 months' time to assess collective progress against these commitments.

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	☒

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		

Bury VCSE/Public Sector Memorandum of Understanding: One Year On

1. Introduction:

The Bury VCSE/Public Sector MoU was developed through a twelve-month co-design process and subsequently endorsed by Locality Board in September 2025. The MoU established a shared commitment to partnership working based on mutual trust, shared responsibility and recognition of the VCSE sector as a strategic partner within the Bury system. The MoU aligns closely with the commitments set out in the GM Accord, providing a local framework for our model of collaborative working.

2. Background

This paper provides a one-year review of progress and outlines key areas where the MoU has contributed to changes in partnership working, alongside opportunities for further development. This annual review process provides an opportunity to continue strengthening the partnership and ensure that the ambitions contained within the MoU increasingly become embedded as part of **"how Bury works"** rather than being viewed as a stand-alone set of commitments.

3. Progress During Year One

Discussion with the VCSE Leadership Group identified several examples where the principles of the MoU appear to have influenced partnership working and decision-making across the locality.

3.1. Enablers and partnership working: Partners highlighted progress in strengthening relationships and creating opportunities for collaborative working including:

- Bury's contribution to the refresh of the Greater Manchester Accord.
- Tender and commissioning training delivered to VCSE organisations.
- Human Factor and prevention-focused conversations across the system.
- Increased dialogue between VCSE and public sector leaders through roundtables and other partnership forums.

3.2 Co-Design and co-production: The MoU has supported greater collaboration in service design and system development, including:

- IDC development session.
- Joint leadership and development of the Bury Live Well Model.
- Co-design of Live Well Spaces of Hope and Connection.

3.3. Voice and representation

- VCSE presence across most major public sector boards and partnerships (although this continues to be mainly led by Bury VCFA).
- Contribution to the refresh of Let's Do It.
- Development of the role of the VCSE Leadership Group as a strategic system partner.
- Relaunch of the VCSE Sector Children and Young People's Network.

3.4. Financial Resilience: Whilst recognising that financial pressures continue across all sectors, partners highlighted several positive developments:

- Ongoing Bury Council financial commitment to the Bury Fund.
- Increased use of grant funding approaches through the Bury Fund, including work linked to skills and MHCLG funding opportunities.

- Launch of the Bury Suppliers List and new Procurement Framework.
- Positive engagement around future SEND, family advocacy and HIU commissioning opportunities.

3.5. Our People: Activity has also focused on strengthening workforce and volunteering infrastructure through:

- Refresh of the Volunteer Strategy.
- Delivery of a trauma-informed training pilot and exploration of external supervision opportunities for practitioners (paid an unpaid) in the VCSE sector.
- Delivery of two rounds of the Let's Value Volunteers funding programme.

3.6. Embedding Social Value: Partners recognised Bury VCFA becoming a Real Living Wage Funder as an example of activity supporting wider social value ambitions.

3.7. Reflection and areas for further development: The VCSE Leadership Group reflected that the MoU has helped move partnership discussions beyond the development of an action plan towards a more mature relationship based on collaboration and shared ownership. However, partners also identified priorities where further progress is required:

- One of the key reflections from the first year is that many of the benefits of the MoU have been experienced at leadership and system-partnership level rather than by VCSE organisations more broadly. In particular, smaller VCSE groups may not yet recognise a direct impact on their ability to influence decisions, access resources or sustain their services. This raises an important question for partners about how the commitments within the MoU are translated into meaningful change across the wider VCSE ecosystem rather than primarily benefitting those organisations already engaged in strategic forums.

- Partners recognise that progress has been made during a period of considerable change within the GM health system. Whilst this has created understandable capacity challenges for health organisations, it also reinforces the importance of maintaining commitment to the principles of the MoU. As resources become more constrained, strong partnership working with communities and the VCSE sector becomes increasingly important.

- Findings from the State of the VCSE Sector 2026 Report (due for release on 02/11/26) highlight challenges around funding and sustainability. Findings point to an increasingly competitive funding landscape and, where funding is secured, it is often short-term, fails to cover the full cost of delivering services, and is rarely uplifted to cover rising costs. These findings reinforce the importance of the MoU commitments relating to financial resilience, fair funding and strengthening the VCSE sector as an equal strategic partner.

- There is a growing need to strengthen workforce support across the VCSE sector. Many staff and volunteers are increasingly supporting individuals and families with complex needs, often without access to the same wellbeing, clinical supervision or reflective practice arrangements available within statutory services. A system-wide approach to workforce support, including access to external supervision, trauma-informed support and wellbeing provision, could help strengthen resilience, retain skilled staff and volunteers, and ensure the VCSE sector remains able to play its vital role in prevention and community support.

4. Risks (if we don't maintain a collective commitment to the MoU)

- The MoU becomes perceived as a VCSE-led initiative rather than a shared partnership agreement, creating imbalance in ownership and accountability.

- Progress slows as a small number of organisations and individuals continue to drive activity without sufficient support from the wider system.

- Trust and confidence may be undermined if VCSE organisations feel that MoU commitments are not being matched by changes in behaviour, decision-making or investment from statutory partners.

- Smaller VCSE organisations may become disconnected, reinforcing concerns that the benefits of the MoU are being experienced primarily at strategic leadership level rather than across the wider sector.

- Financial pressures across public services and the VCSE sector may lead to more transactional relationships, rather than the trust-based partnership approach embedded through the MoU.

- System ambitions, including Live Well, prevention and neighbourhood working, may be harder to achieve if VCSE organisations are not consistently involved as equal partners in design and delivery.

5. Recommendations – in order to mitigate against these risks and maintain and build on the achievements seen in year one, Locality Board is asked to:

- Note the progress made during the first year following adoption of the Bury VCSE/Public Sector Memorandum of Understanding, acknowledging the contribution of both VCSE and public sector partners in embedding the principles of the MoU across strategic and operational partnerships.
- Reaffirm its collective commitment and joint ownership to the principles and ambitions of the Bury VCSE/Public Sector MoU.
- Identify specific actions that each partner organisation can take over the next 12 months to strengthen partnership working, co-production and VCSE influence within decision-making, actively considering VCSE sector involvement at the earliest stages of service design.
- Receive a further annual progress review in 12 months' time to assess collective progress against these commitments.

6. The Locality Board is required to receive and approve the recommendations set out in this report.

Helen Tomlinson, Chief Officer, Bury VCFA: helen.tomlinson@buryvcfa.org.uk

October 2026

BURY INTEGRATED CARE PARTNERSHIP

All things Whitefield…

Part of Greater Manchester Integrated Care Partnership





Whitefield Live Well

Update

October 2026

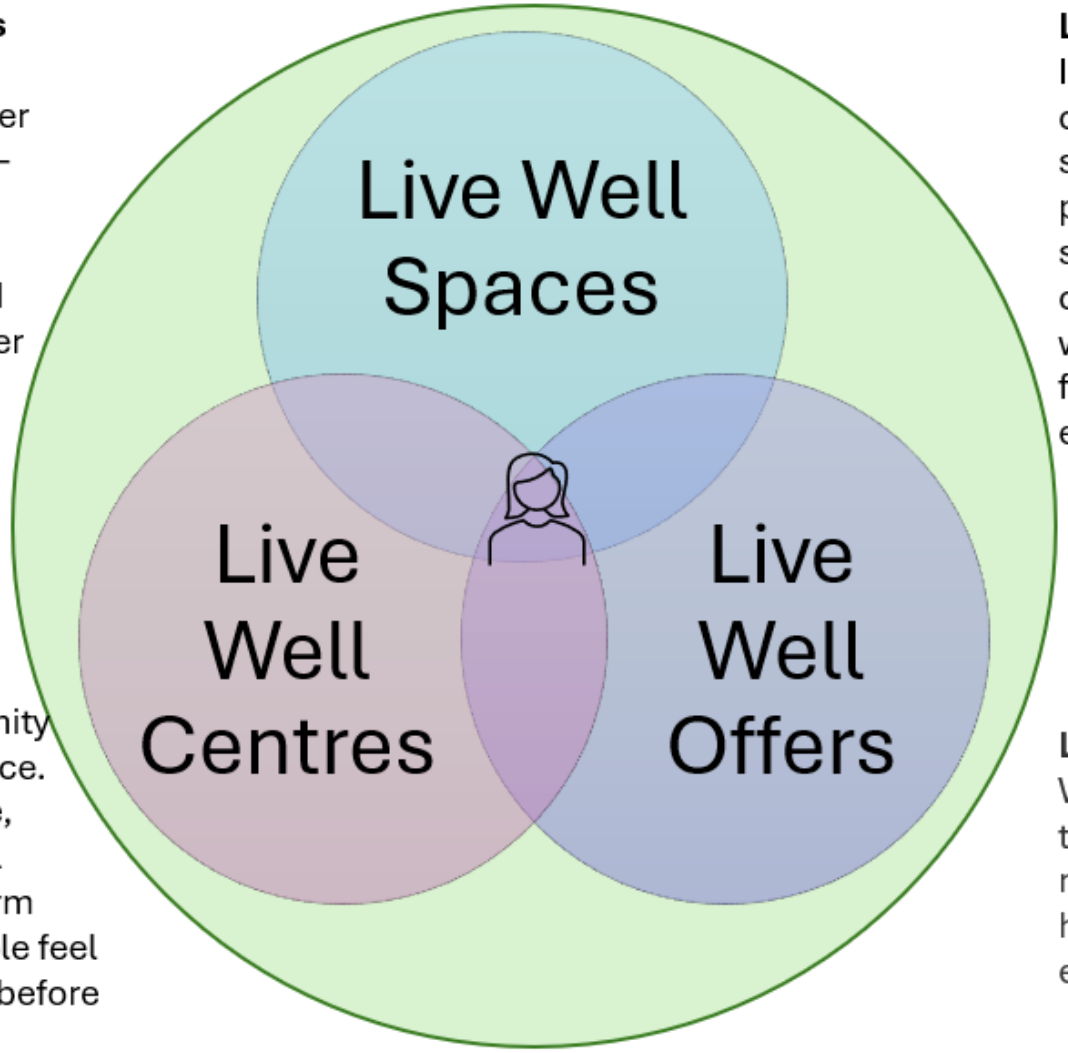
BURY VOLUNTARY, COMMUNITY & FAITH ALLIANCE

Whitefield Live Well
Everyday support for you

Whitefield Live Well

The Whitefield Live Well Centre is the first of its kind in Bury with the aim to have one in each neighbourhood by 2030. The Centres are an important part of Live Well but can only work as part of a larger model.

Live Well Neighbourhoods
Live Well Centres, Spaces and Offers are part of a wider Live Well Neighbourhood — a connected local network of people, communities, VCFSE, public services and businesses working together to improve wellbeing and reduce inequalities.



Live Well Spaces
Informal, welcoming spots where people can drop-in, connect with others and find support. Often run by voluntary groups, peer networks or local volunteers. These spaces could be cafés, libraries, community centres or pop-up areas within other venues. They're designed to feel familiar, accessible and part of everyday life

Live Well Centres
Bring services and community support together in one place. They offer a warm welcome, guidance, and links to local activities. Together, they form trusted spaces where people feel at home and get early help before problems grow.

Live Well Offers
Work together across sectors to ensure that the offers and services local people need are available, whether that's housing or benefits advice through to early years advice and support.

Whitefield Live Well Centre

Welcome area



Community Flexi Space



Hall



Café and Kitchen area







1:1 rooms







Whitefield Live Well Centre - Centre Launch 16th August 2026

Whitefield Live Well
Everyday support for you





Around 200 residents, community organisations and partners came together to celebrate the official opening of the Whitefield Live Well Centre, the first dedicated Live Well Centre in Bury.

Aiming to bring together community activity, advice, support and services under one roof, the launch hosted a programme of free family activities throughout the day, including face painting, balloon modelling, virtual reality experiences, green activities, arts and crafts, free bike repairs, balance bikes, the Museum of Curiosity and much more alongside information and advice from INT, Children's Family services, Live Well and others. The event provided an opportunity for residents to meet local organisations, learn about support available in their area and explore the new facilities.









Grants and Investments – since March 2026

Let's Make Whitefield Green

- Eden Gardens Allotment Association
- Whitefield Bowling Club
- Whitefield Horticultural Society
- Lancashire Wildlife Trust
- Besses Together
- Abington Close

Funding Total Awarded - £10,064

Let's Live Well & Cook Well

- Let Your Light Shine
- Growing Together Radcliffe
- Creative Living Centre
- Caritas red Door
- Flowhesion
- Incredible Edible
- RammyMen
- BAAS – Befriending & Adult Autism Support

Funding Total Awarded - £20,000

Whitefield Summer Club

- Pheonix Outreach CIC
- Unsworth Cricket Club
- Urban Cycle Centre
- Drum Happy
- League of Curiosity
- MaD Theatre
- Lancashire Wildlife Trust
- BeeSports Hub

Funding Total Awarded - £15,246.92

Targeted Grants & Awards – Whitefield

- Happy Me Community
- Whitefield Methodist & Oasis Centre
- St Andrews School Holiday Breakfast Club
- Art in Whitefield
- Inspired women's network – Leadership Programme
- GTR – Leadership Programme
- MaD Theatre – Youth Theatre Club

Funding Total Awarded - £28,100

Let's Live Well & Support Unpaid Carers

- Bury Speakeasy
- Growing Together Radcliffe
- N-Compass – Bury Carers Hub
- Bury2gether CIC
- Spectrum Gaming
- The Big Fandango
- Federation of Jewish Services
- Bury Society for the blind and partially sighted

Funding Total Awarded - £18,586

Pipeline Grants and Investments

Whitefield Capitals Grants – Large

5 grants available up to £20K per application. Closed September 2026 – Panel pending

Funding Total Available - £100,000

Whitefield Capitals Grants – Small

10 grants available up to £1K per application. Closed September 2026 – Panel pending

Funding Total Available - £10,000

Gambling Harms Reduction Initiative

Project in collaboration with Bury Public Health to tackle gambling harms through at least one of the following approaches

- Therapeutic and wellbeing support
- Positive alternatives to gambling through activity
- Information, Awareness Raising and Training

Project will also upskill VCSE partners in gambling harms reduction to provide

Funding Total Available - £15,000

Whitefield Live Well Centre - Health and Wellbeing

Whitefield Live Well
Everyday support for you







On the 29th October, Fare share delivered their Delicious Vegelicious cooking demonstration as part of the Let's Live Well and Cook Well initiative with Bury VCFA.

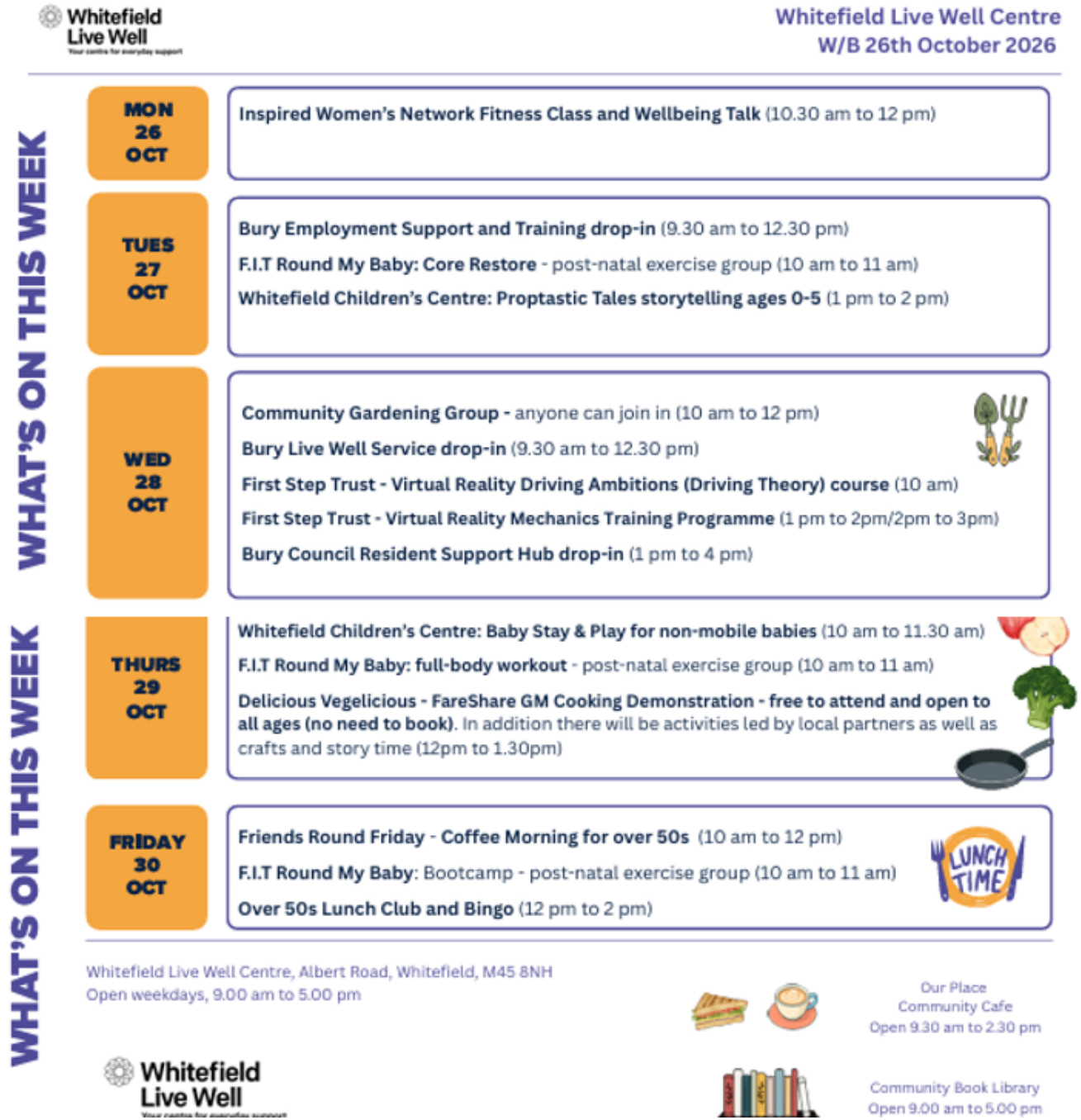
A theme of Live Well Centres is to provide spaces for collaborative offers to support people in the neighbourhood in which they live. Bringing together public and VCSE services, we were able to expand our offer to residents.
Over 100 people attended on the day to gain information and participated in a range of activities including:
Teeth brushing with Whitefield Children's Hub. Fruit kebabs with the Creative Living Centre, Seasonal Crafts with Besses Together, Whitefield Health Visitors, Integrated Neighbourhood Team, School Nurses, Bury Live Well Service with information around sugar contents and free blood pressure checks, Bury Adult Learning promoting training opportunities including cooking classes.

The cooking demonstrations focused on utilising fruits and vegetables in alterative ways, expanding how these can be incorporated into a balanced diet. In addition to the cooking demonstrations, Residents were then able to take away a variety of fruit and vegetables as part of the event for use at home.









What's On!

The timetable for Whitefield Live Well Centre is updated weekly.

- Some provisions are weekly
- Others fortnightly
- Some are special events.

The Whitefield Live Well Centre is building its offer with a range of public services and VCSE provisions. Space is hireable and we currently have a self-employed local resident who hires space for a post natal fitness class.

As Live Well Centres aim to meet the needs of the local community, 2 initial themes were identified which have shaped the services that currently engage with the building:

- Supporting adults of working age in poverty – income, housing, employment, skills, food.
- Children & young people – family hub, engagement, flexible youth space, connections to place, building stronger communities.

Integrated Neighbourhood Team - Whitefield

Part of Greater Manchester Integrated Care Partnership

Jane Wilson –Whitefield Integrated Neighbourhood Lead
Jane.wilson3@nca.nhs.uk
Dr Alistair Webley - Whitefield Integrated Neighbourhood GP Lead
alistair.webley@nhs.net

INT Whitefield Update

- Move in progress

District Nursing and Adult Social Work Team – move to Whitefield Live Well Centre



Revisiting integration and getting to know our Early help, family hub colleagues too..

- December Neighbourhood meeting

Working with PCN assistant manager, District nurse team lead and Specialist palliative care educator in developing a learning session on End of Life and anticipatory medication prescribing for the Whitefield practices. Together with review of GSF meetings. In discussions for a trial of a weekly palliative care huddle.

Improving communication between GPs and DN service.

- Pillar 3 Prevention Population Health and Neighbourhoods – BeCCoR

Target cohort is cardiovascular disease, approx. 1000 high risk patients, with 15-20% considered hard to reach and not had full CVD health checks (2023-2026).

The Neighbourhood plan for Whitefield focuses on alternative ways to reach these patients using the Whitefield Live Well Centre and the extended neighbourhood team to improve awareness of CVD and the importance of the health checks.

This will be achieved by 2 bespoke events at the Live Well Centre inviting patients to attend from the GP practices and opportunity for health checks on the day.

First one is Friday 27th November 2026 and will be a joint event with the ageing in place project.

Targeted CVD health check invites. (160)

Opportunistic over 40s health check, health and well-being promotion.

Hoping for the flu vaccination bus!



- The CVD initiative will also look at appropriate use of Extended access service or extended appointments to support the cohorts identified. (working age, housebound, mental health and LD registers)

- Raising awareness of CVD and importance of health checks

Launch event August 2026 and Family Wellbeing event October 2026.





Whitefield Neighbourhood Leadership Team

Locality Board: 02.11.2026

Background & Context

Joined up services across 5 identified neighbourhoods; working with communities to relentlessly focus on prevention and earlier early intervention; maximising local assets and spaces in each neighbourhood to enable people to thrive.

Bury's model of 'integrated support' with a neighbourhood focus by default:

North	East	West	Whitefield	Prestwich
Each neighbourhood has a Neighbourhood profile and analysis of need, identification of cohorts of risk to tailor and target integrated person-centred activity				
Co-located multidisciplinary teams in each neighbourhood, led by a Public Service Leadership Team, integrating 'integrated support' through a 'Team Around' approach. Includes housing engagement; health and care integrated leads; social prescribers; employment support; Live and Stay Well; police and fire neighbourhood leads; Family Help leads; public health; voluntary sector infrastructure representatives				
Joint delivery of strengthened Integrated Neighbourhood Team (INTs) (Adult Care and Health) model including social prescribing and increasing alignment of mental health early intervention and prevention.				
Rapidly developing model of family hubs described by neighbourhood and delivering the prevention and early intervention strategy for children and increasingly connected to schools				
Finalising the Live Well model and specifically within this the neighbourhood-based employment support model.				
Strengths based approach built on LETS Behaviours to further engagement, participation and reduce inequalities, eg co-designing interventions with lived experience groups.				
Collective insight of community assets and networks, with which to work with communities and connect people at place as examples of Live Well spaces, coordinated by Bury Voluntary, Community and Faith Alliance				

Whitefield Neighbourhood Leadership Team - Membership:

Adult Health and Care Services	Children & Families	Voluntary and Communities	Housing	Blue Light Services
Public Health	Early Years	Bury VCFA	Bury Council Housing	Police
INTs	Early Help	Strategic Partnerships	Homeless Prevention	Fire Service
Social Prescribing	Youth Services	Citizens' Advice		
Bury Live Well		Ageing in Place		

Whitefield Neighbourhood Leadership Team – Cohorts of Risk:

- Cohorts of risk are built on neighbourhood-specific areas of identified joint demand across public services.
- They are geographically and demographically granular.
- Whitefield Neighbourhood Leadership Team has recently undertaken a review of its cohorts, recognising that changes in neighbourhood mean that cohorts remain dynamic.
- The latest cohorts – (subject to final signoff) are the following:
  - Young people aged 10-16 living in the Besses ward who are on the verge of criminality - e.g. not engaging with school, youth provision or community activities, and who are known or assessed to be at risk of involvement in e-bike enabled offending, robbery, burglary or antisocial behaviour.
  - Families with dependent school-age children living in Besses and Unsworth where a parent or primary carer is economically inactive with a long-term health condition or disability, is claiming disability-related benefits (PIP/DLA), and is experiencing financial vulnerability through debt, low income or benefit-related challenges.
  - Children aged 9-11 (Years 5 and 6) living in Besses who are overweight or obese and whose families are experiencing barriers to accessing affordable healthy food.

Success Story – Young People, ASB, and Community Offer

The problem:

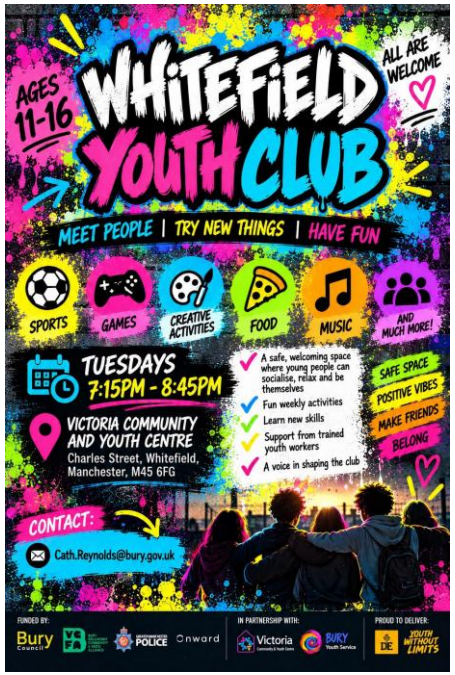
- Sparse low-cost youth offers in Whitefield; most travelling outside of the neighbourhood to access these.
- High numbers of youth ASB.

The process:

- PSLT jointly identified hotspot areas and local need, identifying opportunities to signpost to existing provision or to begin something new.

The outcome:

- Onward Homes, GMP, and Bury VCFA jointly funded a new youth provision pilot in Whitefield, delivered by Youth Services and the third sector.
- The youth service have started a new provision in the Live Well Centre, promoted by GMP.
- VCFA have run targeted funding schemes to enable free holiday activity across Whitefield, open to all.





Success Story – Operation VARDAR

The problem:

- Spate of crime around a geographically focused area- cuckooing, knife crime and drug-related crime. 67 crimes reported within a 100-metre radius of a particular street.

The process:

- GMP worked closely with PSLT members, including Housing and INT, to identify individuals involved, those at risk, and geographic risk.

The outcome:

- GMP and housing worked together to support 2 x closure order warnings, over 60 home visits, 10 breach of tenancy warnings, and an injunction. 7 x new safeguarding referrals opened. Partners worked together to support the closure of a ginnel.
- Wider PSLT were supported with training and information-sharing around spotting the signs of cuckooing.



BURY
INTEGRATED CARE
PARTNERSHIP

Thank you, any questions

Part of Greater Manchester
Integrated Care Partnership

Bury System Winter Planning 2026-27

Part of Greater Manchester Integrated Care Partnership

Presentation by:

David Latham, Transformation and Improvement
Senior Programme Manager (Bury)

Bury System Winter Planning 2026-27

BURY INTEGRATED CARE PARTNERSHIP

Core Principles

In Bury the same approach to winter planning has operated for the past few years, the core principles are:

1) As a Bury system we work together on a wider system plan.
2) The work is driven the Bury Winter Planning Sub-Group which is a sub-group of the Bury UEC Board
3) Bury System Partners are responsible for the development of their own operational winter plans.
4) The system maintains an overview on system pressures throughout the year via a weekly Bronze meeting

Winter Planning Sub-Group

- The Winter Planning Sub-Group commenced meeting in August 2026 and will continue to meeting until no longer required, this is usually late November to early December.
- Once stood down the group can be reconvened at any time should circumstances require.
- The core functions of the group are as follows:
  - Production of Bury System Wide Winter Plan
  - Oversight for the implementation of any new National or GM requirements
  - Co-ordination, as required, of winter related National and GM returns (where a co-ordinated system response is required)

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Bury System Winter Planning 2026-27

BURY INTEGRATED CARE PARTNERSHIP

Winter Planning Sub-Group (cont…)

- Cascading of national and GM guidance as received
- Refresh for Bury system parts contact details
  - Co-ordinating the review and refresh Bury system partners, NHS111, Directory of Service
  - Review and refresh Bury system partners OPEL cards
  - Review and refresh Burys list of Alternative to Admissions Schemes
  - Agree OPEL escalation triggers
  - Mapping Bury system partners, On Call Manager rotas over the Christmas period
  - System planning for Christmas period pressure point days
  - Arranging pre-planned conference calls if required
  - Links to NCA Winter Planning meetings
  - Links to GM locality on call arrangements
  - Ensure Bury attendance and feedback from GM and Regional Winter Events
    - NW Exercise Aegis (18.9.25)
    - NW Winter Event (5.11.26)

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Bury System Winter Planning 2026-27

BURY INTEGRATED CARE PARTNERSHIP

What's In the Bury System Partners Winter Plan?

The Bury System Partners Winter Plan includes the following details:

- Useful Contacts
- GM and Bury UEC System On -Call Arrangements
- Local Authority Civil Contingencies Response
- Admission Avoidance Alternatives
- NHS 111 DOS (refresh and how to amend out of hours)
- Local System Conference Call Arrangements
- Infection Prevention and Control Advise
- Christmas to New Year - Pharmacy Bank Holiday Opening Hours
- System Partner Operational Pressures Escalation Levels (OPEL) Framework and Cards
- System Partners Winter lans
- Bury and GM Escalation Process
- Bury Escalation Process
- OPEL 4 Protocol
- NHS GM Escalation Framework 25/26
- NHS GM System Co-Ordination Centre (GM SCC)- Out of Area Discharge
- NHS GM System Co-Ordination Centre (GM SCC)-Long Waits in Emergency
- GP Urgent Care Directory of Service
- GM Winter Communication Plan
- GM CAS Flyer
- NHS England – NW Communications toolkit: Winter resource pack

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Bury System Winter Planning 2026-27

BURY INTEGRATED CARE PARTNERSHIP

The Robustness of Planning Arrangements in 2025-26

- The Bury UEC System, continues, to performed very well, winter planning arrangements were effective.
- The main goal of winter planning is to try and assure that the local hospital and other services across the UEC partnership do not hit OPEL 4. This was achieved.
- Over the holiday period system wide BH/Weekend conference calls worked well
- Primary Care Surge and Respiratory Hubs worked well to reduce pressure on GP practices and potential A&E attendances
- Flu vaccination rates were very good and in some categories were the best report rates in GM.
- Public Health Infection control and the BARDOC antiviral service worked well to support Care Home Outbreaks.
- Our pharmacy's continued to see patients under pharmacy first.
- The front door arrangements at FGH helped to support lots of people to avoid an A&E pathway.
- IMC services and daily contact across services help to maintain good flow through the hospital
- During occasional spikes in attendances, it was noted by the CQC specifically noted that corridor care was limited and delt with quickly each morning

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Bury System Winter Planning 2026-27

BURY INTEGRATED CARE PARTNERSHIP

System Readiness for Winter

- No part of the Bury (specific) has declared OPEL 4
- DKAFH at the lowest rates for years on the FGH site
- A&E performance YTD at FGH is at 71.13%
- 12 hour waits in department remains below the national threshold of 10%
- Excellent flow from hospital into community services
- Excellent BCF performance on the reduction of NEL Admissions for over 65's
- Hospital At Home service regular preforming above target
- Improvements in the organisation of reablement services which not longer report OPEL 3 daily
- Improved communication, support and relationships for the discharge of Bury patients at NMGH
- Home from Hospital Scheme expanding
- FGH best NCA site for ambulance handover at 18.25 minutes for September.
- Primary Care winter surge hubs and respiratory hubs being set up
- Antiviral Care Home winter cover arrangement being stood up
- System partners all working their own winter plans and support the Bury System Wide Plan

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Locality Performance Report October 2026

Part of Greater Manchester Integrated Care Partnership

BURY 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	S030a	% of patients aged 14+ with a completed LD health check	Monthly	Aug 26	31.2%	23.90%	↗	75.%	373	1,195	Upper
	EH09	Access to Children and Young Peoples Mental Health Services	Monthly	Aug 26	3,505	3,625	↘	5,605	N/A	N/A	Lower
	EAS01	Dementia: Diagnosis Rate (Aged 65+)	Monthly	Jun 26	77.2%	76.30%	↗	66.7%	1,930	2,499	Upper
	S086a	Inappropriate adult acute mental health Out of Area Placement (OAP) bed days (rolling 3 month total)	Monthly	Aug 26	4,200	4,310	↘	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	Sep 26	11	17	↘	N/A	N/A	N/A	Inter
	N/A	Percentage of MH patients with no criteria to reside (NCTR)	Monthly	Sep 26	14.1%	21.25%	↘	N/A	11	78	Inter
	S110a	Overall Access to Community MH Services for Adults and Older Adults with Severe Mental Illnesses	Monthly	Aug 26	2,395	2,385	↗	4,005	N/A	N/A	Inter
	S081a	Talking Therapies: Access Rate	Monthly	Aug 26	245	345	↘	N/A	N/A	N/A	Lower
	S131a	Women Accessing Specialist Community Perinatal Mental Health Services	Quarterly	Aug 26	200	205	↘	N/A	N/A	N/A	Lower
	S125a	Long length of stay for adults (60+ days)	Monthly	Aug 26	30.8%	35.71%	↘	0.%	20	65	Lower
	N/A	Proportion of routine eating disorder referrals cases entering treatment within four weeks, aged 0-18	Monthly	May 26	67.0%	67.00%	→	N/A	67	N/A	Inter
Cancer	N/A	Cancers Diagnosed at an Early Stage (12-month rolling): All Tumours Staged within RCRD	Monthly	Jun 26	63.0%	62.92%	↗	N/A	521	827	Upper
Primary Care	S053b	% of hypertension patients who are treated to target as per NICE guidance	Annual	Mar 26	74.4%	70.60%	↗	77.%	24,658	33,135	Inter
	S053c	% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins	Quarterly	Mar 26	65.9%	64.98%	↗	64.85%	7,260	11,010	Inter
	S129a	GP appointments - percentage of regular appointments within 14 days	Monthly	Aug 26	80.0%	80.70%	↘	81.31%	59,396	74,206	Inter
Quality	S042a	E. coli blood stream infections	Monthly	Aug 26	126	125	↗	N/A	N/A	N/A	Upper
	S044a	Antimicrobial resistance: total prescribing of antibiotics in primary care	Monthly	Jun 25	68.9%	69.78%	↘	87.1%	N/A	N/A	Upper
	S044b	Antimicrobial resistance: proportion of broad-spectrum antibiotic prescribing in primary care	Monthly	Jun 25	5.6%	5.57%	↗	10.%	5,314	95,172	Upper
	S037A	% of patients describing the overall experience of their GP practice as good	Annual	Mar 23	71.4%		→	73.90%	N/A	N/A	N/A

Bury

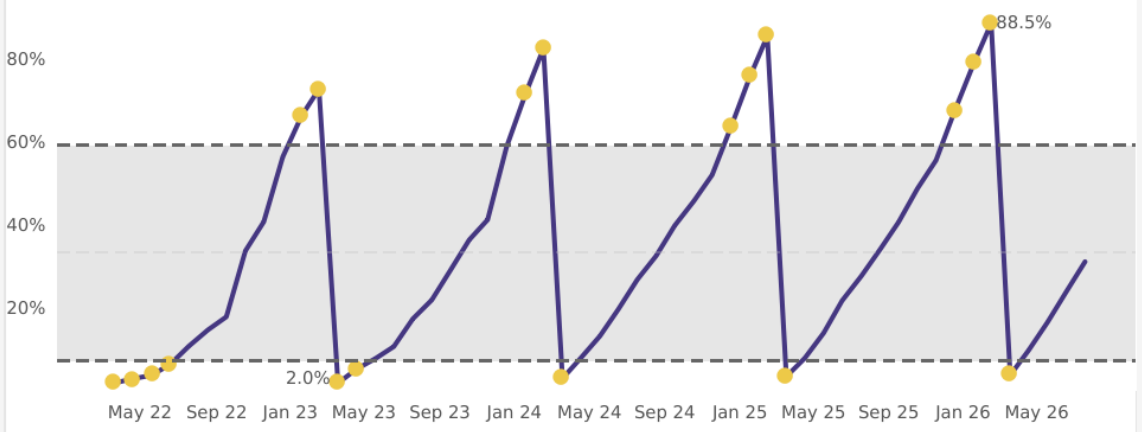
% of patients aged 14+ with a completed LD health check

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)

31.2%	23.9%	13/106	75.%
August 2026	July 2026	National Rank Upper Quartile	National Target

Outliers more than 1 standard deviation from the mean

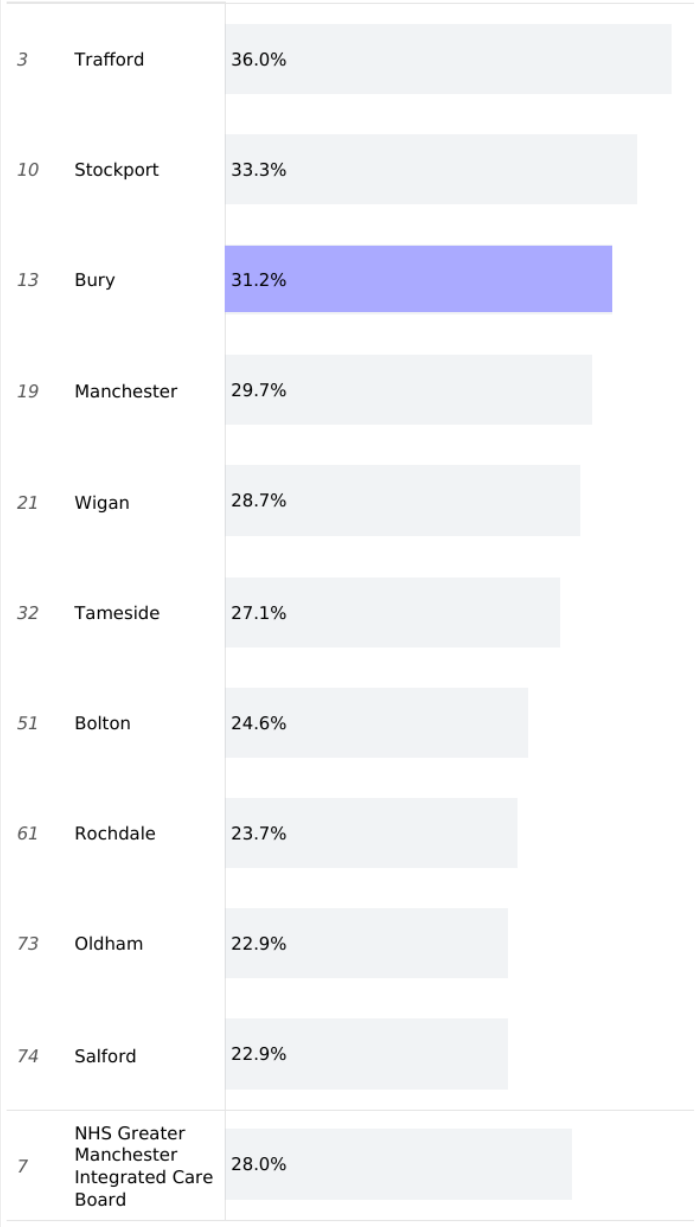


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	2.0%	3.1%	3.9%	6.5%	10.9%	14.8%	18.0%	33.8%	40.8%	56.4%	66.4%	72.7%
2023-24	2.0%	5.4%	7.9%	10.8%	17.5%	22.0%	29.1%	36.5%	41.3%	58.9%	71.7%	82.5%
2024-25	3.2%	8.1%	13.3%	19.8%	26.9%	32.7%	39.9%	45.8%	52.1%	63.7%	75.9%	85.5%
2025-26	3.6%	8.0%	14.1%	21.9%	27.7%	34.2%	40.7%	48.9%	55.6%	67.7%	79.1%	88.5%
2026-27	3.9%	9.9%	16.7%	23.9%	31.2%							

Selected measure at August 2026 has continuously increased for 4 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities



Narrative

- Bury's performance has increased and is above the GM average (28.0), ranking 3rd across localities.

Bury

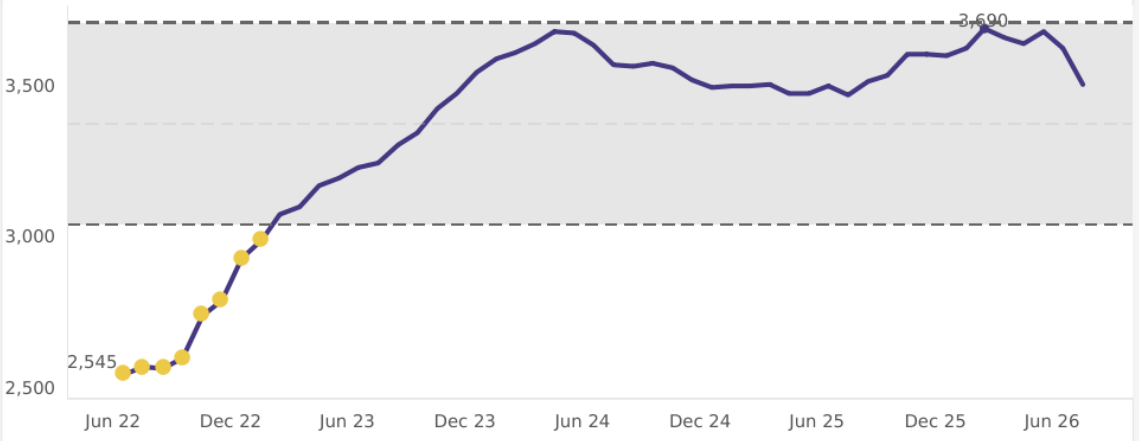
Access to Children and Young Peoples Mental Health Services

Access to Children and Young Peoples Mental Health Services

Source: Published MHSDS (Monthly)

3,505	3,625	88/107	5,605
August 2026	July 2026	National Rank Lower Quartile	National Median

Outliers more than 1 standard deviation from the mean

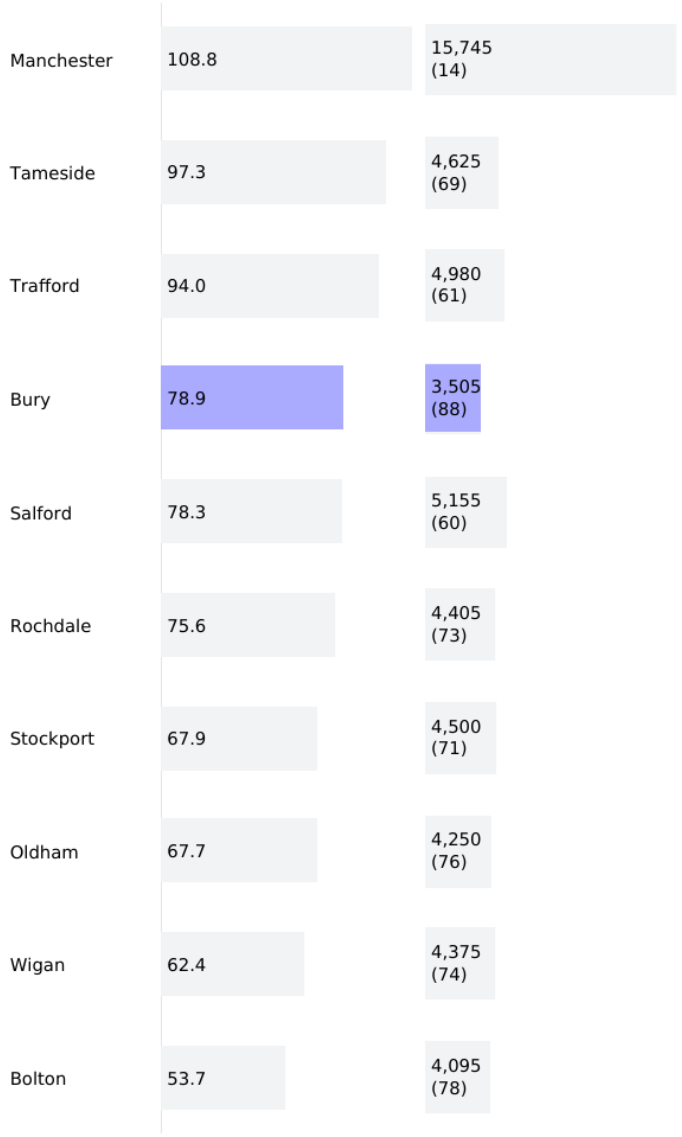


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23				2,545	2,570	2,565	2,600	2,740	2,790	2,930	2,990	3,075
2023-24	3,100	3,170	3,195	3,230	3,245	3,305	3,345	3,425	3,475	3,545	3,590	3,610
2024-25	3,640	3,680	3,675	3,635	3,570	3,565	3,575	3,560	3,520	3,495	3,500	3,500
2025-26	3,505	3,475	3,475	3,500	3,470	3,515	3,535	3,605	3,605	3,600	3,625	3,690
2026-27	3,660	3,640	3,680	3,625	3,505							

Selected measure at August 2026 has continuously decreased for 2 period(s) of time

Latest Value GM Benchmarking

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



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

Narrative

- In August 2026, a total of 3,505 attendances for Children and Young People's Mental Health Services were recorded among patients registered in Bury.
- This represents a decrease compared with the 3,625 attendances reported in July 2026 but is higher than the 3,470 attendances recorded at this time in the previous year.
- Bury currently reports an access rate of 78.9 per 1,000 population, ranking fourth highest among the Greater Manchester localities.

Bury

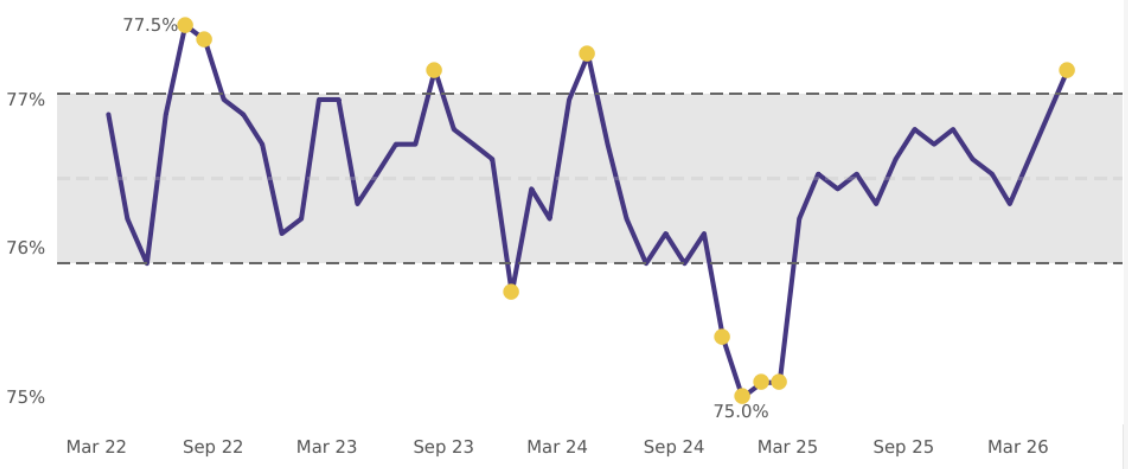
Dementia: Diagnosis Rate (Aged 65+)

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)

77.2%	76.3%	5/106	66.7%
June 2026	March 2026	National Rank Upper Quartile	National Target

Outliers more than 1 standard deviation from the mean

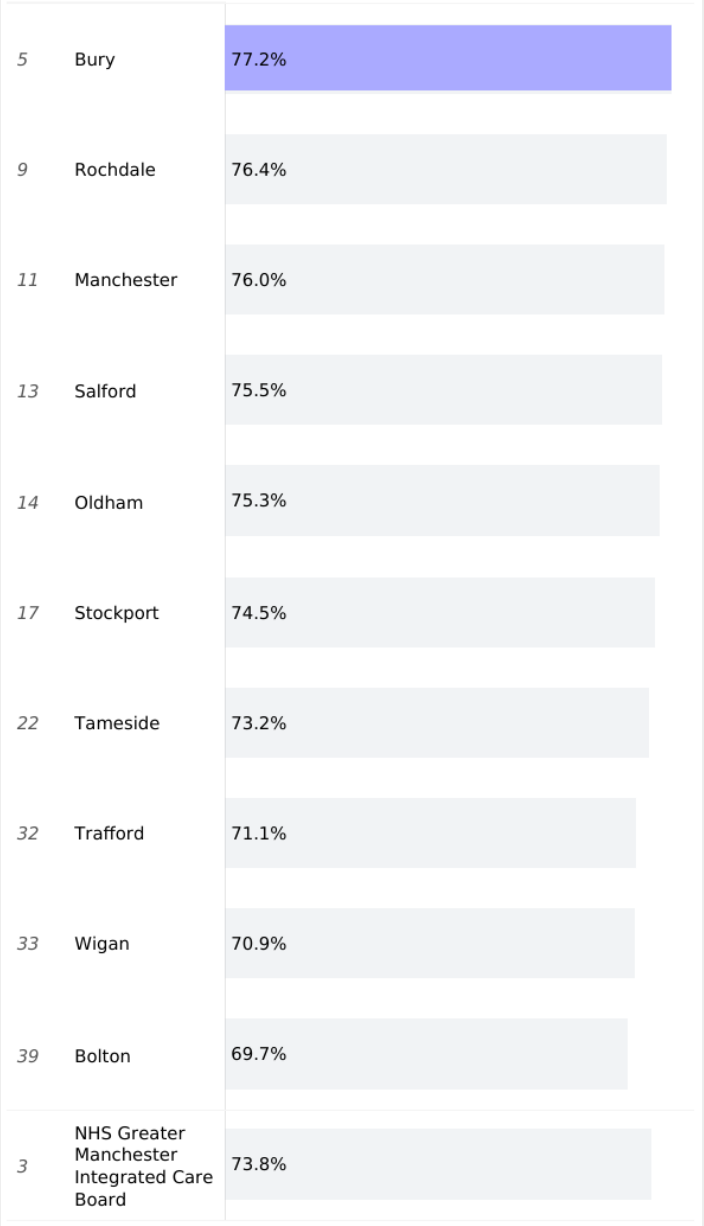


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	76.9%	76.2%	75.9%	76.9%	77.5%	77.4%	77.0%	76.9%	76.7%	76.1%	76.2%	77.0%
2023-24	77.0%	76.3%	76.5%	76.7%	76.7%	77.2%	76.8%	76.7%	76.6%	75.7%	76.4%	76.2%
2024-25	77.0%	77.3%	76.7%	76.2%	75.9%	76.1%	75.9%	76.1%	75.4%	75.0%	75.1%	75.1%
2025-26	76.2%	76.5%	76.4%	76.5%	76.3%	76.6%	76.8%	76.7%	76.8%	76.6%	76.5%	76.3%
2026-27			77.2%									

Selected measure at June 2026 has continuously increased for 1 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities



Narrative

No updated data appearing from June 2026 position.

Bury

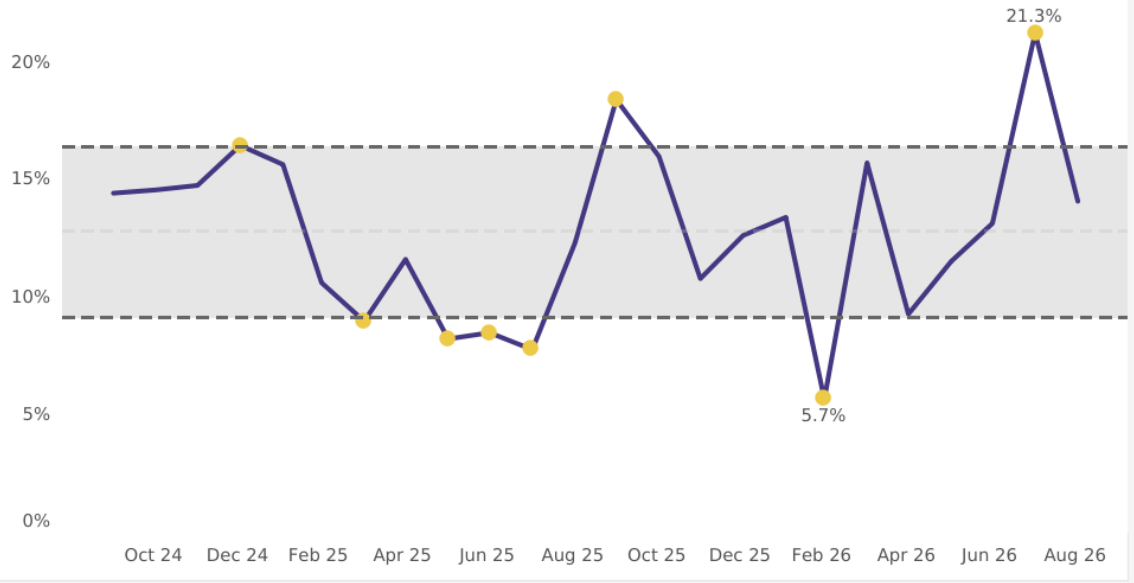
Percentage of MH patients with no criteria to reside (NCTR)
Percentage of beds occupied by MH patients who are ready to be discharged

Source: GM Admissions - Local (Monthly)

14.1%
September 2026

21.3%
August 2026

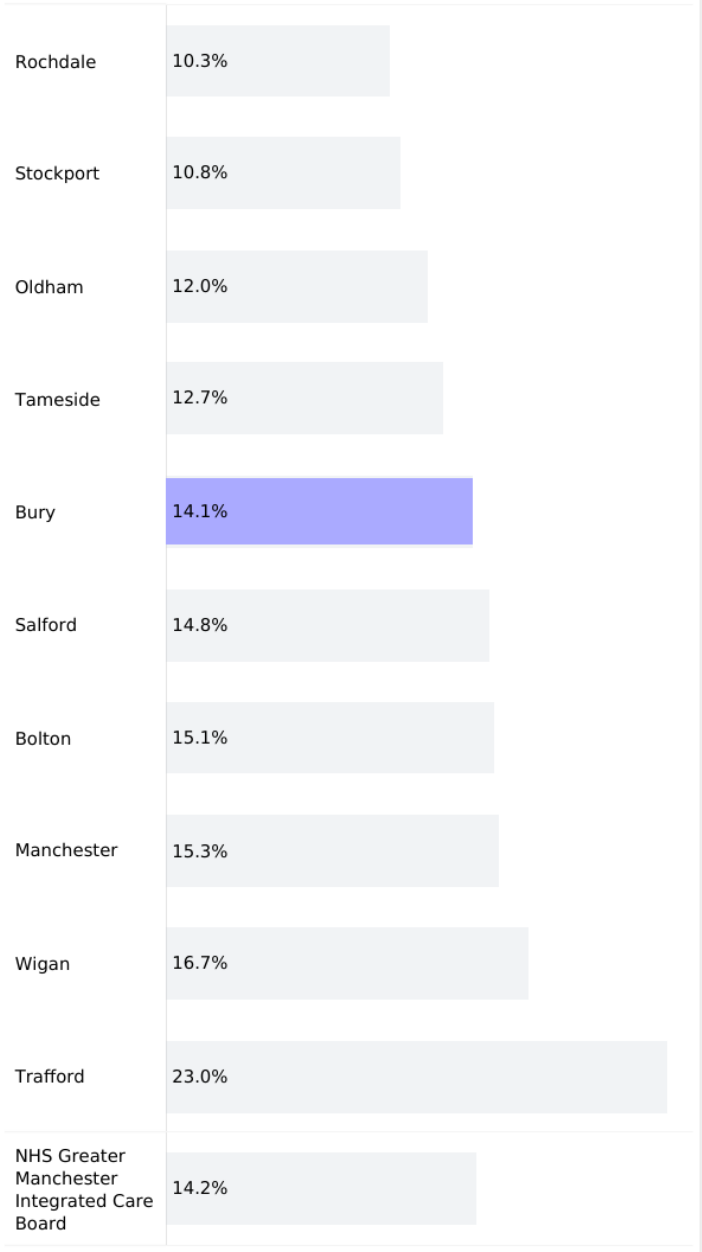
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024-25							14.4%	14.6%	14.8%	16.5%	15.7%	10.6%
2025-26	9.0%	11.6%	8.2%	8.5%	7.8%	12.3%	18.4%	16.0%	10.8%	12.6%	13.4%	5.7%
2026-27	15.7%	9.3%	11.5%	13.2%	21.3%	14.1%						

Selected measure at September 2026 has continuously decreased for 1 period(s) of time

Latest Value GM Benchmarking



Narrative

- As of September 2026, 14.1% of mental health patients in Bury are reported as having no criteria to reside (NCTR), representing a decrease from 21.3% in July 2026.
- Bury's performance is just below the Greater Manchester (GM) average of 14.2%, with Bury ranking as the 5th lowest locality across GM.

Bury

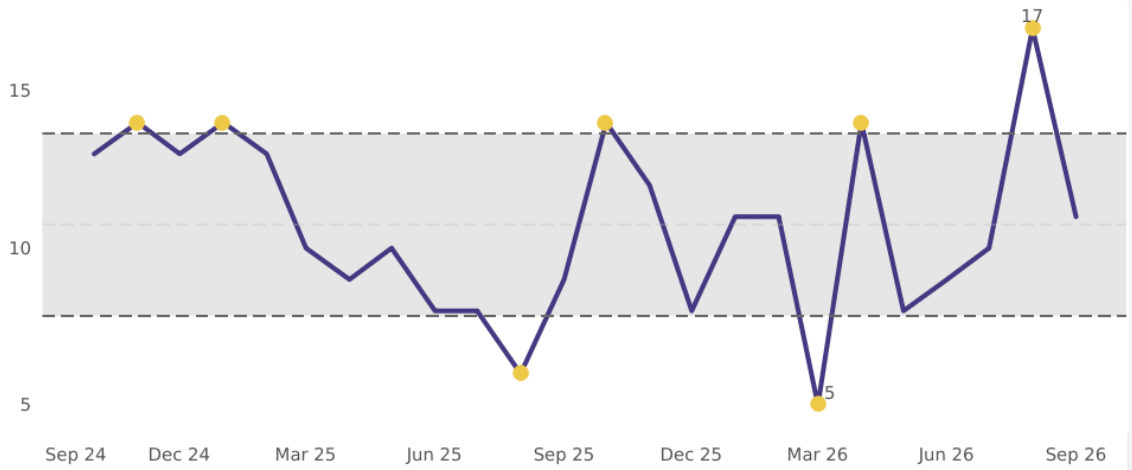
Number of MH patients with no criteria to reside (NCTR)
Number of beds occupied by MH patients who are ready to be discharged

Source: GM Admissions - Local (Monthly)

11
September 2026

17
August 2026

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024-25							13	14	13	14	13	10
2025-26	9	10	8	8	6	9	14	12	8	11	11	5
2026-27	14	8	9	10	17	11						

Selected measure at September 2026 has continuously decreased for 1 period(s) of time

Latest Value GM Benchmarking
Rate per 1000 | Count

Rochdale	0.028	7
Tameside	0.035	8
Wigan	0.028	10
Bury	0.053	11
Salford	0.037	12
Bolton	0.042	14
Stockport	0.046	15
Oldham	0.060	16
Trafford	0.069	17
Manchester	0.049	36
NHS Greater Manchester Integrated Care Board	0.045	146

The rate is calculated using the registered population figure for each locality | Bury: 209,423

Narrative

- This metric is monitored daily to ensure timely oversight and responsiveness.
- In September 2026, the number of mental health patients in Bury recorded as having no criteria to reside (NCTR) decreased to 11, from 17 in August.
- This equates to a rate of 0.053 per 1,000 population, which is above the Greater Manchester (GM) average of 0.045%.

Bury

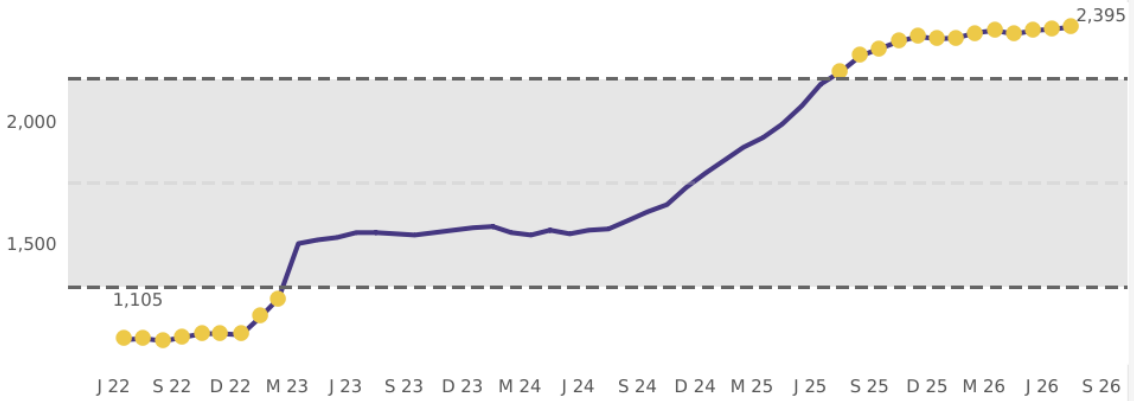
Overall Access to Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses

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)

2,395	2,385	78/107	4,005
August 2026	July 2026	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
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	1,940	1,995	2,070	2,160	2,210	2,275	2,305	2,335	2,355	2,345	2,350	2,370
2026-27	2,380	2,365	2,380	2,385	2,395							

Selected measure at August 2026 has continuously increased for 3 period(s) of time

Latest Value GM Benchmarking

Rate per 1000 | Count (National Rank)

1	Salford	17.7	4,530 (50)
2	Bury	14.5	2,395 (78)
3	Manchester	13.6	8,125 (31)
4	Trafford	13.0	2,490 (75)
5	Tameside	12.2	2,175 (84)
6	Rochdale	12.0	2,320 (80)
7	Bolton	11.9	3,030 (64)
8	Wigan	10.6	2,960 (65)
9	Oldham	9.7	1,970 (88)
10	Stockport	9.6	2,500 (74)

The rate is calculated using the 18+ registered population figure for each locality | Bury: 165,915

Narrative

- Access figures for August 2026 indicate a slight increase from 2,385 in July to 2,395 in August.
- Bury's rate of 14.5 per 1,000 population is the second highest in Greater Manchester.

Bury

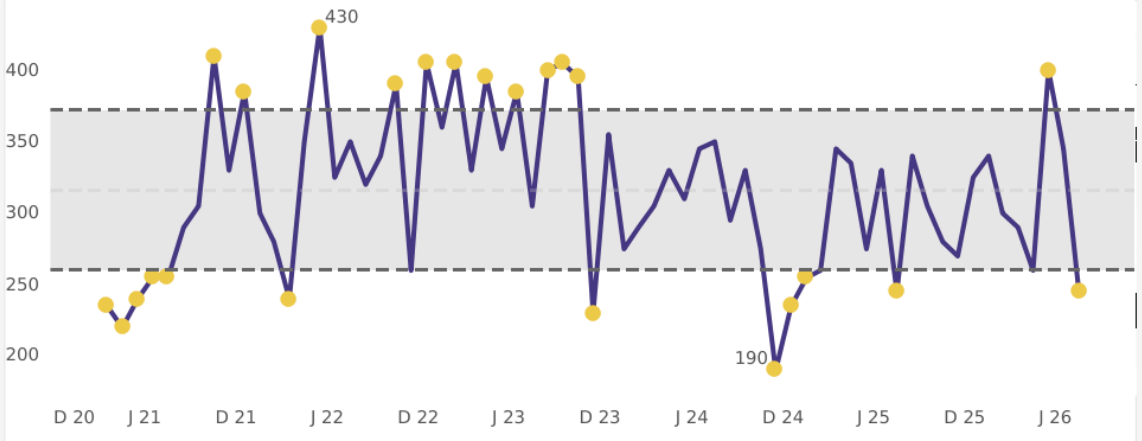
Talking Therapies: Access Rate

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)

245	345	98/110	No Target
August 2026	July 2026	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
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	270	325	340	300
2026-27	290	260	400	345	245							

Selected measure at August 2026 has continuously decreased for 2 period(s) of time

Latest Value GM Benchmarking

Rate per 1000 | Count (National rank)



The rate is calculated using the registered population figure for each locality | Bury: 209,423

Narrative

- In August 2026, 245 people in Bury accessed Talking Therapies services, a significant decrease from 345 in July.
- Bury's rate of 1.2 per 1,000 population ranks 6th across GM.

Bury

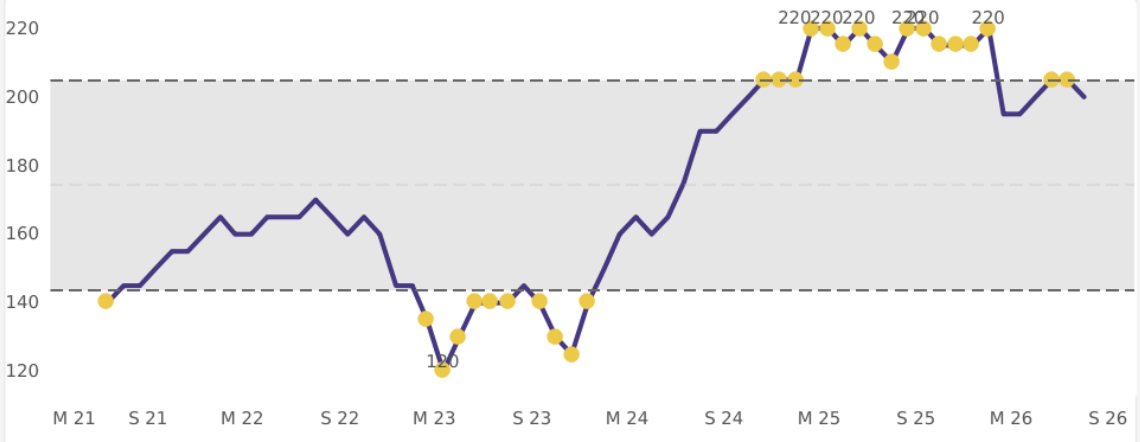
Women Accessing Specialist Community Perinatal Mental Health Services

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

Source: Published MHSDS (Quarterly)

200	205	88/106	No Target
August 2026	July 2026	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
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	220	215	210	220	220	215	215	215	220	195
2026-27	195	200	205	205	200							

Selected measure at August 2026 has continuously decreased for 1 period(s) of time

Latest Value GM Benchmarking

Rate per 1000 | Count (National Rank)

1	Stockport	5.4	340 (60)
2	Bury	4.9	200 (88)
3	Rochdale	4.7	240 (78)
4	Tameside	4.7	215 (82)
5	Trafford	4.1	190 (91)
6	Wigan	3.8	250 (75)
7	Oldham	3.4	185 (92)
8	Salford	3.1	245 (76)
9	Bolton	2.9	195 (89)
10	Manchester	2.8	555 (39)

The rate is calculated using the 15-44 female population figure for each locality | Bury 40,835

Narrative

- In August 2026, 200 women in Bury accessed specialist community perinatal mental health services, a slight decrease from 205 in July 2026.
- Bury's rate of 4.9 per 1,000 population is the second highest in Greater Manchester, indicating strong relative performance within the system.

Bury

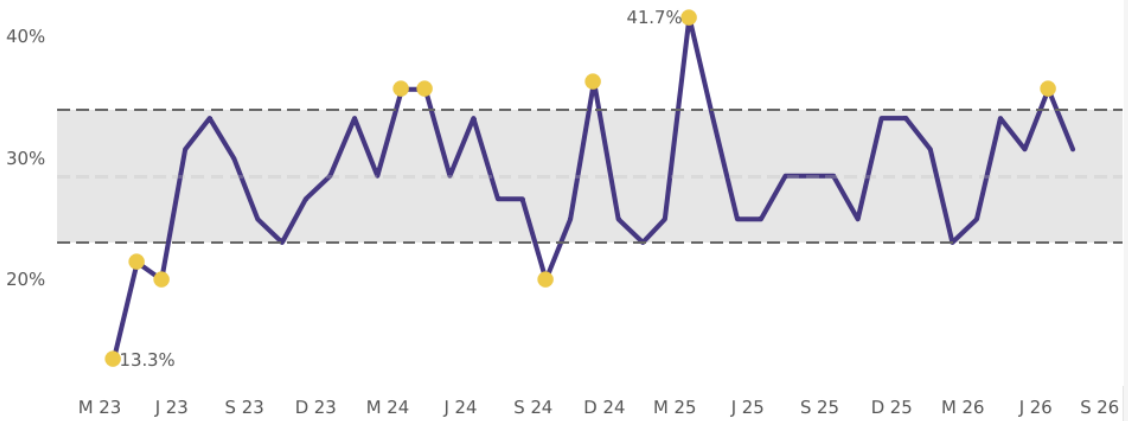
Long length of stay for adults (60+ days) - Mental Health Patients

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)

30.8%	35.7%	76/99	0.%
August 2026	July 2026	National Rank Lower Quartile	National Target

Outliers more than 1 standard deviation from the mean

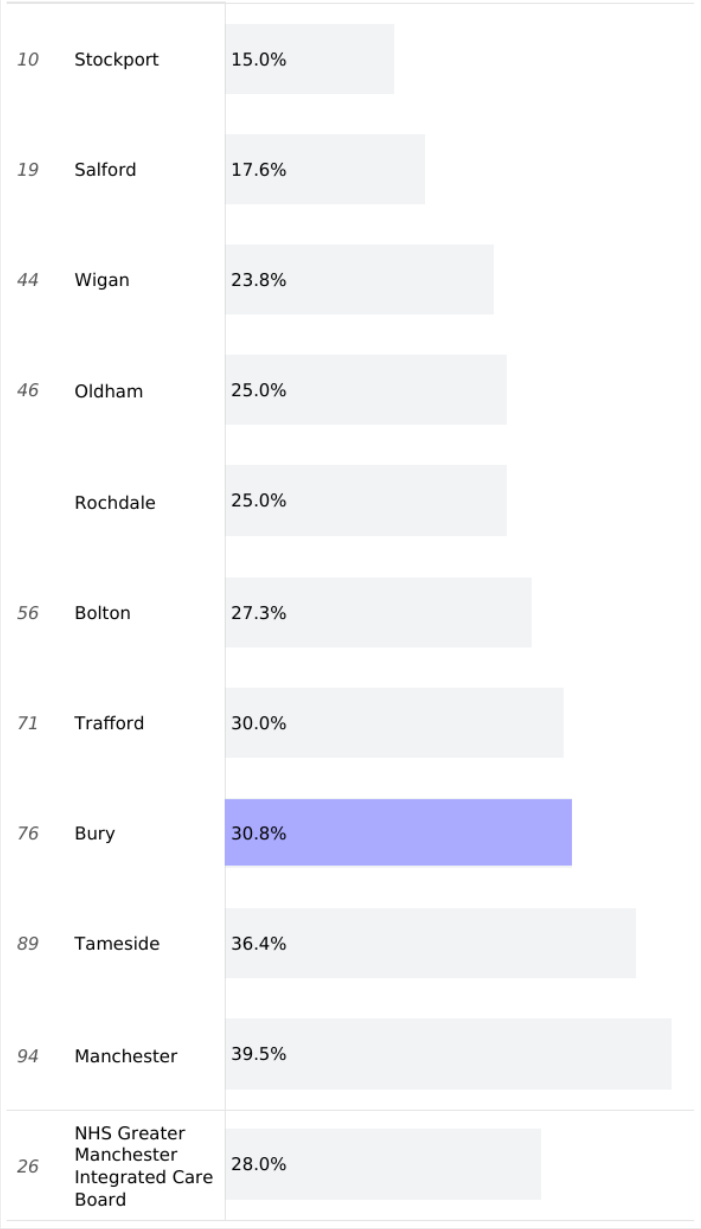


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023-24	13.3%	21.4%	20.0%	30.8%	33.3%	30.0%	25.0%	23.1%	26.7%	28.6%	33.3%	28.6%
2024-25	35.7%	35.7%	28.6%	33.3%	26.7%	26.7%	20.0%	25.0%	36.4%	25.0%	23.1%	25.0%
2025-26	41.7%	33.3%	25.0%	25.0%	28.6%	28.6%	28.6%	25.0%	33.3%	33.3%	30.8%	23.1%
2026-27	25.0%	33.3%	30.8%	35.7%	30.8%							

Selected measure at August 2026 has continuously decreased for 1 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities



Narrative

- In August 2026, 30.8% of adult mental health discharges in Bury had a length of stay exceeding 60 days, a decrease from 35.7% in July.
- Bury's performance is slightly above the Greater Manchester average of 28.0%.

Bury

Proportion of routine eating disorder referrals cases entering treatment within four weeks, aged 0-18 - Mental Health Patients

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

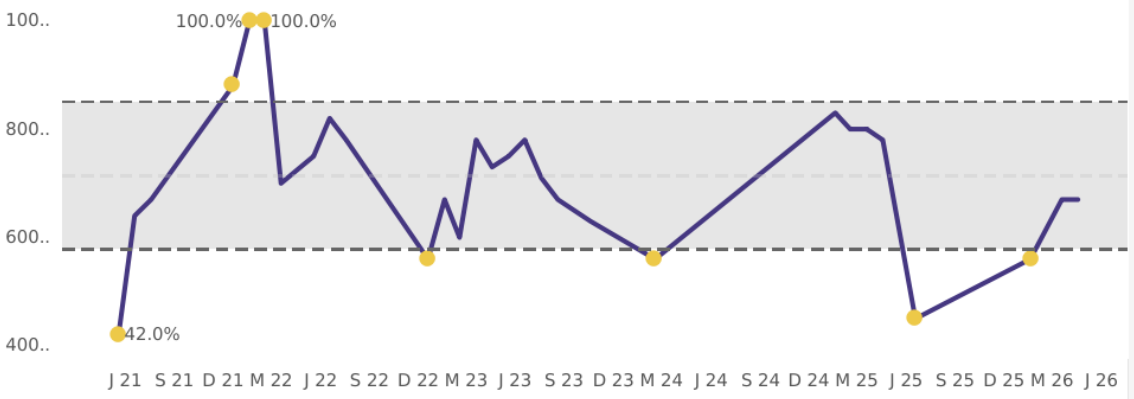
Source: Published MHSDS (Monthly)

67.0%
May 2026

67.0%
April 2026

78/104
National Rank
Inter Quartile

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Nov	Jan	Feb	Mar
2021-22			42.0%	64.0%	67.0%			88.0%	100.0%	100.0%
2022-23	70.0%		75.0%	82.0%	78.0%			56.0%	67.0%	60.0%
2023-24	78.0%	73.0%	75.0%	78.0%	71.0%	67.0%	63.0%			56.0%
2024-25									83.0%	80.0%
2025-26	80.0%	78.0%		45.0%					56.0%	
2026-27	67.0%	67.0%								

Selected measure at May 2026 has continuously remained the same for 3 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities

1	Salford	100.0%
	Wigan	100.0%
28	Stockport	90.0%
42	Trafford	84.0%
43	Bolton	83.0%
55	Manchester	77.0%
58	Oldham	75.0%
78	Bury	67.0%
91	Rochdale	50.0%
	Tameside	50.0%
18	NHS Greater Manchester Integrated Care Board	81.0%

Narrative

- No change in dashboard data from previous report.

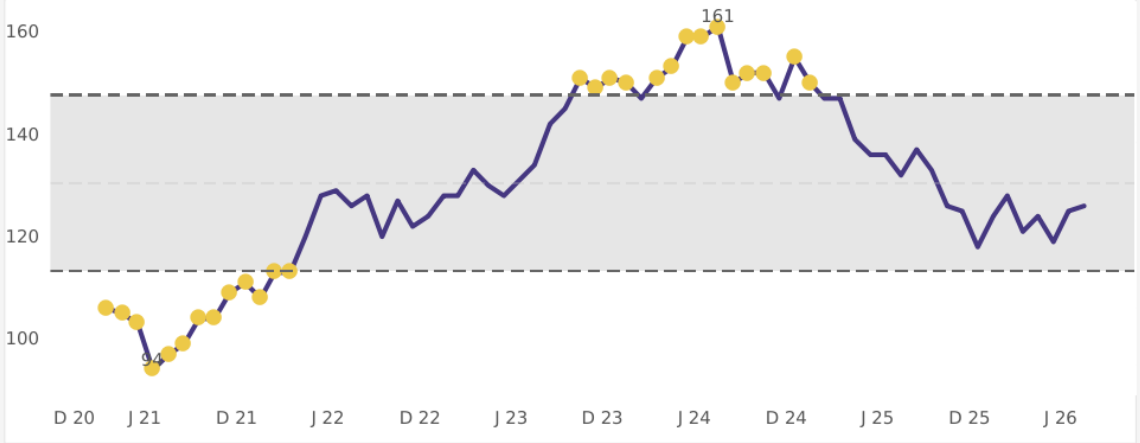
Bury

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	125	11/106	No Target
August 2026	July 2026	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	125	118	124	128
2026-27	121	124	119	125	126							

Selected measure at August 2026 has continuously increased for 2 period(s) of time

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

Salford	0.54	173.0 (23)
Rochdale	0.55	139.0 (14)
Bury	0.60	126.0 (11)
Manchester	0.60	445.0 (69)
Bolton	0.61	202.0 (31)
Oldham	0.63	167.0 (22)
Wigan	0.63	221.0 (39)
Stockport	0.80	264.0 (47)
Trafford	0.90	222.0 (40)
Tameside	0.94	214.0 (36)

The rate is calculated using the registered population figure for each locality | Bury: 209,423

Narrative

- Over the 12-month period ending August 2026, a total of 126 cases of E. coli bloodstream infections were recorded among patients registered in Bury.
- This represents a slight increase compared with July 2026, when 125 cases were reported, and is lower than the 132 cases recorded in August 2025.
- Bury currently reports an infection rate of 0.6 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

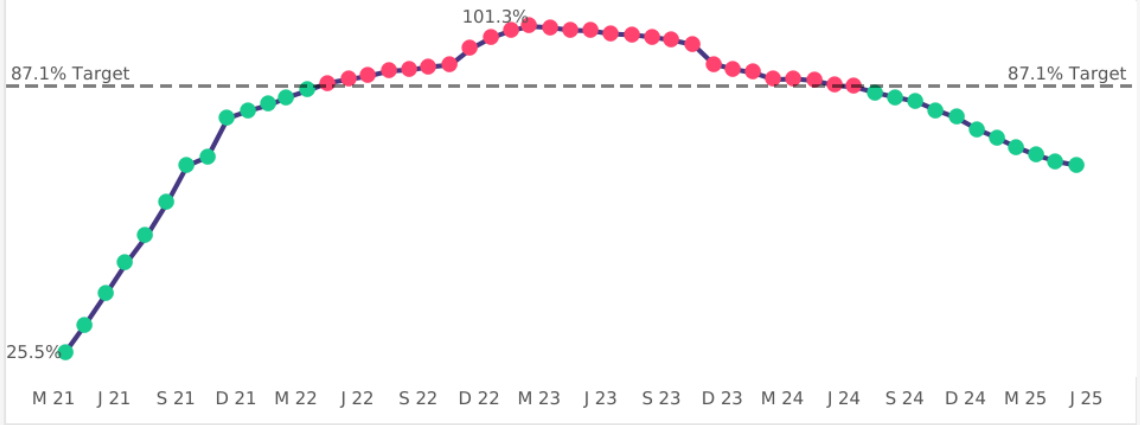
Source: EPACT Prescribing Data (Monthly)

68.9%
June 2025

69.8%
May 2025

87.1%
National Target

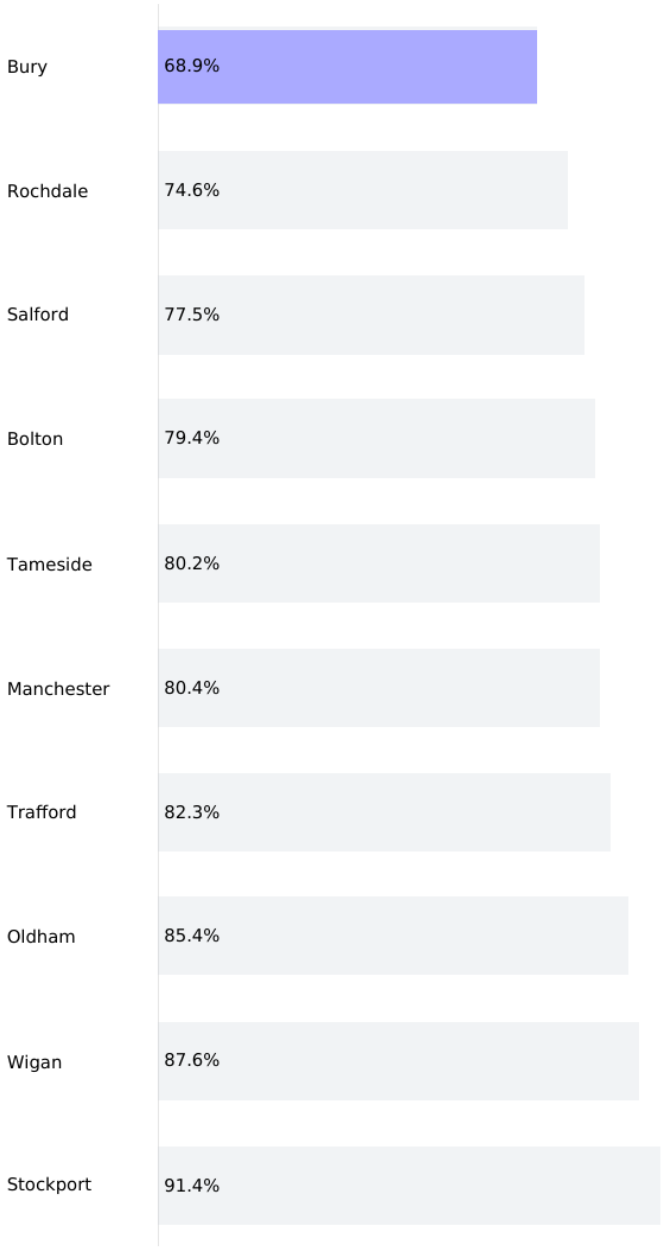
Performance Against National Target of 87.1%



	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

No update in dashboard data for this measure.

Bury

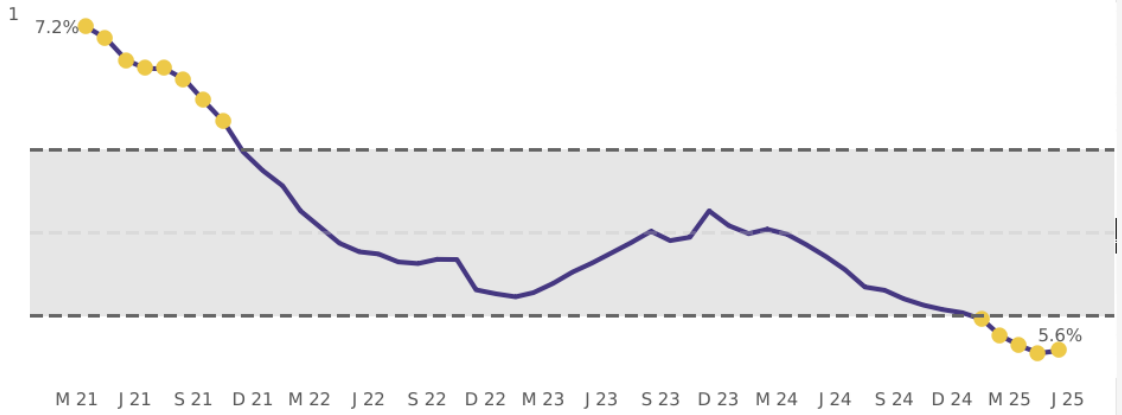
Antimicrobial resistance: proportion of broad-spectrum antibiotic prescribing in primary care

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

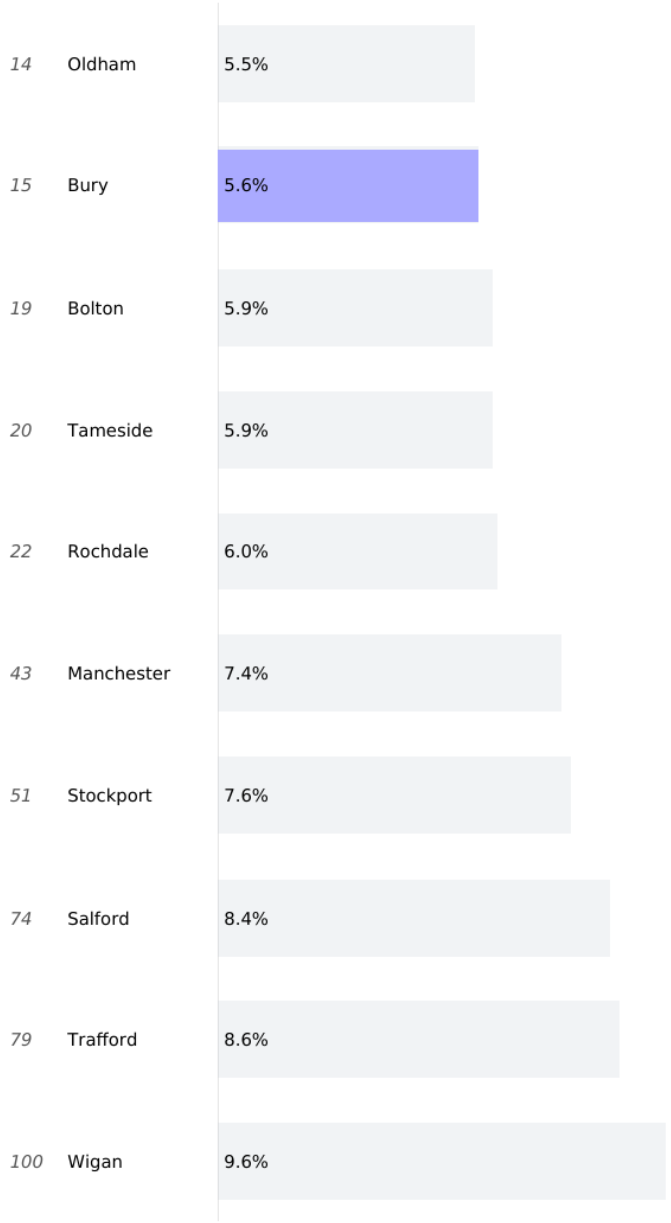


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	7.2%	7.1%	7.0%	7.0%	7.0%	6.9%	6.8%	6.7%	6.6%	6.5%	6.4%	6.3%
2022-23	6.2%	6.1%	6.1%	6.1%	6.0%	6.0%	6.0%	6.0%	5.9%	5.9%	5.9%	5.9%
2023-24	5.9%	6.0%	6.0%	6.1%	6.1%	6.2%	6.1%	6.2%	6.3%	6.2%	6.2%	6.2%
2024-25	6.2%	6.1%	6.1%	6.0%	5.9%	5.9%	5.8%	5.8%	5.8%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

No update in dashboard data for this measure.

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	Sep 26	70.2%	72.5%	↘	78.0%	5,298	7,550	N/A
	N/A	A&E Attendances	Monthly	Sep 26	7,550.0	7,116.0	↗	N/A	7,550	N/A	N/A
	N/A	No Reason/Criteria To Reside patients (NCTR) as % of occupied beds	Monthly	Sep 26	16.2%	18.1%	↘	N/A	1,695	10,460	N/A
	EM11	Total number of specific acute non-elective spells	Monthly	Sep 26	2,291.0	2,097.0	↗	N/A	2,291	N/A	Inter
Elective Care	EB28	Diagnostic 6ww: All	Monthly	Aug 26	16.6%	12.4%	↗	1.%	1,027	6,177	Inter
	EB28x	Diagnostic 6ww: All	Monthly	Aug 26	16.6%	12.4%	↗	1.%	1,027	6,177	Inter
	EB20	RTT incomplete: 65+ week waits	Monthly	Aug 26	38	20.0	↗	0.	38	N/A	Inter
Cancer	S012a	28 Day Wait from Referral to Faster Diagnosis (Monthly): All Patients	Monthly	Aug 26	73.5%	75.9%	↘	80.%	738	1,004	Lower
Maternity	S104a	Number of neonatal deaths per 1,000 total live births	Annual	Dec 24	1.9	1.5	↗	1.4	4	2,077	Lower
	S022a	Number of stillbirths per 1,000 total births	Annual	Dec 24	5.3	5.4	↘	2.5	11	2,077	Lower
Screening and Immunisations	OF0104	Breast screening coverage, females aged 53-70, screened in last 36 months	Annual	Dec 25	74.6%	73.3%	↗	N/A	16,689	22,380	Inter
	S049a	Breast screening coverage, females aged 53-70, screened in last 36 months	Annual	Dec 25	74.6%	73.3%	↗	N/A	16,689	22,380	Inter
	OF0049	COVER immunisation: MMR2 Uptake at 5 years old	Quarterly	Jun 26	87.0%	86.5%	↗	95.%	495	569	Inter
	S046a	COVER immunisation: MMR2 Uptake at 5 years old	Quarterly	Jun 26	87.0%	86.5%	↗	95.%	495	569	Inter
	OF0105	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

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

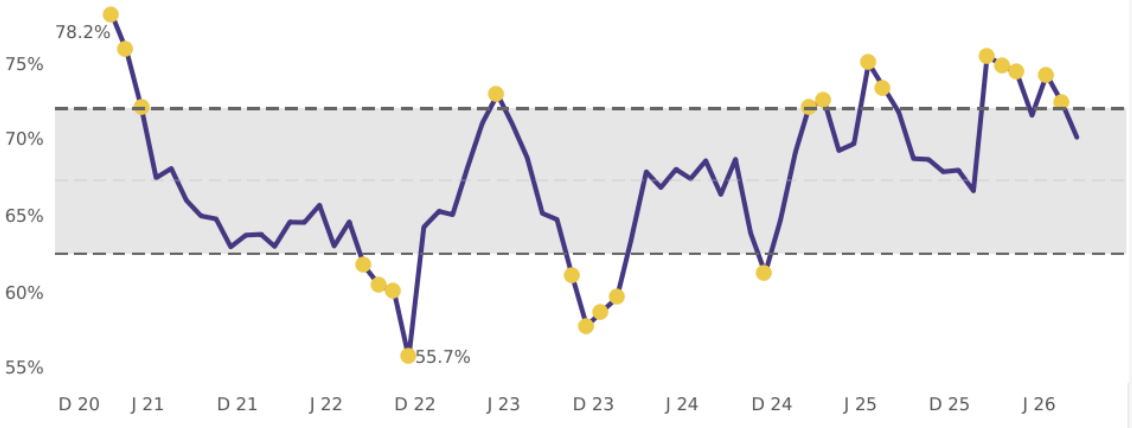
A&E 4 hour performance

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)

70.2%	72.5%	78.0%
September 2026	August 2026	National Target

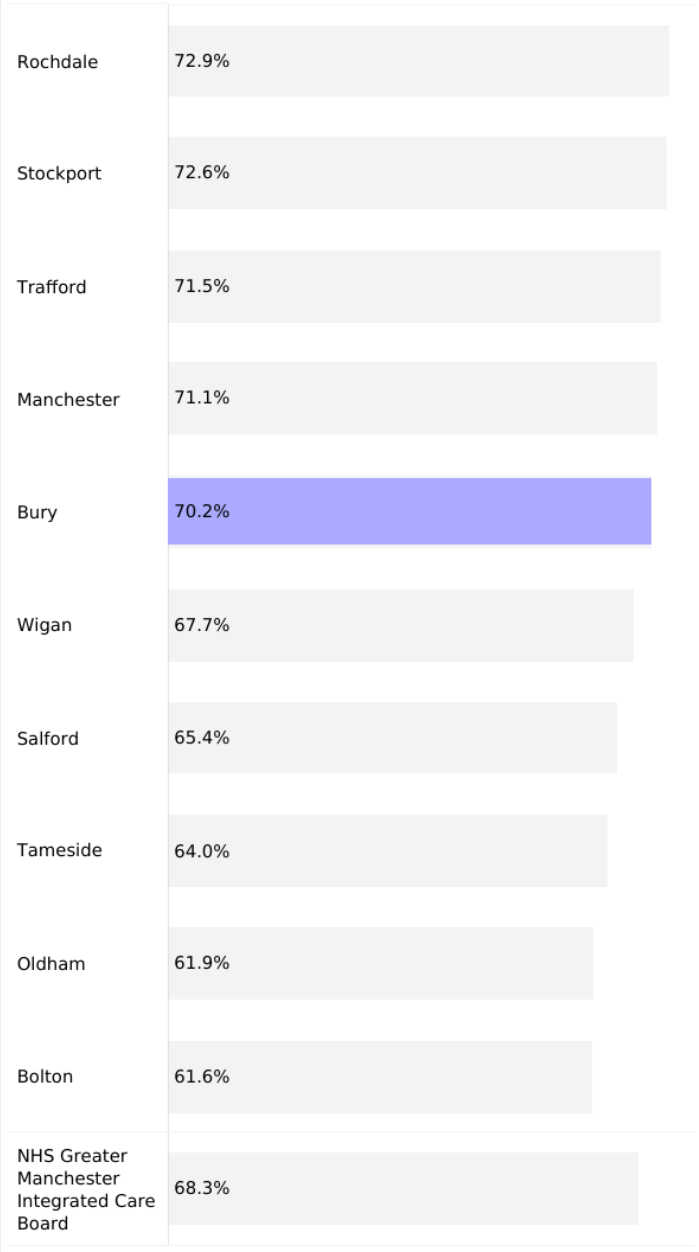
Outliers more than 1 standard deviation from the mean



	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%	63.8%	63.8%	63.0%
2022-23	64.6%	64.6%	65.7%	63.0%	64.6%	61.7%	60.5%	60.1%	55.7%	64.3%	65.3%	65.1%
2023-24	68.2%	71.1%	73.0%	71.1%	68.8%	65.2%	64.8%	61.1%	57.8%	58.7%	59.7%	63.4%
2024-25	67.9%	66.9%	68.1%	67.5%	68.6%	66.4%	68.7%	63.9%	61.3%	64.7%	69.2%	72.2%
2025-26	72.6%	69.3%	69.7%	75.0%	73.4%	71.8%	68.8%	68.7%	67.9%	68.0%	66.7%	75.5%
2026-27	74.9%	74.4%	71.6%	74.3%	72.5%	70.2%						

Selected measure at September 2026 has continuously decreased for 2 period(s) of time

Latest Value GM Benchmarking



Narrative

- This metric is monitored daily to support timely performance oversight.
- In September 2026, Bury achieved a 4-hour emergency care performance rate of 70.2%, decreasing from 72.5% in August 2026.
- This represents a slight year-on-year decrease compared with 71.8% in September 2025.
- Bury's performance exceeds the Greater Manchester average of 68.3%, ranking 5th highest among GM localities.

Bury

A&E Attendances

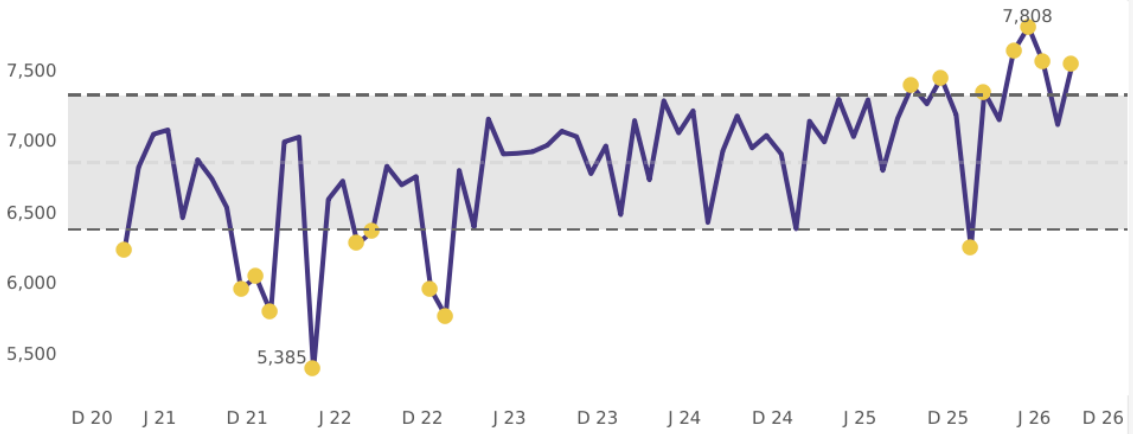
Number of attendances at A&E departments

Source: Emergency Care Dataset (ECDS) (Monthly)

7,550
September 2026

7,116
August 2026

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	6,994	7,296	7,031	7,292	6,793	7,161	7,390	7,263	7,447	7,187	6,245	7,346
2026-27	7,150	7,634	7,808	7,562	7,116	7,550						

Selected measure at September 2026 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: 209,423

Narrative

- In September 2026, Bury recorded 7,550 A&E attendances, an increase from 7,116 attendances in August 2026.
- Bury's attendance rate is 36.1 per 1,000 population, ranking 7th lowest across Greater Manchester localities.

Bury

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

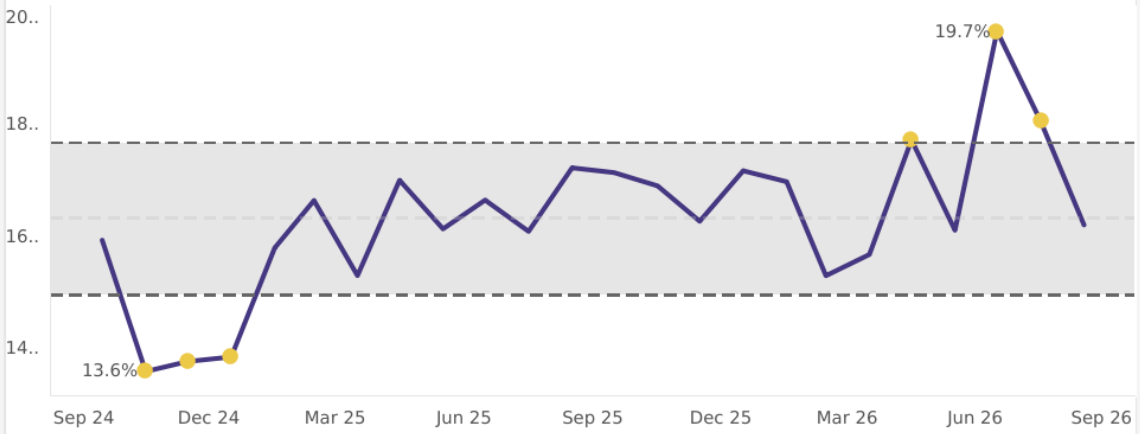
Total occupied beds, and of these, the number of patients who are fit for discharge and have no need to reside in a hospital bed

Source: GM Admissions - Local (Monthly)

16.2%
September 2026

18.1%
August 2026

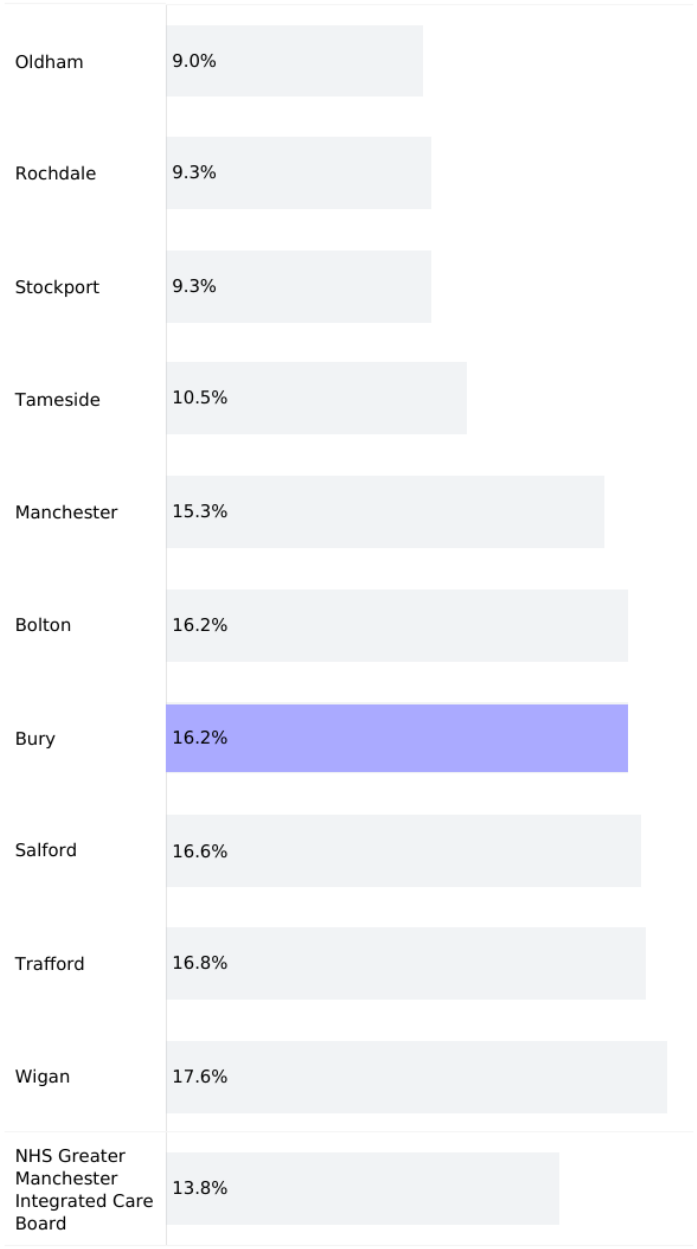
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024-25							15.9%	13.6%	13.8%	13.8%	15.8%	16.6%
2025-26	15.3%	17.0%	16.1%	16.7%	16.1%	17.2%	17.1%	16.9%	16.3%	17.2%	17.0%	15.3%
2026-27	15.7%	17.7%	16.1%	19.7%	18.1%	16.2%						

Selected measure at September 2026 has continuously decreased for 2 period(s) of time

Latest Value GM Benchmarking



Narrative

- This metric is monitored daily to support ongoing performance oversight.
- NCTR has decreased to 16.2% in September 2026 (from 18.1% in August), indicating an improvement in discharge performance.
- Bury is performing below the GM average (13.8%).

Bury

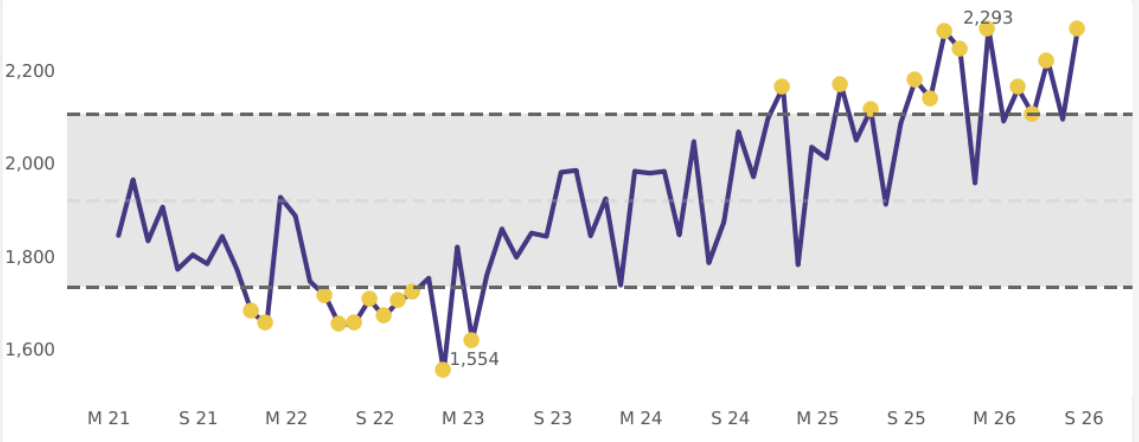
Total number of specific acute non-elective spells

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)

2,291	2,097	3/10
September 2026	August 2026	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	2,013	2,170	2,052	2,118	1,914	2,089	2,182	2,142	2,286	2,248	1,960	2,293
2026-27	2,093	2,163	2,106	2,224	2,097	2,291						

Selected measure at September 2026 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: 209,423

Narrative

- Non-elective activity increased to 2,291 in September 2026 (from 2,097 in August).
- Bury currently ranks 8th with a rate of 10.9 per 1000 population.

Bury

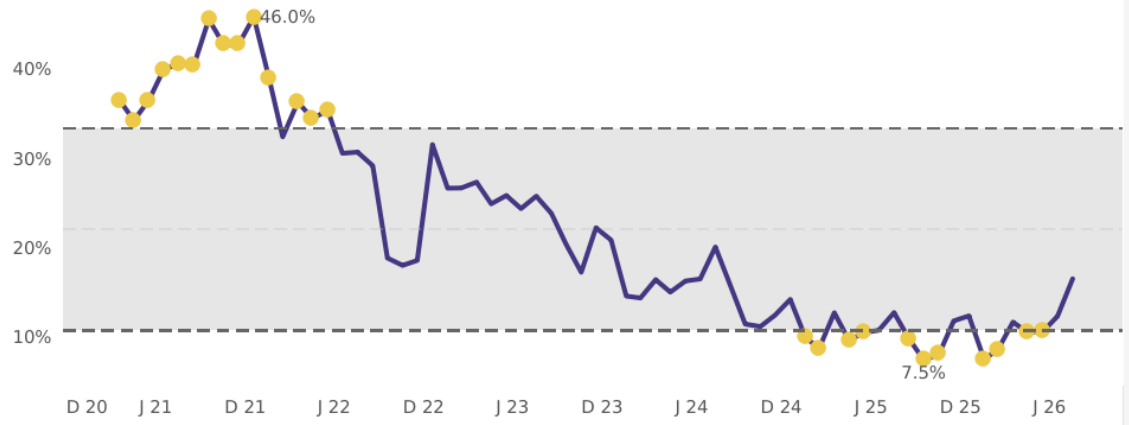
Diagnostic 6ww: All

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

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

16.6%	12.4%	36/106	1.%
August 2026	July 2026	National Rank Inter Quartile	National Target

Outliers more than 1 standard deviation from the mean

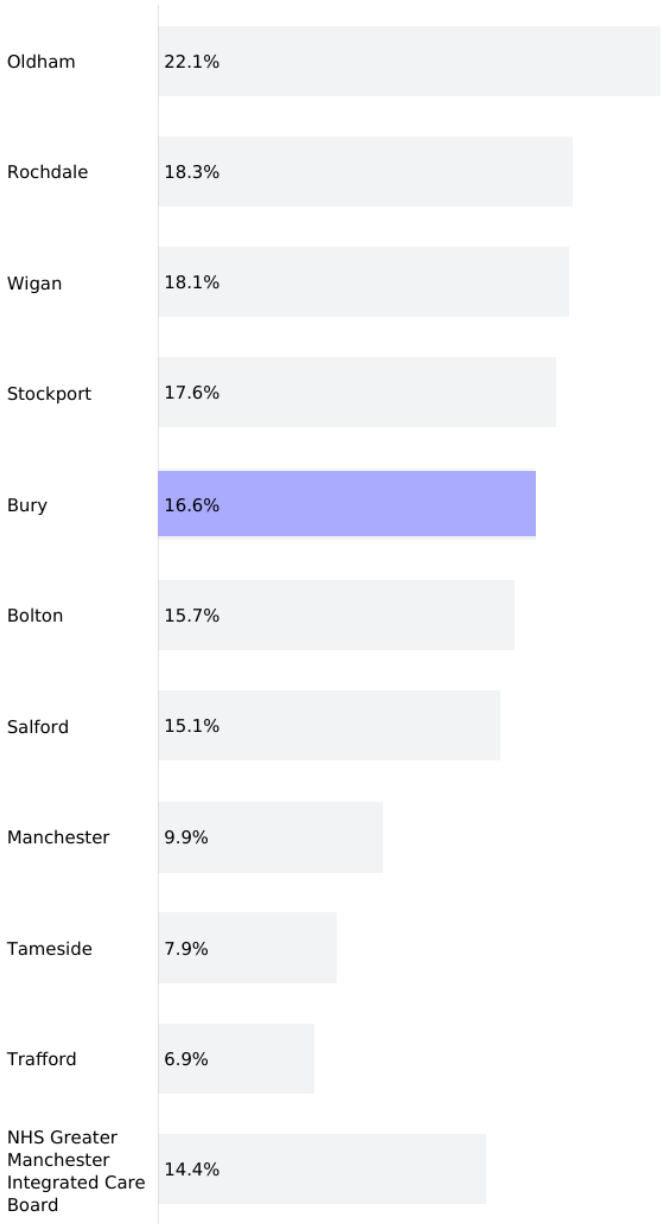


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	36.7%	34.4%	36.7%	40.1%	40.7%	40.6%	45.7%	42.8%	42.9%	46.0%	39.1%	32.5%
2022-23	36.4%	34.6%	35.5%	30.7%	30.8%	29.3%	19.0%	18.1%	18.7%	31.7%	26.8%	26.8%
2023-24	27.5%	25.0%	26.0%	24.5%	25.9%	24.0%	20.5%	17.4%	22.3%	21.0%	14.7%	14.5%
2024-25	16.5%	15.1%	16.4%	16.6%	20.2%	15.8%	11.6%	11.3%	12.6%	14.3%	10.1%	8.8%
2025-26	12.8%	9.7%	10.6%	10.9%	12.8%	9.9%	7.5%	8.2%	11.9%	12.5%	7.6%	8.7%
2026-27	11.8%	10.6%	10.7%	12.4%	16.6%							

Selected measure at August 2026 has continuously increased for 3 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities



Narrative

- The proportion of patients waiting over 6 weeks increased to 16.6% in September 2026 (from 12.4% in July).
- Bury currently ranks 5th in GM.

Bury

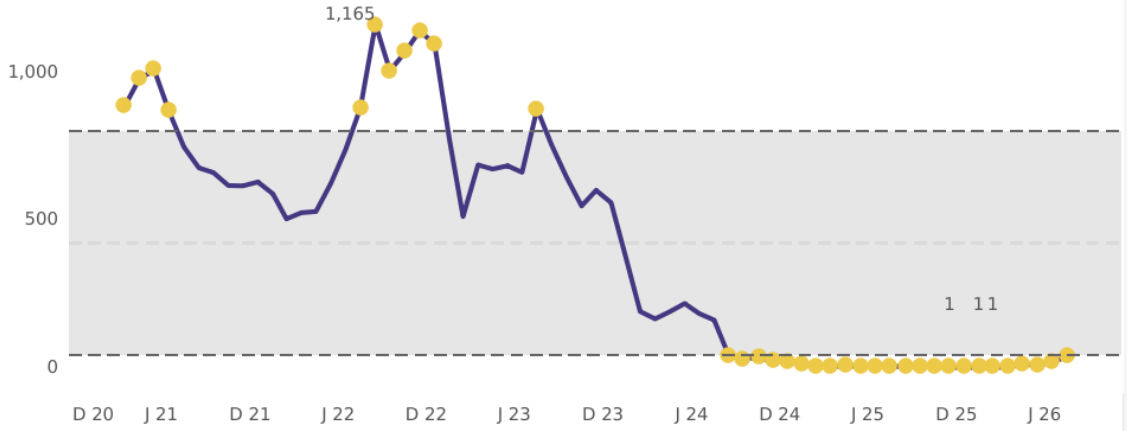
RTT incomplete: 65+ week waits

"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)

38	20	30/121	0.
August 2026	July 2026	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	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	1	2	1	1
2026-27	3	12	9	20	38							

Selected measure at August 2026 has continuously increased for 2 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities



Narrative

- In August 2026, 38 Bury-registered patients were reported as waiting 65 weeks or more, up from 20 patients in July 2026.
- August was the highest figure for Bury since September 2024
- Bury ranks as the 5th highest locality across Greater Manchester for the number of 65+ week waits.

Bury

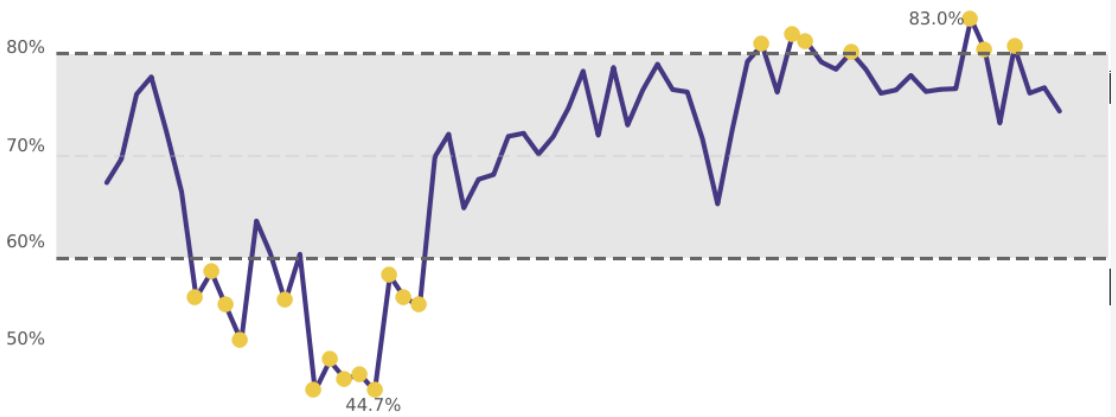
28 Day Wait from Referral to Faster Diagnosis (Monthly): All Patients

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)

73.5%	75.9%	84/106	80.%
August 2026	July 2026	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
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%	75.7%	75.8%	83.0%	79.9%
2026-27	72.3%	80.1%	75.4%	75.9%	73.5%							

Selected measure at August 2026 has continuously **decreased** for **1** period(s) of time

Latest Value GM Benchmarking

National Rank against other localities



Narrative

- 28-day Faster Diagnosis performance decreased to 73.5% in August 2026, from 75.9% in July.
- Performance is currently below the 80% national standard and the GM average (78.5%)

Bury

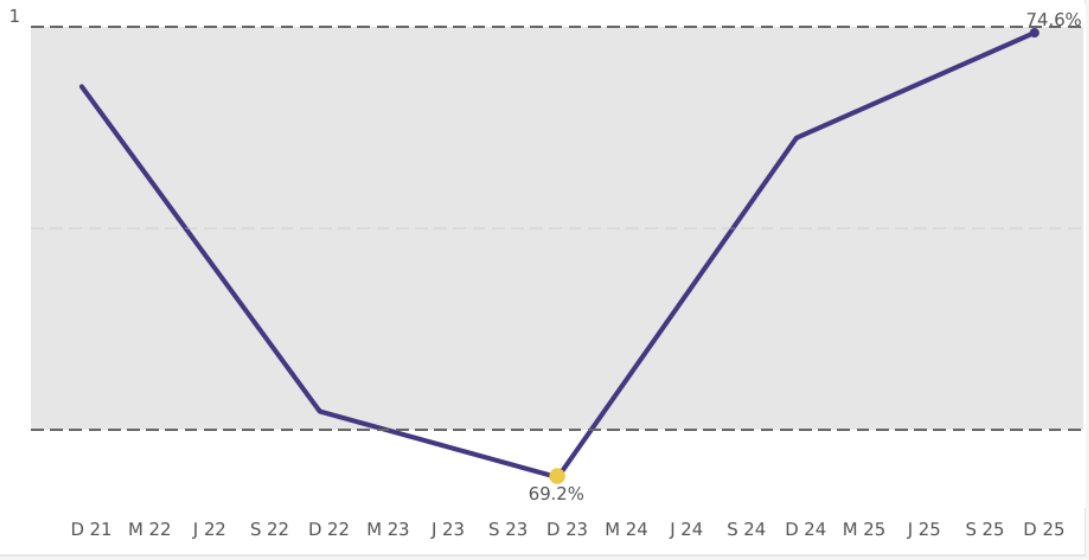
Breast screening coverage, females aged 53-70, screened in last 36 months

3-year screening coverage %: The number of females registered to the practice screened adequately in previous 36 months divided by the number of eligible females on last day of the review period

Source: Fingertips, Public Health Data, Public Health Outcomes Framework (Annual)

74.6%	73.3%	60%
December 2025	December 2024	No Target

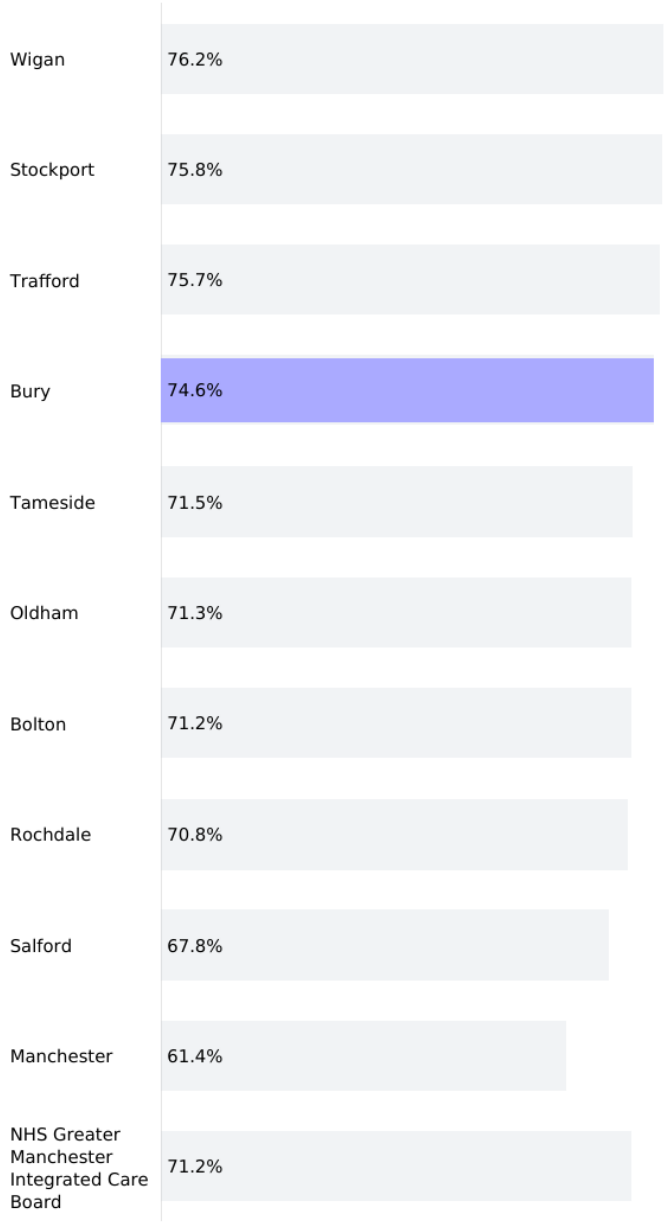
Outliers more than 1 standard deviation from the mean



	Dec
2021-22	73.9%
2022-23	70.0%
2023-24	69.2%
2024-25	73.3%
2025-26	74.6%

Latest Value GM Benchmarking

National Rank against other localities



Narrative

No update in dashboard data from previous month.

Bury

COVER immunisation: MMR2 Uptake at 5 years old

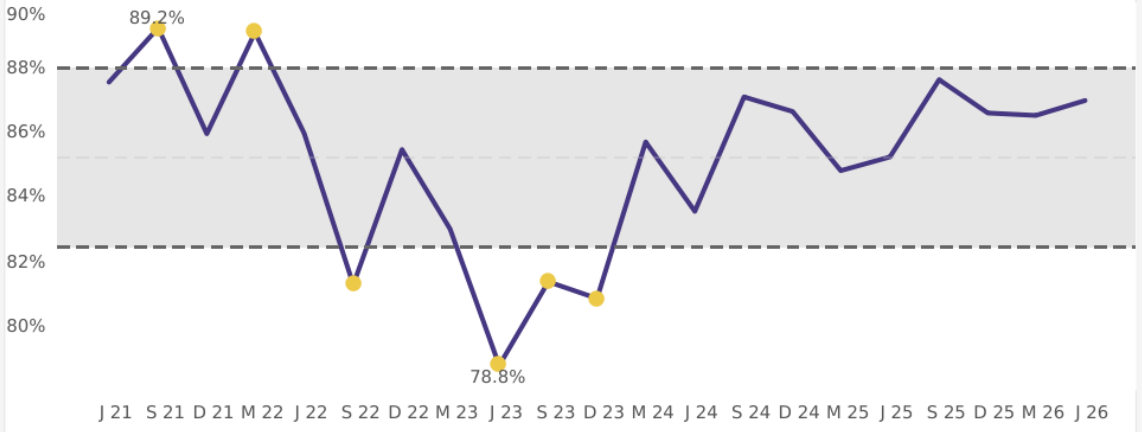
Population vaccination coverage – MMR for two doses (5 years old)

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

87.0%
June 2026

95.%
National Target

Outliers more than 1 standard deviation from the mean

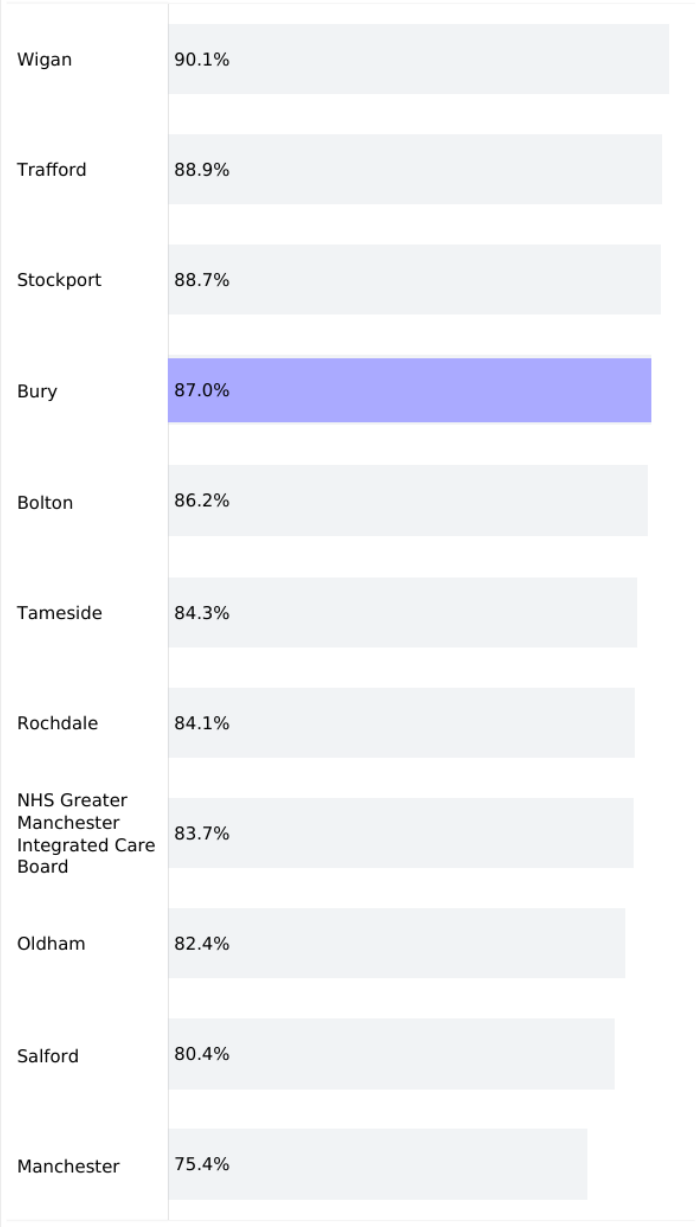


	Jun	Sep	Dec	Mar
2021-22	87.6%	89.2%	86.0%	89.1%
2022-23	86.0%	81.3%	85.5%	83.0%
2023-24	78.8%	81.4%	80.9%	85.7%
2024-25	83.6%	87.1%	86.7%	84.8%
2025-26	85.3%	87.6%	86.6%	86.5%
2026-27	87.0%			

Selected measure at June 2026 has continuously increased for 1 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities



Narrative

COVID immunisation uptake has increased slightly from 86.5% in March 2026 to 87.0% in June 2026

Bury currently rank 4th across GM.

Bury

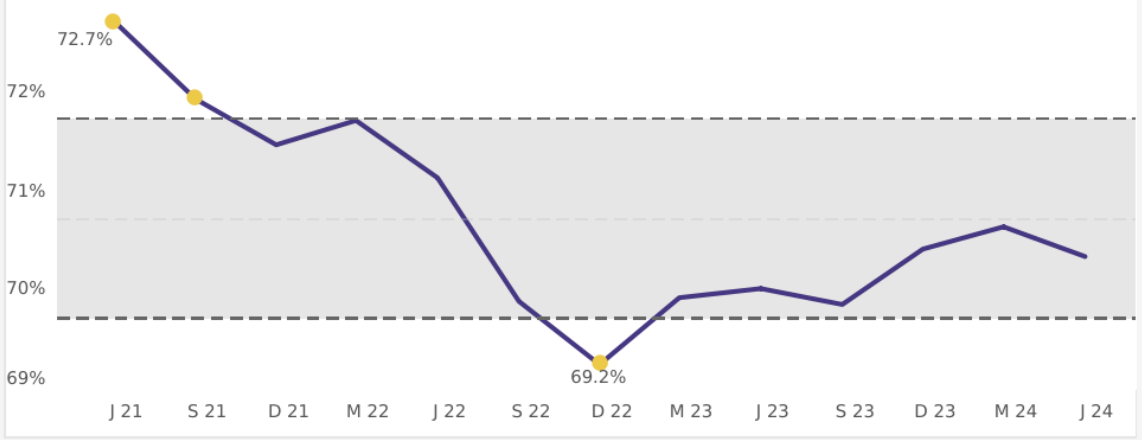
Females, 25-64, attending cervical screening within target period (3.5 or 5.5 year coverage, %)

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%	70.6%	68/106	80.%
June 2024	March 2024	National Rank Inter Quartile	National Target

Outliers more than 1 standard deviation from the mean

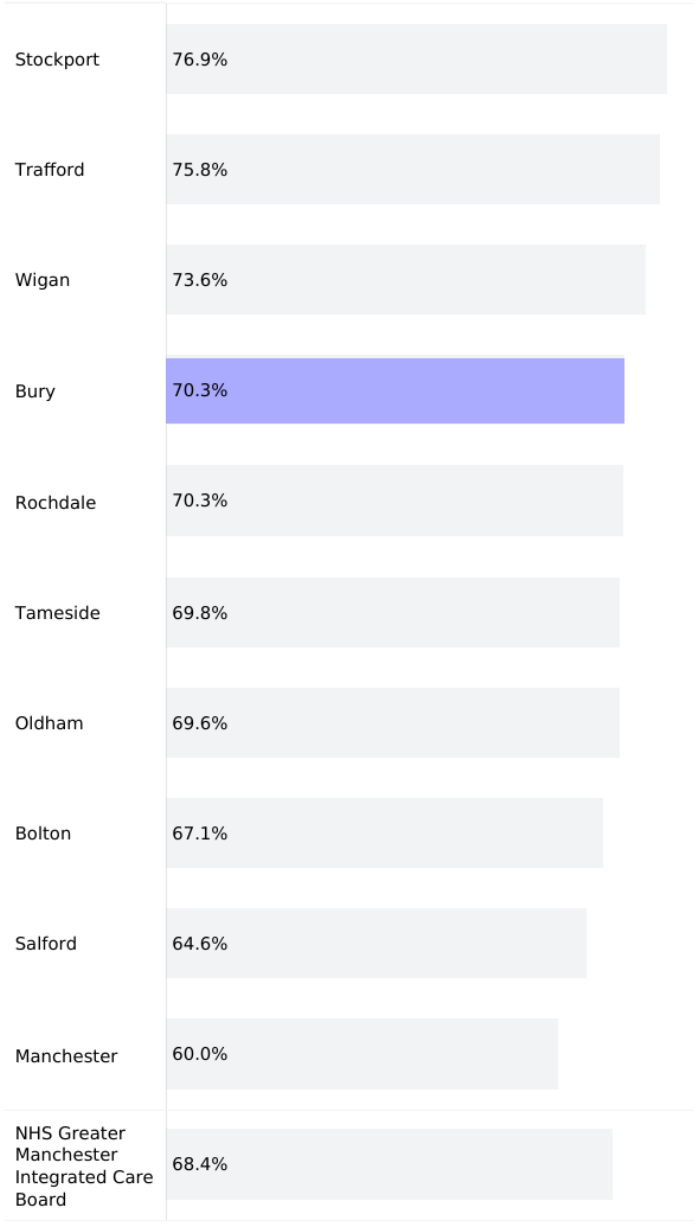


	Jun	Sep	Dec	Mar
2021-22	72.7%	71.9%	71.5%	71.7%
2022-23	71.1%	69.9%	69.2%	69.9%
2023-24	70.0%	69.8%	70.4%	70.6%
2024-25	70.3%			

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

Latest Value GM Benchmarking

National Rank against other localities



Narrative

Cervical Screening has decreased slightly from 70.6% in March 2026 to 70.3% in June 2026.

Bury currently rank 4th across GM.

Bury

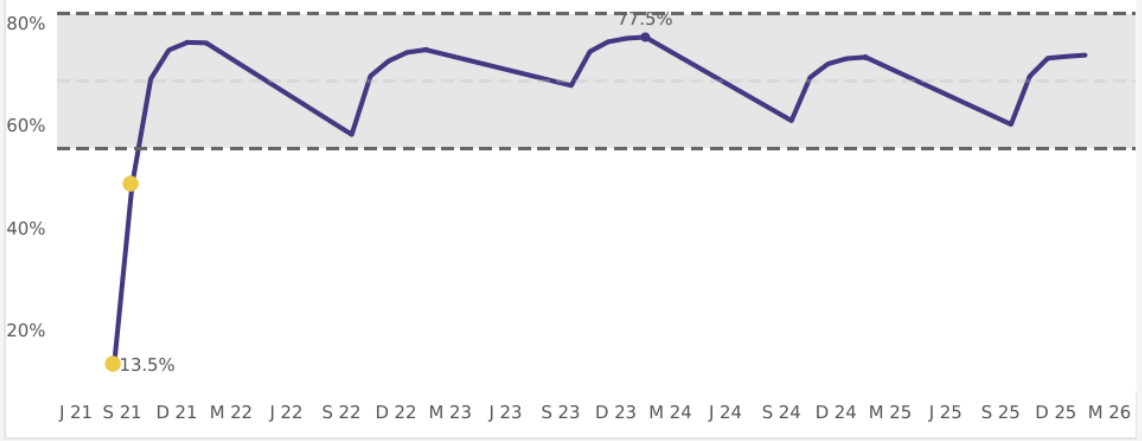
Seasonal Flu Vaccine Uptake: 65 years and over

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)

74.0%	73.8%	70/106	85.%
February 2026	January 2026	National Rank Inter Quartile	National Target

Outliers more than 1 standard deviation from the mean

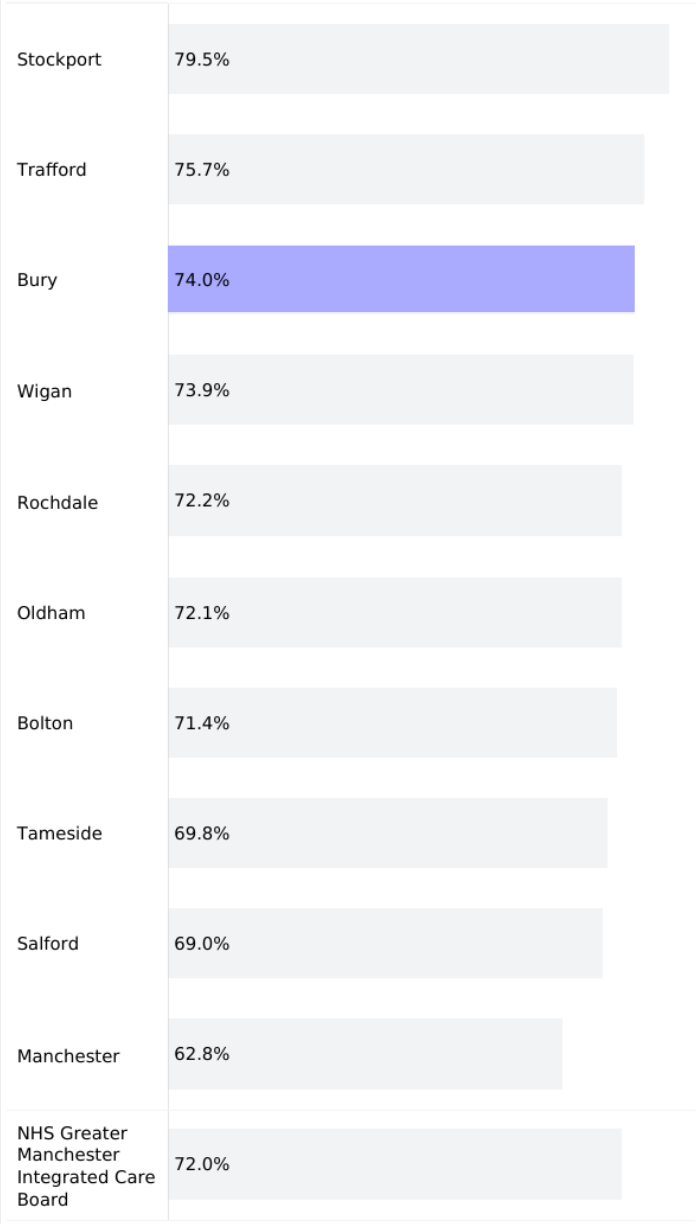


	Sep	Oct	Nov	Dec	Jan	Feb
2021-22	13.5%	48.8%	69.4%	75.0%	76.5%	76.4%
2022-23		58.5%	69.9%	72.8%	74.6%	75.1%
2023-24		68.1%	74.7%	76.6%	77.3%	77.5%
2024-25		61.2%	69.7%	72.3%	73.3%	73.6%
2025-26		60.5%	69.9%	73.4%	73.8%	74.0%

Selected measure at February 2026 has continuously increased for 4 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities



Narrative

No update in dashboard data from previous month. Outside of vaccine period.

Bury

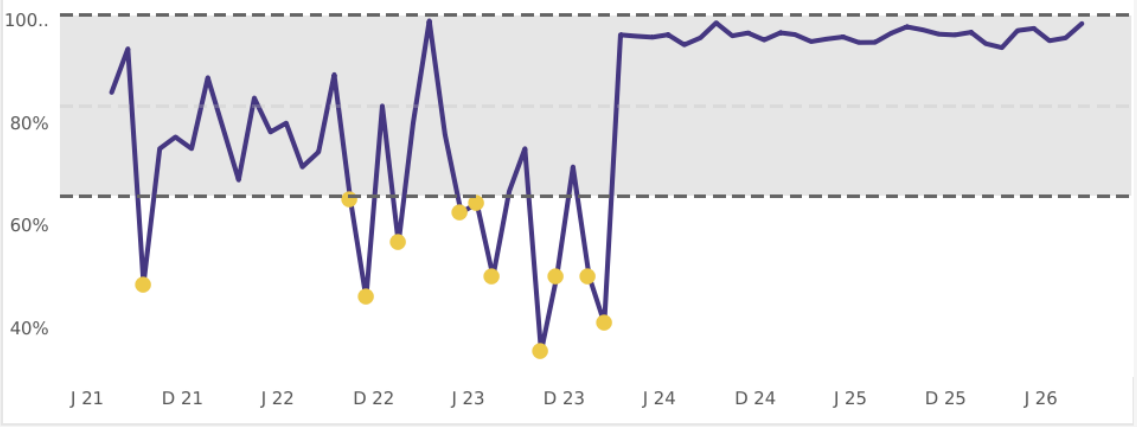
% 2-hour Urgent Community Response (UCR) first care contacts

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)

99.5%	96.7%	70%
September 2026	August 2026	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%	98.2%	97.4%	97.2%	97.8%	95.5%
2026-27	94.8%	98.1%	98.5%	96.1%	96.7%	99.5%						

Selected measure at September 2026 has continuously increased for 2 period(s) of time

Latest Value GM Benchmarking



Narrative

- Performance increased to 99.5% in September 2026, from 96.7% in August.
- Bury are currently ranked 1st in GM with performance currently above the GM average (92.4%)

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	Jun 26	2nd Thursday	National Target	Increase
Mental Health & Learning Disabilit. .	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	Aug 26	2nd Thursday	National Target	Decrease
	S081a	Talking Therapies: Access Rate	Number of people accessing first treatment	Improving Access to Psychological Therapies Data Set	Monthly	Aug 26	2nd Thursday	No Target	Increase
	EAS01	Dementia: Diagnosis Rate (Aged 65+)	Dementia: Diagnosis Rate (Aged 65+)	Primary Care Dementia Data	Monthly	Jun 26	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	Aug 26	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	Aug 26	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	Aug 26	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	Aug 26	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	Aug 26	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	Sep 26	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	Sep 26	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 26	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 26	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	Aug 26	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	Mar 26	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	Aug 26	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	Aug 26	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	Aug 26	National Target	1.%
	EB28x	Diagnostic 6ww: All	% of Patients waiting over 6 weeks for a diagnostic test or procedure	Monthly Diagnostics Waiting Times and Activity Return - DM01	Monthly	Aug 26	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	Aug 26	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 24	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 24	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	Feb 26	National Target	85.%
	OF00..	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	Jun 26	National Target	95.%
	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	Jun 26	National Target	95.%
	OF01..	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.%
	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.%
	OF01..	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 25	No Target	
	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 25	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	Sep 26	National Target	

Bury

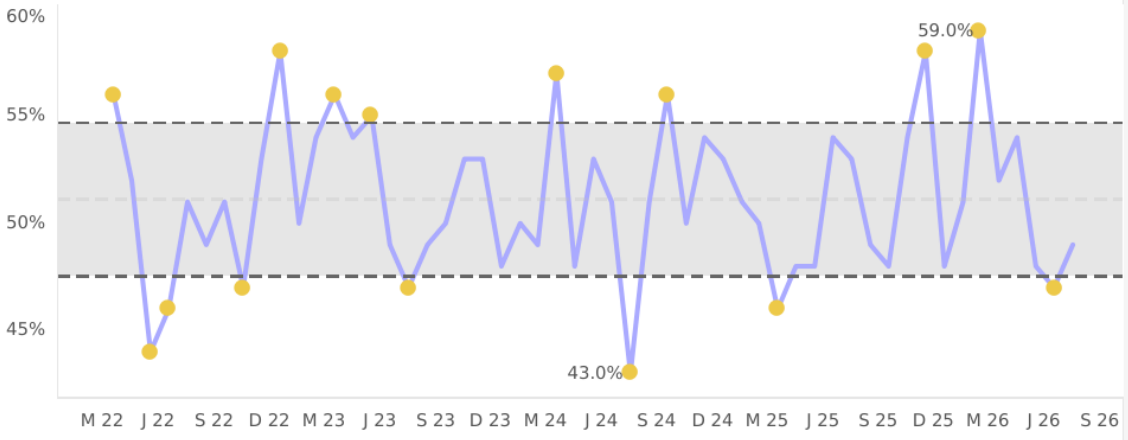
Talking Therapies: Recovery Rate

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

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

49.0%	47.0%	67/110	50.%
August 2026	July 2026	National Rank Inter Quartile	National Target

Outliers more than 1 standard deviation from the mean

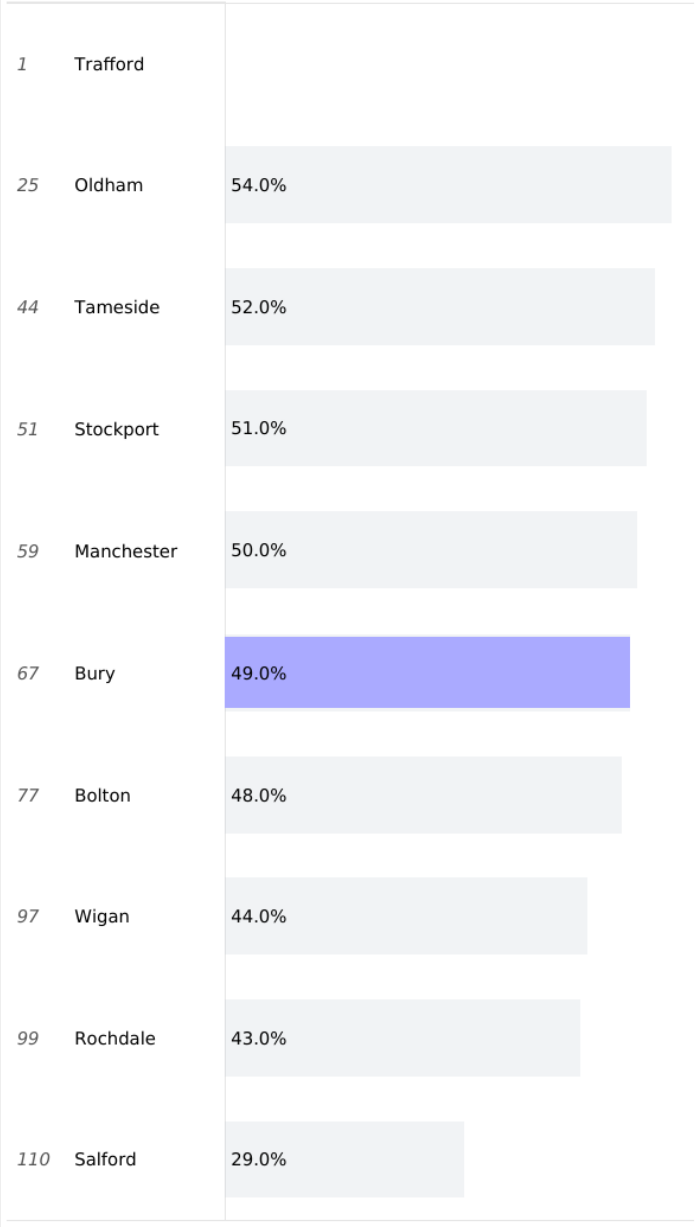


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	56.0%	52.0%	44.0%	46.0%	51.0%	49.0%	51.0%	47.0%	53.0%	58.0%	50.0%	54.0%
2023-24	56.0%	54.0%	55.0%	49.0%	47.0%	49.0%	50.0%	53.0%	53.0%	48.0%	50.0%	49.0%
2024-25	57.0%	48.0%	53.0%	51.0%	43.0%	51.0%	56.0%	50.0%	54.0%	53.0%	51.0%	50.0%
2025-26	46.0%	48.0%	48.0%	54.0%	53.0%	49.0%	48.0%	54.0%	58.0%	48.0%	51.0%	59.0%
2026-27	52.0%	54.0%	48.0%	47.0%	49.0%							

Selected measure at August 2026 has continuously increased for 1 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities



Narrative

- Bury Talking Therapies recovery rate is 49.0% in August, up from 47.0% in July but slightly below the 50% national target.
- Longer-term performance shows fluctuation between ~45%–60%, with no sustained upward trend.
- Recovery rates have consistently varied month-to-month, indicating instability in outcomes.
- Bury currently ranks 6th for performance across GM localities.

Bury

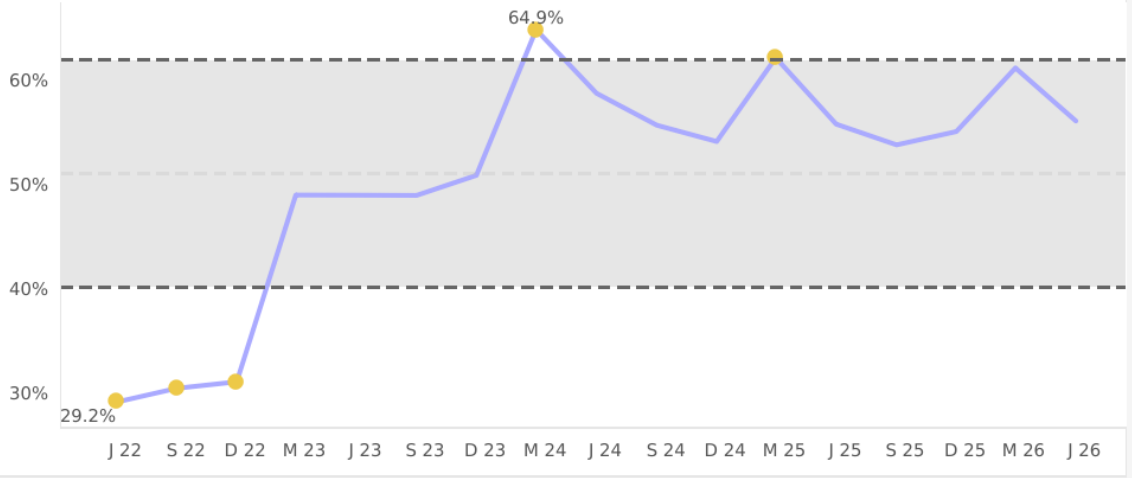
% of people with SMI to receive all six physical health checks in the preceding 12 months. - Mental Health Patients

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)

56.2%	61.3%	68/106	60.%
June 2026	March 2026	National Rank Inter 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%	55.2%	61.3%
2026-27	56.2%			

Selected measure at June 2026 has continuously decreased for 1 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities

14	Tameside	66.5%
15	Salford	65.8%
18	Trafford	65.4%
19	Stockport	65.4%
30	Rochdale	62.7%
35	Wigan	62.0%
37	Oldham	61.4%
55	Manchester	58.3%
57	Bolton	58.0%
68	Bury	56.2%
9	NHS Greater Manchester Integrated Care Board	61.5%

Narrative

- No updated figures for this indicator at this time.

Bury

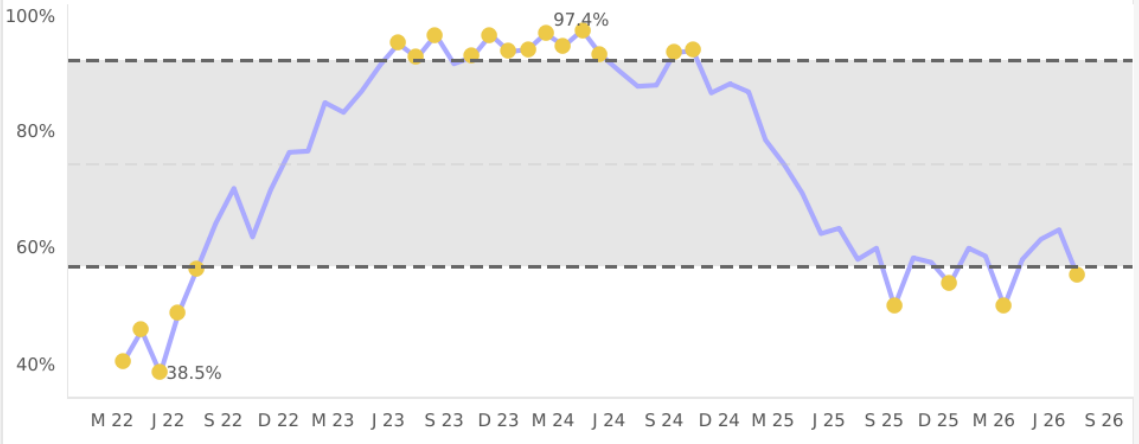
Talking Therapies: 6 Week Waits

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)

55.2%	63.2%	99/110	75.%
August 2026	July 2026	National Rank Lower Quartile	National Target

Outliers more than 1 standard deviation from the mean

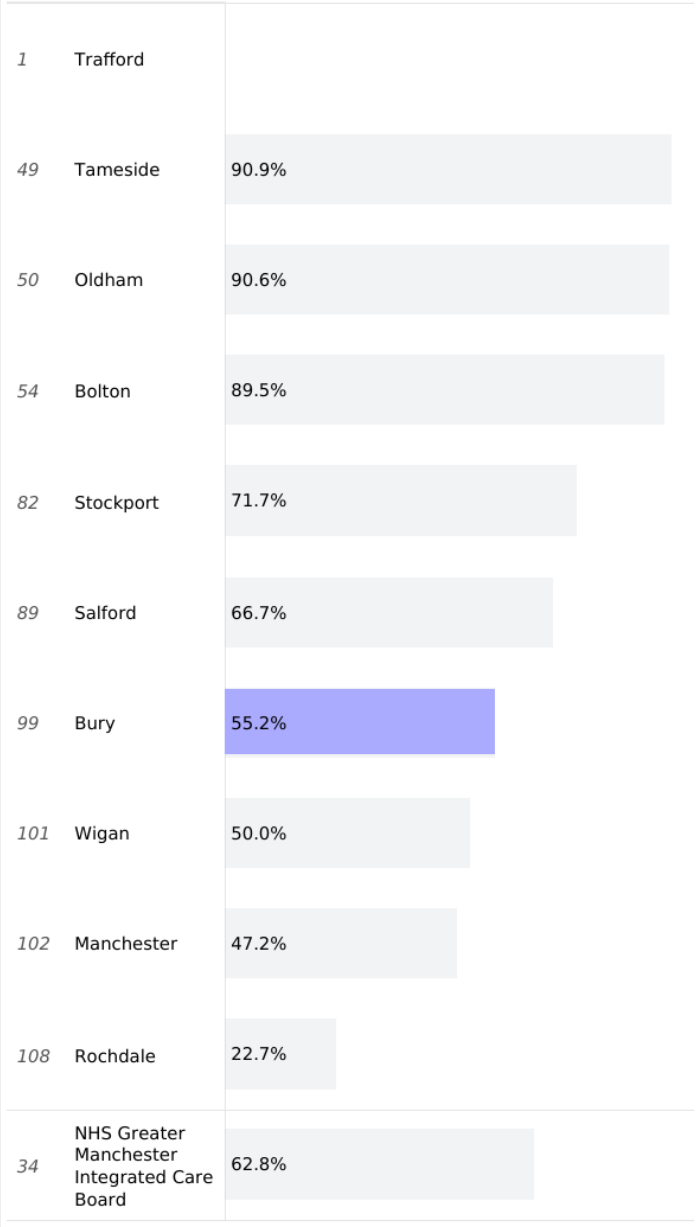


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	40.5%	45.8%	38.5%	48.7%	56.4%	64.3%	70.3%	61.9%	70.0%	76.5%	76.7%	85.0%
2023-24	83.3%	87.0%	91.5%	95.1%	92.7%	96.7%	91.7%	92.9%	96.7%	93.8%	94.1%	96.9%
2024-25	94.7%	97.4%	93.2%	90.5%	87.8%	88.0%	93.5%	93.9%	86.7%	88.2%	86.8%	78.6%
2025-26	74.4%	69.4%	62.5%	63.4%	58.1%	60.0%	50.0%	58.3%	57.6%	53.8%	60.0%	58.6%
2026-27	50.0%	58.1%	61.5%	63.2%	55.2%							

Selected measure at August 2026 has continuously decreased for 1 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities



Narrative

- Talking Therapies 6-week waits in Bury have decreased to 55.2% for August from 63.2% in July
- Performance remains well below the 75% national target
- Over the past 12 months, performance has stabilised at a lower level (~50–60%), with limited recovery
- Bury continues to perform significantly below the GM average (62.8%) and ranks 7th amongst GM localities.

Bury

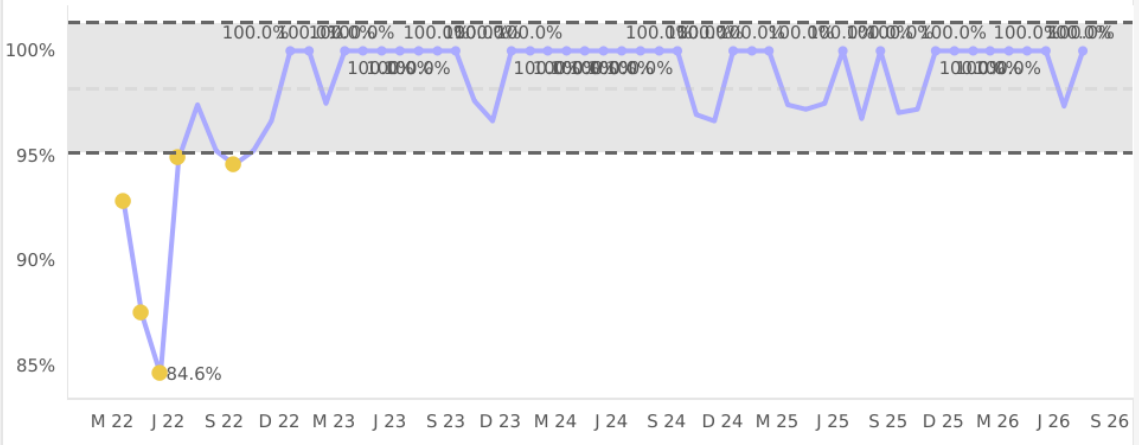
Talking Therapies: 18 Week Waits

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)

100.0%	97.4%	4/110	95.%
August 2026	July 2026	National Rank Inter Quartile	National Target

Outliers more than 1 standard deviation from the mean

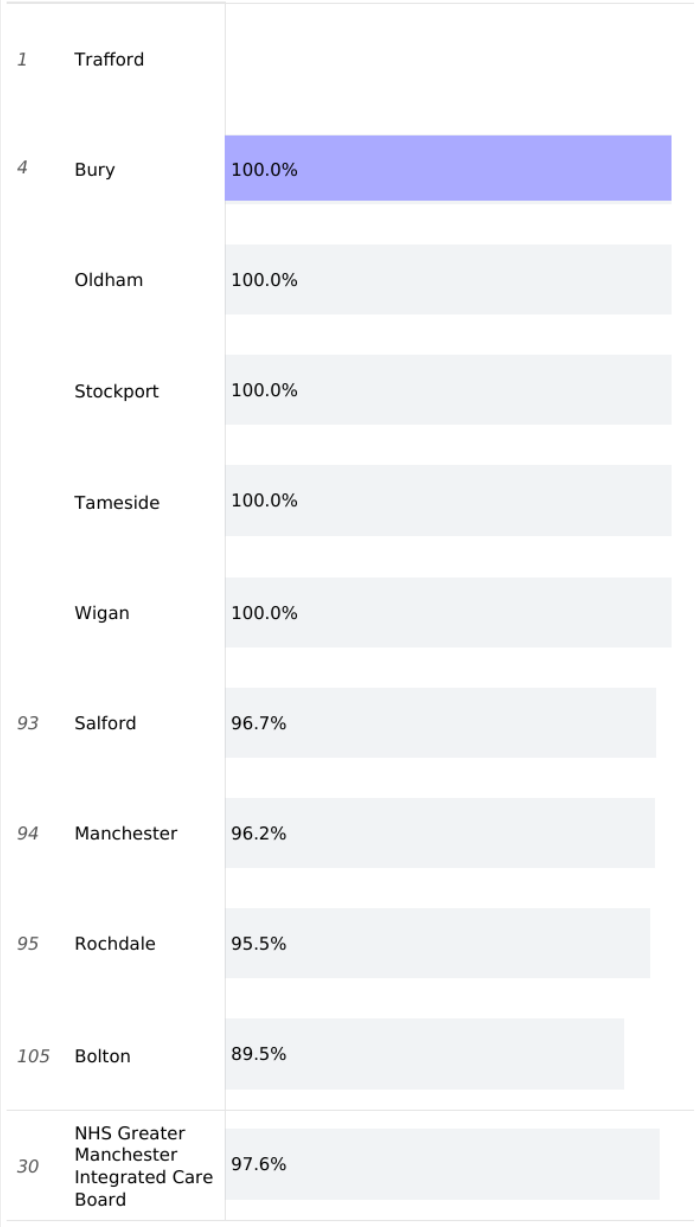


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	92.9%	87.5%	84.6%	94.9%	97.4%	95.2%	94.6%	95.2%	96.7%	100.0%	100.0%	97.5%
2023-24	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.6%	96.7%	100.0%	100.0%	100.0%
2024-25	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.0%	96.7%	100.0%	100.0%	100.0%
2025-26	97.4%	97.2%	97.5%	100.0%	96.8%	100.0%	97.1%	97.2%	100.0%	100.0%	100.0%	100.0%
2026-27	100.0%	100.0%	100.0%	97.4%	100.0%							

Selected measure at August 2026 has continuously increased for 1 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities



Narrative

- Talking Therapies 18-week waits in Bury was 100% in August, sustaining full compliance with the 95% national target.
- Performance has been consistently at or near 100% since 2023, demonstrating sustained high delivery and stability.
- Over recent months, performance has remained stable with minimal variation, indicating robust pathway management.
- Bury continues to perform above the GM average (97.6%) and ranked joint 1st among GM localities.

Bury

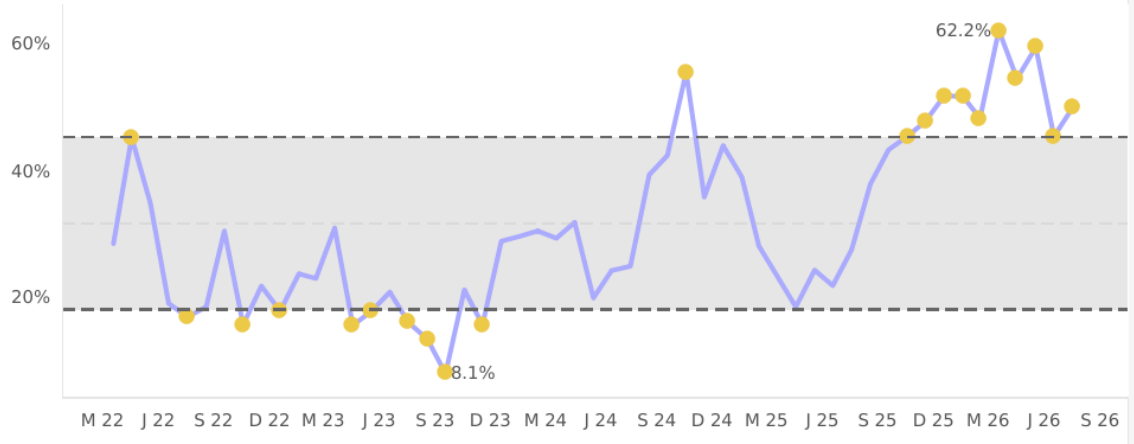
Talking Therapies: Second Treatment Waits

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)

50.0%	45.5%	88/101	10.%
August 2026	July 2026	National Rank Lower Quartile	National Target

Outliers more than 1 standard deviation from the mean

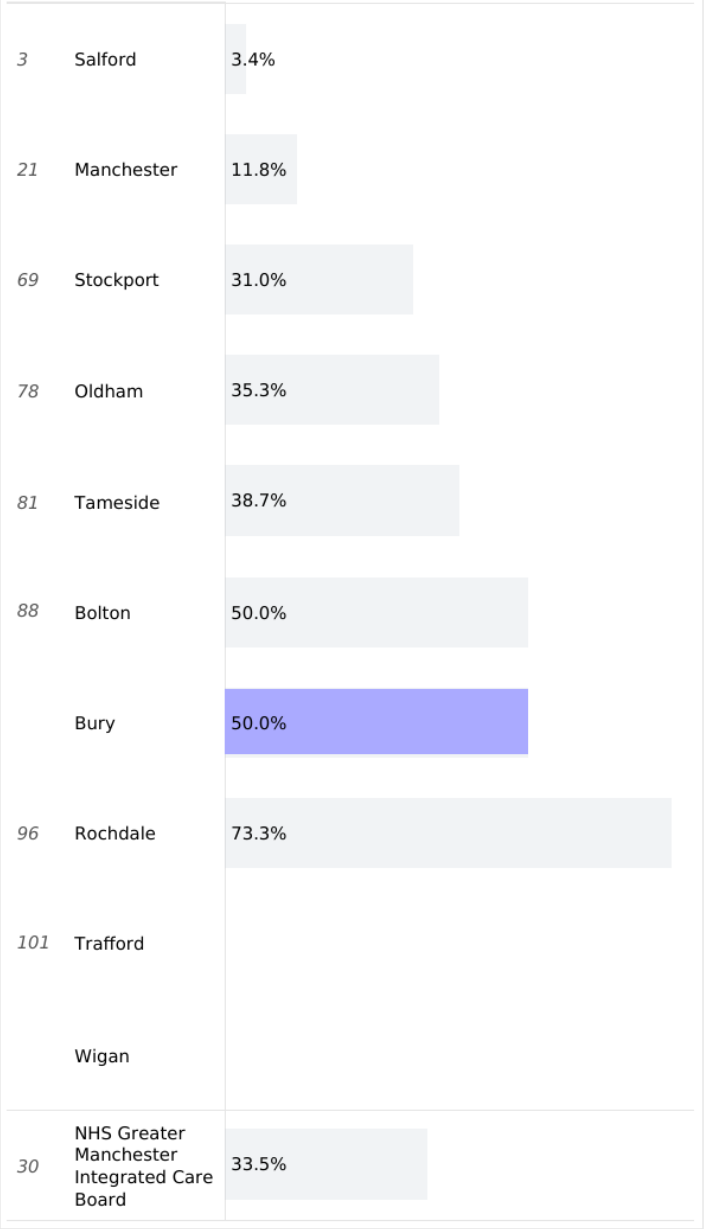


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	28.6%	45.3%	34.9%	19.1%	17.0%	18.6%	30.6%	15.8%	21.9%	17.9%	23.8%	23.1%
2023-24	31.0%	15.7%	17.9%	20.9%	16.1%	13.5%	8.1%	21.3%	15.8%	28.9%	29.7%	30.6%
2024-25	29.4%	31.9%	20.0%	24.3%	25.0%	39.4%	42.4%	55.6%	35.9%	44.0%	39.0%	28.2%
2025-26	23.3%	18.6%	24.4%	22.0%	27.6%	37.9%	43.3%	45.5%	47.8%	51.9%	51.7%	48.3%
2026-27	62.2%	54.5%	59.5%	45.5%	50.0%							

Selected measure at August 2026 has continuously increased for 1 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities



Narrative

- Talking Therapies second treatment waits in Bury have increased to 50.0% in August from 45.5% in July.
- Performance remains substantially above the 10% national target (higher is worse)
- Trend shows clear deterioration over the past 18 months, rising from around 15–25% during 2023/24 to consistently 40–60% in 2025/26
- Bury remains above the GM average (33.5%) and ranked 7th in GM localities, indicating sustained systemic pressure in second treatment access.

Bury

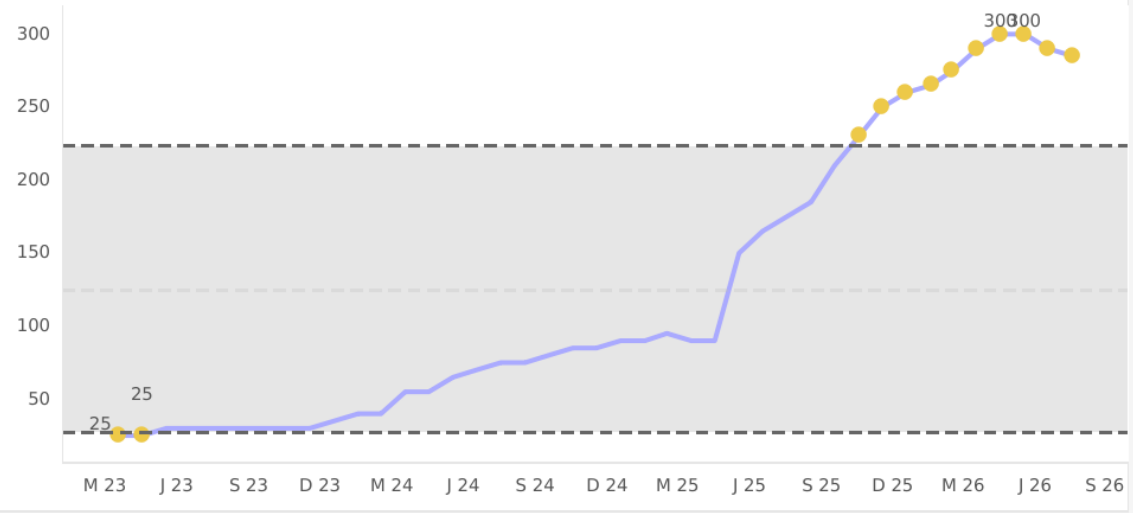
Access to Individual Placement and Support Services - Mental Health Patients

Access to Individual Placement and Support Services

Source: Published MHSDS (Monthly)

285	290	57/106	315.0
August 2026	July 2026	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	185	210	230	250	260	265	275
2026-27	290	300	300	290	285							

Selected measure at August 2026 has continuously decreased for 2 period(s) of time

Latest Value GM Benchmarking

Rate Per 1000 | Count (National Rank)

Salford	2.10	665 (21)
Tameside	1.78	400 (45)
Rochdale	1.59	395 (46)
Stockport	1.51	495 (34)
Wigan	1.45	505 (33)
Oldham	1.40	375 (49)
Trafford	1.39	345 (51)
Bury	1.35	285 (57)
Manchester	1.27	930 (16)
Bolton	1.18	390 (47)

Narrative

Bury – Access to IPS (Employment Support)

- Activity slightly decreased from July (290) to August (285)
- Benchmarking shows Bury's rate (1.35 per 1,000) ranks 8th in GM.

Bury

Percentage of CYP receiving Autism assessment within 18 weeks of referral

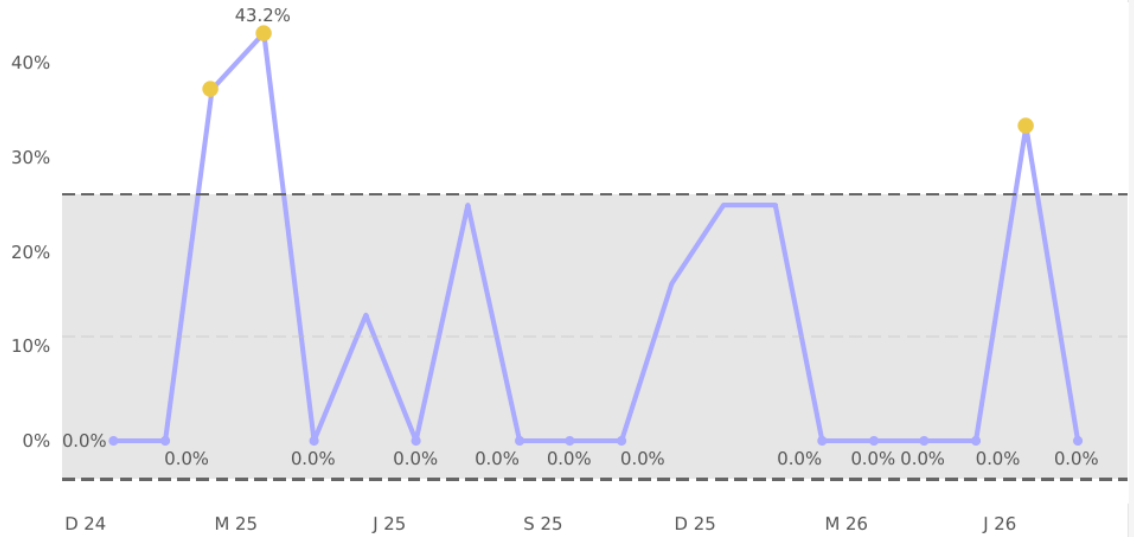
Percentage of CYP receiving Autism assessment within 18 weeks of referral

Source: Local Autism_ADHD Submission (Monthly)

0.0%
August 2026

33.3%
June 2026

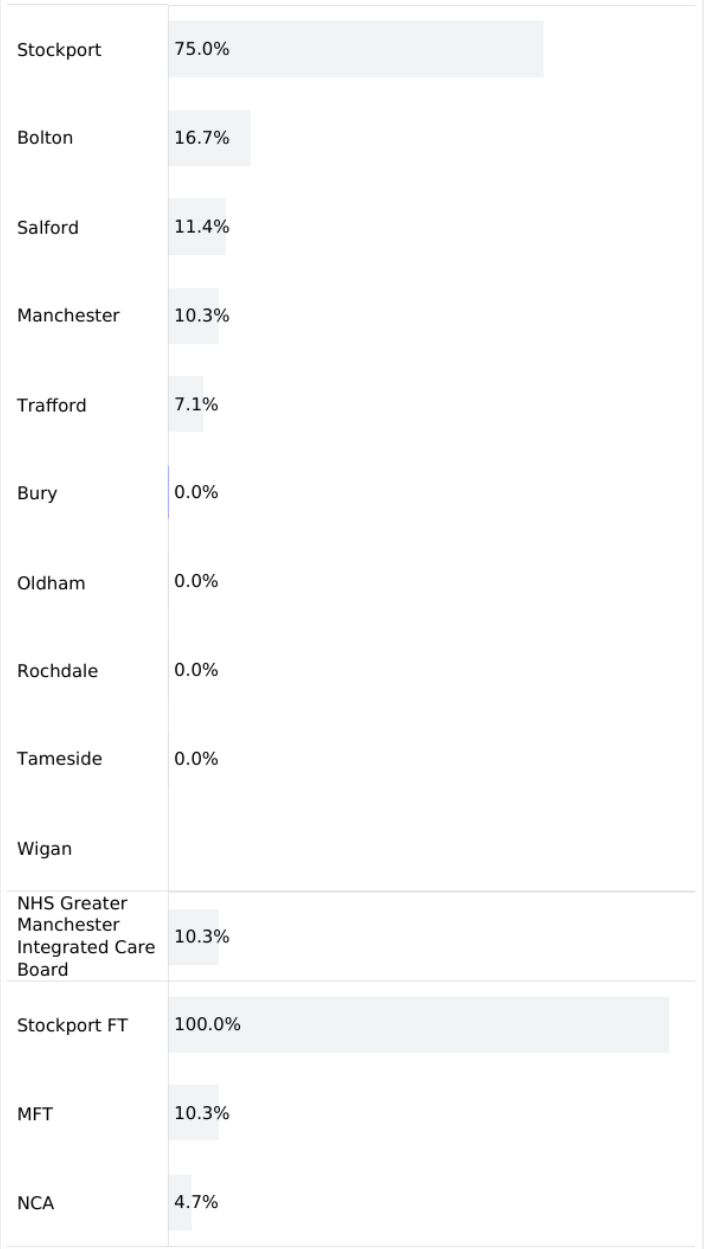
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	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%	16.7%	25.0%	25.0%	0.0%
2026-27	0.0%	0.0%	0.0%	33.3%	0.0%							

Selected measure at August 2026 has continuously **decreased** for **1** period(s) of time

Latest Value GM Benchmarking



Narrative

Bury – CYP Autism Assessment within 18 Weeks

- Performance has decreased from 33.3% in June to 0% in August.
- Performance continues to be highly volatile, with multiple months at 0% over the past year and intermittent short-lived improvements.
- Bury's current performance ranks joint 10th in GM, however future months may indicate if this is sustained.
- Data should be interpreted with caution due to known methodology differences between national and local reporting, with further work underway to address this.

Bury

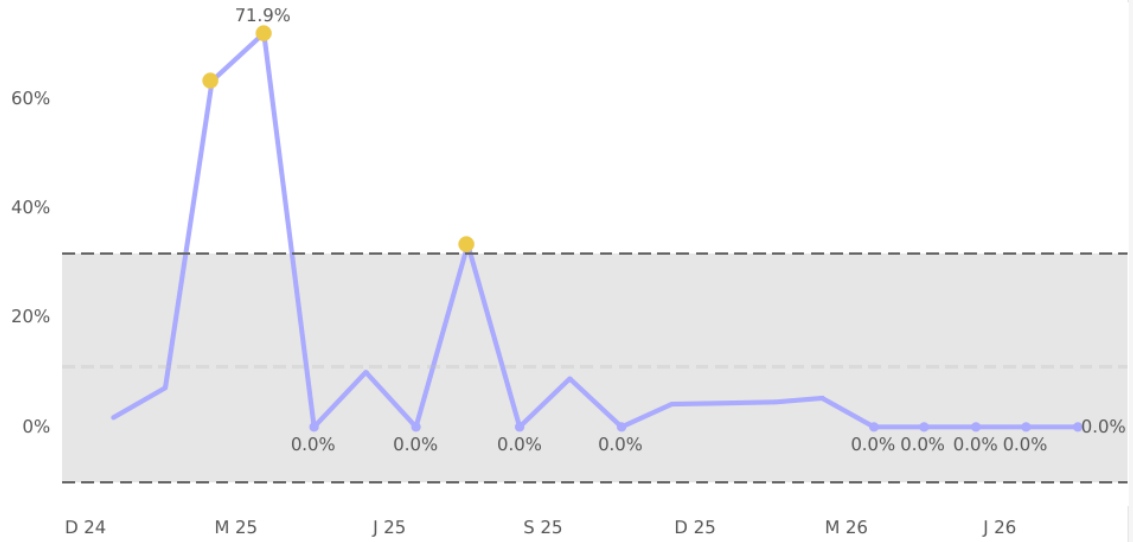
Percentage of CYP receiving ADHD assessment within 18 weeks of referral
Percentage of CYP receiving ADHD assessment within 18 weeks of referral

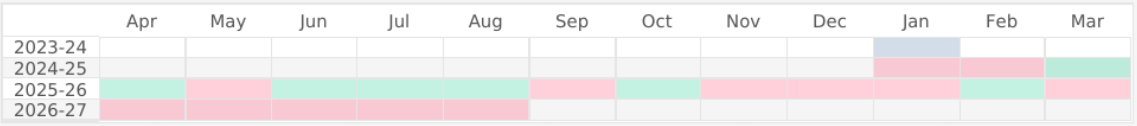
Source: Local Autism_ADHD Submission (Monthly)

0.0%
August 2026

0.0%
June 2026

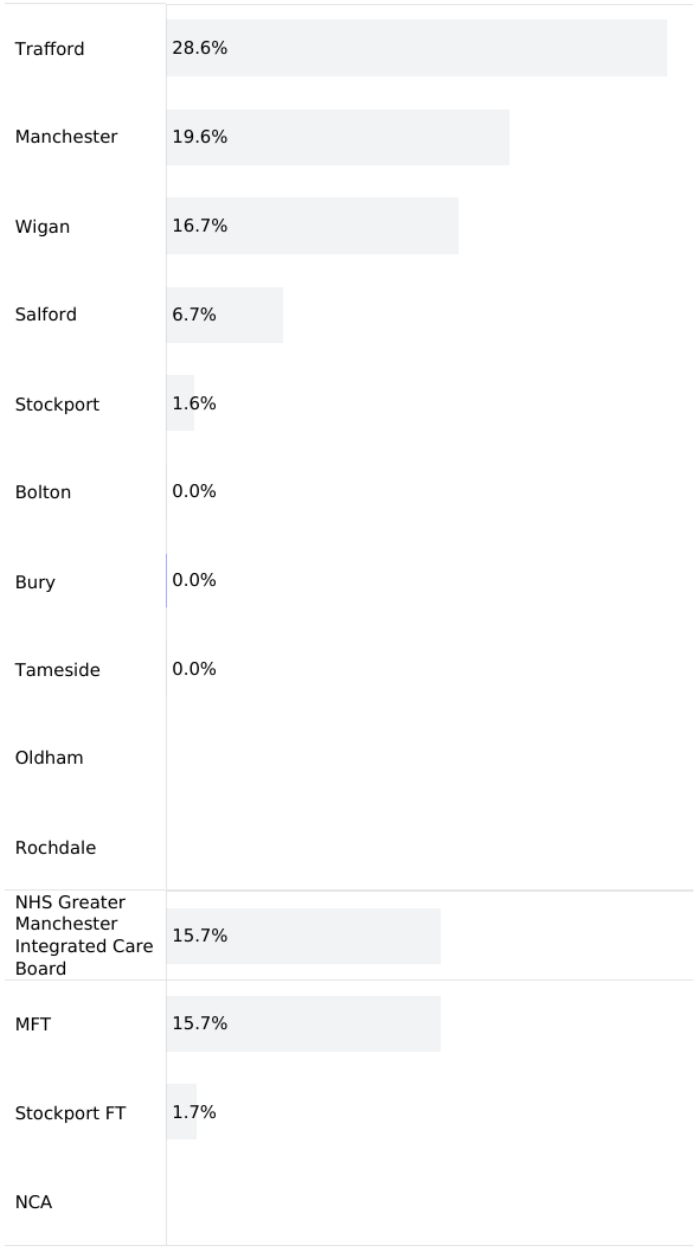
Outliers more than 1 standard deviation from the mean





Selected measure at August 2026 has continuously for 4 period(s) of time

Latest Value GM Benchmarking



Narrative

Bury – CYP ADHD Assessment within 18 Weeks.

- Performance remains at 0.0% since April 2026, indicating no patients seen within the 18-week standard.
- Delivery remains consistently very low and highly variable, with multiple months at or near 0% over the past year.
- Trend shows no sustained improvement, with only sporadic short-term increases followed by deterioration.
- Bury remains well below the GM average (15.7%) and continues to sit among the lowest-performing localities.
- Overall performance indicates significant and ongoing capacity challenges within the assessment pathway.

Bury

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

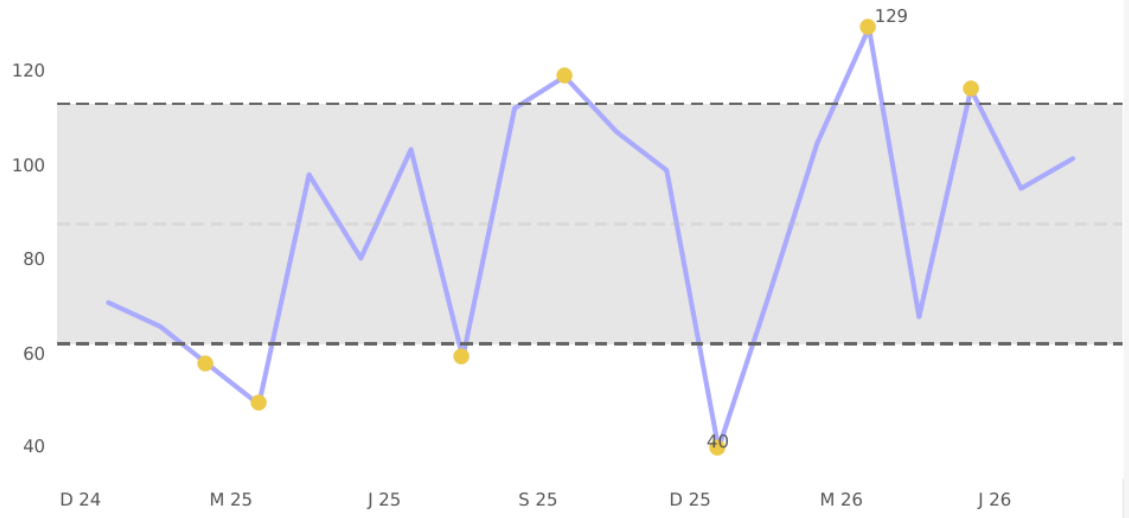
Autism average wait in weeks from referral to first assessment

Source: Local Autism_ADHD Submission (Monthly)

101
August 2026

95
June 2026

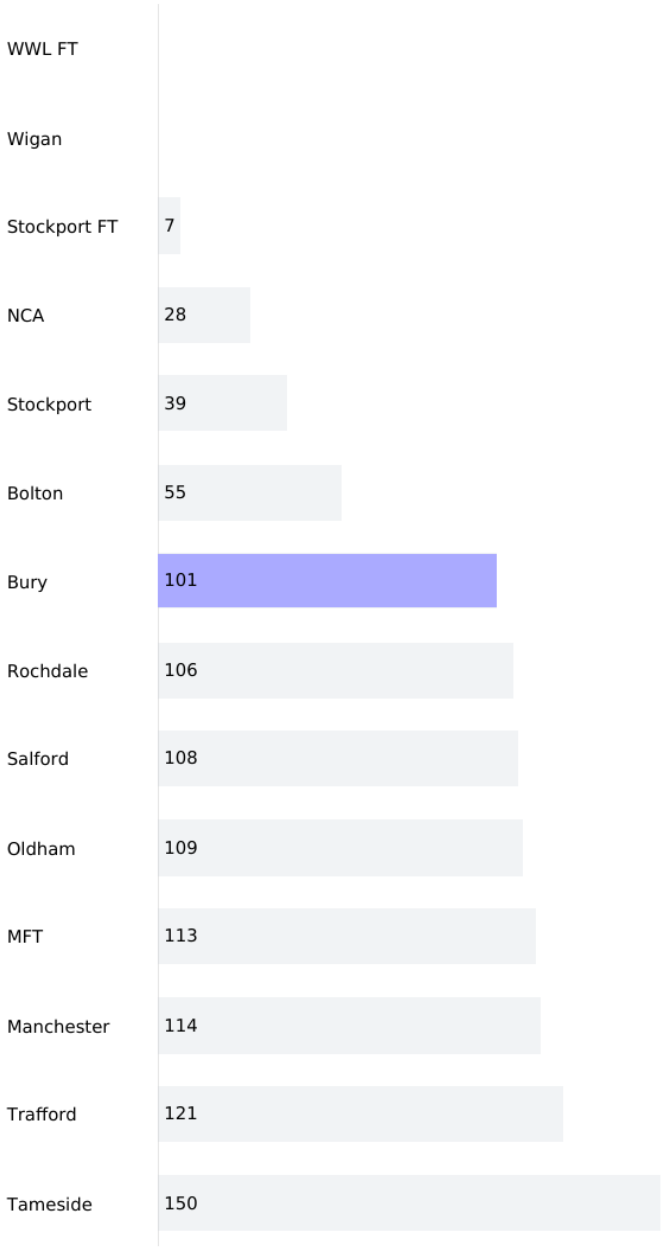
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023-24												
2024-25										71	66	58
2025-26	49	98	80	103	59	112	119	107	99	40	73	105
2026-27	129	68	116	95	101							

Selected measure at August 2026 has continuously **increased** for **1** period(s) of time

Latest Value GM Benchmarking



Narrative

Average wait has increased slightly from 95 in June to 101 in August.

Please note indicator above graph incorrectly displays 95 as the figure for June 2026.

Bury

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

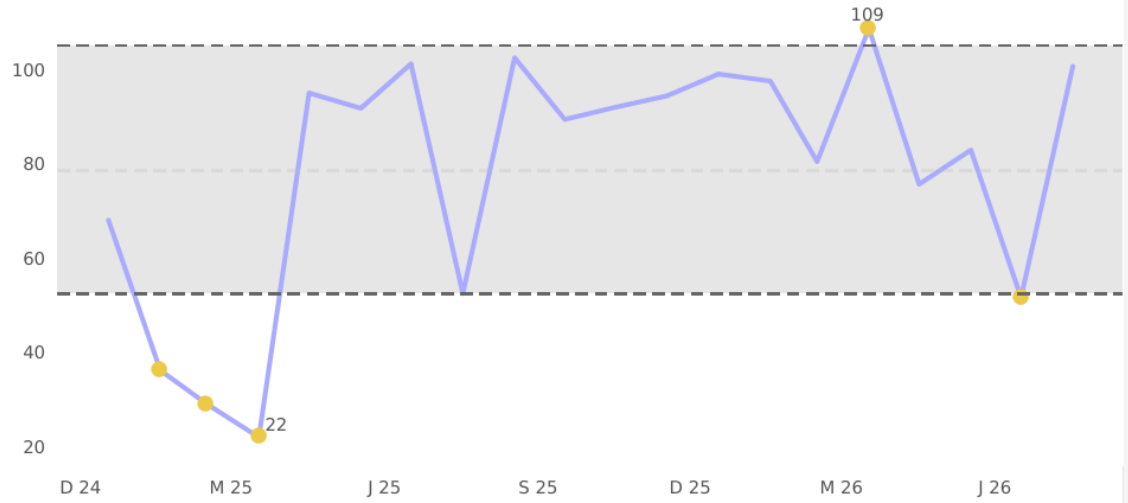
ADHD average wait in weeks from referral to first assessment

Source: Local Autism_ADHD Submission (Monthly)

101
August 2026

52
June 2026

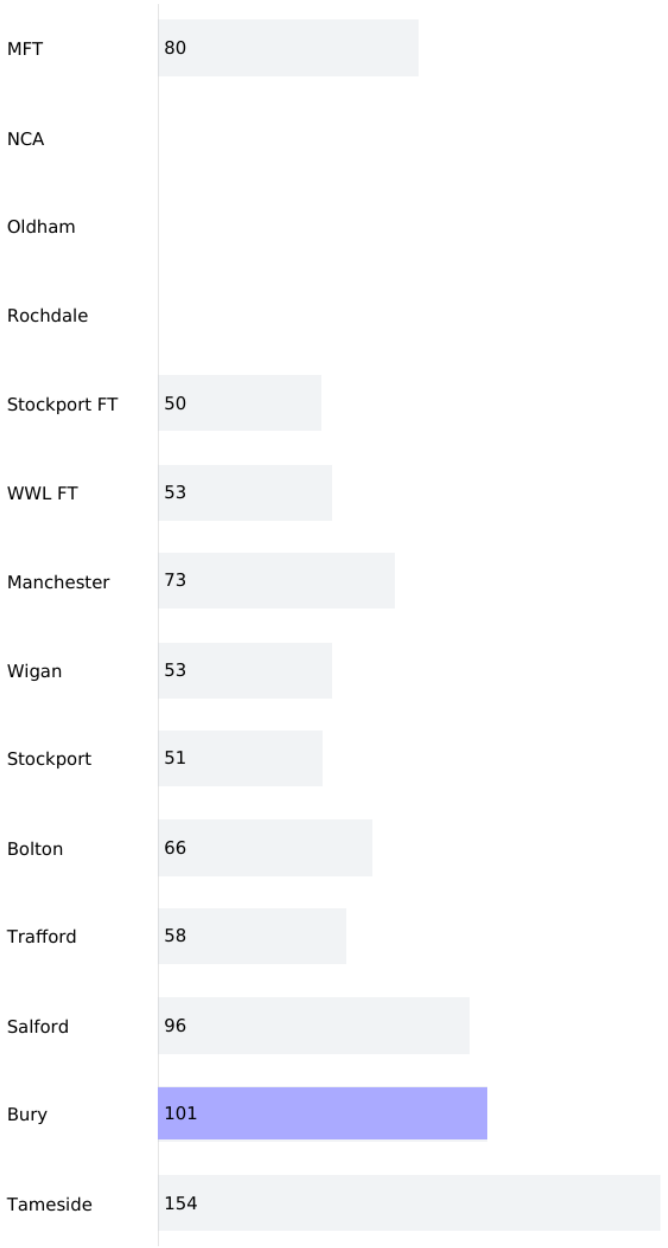
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023-24												
2024-25										68	37	29
2025-26	22	95	92	102	53	103	90	92	95	99	98	81
2026-27	109	76	83	52	101							

Selected measure at August 2026 has continuously increased for 1 period(s) of time

Latest Value GM Benchmarking



Narrative

- Bury – ADHD Average Wait (Referral to First Assessment)
- Average wait has increased from 52 weeks in June to 101 weeks in August.
- Bury sits towards the higher end across GM, with longer waits than most localities.
- Note: Figures may differ locally due to methodology differences; a review paper is in development

Bury

% of CHC referrals completed within 28 days

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

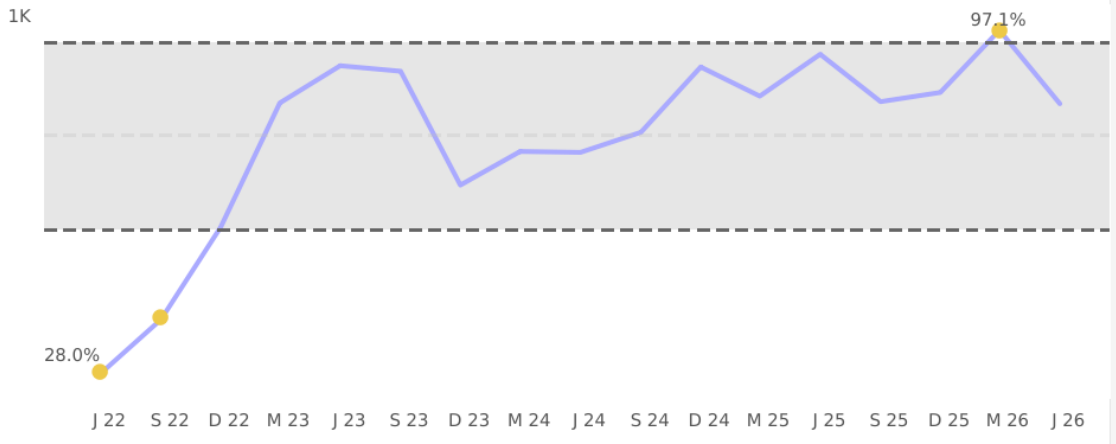
Source: Continuing Healthcare and NHS-funded Nursing Care quarterly published figures (Quarterly)

82.4%
June 2026

97.1%
March 2026

38/106
National Rank
Inter Quartile

Outliers more than 1 standard deviation from the mean

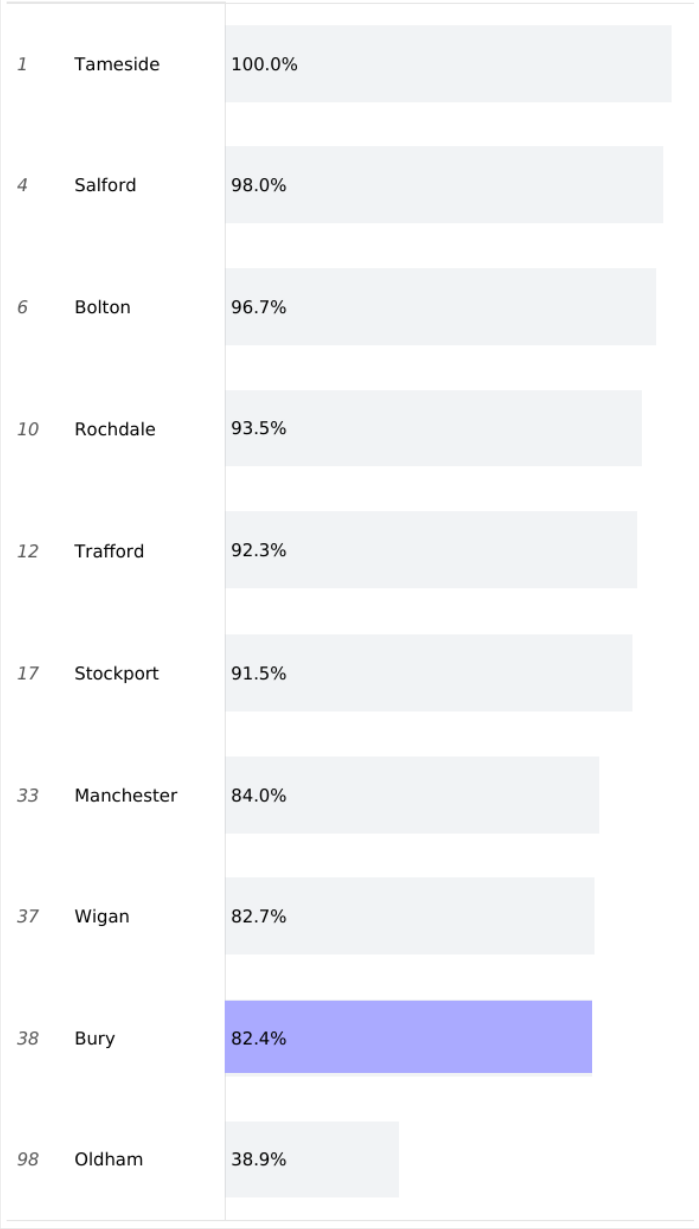


	Jun	Sep	Dec	Mar
2022-23	28.0%	38.9%	57.5%	82.5%
2023-24	90.0%	88.9%	66.0%	72.7%
2024-25	72.5%	76.6%	89.7%	83.9%
2025-26	92.3%	82.8%	84.6%	97.1%
2026-27	82.4%			

Selected measure at June 2026 has continuously decreased for 1 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities



Narrative

No updated figures available for this measure.

Bury

Number of prescriptions dispensed per 1000 patients
Number of prescriptions dispensed per 1000 patients

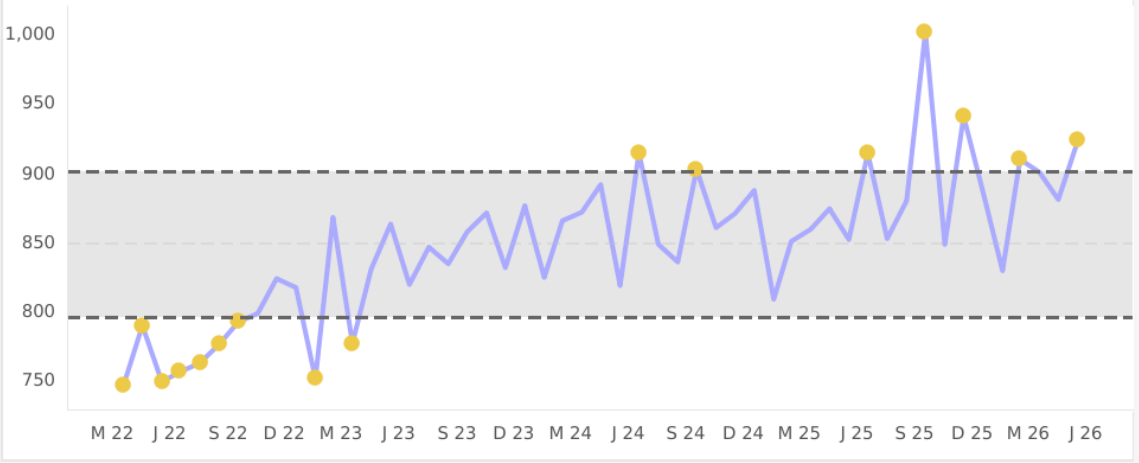
Source: Patient Level Prescribing Data (Monthly)

923.5
June 2026

881.1
April 2026

110/117
National Rank
Lower Quartile

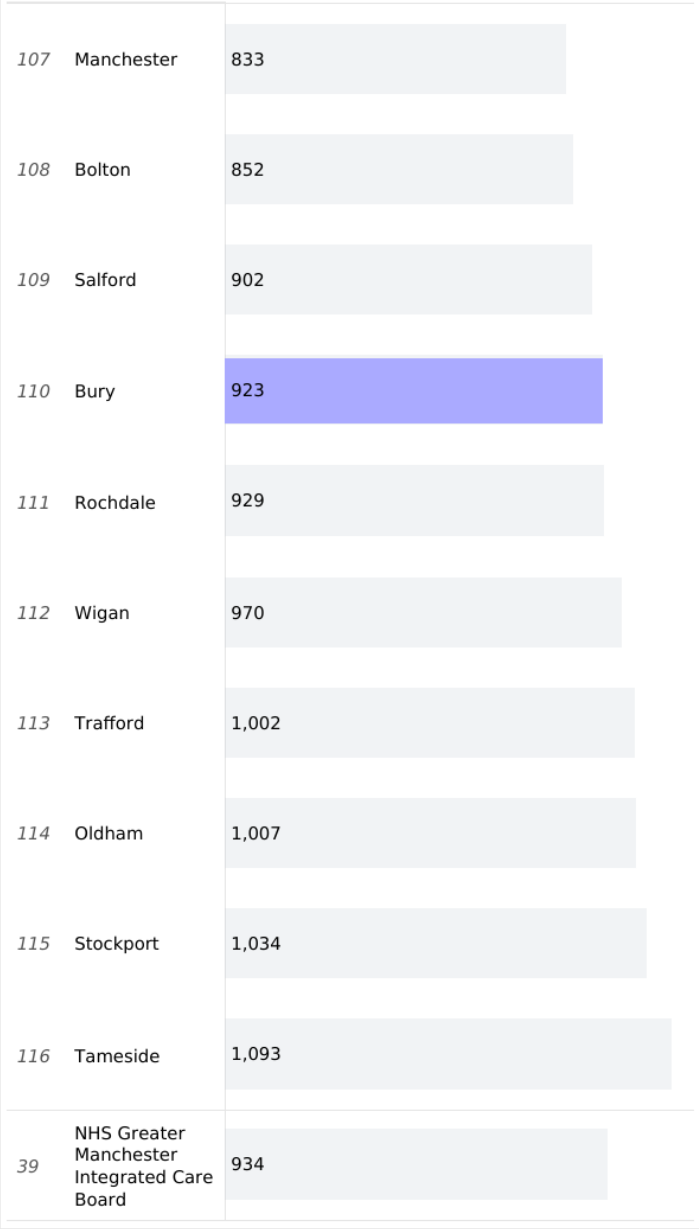
Outliers more than 1 standard deviation from the mean



	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	914.7	852.8	880.2	1,002.6	848.6	941.3	886.4	829.6	910.2
2026-27	900.8	881.1	923.5									

Selected measure at June 2026 has continuously increased for 1 period(s) of time

Latest Value GM Benchmarking
National Rank against other localities



Narrative

Number of prescriptions dispensed has increased from 881.1 in April to 923.5 in June.

Bury's performance is slightly above the GM average and currently 4th in GM.

Bury

Percentage of Care Homes rated Good or Outstanding

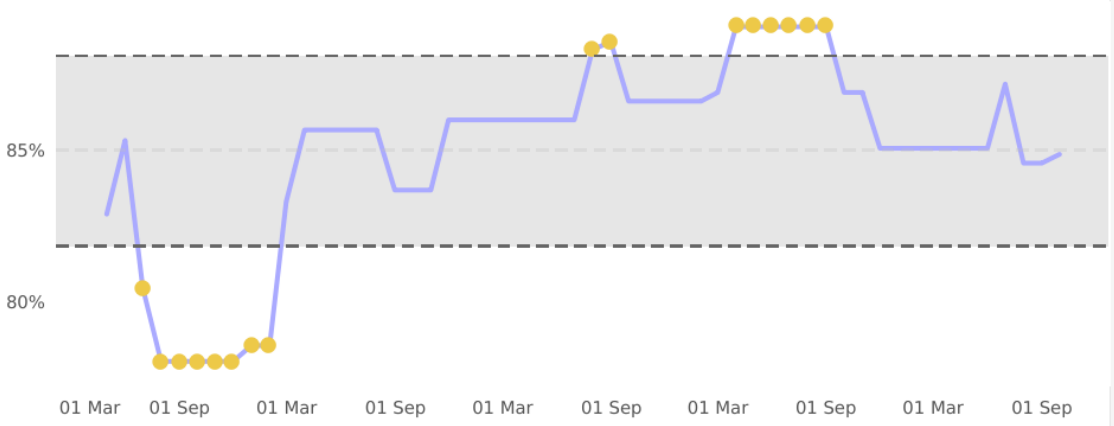
The % of Care Homes rated Good or Outstanding at the end of the period

Source: CQC (Monthly)

84.9%
Sep 26

84.6%
Aug 26

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												
2026-27												

Latest Value GM Benchmarking

Rank against other localities

1	Wigan	92.6%
2	Trafford	85.7%
3	Bury	84.9%
4	Bolton	83.3%
	Oldham	83.3%
6	Manchester	81.9%
7	Salford	80.0%
8	Tameside	73.5%
9	Stockport	72.1%
10	Rochdale	64.2%

Narrative

- Bury – Care Homes Rated Good or Outstanding Performance has increased very slightly to 84.9% in September.
- Bury ranks 3rd across GM.
- Note: issue with tabular view raised with BI.