NHS Greater Manchester Integrated Care

Agenda

Trafford Locality Board Meeting

Date: Tuesday, 15 July 2025

Time: 1.00 pm

Venue: Meeting Room 9, TTH and via MS Teams

Item No.	Time	Duration	Subject	Paper/ Verbal	For Approval/ Discussion/ Information/ Assurance	By Whom
1	1.00	5 mins	**Apologies for Absence**		Info	Chair
2			**Declarations of Interest**		Info	Chair
3			**Minutes of the Meeting Held on 17 June 2025**	1 - 10	Approval	Chair
4			**Action Log & Matters Arising**	11 - 12	Discuss	Chair
5			**Forward Plan**	13 - 14	Info	Chair
6	1.05	5 mins	**Public Questions**	15 - 16	Discuss	Chair
7	1.10	10 mins	**NHS Reform**	17 - 26	Info	GJ
7a			10 year plan	27 - 32	Info	GJ
Finance, Performance & Sustainability						
8	1.20	10 mins	**NHS GM Trafford Finance report**	33 - 42	Assurance/ Info	JF
9	1.30	10 mins	**Trafford Performance and Locality Scorecard**	43 - 92	Assurance/ Discuss/Info	TM
Trafford Provider Collaborative Board						

10	1.40	10 mins	**TPCB Priorities 25-26**	93 - 104	Approval	MK
11	1.50	10 mins	**Strategic Risk Register**	105 - 112	Assurance/ Info	TM
12	2.00	15 mins	**ND Pathways: New Model Of Care Plan**	113 - 128	Approval/ Info	SA
Partner Updates						
13	2.15	5 mins	**Healthwatch Trafford Performance Report**	129 - 138	Info	HF
14	2.20	10 mins	**Development of a prevention framework for the Trafford system**	139 - 154	Info	HG
15			**Any Other Urgent Business**			

Minutes

Trafford Locality Board (TLB)

Date: Tuesday, 17 June 2025

Time: 1.00 pm

Venue: Meeting Room 9, TTH and via MS Teams

Present	Apologies
Jane Wareing (JW) GP Board Representative and Co-Chair Tom Ross (TR) Leader of Council and Co-Chair Elizabeth Calder (EC) GMMH Gareth James (GJ) Deputy Place Lead for Health & Care Integration, NHS Greater Manchester Integrated Care Heather Fairfield (HF) Healthwatch Helen Golllins (HG)Director of Public Health, Trafford Council Darren Banks (DB) Group Director of Strategy, MFT Charlotte Bailey (CB) Chief People Officer NHGM Adam Hebden (AH) as substitute for Tom Rafferty Maggie Kufeldt (MK) Corporate Director of Adults & Wellbeing Bernadette Ashcroft (BA), VCFSE Representative Zahid Ahmed (ZA) GP Board Representative Charlotte Bailey (CB) NHS GM In attendance: Tom Rafferty (TR) MFT Ian Lurcock (IL) TLCO Manish Prasad (MP) Associate Medical Director Cllr Jane Slater (JS) Cllr Karina Carter (KC) Thomas Maloney (TM) Programme Director Health and Care Sarah Owen (SO) Associate Director of Nursing & Quality Julie Flanagan (JF) Finance Lead Jill McGregor (JM) Corporate Director of Children's Services Pippa Dewhirst (PD) Governance Team Leader	Sara Todd (ST) Trafford Place Lead for Health & Care Integration

Item No.	Topic	Action
1	**APOLOGIES FOR ABSENCE** Apologies for absence were received from Sara Todd.	
2	**DECLARATIONS OF INTEREST** There were no declarations of interest received.	
3	**MINUTES OF THE MEETING HELD ON 20 MAY 2025** RESOLVED: the minutes of the meeting held on 20 May 2025 were approved as an accurate record.	
4	**ACTION LOG & MATTERS ARISING** The action log was reviewed, and members took the opportunity to provide updates on outstanding actions. No 116 – Long Length of Stay – GJ confirmed a deep dive had taken place with provider colleagues and had been reviewed at the all age Mental health group. The area remained a key line of enquiry at Trafford Locality Assurance meeting. GJ noted performance was improving and there were zero out of area placements last month. 123 – ADHD – GJ noted ADHD consultation was on-going and there were various opportunities to engage including activities at Limelight. 140 – S75 – GJ advised the S75 agreement had been signed, and the action could be closed. 117 – Locality plan refresh – TM noted the work had been delayed due to capacity within the PMO team and hoped to bring back easy to read products by July meeting. 127 – Approach to live well – TM noted the self-assessment of current neighbourhood model against core aspects of GM live well had been completed and reviewed at TPCB and would be reviewed at the steering group meeting. 141 -Risk – TM noted risk register would be brought to the meeting in July. RESOLVED: the action log was reviewed and updated.	
5	**FORWARD PLAN** The forward plan was reviewed. RESOLVED: the forward plan was noted for information.	
6	**PUBLIC QUESTIONS** No questions were received from members of the public.	

7	**NHS REFORMS** TLB were provided with a short narrative on the NHS GM approach to reform in Greater Manchester. GJ provided a verbal update as per the report noting that all ICB's had to submit a planned operating model and structure to meet the £18.76 per head cost envelope for strategic commissioning and oversight. GJ noted the fast pace of the reforms and the timelines for the various phases with the new structure expected to be delivered by March 2026. GJ advised GM were still awaiting the national position with regards to voluntary redundancy (VR) and hence the vacancy freeze continued. GJ confirmed the expectation to use June and July to co-design the model with partners and staff with the expectation there would be a HR process to implement the structure in early Autumn. GJ noted the model would link to the Mayoral Authority, NHS providers and to the 10 Local Authorities in GM and four key areas would be: • Live well; • Integrated Neighbourhood Health; • Population Health Management; and • Demand Management. GJ hoped to gain more clarity into what the model would look like, what localities would be responsible for and have a more detailed understanding of what the finance and structure could look like in the coming weeks and would update the Board of any progress. GJ offered CB the opportunity to add any further detail to the update and CB noted the Health Service Journal article related to VR scheme and what had been promised nationally, the report suggested there was no funding for VR and CB advised if that was the position it was yet to confirmed locally. HG queried if with regards to the potential VR scheme there had been any consideration about retaining skills. CB advised there was a retention hub to support staff and any decisions would have to go through a robust process at GM level to ensure the ICB could continue as a statutory organisation. GJ advised the final scheme had yet to be agreed and would be shared with the Board when it became available. HF asked if there would be a possibility to change the name of local organisations to place based partnerships as would represent what they aimed to be. GJ noted it would be a good opportunity to build into the new design. MK queried at what point would there be discussions with Local Authorities to ensure any designs fit with local systems, GJ understood localities were being involved with the design groups and partners would be engaged in July. GJ was thanked for the update. RESOLVED: the NHS reforms update was noted.	ACTION
8	**NHS GM TRAFFORD FINANCE REPORT** JF presented the financial position for the ICS overall and the locality delegated budgets by NHS GM for April 2025. JF advised as this was the first reporting month of the financial year, a high-level expenditure position was presented without a forecast. JF highlighted key points to note were:	

	• The ICS had submitted a breakeven plan to NHSE for 2025/26, which included the receipt of deficit support funding of £200m. • The plan was phased for a deficit monthly plan in the earlier months of the year and a surplus plan in the latter months • As at Month 1 the ICS deficit plan was £19.5m, with an actual deficit of £21.4m, • which equated to a £1.8m adverse variance to plan. • The in-month deficit was mainly driven by provide pay pressures and under delivery of savings. • The locality budgets were breakeven overall but continued to show increasing costs in ADHD right to choose. • Efficiency savings were £3m off plan at an ICS level in April. Total savings of £656m required this year. JF confirmed an increased financial control framework remained in place to ensure only essential additional expenditure was committed, and on-going scrutiny of the financial position and delivery of CIP through the System Improvement process continued. JS asked if the ADHD issues would continue as there were not enough people to complete ADHD assessments and suggested investment was needed in the service to enable savings as less people would then use the costlier right to choose option. JF advised there was work ongoing with regards to ADHD pathways which would hopefully support. GJ suggested adding ADHD update to the forward plan as there was currently Adults ADHD consultation on-going. RESOLVED: The Locality Board noted: • the summary nature of the Month 1 financial report. • the overall 2025/26 GM ICS financial plan was balanced following the receipt of £200m of deficit support funding. • the Month 1 year to date reported financial position for GM ICS, which was an • actual deficit of £21.4m, against a planned deficit of £19.5m, which equated to a • £1.8m adverse variance. • the delivery of CIP for the ICS in Month 1 of £53.4m against a plan of £56.4m, a shortfall of £3.0m. • The Locality reported position of breakeven on commissioned services and £40k underspend on corporate services. • Locality CIP delivery of £8k in line with the plan. • the on-going scrutiny of the financial position and delivery of CIP through the System Improvement process, with a requirement to submit weekly monitoring of progress against CIP delivery to NHSE NW. • and supported the continuation of an increased financial control framework to ensure only essential additional expenditure is committed.	ACTION
9	**NHS GM TRAFFORD 2025/26 BUDGET BOOK** JF provided a presentation that detailed the approach being taken with regards to the 25/26 Locality delegated Budget Book, summary of the commissioned services and corporate services budget and an update on the cost improvement plan and recommended TLB agreed the delegated budget. JF highlighted budgets had been set based on GM planning assumptions in line with national planning guidance and the allocation included £200m of deficit control total funding for the ICS of which £50m remained with NHS GM and was contingent on the delivery of the current financial plan and could be withdrawn. JF presented a summary of the 2025/26 delegated budgets by NHS GM to the Trafford Locality Board for approval. JF confirmed the commissioned service budgets	

	were £70.876m which included funding for cost pressures and inflation. The cost efficiency target of £2.9m had also been applied and a summary of the schemes to date totalling £2.2m was included with work on-going to bridge the gap. JF advised the corporate budget of £3.77m was a roll over of the 2024/25 budget. JF noted pay inflation had been planned and held centrally and would be applied in due course and the impact of NHS reforms would be addressed in year. TLB were invited to pose questions. MK noted her support for the approach and whilst recognised financial situation noted the risk to Local Authority (LA) with the case management approach to CHC and MH individual packages may mean pressure moved to the LA. COD was also supporting Market Management element of review. GJ agreed the need to review with partners and ILED programme would support understanding. GJ queried how often the deficit support funding was made available, JF understood it was at the end of each quarter so at the moment only funds for Q1 would be released. TM noted at Finance, Performance and Sustainability there was a discussion on visibility of CIP from all partners and was pleased to confirm a meeting had been scheduled. RESOLVED: Trafford Locality Board: • Noted the approach to financial planning and calculation of the delegated budgets inclusive of cost pressure funding and inflationary uplift. • Noted the total NHS GM Cost Improvement target of £175m and agree the allocated target of £2.919m to the locality budget representing a 4% efficiency. • Agreed the local delegated budget for commissioned services of £70.876m inclusive of cost pressures, inflationary uplift and a cost improvement target. • Agreed the local delegated budget for corporate services of £3.77m noting inflationary uplift has yet to be applied and excluded any impact of the NHS reforms.	
10	**TRAFFORD PERFORMANCE ARRANGEMENTS 25/26** TLB were provided with a report that detailed the proposed performance arrangements for the Trafford Locality for 2025/26 onwards following a performance workshop held in March 2025 which discussed current reporting arrangements and suggestions for a more efficient and comprehensive view of Trafford performance. TM provided a summary of the presentation noting the work was initiated to enable effective decisions to be taken so Trafford could have effective arrangements that ensure accountability and ability to monitor progress and understand risk. TM highlighted the proposed performance arrangements noting the key role of the Finance, Performance and Sustainability (FPS) Committee who will consider performance prior to TLB and highlight any risks or issues. TM noted the performance products that would be utilised including the Trafford outcomes framework on an annual basis, Locality and Neighbourhood scorecard on a monthly basis and the locality sight and oversight and GM sustainability scorecard on a quarterly basis. TM noted the scorecards were always developing and metrics could be updated as needed. TM noted at FPS a member had noted that it was not always in our gift to affect the metrics and how we got support from partners was key and may change as NHS reform develops.	

	TLB were offered the opportunity to pose questions. DB praised the work noting other areas were also looking to utilise, but suggested there may be other metrics that could be utilised. TM thanked DB for raising and noted we could not view metrics in isolation and there would be a review of system risk and how metrics could be supported as there was potential disconnect. GJ gave thanks for the work, noting TM reference to reform and that there was debate about where performance management would sit and so the arrangements would develop as needed. JW noted concern on neighbourhood suggestions as felt neighbourhood team were already at capacity and may struggle to review. TM noted was risk but live well steering group would hopefully help build capacity within neighbourhood structure. HG queried what the 'so what' and what the process would be to hold each other to account. TM advised the proposed process was detailed in slide seven and described how the Boards hold to account. HF felt some issues were raised by individuals in groups but do then not become a collective priority such as district nursing and palliative care. GJ noted part of capacity investment was for palliative care and district nursing provision was being discussed and escalated where possible. TLB reviewed and supported the recommendations. RESOLVED: Trafford Locality Board: a) noted the content of the "Strengthening Our Performance Arrangements" presentation; and b) agreed to the recommended proposals.	ACTION
11	**SUSTAINABILITY & DELIVERY PLAN 25/26** TM gave verbal update on progress of the sustainability and delivery plan for 2025/26. TM noted information previously shared was still accurate but further work had been completed to look at system governance, leadership and what elements were business as usual and what should be prioritised in the plan. TM asked for TLB agreement to bring back the sustainability and delivery plan in July. RESOLVED: the sustainability and delivery plan 25/26 would be considered at the July TLB.	ACTION
12	**TRAFFORD PERFORMANCE AND LOCALITY SCORECARD** TLB received the Trafford Locality Scorecard (June 2025) including explanatory narrative for each metric where available. The report also included summary tables to identify priority metrics and those metrics where Trafford performance was above target or in the upper quartile of national performance. Following feedback at the Finance, Performance & Sustainability meeting on 05 June 2025, the report also included some additional information around the metric S131a – Women accessing specialist community perinatal mental health services. TM noted last time the scorecard was reviewed there had been debate about the women accessing perinatal services metric and if accessing more or less was a good thing. TM advised there was no national target but further benchmarking had been	

done and information on where Trafford ranked locally and nationally was included. TM proposed would want to use this metric to measure the level of access as a positive measure and if that was the case Trafford would rank third.

HG indicated that there was a delay in reporting as no infant deaths were reported on the dashboard, but she was aware there had been two neonatal deaths. HG noted the E coli rates being found in blood streams had increased and this was usually found in older adults. HG advised the public health team had shared information on working on hydration and nutrition in older adults which could help support rates.

HG reported that whilst cdiff rates had increased nationally by 30% in Trafford had decreased by 20% and HG suggested this was due to antimicrobial stewardship as in August 2023 Trafford were 106 out of 106th and now were 63rd due to system work.

GJ also noted previous query over the long length of stay for MH patients over 60, Trafford were now best performance in GM and 21st in the country which showed great improvement which would hopefully continue.

JS queried if any further work would be done on dementia diagnosis. GJ advised work would continue and recognised that when the deep dive took place it was noted progress could be slow and Trafford may take a while to move up the ranking table but were confident that the diagnosis process had been improved. TM noted whilst 10th in GM, Trafford were 47th out of 106th nationally.

RESOLVED: Trafford Locality Board:

a) noted the content of the Locality Scorecard (June 25) and accompanying narrative; and
b) noted the additional information for metric S131a.

13 **TRAFFORD LOCALITY QUALITY REPORT**

The report provided a summary of key areas of quality and safety programmes of work that supported the measurement of quality of care provided to people in Trafford. The report covered Locality Quality Group Escalations, as well as quality and safety updates for MFT, TLCO, GMMH, Primary Care – GPS, Adult Social Care, CHC and Safeguarding team.

SO joined the meeting and provided a summary as per the report, SO noted the new format of highlighting Alert, Assure and Advise areas in the report in the introduction section for ease. SO provided an update on the Alert areas noting that the Home Birth service that had been suspended was now operational and working positively with women who wanted to give birth at home. MFT had a maternity review and action plan in place to ensure they had appropriate staffing capacity and training to ensure the service could continue. SO noted the CQC rating was 'required improvement' but was being overseen by LMS and working to the action plan.

SO noted the issue with District Nurse capacity was an on-going issue that had previously been reported via GM governance and TLCO colleagues had provided detailed reports as to how they manage demand and capacity and the effect it has in community service provision. HF noted concern over ageing district nurse workforce and queried if any provisional plans were in place. SO reported that TLCO were doing work on the profile of the workforce and it was within their action plan and workforce strategy.

SO also noted an issue in Trafford Waters where a care home had been built in an area that was not covered within practice boundaries. MP confirmed that it was close to both Manchester and Traffford boundary and a Manchester practice was currently supporting until the end of the financial year at which point the provision would be

	reviewed. RESOLVED: Trafford Locality Board; • noted the assurance mechanisms that were in place which monitor the quality, safety, and effectiveness of commissioned services; and • celebrated the good work that was being undertaken by partners to improve the quality of health and care provided to Trafford residents.	
14	**HEALTHWATCH**	
14a	**HEALTHWATCH TRAFFORD PERFORMANCE REPORT** Healthwatch Trafford provided a summary of their performance and impact during the period January to March 2025. HF gave an update as per the report and highlighted Healthwatch Trafford had completed interviews with patients about GP Choice to support Healthwatch England's wider project on patient choice in GP services. HF noted there had been a lot of support from volunteers and the output was expected in Mid-June. HF took the opportunity to raise feedback from the public about Dentistry with concerns over cost, access and treatment and noted whilst concerns around Dentistry had been raised over a number of years there did not seem to be any planned change. HF also highlighted feedback on social care had been that bed blocking in hospitals was an issue as there was often no convalescent facility. MK advised Trafford were one of the better performers in the Northwest for this area and whilst there were a few cases where patients had to wait to access service on the whole performance was good. HF also raised patient concerns around ADHD and Autism and acknowledged work had begun to review this area. HF noted the enter and view programme would be relaunched where Healthwatch would visit publicly funded Health and social care facilities. The first visit was intended to be a GP surgery and findings would be shared with TLB. RESOLVED: the Healthwatch report was noted.	
14b	**HEALTHWATCH TRAFFORD END OF YEAR IMPACT REPORT** Healthwatch Trafford provided a summary of the work completed and impact throughout 2024-25. HF provided an overview of the report for the benefit of the Board highlighting the summary of the work completed in each quarter. HF noted Healthwatch worked well with partners to share knowledge and expertise and the work on the vaping habits of children and young people (CYP) had reduced the number of CYP vaping. HF noted next year there was a planned focus on children's oral health and mental health for all. HR reiterated the supporting data with regards to engagement, research and communication channels and was pleased to report that Healthwatch regularly	

	attended a number of meetings and had regular meetings with Trafford colleagues. TR gave thanks for the clear, concise report which he praised for being accessible to all. TR also gave thanks to the Public Health team for their collaborative working with Healthwatch this past year and looked forward to the Oral Health work Healthwatch had planned. TM also took the opportunity to give thanks for Healthwatch input and recognised the benefit of having an independent voice contributing to work programmes. TM suggested further work was needed to include personal stories in our work and act upon them and would take this into the participation framework space. TLB noted the recommendations. RESOLVED: Trafford Locality Board: • Agreed to continue to support and work towards the recommendations made within the report; and • Where Healthwatch did not have established relationships with TLB stakeholders to provide support to put these into place.	
17	**PCCC HIGHLIGHT REPORT** TLB were provided with a highlight report from the April Primary Care Commissioning Committee meeting. GJ noted the report was provided for information and gave a summary of what was discussed at the meeting. RESOLVED: the PCCC highlight report was noted.	
18	**S75 ANNUAL REPORT** TLB were provided with the section 75 monitoring report for the financial year April 2024 to March 2025. The report provided an overview of the Better Care Fund and Learning Disabilities pool performance in 24/25 and highlighted achievements, challenges and performance of both the BCF and LD metrics. GJ confirmed the paper was intended to provide assurance but s75 was also considered at the Health and Wellbeing Board. The paper was taken as read and TLB were given the opportunity to pose questions. DB queried where in BCF or pooled budget arrangements value for money was considered. MK noted were clear on activity but not clear on outcome and impact and needed to get to point where benefit for people and the organisation was understood. MK gave thanks to colleagues for their contribution but noted further work was needed to provide narrative on the difference made for the next iteration. RESOLVED: TLB noted: • the 2024/25 performance of the Better Care Fund National Metrics and Learning Disabilities Pooled Budget; and • the performance and progress of key schemes within the Better Care Fund Programme and next steps in their development.	
19	**ANY OTHER URGENT BUSINESS** There was no other urgent business to consider and the meeting was closed.	

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Trafford Locality Board - Action Log 25/26

Action No.	Date of Meeting	Agenda Item Ref.	Action	Update	Lead	Target Date	Status
117	17/12/24	Trafford Locality Plan Refresh	TM to prepare easy to read version of the plan and power point presentations to convey key messages.	Team working on and update to be brought back to the August meeting.	TM	19/08/25	In Progress
129	18/02/25	Trafford Delivery Plan: Interim Impact Report	MK agreed to bring back further update on PIPOT process and development of the boards referred to in the risks and issues section of the report.	This will be included as part of the impact report being brought back to the Board in July.	MK	19/08/25	In Progress
139	18/02/25	TCAPs Highlight Report	MP to provide update regarding GM Clinical Governance Framework when available.	Update from GM not expected until later in year.	MP	16/09/25	In Progress
148	17/06/25	NHS Reforms	GJ to update the Board on NHS reforms progress.	Scheduled on forward plan.	GJ	On-going	Closed
149	17/06/25	Finance - ADHD	ADHD right to choose discussed, noted consultation taking place on ADHD and TLB reuqets update be scheduled.	Added to forward plan.	GJ	15/07/25	Closed
150	17/06/25	Performance Metrics	Risk to be considered when reviewing performance metrics to see if any furtehr performance metrcis could be utilised to offer assurance.		TM	16/09/25	In Progress
151	17/06/25	Sustainability and Delivery Plan 25/26	TM to provide the sustainability and delivery plan at the July meeting.	Due to available time on the agenda this item has been deferred to August.	TM	15/08/25	In Progress

In Progress
Overdue
Completed

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Date & Time of Meeting	19 August 1pm	16 September 1pm	21 October 1pm	18 November 1pm	16 December 1pm	20 January 1pm	17 February 1pm	17 March 1pm
Agenda and Papers Sent out	12-Aug	09-Sep	14-Oct	11-Nov	09-Dec	13-Jan	10-Feb	10-Mar
Deadline for Papers	11-Aug	08-Sep	13-Oct	10-Nov	08-Dec	12-Jan	09-Feb	09-Mar
Chair	Jane Wareing	Tom Ross	Tom Ross	Jane Wareing	Tom Ross	Jane Wareing	Tom Ross	Jane Wareing
Part 1 – GM ICB Committee (Trafford)								
	Locality Update and Governance	Locality Update and Governance	Locality Update and Governance	Locality Update and Governance	Locality Update and Governance	Locality Update and Governance	Locality Update and Governance	Locality Update and Governance
	GM Integrated Care Partnership Update – ST (GJ)	GM Integrated Care Partnership Update – ST (GJ)	GM Integrated Care Partnership Update – ST (GJ)	GM Integrated Care Partnership Update – ST (GJ)	GM Integrated Care Partnership Update – ST (GJ)	GM Integrated Care Partnership Update – ST (GJ)	GM Integrated Care Partnership Update – ST (GJ)	GM Integrated Care Partnership Update – ST (GJ)
	Contract Renewal	Clinical Effectiveness Group Arrangements	Trafford Governance Review of ToR		Trafford Governance Questionaire			
	Finance, Performance and Sustainability	Finance, Performance and Sustainability	Finance, Performance and Sustainability	Finance, Performance and Sustainability	Finance, Performance and Sustainability	Finance, Performance and Sustainability	Finance, Performance and Sustainability	Finance, Performance and Sustainability
	Finance Report - JF	Finance Report - JF	Finance Report - JF	Finance Report - JF	Finance Report - JF	Finance Report - JF	Finance Report - JF	Finance Report - JF
	Locality Scorecard	Locality Scorecard	Locality Scorecard	Locality Scorecard	Locality Scorecard	Locality Scorecard	Locality Scorecard	Locality Scorecard
	Risk	Risk	Risk	Risk	Risk	Risk	Risk	Risk
			TLB Risk Register			TLB Risk Register		TLB Risk Register
	Quality	Quality	Quality	Quality	Quality	Quality	Quality	Quality
	Quality Report - SO			Quality Report - SO			Quality Report - SO	
	Primary Care Commissioning Committee	Primary Care Commissioning Committee	Primary Care Commissioning Committee	Primary Care Commissioning Committee	Primary Care Commissioning Committee	Primary Care Commissioning Committee	Primary Care Commissioning Committee	Primary Care Commissioning Committee
	PCCC Highlight Report		PCCC Highlight Report		PCCC Highlight Report		PCCC Highlight Report	
	Childrens	Childrens	Childrens	Childrens	Childrens	Childrens	Childrens	Childrens
	Children Commssioning Board update			Children Commssioning Board update		SEND Board Update	Children Commssioning Board update	
	SEND Board Update							
	TCAPS	TCAPS	TCAPS	TCAPS	TCAPS	TCAPS	TCAPS	TCAPS
	TCAPS Highlight Report		TCAPS Highlight Report		TCAPS Highlight Report		TCAPS Highlight Report	
	Trafford Provider Collaborative	Trafford Provider Collaborative	Trafford Provider Collaborative	Trafford Provider Collaborative	Trafford Provider Collaborative	Trafford Provider Collaborative	Trafford Provider Collaborative	Trafford Provider Collaborative
	Winter Planning - tbc		Winter Planning - tbc		Winter Planning - tbc	Workwell		
	24/25 TPCB Impact Report		Workwell					
	Trafford Workforce Group	Trafford Workforce Group	Trafford Workforce Group	Trafford Workforce Group	Trafford Workforce Group	Trafford Workforce Group	Trafford Workforce Group	Trafford Workforce Group
	Workforce Update			Workforce Update			Workforce Update	
	Trafford Participation Group	Trafford Participation Group	Trafford Participation Group	Trafford Participation Group	Trafford Participation Group	Trafford Participation Group	Trafford Participation Group	Trafford Participation Group
		Trafford Participation Group Update			Trafford Participation Group Update			Trafford Participation Group Update
	Partner Update	Partner Update	Partner Update	Partner Update	Partner Update	Partner Update	Partner Update	Partner Update
	Early diagnosis strategy	Fairer Health for Trafford	Healthwatch Performance Report			Healthwatch Performance Report		Heathwatch 26/27 Plan
	Community Collective 25/26 Forward Plan							
	Community Collective Annual Review							
								Community Collective 26/27 Annual Plan
Part 2 – Section 75 Committee								
	BCF Q1		s75 Quarterly Report			s75 Quarterly Report		
			BCF Q2			BCF Q3		

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Public Question Time – Trafford Locality Board

This item is time limited to 5 minutes.

Public Questions

Any Member of the public wishing to ask a question with regards to an agenda item at the above meeting can only do so if a written copy of the question is submitted to the governance team one working day before the meeting.

Where possible questions will be responded to verbally in the 5 minutes allocated at the meeting, if this is not possible the question will be raised at the meeting and a response will be provided in writing to the requestor.

Please complete the form below and return it to gmicb-tr.governance@nhs.net

Name:

Contact Details:

Question:

Should you have any queries, please contact the Governance team at gmicb-tr.governance@nhs.net.

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NHS
Greater Manchester

NHS reform key messages
Updated 03 July 2025

Part of Greater Manchester
Integrated Care Partnership

Date: 03 July 2025

Background to NHS Reform

NHS Greater Manchester

Integrated Care Boards

- On 1 April 2025, NHS England wrote to ICB and provider leaders outlining how we will work together in 2025/26 to deliver our core priorities, laying the foundations for reform in preparation to deliver the ambitions of the 10 Year Health Plan
- Delivering the 10 Year Health Plan will require a leaner and simpler way of working, where every part of the NHS is clear on their purpose, what they are accountable for, and to whom. Our focus is to deliver the three strategic shifts:
  - **Treatment to prevention** – stronger emphasis on preventative health and wellbeing, addressing the causes of ill health before medical intervention is needed
  - **Hospital to community** – reducing reliance on acute care by building more joined up, person-centred care closer to home in local neighbourhoods
  - **Analogue to digital** – Using technology and data to make healthcare smarter, faster, and more tailored to each person's needs
- NHS England has worked with ICB leaders across the country (including some of our own) to co-produce a **draft Model ICB Blueprint** that clarifies the role and purpose of ICBs, our core functions and what needs to be in place to ensure success:
  - **ICBs will continue to play a vital leadership role**, focused on understanding population health needs, planning for the long term, reducing health inequalities and ensuring access to consistently high quality and efficient care
  - **Our functions will be more focused**, with some responsibilities moving to providers or regional/national teams over time. We will need to streamline in places and do some things differently, more efficiently and/or at scale
  - **Not all changes can be done this year** as some need legislation and some functional changes/transfers will need time to be done safely
  - **There will be a national support offer**, including advice on voluntary redundancy/mutually agreed resignation schemes (MARS), guidance on redeployment, training and help with career transitions if necessary. The detail of this is still TBC

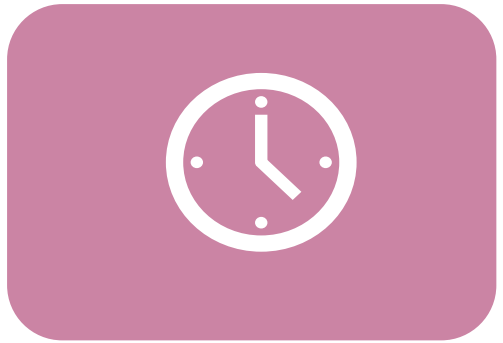
NHS GM – where we are today

NHS Greater Manchester

Fewer people are waiting a long time for hospital treatment

Faster test turnaround times

Most improved in the region for A&E core standards



People with cancer diagnosed faster and earlier

Significant reduction in Out of Area Placements (OAP) for mental health

GP consultations increased year on year

Ambulance response times consistently above national average

Hospital@Home saved more than 200,000 bed days

NHS GM – where we ended 2024/25

Exceeded savings targets: delivered £497.3 million in savings, surpassing our target by an additional £7 million

We were able to access our full cash limit (total amount of funding allocated by NHS England)

NHS GM running costs were under our budget allocation

Our approach to reform in NHS Greater Manchester

- We are committed to delivering an operating model for NHS GM in line with the model ICB blueprint, build on strong partnerships, local needs and a shared ambition for population health improvement
- **GM will retain footprint aligned with GMCA** (supported by the ICP) and are not merging with any other ICBs
- GM is ahead nationally, already using an integrated place model, and we have reaffirmed **our commitment to 10 places** aligned with local authorities
- Our vision for Greater Manchester still applies as does our commitment to our 6 missions as outlined in the ICP strategy
- We continue to be committed to our Sustainability Plan and the three shifts (outlined in 'Background')
- We need to **reduce operating costs by at least 39%** (equating to approximately 600 staff)
- Around 90% of our operating cost are staff costs, therefore there will be a **significant reduction in headcount**
- NHS GM will be **accountable for the £8.5bn of health spend** across Greater Manchester
- We will aim to **influence the wider public sector spend** across Greater Manchester by working in partnership with colleagues from across a range of services

Our approach (continued)

- We will deliver a completely new structure by the end of March 2026 and deliver a full year of savings in 2026/27. Our reformed ICB model for Greater Manchester will:
  - set NHS GM as the **strategic commissioner** for health for over 3 million residents
  - set **outcomes**, **strategy**, and **resource allocation** for our providers - most importantly our 9 provider trusts and primary care – once
  - oversee results and convene the system
- To oversee our progress, a Task and Finish Group, chaired by NHS GM's chair, Sir Richard Leese is now established with membership from senior leaders representing providers, Place and staff alongside our chief officers
- We continue to engage with stakeholders from across the ICP, including the voluntary, community, faith and social enterprise (VCFSE) sector, provider trusts and primary care

Supporting our colleagues

- Over the next 12-18 months, approximately 5,000 people will be displaced or move employment across our public services in Greater Manchester
- We will connect individuals to good work, upskill transferable portfolios into areas where there are opportunities in need of skilled workers, and role model an equitable and compassionate approach to looking after our people
- We will stand up a **Workforce Transition Hub** that adopts the best approaches to support our NHS colleagues through this troubling time – and to ready our system for future crisis moments in our economy

Our commitments throughout reform

- Place-based approach and strong commitment to Live Well
- Neighbourhood health services are key
- Our operating model will align with the particular needs of our population, and make the most of strong partnerships
- We embrace a new opportunity for clarity of role, reduced duplication, and deepening of partnership working
- We will:
  - deliver a safe, good quality and financially sustainable health and care system which aims to improve the health of the population
  - enhance our approach to strategic commissioning and oversight
  - strengthen our locality models
  - move our transactional services to be delivered through wider partnerships
- We will also minimise the economic impact of the loss of NHS GM staff by working in partnership across public service in Greater Manchester

Next steps

Q2 2025/26

Complete detailed design of the organisation

Q3 2025/26

Consult with staff, fill posts and finalise exits through voluntary redundancies*

Q4 2025/26

Move to new organisational function and operating model

We will deliver a completely new structure by the end of March 2026 and deliver a full year of savings in 2026/27.

*At time of writing, detail of the national support scheme and its funding are still to be confirmed

NHS
Greater Manchester

To receive our NHS Reforms updates, please contact the Internal and Stakeholder team
gmhscp.gm-stakeholders@nhs.net

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Fit for the Future – the 10 Year Plan for Health – Summary for GM Partners and Considerations

Introduction

The 10 Year Plan for Health was published by the Government on 3rd July 2025. The Plan is part of the government's health mission to build a health service fit for the future. It sets out how the government will reinvent the NHS through 3 radical shifts:

- hospital to community
- analogue to digital
- sickness to prevention

To support the scale of change implied in these shifts, the Plan emphasises system changes to be implemented:

- a new operating model
- greater transparency on care quality
- a new workforce model
- a reshaped innovation strategy
- a different approach to NHS finances

This report summarises the key changes and highlights particular points of relevance to Greater Manchester.

Neighbourhood Health Service (Hospital to Community)

- Bringing more service delivery closer to local communities, following recognition that current system is hospital centric. Convening professionals into patient-centred teams who are co-located. To eventually combine with a genomics population health service to predict population health and advise targeting of preventative care.
    - Neighbourhood Health Centre (NHCs) to be established in every 'community' – beginning with places where healthy life expectancy is lowest – 'one stop shop model' to open for 12 hours a day, 6 days per week.
    - Additional urgent care and outpatient services in the community delivered via the Neighbourhood Health Centres.
    - Changes will be reliant on a shift in pattern of health spend – driven by proportionally greater investment in *out of hospital* care over the next 3-4 years.
    - End 8am scramble by recruiting more GPs, expanding NHS App, same day GP appointment for those who need one.
    - Introduce 2 new contracts beginning next year:
        1. Creation of 'Single Neighbourhood Providers' to deliver enhanced services to ~50,000 people neighbourhood areas. Built on the PCN model.
        2. Creation of 'Multi neighbourhood providers to geographies of ~250,000 people to deliver care requiring work over multiple neighbourhoods such as end of life care. Further implementation to involved shared back-office function, digital transformation and data analytics.
    - 1 million people to be offered a personal health budget by 2030 – universal offer by 2035
    - Mention to increased role for Community Pharmacy and dentistry, including community pharmacy addition to the single patient record and support to long term condition management.
    - Recognition given to wider determinants of health throughout the document, NHCs will work in partnership with family hubs, schools, nurseries to offer early years support including to those with Special Educational Needs and Disabilities.

Analogue to Digital

- Ensuring rapid access for those in generally good health, free up physical access for those with complex needs and to ensure NHS financial sustainability.
    - Patients to be able to access a single patient record
    - Development of the NHS App to get instant advice, find services via My NHS GP, **choose a preferred provider** via My Choices, **book tests** via My Specialist and **book consultations** with My Consult, **medicine management** and **vaccine booking**, **long term conditions management** and **upload of medical data**
    - Coordination feature also to be added for dependents – children and carers.
- Enabling real time feedback to providers via the app
- Rollout of *continuous monitoring* to support proactive care at first signs of deterioration
- 'Health Store' to be developed for management of approved digital tools
- Single Sign on for staff and use of tech such as AI Scribes.

Sickness to prevention

- Rollout of cross societal approaches to health prevention, such as:
    - Delivering on the tobacco and vapes bill – making it illegal to sell tobacco to those 16 and younger from this year, resulting in a smoke free generation. Reducing number of children who vape.
    - Ending obesity epidemic and restoring Healthy Start
    - Progressing weight loss medication breakthroughs and providing access to treatment – industries to be paid on *impact on health outcomes* basis
    - Health reward scheme and work with the Great Run Company to motivate people to move more
    - Join up support from across work, health and skills systems to help people find and stay in work. We will work with all integrated care boards (ICBs) to establish **Health and Growth Accelerators models**
    - Increased mental health support in schools and support to young people via Young Futures Hubs
    - Development of a new genomics population health service to support with population health risk stratification and interventions.
    - There are links to clean air and awarded monies to MSA's for transport as part of the prevention chapter.

New Operating model

- Reforms to simplify the system and to push power to places, providers and patients.
    - Combining NHSE with the DHSC, reducing central headcount by 50%
    - Streamlining how local government and the NHS work together – making ICBs coterminous with strategic authorities by the end of the plan where possible.
    - System of 'earned autonomy – new failure regime for underperforming systems, ultimate ambition for high autonomy after 10-year plan ends.
    - Progression of Foundation Trust model – ambition for every NHS provider to be an FT with the ability to retain and reinvest surplus – using flexibility to improve population health outcomes and encouraging partnership working.
    - Creating opportunities for the best FTs to hold the whole health budget as an integrated health organisation (IHO) – authorisation to be led by a new DHSC function.
    - Setting higher standards for leaders – pay tied to performance
    - Using private sector capacity and expanding private provider use in the most disadvantaged areas.
    - Introduction of a Patient Choice Charter

The role of the ICB as a Strategic Commissioner

- Responsible for all but the most specialised commissioning using multiyear budgets. This means ensuring that the money available to each local care system is put to the best possible use: to improve their population's health, reduce health inequalities and improve access to consistently high-quality services.
    - Rationalised commissioning support functions – Commissioning Support Units to be closed
    - Responsible for commissioning the best, most appropriate neighbourhood providers – Market Making and provider cultivation both within and beyond the NHS.
    - Providers will be expected to have a clear plan for sustainability and productivity – quality to be based at the centre of commissioning
    - Provider orgs to no longer sit on ICBs
    - Mayors or delegated representatives to become board members of ICBs rather than local authority representatives to align strategic planning across the NHS and MSAs.
    - ICBs to become coterminous with MSAs where possible by the end of the plan
    - ICPs to be abolished – work to commence with the Local Govt Association to consider democratic oversight and accountability – role of mayors and local govt reforms.

Transparency of Care Quality

- Development of league tables, ranking providers against key indicators
- Developing the use of patient reported experience measures and linked with a 'choose your provider' function on the NHS App
- Reform to the complaints process and improving response times
- Development of a new national quality board and strategies to be developed in conjunction with the Royal Colleges
- Providers to be able to make additional payments to clinical teams with high outcomes and good feedback
- Consistently poor-quality care to result in decommissioning of services/providers.

Workforce

- Proposes fewer staff will be in place by 2035 than those projected in the 2023 Long Term Workforce Plan, but those in place will be better treated, trained and more motivated.
    - AI assistants to be introduced and well established in front line clinical care (note taking and recording)
    - Staff standards to be developed, outlining minimum standards for employment
    - Focus on 'growing our own' medical and clinical workforce as priority – reduce overseas recruitment to less than 10% by 2035 – increased nursing apprenticeships over next 3 years.
    - Increasing the number of nurse consultants in neighbourhood settings
    - Establishment of a new college of executive and clinical leadership
    - New freedoms to leaders and managers to reward good work, and new arrangement for VSM pay to reward good work and penalise poor performance.

Innovation to drive reform

- Links with life sciences and economy across 5 technology areas – data, AI, genomics, wearables and robotics to improve outcomes and boost economic growth.
    - Establishment of regional health innovation zones which will being together ICBs, providers, mayors and industry to experiment, test and generate evidence behind innovation.

Productivity and finance

- Progressing a value-based approach focused on better outcomes rather than more money without reform under the proviso that community care is cheaper than hospital care, digitisation will increase productivity and prevention will reduce front door demand.
    - 2% year on year productivity gain over the next 3 years

- Stopping the practice of providing additional funding to cover deficits (though more deprived with disproportionate economic and health challenges will be offered additional funding)
- 5-year plans to be requested of all organisations to demonstrate how financial stability will be achieved.
- Deconstruction of block contracts to align with activity delivered and funding provided via the ICB. Poor quality care will result in withheld payment.
- Review of tariffs to focus on those which result in increased productivity and outcomes – **Year of Care payments** from 2026/27 will drive shift of activity from hospital to community.
- Business case to be developed for use of public/private partnerships for neighbourhood health centres – final decision at autumn budget.
- Moving the NHS to a new financial model where money will follow patients through their lifetime – providers to be rewarded based on outcomes per individual as well as how they involve people in their own care design. Moving away from episodic instances of care at demand.

Direct mentions of Greater Manchester in the 10 Year Plan

- **Case Study:** Live Well Greater Manchester (p59)
- **Reference to the Get Britain Working White paper** (p68) and the role of health and growth Accelerators, ICBs will be required to establish specific outcome targets on contribution to reducing economic inactivity and unemployment, working with local government partners.
- **Greater Manchester coined as the prevention demonstrator** (p83)- *… a partnership between the NHS, single or upper tier authorities and strategic authorities to trial new innovative approaches to prevention – supported by mayoral **'total place'** powers, and advances in genomics and data. We will support these areas with increased autonomy, including supporting areas through exploring opportunities to pool budgets and reprofile public service spending towards prevention.*
- **Lilly trial in Greater Manchester** and links to economic inactivity and weight loss (p124)

Reflections and Implications for GM ICB

- **The confirmation of Greater Manchester as the first prevention demonstrator** is a significant opportunity. It connects the discussions between GM and across government in relation to devolution and the integrated settlement; Live Well and neighbourhood working; innovation and growth; health and economic inactivity; the NHS GM Sustainability Plan; and the relationship between prevention and proactive care and improvements in NHS performance. The discussions with senior officials on providing focus and connecting teams on the Demonstrator are already underway.
- Greater Manchester's movement for **transformed neighbourhood delivery through Live Well** is identified as a case study within the Plan. This is regarded nationally as an advanced model for neighbourhood health and the shift from treatment to prevention.
- Further reference in this context is made to development of **Neighbourhood Health Plans** which will be drawn up by local government, NHS and partners under the leadership of the Health and Wellbeing boards which will also include public health and social care. It will be necessary for GM partners to reconcile the development of the neighbourhood health centres emphasised in the Ten Year Plan with the development of LiveWell centres, spaces and places. Similarly for young people's mental health and Young Futures Hubs.
- The ICB will bring local neighbourhood health plans into a **population health improvement plan** for the footprint which will be used to inform commissioning. Greater Manchester's approach has always been to equate 'place' with upper tier local authority areas and this is consolidated through this expectation in the Plan.
- There are a number of provider collaboration intentions in the plan which will need to be explored and aligned to shared intentions around integrated delivery, Live Well and neighbourhood and place based working. In particular, there is an invitation for the best **trusts to hold health budgets for populations as an Integrated Health Organisation** and for GPs to lead single and multiple **neighbourhood providers** with new contracting options being made possible.

- **Abolition of Integrated Care Partnership** and **changes to the ICB make up** – It is expected that this removes the statutory requirement to establish an ICP as a joint committee between ICBs and local authorities in their areas. It remains open to GM partners to establish appropriate arrangements to ensure connection between NHS GM, the Mayor and GMCA and elected members, and wider system level partners across the VCFSE, GM Housing Providers, Universities, Trade Unions etc. This would reflect the longer term intent, signalled in the plan for greater convergence between Strategic and Combined Authorities and ICBs which is already realised in GM, but remains rare (with only GM and S Yorkshire systems being fully coterminous).
- The **NHS App as a single digital front door** to care – it will be necessary to remain proactive in addressing the implications for those who are digitally excluded as recognised through work of Digital First Primary Care GM Digital Facilitators in recent years within the GM Digital Inclusion Taskforce.
- The reference to **increased physical activity** in the prevention chapter and partnership with the Great Run Company will need to align with the longstanding and much wider approach to addressing inactivity through **GM Moving**.
- GM partners will need to reconcile the **minimum staff standards** to the **GM Good Employment Charter**.
- A refresh or extension of the existing NHS GM **sustainability plan** may be necessitated by the ask to develop 5-year financial sustainability plans

Next Steps for NHS GM

- Summary from DeHavilland to be shared following receipt from GMCA colleagues
- Readout from parliamentary questions on the 10-year plan to be shared following receipt from GMCA colleagues
- Development of a gap analysis and roadmap to describe
  1. Things we are already doing in GM in relation to the plan
  2. New Developments that we need to build into
  3. Fit with sustainability plan

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Trafford
Integrated Care Partnership

Name of Committee / Board	**Trafford Locality System Board**			
Date of Meeting	**15 July 2025**			
Report Title	**NHS GM Trafford Finance report**			
Report Author & Job Title	**Julie Flanagan NHS GM Trafford**			
Organisation Exec Lead	**Gareth James**			
OUTCOME REQUIRED *(please highlight)*	Approval	Assurance X	Discussion	Information X

EXECUTIVE SUMMARY

The attached slide deck presents the financial position for the ICS overall and the locality delegated budgets by NHS GM for May 2025.

As at Month 2 the total ICS year to date deficit is £45.3m, a £3.7m adverse variance against the plan (Month 1: variance of £1.8m), which is a deterioration from the prior month.

The ICS level overspend relates to pay pressures and under delivery of savings within provider organisations. The NHS GM position is breakeven but there are pressures within ADHD which are currently offset.

The Locality position is underspent £150k YTD with a forecast outturn of £248k overspent. The underspend in May relates to MH care packages however this is not expected to continue with pressures continuing in ADHD referrals which is driving the forecast.

The locality CIP position is broadly in line with plan at month 2 however there remains significant risk to the delivery of the target which is increasingly phased from quarter 2. Work continues to identify further schemes to bridge the gap with the RAG rating of identified schemes under review and indicating an improvement.

An increased financial control framework remains in place to ensure only essential additional expenditure is committed, and on-going scrutiny of the financial position and delivery of CIP through the System Improvement process continues.

RECOMMENDATIONS

The Locality Board is requested to note:

- Note the Month 2 year to date reported financial position for GM ICS of £45.3m deficit, against a planned deficit of £41.6m, resulting in a variance against plan of a £3.7m deficit.
- Note the breakeven forecast outturn position in line with NHSE reporting requirements.
- Note the Locality reported forecast outturn variance of £248k on commissioned services but a forecast underspend on corporate budgets
- Note the delivery of ICS CIP as at Month 2 of £79.3m against a plan of £87.1m, a shortfall of £7.9m.
- Note the locality CIP delivery of £45k year to date and current risk adjusted forecast of £1.12m

• Note the risk of the deficit support funding being withheld if the plan is not delivered and CIP schemes are not fully identified by the end of Q1.	
CONSIDERATIONS – these must be completed before submission to the Board – Reports with incomplete coversheet information will not be accepted and shared with the board	
Risk implications *(Please provide a high-level description of any risks relating to this paper, including reference to appropriate organisational risk register)*	Delivery of the locality cost improvement target and management of the individual placement and ADHD expenditure in line with budget are key to ensuring the locality meets its control total.
Financial implications and comment/approval *(Please detail which organisation(s) will be impacted, and if not required, please briefly detail why)*	Name/Designation: Locality savings are profiled more from quarter 2 onwards. The demand for ADHD right to choose services continues to be high across GM.
Comment by Trafford Clinical and Practitioner Senate (TCAPS) and/or Clinical Lead *(If not required, please briefly detail why)*	N/A Name/Designation: (If appropriate) Comment:
What is the impact on inequalities? (P*lease provide a high-level description of any known impacts)*	N/A
Equality Impact Assessment / Quality Impact Assessment Outcome *(If not appropriate at this stage please state if an EIA or QIA is necessary)*	N/A
People and Communities: Communications & Engagement *(Please detail relevant patient/public engagement completed and/or planned, and if not required please briefly detail why)*	N/A
Trafford's Carbon Footprint *(Please provide a high-level description of any known positive and/or negative impacts – consider the following topics: energy usage; staff or public transport; waste or materials used. Include steps that could be taken to reduce carbon within relevant plans)*	N/A
Links to Measurement / Outcomes *(Please detail if this is included within the report)*	
Enabler implications	**Legal implications: N/A**

	Workforce implications: N/A
	Digital implications: N/A
	Estates implications: N/A
Sub-Board Sign-Off / Comments **(i.e. Trafford Provider Collaborative Board, H&SC Delivery Steering Group)**	
Organisation Exec Lead Sign off	Gareth James

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Trafford Locality Finance Report Month 2 May 2025

Trafford
Integrated Care Partnership

Part of Greater Manchester
Integrated Care Partnership

GM System Financial Position

Introduction

Trafford
Integrated Care Partnership

As at Month 2 the total ICS year to date deficit is £45.3m, a £3.7m adverse variance against the plan (Month 1: variance of £1.8m), which is a deterioration from the prior month.

M2 2025/26 (£m)	YTD Plan	YTD Actual	YTD Variance	Full Year Plan	Full Year Forecast	Full Year Variance
GM NHS Providers	-£40.4	-£44.1	-£3.7	£7.5	£7.5	-£0.0
NHS GM	-£1.2	-£1.2	£0.0	-£7.5	-£7.5	£0.0
S Total	-£41.6	-£45.3	-£3.7	£0.0	£0.0	-£0.0

Key points of note for Month 2 are:

- The YTD provider position has worsened again in M2, driven mainly by pay pressures and under delivery of savings.
- The NHS GM position has remained on plan, with the continuation of the pressures relating to ADHD and ASC within Mental Health and delays in the identification and delivery of savings for a number of schemes, which are currently being offset in the overall position.
- As a system it is forecast that CIP targets will be met in full by the end of the year, albeit with associated risk. On a YTD basis, delivery is £7.9m behind target as a system (£2.1m in providers, with a further £5.8m in the ICB).
- NHSE has issued guidance which confirms that the DSF will only be allocated for the remainder of the financial year if the system can demonstrate that it is on track to deliver the overall plan and an additional request has been made to identify 100% of CIP schemes by the end of Quarter 1.
- An increased financial control framework therefore remains in place to ensure only essential additional expenditure is committed, and on-going scrutiny of the financial position and delivery of CIP through the System Improvement process continues. Urgent recovery meetings will be held this month to address any current shortfall.

GM Key messages

Month 2

Trafford
Integrated Care Partnership

The below table outlines key areas to note for Month 2:

Key area	M2 Overview
Financial plan	The ICS submitted a breakeven plan to NHSE for 2025/26, which included the receipt of deficit support funding (DSF) of £200m. The distribution of the £200m funding was originally split £150m for providers and £50m for NHS GM. In setting the final plan at organisation level, The Christie plans to deliver a surplus of £7.5m and so a technical adjustment to the DSF to the other GM NHS providers has been made to ensure that overall, the system will deliver a compliant plan. This has resulted in a deficit of £7.5m remaining with NHS GM which has been allocated from Programme Costs to meet the system control total.
Year to date variances	The drivers of the YTD deficit position are: •The YTD provider position has worsened again in M2, driven mainly by pay pressures and under delivery of savings. •The NHS GM position has remained on plan, with the continuation of the pressures relating to ADHD and ASC within Mental Health and delays in the identification and delivery of savings for a number of schemes, which are currently being offset in the overall position. •
Efficiencies/CIP	As at M2 £79.3m of CIP has been delivered against a plan of £87.1m, an underachievement of £7.8m. The forecast CIP position is £656.0m which matches the target of £656.0m although there are risks and unidentified CIP of £118.4m.
Capital	A system allocation is issued to GM on both internally generated and IFRS 16 capital expenditure. This allocation is currently £396.0m. The forecast capital position shows a £0.2m overcommitment.
Cash	At present provider cash balances are above plan by £46.5m. The cash position will continue to be monitored closely to ensure appropriate levels of working capital in the system. At M2 NHS GM had drawn down 18.0% of its annual cash allocation vs a straight line run rate of 16.7%. In part this reflects the need to settle 24/25 liabilities, but also that future allocations will be received to offset this. The allowable cash balance at the end of M2 equated to £8.6m, with an actual closing balance of £3.4m.
Risk & Mitigations	At M2 the total gross risk has been estimated at £319.3m. The vast majority of this relates to the risk associated with delivery of efficiency targets. It is currently assumed that all risk will be fully mitigated resulting in zero net risk.

Trafford Locality Financial Position

Month 2

Trafford
Integrated Care Partnership

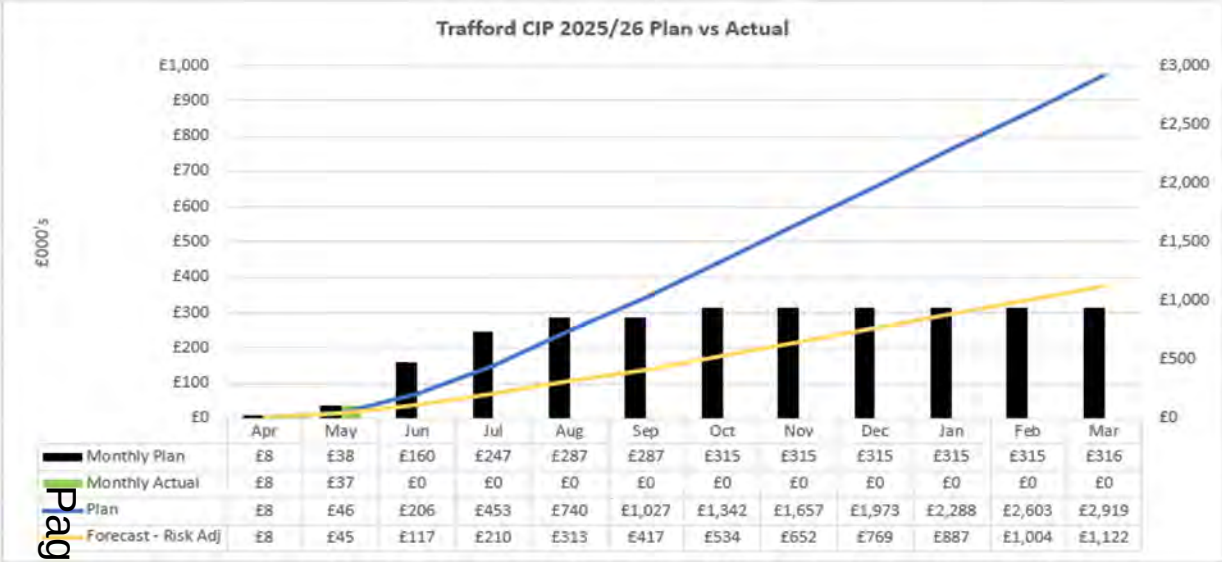
Summary Financial Position as at Month 2	Budget	Expenditure	Variance	In Month Movement	Forecast Budget	Forecast Expenditure	Forecast Variance	In Month Movement
	£'000	£'000	£'000		£'000	£'000	£'000	
Commissioned Services								
Mental Health Services	901	985	-84	↓	5,406	5,683	-277	↓
Community Services	2,076	2,073	4	↓	12,207	12,207	-0	→
Personalised Packages of Care	7,448	7,173	274	↑	43,282	43,253	29	↑
Primary Care Locally delegated	1,217	1,253	-37	↓	7,300	7,300	0	↑
Estates void & subsidy	392	400	-8	↓	2,320	2,320	0	→
Capacity & Discharge Fund	436	436	0	→	1,665	1,665	0	→
Total Commissioned Services	**12,470**	**12,320**	**150**	↑	**72,179**	**72,427**	**-248**	↓
Corporate Services	628	566	62	↑	3,771	3,533	237	↑
Total Locality Delegated Services	**13,099**	**12,887**	**212**	**-172**	**75,950**	**75,960**	**-11**	
Shadow Reported Services								
Prescribing	7,655	7,295	359	↑	46,237	46,206	31	↑
Primary Care Co commissioned	8,433	8,298	135	↑	50,597	50,311	286	↑
Total Shadow Reported Services	**16,088**	**15,593**	**494**		**96,834**	**96,517**	**317**	

- The locality is reporting a £0.2m underspend on commissioned services with a forecast deficit variance of £0.2m by year end. Any year to date benefits within personalised care are expected to erode by year end, while under MH, ADHD assessments showing a significant overspend due to increasing demand. We anticipate following the ADHD service consultation, proposed pathway changes will start to have an impact in the latter half of the year.
- The year to date position includes delivery of £45k of savings, being £1k under plan. The non recurrent CIP delivered in 24/5 has a remaining balance of £380k, and is being addressed alongside other draft plans against the remaining in year CIP target.
- Corporate budgets are forecast to underspend by £237k reflecting a continuation of current vacancy levels.
- Shadow reported services are showing a YTD and forecast underspend

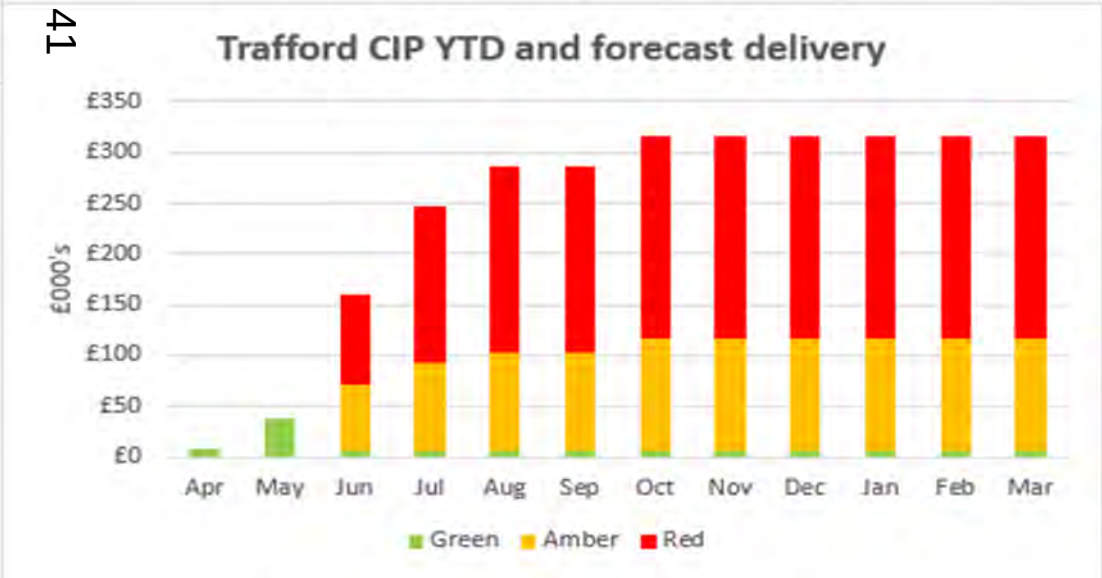
Trafford Locality CIP

Month 2

Trafford
Integrated Care Partnership



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Monthly Plan	£8	£38	£160	£247	£287	£287	£315	£315	£315	£315	£315	£316
Monthly Actual	£8	£37	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Plan	£8	£46	£206	£453	£740	£1,027	£1,342	£1,657	£1,973	£2,288	£2,603	£2,919
Forecast - Risk Adj	£8	£45	£117	£210	£313	£417	£534	£652	£769	£887	£1,004	£1,122



- Listed schemes total £2.2m with a further £0.7m to be identified.
- 52% of the target required is currently risk rated high (red).
- Given the current RAG ratings, the post optimisation bias predicts a delivery of £1.12m
- We have seen further progress on the schemes in June and expect to improve the RAG ratings for the next report.
- Good progress has been made in individual packages of care with the highest risk schemes being the contract activity management plans and reviews.
- Proposals to address the unidentified value are under discussion

Summary & Recommendations

Month 2

Trafford
Integrated Care Partnership

The Locality Board is requested to:

- Note the Month 2 year to date reported financial position for GM ICS of £45.3m deficit, against a planned deficit of £41.6m, resulting in a variance against plan of a £3.7m deficit.
- Note the breakeven forecast outturn position in line with NHSE reporting requirements.
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- Note the delivery of ICS CIP as at Month 2 of £79.3m against a plan of £87.1m, a shortfall of £7.9m.
- Note the locality CIP delivery of £45k year to date and current risk adjusted forecast of £1.12m
- Note the risk of the deficit support funding being withheld if the plan is not delivered and CIP schemes are not fully identified by the end of Q1.

Trafford
Integrated Care Partnership

Name of Committee / Board	**Trafford Locality Board**			
Date of Meeting	**15 July 2025**			
Report Title	**Trafford Performance and Locality Scorecard**			
Report Author & Job Title	**Thomas Maloney Programme Director Health and Care, NHS GM (Trafford) / Trafford Council, Phil Jefferson, Senior Intelligence Analyst NHS GM (Trafford)**			
Organisation Exec Lead	**Gareth James, Deputy Place Lead for Health and Care Integration, NHS GM (Trafford)**			
OUTCOME REQUIRED	Approval	**Assurance X**	**Discussion X**	**Information X**

EXECUTIVE SUMMARY

The purpose of this paper is to share the existing Trafford Locality Scorecard (June 2025) including explanatory narrative for each metric where available. This report also includes summary tables to identify priority metrics and those metrics where Trafford performance is above target or in the upper quartile of national performance.

Please note the newly agreed performance arrangements will be brought to the August meeting of the Locality Board. Constraint capacity and technical delays in accessing data has resulted in a slight delay – it is proposed the new monthly Locality Scorecard be tabled at the August Finance, Performance and Sustainability meeting and subsequently the Locality Board in the same month.

RECOMMENDATIONS

The Board is asked to:

a) Note the content of the Locality Scorecard (June 25) and accompanying narrative.

CONSIDERATIONS – these must be completed before submission to the Board – Reports with incomplete coversheet information will not be accepted and shared with the board

Risk implications ***(Please provide a high-level description of any risks relating to this paper, including reference to appropriate organisational risk register)***	There is a general risk that if we don't mobilise adequate performance arrangements in the locality, we will be unable to have the correct levels of assurance specifically at our Locality Board of the localities delegated responsibilities.
Financial implications and comment/approval ***(Please detail which organisation(s) will be impacted, and if not required, please briefly detail why)***	Name/Designation: Thomas Maloney, Programme Director Health and Care, NHS GM (Trafford) / Trafford Council
	Comment / Approval: Finance can be linked directly and indirectly to performance and therefore its imperative finance and performance together inform our efforts on sustainability in its broadest sense.
	Date of TCAPS / Clinical Lead comment: 08/07/25

Comment by Trafford Clinical and Practitioner Senate (TCAPS) and/or Clinical Lead ***(If not required, please briefly detail why)***	Name/Designation: Thomas Maloney, Programme Director Health and Care, NHS GM (Trafford) / Trafford Council
	Comment: There are various targets relating to clinical and practitioner practice and therefore not understanding our performance in these areas poses a risk. It is important the correct forums are engaged in managing performance in relation to appropriate health and care services.
What is the impact on inequalities? ***(Please provide a high-level description of any known impacts)***	Without robust performance arrangements we will be unable to understand if we are tackling inequalities successfully. There are clear and obvious links with the work of the HWBB and Trafford Fairer Health For All Partnership to strengthen work in this area.
Equality Impact Assessment / Quality Impact Assessment Outcome ***(If not appropriate at this stage please state if an EIA or QIA is necessary)***	N/A
People and Communities: Communications & Engagement ***(Please detail relevant patient/public engagement completed and/or planned, and if not required please briefly detail why)***	N/A
Trafford's Carbon Footprint ***(Please provide a high-level description of any known positive and/or negative impacts – consider the following topics: energy usage; staff or public transport; waste or materials used. Include steps that could be taken to reduce carbon within relevant plans)***	Impact on our carbon footprint is monitored through different governance but it is important we understand our performance in relation to appropriate services and schemes through our locality performance arrangements in health and care.
Links to Measurement / Outcomes ***(Please detail if this is included within the report)***	Contained within the paper
Enabler implications	**Legal implications:** N/A
	Workforce implications: N/A
	Digital implications: N/A
	Estates implications: N/A
Sub-Board Sign-Off / Comments **(i.e. Trafford Provider Collaborative Board, H&SC Delivery Steering Group)**	A separate presentation on the proposed process for the monthly and quarterly update cycle of producing and co-ordinating the Locality Scorecard has been discussed and agreed at Trafford Finance, Performance & Sustainability Group 03-Oct-2024.
Organisation Exec Lead Sign off	Gareth James, Deputy Place Lead for Health and Care Integration, NHS GM (Trafford)

Trafford
Integrated Care Partnership

1. Introduction

1.1 The purpose of this paper is to share the Trafford Locality Scorecard (June 2025) including basic explanatory narrative for each metric. Where available we have included further narrative to explain to Board members progress, activity and mitigation where appropriate.

1.2 Narrative provided by Service Leads as part of the Locality Assurance Meeting in April 2025 has been included where available.

1.3 As per the reporting process, the Locality Scorecard and other performance related information is discussed first at the Finance, Performance & Sustainability Group. Feedback and narrative gathered from Service Leads and Subject Matter Experts is used to identify priority areas. This enables a summarised report to be presented at Trafford Locality Board.

1.4 We have included summary tables to provide a clearer view of which metrics or areas Trafford Locality may wish to prioritise. Originally, the Oversight metrics scorecard was reported monthly and the Sigh metrics scorecard quarterly. Due to ongoing changes related to Locality Assurance Meetings, both scorecards are now reported on a monthly basis.

1.5 The summary tables are:

- Metrics where Trafford performance is below target.
- Metrics where Trafford performance has declined from the last reporting position.
- Metrics where Trafford performance falls into the National Lower Quartile.
- Metrics associated with the Locality Assurance Meeting (KLOEs).
- Metrics where Trafford is above target or within the upper quartile of national performance.

1.6 Scorecards and dashboards are available from the GM Intelligence Hub.
Home Page > Corporate > Performance & Quality
Link here: GM Intelligence Hub

NHS
Greater Manchester
Integrated Care

Trafford P1 Oversight Metrics
June 2025

File created on 7 July 2025

Part of Greater Manchester
Integrated Care Partnership

GM Intelligence Hub

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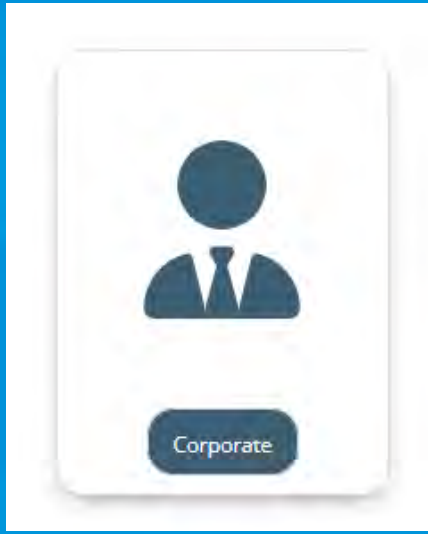
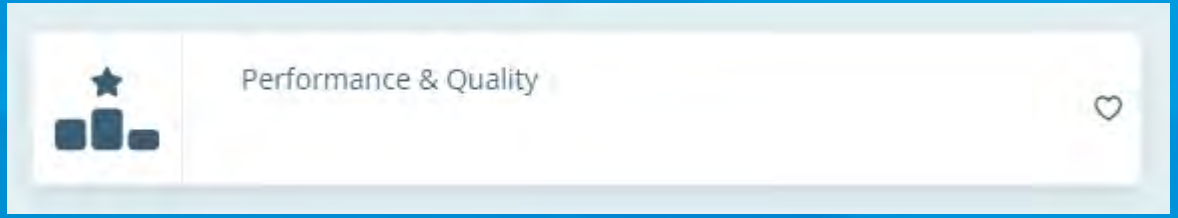




Trafford - Oversight Metrics

Show Definitions

Domain	Code	Measure	Frequency	Date	Latest	Previous	Change	Target/Median	Numerator	Denominator	Quartile
Cancer	N/A	Cancers Diagnosed At Early Stage using Full Registration Data	Annual	Dec 21	56.2%	53.7%	↗	75.0%	593	1,056	Upper
Mental Health & Learning Disabilities	S030a	% of patients aged 14+ with a completed LD health check	Monthly	Apr 25	4.3%	83.9%	↘	75.%	48	1,122	Upper
	EH09	Access to Children and Young Peoples Mental Health Services	Monthly	Apr 25	4,805	4,815	↘	5,468	N/A	N/A	Inter
	EAS01	Dementia: Diagnosis Rate (Aged 65+)	Monthly	May 25	67.8%	67.4%	↗	66.7%	1,984	2,925	Inter
	S086a	Inappropriate adult acute mental health Out of Area Placement (OAP) bed days (rolling 3 month total)	Monthly	Apr 25	795	665	↗	0	N/A	N/A	Inter
	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	Jun 25	8	12	↘	N/A	N/A	N/A	Inter
	N/A	Percentage of MH patients with no criteria to reside (NCTR)	Monthly	Jun 25	10.7%	16.7%	↘	N/A	8	75	Inter
	S110a	Overall Access to Community MH Services for Adults and Older Adults with Severe Mental Illnesses	Monthly	Apr 25	2,295	2,350	↘	3,928	N/A	N/A	Inter
	S081a	Talking Therapies: Access Rate	Monthly	Apr 25	455	480	↘	N/A	N/A	N/A	Inter
	S131a	Women Accessing Specialist Community Perinatal Mental Health Services	Quarterly	Apr 25	230	230	→	N/A	N/A	N/A	Lower
	S125a	Long length of stay for adults (60+ days)	Monthly	Apr 25	66.7%	28.6%	↗	0.%	20	30	Lower
	N/A	Proportion of routine eating disorder referrals cases entering treatment within four weeks, aged 0-18	Monthly	Apr 25	79.0%	79.0%	↘	N/A	79	N/A	Lower
Primary Care	S053b	% of hypertension patients who are treated to target as per NICE guidance	Annual	Mar 24	68.4%	68.3%	↗	77.%	25,152	36,755	Inter
	S053c	% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins	Quarterly	Dec 24	66.5%	66.8%	↘	62.9%	7,870	11,830	Upper
	S129a	GP appointments - percentage of regular appointments within 14 days	Monthly	May 25	83.3%	83.6%	↘	81.8%	77,995	93,588	Inter
Quality	S042a	E. coli blood stream infections	Monthly	May 25	182	180	↗	N/A	N/A	N/A	Upper
	S044a	Antimicrobial resistance: total prescribing of antibiotics in primary care	Monthly	Apr 25	84.2%	85.1%	↘	87.1%	N/A	N/A	Inter
	S044b	Antimicrobial resistance: proportion of broad-spectrum antibiotic prescribing in primary care	Monthly	Apr 25	8.5%	8.5%	↗	10.%	10,771	127,044	Inter
	S037A	% of patients describing their overall experience of making a GP appointment as good	Annual	Mar 23	80.3%		→	73.9%	N/A	N/A	N/A

P1 Metrics where performance is below target

NHS Greater Manchester Integrated Care

Metric	May-25	Jun-25	Target	GM	Distance From Target
Cancers Diagnosed At Early Stage using Full Registration Data	53.7%	56.2%	75.0%	2nd	199 patients
Inappropriate adult acute MH OAP bed days	665	795	0	7th	795 patients
A&E 4 hour performance	71.7%	70.7%	78.0%	3rd	568 patients
Cancer 28 day wait from referral to faster diagnosis	73.4%	73.1%	80.0%	10th	42 patients

GM Rank : 1st = Better Performance; 10th = Worse Performance

P1 Metrics where performance is declining (current v previous month)

NHS Greater Manchester Integrated Care

Metric	May-25	Jun-25	Target	GM	Change
Inappropriate adult acute MH OAP bed days	665	795	0	7th	Increased by 130 patients
E. coli blood stream infections	180	182	0	8th	Increased by 2 patients
A&E 4 hour performance	71.7%	70.7%	78.0%	5th	Decreased by 1 perc. points
Long LOS for adult mental health patients	28.6%	66.7%	0.0%	8th	Increased by 38.1 perc. points

P1 Metrics where performance is in National Lower Quartile

Metric	May-25	Jun-25	Target	GM	National Ranking
Long LOS for adult mental health patients	28.6%	66.7%	0.0%	8th	95 / 106

GM Rank : 1st = Better Performance; 10th = Worse Performance

P1 Metrics included in Locality Assurance Meeting

Key Lines of Enquiry

Metric	May-25	Jun-25	Target	GM	National Ranking
Cancers Diagnosed At Early Stage using Full Registration Data	53.7%	56.2%	75.0%	2nd	14 / 106
Dementia: Diagnosis Rate (Aged 65+)	67.8%	67.4%	66.7%	10th	45 / 106
MH - Long Length of Stay for Adults (60+ Days)	28.6%	66.7%	0.0%	8th	99 / 105

GM Rank : 1st = Better Performance; 10th = Worse Performance

P1 Oversight Metrics

Metrics Above Target or Performance within National Upper Quartile

NHS Greater Manchester Integrated Care

Above Target

Metric	May-25	Jun-25	Target	GM	National Ranking
% of patients aged 14+ with a completed LD health check	83.9%	4.3%	75.0%	2nd	19 / 106
Dementia: Diagnosis Rate (Aged 65+)	67.8%	67.4%	66.7%	10th	45 / 106
Routine Eating Disorder Refs Entering Treatment Within 4 Weeks	79.0%	79.0%	n/a	n/a	n/a
CVD Risk Patients Treated With Statins	66.8%	66.5%	62.5%	5th	21 / 106
GP Appointments - % of Regular Appts Within 14 Days	83.3%	83.6%	81.6%	6th	38 / 106
Antimicrobial resistance: All antibiotics	85.1%	84.2%	87.1%	7th	n/a
Antimicrobial resistance: Broad-spectrum antibiotics	8.5%	8.5%	10.0%	9th	77 / 112
% of patients describing their overall GP appt experience as good	-	80.3%	73.9%	2nd	n/a

National Performance Upper Quartile

Metric	May-25	Jun-25	Target	GM	National Ranking
Cancers Diagnosed At Early Stage using Full Registration Data	53.7%	56.2%	75.0%	2nd	14 / 106
% of patients aged 14+ with a completed LD health check	83.9%	4.3%	75.0%	2nd	19 / 106
CVD Risk Patients Treated With Statins	66.8%	66.5%	62.5%	5th	21 / 106

GM Rank : 1st = Better Performance; 10th = Worse Performance

NHS
Greater Manchester
Integrated Care

Further analysis and metric data

Metric narrative provided by Service Leads relates to the Locality Assurance Meetings in January and April 2025.

Trafford

Narrative

Cancers Diagnosed At Early Stage using Full Registration Data

Proportion of cancers diagnosed at stages 1 and 2 relative to the total cancers staged

Source: Cancer Early Staging Data Statistics via The National Disease Registration Service (NDRS) (Annual)

56.2%	53.7%	14/106	75.0%
December 2021	December 2020	National Rank Upper Quartile	National Ambition

Latest Value GM Benchmarking

National Rank against other localities

4	Rochdale	58.0%
14	Trafford	56.2%
38	Manchester	54.3%
43	Tameside	54.0%
50	Bury	53.7%
55	Stockport	53.3%
68	Wigan	52.6%
89	Oldham	51.1%
90	Bolton	51.0%
91	Salford	50.9%
29	NHS Greater Manchester Int..	53.5%

Selected measure at December 2021 has continuously increased for 1 period(s) of time

Trafford

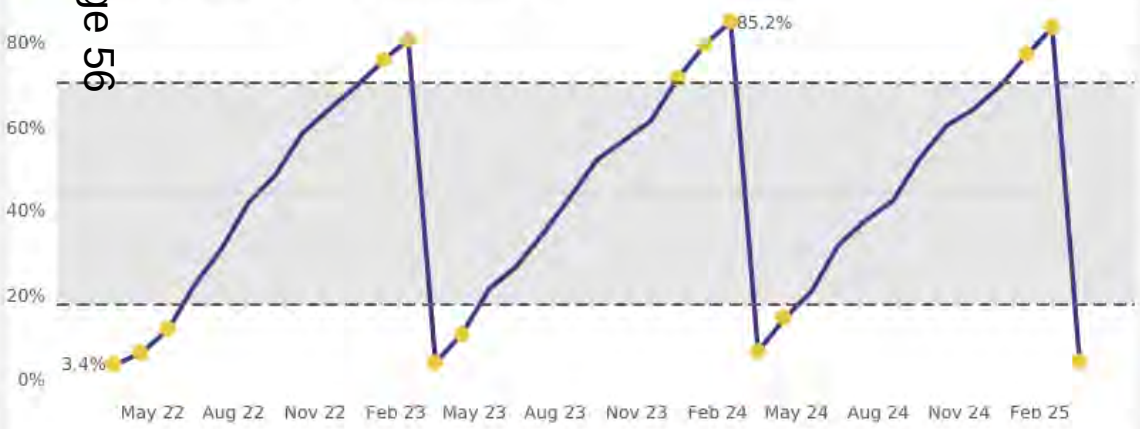
% of patients aged 14+ with a completed LD health check

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)

4.3%	83.9%	19/98	75.%
April 2025	March 2025	National Rank Upper Quartile	National Target

Deviation more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	3.4%	6.2%	11.7%	22.4%	31.1%	42.2%	48.7%	58.7%	64.4%	69.9%	76.0%	81.1%
2023-24	3.9%	10.9%	21.6%	26.8%	34.8%	43.5%	52.3%	57.0%	61.6%	71.7%	79.9%	85.2%
2024-25	6.7%	14.6%	21.0%	32.0%	37.9%	42.6%	52.5%	60.5%	64.3%	70.0%	77.5%	83.9%
2025-26	4.3%											

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

Latest Value GM Benchmarking

National Rank against other localities

1	Stockport	6.8%
19	Trafford	4.3%
21	Wigan	4.3%
39	Bury	3.6%
44	Oldham	3.4%
57	Rochdale	3.1%
61	Bolton	3.1%
77	Manchester	2.7%
87	Salford	2.2%
93	Tameside	1.8%
17	NHS Greater Manchester Integrated Care Board	3.4%

Narrative

Trafford health check rate is 2nd highest in GM and places Trafford 19th highest out of 106 nationally. Annual performance continually exceeds the national target.

Performance is measured at the end of each financial year. The number of health checks starts from zero in April and is reported cumulatively on a monthly basis.

Trafford

Access to Children and Young Peoples Mental Health Services

Access to Children and Young Peoples Mental Health Services

Source: Published MHSDS (Monthly)

4,805	4,815	63/106	5,468
April 2025	March 2025	National Rank Inter Quartile	National Median

Deviation more than 1 standard deviation from the mean

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2021-22				2,895	2,895	2,900	2,875	2,870	2,895	2,865	2,860	2,865
2022-23	2,980	3,045	3,100	3,175	3,215	3,325	3,415	3,525	3,530	3,650	3,725	3,795
2023-24	3,860	3,910	3,960	3,970	4,020	4,105	4,200	4,265	4,320	4,335	4,420	4,385
2024-25	4,150	4,170	4,220	4,245	4,310	4,345	4,455	4,565	4,645	4,795	4,825	4,815
2025-26	4,805											

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

Latest Value GM Benchmarking

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

Manchester	106.3	15,720 (13)
Tameside	103.7	5,020 (60)
Trafford	88.6	4,805 (63)
Rochdale	81.7	4,800 (64)
Bury	77.1	3,500 (84)
Salford	72.1	4,745 (65)
Wigan	62.2	4,405 (69)
Oldham	61.9	3,960 (77)
Stockport	59.7	4,015 (75)
Bolton	57.5	4,430 (68)

The rate is calculated using the 0-17 registered population figure for each locality | Trafford: 54,482

Narrative

Trafford is ranked 3rd out of 10 in GM and 63rd out of 106 nationally.

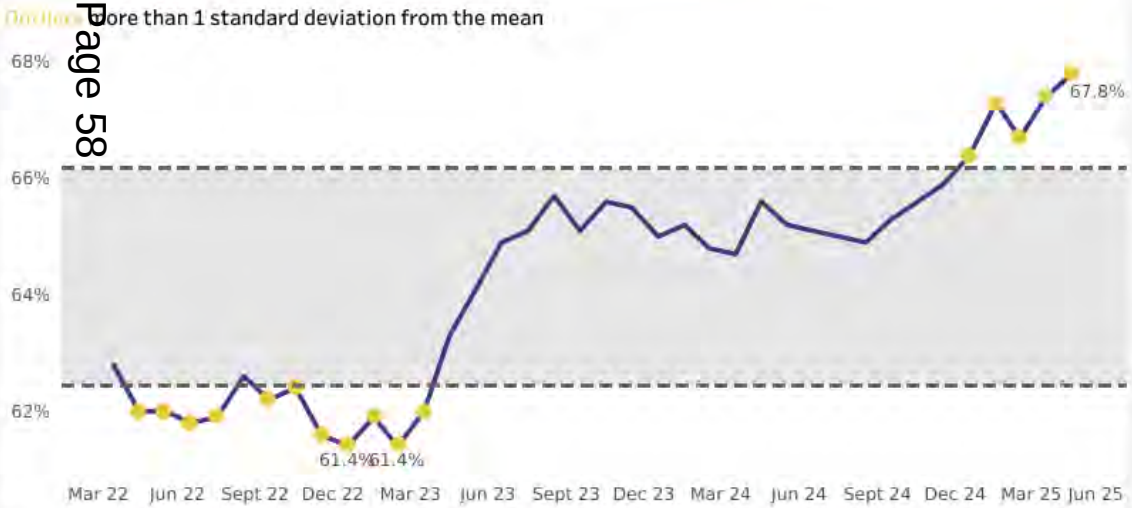
Trafford

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)

67.8%	67.4%	45/106	66.7%
May 2025	April 2025	National Rank Inter Quartile	National Target



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	62.8%	62.0%	62.0%	61.8%	61.9%	62.6%	62.2%	62.4%	61.6%	61.4%	61.9%	61.4%
2023-24	62.0%	63.3%	64.1%	64.9%	65.1%	65.7%	65.1%	65.6%	65.5%	65.0%	65.2%	64.8%
2024-25	64.7%	65.6%	65.2%	65.1%	65.0%	64.9%	65.3%	65.6%	65.9%	66.4%	67.3%	66.7%
2025-26	67.4%	67.8%										

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

Latest Value GM Benchmarking

National Rank against other localities

4	Salford	78.4%
5	Rochdale	78.2%
7	Bury	76.5%
10	Stockport	75.5%
12	Manchester	75.2%
13	Oldham	74.5%
22	Wigan	73.0%
26	Bolton	72.4%
	Tameside	72.4%
45	Trafford	67.8%
2	NHS Greater Manchester Integrated Care Board	74.3%

Narrative

LAM Meeting April 2025

The Performance for dementia diagnosis was below the the required rate.

ICB in collaboration with GMMH the provider have worked to improve - the rate is now above the target (67.3%). This is a result of monthly meetings between the ICB and provider over the prior 6 months (note improvement).

This project has highlighted the following issues related to historically low dementia diagnosis rates:

Early Diagnosis Challenges: The MATS team in Trafford has historically lower dementia conversion rates compared to other Greater Manchester locality teams. The high rate of Mild Cognitive Impairment (MCI) diagnosis contributes to this issue. The team has and is actively reviewing diagnostic thresholds.

Data Transfer Issues: Problems with data transfer from GMMH to GPs and to the GP clinical record have been addressed, with ongoing monitoring implemented.

Lower Diagnostic Rates in South Trafford: This affluent area with an older population has the lowest diagnosis rates, raising questions about its significance. This information has been shared with the South Trafford PCNs.

Care Home Diagnoses: Efforts to diagnose dementia in care homes continue, with positive recent data. GP training sessions have been carried out in February, and include use of the DiADeM tool.

Feedback from the provider regarding the current Memory Assessment Service (MATS) Model:

- Trafford is under funded for MATS service and referral rates, with 110 referrals received, funded for 70. This means there is not provide enough clinic time, while referral rates continue to rise – review the model.
- Alternative MDT led models have been discussed as a potential solution.
- Historical diagnosis of MCI will continue to impact improvement at pace.
- System wide plan remains in place with PCN's, MATS Provider and ICB

Trafford

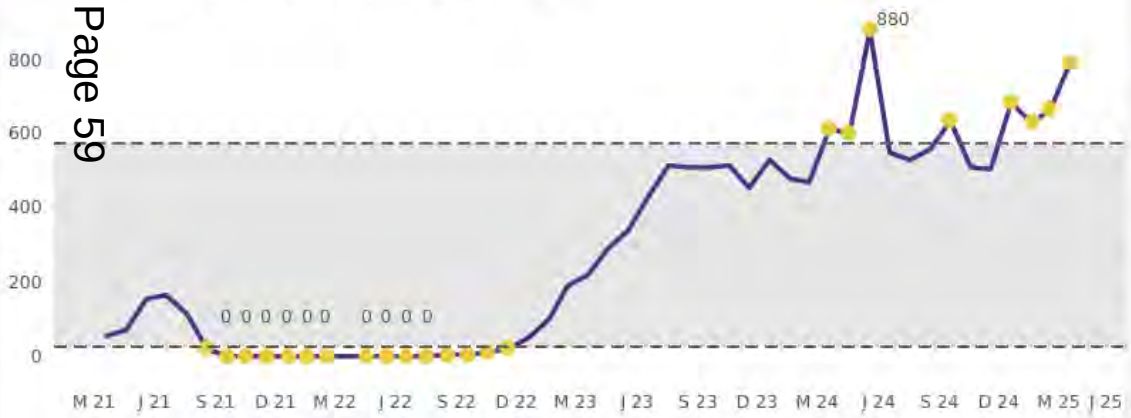
Inappropriate adult acute mental health Out of Area Placement (OAP) bed days

Number of inappropriate OAP bed days for adults that are either 'internal' or 'external' to the sending provider

Source: Out of Area Placements in Mental Health Services Official Statistics (Monthly)

795	665	64/106	0
April 2025	March 2025	National Rank Inter Quartile	National Target

Deviation more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	55	70	155	165	115	20	0	0	0	0	0	0
2022-23		0	0	0	0	5	5	10	20	50	100	190
2023-24	220	290	340	430	515	510	510	515	455	530	480	470
2024-25	615	600	880	550	530	560	635	510	505	685	630	665
2025-26	795											

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

Latest Value GM Benchmarking

Rate per 1000 | Count (National rank)

1	Tameside	0.79	180 (19)
2	Stockport	1.90	625 (55)
3	Rochdale	2.02	510 (45)
4	Oldham	2.71	730 (61)
5	Bolton	2.95	985 (70)
6	Wigan	3.14	1,105 (74)
7	Trafford	3.19	795 (64)
8	Salford	3.26	1,055 (73)
9	Manchester	5.23	3,925 (100)
10	Bury	14.48	3,080 (95)

The rate is calculated using the registered population figure for each locality | Trafford: 249,404

Narrative

Trafford is ranked 7th out of 10 in GM and 64th out of 107 nationally. From August 2022 the number increased from 0 to 515 in August 2023. This has increased to the current position of 795 in April 2025.

Trafford

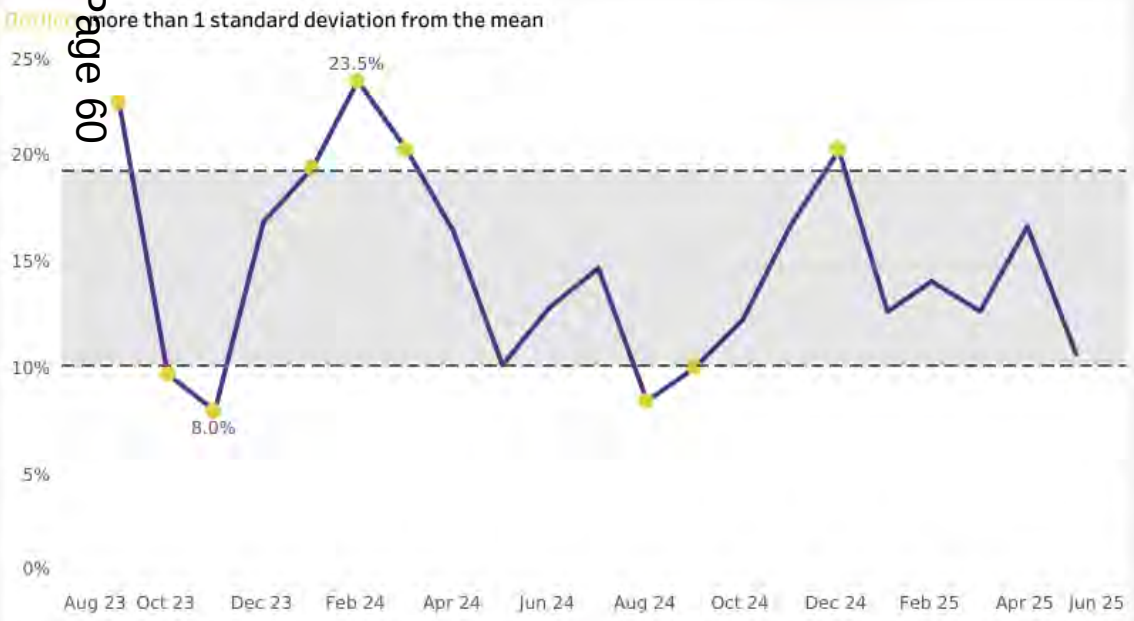
Percentage of MH patients with no criteria to reside (NCTR)

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

Source: GM Admissions - Local (Monthly)

10.7%
June 2025

16.7%
May 2025



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2023-24							22.5%	9.7%	8.0%	16.9%	19.4%	23.5%
2024-25	20.3%	16.4%	10.1%	12.9%	14.7%	8.5%	10.0%	12.3%	16.7%	20.3%	12.7%	14.1%
2025-26	12.7%	16.7%	10.7%									

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

Latest Value GM Benchmarking

Stockport	4.4%
Oldham	8.2%
Bury	8.3%
Rochdale	9.2%
Trafford	10.7%
Bolton	11.2%
Wigan	13.7%
Tameside	16.1%
Manchester	18.5%
Salford	20.0%
NHS Greater Manchester Integrated Care Board	12.4%

Narrative

Trafford is ranked 5th out of 10 in GM.

Trafford

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)

8
June 2025

12
May 2025

Outliers more than 1 standard deviation from the mean

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

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

Latest Value GM Benchmarking

Rate per 1000 | Count

Rochdale	0.028	7
Stockport	0.021	7
Bury	0.038	8
Trafford	0.032	8
Oldham	0.037	10
Tameside	0.044	10
Wigan	0.028	10
Bolton	0.033	11
Salford	0.059	19
Manchester	0.065	49
NHS Greater Manchester Integrated Care Board	0.042	139

The rate is calculated using the registered population figure for each locality | Trafford: 249,404

Narrative

Trafford is ranked 4th out of 10 in GM.

Trafford

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)

2,295	2,350	75/106	3,928
April 2025	March 2025	National Rank Inter Quartile	National Median

Outliers more than 1 standard deviation from the mean

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2021-22									1,460	1,480	1,485	1,500
2022-23	1,470	1,445	1,435	1,440	1,445	1,450	1,440	1,430	1,425	1,495	1,555	1,585
2023-24	1,780	1,810	1,850	1,865	1,890	1,915	1,960	2,025	2,055	2,040	2,055	2,085
2024-25	2,015	2,035	2,060	2,110	2,135	2,160	2,175	2,210	2,270	2,315	2,335	2,350
2025-26	2,295											

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

Latest Value GM Benchmarking

Rate per 1000 | Count (National Rank)

1	Salford	18.9	4,855 (44)
2	Manchester	13.4	8,055 (29)
3	Wigan	12.6	3,540 (58)
4	Trafford	11.8	2,295 (75)
5	Tameside	11.8	2,120 (79)
6	Bury	11.7	1,945 (83)
7	Bolton	10.1	2,590 (68)
8	Rochdale	9.2	1,785 (87)
9	Oldham	8.0	1,650 (90)
10	Stockport	6.4	1,665 (88)

The rate is calculated using the 18+ registered population figure for each locality | Trafford: 194,593

Narrative

Trafford rate is 4th best in GM and is ranked 75th out of 106 nationally. There has been a month on month increase in patient numbers between April 2024 and March 2025, and a slight decline in April 2025

Trafford

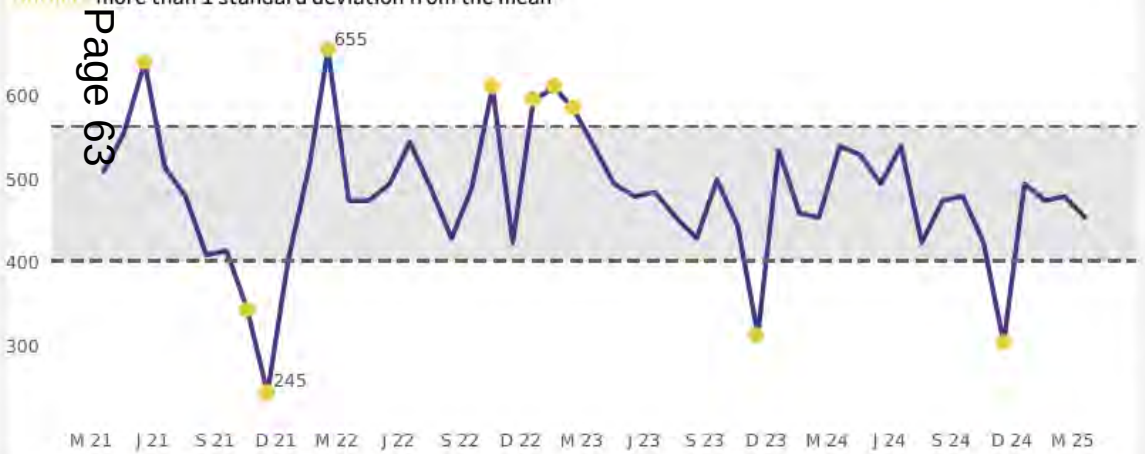
Talking Therapies: Access Rate

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)

455	480	72/109	No Target
April 2025	March 2025	National Rank Inter Quartile	

Deviation more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	510	555	640	515	480	410	415	345	245	405	515	655
2022-23	475	475	495	545	490	430	490	610	425	595	610	585
2023-24	540	495	480	485	455	430	500	445	315	535	460	455
2024-25	540	530	495	540	425	475	480	425	305	495	475	480
2025-26	455											

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

Latest Value GM Benchmarking

Rate per 1000 | Count (National rank)

1	Salford	2.7	885 (44)
2	Manchester	2.2	1,660 (17)
3	Bolton	1.9	630 (53)
4	Tameside	1.9	425 (75)
5	Trafford	1.8	455 (72)
6	Oldham	1.7	445 (73)
7	Wigan	1.6	575 (62)
8	Bury	1.6	345 (88)
9	Stockport	1.6	520 (64)
10	Rochdale	0.8	205 (104)

The rate is calculated using the registered population figure for each locality | Trafford: 249,404

Narrative

Trafford rate is 5th best in GM and 72nd out of 110 Nationally.

Trafford

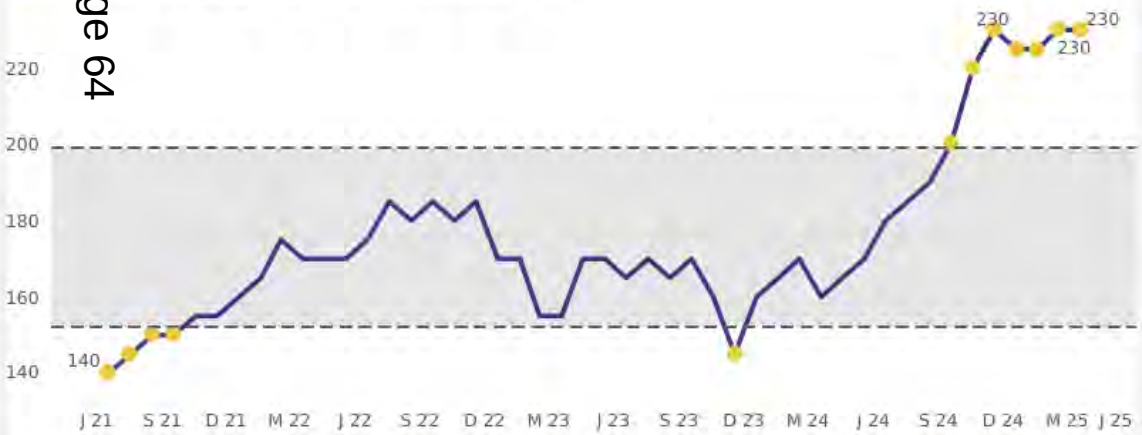
Women Accessing Specialist Community Perinatal Mental Health Services

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

Source: Published MHSDS (Quarterly)

230	230	87/107	No Target
April 2025	March 2025	National Rank Lower Quartile	

Outlier more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2021-22				140	145	150	150	155	155	160	165	175
2022-23	170	170	170	175	185	180	185	180	185	170	170	155
2023-24	155	170	170	165	170	165	170	160	145	160	165	170
2024-25	160	165	170	180	185	190	200	220	230	225	225	230
2025-26	230											

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

Latest Value GM Benchmarking

Rate per 1000 | Count (National Rank)

1	Bury	5.3	220 (88)
2	Stockport	5.1	320 (63)
3	Trafford	4.9	230 (87)
4	Tameside	4.8	220 (88)
5	Oldham	4.7	260 (77)
6	Rochdale	4.6	235 (86)
7	Wigan	4.4	295 (68)
8	Bolton	3.9	260 (77)
9	Salford	3.3	255 (80)
10	Manchester	2.7	535 (42)

The rate is calculated using the 15-44 female population figure for each locality | Trafford 47,263

Narrative

Trafford is ranked 3rd out of 10 in GM in relation to the access rate per 1,000 females aged 15-44 indicating good performance.

This would place Trafford in the upper quartile of performance nationally, ranked 23 / 107.

The national benchmark displayed here is incorrect as it is based on actual numbers accessing the service, rather than the rate.

This is being investigated by the ICB DII team.

Trafford

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)

66.7%	28.6%	99/105	0.%
April 2025	March 2025	National Rank Lower Quartile	National Target

Deviation more than 1 standard deviation from the mean

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2021-22				37.5%	37.5%	60.0%	33.3%	57.1%	50.0%	50.0%	50.0%	37.5%
2022-23	50.0%	50.0%	50.0%	37.5%	50.0%	42.9%	50.0%	50.0%	50.0%	85.7%	80.0%	55.6%
2023-24	80.0%	57.1%	57.1%	66.7%	71.4%	83.3%	125.0%	71.4%	100.0%	85.7%	85.7%	87.5%
2024-25	62.5%	50.0%	66.7%	83.3%	83.3%	100.0%	57.1%	42.9%	66.7%	33.3%	50.0%	28.6%
2025-26	66.7%											

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

Latest Value GM Benchmarking

National Rank against other localities

19	Salford	22.2%
65	Rochdale	44.4%
67	Stockport	45.5%
71	Bolton	50.0%
	Tameside	50.0%
	Wigan	50.0%
88	Bury	55.6%
99	Trafford	66.7%
103	Manchester	71.4%
104	Oldham	83.3%
40	NHS Greater Manchester Integrated Care Board	54.6%

Narrative

Trafford long lengths of stay increased in the past month, but remain below the high rates seen in September 24 and before

Trafford

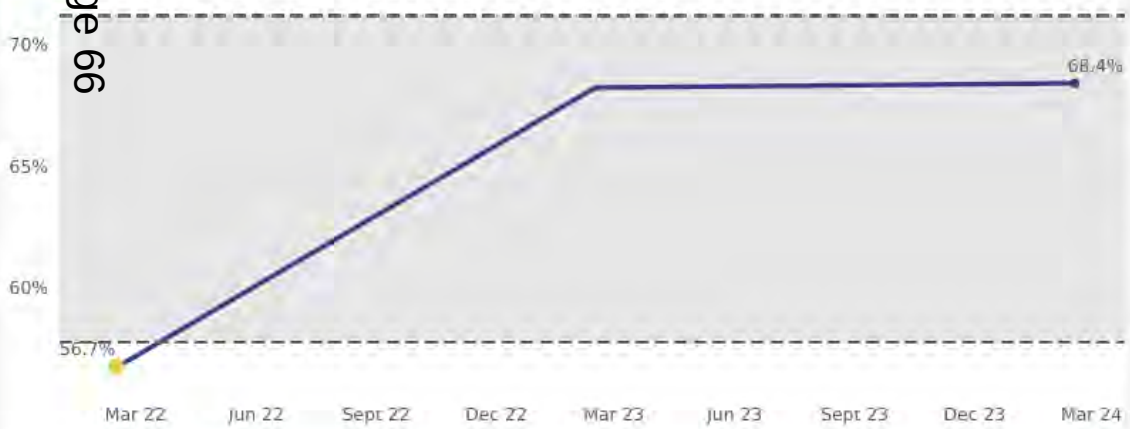
% of hypertension patients who are treated to target as per NICE guidance

% of hypertension patients who are treated to target as per NICE guidance

Source: NHS Quality Outcome Framework (Annual)

68.4%	68.3%	77/106	77.%
March 2024	March 2023	National Rank Inter Quartile	National Target

Deviation more than 1 standard deviation from the mean



	Mar
2021-22	56.7%
2022-23	68.3%
2023-24	68.4%

Selected measure at March 2024 has continuously increased for 3 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities

5	Stockport	73.6%
7	Salford	73.1%
10	Wigan	72.8%
55	Bolton	69.6%
56	Bury	69.6%
66	Rochdale	69.0%
77	Trafford	68.4%
86	Oldham	67.2%
100	Manchester	65.9%
101	Tameside	65.7%
19	NHS Greater Manchester Integrated Care Board	69.5%

Narrative

Trafford is 7th out of 10 in GM and 77th out of 106 nationally. The latest rate of 68.4% is below the national target of 77%.

Data is sourced from QOF which is an annual publication.

The published rate for 2023/24 shows a small increase to 68.4% and Trafford remains 7th best in GM.

Trafford

% 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

Source: CVD Prevent (Quarterly)

66.5%	66.8%	21/106	62.5%
December 2024	September 2024	National Rank Upper Quartile	National Median

Deviation more than 1 standard deviation from the mean

	Jun	Sept	Dec	Mar
2022-23	62.2%		62.9%	63.4%
2023-24	63.8%	63.2%	64.7%	67.0%
2024-25	66.9%	66.8%	66.5%	

Selected measure at December 2024 has continuously decreased for 3 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities

3	Oldham	70.9%
8	Manchester	69.1%
9	Tameside	68.6%
14	Rochdale	67.7%
21	Trafford	66.5%
27	Salford	65.7%
43	Stockport	63.6%
46	Wigan	63.2%
47	Bury	63.2%
52	Bolton	62.8%
6	NHS Greater Manchester Integrated Care Board	66.1%

Narrative

Trafford rate is 66.5% and is above the National Median of 62.5%. Trafford is 5th best in GM and ranked 21st out of 106 nationally. The current rate is within the upper quartile of performance nationally.

Trafford

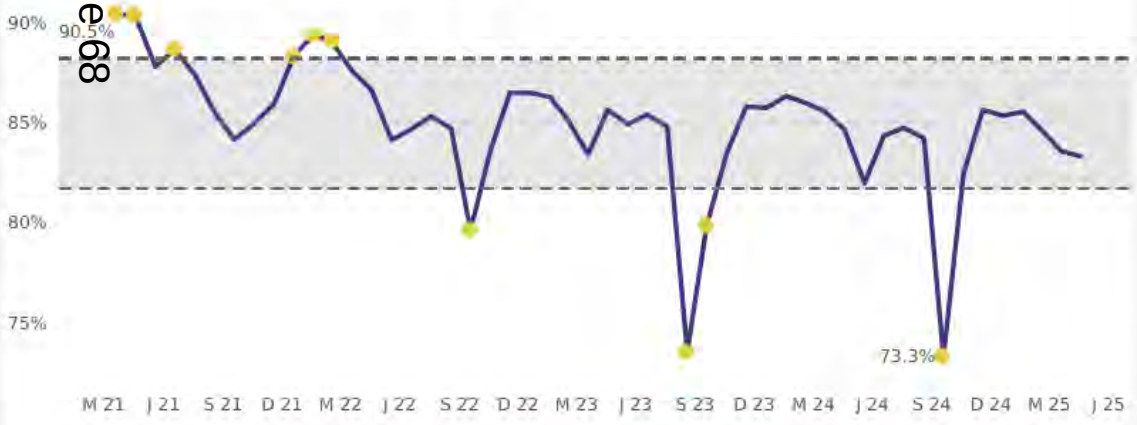
GP appointments - percentage of regular appointments within 14 days

Percentage of appointments where the time between booking and appointment was 'Same day', '1 day', '2 to 7 days' or '8 to 14 days'

Source: Appointments in General Practice (Monthly)

83.3%	83.6%	38/106	81.8%
May 2025	April 2025	National Rank Inter Quartile	National Median

Deviation more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	90.5%	90.4%	87.8%	88.7%	87.4%	85.5%	84.2%	85.0%	85.9%	88.4%	89.4%	89.0%
2022-23	87.6%	86.7%	84.2%	84.7%	85.3%	84.7%	79.6%	83.7%	86.5%	86.5%	86.3%	85.1%
2023-24	83.4%	85.7%	84.9%	85.4%	84.8%	73.5%	79.9%	83.5%	85.8%	85.8%	86.3%	86.0%
2024-25	85.6%	84.7%	82.0%	84.4%	84.8%	84.2%	73.3%	82.5%	85.7%	85.4%	85.6%	84.7%
2025-26	83.6%	83.3%										

Selected measure at May 2025 has continuously decreased for 3 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities

19	Manchester	86.4%
28	Rochdale	84.3%
30	Wigan	84.1%
31	Oldham	84.0%
37	Salford	83.4%
38	Trafford	83.3%
41	Stockport	83.0%
52	Bolton	81.9%
65	Bury	80.2%
71	Tameside	79.4%
12	NHS Greater Manchester Integrated Care Board	83.5%

Narrative

Trafford is 6th best out of 10 in GM and 38th out of 106 nationally. The current rate of 83.3 is above the national median of 81.6.

Trafford

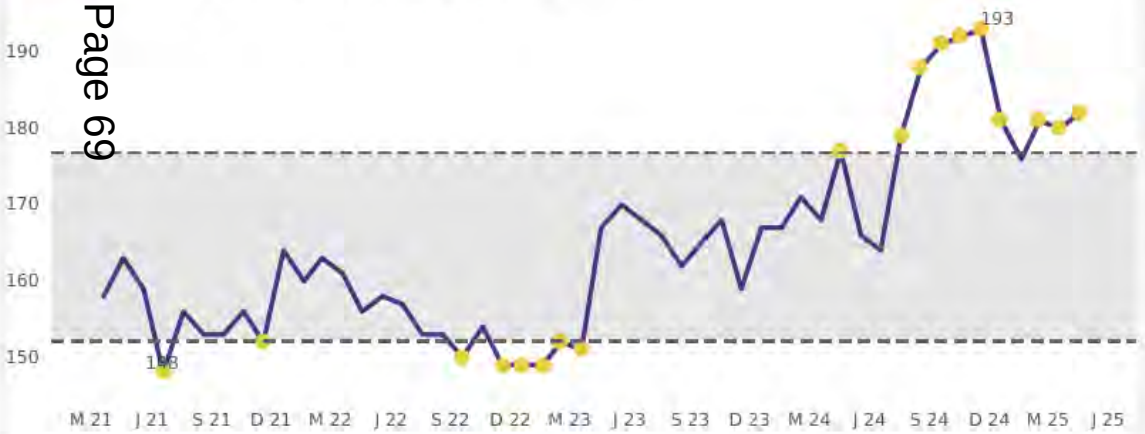
E. coli blood stream infections

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

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

182	180	25/107	No Target
May 2025	April 2025	National Rank Upper Quartile	

Deviation more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	158	163	159	148	156	153	153	156	152	164	160	163
2022-23	161	156	158	157	153	153	150	154	149	149	149	152
2023-24	151	167	170		166	162	165	168	159	167	167	171
2024-25	168	177	166	164	179	188	191	192	193	181	176	181
2025-26	180	182										

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

Latest Value GM Benchmarking

Rate per 1000 | Count (National Rank)

Wigan	0.53	185.0 (27)
Salford	0.54	173.0 (23)
Rochdale	0.56	141.0 (17)
Bolton	0.57	192.0 (30)
Manchester	0.57	431.0 (66)
Bury	0.65	139.0 (15)
Trafford	0.73	182.0 (25)
Oldham	0.74	198.0 (32)
Stockport	0.77	253.0 (47)
Tameside	0.98	224.0 (39)

The rate is calculated using the registered population figure for each locality | Trafford: 249,404

Narrative

Trafford is ranked 7th out of 10 in GM and 25th out of 107 Nationally.

From March 2023, numbers increased and continued to be above the statistical mean by more than 1 standard deviation.

Since December 2024, numbers have decreased to 182 in May 2025.

Trafford

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

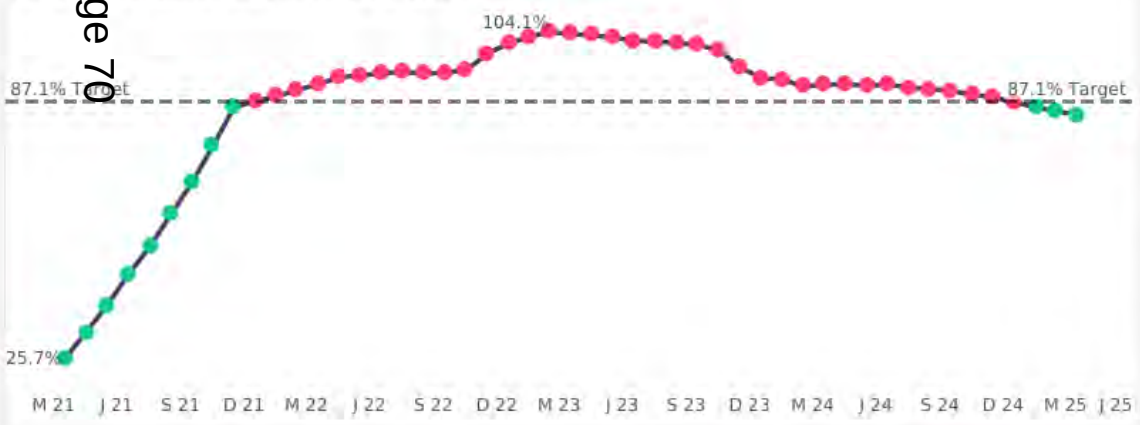
Source: EPACT Prescribing Data (Monthly)

84.2%
April 2025

85.1%
March 2025

87.1%
National Target

Performance Against National Target of 87.1%



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	jan	Feb	Mar
2021-22	25.7%	31.8%	38.4%	45.7%	52.5%	60.4%	67.9%	77.0%	86.0%	87.6%	88.7%	90.1%
2022-23	91.5%	93.2%	93.7%	94.2%	94.6%	94.0%	94.4%	94.9%	98.8%	101.4%	103.0%	104.1%
2023-24	103.6%	103.3%	102.8%	102.0%	101.8%	101.5%	101.0%	99.8%	95.6%	93.1%	92.7%	91.0%
2024-25	91.4%	91.5%	91.2%	91.5%	90.8%	90.4%	89.9%	89.1%	88.4%	87.3%	85.9%	85.1%
2025-26	84.2%											

Selected measure at April 2025 has continuously decreased for 9 period(s) of time

Latest Value GM Benchmarking

Narrative

This metric measures the total number of all antibiotic items prescribed using STAR-PU as a denominator. This takes account of age/sex differences across Localities.

Trafford rate is 7th highest in GM and recent initiatives have seen a reduction in the rate.

In February 2025 the rate of 85.9% was below the national target of 87.1% for the first time since December 2021.

Reductions have continued into March.

Trafford

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)

8.5%	8.5%	77/111	10.%
April 2025	March 2025	National Rank Inter Quartile	National Target

Deviation more than 1 standard deviation from the mean

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	13.1%	13.1%	13.0%	13.0%	13.0%	13.1%	12.8%	12.5%	12.3%	12.2%	12.1%	12.0%
2022-23	12.0%	11.9%	11.8%	11.7%	11.7%	11.7%	11.8%	11.7%	11.3%	11.2%	11.0%	10.9%
2023-24	10.8%	10.8%	10.8%	10.8%	10.7%	10.6%	10.4%	10.2%	10.2%	9.9%	9.7%	9.4%
2024-25	9.2%	9.0%	8.8%	8.6%	8.5%	8.4%	8.3%	8.3%	8.3%	8.3%	8.3%	8.5%
2025-26	8.5%											

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

Latest Value GM Benchmarking

National Rank against other localities

13	Oldham	5.5%
14	Bury	5.6%
19	Bolton	5.9%
21	Rochdale	6.0%
23	Tameside	6.0%
45	Manchester	7.3%
49	Stockport	7.5%
74	Salford	8.3%
77	Trafford	8.5%
99	Wigan	9.6%

Narrative

This metric measures the proportion of broad-spectrum antibiotics out of all antibiotic prescribed items.

Trafford has the second highest rate in GM but recent initiatives have seen a reduction in numbers and this decrease continued throughout 2023-24.

In January 2024 the Trafford rate fell below the 10% national target for the first time since April 2021 and this continues to be the case up to the latest data for April 2025.

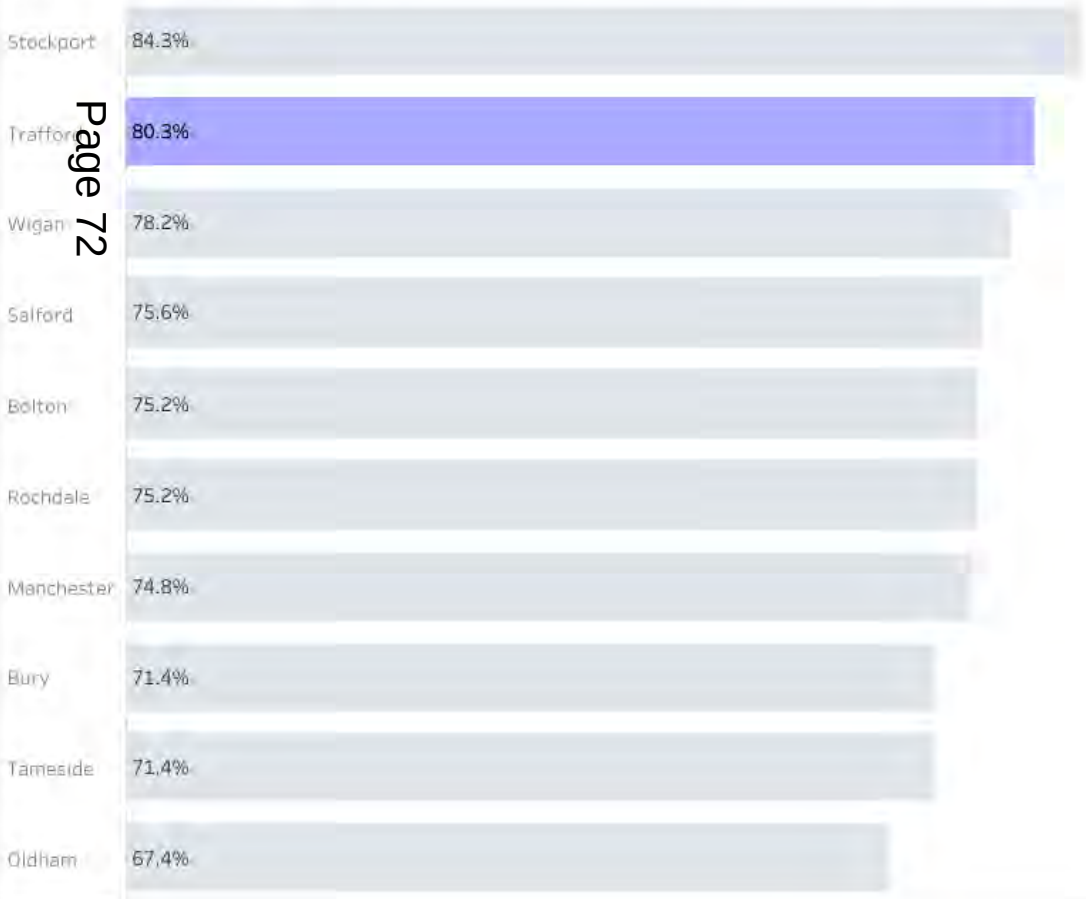
Trafford

% of patients describing their overall experience of making a GP appointment 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'

Source: GP Patient Survey (Annual)

Please note: The publication of the 2024 survey results is the start of a new time series for GPPS. This means that trend data for previous years of the survey is not presented alongside the 2024 results as it would normally be. The 2024 results are not comparable with previous years because of two significant changes which have been made to the survey in 2024



Narrative

80.3% of Trafford respondents in the National GP Patient survey reported a positive experience of making a GP appointment. This is 2nd best in GM.

NHS
Greater Manchester
Integrated Care

Trafford P1 Sight Metrics June 2025

File created on 7 July 2025

Part of Greater Manchester Integrated Care Partnership

Trafford - Sight Metrics

Domain	Code	Measure	Frequency	Date	Latest	Previous	Change	Target/Median	Numerator	Denominator	
Urgent Care	N/A	A&E 4 hour performance	Monthly	Jun 25	70.7%	71.7%		78.0%	5,501	7,780	N/A
	N/A	A&E Attendances	Monthly	Jun 25	7,780.0	8,251.0		N/A	7,780	N/A	N/A
	N/A	No Reason/Criteria To Reside patients (NCTR) as % of occupied beds	Monthly	Jun 25	14.7%	17.8%		N/A	2,151	14,667	N/A
	EM11	Total number of specific acute non-elective spells	Monthly	Jun 25	1,368.0	1,542.0		N/A	1,368	N/A	Upper
Elective Care	EB28	Diagnostic 6ww: All	Monthly	Apr 25	8.0%	6.2%		1.%	623	7,801	Upper
	EB20	RTT incomplete: 65+ week waits	Monthly	Apr 25	5.000	2.0		0.	5	N/A	Upper
Cancer	S012a	28 Day Wait from Referral to Faster Diagnosis: All Patients	Monthly	Apr 25	76.8%	73.1%		80.%	1,007	1,312	Inter
Maternity	S104a	Number of neonatal deaths per 1,000 total live births	Annual	Dec 23	0.0	2.3			0	2,178	Upper
	S022a	Number of stillbirths per 1,000 total births	Annual	Dec 23	2.8	3.2		3.1	6	2,178	Inter
Screening and Immunisations	S049a	Breast screening coverage, females aged 53-70, screened in last 36 months	Annual	Dec 24	72.1%	64.8%		N/A	19,434	26,958	Inter
	S046a	COVER immunisation: MMR2 Uptake at 5 years old	Quarterly	Mar 25	91.2%	90.8%		95.%	571	626	Upper
	S050a	Females, 25-64, attending cervical screening within target period (3.5 or 5.5 year coverage, %)	Quarterly	Jun 24	75.8%	76.1%		80.%	48,140	63,495	Upper
	S047A	Seasonal Flu Vaccine Uptake: 65 years and over	Monthly	Feb 24	79.3%	79.2%		85.%	34,556	43,567	Inter
Community	N/A	% 2-hour Urgent Community Response (UCR) first care contacts	Monthly	May 25	93.4%	94.3%		N/A	71	76	N/A

Trafford - 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

Trafford

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)

70.7%
June 2025

71.7%
May 2025

78.0%
National Target

Outliers more than 1 standard deviation from the mean

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	82.6%	80.3%	75.3%	71.0%	70.9%	64.7%	61.6%	65.9%	64.8%	64.5%	62.9%	62.4%
2022-23	63.0%	64.1%	62.0%	59.1%	62.3%	54.9%	54.7%	55.0%	51.8%	62.5%	62.2%	62.2%
2023-24	70.8%	71.2%	69.2%	69.8%	68.9%	70.3%	66.6%	63.9%	62.0%	61.4%	62.1%	63.9%
2024-25	65.8%	66.3%	67.5%	68.2%	72.5%	68.4%	68.3%	64.6%	65.8%	67.7%	70.0%	73.8%
2025-26	68.8%	71.7%	70.7%									

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

Latest Value GM Benchmarking

Narrative

Trafford

A&E Attendances

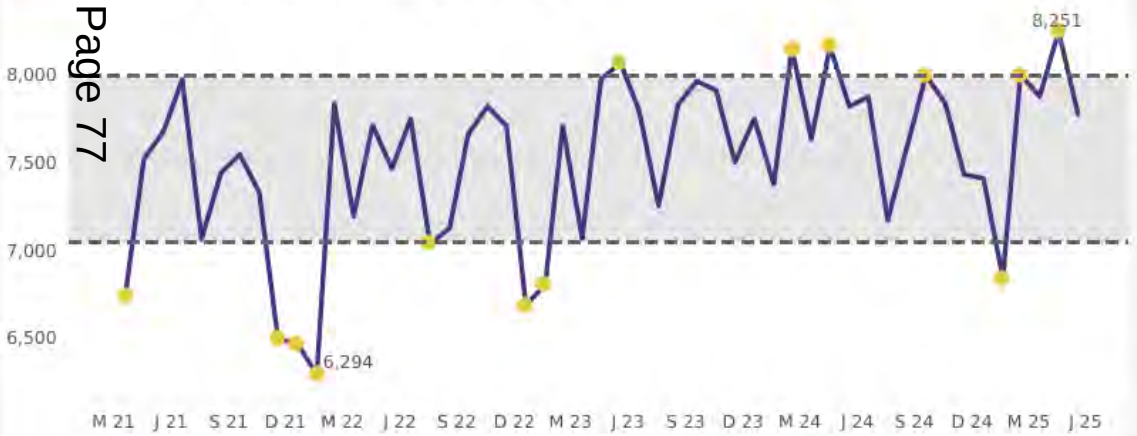
Number of attendances at A&E departments

Source: Emergency Care Dataset (ECDS) (Monthly)

7,780
June 2025

8,251
May 2025

Deviation more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	6,742	7,525	7,678	7,976	7,067	7,445	7,549	7,334	6,497	6,473	6,294	7,834
2022-23	7,196	7,716	7,468	7,752	7,040	7,127	7,665	7,823	7,713	6,689	6,808	7,712
2023-24	7,071	7,976	8,073	7,798	7,257	7,833	7,966	7,915	7,503	7,753	7,380	8,152
2024-25	7,638	8,162	7,821	7,880	7,173	7,595	7,998	7,841	7,435	7,412	6,844	8,003
2025-26	7,880	8,251	7,780									

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

Latest Value GM Benchmarking

Attendances Rate per 1000 population & Count

Stockport	29.4	9,698
Salford	30.8	9,970
Trafford	31.2	7,780
Bolton	31.4	10,512
Bury	33.2	7,063
Manchester	35.3	26,521
Wigan	37.9	13,342
Oldham	39.3	10,579
Rochdale	43.5	10,995
Tameside	45.0	10,300

The rate is calculated using the registered population figure for each locality | Trafford: 249,404

Narrative

Trafford

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

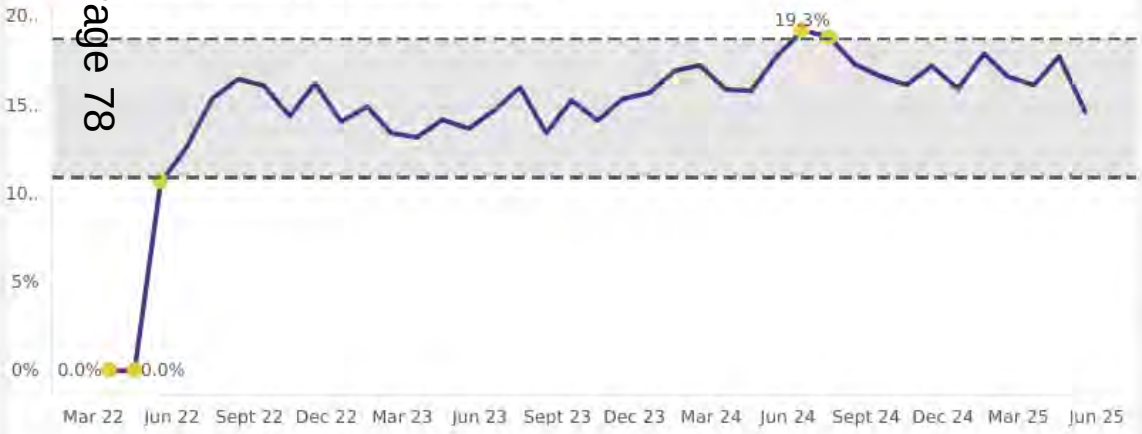
Total occupied beds, and of these, the number of patients who are fit for discharge and have no need to reside in a hospital bed

Source: GM Admissions - Local (Monthly)

14.7%
June 2025

17.8%
May 2025

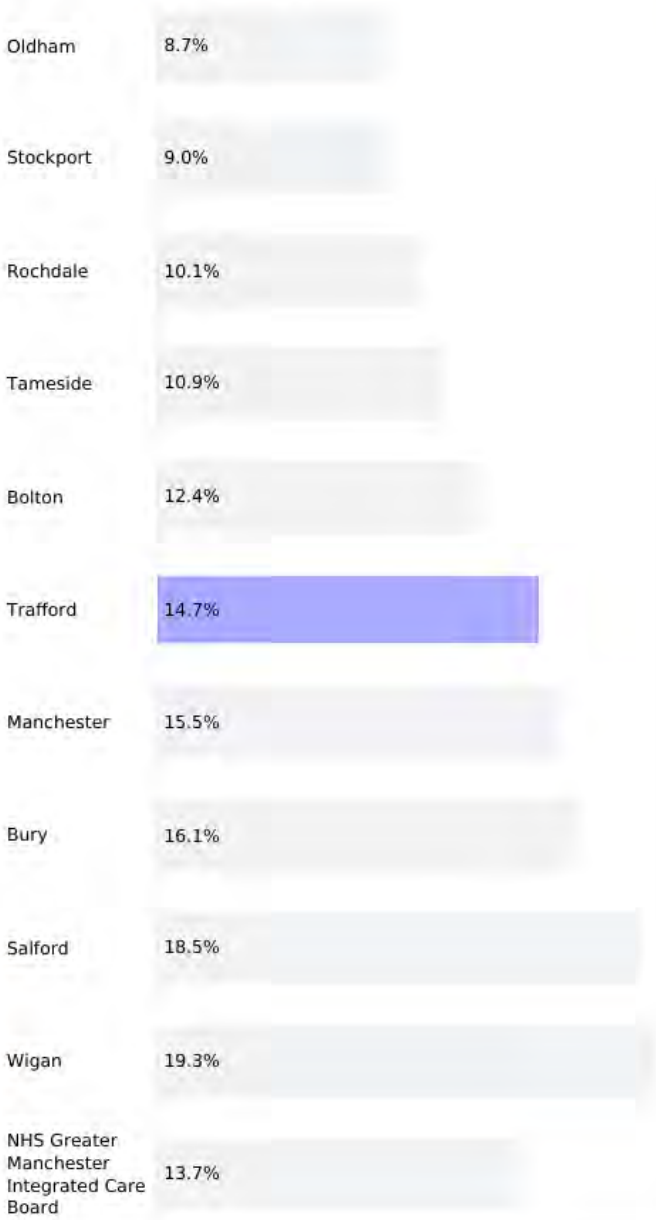
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	0.0%	0.0%	10.7%	12.6%	15.4%	16.5%	16.1%	14.4%	16.3%	14.1%	14.9%	13.5%
2023-24	13.2%	14.2%	13.7%	14.7%	16.0%	13.5%	15.3%	14.2%	15.4%	15.7%	17.0%	17.3%
2024-25	15.9%	15.8%	17.9%	19.3%	18.9%	17.3%	16.7%	16.2%	17.3%	16.0%	17.9%	16.7%
2025-26	16.2%	17.8%	14.7%									

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

Latest Value GM Benchmarking



Narrative

Trafford

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)

1,368
June 2025

1,542
May 2025

1/10
GM Rank

Outliers more than 1 standard deviation from the mean

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	1,995	2,158	2,328	2,163	2,085	2,217	2,225	2,210	2,159	1,981	1,856	2,170
2022-23	1,972	2,051	1,970	1,972	1,813	1,615	1,517	1,527	1,609	1,526	1,415	1,613
2023-24	1,536	1,588	1,671	1,551	1,561	1,514	1,559	1,568	1,566	1,533	1,495	1,540
2024-25	1,400	1,479	1,446	1,483	1,426	1,443	1,529	1,427	1,524	1,423	1,300	1,501
2025-26	1,455	1,542	1,368									

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

Latest Value GM Benchmarking
Count & Rate Per 1000 Population

Trafford	5.5	1,368
Manchester	5.5	4,163
Oldham	6.9	1,848
Tameside	8.0	1,820
Bury	8.1	1,716
Salford	8.1	2,626
Bolton	8.6	2,888
Rochdale	8.8	2,224
Wigan	9.3	3,289
Stockport	10.4	3,435

The rate is calculated using the registered population figure for each locality | Trafford: 249,404

Narrative

Trafford

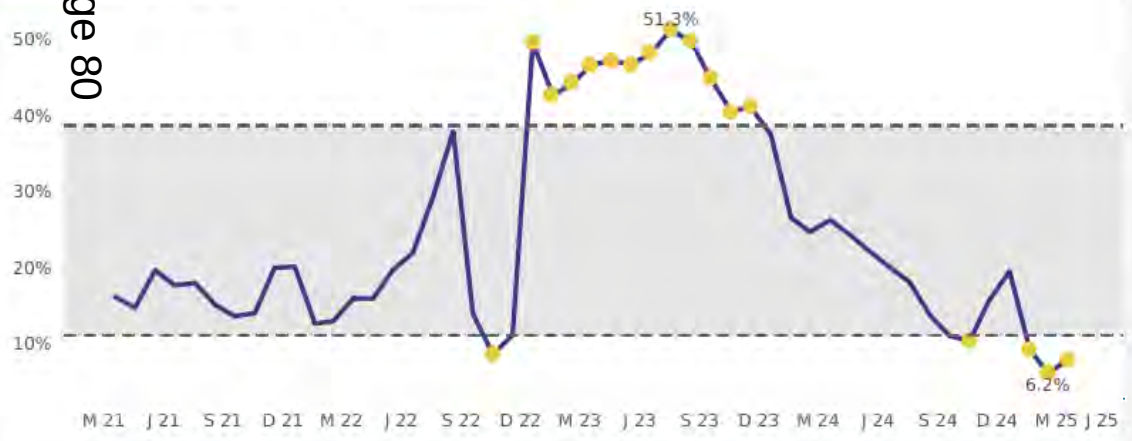
Diagnostic 6ww: All

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

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

8.0%	6.2%	12/107	1.%
April 2025	March 2025	National Rank Upper Quartile	National Target

Deviation more than 1 standard deviation from the mean

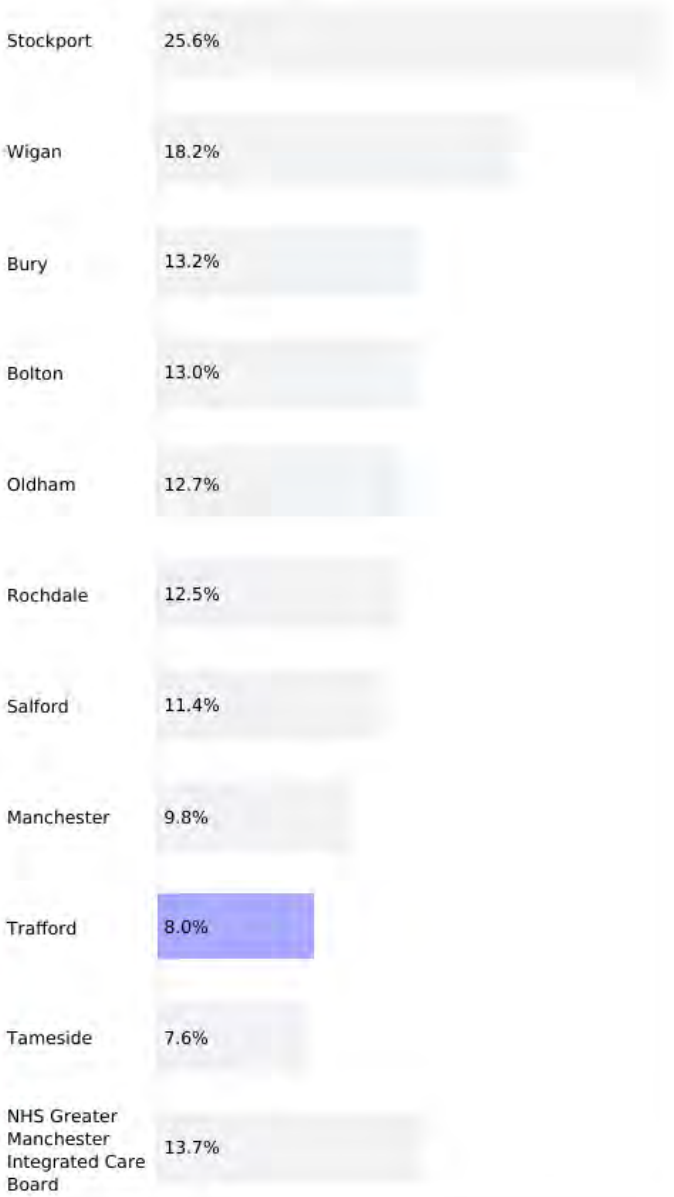


	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	16.2%	14.8%	19.7%	17.7%	18.0%	15.2%	13.7%	14.1%	20.0%	20.2%	12.7%	13.0%
2022-23	16.0%	16.0%	19.8%	22.0%	29.4%	38.0%	14.0%	8.7%	11.2%	49.6%	42.7%	44.2%
2023-24	46.7%	47.3%	46.7%	48.3%	51.3%	49.8%	44.9%	40.6%	41.2%	37.6%	26.6%	24.8%
2024-25	26.3%	24.4%	22.2%	20.1%	18.1%	13.8%	11.1%	10.5%	15.8%	19.5%	9.3%	6.2%
2025-26	8.0%											

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

Latest Value GM Benchmarking

National Rank against other localities



Narrative

Trafford

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)

5.000	2	5/121	0.
April 2025	March 2025	National Rank Upper Quartile	National Target

more than 1 standard deviation from the mean

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	1,321	1,533	1,628	1,492	1,353	1,210	1,025	916	1,033	1,131	1,134	1,053
2022-23	1,084	1,104	1,262	1,497	1,727	2,096	148	168	191	2,135	1,889	1,494
2023-24	1,770	1,634	1,609	1,524	1,718	1,529	1,433	1,201	1,113	858	504	109
2024-25	132	173	201	175	172	49	56	53	46	31	23	2
2025-26	5											

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

Latest Value GM Benchmarking

National Rank against other localities

Narrative

Trafford

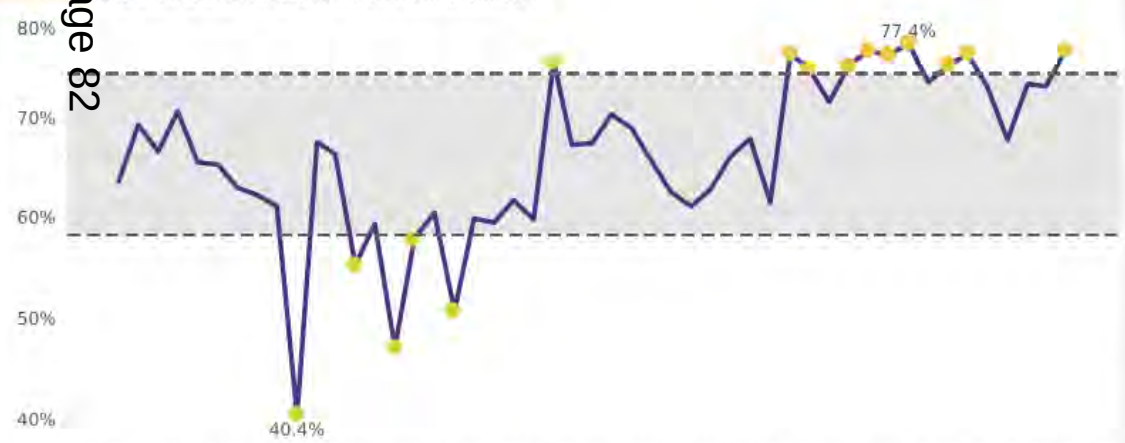
28 Day Wait from Referral to Faster Diagnosis: All Patients

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

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

76.8%	73.1%	52/114	80.%
April 2025	March 2025	National Rank Inter Quartile	National Target

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	63.7%	69.3%	66.7%	70.6%	65.6%	65.4%	63.1%	62.3%	61.2%	40.4%	67.6%	66.4%
2022-23	55.4%	59.5%	47.2%	58.0%	60.6%	50.8%	60.0%	59.6%	61.8%	59.9%	75.6%	67.3%
2023-24	67.5%	70.3%	69.0%	65.8%	62.6%	61.2%	62.9%	66.2%	67.9%	61.6%	76.4%	74.9%
2024-25	71.6%	75.2%	76.7%	76.2%	77.4%	73.6%	75.2%	76.3%	73.0%	67.8%	73.4%	73.1%
2025-26	76.8%											

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

Latest Value GM Benchmarking

National Rank against other localities

Narrative

Trafford

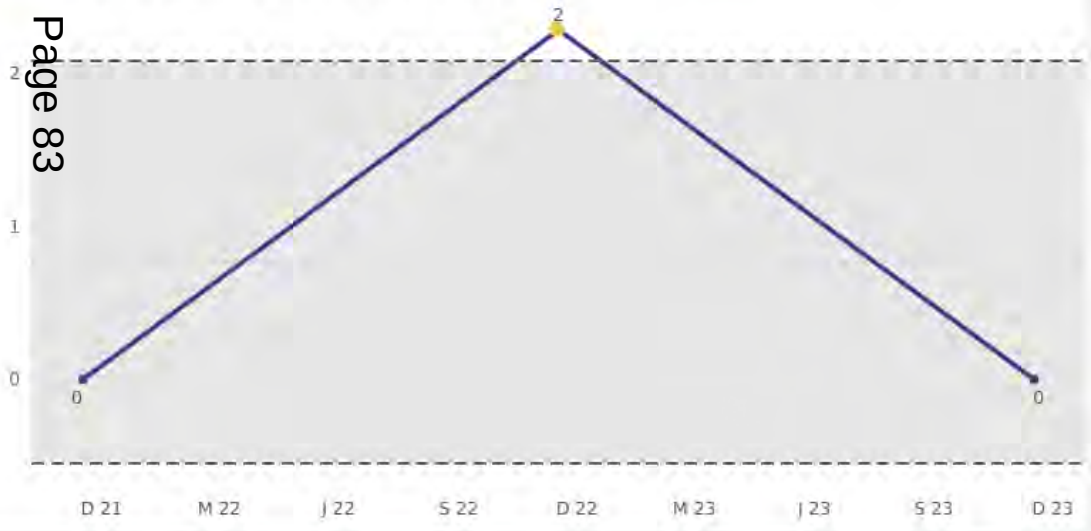
Number of neonatal deaths per 1,000 total live births

Number of neonatal deaths per 1,000 total live births

Source: MBRRACE-UK - Perinatal Mortality Surveillance Report (Annual)

0.0	2.3	1/173	1.4
December 2023	December 2022	National Rank Upper Quartile	National Median

Outliers more than 1 standard deviation from the mean



	Dec
2021-22	0.0
2022-23	2.3
2023-24	0.0

Latest Value GM Benchmarking

National Rank against other localities

Oldham	3.7
NCA	2.3
Manchester	1.8
Salford	1.8
Tameside	1.7
Bury	1.5
Stockport	1.4
Wigan	1.2
Bolton	1.2
Rochdale	0.0
Trafford	0.0

Narrative

Trafford

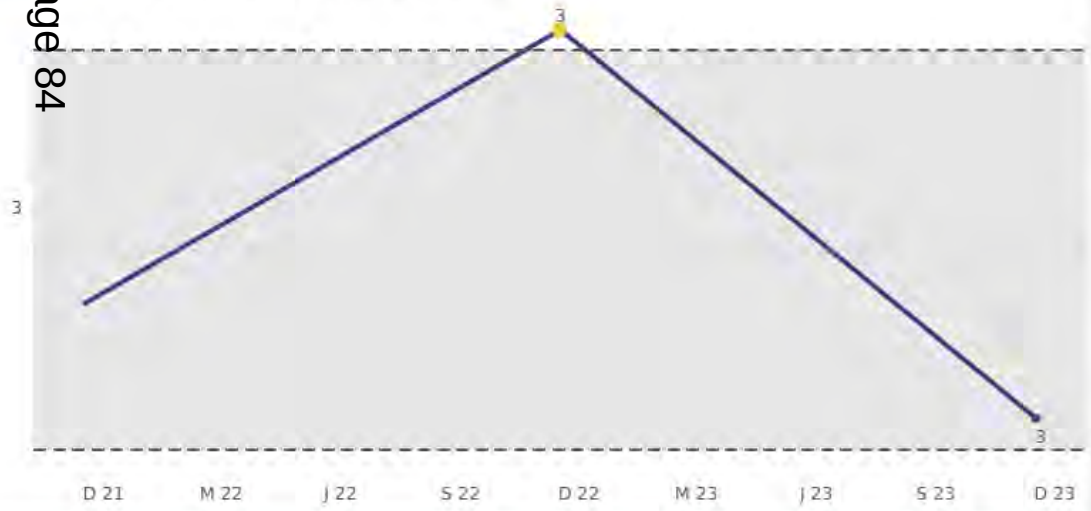
Number of stillbirths per 1,000 total births

Number of stillbirths per 1,000 total births

Source: MBRRACE-UK - Perinatal Mortality Surveillance Report (Annual)

2.8	3.2	52/173	3.1
December 2023	December 2022	National Rank Inter Quartile	National Median

Outliers More than 1 standard deviation from the mean



	Dec
2021-22	2.9
2022-23	3.2
2023-24	2.8

Latest Value GM Benchmarking

National Rank against other localities

Salford	6.5
Rochdale	5.6
Bury	5.4
Bolton	3.8
Wigan	3.7
Manchester	3.6
Oldham	3.0
Trafford	2.8
Tameside	1.7
Stockport	1.4

Narrative

Trafford

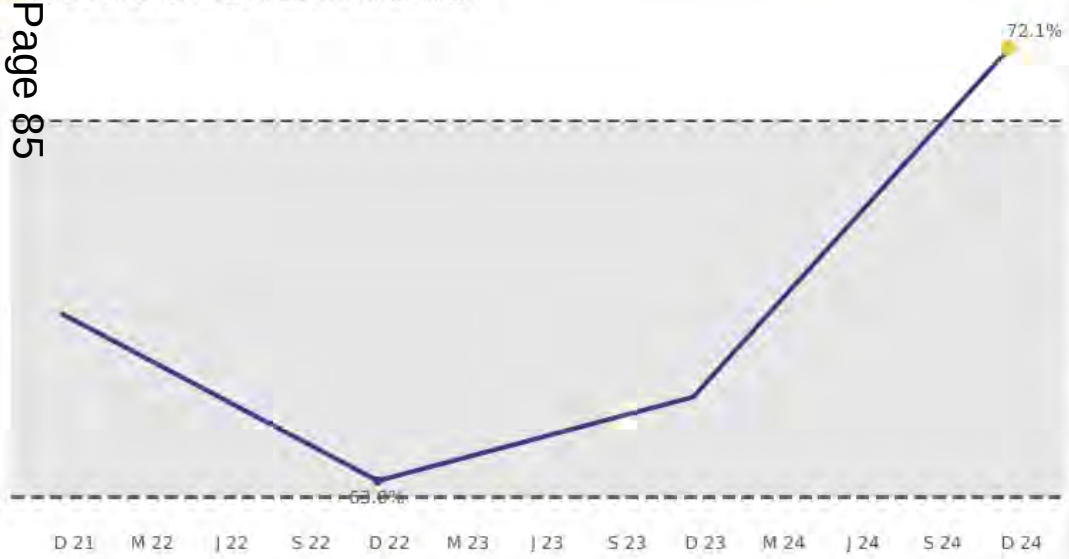
Breast screening coverage, females aged 53-70, screened in last 36 months

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)

72.1%	64.8%	60%
December 2024	December 2023	No Target

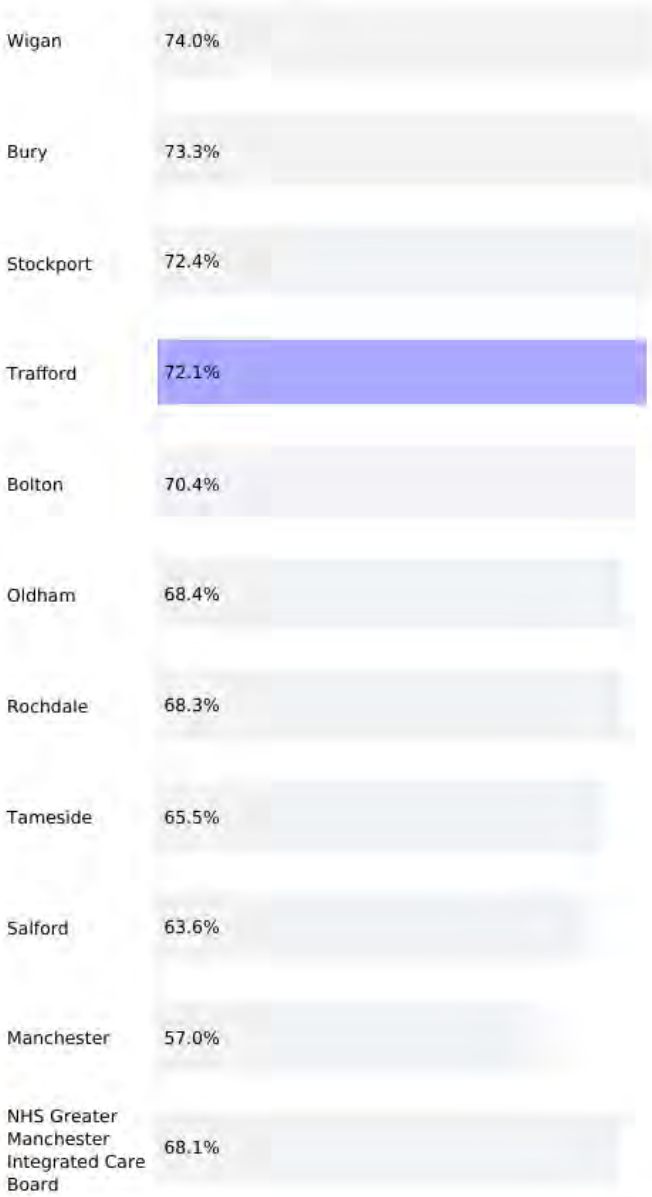
Deviation more than 1 standard deviation from the mean



	Dec
2021-22	66.5%
2022-23	63.0%
2023-24	64.8%
2024-25	72.1%

Latest Value GM Benchmarking

National Rank against other localities



Narrative

Trafford

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)

91.2%
March 2025

95.%
National Target

Deviation more than 1 standard deviation from the mean

	Jun	Sept	Dec	Mar
2021-22	93.6%	90.1%	88.6%	91.0%
2022-23	90.2%	88.6%	89.7%	89.9%
2023-24	88.2%	92.1%	90.3%	91.6%
2024-25	92.2%	88.5%	90.8%	91.2%

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

Latest Value GM Benchmarking

National Rank against other localities

Narrative

Trafford

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)

75.8%	76.1%	6/106	80.%
June 2024	March 2024	National Rank Upper Quartile	National Target

Deviation more than 1 standard deviation from the mean

	Jun	Sept	Dec	Mar
2021-22	76.0%	75.2%	75.0%	75.9%
2022-23	75.7%	74.8%	74.4%	75.4%
2023-24	75.5%	75.4%	75.9%	76.1%
2024-25	75.8%			

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

Latest Value GM Benchmarking

National Rank against other localities

Stockport	76.9%
Trafford	75.8%
Wigan	73.6%
Bury	70.3%
Rochdale	70.3%
Tameside	69.8%
Oldham	69.6%
Bolton	67.1%
Salford	64.6%
Manchester	60.0%
NHS Greater Manchester Integrated Care Board	68.4%

Narrative

Trafford

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)

79.3%
February 2024

79.2%
January 2024

49/106
National Rank
Inter Quartile

85.%
National Target

Deviation more than 1 standard deviation from the mean

	Sept	Oct	Nov	Dec	Jan	Feb
2021-22	16.4%	67.1%		83.7%	84.9%	84.4%
2022-23		72.9%	79.5%	81.5%	82.2%	82.5%
2023-24			77.6%	78.7%	79.2%	79.3%

Selected measure at February 2024 has continuously increased for 3 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities

Narrative

Trafford

% 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

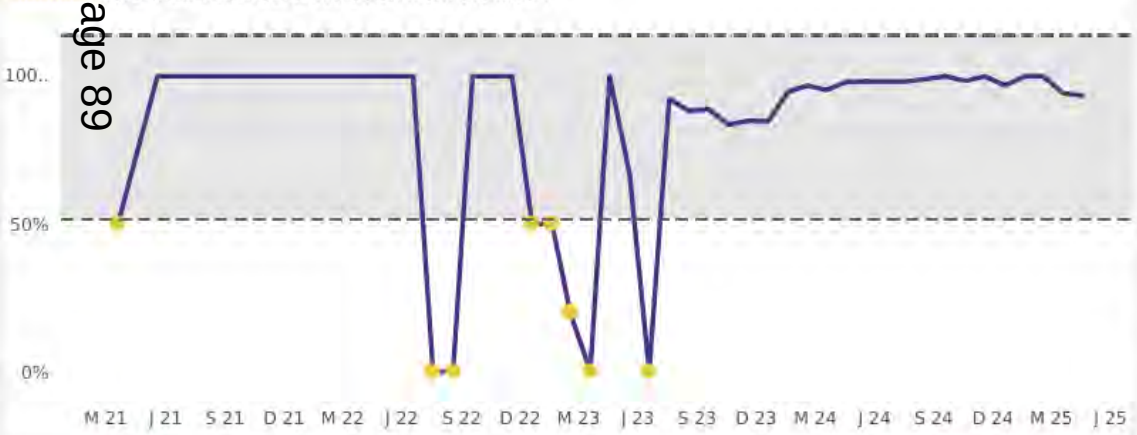
Source: Community Services Data Set (CSDS) (Monthly)

93.4%
May 2025

94.3%
April 2025

70%
National Target

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	50.0%		100.0%				100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
2022-23	100.0%	100.0%		100.0%	0.0%	0.0%	100.0%	100.0%	100.0%	50.0%	50.0%	20.0%
2023-24	0.0%	100.0%	66.7%	0.0%	92.3%	88.2%	88.9%	83.5%	84.9%	84.7%	94.8%	96.8%
2024-25	95.3%	98.1%	98.2%	98.2%	98.2%	99.1%	100.0%	98.4%	100.0%	96.9%	100.0%	100.0%
2025-26	94.3%	93.4%										

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

Latest Value GM Benchmarking

Narrative

Oversight Metrics Glossary

Domain	Code	Measure	Description	Data Source	Frequency	Latest	Updated	RAG rated against	Desired Direc
Cancer	N/A	Cancers Diagnosed At Early Stage using Full Registration Data	Count of cancers diagnosed at stages 1 and 2 divided by count of cancers diagnosed at stages 1, 2, 3, and 4	Cancer Early Staging Data Statistics via The National Disease..	Annual	Dec 21	2nd Thursday	National Median	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	Apr 25	2nd Thursday	National Target	Decrease
	S081a	Talking Therapies: Access Rate	Number of people accessing first treatment	Improving Access to Psychological Therapies Data Set	Monthly	Apr 25	2nd Thursday	No Target	Increase
	EAS01	Dementia: Diagnosis Rate (Aged 65+)	Dementia: Diagnosis Rate (Aged 65+)	Primary Care Dementia Data	Monthly	May 25	2nd Thursday	National Target	Increase
	S030a	% of patients aged 14+ with a completed LD health check	% of patients aged 14+ with a completed LD health check	Learning Disabilities Health Check Scheme	Monthly	Apr 25	2nd Thursday	National Target	Increase
	S110a	Overall Access to Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses	Number of people who receive two or more contacts from NHS or NHS commissioned community mental health services (in transformed and non-transformed PCNs) for adults and older adults wit..	Published MHSDS	Monthly	Apr 25	2nd Thursday	National Median	Increase
	S125a	Long length of stay for adults (60+ days)	Number of people for a given CCG discharged from an adult acute inpatient bed with a hospital spell over 60 days (calculated from the point of admission to the point of discharge)	Published MHSDS	Monthly	Apr 25	2nd Thursday	National Target	Decrease
	EH09	Access to Children and Young Peoples Mental Health Services	Number of CYP aged 0-17 supported through NHS funded mental health services receiving at least one contact.	Published MHSDS	Monthly	Apr 25	2nd Thursday	National Median	Increase
	S131a	Women Accessing Specialist Community Perinatal Mental Health Services	Number of women accessing specialist community PMH and MMHS services in the reporting period	Published MHSDS	Quarterly	Apr 25	2nd Thursday	No Target	Increase
	N/A	Number of MH patients with no criteria to reside (NCTR)	Number of MH patients with no criteria to reside	GM Admissions - Local	Monthly	Jun 25	1st	No Target	Decrease
	N/A	Percentage of MH patients with no criteria to reside (NCTR)	Percentage of MH patients with no criteria to reside	GM Admissions - Local	Monthly	Jun 25	1st	No Target	Decrease
	N/A	Proportion of urgent eating disorder referrals cases entering treatment within one week, aged 0-18	Proportion of referrals with eating disorders categorized as urgent cases entering treatment within one week in RP, aged 0-18	Published MHSDS	Monthly	Apr 25	2nd Thursday	National Target	Increase
	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	Apr 25	2nd Thursday	National Target	Increase
Primary Care	S053b	% of hypertension patients who are treated to target as per NICE guidance		NHS Quality Outcome Framework	Annual	Mar 24	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	May 25	Last Thursday	National Median	Increase
	S053c	% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins	% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins	CVD Prevent	Quarterly	Dec 24	2nd Thursday	National Median	Increase
Quality	S037A	% of patients describing their overall experience of making a GP appointment 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	May 25	1st Wednesday	No Target	Decrease
	S044b	Antimicrobial resistance: proportion of broad-spectrum antibiotic prescribing in primary care	The proportion of broad-spectrum antibiotic prescribing in primary care	EPACT Prescribing Data	Monthly	Apr 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	Apr 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	Apr 25	National Target	0.
	EB28	Diagnostic 6ww: All	% of Patients waiting over 6 weeks for a diagnostic test or procedure	Monthly Diagnostics Waiting Times and Activity Return - DM01	Monthly	Apr 25	National Target	1.%
Cancer	S012a	28 Day Wait from Referral to Faster Diagnosis: All Patients	Count of patients told cancer diagnosis outcome within 28 days divided by total count of patients told cancer diagnosis outcome following their TWW referral for suspected cancer, TWW referral for exhibited breast symptoms, or urgent screening referral	National Cancer Waiting Times Monitoring Data Set (CWT)	Monthly	Apr 25	National Target	80.%
Materni..	S022a	Number of stillbirths per 1,000 total births	Count of cancers diagnosed at stages 1 and 2 divided by count of cancers diagnosed at stages 1, 2, 3, and 4	MBRRACE-UK - Perinatal Mortality Surveillance Report	Annual	Dec 23	National Median	3
	104a	Number of neonatal deaths per 1,000 total live births	Number of neonatal deaths per 1,000 total live births	MBRRACE-UK - Perinatal Mortality Surveillance Report	Annual	Dec 23	National Median	1
Screening and Immunisations	S047A	Seasonal Flu Vaccine Uptake: 65 years and over	number of people over 65 who received the seasonal influenza vaccination divided by the number of eligible people who are aged 65 and over	Seasonal influenza vaccine uptake in GP patients: monthly data, 2022 to 2023	Monthly	Feb 24	National Target	85.%
	S046a	COVER immunisation: MMR2 Uptake at 5 years old	% children whose fifth birthday falls within the time period who have received two doses of MMR vaccination	Cover of vaccination evaluated rapidly (COVER) programme	Quarterly	Mar 25	National Target	95.%
	S050a	Females, 25-64, attending cervical screening within target period (3.5 or 5.5 year coverage, %)	% of females, age 25-64 yrs, attending cervical screening within target period (3.5 yrs if aged 24-49 or 5.5 yrs if aged 50-64)	Cervical Screening Programme - Coverage Statistics [Management Information]	Quarterly	Jun 24	National Target	80.%
	S049a	Breast screening coverage, females aged 53-70, screened in last 36 months	% women eligible for screening who have had a test with a recorded result at least once in the previous 36 months	Fingertips, Public Health Data, Public Health Outcomes Framework	Annual	Dec 24	No Target	
Commu..	N/A	% 2-hour Urgent Community Response (UCR) first care contacts	Percentage of 2-hour Urgent Community Response referrals subject to the 2-hour standard where care was provided within two hours	Community Services Data Set (CSDS)	Monthly	May 25	National Target	

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Trafford
Integrated Care Partnership

Name of Committee / Board	**Trafford Locality Board**			
Date of Meeting	**15/07/2025**			
Report Title	**TPCB Priorities 25-26**			
Report Author & Job Title	**Thomas Maloney, Programme Director Health and Care, Trafford Council / NHS GM Trafford**			
Organisation Exec Lead	**Maggie Kufeldt, DASS, Trafford Council / Elizabeth Calder, Director of Strategy and Partnerships, GMMH**			
OUTCOME REQUIRED *(please highlight)*	**Approval X**	Assurance	**Discussion**	Information

EXECUTIVE SUMMARY

This report is to outline the activity being undertaken in 25-26 across the Strategic and Ancillary priorities of the Trafford Provider Collaborative Board.

Each priority has its own direct governance arrangements, and updates will be brought on a cyclical basis, and by exception, by the relevant priority lead/s throughout the year for assurance, guidance and support and were required decision making in line with delegated responsibilities of Board members.

For 25-26 the priorities agreed in 24-25 were reviewed, with Intermediate Care becoming a new Strategic Priority and Long Term Conditions a new Ancillary Priority. With the implementation of the recommendations from the Urgent Care Review underway, and the ending of the Women's Health Hub pilot, these are no longer specific Board priorities but remain important work programmes.

A more detailed version of the strategic and ancillary priorities was agreed in-principal at the June meeting oft eh Provider Collaborative Board and is available on request.

RECOMMENDATIONS

The Board are asked to:

1. Note and acknowledge the planned activity across the priority areas of work for 25-26
2. Consider any comments or questions to be fed back to the relevant priority leads

CONSIDERATIONS – these must be completed before submission to the Board – Reports with incomplete coversheet information will not be accepted and shared with the board

Risk implications ***(Please provide a high-level description of any risks relating to this paper, including reference to appropriate organisational risk register)***	No new risks resulting from this update – risks to be managed through thematic governance and organisationally where applicable.
Financial implications and comment/approval ***(Please detail which organisation(s) will be impacted, and if not required, please briefly detail why)***	Name/Designation: N/A for this report
	Comment / Approval: N/A for this report
	Date of Clinical Lead comment: N/A for this report

Comment by Trafford Clinical and Practitioner Senate (TCAPS) and/or Clinical Lead ***(If not required, please briefly detail why)***	Name/Designation: N/A for this report
	Comment: N/A for this report
What is the impact on inequalities? ***(Please provide a high-level description of any known impacts)***	N/A for this report
Equality Impact Assessment / Quality Impact Assessment Outcome ***(If not appropriate at this stage please state if an EIA or QIA is necessary)***	Relevant EIA/QIAs completed by individual work areas and reported through their relevant governance groups
People and Communities: Communications & Engagement ***(Please detail relevant patient/public engagement completed and/or planned, and if not required please briefly detail why)***	N/A for this report
Trafford's Carbon Footprint ***(Please provide a high-level description of any known positive and/or negative impacts – consider the following topics: energy usage; staff or public transport; waste or materials used. Include steps that could be taken to reduce carbon within relevant plans)***	N/A for this report
Links to Measurement / Outcomes ***(Please detail if this is included within the report)***	There is an ask of the priority leads to develop and enhance their data and impact arrangements and to update these though the TPCB when appropriate – Trafford's Finance Performance and Sustainability Group will provide advice and guidance linked to its role leading the required performance arrangements of the Locality Board
Enabler implications	**Legal implications:** N/A
	Workforce implications: N/A
	Digital implications: N/A
	Estates implications: N/A
Sub-Board Sign-Off / Comments **(i.e. Trafford Provider Collaborative Board, H&SC Delivery Steering Group)**	A more comprehensive presentation of the 25/26 priorities was supported in-principal by the Provider Collaborative Board at its meeting on the 26th June 25.
Organisation Exec Lead Sign off	Maggie Kufeldt, DASS, Trafford Council / Elizabeth Calder, Director of Strategy and Partnerships, GMMH

2025-26 Priorities of the Trafford Provider Collaborative Board

Trafford
Integrated Care Partnership

Part of Greater Manchester
Integrated Care Partnership

Background and Context

Trafford
Integrated Care Partnership

- In 2024/25 the Trafford Provider Collaborative Board set an array of **strategic and ancillary priorities** for the year.

- The work undertaken through 24/25 was presented back through an interim **Impact Report** in January 2025, and a fuller End of Year report was agreed to be tabled following year-end.

- These priorities have been reviewed and updated for 25/26, with a new Strategic Priority of **Intermediate Care**, and a new Ancillary Priority of **Long-Term Conditions**. With the implementation of the recommendations from the Urgent Care Review underway, and the ending of the Women's Health Hub pilot, these are no longer specific Board priorities but remain important work programmes.

- An action to define and agree the specific programmes of work under each strategic and aligned priority was taken away and has been built upon to form the **final strategic and ancillary priorities** presented in this report to form a full 25/26 work programme for the TPCB, pending agreement.

Trafford
Integrated Care Partnership

TPCB Priorities 25/26

TPCB Strategic Priorities

Trafford
Integrated Care Partnership

- Board has **4 strategic priorities for 25-26,** that it will provide support and guidance for through the year
- These are our Neighbourhood Model, Mental Health, Children's, and Intermediate Care
- The detail of these priorities is contained in this report where available.
- The priorities reflect the input from key partners across the system, and regular updates will be brought on activity and progress

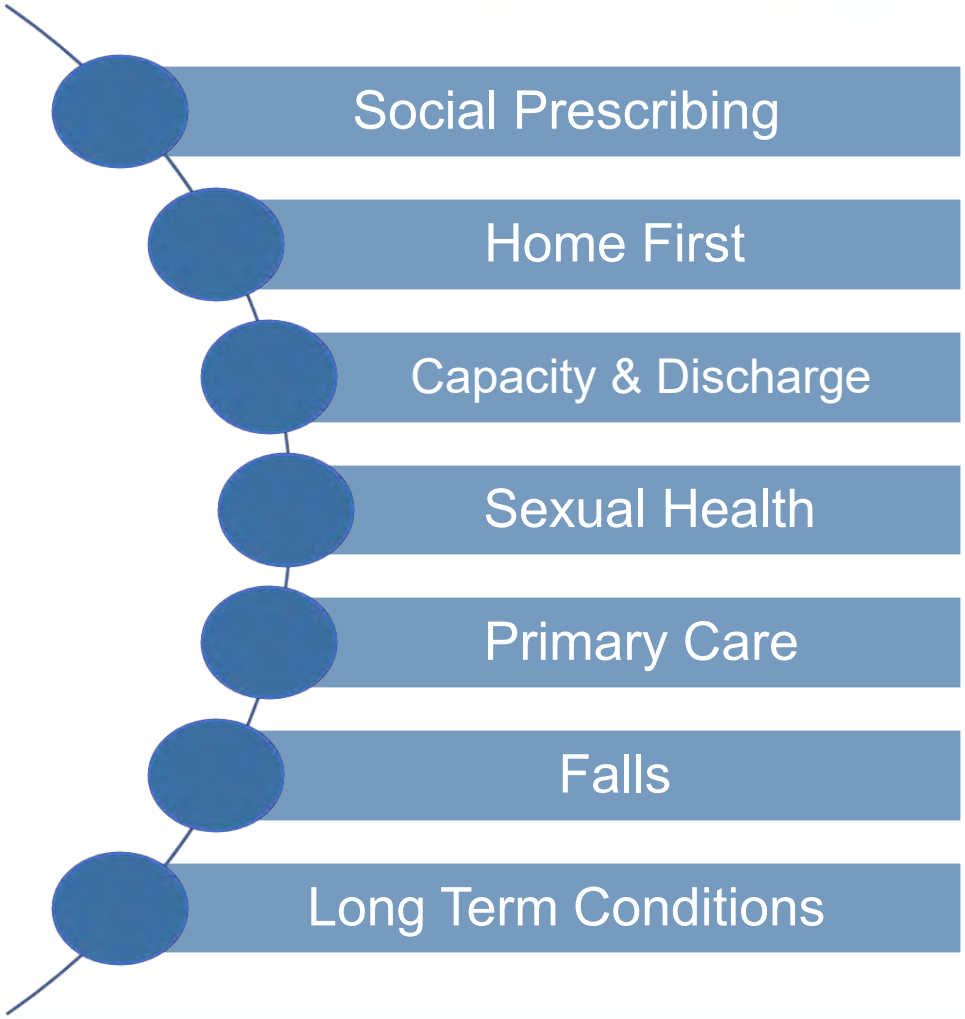
TPCB Ancillary Priorities 25/26

Trafford
Integrated Care Partnership

- Although the Board has prioritised its efforts to focus on four strategic priorities it has also acknowledged its pivotal role in shaping, guiding and assuring a variety of additional services, projects and programmes.

  The list of additional priorities are reflective of the Commissioning Intentions and Priority exercise undertaken but remain open to change.

- The Board will remain flexible throughout the year to emergent need where required and will engage partners through the Board if further prioritisation is required.



TPCB Ancillary Priorities 25/26

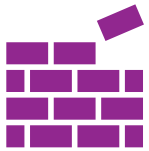
Trafford
Integrated Care Partnership

Social Prescribing
- Enhancing our social prescribing offer looking at workforce and operating model, ensuring our data and comms are effective, and increasing the strategic footprint of the service

Home First / Care Closer to Home
- Supporting and reporting the Strategic metrics of the Home First Board. Aligning BAU activity with Home First programmes of work

Capacity & Discharge Planning (Winter Planning)
- Alignment and socialization of system and organisational Plans for 24/25

Sexual Health
- To reduce sexual and reproductive health inequalities within Trafford with particular focus on improving public information, addressing capacity pressures, and access issues within the service



Primary Care
- New Primary Care Standards for 25/26 with a focus on CVD, Diabetes, CKD, and Prescribing. Two new locality schemes looking at High Intensity Users and Severe Mental Illness.

Long Term Conditions
- Developing the new LTC programme to target 8 strands of work, in order to prevent and detect early the factors that lead to LTCs.

Falls
- To ensure that individuals can access evidence-based falls prevention advice and support, where they reside, so they can maximise their independence and enjoy good quality later life. Rolling out of the new falls prevention service.

TPCB Forward Plan 25/26

Trafford
Integrated Care Partnership

- We will schedule onto the forward plan a monthly cycle of updates from the 4 Strategic Priorities
- We will also do the same for the Ancillary Priorities, whilst remaining flexible for any new priorities
- At periods of high activity or importance there may be additional updates brought to the Board in addition
- The forward plan order for illustration only, decisions on the appropriate months to bring updates will be decided in liaison with the leads
- There is no meeting currently planned for December 25, as is customary

Month	Strategic	Ancillary
July	Neighbourhood	Falls
August	Mental Health	Primary Care
September	Intermediate Care	Capacity & Discharge
October	Children's	Long Term Conditions
November	Neighbourhood	Sexual Health
January	Mental Health	Social Prescribing
February	Intermediate Care	Home First
March	Children's	tbc, cycle to repeat

TPCB Governance Arrangements

Trafford
Integrated Care Partnership

Priority	Type	Thematic Partnership Governance
Neighbourhood	Strategic	Live Well Steering Group
Mental Health	Strategic	All-Age Mental Health Group
Intermediate	Strategic	Intermediate Care Working Group
Children's	Strategic	Children & Young People's Strategic Partnership
Falls	Ancillary	Falls Partnership
Primary Care	Ancillary	Primary Care Commissioning Committee
Capacity & Discharge	Ancillary	Trafford & Manchester Urgent Care Board
Long Term Conditions	Ancillary	Long Term Conditions Working Group
Sexual Health	Ancillary	Sexual Health Network
Social Prescribing	Ancillary	Social Prescribing Steering Group
Home First/Care Closer to Home	Ancillary	Trafford & Manchester Urgent Care Board

- The priorities of the Board have their own operational governance routes for delivery and appropriate level decision-making.
- Reports and updates will be taken through these groups in the first instance, including output & outcome data and any qualitative case studies and feedback.
- Enhanced communication channels to be established between TPCB and thematic partnership governance enabled by Programme Management arrangements.

Data & Impact

Trafford
Integrated Care Partnership

- As part of the refresh of Performance Arrangements, we are seeking to enhance our data offer to give governance groups greater **clarity and grip** on the performance of our priorities
- The performance **metrics, KPIs, and qualitative reports** will be managed by the respective partnership governance as detailed on the previous slide
- There may be **new processes** required to manage the collation, analysis and narrative of the data
- New **data products** may be created such as dashboards and scorecards, where needed – being mindful of capacity and changes to operating models due to NHS Reform
- We seek to be in a position where data and impact is reported at the working group level, then flowing into TPCB, and to other governance as appropriate, that gives **assurance** to the work being undertaken and an accurate reflection of current trends, successes, and areas of improvement

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Trafford
Integrated Care Partnership

Name of Committee / Board	Trafford Locality Board			
Date of Meeting	15 July 2025			
Report Title	Trafford Strategic Risk Register 2025/26			
Report Author & Job Title	Pippa Dewhirst, Governance Manager, NHS GM ICB			
Organisation Exec Lead	Thomas Maloney, Programme Director Health and Care, Trafford Council / NHS GM (Trafford)			
OUTCOME REQUIRED *(please highlight)*	Approval	Assurance X	Discussion X	Information

EXECUTIVE SUMMARY

The purpose of this report is to present the Locality Board with an overview of the strategic risks for the 2025/26 Trafford Locality Board Strategic Risk Register and provide assurance that risks are effectively identified, monitored and managed.

There are currently 10 strategic risks on the Locality Board register, four of the risks are rated extreme (red), three rated high (orange) and three rated moderate risk (yellow).

Since the risks were last presented to the Locality Board in March 2025, two new risks have been added (SR14 and SR15) 1 risks (SR03,) has been reduced and two of the risks (SR12 and SR04) have increased. The other risk scores remain the same and are all detailed in Appendix 1.

RECOMMENDATION

Trafford Locality Board is asked to:

1. note the content of this report and supporting appendix for assurance purposes; and

2. review the strategic risk position and confirm that the current level of risk, risk scores, controls, gaps in control and action plans are acceptable and in line with risk treatment plans.

CONSIDERATIONS – these must be completed before submission to the Board – Reports with incomplete coversheet information will not be accepted and shared with the board

Risk implications (***Please provide a high-level description of any risks relating to this paper, including reference to appropriate organisational risk register***)	Risk is requested to be on meeting agendas' to further embed risk management activities. Risk management is an integral part of the organisation's statutory requirements. Risks considered and mitigated in the body of the report.
Financial implications and comment/approval ***(Please detail which organisation(s) will be impacted, and if not required, please briefly detail why)***	Name/Designation: N/A
	Comment / Approval: N/A
Comment by Trafford Clinical and Practitioner Senate (TCAPS) and/or Clinical Lead ***(If not required, please briefly detail why)***	Date of TCAPS / Clinical Lead comment: N/A
	Name/Designation: N/A
	Comment: N/A

What is the impact on inequalities? (P*lease provide a high-level description of any known impacts)*	N/A
Equality Impact Assessment / Quality Impact Assessment Outcome *(If not appropriate at this stage please state if an EIA or QIA is necessary)*	N/A
People and Communities: Communications & Engagement *(Please detail relevant patient/public engagement completed and/or planned, and if not required please briefly detail why)*	N/A
Trafford's Carbon Footprint *(Please provide a high-level description of any known positive and/or negative impacts – consider the following topics: energy usage; staff or public transport; waste or materials used. Include steps that could be taken to reduce carbon within relevant plans)*	N/A
Links to Measurement / Outcomes *(Please detail if this is included within the report)*	N/A
Enabler implications	**Legal implications:** N/A
	Workforce implications: N/A
	Digital implications: N/A
	Estates implications: N/A
Sub-Board Sign-Off / Comments **(i.e. Trafford Provider Collaborative Board, H&SC Delivery Steering Group)**	N/A
Organisation Exec Lead Sign off	Thomas Maloney, Programme Director Health and Care

1.0 Introduction and Background

1.1 The Locality Board has a responsibility to maintain an on-going risk profile of the Trafford locality through the Locality Board Strategic Risk Register as set out in NHS GM's Risk Management Strategy. Accountability for each of the strategic risks recorded on the risk register is assigned to an Executive Lead and managed by a risk Lead Manager. The strategic risk register provides evidence and ensures that a systematic process for identifying Trafford locality's strategic objectives as well as its associated strategic risks, towards the achievement of its objectives, is in place. It is a key document for the Locality Board and should be used to monitor key risks and to assure itself that the risks are being managed and mitigated.

1.2 The Locality Board should; challenge the risk ratings and target risk scores; assess the robustness of the controls and actions plans identified and ensure that progress is made to reduce the gap between the current risk rating and the target score.
Other Boards and Working Groups that report into the Trafford Provider Collaborative Board (TPCB) and/or the Locality Board will have oversight of individual risks recorded on the register, in accordance with the terms of reference of each Board and/or Group.

1.3 The Locality Board has been working in an integrated manner with partner organisations and other stakeholders under the established Trafford Integrated Care Partnership. Joint priorities and work areas for the health and social care system have been developed to address challenges that have been identified. These are set out in the aspirations of the Trafford Locality Plan.

2.0 The status of the 2025/26 Trafford Locality Board Strategic Risk Register

2.1 There are currently 10 strategic risks identified on the 2025/26 Locality Board strategic risk register which align and directly link to the strategic priorities and objectives of NHS GM. All the risks have been reviewed and updated.

2.2 There has been some changes to the strategic risks since they were last presented to the Locality Board in March 2025. The changes are detailed below:

- Two new risks have been added.

  - SR14 relates to the risk to the ICB due to NHS Reforms. In GM the planned NHS reforms will result in a 39% reduction. The uncertainty is likely to effect the workforce and will impact business continuity. The reforms pose a risk to being able to deliver the key aims of the Trafford Locality Plan. Key controls are in place to support the management of the risk including regular staff engagement, development of people and culture action plan, prioritisation of workloads and robust GM design governance working on the new operating

model. TLB are provided with regular updates regarding the progress of NHS Reforms at each meeting.

- SR15 relates to the current financial struggle relating to the rising cost of nursing care in private Trafford care homes as care homes demand fees above the contract rate. Work has been initiated to review the care market and inconjunction with Trafford Council the ICB have procured care cubed to provide an evidence base to support negotiations with care homes.The risk is reviewed at the Cost improvement plan meeting.

- 2 risks have increased.

  - SR04 relates to the risk of children suffering from adverse healthcare due to insufficient funding and capacity. This risk was discussed at the last review by TLB of the strategic risk register and it was felt the scoring was too low at 10 and did not reflect the current risk. The risk has subsequently been reviewed and rescored at 20 to reflect the current wait times for services including ADHD and Autism assessment. Work is in train to review the ND pathway and a paper is included with the agenda which seeks approval for a new pathway which should reduce wait times.

  - SR12 has increased from 15 to 20. The strategic finance risk aligns with the rating we report as an ICB reflecting the overall system risk. The previous risk referred to the 2024/25 position and the level of risk associated with its delivery in the latter stages of the year. As we are in the early stages of the current year with significant savings to be delivered to meet our financial control total, the risk has been rebased for 2025/26.

- 1 risk, SR03 has had the risk rating reduced. There was a risk to the delivery of equipment for patients within Trafford following the Trafford LCO serving notice to cease delivery of the service form the 31st March 2025. The team were able to ensure a provider was in place to cover this service on an interim basis for 12 months until the end of the financial year. Manchester Equipment & Adaptations Service are currently providing the service as previously discussed and approved at Trafford Locality Board. A working group regularly reviews the service and will support the longer term procurement plan.

- All other risks have been reviewed by their risk leads and the scoring has remained the same, the risk register in appendix 1 provides further detail about action plans in place to mitigate the risks.

2.3 The movement of the strategic risks are presented in the two Heat Maps below.

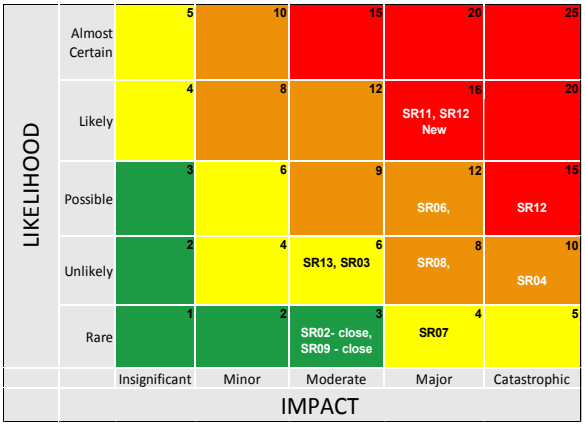

Figure 1: Heat Map (March 2025)

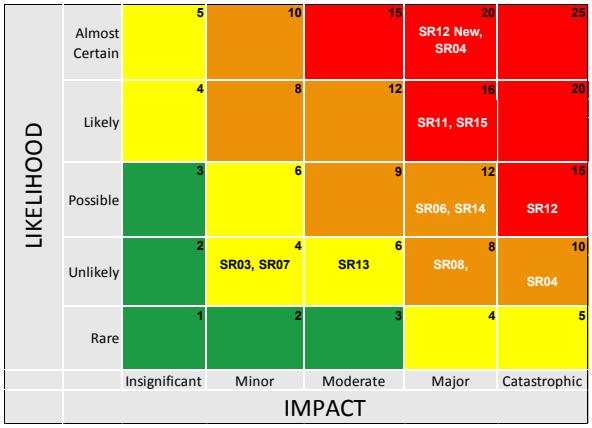

Figure 2: Heat Map (July 2025)

2.4 There are four extreme rated risks (coloured red, rated between 20 and 16) and three high risks (coloured orange, rated between 8 and 12) and three moderate risks (coloured yellow rated between 4-6).

2.5 The individual strategic risks, as well as their updates are detailed in Appendix 1.

2.6 The addition, review and updating of the strategic risks are ongoing and are discussed with the risk owners during the Risk Assurance Group. The review of the mitigating actions is also ongoing to assess, for example, whether the controls, gaps in controls and action plans identified, are adequate, effective or working as they should. For those high scoring risks of 15 and above, there is a need to review these regularly, reflecting the severity of these risks.

3.0 Performance

3.1 As part of our commitment to continuously evaluate our performance products to ensure they support our objectives and enable us to monitor risks effectively we have scheduled a review of our performance products in line with our risk registers . As highlighted at FPS and discussed at TLB this is an area of development that could provide significant support in giving reassurance risks are being monitored effectively.

3.2 The intention is to compare the strategic risk register with the performance products we are currently considering and highlight any areas we could develop further to support risk management. Risk leads will be engaged to discuss if any complementary or additional performance metrics could be added to our dashboards to support any discussion on progress or mitigation of risks. The Locality team will work with the BI team to establish if complementary metrics could be included in the locality scorecard and outputs will be brought back to the August FPS for consideration with the outputs being brought to TLB for review.

3.3 An area that could potentially be developed would be additional workforce measures on our Locality Scorecard to support the risk of workforce de-stablisation issues due to the NHS reform risk.

4.0 Recommendations

4.1 Trafford Locality Board is asked to:

1. note the content of this report and supporting appendix for assurance purposes; and

2. review the strategic risk position and confirm that the current level of risk, risk scores, controls, gaps in control and action plans are acceptable and in line with risk treatment plans.

NHS GM Priorities	Risk ID	Date Added	Executive Lead	Risk Description	Lead Manager	Committee Oversight	Likelihood	Impact	Initial Risk Rating (L x I)	Key Controls in place	Gaps in Control	Likelihood	Impact	Current Risk Rating (L x I)	Action Plans (*Action owner, Expected date of completion*)	Progress against Actions Plans	Assurance	Gaps in Assurance	Likelihood	Impact	Target Risk Rating (L x I)	Risk Movement	Last Reviewed Date	Estimated Closure Date	Status
Help people stay well and detect illness earlier. We will work together to prevent illness and reduce risk and inequalities.	**SR11**	17/10/23	Gareth James	There is a risk that the capacity of the Designated team at place will be unable to fulfil the requirements of the three delivery group functions adequately. This will lead to gaps in oversight and assurance of contracts, statutory functions, training, and abilities to embed new requirements such as the serious violence duty.	Sarah Owen	Trafford Strategic Safeguarding Partnership	4	4	16	•Safeguarding Quarterly report to GM and 6 weekly flash reports including situation report on workforce to reflect MIAA review. • Prioritisation of work streams. • Regular review of work streams to assist with the task of prioritisation through team meetings. • Engagement with all Partner agencies. •Maintaining virtual meetings where possible to maximise time available to team. • Statutory functions matrix is being established through the delivery groups to map minimum statutory requirements. • Mutual aid protocol to be designed for GM cover across the wider safeguarding workforce to assist with cover where possible.	• Business continuity and associated workstreams are not secure due to vacant posts in the Adult Named GPs and the Designated Doctor for child deaths not in post. • The current team capacity limits availability to engage in quality and service improvement. Examples of this can be seen in relation to: - domestic abuse, provider assurance visits, review of GP assurance tool kit, limited audit and assurance activity, - evidence gathering with provider organisations, - oversight of safeguarding within contracts, particularly since the changes to the quality team support. • The reduced capacity directly impacts the teams ability to be proactive. • The Named and Designated professionals have approximately half of the recommended allocation of time set out in the intercollegiate guidance and by definition can therefore only carry out half of the necessary aspects of the role. • Attendance at Named and Designated National Networks to facilitate awareness and alignment of wider workstreams throughout GM. The Designated Nurse - Safeguarding Children and Cared For Children has a dual role, this limits ability to engage fully in either role. In addition, one day per week is dedicated to the NHS EGA leadership Masters which reduces available time for locality work.	4	4	16	1.1 Arrangement to recruited Adult Named GP. 1.2 Further discussions around the GM Safeguarding Model	1.1 Recruitment to Adult GP role is not currently progressing - business critical form completed - not authorised due to wider GM capacity and possibility of mutual aid. 1.2 Deputy Designated Nurse post remains vacant due to interim arrangements within the organisation. Rationalisation of workload - sticking to prioritisation plans. 1.3Following the presentation of the Safeguarding compliance to the intercollgiate guiadance and Trafford locality safeguarding budget at SLT 15.10.24, authorisation was provided to commence applications to the business critical panel for the advertisemnt of vacant posts. The Designated Team are currently completing this process. 06.03.2025 - 1.1 The current Named GP has resigned with a 12 week notice period. The Designated Safeurding team are currently completing TRAC application and associated BCF authorisation. 1.2 Deputy Designated Nurse post has been successfully recruited to, expected start date June/July 2025. 26.06.25 The Designated Nurse for LAC is now in post- making the team complent with intercollegiate guidance and improving capacity to engage in both GM and locality work. vacancy freeze remains in place across the organisation, pending structural reform of the ICB, therfore There are no plans to recruit to the Named GP post for adults and Children, which is a significant gap for Primary Care. This also means that key functions will not be deliverable for the ICB within the locality as the business continuity / mutual aid offer does not extend to periods exceeding 1 month. The Designated Dr for child death post also also remains vacant, posing a challenge for the current CDOP model.	Trafford Locality Board	None identified yet	3	4	12	↔	26/06/25	01/09/25	Active
Achieve Financial sustainability. We will spend public money well to achieve our objectives.	**SR12 New**	10/05/24	Gareth James	**Risk** - Failure to deliver the financial plan for 2025/26 for GM ICS as agreed with NHSE. **Cause** - Failure to develop and / or deliver recurrent saving schemes across the ICS or operational cost pressure above planned level of expenditure Implementation of NHS reform may impact delivery income is lower than planned **Impact** - Further scrutiny and intervention by NHSE unable to deliver GM ICS strategy health of GM population worsens continued inequalities and variation in health and care	Julie Flanagan	Trafford Locality Board Trafford Finance, Performance & Sustainability Group	4	5	20	• Financial Performance Recovery Oversight Group, Provider Oversight meetings and Locality Assurance meetings established which include financial assurance and scrutiny. • ICB CIP groups established reporting to EMT/ Chief Officers meeting/ Finance Committee, Finance Recovery Oversight Group which in turn reports to Finance Committee and Exec Committee • All organisations report financial and operational performance to their respective Finance Committees and Boards • Continuation of the grip and control measure implemented in 2023/24 including expenditure >£10k for ICB proposals and >£100k for NHS provider proposals is subject to review and approval by the ICB Exec team via the STAR process • All ICB contract renewals or extensions must also be submitted to the STAR process • If approval is granted via STAR then the governance route as identified in the SoRD is followed for ICB incurred costs or via NHS provider internal governance	• In year financial reporting of the Trafford system partner position still to be develop to provide insight to Trafford Locality board of the challenge	5	4	20	• Grip and control measures e.g. STAR process and Business Critical Post panel remain in place to control expenditure. CIP plans are further being developed and implemented to realise efficiencies along with commissioning intentions that will deliver efficiencies while improving services. Work ongoing through PMO All budgets reviewed to identify non recurrent slippage opportunities on a monthly basis. • Financial reporting and monitoring taking place on monthly basis • Provider oversight and ICB locality assurance meetings either monthly or quarterly dependent on level of risk •To develop in year financial reporting of the Trafford system partner position to provide insight to Trafford Locality board of the challenge • Red lines - GM developed trigger points that will require corrective actions. •ICB is adopting a new reporting pack with a focus on run rate to allow identification of potential issues so a mitigation plan can be implemented to address the risks on in year delivery	• ICB Locality CIP plan developed to deliver 3% efficiency with further work to underway to meet the final 1% Schemes shared with Locality board monthly • ICB locality report and high level ICS position reported to Locality board monthly • Locality Assurance meetings in place • First draft of a locality partnership finance report shared via FPS. Aim to provide enhanced report to Locality board from Q1 25/26 • Red line trigger points for ICB locality variances developed and shared •	• ICB finance Committee • Each NHS Organisation reports via their internal finance committee and board meeting • NHS GM reviews NHS provider performance as well as ICB financial performance at their EMT, finance committee and board • Trafford Locality Board to oversee financial performance of the ICB locality delegated budgets • Trafford Finance Performance And Sustainability Group established	In year financial reporting of the Trafford system partner position still to be develop to provide insight to Trafford Locality board of the challenge	4	3	12	↑	24/06/25	31/12/25	Active
Recover core NHS and care services. We will continue to improve access to high quality services and reduce long waits.	**SR06**	17/10/23	Gareth James	There is a risk to the delivery of a sustainable and clinically safe model of Intermediate Care due to: - longstanding financial challenges and complex governance and delivery arrangements. - the challenges in obtaining system agreement for longer term redesign and transformation of services to enable more sustainable provision.	Cathy O'Driscoll	Home First Board.	4	4	16	• NHS GM and Trafford Council- S75 Group • Locality Board • MFT Contract and Contract Governance • Better Care Fund Programme Funding and Governance. • Pause in one bedded unit to lower costs in year.	• Sign-off of financial agreements for 25/26 as part of BCF planning. Full Programme scope, plan and arrangements for the Transforming IMC Programme, a named priority for 25-27.	3	4	12	1.1.System buy in and implementation of the recommendations of the Independent Changeology Review of IMC and D2A Pathways in Trafford, undertaken in 2024. 1.2 Development of IMC strategy and new models of care inc. delivery plans, and supporting governance to drive delivery.	1.1 25/26 BCF planning discussions are underway within S75 Steering Group. Plans to be agreed and submitted to NHSE by 31st March 2025. This will include finanical arrangements for the cost pressures for 25/26. 1.2. Exec to Exec discussions regarding Review recommedations underway, led by TC DAS. 1.3. Additional Programme support identified. 1.4. Programme governance in development. This programme will sit within the wider strategic Improving Lives Everyday Programme.	Better Care Fund Programme. Provider Collaborative Locality Board. Improving Lives Everyday Programme	Formal sign-up by all key partners and programme development and new models of care to be developed.	3	3	9	↔	09/07/25	01/09/26	Active
Help people stay well and detect illness earlier. We will work together to prevent illness and reduce risk and inequalities.	**SR04**	17/10/23	Gareth James	There is a risk that children and young people will suffer from adverse healthcare due to insufficient funding and capacity across health services to meet the surge in demand. This could lead to delayed diagnosis/treatment and care resulting in poorer outcomes for children and young people especially in delayed access to mental health services and delays in the assessment and diagnosis of Autism and ADHD Waiting times for Autism and ADHD continue to increase, with high presentation of CYP waiting for diagnosis across multiple services across education, health and social care.	Sally Atkinson	Trafford Locality Board	5	4	20	• NHS Long Term Plan • Trafford All Age Mental Health Strategy • GM Mental Health Strategy • GM Autism Minimum Standards • Trafford SEND Ambition Plan	•Workforce challenges across providers • No current financial agreements in place to bridge the current gap between service delivery budget and service costs for 2024/25. •SEND commissioning Strategy needs to be developed •Trafford All Age Mental Health Strategy is currently being refreshed •Significant increase in demand across all CYP health services	5	4	20	1.1 'Review of CYP Community Health Services 1.2 Redesign VCSE mental health service offers to meet demand within financial envelope 1.3 Develop a SEND Commissioning strategy and mental health strategy to progress system approach to reducing health inequalities 1.4 Developing a support offer for families whilst they are waiting for services 1.5 Implementation of the GM ND Pathway transformation programme.	A support whilst you are waiting included pre/post diagnostic offer has been developed and implementation has commenced through a staged approach. The support will be delivered from a 'system' approach across Education, health and social care teams'. There has been a focus on broadening the universal offer initially. Recurrent funding has been secured to improve the early intervention and prevention mental health offer. Proposals are currently being drafted. The review of community services has commenced focussing initially on the Physiotherapy and Occupational Therapy Service. A SEND commissioning strategy has been developed and is going to SEND board at the end of March for sign off.	All Age Mental Health Board CYP Commissioning Board SEND Board Locality Board	Routine performance data and transparency around finances from providers to support commissioning of services.	2	4	8	↑	26/06/25	01/09/25	Active

NHS GM Priorities	Risk ID	Date Added	Executive Lead	Risk Description	Lead Manager	Committee Oversight	Likelihood	Impact	Initial Risk Rating (L x I)	Key Controls in place	Gaps in Control	Likelihood	Impact	Current Risk Rating (L x I)	Action Plans (*Action owner, Expected date of completion*)	Progress against Actions Plans	Assurance	Gaps in Assurance	Likelihood	Impact	Target Risk Rating (L x I)	Risk Movement	Last Reviewed Date	Estimated Closure Date	Status
Strengthen our communities. We will help people, families and communities feel more confident in managing their own health.	SR08	17/10/23	Ian Lurcock	There is a risk that the neighbourhood programme may not be able to deliver person-centred and community-based care in neighbourhoods if all partners don't fully commit to providing capacity, funding, engagement, and commitment in relation to the Neighbourhood Programme's four strategic objectives.	Richard Spearing	Trafford Provider Collaborative Board	2	4	8	• Neighbourhood Programme SRO, programme manager and administrative support in place • Programme management approach and documentation established and in place including action plans, risk registers, RAID logs, etc • Neighbourhood Programme governance in place including steering group, working groups and bi-annual design forum • Trafford Live Well Steering Group has been established to anage the Broader Live Well programme and associated funding for 25/26 • Reporting mechanisms to TPCB, Live Well Steering Group and by escalation to the Locality Board and/or HWBB • Secured programme management capacity for 2025 - pending outcome of NHS Reform • Secured funding to support VCFSE model of engagement for 25/26 and 26/27 • Structured business / administrative support in place for the integrated neighbourhood teams who have gone live in central neighbourhood (June 25)	• Sustainable funding model for general practice participationin the integarted neighbourhood teams • Sustainable funding model yet to be confirmed for Trafford Community Hubs (26/27 onward) • Future funding of GM Live Well into localities post 25/26 • Unknown impact of NHS Reform on 'Place Partnerships' yet to be understood	2	4	8	1.1 Ongoing partnership discussions and curation of Neighbourhood Programme and Trafford Live Well priorities for 25/26 (and beyond). Development of investment principles to utilise the Live Well grant allocation (25/26) 1.2 Dynamic review of performance metrics in-year related to the neighbourhood plans. Adoption of population and cohort level measures in our recently agreed TLB Performance Arrangements for 25/26 1.3 Establishment of a VCFSE Community Engagement model across Trafford. 1.4 Establish Trafford's response to GM Live Well, including vision, mission statements, centres, spaces, offers, VCFSE sustainability, prevention	1.1 Strategic reset conversations have contributed to priority areas of work. Paralell Trafford Live Well conversations have earmarked specific priorities for 25/26 including sustainability of the VCFSE sector, mobilisation of live well spaces and centres - inclduing a flag ship centre. We have drafted the principles to help shape our investment from the allocated monies for 25/26. 1.2 Continued review of agred performance metrics and associated products through Finance, Performnace and Sustainability - flex as and when requied and nuance reporting products as the neighbourhood priorities evolve and change. 1.3 Task and Finish group to develop our desired VCFSE Engagement Model (July 25) - mobilisation anticipated October 25 1.4 Live Well Steering Group, with direct support from dedicated Project Manager and Project Coordinator, developing the required 'Programme Plan'	Trafford Provider Collaborative Board Trafford Locality Board Trafford Live Well Steering group Neighbourhood Programme Steering Group (and directly reporting groups)	None identified yet	1	4	4	↔	08/07/25	01/09/25	Active
Support our workforce and our carers. We will ensure we have a sustainable, supported workforce including those caring at home	SR13	17/10/23	Gareth James	There is a risk that without adequate resource, planning and controls we will fail to attract and retain our workforce; this may lead to a critical shortage of skills which could result in the organisation failing to deliver on its strategic priorities.	Tom Maloney	Trafford Locality Board	3	3	9	• GM Joint Forward Plan • GM People and Culture Strategy • Trafford Workforce Group established with strong multi-partner membership reflective of TLB and TPCB membership • Completed a organisational self assessment of existing practice against the 10 aims of the GM People and Culture Strategy • Organisational Strategy, Policy and Work Programmes in place for the different operational teams within Locality Board member organisations (i.e. Adult Social Care Policy) • Mandated Locality Workforce Updates to the GM One Workforce Committee (Quarterly) • Trafford Workforce Delivery Plan taken to each Locality Assurance Meeting (LAM) • Trafford People and Culture Action Plan - coproduced with staff via face to face engagement • NHS GM SLT 'Prioritisation' of key deliverables (July 25) • Continued engagement with staff via face to face staff briefings and Time Together sessions	• Feasibility study regarding the adoption and spread of good practice not fully completed but has started and a PID produced to direct the work project • Regular usage of data and information from Virtual Workforce Information System (VWIS) to aid strategic and operational workforce planning not yet mobilised but embedded as a strategic priority in the Trafford Workforce Delivery Plan • Inclusion of wider workforce metrics from independent adult social care and other sectors into VWIS to aid true collaborative workforce planning • SRO for VWIS has retired and gap in senior leadership to progress the proposed work • SRO for Integrated Career Pathway priority has been affected by organisational changes and capacity remains an issue - work programme has been posponed pending system reform conversations	2	3	6	1.1 Workforce repositry: This priority has been deferred to a later date when capcity enables reprioritisation of this deliverable 1.2 Workforce planning using VWIS, initial reports produced July 25 focussed on primary care data - noting there could be restrictions on locality and/or GM central capacity to enable this workstream to its full potential. Initial reports have been made available to officers of the Trafford Workforce Group for initial exploration and comment. 1.3 Integrated Induction, has been mobilised (July 25), a task and finish group has been established (July 25) and learning from Stockport has been shared and will be utilised to form the core elemets of the model.	1.1 The repositry has been drafted and placed onto 'Padlets' for officers to utilise - feedback has been sought from the working group and partners made a decision to priortise available capacity on driving forward the other strategic priorities contained in the Workforce Delivery Plan. This action has been stood down untilthere is adequate capcity and clear benefits of completing the work. 1.2 SRO for VWIS has retired leaving a gap in capacity - Programme Director has taken temporary leadership responsibility to mobilise the work programme and various partnership meetings have taken place to establish a baseline reporting process and assocuated products. Draft scorecards are being developed with help from the central DII function / Locality BI Leads and these have been shared in the first quarter of 25/26 1.3 This priority has gone live in Q1 25/26. An agenda for a stakeholder T&F Group has been produced and administrative support is being sought to arrange the neccessary logistics.	Trafford Locality Board	None identified yet	2	2	4	↔	08/07/25	01/03/26	Active
Strengthen our communities. We will help people, families and communities feel more confident in managing their own health.	SR03	08/05/24	Gareth James	There is a risk to the delivery and provision of equipment for patients within Trafford following the LCO serving notice to cease delivery of the One Stop Resource Centre. There will be a requirement to seek a new provider for the service following notice being provided. There is a risk to the delivery of this service given the tight timelines for the service ceasing and procurement timeline requirements.	Cathy O'Driscoll	Trafford Locality Board	3	4	12	Programme Group estabilised with all system partners and NHS GM procurement colleagues. There is a framework approach to the recommissioning of the service. Associate Director acting as SRO for the programme of work	• Structured business / administrative support needed for the working groups • Sustainable funding model for general practice engagement in the design and delivery work • No guarantee that all the set of priorities identified will be funded • new GM controls in place will require being embedded into governance and timelines including STAR/PSR etc	2	2	4	Full procurement timeline has been developed and socialised with partners. Soft market testing was due to commence week starting 18th November through SBS. SBS were no longer able to support the programme of work and therfore due to the risks associated with continued service delivery it was agreed at Trafford Locality Board that the only option was to consider an Urgent Direct award to another provider for 12 months whilst a full procurement took place. The provider identified was Manchester City Council (MCC)and following agreement with MCC and through approval in internal governance a programme is in place to support the transfer of the service into MCC from the 1st April.	procurement timeline developed and socialised through governance and soft market testing materials developed. Full programme plan and outline timeline for the transfer of the service has been developed between the ICB / MCC TLCO to ensure the smoother trnasition of the service form the LCO from the 1st April 2025. A project plan with weekly working groups has been established to prograess areas of work and key actions required to ensure delivery by the 1st April 2025. follwing the transfer on the 1st April the working group will remain in place until all elements of the transfer have been completed including financials etc. and steps will be undertaken to agree the new procurement for 25/ 26 for this service.	Provider Collaborative Board Trafford Locality Board Trafford Senior Leadership Team Trafford Clinical Advisory Practitioner Senate	None identified yet	2	2	4	↓	09/07/25	03/04/25	Active
Recover core NHS and care services. We will continue to improve access to high quality services and reduce long waits.	SR07	08/05/24	Gareth James	There is a risk to the Outpatient programme and attendance of patients at Outpatient appointments due to the expiration of the Non Emergency Patient Transport Booking Service contract provided by the Midland and Lancs CSU. The contract expired in March 24 and the MLCSU have advised the ICB they require a 53% uplift to their current contract. The contract is currently being provided on implied terms.	Cathy O'Driscoll	Trafford Locality Board	3	4	12	Updates to Trafford Senior Leadership Team	• Structured business / administrative support needed • Sustainable funding model • No guarantee the service will be funded further • new GM controls in place will require being embedded into governance and timelines including STAR/PSR etc	2	2	4	a paper outlining the implications has been to the Trafford Senior Leadership Team to outline the risks and implications of the contract and the financial requirements of the CSU and the extension of the contract was supported.	The contract extension was supported and the appropriate paperwork has been progressed through STAR and we are awaiting the outcome of the PSR Panel.	Provider Collaborative Board Trafford Locality Board Trafford Senior Leadership Team	None identified yet	2	2	4	↔	09/07/25	14/03/25	Active
Support our workforce and our carers. We will ensure we have a sustainable, supported workforce including those caring at home	SR14	25/06/25	Sara Todd	**Risk** - NHS Reforms announced in mid-March '25 will have a significant impact on the level of ICB resource and the ability to deliver against GM strategy, due to the resource reductions and the current uncertainty there are risks to the delivery of the Trafford locality plan. There are further risks to the morale and wellbeing of ICB staff in the locality. it feels inevitable that we will enter a period of business continuity. **Cause** - likely that the delivery of 39% corporate cost reductions will have a wide ranging impact. during the transition design phase there is a high degree of uncertainty for staff and partners. **Impact** - slow-down of delivery of locality delivery and sustainability plans, potential lack of improvement against issues raised in the most recent staff survey, a period of business continuity with further risk to delivery of statutory duties.	Gareth James	Trafford Locality Board	3	4	12	• Robust GM design governance • Significant level of engagement ensuring locality colleagues have opportunity to contribute to the design of the new operating model • Development of Trafford locality people and culture action plan - co-produced with locality colleagues • Prioritisation of locality team workloads • Ensure that locality colleagues are given time and opportunity to take advantage of ogramme management capacity for 24/25 • Engagement at locality level - part 3 TLB conversations • Regular and honest communication with locality team	• Lack of detail underpinning the operating model • Lack of clarity on the availability of a voluntary redundancy offer • Locality team capacity during the vacancy freeze period • Lack of consistency in messaging between design groups	3	4	12	**1** A detailed Trafford people and culture action plan is being co-designed with locality team colleagues, covering the following 3 key areas: - supporting staff throughout the period of reform - including time for wellbeing, regular appraisals, regular and honest communications - prioritisation of workloads - to address issues raised in staff survey and to manage current capacity issues - commincation - regular face-to-face time together and flexible timing of comms **2** Ensure Trafford locality colleagues are embedded throughout GM design process **3** Regular locality partnership engagement	**1** Detailed actions agreed by SLT across the 3 areas and shared with staff at locality briefing - final plan agreed at time together iat end of July **2** SLT colleagues have been attending design forums and specific work-streams. Other Trafford partners also part of design phase **3** TLB part 3 workshop held in May and follow up discussions in June and July (standing item on TLB). also, conversations with key locality partners and neigjhbouring localities	SLT TPCB TLB	Lack of new information to share with colleagues lack of information on HR framework	3	3	9	New	07/07/25	On-going	Active
Achieve Financial sustainability. We will manage our money well to achieve our objectives.	SR15	01/07/25	Gareth James	**Risk**: The cost of Nursing Home care is difficult to control, across NHS GM ICB, as private care providers are demanding rates higher than the agreed contract rate. **Cause**: Risks mainly stem from the development and management of the market infrastructure, including pricing frameworks, standard contract and the ongoing spot purchase of specialist or out-of-area services. **Impact**: There is a financial impact as Personalised Care teams across NHS GM ICB may be paying above the budgeted cost to support CHC eligible patients. High provider costs may result in care needing to be sourced out of area, potentially affecting the continuity and quality of patient care.	Sarah Owen	Trafford Locality Board	5	4	20	The Service has access to a pricing framework negotiated with key providers of nursing and homecare services within the borough. This offers an agreed weekly/hourly rate for services rather than variable or spot pricing. Spot purchase is still used in situations where care need cannot be met on-framework due to market saturation or a requirement for specialist services.	Market management and contract monitoring are now within NHS GM centrally, with the ongoing need for all staff to review KPI's when reviewing care packages. LA spot purchase costs for D2A become difficult for the service to resolve, with health becoming responsible for the ongoing costs of placements they have not procured or been involved in the procurement of beds.	4	4	16	1.1 CIP programme with identified schemes to ensure adherence to the CHC framework and quality reviews of packages of 1.2 Procurement of Care Cubed to provide an evidence base to support negotiation with the care home market 1.3 Improved data/dashboard metric via CHS	1.1 CIP plan is monitored monthly via SLT oversight and reported 1.2 ILED prroject plan - market management and care cubed implementation plan 1.3 CHS have created a tailored dashboard	Senior Leadership Team All Age Continuing Care (AACC)	Progess of ILED workstreams	4	3	12	New	01/07/25	01/07/26	Active

Trafford
Integrated Care Partnership

Name of Committee / Board	**Trafford Locality Board**			
Date of Meeting	**Tuesday 15th July 2025**			
Report Title	**ND Pathways: New Model Of Care Plan**			
Report Author & Job Title	**Sally Atkinson, Specialist Commissioner CYP Health**			
Organisation Exec Lead	**Gareth James, Deputy Place Lead, GM ICB**			
OUTCOME REQUIRED *(please highlight)*	Approval X	Assurance	Discussion	Information X

EXECUTIVE SUMMARY

- To tackle the significant challenges across GM in addressing the needs of Children and young people (CYP) with neurodevelopmental (ND) symptoms, including extremely long waiting lists, a new needs-led CYP ND model of care for Autism and ADHD has been developed, with the intention to implement it across all 10 GM localities.
- This proposed model is aligned with national best practice and incorporates insights from successful pilots and initiatives, ensuring that it meets the holistic needs of CYP and their families/carers.
- The implementation of the new CYP ND model of care across GM is a highly complex and ambitious endeavour, requiring a concerted effort from both GM wide and locality specific teams.
- Despite these hurdles, significant progress has been made in co-producing a core offer as the new model of care for the ND pathway.
- This model has been designed with a strong focus on outcomes for CYP, incorporating insights from a wide range of professionals across health, local authority, parents/carers and the VCSE sector.
- The current system is plagued by inconsistent service delivery, and inadequate support structures, leading to poor outcomes for many families
- This proposed model aims to address these challenges through a unified, needs-led approach, emphasising early intervention, consistent service delivery, and multi-disciplinary collaboration.
- The attached paper details Trafford's implementation plan in line with the core components of the programme.

RECOMMENDATIONS

- **Locality Board are asked to agree to the proposed implementation plan in line with GM ICB's core requirements.**

CONSIDERATIONS – these must be completed before submission to the Board – Reports with incomplete coversheet information will not be accepted and shared with the board

Risk implications ***(Please provide a high-level description of any risks relating to this paper, including reference to appropriate organisational risk register)***	Linked to risk SR04 on the locality board risk register. CYP are at risk of increased needs whilst awaiting a ND diagnosis. Support is required to all children who identify as neurodiverse and for options to be available based on the level of their presenting need, and for this support to be available in their community / neighbourhood.

Financial implications and comment/approval *(Please detail which organisation(s) will be impacted, and if not required, please briefly detail why)*	Name/Designation:
	Comment: GM ICB have identified the funding streams to deliver the proposed hub. This funding is recurrent.
Comment by Trafford Clinical and Practitioner Senate (TCAPS) and/or Clinical Lead *(If not required, please briefly detail why)*	Date of TCAPS:19th June 2025
	Name/Designation: (If appropriate)
	Comment: TCAPS approved the proposal.
What is the impact on inequalities? (P*lease provide a high-level description of any known impacts)*	n/a
Equality Impact Assessment / Quality Impact Assessment Outcome *(If not appropriate at this stage please state if an EIA or QIA is necessary)*	N/A
People and Communities: Communications & Engagement *(Please detail relevant patient/public engagement completed and/or planned, and if not required please briefly detail why)*	Parent / Carer forums have been involved from the beginning of the consultation process. Consistent communications will be shared across the region in line with the changes to the CAMHs specification, and later regarding the changes to the eligibility for assessment.
Trafford's Carbon Footprint *(Please provide a high-level description of any known positive and/or negative impacts – consider the following topics: energy usage; staff or public transport; waste or materials used. Include steps that could be taken to reduce carbon within relevant plans)*	
Links to Measurement / Outcomes *(Please detail if this is included within the report)*	
Enabler implications	**Legal implications:**
	Workforce implications:
	Digital implications:
	Estates implications:
Sub-Board Sign-Off / Comments **(i.e. Trafford Provider Collaborative Board, H&SC Delivery Steering Group)**	Children's Commissioning Board, TCAPS, SEND Steering Group.
Organisation Exec Lead Sign off	

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NHS
Greater Manchester
Integrated Care

ND Pathways: New Model Of Care Plan

Part of Greater Manchester
Integrated Care Partnership

Background

- To tackle the significant challenges across GM in addressing the needs of Children and young people (CYP) with neurodevelopmental (ND) symptoms, including extremely long waiting lists, a new needs-led CYP ND model of care for Autism and ADHD has been developed, with the intention to implement it across all 10 GM localities.

- This proposed model is aligned with national best practice and incorporates insights from successful pilots and initiatives, ensuring that it meets the holistic needs of CYP and their families/carers.

- The implementation of the new CYP ND model of care across GM is a highly complex and ambitious endeavour, requiring a concerted effort from both GM wide and locality specific teams.

- Despite these hurdles, significant progress has been made in co-producing a core offer as the new model of care for the ND pathway.

- This model has been designed with a strong focus on outcomes for CYP, incorporating insights from a wide range of professionals across health, local authority, parents/carers and the VCSE sector.

- The current system is plagued by inconsistent service delivery, and inadequate support structures, leading to poor outcomes for many families

- This proposed model aims to address these challenges through a unified, needs-led approach, emphasising early intervention, consistent service delivery, and multi-disciplinary collaboration.

Transformation Programme

NHS Greater Manchester Integrated Care

- The GM CYP neurodiversity transformation programme, aims to establish a consistent, evidence-based, needs-led model for neurodevelopmental pathways, initially focusing on Autism and ADHD.

- The new approach prioritises early intervention, multi-disciplinary collaboration, and moves beyond a diagnosis-led system to a more holistic, needs-driven model, ensuring neurodivergent children and their families receive the right support from the outset.

- We will deliver a core offer aligned with the THRIVE model, providing timely and personalised support for neurodivergent children and families which will be integrated into local networks

- To support implementation of the new model of care, GM has identified a funding investment, with an allocation to each locality, as well as an allocation for the development of a pan GM offer.

- Localities have been asked to submit details of their implementation plan and a breakdown of their funding allocation.

Core Components

- Plans should focus on increasing access to early help provision and VCSE delivery in the community.
- Clear first points of contact for families seeking neurodivergence-related support.
- A coordinated approach to ensure timely early support, including roles for existing services (e.g., Thrive teams, Early Help, Mental Health Support) and new role
- An identified lead within the locality to manage referrals, review needs, and connect families with relevant resources.
- Centralised resources (e.g., local padlet) offering guidance and service access.
- Workshops and webinars on neurodivergence, sensory needs, communication, and education.
- SEND reasonable adjustments and Local Offer documentation.
- Implementation of neuro-profiling to better understand needs and provision of supporting strategies
- Implementation of training and delivery of group support for communication problems and distress through behaviour (for example, Riding the Rapids, PACT) and sensory needs.
- Peer support networks and mental health support tailored for neurodivergence
- Include any elements of the above that are already in place in your locality and how they will be aligned to support full roll out of the new model.

Progress against core components

ND Navigator

- The ND Navigator is currently running drop-ins for parents/ carers of neurodiverse children and young people to help navigate the current offer, and signpost them to specific services. These sessions currently run monthly in both Partington and Stretford Family Hub.

- 15-minute advice surgeries with the ND Navigator have also been stepped up. This offer provides parents/ carers with 1-1 support so that they can be listened to and signposted to services that can help, as well seeking advice around referral processes, etc.

- The ND Navigator has also organised quarterly workshops that will run from the Family Hubs. These are currently scheduled for July and September and are based around support with toileting for ND children and sleep support. These sessions will run as evening webinars and will be recorded to be stored on the SEND padlet and local offer.

- Riding the Rapids is also currently being delivered by the ND Navigator.

NiS/ PINS

- The Neurodiversity in Education projects are being funded for another year, and we have chosen three more schools for PINS and NiS. This makes a total number of 12 secondary schools and 10 primary schools being supported by the project.

- This year, we are looking at ways we can offer support to further schools across Trafford. Plans currently involve the following:
    - Recording modules 1 and 2 of the project so that the videos can be given to all schools to support all school staff CPD and new starter inductions.
    - Commissioning services within the project (Starling, Barnardos and SLT) to deliver more online based training so that more schools can attend. Also, recording these sessions to provide a bank of resources that can be used to continue the project.
    - Providing all schools with mini ND libraries to be used for assemblies, PSHE lessons, etc.
    - Creating a 'NiE champions' to support other schools who are not involved in the project.
    - Running termly 'Community of Practice' events for all schools to attend and share good practice.

- We want to be able to continue the project even if funding is no longer available, so are looking at a more sustainable way of working.

Getting Advice:

- Trafford Directory (Local Offer)
- Padlets (Trafford and TLCO)
- Essential Parent (0-25)
- What's on Guide (Family Hubs)
- TPF Drop ins/ Coffee mornings
- Chatty Cafes
- **Coffee morning/ drop ins – Family Hubs (Stretford/ Partington)**
- SENAS/ SENDIASS
- **ND Navigator advice surgeries**
- EBSNA Parent drop ins (EP service)
- **School support (NiS/ PINS)**
- **GMAC online videos/ webinars**
- Trafford Sleep Therapy Universal Support

Getting Help:

- **Parent webinars (ND Navigator)**
- **Parent Workshops (ND Navigator)**
- Solihull Approach (0-25)
- **Starting Strong (5+)**
- Silvercloud
- Kooth (*ND CYP can request a neurodivergent counsellor)*
- Talkshop (*ND CYP can request a neurodivergent counsellor)*
- TLCO Community Services
- **Starling (*after school peer-to-peer support groups)***
- Reducing Parental Conflict (RPC)
- **Riding the Rapids (3-14)**
- Leisure/ Activities offer
- **MHST offer – post diagnostic pilot**
- Trafford Sleep Support Service (targeted support?)
- **IBASIS/ SACS-R**
- **PACT**
- STEP (TPF)
- MHST in Schools

Getting More Help:

- 42nd Street
- CAMHS (CED/ STAMP – anxiety/ parent groups/ understanding myself group)
- TCAS/ TASC Pathway
- TLCO Community Services
- Trafford Sleep Support Service (Specialist provision)
- Shortbreaks
- ARFID
- ND Nursing

Getting Risk Support:

- Dynamic Support Register (post diagnosis)
- First Response Team
- Barnardos Keyworker service (part of the DSR)
- Intensive Behaviour Support (part of the DSR)
- Safe zones

Progress against core components

NHS Greater Manchester Integrated Care

Starting Strong/ Riding the Rapids

- We have been working with Starting Strong providers to promote the service with families of neurodiverse CYP in order to create a new pathway for Trafford's parenting courses. Families will now be expected to have completed a Starting Strong course before being referred to Riding the Rapids.

- From October 2025, all referrals for the courses will come in via the ND Hub and will be coordinated by the ND Navigators. There will be courses for both Starting Strong and Riding the Rapids scheduled for the year and, therefore, the ND Navigators will be able to book families on when necessary.

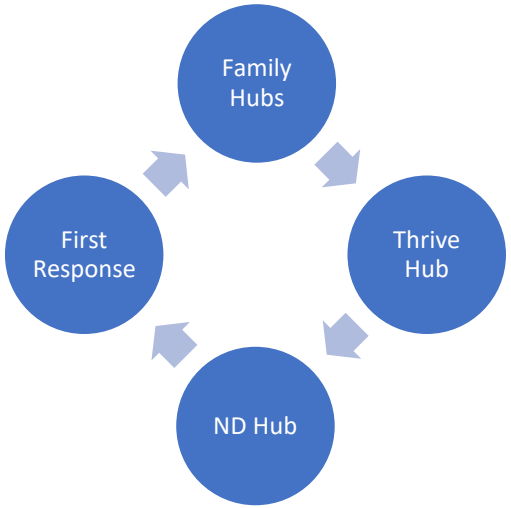
- Taking learning from Manchester, we have used some of the Neurodiversity in Education funding to fund training spaces for Riding the Rapids so that we can create a pathway through schools for families in need of support. By the end of this year, we will have 4 members of staff from schools within the project trained. The ND Navigator is currently setting up a referral pathway with school SENCOs.

- We have 2x MHSTs trained in Riding the Rapids as well. They are going to begin delivering in September 2025 and for the time being, referrals will come from SENCOs. The MHSTs will also facilitate with trained school staff. Our aim, is to grow the number of MHSTs and school staff trained so that courses can run termly and support families at the earliest point of need. The Family Hub workers and ND Navigators will then be able to run courses across communities for families who come through Early Help, etc.

- To deliver mainstream Riding the Rapids support in Trafford, we will have a total number of **18 facilitators by April 2026.**

Trafford's ND Implementation Plan

- The aim of the implementation plan is to show how Trafford propose to meet the core elements of the new model of care, with a focus on increasing early help provision and VCSE delivery across the borough.
- The hub will include the core components set out by the ICB and will be developed over time with wider partners, and in line with the roll out of family hubs in the borough over the next 12 months.
- The plan has been developed with the imminent social care and health reforms in mind, moving towards an early intervention and prevention family help approach through our neighborhoods.
- Trafford want to use the development of the ND hub as an opportunity to move towards a 'One Trafford Support Offer' to ensure Trafford children and young people receive needs led support no matter which service they are open to, and ensure our offer is consistent across the borough and aligns with the neighbourhood model.
- This means our First Response Team, Family Hubs, Thrive Hub and ND Hub will work together to deliver a co-ordinated approach to a front door system.
- The hub will be a clear first points of contact for families seeking neurodivergence-related support and deliver a coordinated approach to ensure timely early support, including roles for existing services (e.g., Thrive teams, Early Help, Mental Health Support) and new roles like ND Navigators.
- Training the wider workforce around neurodiversity and increasing confidence in professionals supporting families and young people who are neurodivergent.
- Co-deliver support sessions alongside other services for example Homestart, Mental Health Support Teams including Whole School Approach offer via Educational Psychologist, Health Visiting, School Nursing for example
- The hub will offer accessible information which reflects the diverse cultural and inclusive needs of the borough, as well as interpreters where required
- Deliver targeted intervention including Riding the Rapids, PACT and Ibasis



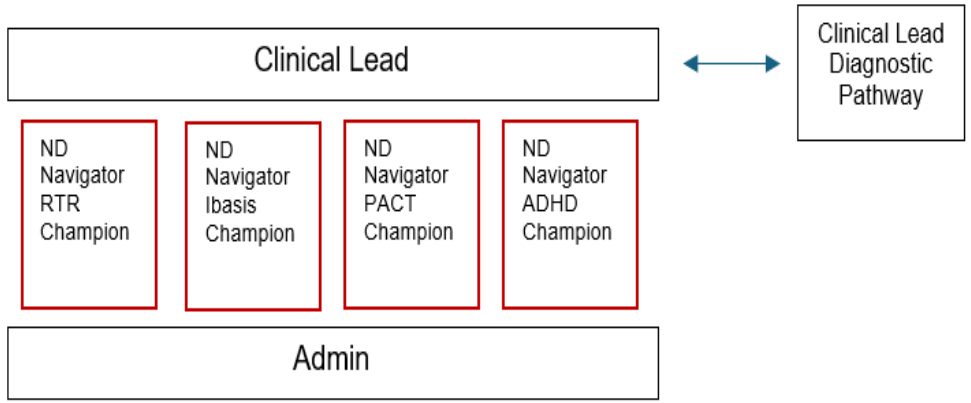
Proposed Model – ND Hub

The recurrent funding allocation for Trafford is £200-£205k – locality will fund £20k recurrently into the hub to secure the staffing structure.

This is the proposed model and staffing structure for the ND Hub:

- A **clinical lead** to triage referrals and manage the day-to-day function of the hub.
- We want to commission **4 navigators** to deliver support in line with the neighbourhood model. There is a business case currently being produced so that we can begin the recruitment process as soon as possible.
- The **admin support** will carry out all admin duties within the hub, freeing up more capacity for the ND Navigators to deliver the support offers.
- **Peer Support** is a core component of the hub to account for in the allocated funding
- Staffing to sit and recruited into the Family Help Directorate

Role	Band	WTE	Cost
Clinical lead	7	1	46,148.00
ND Navigator	6	0.8	34,497.60
ND Navigator	6	0.8	34,497.60
ND Navigator	6	0.8	34,497.60
ND Navigator	6	0.8	34,497.60
Admin	3	1	27,402.00
Peer Support Offer (VCSFE)			15,000.00
Total			226,540.40



Non recurrent funding remaining from current ND Navigator post (£36k) will fund one off costs including:

- Year 1 of £20K additional staffing cost into hub

Reasonable Adjustments - Community Settings

- Purchase of mini neurodiverse libraries (following PINS project success) for community settings and family hubs
- Purchase of sensory packs for community settings and family hubs

Interpreters

- We know in areas of the borough we have high numbers of children / families with high levels of SEND, deprivation from culturally diverse backgrounds. We want to make sure our hub resource is accessible for all families across Trafford.

Hub Resource development, Venue Hire, ad hoc costs

- We want to maintain a small budget to support the development of resources, cost of venue hires to run events, workshops etc, any training needs and ad-hoc requests to support the function of the offer

New CAMHs Specification Update

- The CAMHS service specification has been reviewed and updated
- Standalone referrals for ADHD/autism assessments will be considered an exclusion criterion in the absence of a primary mental health need.
- The implementation date for the specification is January 1st. How this will be launched is still under discussion, communication will be circulated at the end of July.
- The ICB are analysing waiting times data across localities.
- GM are developing prioritisation and eligibility criteria for NHS assessments which will determine who will be eligible for assessment by the NHS.

Impact of New Criteria:

- Fewer children will be eligible for NHS assessments, potentially driving up private assessments.
- The needs-led model will become more important, requiring significant impact on daily functioning for assessment eligibility. This indicates the need for the ND Hub and core elements of the support offer to be fully operational before the changes come into fruition.
- The guidance around independent assessments still requires strengthening.
- Impact on community services to diagnose when a child doesn't present with a co-occurring mental health need

Communication

- Communication with families will occur ahead of the January launch date.
- The ICB will develop all communication materials after the key statement is agreed.
- A formal consultation on the expected criteria will take place in June/ July 2025.

Wider System Implications

- Changes will impact community paediatricians and primary care.
- There is a need to manage and commission services for CYP who no longer fit the eligibility criteria.
- A QIA (Quality Impact Assessment) and EQIA (Equality Impact Assessment) are expected to be produced to detail the impact of the new changes.

Next steps:

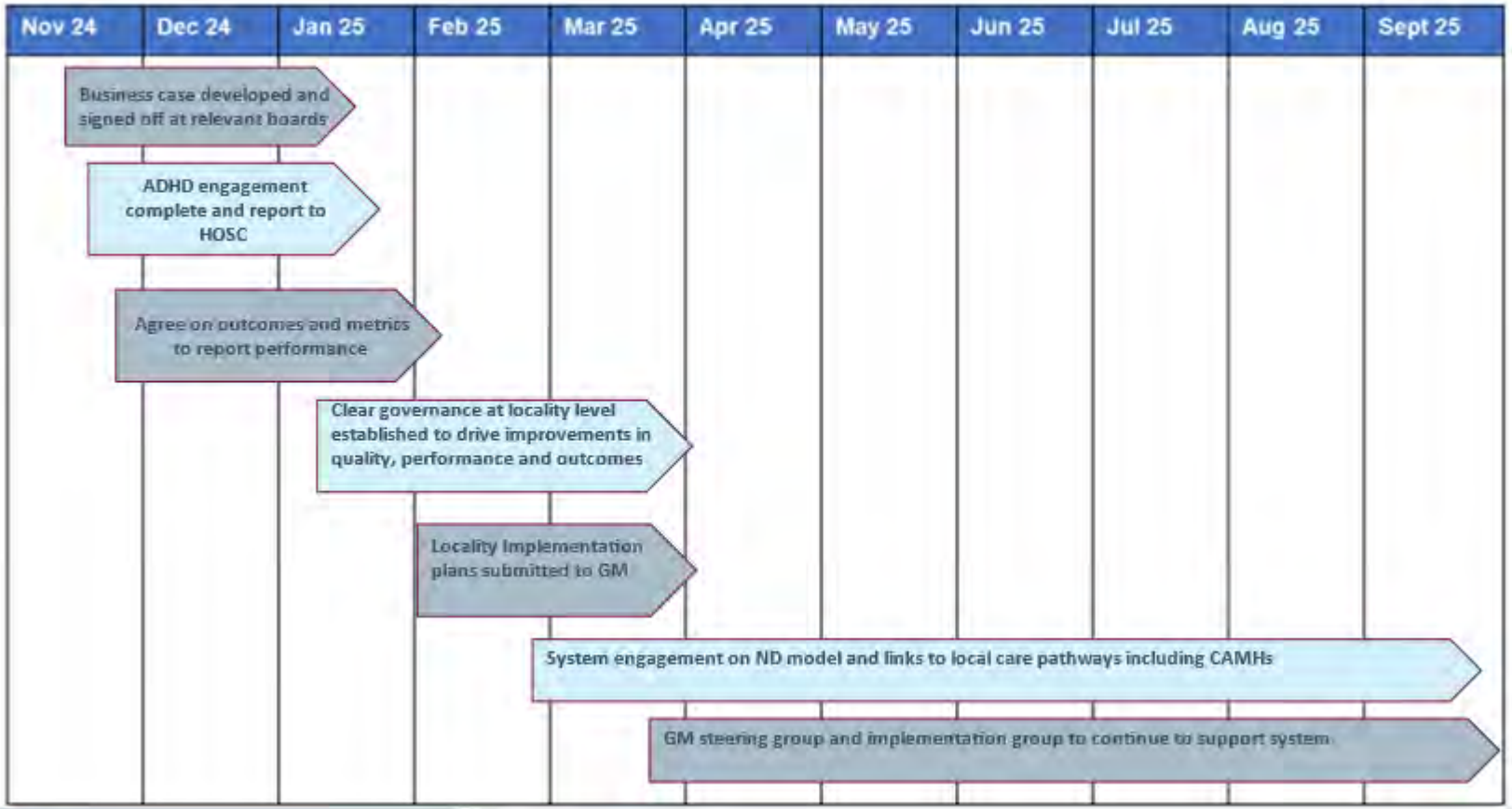
- **More guidance needs to be developed around the independent sector as Trafford maybe disproportionately impacted by private diagnosis.**
- **Diagnostic conversations are planned for June/ July and will be added to the next ND Steering Group agenda to be discussed.**

GM Timeline

NHS Greater Manchester Integrated Care

CYP ND New Model of Care timelines 24/25

NHS Greater Manchester



Next Steps

- We will be sending letters to all families on the waitlist for both pathways confirming how to access our support offer whilst waiting for assessment
- We have started the recruitment process to ND Hub posts
- The neuroprofiling tool will be trialled with families presenting with emerging SEND needs within the family help space. We will look initially at trialling this with a small cohort of CYP already open to the service which will include families open to Homestart, Family Help Support Team and Trafford's Edge of Care Support Team.
- Continue to progress stepping up universal, targeted and specialist support offers
- Timeframe – Localities have been asked to have the hubs in place by the Autumn term
- We are working with information governance to ensure we have the appropriate data security in place and working with system teams to develop a pathway through the systems to support the function of the hub
- Clinical teams are working through a review of the diagnostic pathways
- MFT are working alongside the GM ICB 'central' team on options to reduce waiting times for those already waiting
- The ICB will be circulating communication at the end of July re the CAMHS specification
- We are work through the impact on the community services offer with the changes in line with CAMHS specification.

NHS
Greater Manchester
Integrated Care

Trafford
Integrated Care Partnership

Name of Committee / Board	**Trafford Locality Board**			
Date of Meeting	**15/07/2025**			
Report Title	**Healthwatch Trafford Performance Report April - May – June 2025**			
Report Author & Job Title	**Andrew Latham, Chief Officer**			
Organisation Exec Lead	**Andrew Latham**			
OUTCOME REQUIRED *(please highlight)*	Approval	Assurance	Discussion	Information

EXECUTIVE SUMMARY

A summary of Healthwatch Trafford's performance and impact during the period April 2025 to June 2025. This includes research, engagement activities, local concerns, and strategic updates.

RECOMMENDATIONS

1. To note the update.

CONSIDERATIONS – these must be completed before submission to the Board – Reports with incomplete coversheet information will not be accepted and shared with the board

Risk implications ***(Please provide a high-level description of any risks relating to this paper, including reference to appropriate organisational risk register)***	None
Financial implications and comment/approval ***(Please detail which organisation(s) will be impacted, and if not required, please briefly detail why)***	Name/Designation: **N/A** Comment / Approval *(Delete appropriately)* **N/A**
Comment by Trafford Clinical and Practitioner Senate (TCAPS) and/or Clinical Lead ***(If not required, please briefly detail why)***	Date of TCAPS / Clinical Lead comment (Delete appropriately): **N/A** Name/Designation: (If appropriate) **N/A** Comment: **N/A**
What is the impact on inequalities? ***(Please provide a high-level description of any known impacts)***	**N/A, update only**

Equality Impact Assessment / Quality Impact Assessment Outcome ***(If not appropriate at this stage please state if an EIA or QIA is necessary)***	**N/A**
People and Communities: Communications & Engagement ***(Please detail relevant patient/public engagement completed and/or planned, and if not required please briefly detail why)***	**N/A, update only**
Trafford's Carbon Footprint ***(Please provide a high-level description of any known positive and/or negative impacts – consider the following topics: energy usage; staff or public transport; waste or materials used. Include steps that could be taken to reduce carbon within relevant plans)***	**N/A**
Links to Measurement / Outcomes ***(Please detail if this is included within the report)***	**N/A**
Enabler implications	**Legal implications:**
	Workforce implications:
	Digital implications:
	Estates implications:
Sub-Board Sign-Off / Comments **(i.e. Trafford Provider Collaborative Board, H&SC Delivery Steering Group)**	
Organisation Exec Lead Sign off	

healthwatch Trafford

Performance Report

April – May – June 2025

Contents

Activities during reporting period April - June '25

RESEARCH

- Following our agreed **Work Plan**, we have been in the early stages of scoping, planning and meeting with partners regarding upcoming projects for the next year; these include **Women's Health**, **Oral Health in Under 5s** and **Palliative and End of Life care**.
- Following on from plans outlined in the last quarter, we are conducting an **evaluation** of the **Feel Better Partington** and **Healthier Happier Me** programmes. We have conducted interviews with colleagues from partner organisations and have gathered case studies of individuals who took part. These are currently being analysed, alongside supplementary data captured by partners, and a report is taking shape. We hope that the strengths and challenges identified in this report can be used to inform similar programmes in future.
- For this ongoing project we have been asked to **evaluate the Changing Futures (CF) programme**. Whilst there are plans to capture participants' experiences further down the line, we have now opened a survey for professionals working across the Trafford borough with the aim of gathering views on how effectively individuals who face multiple disadvantages are supported. We then plan to follow this up at the end of the project to assess any potential impact the CF programme will have.
- We have been preparing for our **summer intern** from the University of Manchester to join us for eight weeks at the end of June. We will be working on a project looking at **Patient Participation Groups**.

ENGAGEMENT

- In April, we attended the **South Neighbourhood Network Meeting** where we learnt more about inequalities in the borough. We heard that concerns included **low vaccine and cancer screening rates** among people with learning disabilities, as well as **low levels of employment**.
- We were present at the **Trafford Deaf Partnership** and **West Neighbourhood Network** meetings, where we spoke about our current projects, including oral health in under 5s, and long-term conditions. We also presented a summary of the information shared with

us by the Deaf community as part of our community engagement work. We also **shared this insight with system leaders** and are looking at which forums to present it to as part of the governance pathway.

- We met with the Communications and PPIE (patient and public involvement and engagement) Lead at NHS **North West Genomic Medicine Service Alliance** to discuss a joint engagement plan for the Trafford area. We have reached out to community groups and venues in Trafford to look at hosting a **Genomic Café** to increase awareness and educate people about the importance of the topic.

VOLUNTEERING

- Our Enter & View Representatives continued to contribute to our plan to **Enter & View a GP practice** in the summer. Together, volunteers and staff have worked to plan the process and timeline, as well as made decisions on location and scope.
- In June we got the chance to advertise our volunteer opportunities at the **Trafford Volunteer Showcase Fair** in Sale. We also got to promote the present projects we're working on.
- We were able to represent the Trafford community and their needs via our readers panel during the development of **Manchester University NHS Foundations Trusts' (MFT) Visitor Policy (5th ed.)**. The policy will be adopted across MFT sites and will apply to family, carers and friends visiting patients at their hospitals.
- 50 volunteers from 6 local organisations including Healthwatch Trafford came together for the **Volunteers' Week Stretford Volunteer social** and were entertained by BlueSci's very own ukelele band!

From the Trafford community

- We gathered feedback from over 50 Trafford residents who had been **deregistered as NHS patients by a local dental practice without notice or consultation** and were told they would need to **register as a private patient or find a new practice**. We contacted the practice manager and while we did receive an initial response, it contained no detail. We followed this up with a request for more information but heard nothing further. We will now write again noting the obligation of the practice to respond to formal requests from local Healthwatch within 21 days. We hope the practice will reply and that we will be able to gain insight on the situation.

- We heard from the family member of a patient who was concerned about the plans for discharging them from hospital. With permission, we contacted Manchester Foundation Trust (MFT) Patient Services on the family's behalf but before we received a response, the patient was sent home. They were discharged with the understanding that a District Nurse would make daily visits. No visits were received, and the patient was re-admitted 3 days later. An MFT representative suggested this may have been an **unsafe discharge**. We were able to share with MFT the family member's desire to be involved in decisions around the patient's care, specifically to prevent discharge before arrangements were discussed with the relevant care teams.

  As a result of both the family member's efforts and our intervention, the patient was able to remain safely in hospital with assurances that they would not be discharged at this time.

  We also raised the issue with the Director of Nursing for Quality and Patient Experience, identifying the key issue of patients and family not knowing how or who to contact to discuss such situations.

Strategic updates

The first quarter of the year is generally a period of transition, where we have one eye looking back at what we achieved in the preceding 12 months and the other looking forward to delivering on our Work Plan for 2025-26.

The review process for 2024-25 culminated in the publication of our Annual Report in June and prior to that the publication of our Impact & Outcomes Report. It's pleasing to see that the work we undertook last year (and in some cases from previous years) continues to have impact and to be used to help shape the future delivery of services in health & social care.

Looking forward, as you can see from the main body of this report, we have begun to set out project plans and to liaise with external partners to deliver on our work plan. We will be looking at quite a wide variety of topic areas this year, many of which will complement the priority areas identified by both TMBC and TICP.

We are delighted to have Adella Tobing join us as an intern from Manchester University for the summer months. Adella will be working on a project looking at Patient Participation groups within Trafford; this will include looking at how many are active, how they operate, how effective and how representative they are. We hope to engage with GP Practices and Health Centres across Trafford and to highlight best practice but also to look at what could be done to help improve the flow of patient led feedback.

Both our Chief Officer and I attended the recent symposium of the Health & Well Being Board and Trafford Locality Board. This was a well-attended event with key partners from all sectors having the opportunity to both hear about and commit to the planned and ongoing work towards driving forward neighbourhood integration for health and social care. We look forward to supporting this work as it is developed into a draft action plan that we can collectively use to hold ourselves to account.

I met with the new independent chair of ILED which was useful and pleasing to see under the new arrangements, positive progress being made.

Some of the GMICB meetings have been stood down pending the publication of the 10-year plan. We continue to monitor changes taking place in the NHS both nationally and locally leading up to the publication of the plan and the Dash Report on quality; I attended the Confederation Conference and heard from both Sir James Mackay and Dr. Penny Dash on this.

The Age Well Board met and took an initial look at priorities which will be refined at its next meeting. The meeting was well attended and many useful ideas were put forward.

Heather Fairfield

Chair of Directors

Trafford Integrated Care Partnership

Name of Committee / Board	**Trafford Locality Board**			
Date of Meeting	**15/7/25**			
Report Title	**Development of a prevention framework for the Trafford system.**			
Report Author & Job Title	**Helen Gollins, Director of Public Health**			
Organisation Exec Lead	**Cllr Slater**			
OUTCOME REQUIRED *(please highlight)*	Approval	Assurance	Discussion	**Information**

EXECUTIVE SUMMARY

To provide an update on our approach to improving health and reducing inequalities in Trafford, through the development and implementation of a prevention framework.

RECOMMENDATIONS

It is recommended that Trafford's Locality Board:

I. commit to redressing the system to ensure a balance in investment and strategic approach between treatment and prevention.
II. review the draft framework and agree that this approach will support the Board to strengthen prevention across the system.
III. once agreed, encourage member organisations to review delivery plans against the framework and use the outputs of this review to inform their future strategic direction.

CONSIDERATIONS – these must be completed before submission to the Board – Reports with incomplete coversheet information will not be accepted and shared with the board

Risk implications ***(Please provide a high-level description of any risks relating to this paper, including reference to appropriate organisational risk register)***	N/A
Financial implications and comment/approval ***(Please detail which organisation(s) will be impacted, and if not required, please briefly detail why)***	Name/Designation: N/A Comment / Approval *(Delete appropriately):*
Comment by Trafford Clinical and Practitioner Senate (TCAPS) and/or Clinical Lead ***(If not required, please briefly detail why)***	Date of TCAPS / Clinical Lead comment (Delete appropriately): N/A Name/Designation: (If appropriate) Comment:

What is the impact on inequalities? (P*lease provide a high-level description of any known impacts)*	The prevention framework will adopt the Fairer Trafford principles to ensure that prevention strategies are equitable and targeted where necessary.
Equality Impact Assessment / Quality Impact Assessment Outcome *(If not appropriate at this stage please state if an EIA or QIA is necessary)*	Not required at this stage.
People and Communities: Communications & Engagement *(Please detail relevant patient/public engagement completed and/or planned, and if not required please briefly detail why)*	The prevention framework is a system wide approach which aims to enhance our collective prevention offer across a number of key workstream including ILED – which has a dedicated participation strand and joint work arrangement with prevention, and Live Well implementation - which has a culture of prevention and resident participation as central themes.
Trafford's Carbon Footprint *(Please provide a high-level description of any known positive and/or negative impacts – consider the following topics: energy usage; staff or public transport; waste or materials used. Include steps that could be taken to reduce carbon within relevant plans)*	N/A
Links to Measurement / Outcomes *(Please detail if this is included within the report)*	To be defined, as described in report.
Enabler implications	**Legal implications: N/A**
	Workforce implications: Workforce development TBC
	Digital implications: Digital information and advice to be reviewed.
	Estates implications:N/A
Sub-Board Sign-Off / Comments **(i.e. Trafford Provider Collaborative Board, H&SC Delivery Steering Group)**	N/A
Organisation Exec Lead Sign off	Cllr Slater

1. Introduction

Creating the conditions for good health and wellbeing is essential to enable people to live longer, healthier lives. Achieving this requires coordinated action across sectors and communities. Preventing ill health before it arises is fundamental to supporting a thriving population, tackling health inequalities, and reducing long-term demand on health and care services. To realise this vision, a strategic shift is needed—redirecting focus and resources upstream to create the conditions that empower residents to lead healthier, more independent lives.

This report outlines the critical importance of preventing ill health for both our residents and local services. It sets out our vision to shift the balance of focus and investment from treatment to prevention, highlighting the collaborative efforts being made across the wider system to embed prevention at the heart of our health and wellbeing approach.

2. Why prevention is important

In 2023, more than 1 in 8 deaths (13.9%) in England were considered preventable at the time of death – equating to 75,694 people. Examples of illnesses where a substantial proportion of deaths are preventable include heart disease, and lung, liver and skin cancers. The Department of Health and Social Care estimate that more than half of the total burden of disease, including years of life lived in poor health, is preventable. There are also unfair inequalities in preventable early deaths between those living in the richest and poorest areas[i].

Research shows that up to 80% of a person's health is influenced by wider determinants beyond direct medical care, such as income, education, housing, employment, and the physical environment. Clinical care contributes only around 20% to overall health outcomes, while social and economic factors, along with the physical environment, account for approximately 50%. These wider determinants shape the conditions in which people are born, grow, live, work, and age, and they significantly impact health equity and life expectancy. For example, people living in poverty or in substandard housing are more likely to experience chronic illness, mental health issues, and reduced access to nutritious food and healthcare. By addressing these root causes through early intervention and integrated community support, we can reduce the burden on healthcare systems, improve population health, and close the gap in health inequalities. Prevention strategies that tackle these social determinants, such as improving housing, education, and access to social support, are essential for creating healthier, more resilient communities.

The NHS 10-Year Plan sets out a vision that places prevention at the core of future healthcare delivery. It aims to shift the system from one that primarily treats illness to one that proactively prevents it. This includes a strong emphasis on predictive and personalised care, leveraging technologies and digital tools to identify risks early and intervene before conditions develop. A key component of the NHS 10-Year plan is the development of Neighbourhood Health Centres, which will serve as local hubs

for integrated, community-based care. These centres are designed to make preventive services more accessible and tailored to local needs, supporting people to stay well in their own homes and communities.

Prevention is a central pillar of the Greater Manchester (GM) Live Well approach, which aims to tackle health, social, and economic inequalities by transforming how public services are delivered and how they collaborate with communities. A key ambition is to reprofile public spending, moving investment upstream into prevention, rather than downstream into crisis response. This is seen as essential for sustainable public services and better outcomes.

The NHS 10-Year plan also commits to tackling health inequalities by focusing preventive efforts in underserved areas and ensuring that care is inclusive and equitable. The aspiration is that by 2027, most people with complex needs will have personalised care plans, and by 2030, one million people will benefit from personal health budgets. These measures are supported by a reallocation of resources toward out-of-hospital care and a reformed workforce model to deliver prevention at scale.

Prevention is a core pillar within the GM sustainability plan.

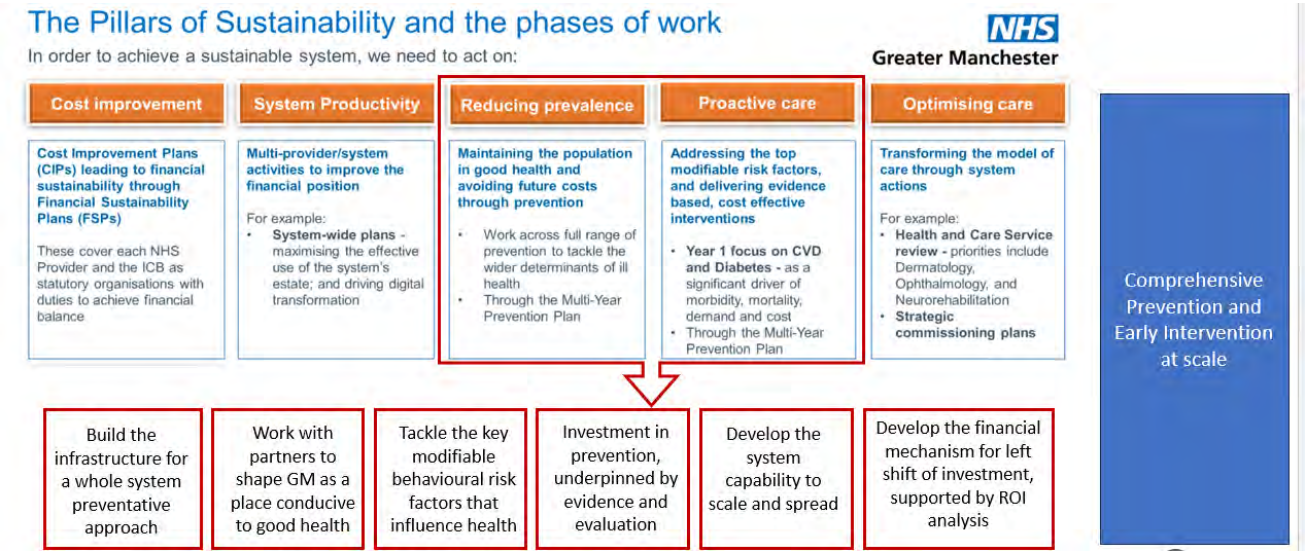


Figure 1 – The pillars of sustainability – GM population health and prevention annual plan (2025)

Despite a renewed focus on prevention, the reality is stark: public health funding to local authorities has been reduced by over a quarter (26%) per person in real terms since 2015/16. Now more than ever, it is critical to embed prevention at the heart of all services, care pathways, and programmes. Only through a system-wide commitment can we generate the scale and momentum needed to reverse the rising tide of demand and improve population health.

3. What do we mean by prevention?

Prevention and treatment should be seen as a dynamic balance rather than a problem with a fixed solution. A shift toward "health creation" offers a more asset-based approach, focusing on building thriving communities and enabling residents to live a good life, rather than merely preventing illness. Managing prevention as an ongoing balance means recognising that different priorities, such as funding, focus areas and success measures, must be adjusted over time. Instead of aiming for a final solution, it encourages a continuous process of adapting and improving strategies over time to create resilient systems that protect and promote wellbeing.

The model below illustrates the comprehensive, system-wide approach required to improving health outcomes.

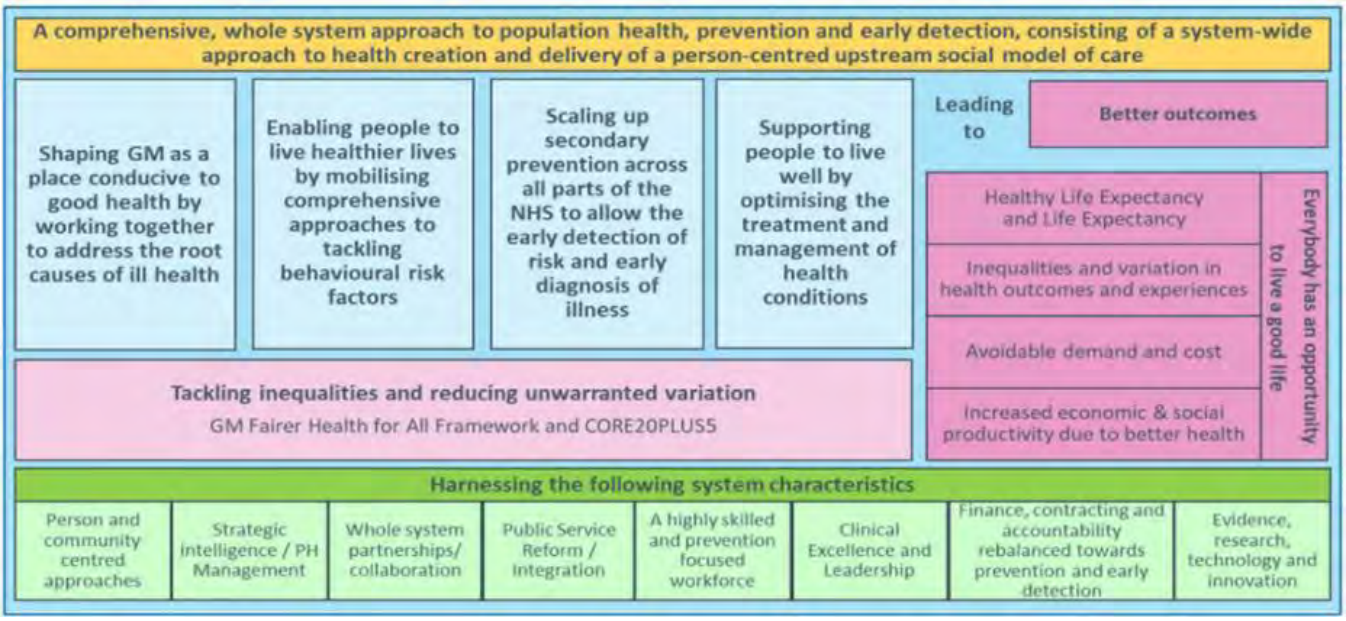


Figure 2 - GM Prevention and Early Intervention Framework, from GM population health and prevention annual plan (2025)

4. Evidence base for Prevention

There is a robust evidence base for prevention activity through public health interventions resulting in substantial cost-saving, with a median return on investment of more than 14:1 (see appendix A). Investing in prevention can be 3-4 times more cost-effective than investing in treatment. Prevention costs £3,800 per Quality-Adjusted Life Year (QALY), whereas treatment through the NHS budget costs £13,500 per QALY[ii].

The evidence base for preventative care in adult social care is currently limited, making it difficult for local policymakers to determine the most effective investments. Existing research focuses on areas such as reablement, telecare, falls prevention, and community interventions, but robust evidence on cost-effectiveness is scarce. Skills for Care highlights promising areas such as advice and guidance, physical activity promotion, and social prescribing, though evidence in social care remains inconclusive. Emerging strategic initiatives include strengths-based social work

models, community capacity-building efforts, and mobilising personal networks to delay or reduce care needs[iii].

5. System-wide approach to prevention in Trafford

Lead by Trafford's Public Health Directorate, the local approach to prevention and health improvement is based on six principles:

1. We work as a system to deliver prevention- supporting health in all policies and accounting for the wider determinants of health.
2. We commission evidenced-based and effective programmes. Where the evidence base is uncertain, we ensure a robust evaluation is implemented.
3. Programmes are place based, with a geographic and/or characteristic community focus.
4. We recognise the impacts of, and address health inequalities, implementing proportional universalism if required.
5. We are committed to our priorities-recognising that the impacts of preventive programmes take an extended period.
6. We measure what we are doing to ensure we are making a difference.

The importance of prevention is well understood and features prominently in local plans and priorities across the Trafford system; however, a co-ordinated approach is required to maximise resources and translate these strategic intentions into action that results in improved resident outcomes.

6. Local Examples of Collaborative Prevention

There are many examples of collaborative prevention activity improving resident outcomes in Trafford, these include increasing MMR uptake and Health In Communities.

6.1 Preventing cases of vaccine preventable illness and outbreaks

As part of Greater Manchester's measles preparedness efforts, Trafford developed its own measles action plan. Increasing uptake and coverage of measles, mumps and rubella (MMR) vaccination in 0–5-year-olds and reducing inequalities in coverage between groups in our population. The current MMR uptake for 0–5yr olds in Trafford are as follows: MMR1 92.2%, (given at between 12-13 months), MMR2 84.7%[iv], (given at approximately 3 years and 4 months). Evidence shows that a population uptake rate of 95% will reduce the likelihood of an outbreak.

Measles is one of the most contagious vaccine-preventable infections that can lead to large outbreaks. For most cases the impact is mild and self-limiting but for others it can lead to numerous complications, hospital admission, lifelong disability and in some cases can prove fatal. In terms of economic costs to the system, an outbreak in Cheshire and Merseyside in 2012-2013 is estimated to have costs the system, £4.4 million [v]. If investment and support had been focussed on increasing the uptake of MMR pre-outbreak to 95% coverage, this would have cost the system £182, 909 preventing the wide scale outbreak.

Trafford Public Health, TLCO and Voluntary, Community, Faith and Social Enterprise (VCFSE) sector partners are working together to increase uptake and coverage of measles, mumps and rubella (MMR) vaccination across the borough, prioritising areas in the North and West neighbourhoods where uptake is lowest. As part of this work, the Neighbourhood Engagement Co-ordinator is working with anchor VCFSE organisations in the two neighbourhoods, providing support and resources around having positive conversations about immunisations. One outcome of this work will be that VCFSE organisations will have community champions who are skilled and confident talking about immunisations, and another is the provision of engaging children's books within libraries, play groups and nurseries that are used for story times.

6.2 Increasing engagement with primary care, Health in Communities

Health in Communities is an evolution of Trafford's successful Test and Learn model, originally piloted in the most deprived areas in the Central Trafford neighbourhood, Sale West and Sale Moor. This initiative adopts an inclusive, place-based approach to delivering health and care services directly to communities experiencing the greatest health inequalities.

The model is informed by the ambitions of the Poverty Truth Commission and aligns with the Core20PLUS5 framework, ensuring a targeted and equitable approach. Initially funded through a 10GM six-month pilot, the success of the programme led to its refinement, rebranding as Health in Communities, and continued support through Multiple Deprivation Funding.

Residents have responded positively to accessing health support in familiar community settings, such as foodbanks or Citizens Advice Bureaux, where they may already be seeking other forms of assistance. This approach enables both opportunistic health conversations and a broader population health management strategy, ultimately aiming to improve overall health and wellbeing.

A health care professional is on site when people access the food bank or other support. As the health professional becomes familiar to the residents, trust developed, and residents begin conversations which evolve into health consultations. The health professional had access to patient records and can complete some key health assessments, including blood pressure and health checks. Due to this interaction, the residents then develope the confidence to either register with a practice or access their primary care practice for ongoing treatment.

Between March and December 2024, 316 residents accessed a health check through Health in Communities. The initiative has also strengthened collaboration across the system. Notably, the partnership between Primary Care Networks (PCNs) and the VCFSE sector has deepened, extending into a range of other initiatives such as Active Practices and Trafford Moving.

There is strong evidence to support this approach in the community. Reports estimates that for a 20% improvement in management of hypertension, to 140/90 mmHg target, system net savings would be estimated to be c£14 p.a. per controlled

patient over a 5-year period. Of these, c£5.75 would accrue to the NHS and c£7.91 would accrue to local authorities[vi].

Further evidence demonstrates, at a 50% take up rate, every £1 spent on the current NHS Health Check programme achieves a return of £2.93. Increasing take-up to 60% could achieve an additional return on investment of £3.55 for every £1 spent, while improving follow-up could achieve a further return of £5.18 for every £1 spent[vii].

Over 10 years a reduction in the population average blood pressure by 5mmHg through improved prevention, detection and management could save an estimated 45,000 quality adjusted life years (QALYs) and save £850m on related health and social care costs[viii].

Preventive interventions, improve and save lives and have significant financial and service benefits.

7. Prevention Framework Development

The development of a single shared prevention framework for Trafford ensures that prevention is central to everything we do and built into plans, rather than create a standalone strategy. The development of a joint and consistent approach to prevention will achieve the following objectives:

- Agreement of shared prevention objectives and outcomes.
- Development of a coherent description of our collective approach to helping our residents stay well and support them to remain independent if they do develop a health or care need.
- Oversight of prevention activity across organisations and departments, maximising investment and measuring impact.
- Identification of gaps, opportunities and duplication which will support future prevention investment and commissioning decisions.
- Support a collective approach to key enablers of effective prevention.

Phase 1 of the framework development has centred on adults, in-line with the refreshed Improving Lives Every Day (ILED) operating model and priorities, including the ASC front door review. The framework will underpin the improvement programme with the evidence being used to inform the pathways and support people to remain at home for longer.

Key enablers of effective prevention include:

- Leadership
- Staff knowledge and skills
- Effective communication
- Strong working relationships

Exploring and strengthening these enablers across the Trafford system underpins the framework development.

The first phase in the development of the prevention framework was to agree shared language and classification of prevention levels. Following input from key health and social care partners, the following levels were defined.

- **Level 1 - Primary prevention (Prevent)** - taking action to reduce the incidence of disease and health problems within the population through universal services that promote health and wellbeing in the places we live, work and grow.
- **Level 2 - Secondary Prevention (Delay)** - supporting those at higher risk of health and care needs, intervening early to prevent needs escalating and reduce harm.
- **Level 3 - Tertiary Prevention (Reduce)** – taking action to prevent further deterioration and promote rehabilitation for individuals with existing health and/or care needs.

Levels of prevention are not always clear-cut due to individual interpretation of risk, disease progression and activities that impact on more than one individual or group e.g. maternal health interventions improving outcomes for mother and baby.

Please see appendix B for Prevention Framework.

8. Testing the Framework: Prevention Mapping

Public health has started mapping commissioned prevention services. To date Public Health services for people aged 18yrs+ and Adult Social Care (ASC) funded prevention activity, have been mapped along with spend against each prevention level. This involved understanding the remit of commissioned and in-house services and classifying them in line with the framework. This mapping provides an important baseline from which a left shift in allocation of resources can be evidenced.

NB: Mapping does not include staffing costs for Trafford Council's Public Health Directorate.

Figure 8: Public Health and ASC prevention spend, 2024-2025.

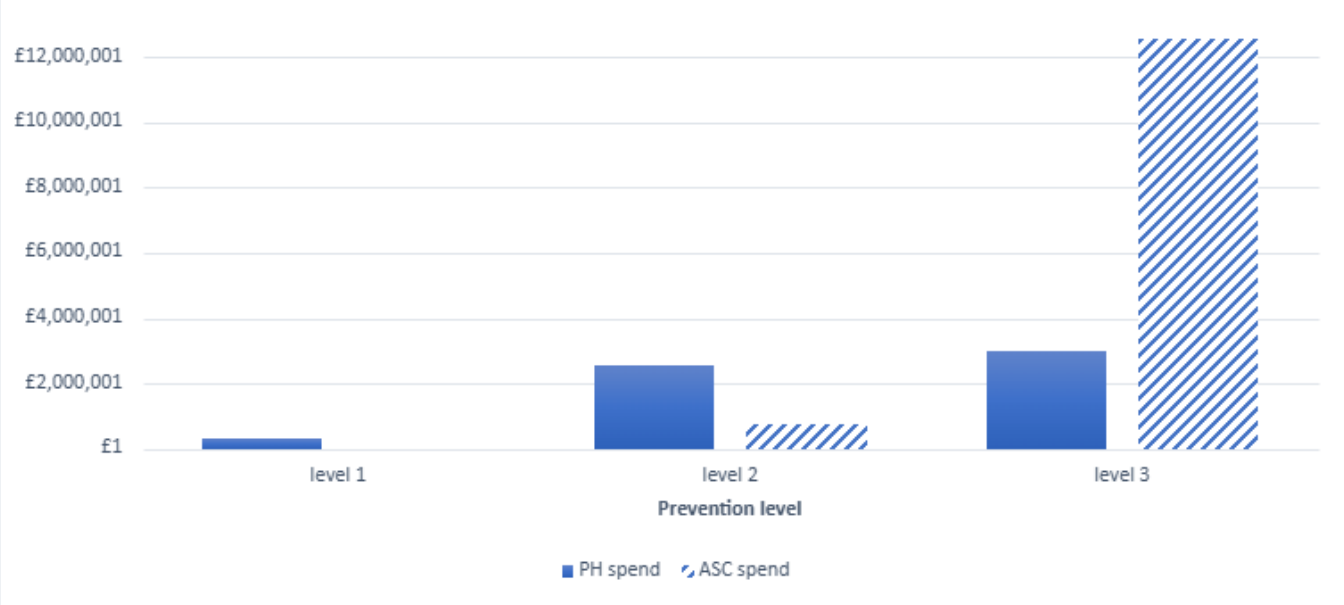


Table 8: Public Health and ASC prevention spend, 2024-2025.

	Level 1	Level 2	Level 3
Public Health prevention spend	£303,786	£2,551,423	£2,996,659
Adult Social Care prevention spend	0	£765,717	£12,569,506

The initial stages of this mapping have been impactful in understanding the level of spend across the commissioned services. The next stages of this exercise are to understand how many residents access each level of the framework and to map ICB, and Children and Families commissioned services against the framework. Further work with be to understand the proportion of each budget committed to prevention activity.

9. Developing Our Prevention Approach

The development of the framework and subsequent mapping has highlighted key opportunities to enhance collaboration and reinforce systematic approaches to prevention. Strengthening partnerships between the local authority, health services, and the VCFSE sector is essential to improving access to early intervention services and ensuring coordinated support. This will be achieved by supporting the ASC front door review to fully integrate VCFSE support into the triage hub and offer a pathway for residents who don't meet eligibility thresholds. The development of the Live Well approach in Trafford, with a strong focus on community-based prevention, will facilitate further development of joint strategies to improve health and wellbeing.

Enhancing the availability of information and support is vital to enabling individuals to access advice and early intervention resources before crises emerge. This will involve mapping current prevention approaches across the health and social care workforce and further developing workforce resources to ensure prevention strategies are effectively utilised at key touchpoints.

Building on recommendations from the recent Mental Health, Older Peoples, and Inequalities Needs Assessments, a review of prevention approaches and support is essential to identify gaps and opportunities for improvement. Key areas of focus include promoting healthy lifestyles through targeted wellbeing interventions that support physical activity, tackling food-related ill health and reducing health-harming behaviours, whilst aligning with Fairer Trafford priorities. Additionally, preventing frailty and falls requires collaboration with system-wide partners to provide higher risk cohorts with strength and balance training, mobility assistance, and home adaptations to enhance quality of life and reduce hospital admissions, alongside further development of early intervention and prevention strategies. Strengthening community networks to address social isolation is also a priority area, fostering social participation and building on the opportunity to grow and spread learning from the Ageing in Place Pathfinder Pilot.

By working collaboratively on prevention, demand management can be improved through early intervention, integrated services, and community involvement, ultimately reducing pressure on Adult Social Care while enhancing resident wellbeing. These emerging themes and future recommendations will be explored and implemented through the ILED prevention action plan, reporting into the ILED board.

The next phase of the prevention framework development will focus on mapping and aligning support for families and children.

10. Measuring Outcomes

A key objective of the prevention framework is to identify indicators that prove that prevention objectives are being met across the system. Although longer term outcomes such as decrease in preventable ill health and reduction in health harming behaviours are the ultimate shared goals, short term inputs and outputs will be defined as part of the action plan, that evidence system change and a culture shift towards collaborative early intervention and prevention.

11. Summary and Recommendations

This report provides an update on the prevention framework development and plans to strengthen our prevention approach. It describes how Public Health and Adult Social Care are working together on joint approaches to prevention to improve outcomes for residents.

It is recommended that Trafford's Locality Board:

I. commit to redressing the system to ensure a balance in investment and strategic approach between treatment and prevention.
II. review the draft framework and agree that this approach will support the Board to strengthen prevention across the system.
III. once agreed, encourage member organisations to review delivery plans against the framework and use the outputs of this review to inform their future strategic direction.

Trafford
Integrated Care Partnership

Appendix A: Return on investment of Public Health Interventions[ix].

Trafford
Integrated Care Partnership

Appendix B – Trafford's Prevention Framework. (adapted from Oldham's Prevention Framework)

What residents are experiencing	Objectives (what is needed to improve outcomes)	Outcomes for residents	Current offer/work programmes	Areas for development
Residents experiencing problems or challenges – health or care needs affecting daily activities. **Level 3 – Tertiary REDUCE**	People have the support they need to reduce the impact and/or tackle problems when they occur and live as well as possible. Services work together to provide the right support at the right time to keep people safe and enable them to live fulfilling lives by tackling the root causes of problems.	Improved individual wellbeing. Care feels coordinated and person centred. People do not reach crisis.	**Specialist advice & representation** e.g. mediation/dispute resolution, welfare rights, advocacy. **Specialist support** e.g. substance misuse, aids and adaptations, assistive tech, tenancy support, day services, shared lives, reablement, autism and LD support, dementia support, hospital discharge support, domestic abuse **Co-ordinated support** e.g. care navigation, Multi-Disciplinary Team (MDT) working - co-occurring conditions, multiple disadvantage.	Front door review. Prevention education/awareness for Health and Social care staff. Leverage assistive technologies to support independent living. Direct payments utilised for preventative activity. Thematic workstreams e.g Hoarding - early identification and support to be explored. Review multi-agency panels.
Residents at increased risk of poorer health and wellbeing **Level 2 – Secondary**	Individuals and communities have the capacity to develop, implement and sustain their own solutions to problems and improve health, wellbeing & resilience.	Reduced health inequalities. Residents have equitable access to help/support	**Targeted offers within wider services** e.g. debt/welfare, leisure, carers support. **Targeted support for specific cohorts** e.g. asylum seekers & refugees, ageing well, physical activity referral scheme, mental health support, health checks, smoking cessation, alcohol reduction, falls	Implementation of Fairer Trafford recommendations. Development of screening tools/risk stratification to identify individuals at higher risk of health & care needs.

DELAY	Identify and provide targeted activity for populations/groups identified as having the highest risks of poorer outcomes.	and services are effective for them. People and communities are empowered to do more for themselves.	prevention, Fairer Trafford, carer support & respite, population health management, social prescribing, sexual health support. **Coordinated support** e.g. social prescribing, community hubs.	Equity audits of existing policies and practices. Review information and advice. Comparison of service uptake, outcomes/experiences by priority cohorts. Embed voice of our people in plans. Develop Population Health Management approaches
Residents living independent lives. **Level 1 – Primary PREVENT**	High quality services for everyone that are accessible and equitable. The environment and community in which people live creates healthy, resilient and independent communities/residents.	Improved population health and wellbeing. People and communities are empowered to do more for themselves.	**Information and Advice** e.g. online information, general advice & signposting **Open access facilities** e.g. libraries, parks, leisure centres, pharmacies, community hubs **Universal services** e.g. policing, waste, GPs, housing allocations, imms and vaccs, healthy weight support **Community offer** e.g. VCFSE groups and activities, population level advice & support, neighbourhood networks, community safety.	Reduce impact of HFSS Advertising. Develop resident facing comms/ awareness. Further expansion of community hubs.
Underpinned by wider work programmes to improve the **Building Blocks of Health** e.g active travel, climate change, food environment, inclusive employment.				

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[ix] Trafford Council Public Health Directorate, (2024), *Trafford's Public Health Budget Report.*