Agenda

Salford Integrated Care Partnership Committee

Date: 26 February 2026

Time: 9.00am to 12.00pm

Venue: Salford Suite, Civic Centre & Microsoft Teams

Item No.	Time	Duration	Subject	Paper/ Verbal	For Approval/ Discussion/ Information	By Whom
1.	9.00	5 mins	Welcome, Introductions and Apologies	Verbal	Discussion	Chair – Paul Dennett
2.	9.05	10 mins	Patient Story	Verbal	Information	Engagement Officer
3.	9.15	5 mins	Declarations of Interest	Verbal	Discussion	Chair
4.	9.20	10 mins	Minutes of Previous Meeting, Action Log and Matters Arising	Paper	Approval	Chair
5.	9.30	20 mins	**Annual Reports** a) Information Management & Technology (Digital) Annual Report	Paper	Information / Assurance	Associate Director of Finance (Salford)
6.	9.50	20 mins	**General Items** a) Update on Urgent and Emergency Care / Winter Planning	Paper	Information	Associate Director of Delivery & Transformation
	10.10	20 mins	b) Adult Social Care Overspend	Paper	Information / Assurance	Strategic Head of Finance for People (Children's and Adults)
	10.30	30 mins	c) Voluntary, Community and Social Enterprise Strategic Update	Verbal	Information	Chief Executive, Salford CVS
	11.00	20 mins	d) Place Partnership Development	Paper	Decision / Assurance	Delivery Lead for Health and Care Integration

7.	11.20	30 mins	**System Updates** a) System Partner Updates b) Place Lead Report	Verbal Paper	Information Information	All Place Lead
8.	11.50	10 mins	Any Other Business	Verbal	Discussion	All
9.	12.00		Date and Time of Next Meeting: **TBC**			

Minutes

Salford Integrated Care Partnership Committee

Date: 29 January 2026

Time: 9.00 am to 12.00 pm

Venue: Microsoft Teams / Salford Suite

Present	Apologies
• Tom Regan, Associate Medical Director, NHS Greater Manchester (TR) (*Chair*) • Alison Page, Chief Executive, Salford Community & Voluntary Services (AP) • Claire Vaughan, Associate Director of Clinical Leadership & System Integration (Salford), NHS Greater Manchester (CV) • Elaine Vermeulen, Associate Director of Finance (Salford), NHS Greater Manchester (EV) • Gillian McLauchlan, Interim Director of Public Health, Salford City Council (GMc) • Hannah Dobrowolska, Delivery Director for Health and Care Integration (Salford), NHS Greater Manchester (HD) • Jim Cammell, Lead Member for Children's and Young People's Services (JC) • Joanna Fawcus, Chief Officer / Director of Operations, Northern Care Alliance NHS Foundation Trust (JF) • Juliette Cosgrove, Group Chief Nursing Officer, Northern Care Alliance (JCo) • Melissa Caslake, Executive Director of Childrens Services, Salford City Council (MC) • Paul Dennett, City Mayor (PD) • Rachel Rosewell, Chief Finance Officer (S151), Salford City Council (RR) • Sam Cook, Chief Officer, Healthwatch Salford (SC) • Samuel Russell, Strategic Head of Finance for People (Children's and Adults) (SR) • Sapna Tandon, Primary Medical Services Representative (ST) • Stephen Young, Chief Executive and Place Lead, Salford City Council (SY) • Van Selvaraasan, Primary Medical Services Representative (VS) • Elaine Redwood, Admin Support, NHS Greater Manchester (Minutes) (ER) • Di Critchley, Engagement Officer, Salford City Council (for patient story) (DC) • Alistair Craig, NCA Director of Clinical Strategy and Development, Northern Care Alliance (item 6a) (AC) • Joanne Farrell, Head of the City Mayor's Office (observing) (JFa)	• Becky Bibby, Interim Executive Director for Children's Services, Salford City Council (BB) • Becky Wilkinson, Executive Director for Adult Social Care & Health Partnerships, Salford City Council (BW) • Ben Whalley, Chief Executive Officer, Gaddum (BWh) • Colin Scales, Deputy Chief Executive, NHS Greater Manchester (CS) • Elaina Quesada, Interim Director of Adult Social Care Operations, Salford City Council (EQ) • Elliott Patrick, Wider Primary Care Services Representative (EPa) • Harry Golby, Associate Director of Delivery and Transformation (Salford), NHS Greater Manchester (HG) • John Merry, Lead Member for Adult Social Care and Health (Deputy City Mayor responsibilities for LGA & Key Cities) (JM) • Liz Calder, Director of Performance and Strategic Development, Greater Manchester Mental Health NHS Foundation Trust (LC) • May Moonan, Director Healthcare Public Health, Salford City Council (MM) • Michelle Williamson, Associate Director - Quality & Safety (Salford), NHS Greater Manchester (MW) • Mishal Saeed, Executive Support Member for Social Care and Mental Health (MS) • Tracy Kelly, Statutory Deputy City Mayor and Lead Member for Housing and Anti-Poverty (TK) • Victoria Halliwell, Dean / Professor of Industry Collaboration in Health Care Education, School of Health and Society, University of Salford (VH)

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Item No.	Topic	Action
1.	**Welcome, Introductions and Apologies** TR welcomed everyone to the meeting and the above apologies were noted. It was highlighted that JCo needed to leave the meeting early and, as a decision was required for item 5c, JCo needed to be in attendance to ensure quoracy for the decision.	
2.	**Patient Story** DC presented the story of a Salford resident and her experiences of community groups. AP mentioned that the story highlighted the importance of face-to-face services and this helps people to stay independent longer.	
3.	**Declarations of Interest** TR reminded board members of their obligation to declare any interest they may have on any issues arising at the meeting which might conflict with the business of the Locality. None were declared.	
4.	**Minutes of Previous Meeting, Action Log and Matters Arising** The minutes from the meeting held on 27 November 2025 were approved. AP passed on her thanks to those who supported the appeal of the STAR decision around the Salford CVS contract. The appeal was successful and a 5-year contract has been agreed. In relation to the action log, HD mentioned that an update had been received in relation to the children's transport action. JC mentioned that Cabinet have signed off the consultation around a new policy for post 16 transport. MC highlighted the council are working closely with the Parent and Carer Forum in terms of the transport model in terms of their wants/needs. A number have said they want independence for young people. PD raised concerns around how the NHS GM STAR process operates, especially in terms of its efficacy. AP stressed the need for local input into GM decisions. RR queried if the Place Based Grants would need to go through the STAR process. HD explained that she is currently awaiting the detail of the proposed place grant, but the view is that financial arrangements will be determined by the host. PD asked if Place had been engaged with on the Grant allocation. HD noted the challenge is that the 10 localities provide services differently and work is being done to ensure local systems aren't destabilised through any changes. EV has been involved in the working group looking at how funding is allocated and there will be subsequent engagement with partners. RR mentioned that Sam Evans had been to Treasurers twice in relation to the quantification of grants. The BCF minimum values have been confirmed. Next steps include an overarching Locality Grant Framework, which is being consulted on with the ICB Chief Officers and a piece of work is being done around current levels of spend across 7 areas of contracts. RR is waiting for more information on this and will provide an update once received. GMc's main concern is around establishing need, as we must ensure our population needs are met. She isn't sure if Population Health is in the cycle yet. CV highlighted the Place Partnership needs to work together to design services and there is an opportunity to reset this under the new Operating Model. Neighbourhood health gives us this opportunity. PD suggested that an action is needed around this and that the Salford leaders should meet with Sam Evans/Colin Scales to discuss. We need to ensure that the money follows need. **Action: Salford leadership to meet NHS GM colleagues in relation to the Place Grant.** ST highlighted a risk around the BeCCoR scheme. Salford were performing well as an outcome of the Salford Standard and there is concern around possible reduced investment, which may impact on the great things which have been achieved in Salford. We need to continue to invest in areas of greatest need.	**HD**

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5.	**Regular Reports** a) **Finance Report** EV talked through the report (as at the end of December) and highlighted: • The current NHS GM position as a whole for the Integrated Care System had a planned deficit of £71.8 but were at £82.2m (£10.4m adverse to plan as at the end of October). The majority of this was within the provider sector. GM ICB were on plan with the planned deficit, but there are issues around ADHD, Autism, Section 117 pressures linked to Right to Choose, continuing pressures on Continuing Care and finalising/identifying the savings needed. • CIP delivery is slightly ahead of target on a YTD basis. The Provider sector have overachieved by c£20m. The ICB are slightly behind target (by £2.4m). • NHS GM have been notified that they will receive the deficit support funding for November/December. Just one quarter left to be confirmed. • We are forecasting in accordance with our plan. The risk to not achieving this is £133m as a system. This is an improvement since September. £53m relates to providers and £80m for the ICB. • In terms of the Integrated Fund, the way the information is presented has been changed section 3.2 of the report sets out the details behind this. This includes that it has been assumed that the Risk Share is carrying on with the exception of the SCC funding the full overspend of children's services. Up to now we have assumed that the contract in the Integrated Fund for Health & Adults Social Care contract is at breakeven. No contract variation has been agreed as yet in terms of the significant risk of overspend previously highlighted. It has also been assumed that the council will make an additional contribution to the income of the fund to offset the overspend for Childrens services. There was a small underspend reported at the end of October. As a result of the early work done on the repatriation of the ASC contract, this is now showing a YTD overspend for the NCA of £4m as at the end of October. For consistency they have taken out the £3.1m assumption of income from the council being put in the fund. • For NHS GM to afford the current pressures, areas of underspend funding have been moved into the In-View section of the Integrated Fund (c£1.7m). • Overall, there has been a slight improvement to the Integrated Fund of £93k. • For Adult Social Care (ASC) the forecast position has now come through and the NCA requested support of £8.7m overperformance, but this has now been reduced £8.3m. A contract variation has not yet been transacted, as the Finance team are continuing to work on validating it. • For Childrens services, these have not changed in overall position. • Primary Care worsened slightly due to additional costs for minor surgery. • In terms of proposed changes for 2026/27 for the fund, the formal method of the Integrated Fund has now run its course and has become more difficult to manage. The introduction of the Locality Grant and other reforms will reduce the scope of budgets managed within Place, particularly around individual packages of care (will be managed centrally at GM). The ILT met in December and recommended that the Integrated Fund should finish at the end of March 2026. This will mean there will be no Risk Share arrangements for the pool or aligned elements of the fund going forward. There will still be the Better Care Fund and this will continue to be reported, but we need to consider how to do this going forward. • The Salford Locality In-view position is showing an underspend of £747k, which is an improvement from last time. Due to underspending budgets being brought into In-view, the Salford Locality have afforded our proportion of the Risk Share and have released some of the transformation funding to improve the overall ICB position. • Section 6 sets out the contract extensions supported by the SSFG. • The main risk is that the fund has recognised £4m YTD for ASC but expect this to grow to £8.3m. work is still being done on this with the provider.	

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	PD mentioned ASC and the need to be careful of the language used. Saying the NCA are operating at an overspend of £8.3m is not indicative of over performance. He is concerned around what sits behind the figure and why they are in this position. Assurance is needed that cost shunting is not taking place. PD also mentioned issues around the quality of Childrens 16+ supported accommodation. We need assurance that Salford provision is of good quality. In terms of Residential Placements he is aware that there are a number of things being done in Salford around this. He mentioned that Warrington Borough Council are saving 1/3 by bringing people back into the borough and asked where are we up to with Project Skyline. PD also mentioned the PH variance of £398k on the 0-19 service and asked what the thinking is behind this. He believes there are missed opportunities around sports and leisure and how we work with grass routes sports clubs/schools to deliver a Sports & Leisure Strategy for Salford. PD's primary concern is around the update on Adults and that we are not getting the detail needed around this. JF mentioned that, since the last meeting, a lot of work has been done on this. She highlighted there is an underachievement on CIP (£2.4m). The deficit position is driven by cost increases in packages of care (£2.2m overspend including backdated hospital costs). Packages of care monthly costs have increased and this is causing significant issues. Pay is showing a £0.5m overspend. Diane Morrison is working with RR on this and a lot of work has been done on individual budget lines. It was agreed that a paper is needed at the next meeting in order to discuss this in more detail. **Action: ER to add to next agenda.**	**ER**
	MC mentioned that Childrens 16+ providers are now regulated by Ofsted but are yet to be assessed. MC chairs a meeting which reviews all external placements and all provisions have been visited and relationships are being built. Salford are looking at developing their own provision to improve the position. In terms of Residential estate, Salford have opened a new home, which is awaiting Ofsted approval and another is in the pipeline. An Options Appraisal paper will be drawn up around opening further provision. We need to invest more in prevention. GMc mentioned the underspend on the 0-19 service and she is working with RR on this. She is also working on the connectivity of Sports & Leisure. AP mentioned it is interesting about Physical Activity and Arts & Culture. She highlighted that the Health & Wellbeing Board is not currently meeting and this is creating issues. The VCSE are really involved in the work, but wider determinants needs more discussion to show if it is over or under spending. GMc mentioned there is a Health & Wellbeing Board scheduled for March and she will ensure Move More is added to the agenda. **Action: GMc to add to March Health & Wellbeing Board.**	**GMc**
	AP mentioned there was a good conversation at SSFG regarding Advocacy & Guidance contracts, but this is not mentioned in the report. This is now going to STAR, but she is unsure of the timescales. EV's understanding is that the Advice & Guidance contracts have gone to STAR this week, with a response due next week. AP mentioned there was also a conversation around cost-of-living uplifts and she wished to flag concern around this. PD mentioned the council are currently going through budget setting and have talked about the VCFSE contracts. He asked RR where this is up to in terms of uprating the ones SCC holds. RR mentioned that they have tried to address this in the SCC budget. However, there is a worry in terms of health not doing the same with their contracts. We need to consider this going forward when contracting. RR mentioned they have been reporting as breakeven on the Integrated Fund. However, in October 2025 the NCA wrote to the council around ASC being overspent	

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	by £8.7m. The Finance Team set in train work to understand the situation, which has since improved slightly. SR has written a paper detailing the work which has been done and this can be shared at the next meeting. TR asked JCo to contribute to the paper by sharing the information on where the overspend is and what is driving it. PD queried if this could wait for next meeting or if a separate meeting was needed due to the urgency of the situation. RR mentioned that a lot of work has already been done by the NCA to provide clarity. RR highlighted that the team have more clarity on what is driving it now and will have even more in the future when the service comes in-house. The overperformance means they have overperformed on the contract. ASC costs of packages have also grown and have driven the overspend. PD highlighted that, from a legal point of view, the Care Act is specific that the city council carry the responsibility and therefore need to manage the market. Assurance back to SCC is needed around managing the market. **Action: Bring back to the next meeting for discussion.** VS raised concern around an apparent shortage of staff in Child Protection and there was a lack of input from the Safeguarding side into a recent death of a child. She highlighted it is good that the paper mentions creating regular jobs for these staff. She mentioned it would be useful to receive an update in 6 months' time. MC thinks the narrative is misleading in terms of agency staff. Agency spend in Salford is less than 6% for Children's services. She asked VS to highlight any specific issues to her outside of the meeting. ***The committee:*** • ***noted the financial positions forecast for 2025/26 and risks to the position.*** • ***noted the work undertaken by the Salford System Finance Group.*** • ***agreed the intention to disestablish the Integrated Fund from the end of March.*** b) **Salford City Council Budget Planning** RR mentioned the paper is going to full council in February. c) **Salford Health and Care System Planning Update 2026/27** CV talked through her presentation. JC highlighted he is happy to see Children and Young People (CYP) as a priority. However, there is a need to avoid duplication in terms of the work that is being done at the various boards around this. He asked which board would be best to take a lead on this. MC mentioned the School Readiness Board as the appropriate governance, but she is unsure if health is embedded on that board. **Action: MC to confirm if there is health representation on the board.** CV stressed that it is not the intention to add more layers of governance. There is lots of good work going on, but it isn't connected. Leaders in the space need to shape this. Discussions around the CYP accelerator have been paused until the 0-19 contract has been agreed. GMc believes that the School Readiness Board is where the discussions need to take place. The council are about to award the 0-19 contract and this will put us in a good place. GMc mentioned she is nervous in terms of Frailty, as previously they have focused on scores of 6-9, but need to look at 4 and below. In terms of Neighbourhoods, she queried if Primary Care should be our first step as General Practice is widely viewed as the 'front door' so we need to look at how services wrap around it. CV mentioned this is a priority in terms of Neighbourhoods. There is a need for integrated Neighbourhood teams.	**SR / RR / JCo** **MC**

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	Frailty needs to talk about people using multiple services and the design groups need to look at this. We need to listen to frontline staff about the focus being further up the pathway in order to stop people attending A&E due to Frailty. TR highlighted that the system is poor with telling people they are in the end of their life and that going back and forth to the hospital is not good for them, or the flow through the hospital. Need a positive approach to people in the last months of life to provide better care for them. TR mentioned the patient story today shows us we need to move to a system that is genuinely strengths-based and we need to hold people to account on this piece of work going forwards. PD asked to reflect on the terms of 'outcomes' and 'outputs'. When we factor in all the work being done, all of this points to how we do things as a system as being really important. PD raised concern around MH. Salford has been leading the way on this, but he is concerned around the financial challenges facing GM and that these may impact on our performance in Salford. PD is supportive of School Readiness being an area of focus. He highlighted that a focus on SEND is needed for school readiness and the impacts on health. We need to consider where all the services sit around this. He is also concerned that we are not seeing wider determinants front and centre to all this. We need to shift resources and work together. CV highlighted the need to reinforce health and care priorities and the ICPC will link in with the Health & Wellbeing Board on wider determinants. The Health & Wellbeing Strategy will set the outcomes around how we develop this. MC flagged an issue in relation to communication between Midwifery and Health Visitors. There have been 3 cot deaths recently and reviews have shown that communication isn't where it needs to be. This has been an action in the Safeguarding Plan for a while. The council have not had assurance that communication lines are working effectively. She asked for locality support on this. JCo mentioned she wasn't aware of the issues around Midwifery and asked MC to raise this directly with her. AP highlighted that the point around awaiting national guidance is important and that the paper gives a granular understanding of the role of VCSE in this. The report gives examples of where the VCSE is taking lead on areas e.g. Live Well. The VCSE are undertaking some Live Well experiments and have a role in Social Prescribing. Live Well should be a future item either here or at the Health & Wellbeing Board in order to think about the role of Place on this. AP highlighted that the report mentioned the Prevention Demonstrator, the role of this needs to be on a future agenda. AP is concerned around the lack of Salford representation on GM Boards, demonstrators/trailblazers. A lot of work is needed on the Salford and GM relationship. TR mentioned he sees the impact that the VCSE has in his GP role and that it helps to keep people healthy. They really make a difference to the people of Salford and we need to support the VCSE sector as much as possible. ***The committee:*** • ***agreed and signed off the proposed areas of focus for 2026/27.*** • ***agreed to the submission of a draft version of the Neighbourhood Health Plan 2026/27 to NHS GM by 13 February 2026, subject to ongoing review, pending further national guidance.*** • ***noted the content of the report and supporting appendix for information and assurance.***	

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6.	**a)**	**Our Plan for Transforming Care – Northern Care Alliance Clinical Strategy** AC talked through his presentation. He explained the context behind the strategy and that a decision had been made to refresh the strategy when the Darzi Report was published, which was prior to the NHS 10-year strategy being released. He explained the aim is to take the NCA and its colleagues on the journey set out in the strategy. There is a lot going on in this space in reference to the GM organisational changes, the Financial Sustainability Plan, the new Operating Model and challenges with estate. There is opportunity to undertake more engagement, so that colleagues can have more input. There is further work still to do. He mentioned that some other strategies he has read are generic, whereas the NCA strategy has focused on the inequalities across the areas they cover and the conditions they are affected by. It is also about them as an organisation. RAAC and some significant changes in how services will be delivered have been taken into consideration and the need to think how and where they will provide services going forward has also been considered. They are working with partners, looking at population health and prevention work and changing what they do in order to provide services in different ways, spend money as wisely as can and evidence informs everything they do (for example using national GIRFT data and approach - Getting It Right First Time). In terms of next steps, the work left to do is key. They have substantial challenges with estate (RAAC) and challenges with flow on all sites. Bed rates will reduce, through the RAAC programme and they will describe this in detail for each site. They will work with clinical services to develop a 10-year strategy for each service and they will work with partners to develop a left-shift strategy for prevention. PD highlighted that, from a Salford perspective, we have been on a significant journey with the NCA. Before the NCA was established we had an outstanding hospital and outstanding CCG which did a good job of holding the NHS to account. Since then, there have been various issues which have concerned him. He asked how the NCA can assure us that it can be turned around, especially with all that is happening in terms of budget cuts etc. AC highlighted there is an issue regarding organisational culture. The NCA need to deliver tangible outcomes for the people of Salford and also need to stem the flow of people going into the hospital. PD mentioned work is being done at GM around NHS Estate, which seems positive, but is being done in isolation and this needs to be joined up. There are opportunities here to deepen partnership working on this. AC believes that some of the difficulties being described were as a result of the way the NCA was designed/created, but this strategy will help to address some of this. The NCA are committed to the eradication of RAAC and this provides an opportunity to redesign/transform their sites. The NCA leadership team want to change the culture and the strategy is setting out how they want to do this and also change how services are being provided. It will be a cultural journey for staff. ST queried what AC's understanding of the term "left-shift" was. She also mentioned the use of Independent Providers to fix short-term waiting lists in the NHS and that this can also be used to benefit the system. AC mentioned that the common understanding of left-shift is that hospital services move into the community. There is a need for collective ownership of care between Primary and Secondary Care, as left-shift occurs along the whole journey. He agrees there is a misunderstanding by hospital colleagues regarding the definition of left-shift. AC asked ST to contact him around working collaboratively together. CV queried how long the strategy is for and AC confirmed it is for 5 years. CV	

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	highlighted that it is a difficult time to be writing strategies at the moment, but it needs to be strengthened with the Neighbourhood Approach. People should only be at the hospital if there is an absolute need. We need to embed this shift in thinking and link it with prevention etc. The NCA need to be involved in this through the PCB in order to drive this forward. VS mentioned the Advice & Guidance service and these services need to continue to be developed over the next 5 years. As the plan is to try to bring more specialist services into the community, she asked what are the plans for embedding these with General Practice. AC confirmed the NCA will increase the amount of Advice & Guidance they are doing and Diagnostic Centres will be key to this. In terms of the specialities they will look to do he isn't sure which they will be as yet. However, when looking at RAAC, this includes 90 community sites, so when they look at moving services out, the challenges will be around access to imaging and access to clinical rooms etc. GMc stressed the need to consider bus routes/public transport options if they are planning to move services out into the community. TR mentioned he has lots of discussions with NCA colleagues and there is a clear understanding of what we are discussing here, but the challenge is shifting the culture within the rest of the organisation. The Clinical Leadership model will help with this. This will be a radically different way of working and a real challenge. He believes the discussions at the NCA Board in March will also be challenging due to problems in the system and it is sometimes difficult to look at solutions outside of the hospital. They need to see themselves as a bigger/wider system and need to link with Place leadership on this, especially around key enablers to its success. ***The committee:*** • ***reviewed the draft strategy content appended to the report.*** • ***noted that the final draft of the strategy will progress through the NCA's formal governance for final review and approval in February and then go to NCA Board in March 2026.***	
7.	**System Updates** a) **System Partner Updates** • None b) **Place Lead Report** • HD highlighted that the decision around IVF had now been agreed across GM to be 1(+1 for those cancelled or abandoned cycles). SC asked that it is noted that Healthwatch were disappointed with the decision made, as there was overarching feedback from the public that they were against it, but the original decision still stood. This means Salford will go from 2 cycles to 1. AP asked if there was a way that this could be fed back to GM. • In terms of the NHS Reforms, HD mentioned that we need to think what the future Place Partnership will look like going forward. The consultation on the structures within NHS GM has begun. • AP stressed that the NCA Strategy will need ongoing and continuous engagement, as there is a lot more work needed on it. • AP mentioned the new 5 GM Chief Officers' approach and that Salford haven't had an opportunity to influence what is happening in GM. We need to be more proactive in influencing what happens next. • PD raised an issue in relation to a Tik Tok video which had stated that NHS GM are spending £675m to support Asylum Seekers and Refugees through General Practice. He has looked into this and the amount is incorrect. The GMCA have now flagged this with GM Police to look into. NHS GM funds a Salford-specific Asylum service. GMMH are the main providers, but it is believed that the service would be better placed with Primary Care being the provider. It was noted that, in	

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	September last year, GMMH gave notice on providing the service. The actual figure is £675k, with an annual cost to Salford of £201k. NHS GM has commissioned a similar service from Bolton. We need to have an understanding of all the contracts for asylum seekers. There is an opportunity for the Local Authority, GMCA and health to collaborate on this to create better outcomes for these people. PD mentioned that he leads on Asylum and Refugees in GM and isn't fully aware of the situation. He suggested the need to discuss the commissioning landscape and effect some efficiencies in GM. **Action: HD to gather together information around Asylum Seeker & Refugee contracts across GM.** • JC highlighted that the link to ADHD/Autism explains the situation in relation to supporting the financial recovery, however the information is out of date and needs updating (especially around waiting lists). He suggested it would be useful to receive regular updates at ICPC in terms of how many people are being removed from the waiting lists. • VS mentioned the Men's Health Strategy and that PCNs are focusing on Men's Health as a priority. They are focusing on men who have not attended their GP practice in the last 5 years and are also holding an event at Pendleton Gateway in March to showcase the collaborative work which is being done in this area. • GMc mentioned that the Women's Health Strategy is being relaunched around March time. AP asked if the revised strategy will take into account the recent decision around sex versus gender. GMc is awaiting the national guidance for this and will share with AP once received. • Congratulations were passed onto Jane Roberts for winning an award at the recent Voluntary Sector Northwest (VSNW) Conference in Manchester. • TR mentioned that MW is retiring today. He thanked her for her hard work and dedication to improving patient safety over the years. It was also mentioned that Becky Bibby was leaving and TR passed on his thanks to her. ***The committee:*** • ***noted the contents of the report.*** • ***agreed to disseminate and cascade the necessary key messages and information as appropriate.*** c) **Provider Collaborative Board Report** It was noted this was provided for information. ***The committee noted the contents of the report.***	**HD**
8.	**Any Other Business** None.	
9.	**Date and Time of Next Meeting:** The meeting closed at 12.00 pm. The next meeting is scheduled for Thursday 26 February 2026, 9.00 am - 12.00 pm, Salford Suite / Teams	

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Actions Log: Salford Integrated Care Partnership Committee (previously Locality Board)

No	Date	Section	Details of the issue	Details of action agreed	Action Lead	Timescale / Deadline	Status	Update
172	27/03/2025	**Place Lead Report**	GMc mentioned that the expansion of the blood borne viruses testing is good, but she highlighted that there are different funding streams for each and we need to recognise this and the different patient pathways.	GMc to contact Jane Pilkington around this.	**Gillian McLauchlan**	**26/02/2026**		17/4/25 - Jane Pilkington now left NHSE so GM will pick up conversations with Alison Pye at GM 24/4/25 - In respect of blood borne viruses Salford Royal Emergency Department tested for Hepatitis C but not Hepatitis B because of pathways and capacity. A solution for this was being discussed with the Greater Manchester team. The action was ongoing. 22/05/25: GMc mentioned that Salford were the last to roll out HIV testing. We can now test for HIV, Hepatitis B and Hepatitis C, however there is an issue at SRFT in relation to managing the demand. We need to push this with the ICB. 23/10/25: Ongoing. **18/01/26 – Opt out testing in ED is a ICB commissioned service and responsibility. Locality team to action with respective team in the GM team. Note this is a risk as likely to be affected by reforms**
179	22/05/2025	**Action Log**	HG mentioned that an update on blood borne viruses had been provided to the PCB and it was highlighted that there is not enough capacity within the treatment pathway, which is causing the issue.	HD to pick this up with CS/JF and provide an update at the next meeting.	~~**Hannah Dobrowolska**~~ **Harry Golby**	**26/02/2026**		16/06/25: HG to pick up on behalf of HD. 19/06/25: JF spoke to Mark Kellett about this a couple of weeks ago and will provide an update**.** 24/07/25: HG has chased and is awaiting an update. Ongoing. 23/10/25: Ongoing. 14/11/25 Internal discussion ongoing within NCA to find investment required to increase capacity in treatment pathway. **19/02/26: HG is awaiting an update from the NCA.**
191	24/07/2025	**Ingleside Update**	JC mentioned the city mayor and local MP are keen to get the unit re-opened for births. However, the report predicts that the earliest birth will take place in 2027. Occupancy review details are needed as this is a council owned building which is leased to Bolton FT.	HG to obtain details of occupancy and future proposals for births up to 2027.	**Harry Golby**	**26/02/2026**		25/09/25: HG is trying to get hold of utilisation information – ongoing. 09/10/25: Discussed at Ingleside Collaborative, chased 29/09/25, no further update as at 09/10/25. 23/10/25: Ongoing 14/11/25: HG to email Wendy Hodgson in relation to this action. **19/02/26: As above.**
225	29/01/2026	**Minutes of Previous Meeting, Action Log and Matters Arising**	PD suggested that an action is needed around this and that the Salford leaders should meet with Sam Evans/Colin Scales to discuss. We need to ensure that the money follows need.	Salford leadership to meet NHS GM colleagues in relation to the Place Grant.	**Hannah Dobrowolska**	**26/02/2026**		**13/02/26: Meeting is in the process of being arranged.**
Actions Closed Since the Last Meeting								

169	27/03/2025	**Finance Report**	JC mentioned the biggest issue in Children's is around SEND transport and he asked if we have figures available across GM to see if we are in line or above/below.	BB will check	**Becky Bibby**	**29/01/2026**		24/4/25 - BB confirmed a comparison of figures was being done and a Special Educational Needs and Disability transport squad had been set up. The action was outstanding. 15/05/25: Ongoing 22/05/25: BB updated that a SEND Transport Working Group has now been established. BB will bring the action plan back here for oversight. 24/07/25: ER will follow up with BB for an update. 23/10/25: Ongoing. 22/01/26: Update requested. **28/01/26: There is no meaningful comparator data which compares GM spend. We are working closely across GM to share good practice to reduce costs. Bury, Oldham and Wigan have amended their Post 16 SEN transport policy which has reduced budget. Salford is about to consult on these proposals**
180	22/05/2025	**Action Log**	GMc mentioned, in relation to action 149 around Screening and Immunisations being in Business Continuity, delegation is devolved at the moment and Directors of Public Health are not currently assured around Screening and Immunisation programmes.	GMc to pick up this conversation with CS and Warren Heppolette.	**Gillian McLauchlan**	**29/01/2026**		24/07/25: GMc contacted Warren Heppolette around immunisations and vaccinations. These have been devolved to localities, but not yet delegated. They are doing some work around the transfer to the ICB. Ongoing. 23/10/25: Ongoing. 21/01/26 – WH now left the ICB and function in the medical directorate. Screening and Immunisations team and function at GM set to potentially lose 43% of staff and moving again into business continuity. Screening and Immunisations set to migrate to NW OPIC in reforms. No clarity on staffing and structure of SI in NW OPIC therefore not assured. Session with Health Scrutiny on immunisation coverage in Sept 25 and Jan 26. Public Health team supporting the uptake. **19/02/26 - Meeting NW region to understand OPIC plans and SI capacity**
221	27/11/2025	**Quality of Health & Care Services Report**	VS asked what support is available for LD in relation to smear tests.	ND to take this forward.	**Nicola Dugdale**	**29/01/2026**		20/01/26: Michelle Williamson has contacted the Integrated Commissioning Manager (Learning Disabilities/Complex Needs) for a response. **27/01/26: For bowel and breast screening, there is a dedicated pathway for ladies to access learning disability nurse input to access extra help with bowel or breast screening. Currently, there is not such a pathway that covers cervical screening but we are very much aware that this is needed and is in the pipeline. Additional specific advice was provided and shared with VS, this is available on request from ER.**
226	29/01/2026	**Finance Report**	PD's primary concern is around the update on Adults and that we are not getting the detail needed around this. JF mentioned that, since the last meeting, a lot of work has been done on this. Diane Morrison is working with RR on this and a lot of work has been done on individual budget lines. It was agreed that a paper is needed at the next meeting in order to discuss this in more detail.	ER to add to next agenda.	**Elaine Redwood**	**26/02/2026**		**02/02/26: Item added to the February agenda.**

227	29/01/2026	**Finance Report**	AP mentioned it is interesting about Physical Activity and Arts & Culture. She highlighted that the Health & Wellbeing Board is not currently meeting and this is creating issues. The VCSE are really involved in the work, but wider determinants needs more discussion to show if it is over or under spending. GMc mentioned there is a Health & Wellbeing Board scheduled for March and she will ensure Move More is added to the agenda.	GMc to add to March Health & Wellbeing Board.	**Gillian McLauchlan**	**26/02/2026**		**19/02/26: Plans in place for HWB**
228	29/01/2026	**Finance Report**	RR highlighted that the team have more clarity on what is driving the overspend now and will have even more in the future when the service comes in-house. The overperformance means they have overperformed on the contract. ASC costs of packages have also grown and have driven the overspend. PD highlighted that, from a legal point of view, the Care Act is specific that the city council carry the responsibility and therefore need to manage the market. Assurance back to SCC is needed around managing the market.	Bring back to the next meeting for discussion.	**Samuel Russell, Rachel Rosewell & Juliette Cosgrove**	**26/02/2026**		**19/02/26: Included on the agenda for 26-02-26**
229	29/01/2026	**Salford Health and Care System Planning Update 2026/27**	CV talked through her presentation. JC highlighted he is happy to see Children and Young People (CYP) as a priority. However, there is a need to avoid duplication in terms of the work that is being done at the various boards around this. He asked which board would be best to take a lead on this. MC mentioned the School Readiness Board as the appropriate governance, but she is unsure if health is embedded on that board.	MC to confirm if there is health representation on the board.	**Melissa Caslake**	**26/02/2026**		**19/02/26: MC has confirmed there is health representation on the board.**
230	29/01/2026	**Place Lead Report**	NHS GM funds a Salford-specific Asylum service. GMMH are the main providers, but it is believed that the service would be better placed with Primary Care being the provider. It was noted that, in September last year, GMMH gave notice on providing the service. NHS GM has commissioned a similar service from Bolton. We need to have an understanding of all the contracts for asylum seekers. There is an opportunity for the Local Authority, GMCA and health to collaborate on this to create better outcomes for these people. PD suggested the need to discuss the commissioning landscape and effect some efficiencies in GM.	HD to gather together information around Asylum Seeker & Refugee contracts across GM.	**Hannah Dobrowolska**	**26/02/2026**		**13/02/26: Close - action is being co-ordinated through the Mayor's office. Salford information from health, public health, adults and children's services has been provided.**

Salford Integrated Care Partnership Committee
26 February 2026
Item 5 (a) – Information Management & Technology (Digital) Annual Report

Item for: Decision/**Assurance**/**Information**

Report of:	Associate Director of Finance (Salford)	
Date of Paper:	13 February 2026	
In case of query, please contact:	Chris Upton Christopher.upton@nhs.net	
System Priorities: (Please tick as appropriate)	Physical activity and movement	
	Child Friendly City	
	Live well, Neighbourhoods and Communities	
	Adults and Ageing Well	
	Preventable illness - CVD and Diabetes	
	Urgent and emergency care	
	Mental health and emotional wellbeing	
	Triple aim – population health, performance recovery, financial sustainability	
	Other system enabler i.e. Workforce, Transformation, Digital etc.	✓

Purpose of Paper:

The paper is designed to provide the Salford Integrated Care Partnership with an oversight of Digital & Information Technology (IT) programme work supporting Salford's delivery of high-quality care.

Salford
Integrated Care Partnership

Further information

How will this benefit the health and wellbeing of Salford residents, or the Integrated Care Partnership?	The aim of IT & Digital programme work is to improve the experience for citizens and patients in their interaction with services.
How does this paper address health inequalities and promote inclusion?	The risk of digital exclusion exacerbating inequality is discussed within the paper.
What risks may arise as a result of this paper and how will they be mitigated?	Current reform and model blueprint activity presents a risk to resources and capacity.
Does this address any existing high risks facing the organisation and how does it reduce them?	Digital innovation is designed to make services more effective and better value. This supports the financial risk facing organisations.
Are there any possible conflicts of interest associated with this paper?	No
Will any current services or roles be affected by issues within this paper and what are they?	Report only.

Note: Where appropriate, please ensure detail is provided.

Document Development

Has there been Public Engagement?	No unless part of activity reported.
Has there been Clinical Engagement?	No
Has the impact on Salford socially, economically and environmentally been considered?	No
Has an Equality Impact Analysis been completed?	No
Has legal advice been obtained?	N/A
Has this been to any groups or committees for engagement, comments, or approval?	No

Note: Where relevant, please provide detail and ensure that it is clear how and when particular stakeholders were involved in this work, that there is clarity of what the key message/decision was, and whether amendments were requested about any part of the work.

Salford
Integrated Care Partnership

Information Management & Technology (Digital) Annual Report

1. Executive Summary

This report gives an update on activities during the past financial year and reports in detail on a number of key programmes:

- *North-East Sector Alliance – reflecting changes in locality IT management following the previous postholder's retirement.*
- *NHS Reforms and Blueprint – Impact of reform and Integrated Care Board (ICB) Model Blueprint on ICB IT & Digital programme work.*
- *Information Management & Technology (IM&T) Update*
  - *EMIS – some practices can reduce outstanding workflow tasks to address performance issues.*
  - *Greater Manchester Care Record:*
    - *Children's social care integration is under way due for completion by the end of March 2026.*
    - *EPaCCS (Electronic Palliative Care Coordinating Systems) engagement is being relaunched as part of a Greater Manchester (GM) and Sector-wide approach.*
  - *Online Consultation/Video Consultation (OCVC) Procurement – framework to be implemented in 2026/27. Funding available for licence costs, but practices choosing to change products will need to cover any additional costs of change.*
  - *Ardens renewal and Local Commissioning Scheme (LCS) support – Ardens contract extension currently going through procurement. Future support being defined in conjunction with GM Business Intelligence (BI) team.*
  - *Hardware refresh and associated risks.*
- *Digital Transformation*
  - *NHS App onboarding and engagement continues.*
  - *Artificial Intelligence (AI) onboarding process now in place and advice provided to practices on their responsibilities regarding clinical safety.*
- *Future Plans*
  - *Ensuring continued digital support throughout NHS reforms.*
  - *Digital workflows and information sharing across locality/region.*
  - *Supporting delivery of the NHS Blueprint.*
  - *Online Consultation products – GM framework.*
  - *Support for Robotic Process Automation/Artificial Intelligence solutions.*
  - *NHS App uptake.*
  - *Website audits and reviews.*
  - *Accurate provision of GP Appointment Data (GPAD) to NHS England.*
  - *Patient Online Access to records.*
  - *Working with the Northern Care Alliance (NCA) to deploy the Laboratory Information Management System (LIMS).*
  - *Optimising Cloud Based Telephony systems.*

2. North-East Sector Alliance

2.1 Ongoing NHS reform, including financial recovery programmes, workforce constraints, and a renewed focus on statutory core functions, has had a material impact on the NHS Greater Manchester ICB digital portfolios. As a result, a number of ICB-led activities and digital programmes have been paused, slowed, or discontinued in order to realign delivery with the Model ICB Blueprint and national priorities set by NHS England.

The immediate impact of this realignment is a slower pace of visible digital transformation at place and neighbourhood level, an increased risk of partner organisation disengagement, and delays to benefits realisation from in-flight digital strategy and programme activity.

In the context of the current organisational restructure, there is a significant risk of losing specialist digital expertise, alongside a potential mismatch between the future digital ambition set out in the Model ICB Blueprint and the delivery capability retained within the ICB. While this transition period represents a consolidation and realignment of strategy rather than a retreat from digital transformation, there however remains uncertainty at this stage regarding the scale and shape of the ICB's future digital capability. It is expected that further clarity on this will be defined as part of the reform / consultation process.

3. NHS Reforms and Blueprint

3.1 Following the retirement of the previous postholder in April 2025 management responsibility for the Salford locality IT remit was passed to the Head of IT and Assurance for Heywood, Middleton & Rochdale.

3.2 As part of GM-wide reforms this was subsequently expanded to include a planned sector-based approach with the North-East Sector team covering Bury, Rochdale, Oldham and Salford (also known as the BROS model).

3.3 Since becoming involved in managing the digital programme, the North-East Sector IT Team participates in (and provides updates as appropriate to) the following meetings:

- Senior Leadership Team
- Primary Care Commissioning Committee (PCCC)
- Practice Managers IT
- Primary Care Project Group
- Air & Share
- Ad hoc meetings to support projects and issues.

3.4 The North-East Sector IT Team also links with the Digital Facilitator team and has shared responsibility for the delivery of associated programmes of work.

4. EMIS

4.1 GM IT continues to investigate reported issues/problematic PCs to resolve root cause, in addition to a rolling hardware upgrade programme to meet the revised EMIS environment specification. NHS Digital continues to engage with EMIS on performance with quarterly update meetings held by GM.

4.2 Work is nearing completion on a refresh programme to upgrade memory in practice PCs to meet EMIS Working Environment Specifications. There are current delays to the upgrade and refresh programme due to low availability of resources in the engineering team.

4.3 Outstanding workflow tasks statistics have been received showing large numbers of tasks in some practices and this will impact on EMIS performance. Practices are advised that reducing workflow tasks to under 4,000 will help improve performance.

4.4 As a general guide, the average number of outstanding tasks across all GM practices is 4,824. There are 147 practices across GM with over 4000 active tasks.

4.5 There are 16 Salford practices that have more than 4,000 active tasks and the Digital First team will provide support where appropriate in helping practices to reduce these levels.

5. Greater Manchester Care Record (GMCR)

5.1 EPaCCS (Electronic Palliative Care Co-ordination System) – An engagement refresh led by Health Innovation Manchester is under way to drive the uptake and use of EPaCCS care plans across GM.

5.2 There is no incentivisation built into the programme but there is evidence that the use of EPaCCS delivers benefits to patients in terms of improved outcomes and to practices and partner organisations in terms of resource savings.

5.3 Health Innovation Manchester is currently working to produce a benefits report to document these benefits. The report is due to be published by Health Innovation Manchester in the coming months.

5.4 Childrens Social Care integration – Work is underway to integrate the Salford City Council (SCC) Liquid Logic Childrens Social Care system with the GM Care Record. This includes two aspects:

5.4.1 Single Sign On: to allow council staff supporting Children's & Young Persons (CYP) to access the GM Care Record and see health records. This will enable council staff to expedite support where an assessment may need to include health information.

5.4.2 Data feed: the SCC Liquid Logic Childrens Social Care system will contribute a minimised data set into the GM Care Record, enabling health staff to view, for example to check whether a presenting child has an active social care case for potential safeguarding.

5.5 A project group is meeting regularly including stakeholders, system suppliers, Information Governance and digital/system support, to support delivery.

6. Online Consultation/Video Consultation (OCVC)

6.1 NHS GM is progressing the procurement of Online Consultation, Triage, Messaging, and Booking tools to support the Modern General Practice model. Details of the selected solutions will be shared when work on the model is completed.

6.2 Once the final selection is confirmed, the Digital Facilitation team will schedule online supplier demonstrations for practices.

6.3 For 2026/27, the number of NHS GM-funded solutions will be streamlined to reduce complexity, while maintaining high standards of patient care and meeting funding constraints. Practices wishing to use these funded solutions can opt-in.

6.4 Any practices choosing not to proceed with any of the funded solutions from the framework will need to self-fund an alternative, compliant solution available through an NHS procurement framework.

6.5 With fewer solutions available, some practices may need to change systems.

6.6 There may be a short period of dual running to support practices that need to transition.

6.7 Practices will be advised around requirements for training and onboarding once the framework model is complete.

7. Ardens Contract Renewal and Local Commissioning Scheme Support

7.1 A series of meetings have been held to consider the renewal of the Ardens contract in order to maintain continuity of Local Commissioning Scheme (LCS) support and reporting during a period of wider digital and organisational change.

7.2 This approach is intended to provide stability for practices while the ICB transitions towards a more strategic, business-intelligence-led reporting model, ensuring that existing incentive monitoring, reporting, and assurance requirements can continue without interruption.

7.3 In the context of impending changes to incentive schemes aligned to the Model ICB Blueprint, a new contract is currently in the process of procurement. This mitigates the risk of a gap in LCS reporting capability, loss of data visibility, and increased administrative burden on practices.

7.4 It also reduces the risk of unmanaged variation during scheme transition, supports consistent application of commissioning rules, and provides a controlled pathway from the current Ardens-based approach to a future Business Intelligence supported model without compromising operational delivery or assurance.

7.5 System for Thorough Assessment of Resources Chamber (STAR) Approval has been given for the contract extension, and an agreement in in place with Salford City Council to share the costs over the 14-month Ardens contract term.

8. Hardware Refresh and Associated Risks

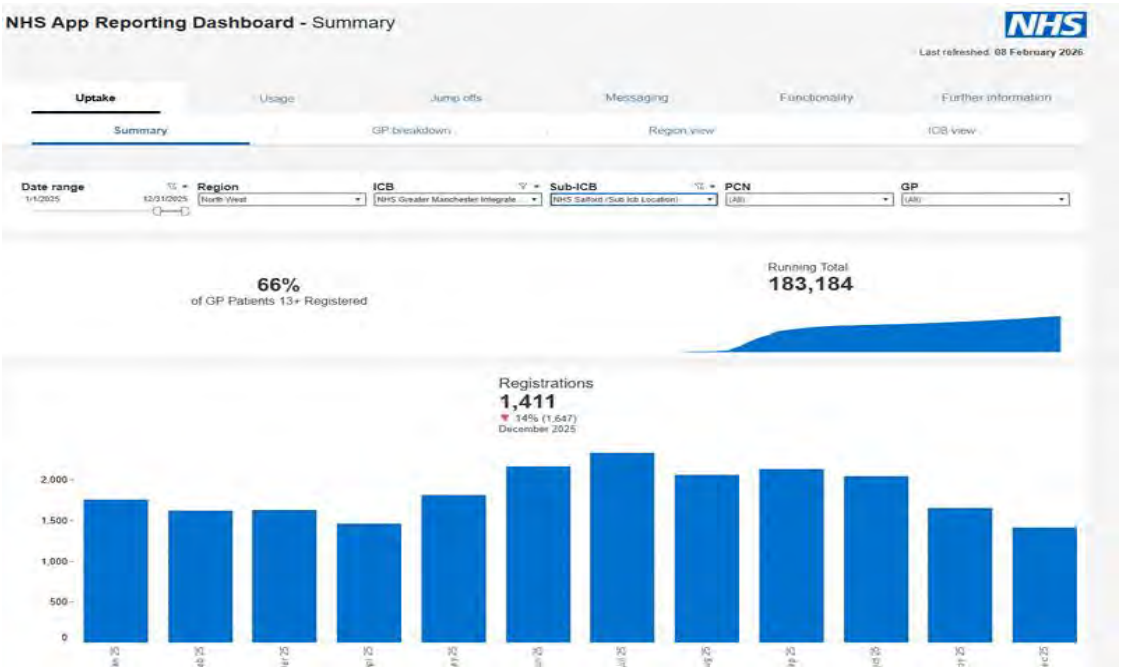
8.1 The ICB IT desktop and laptop hardware refresh programme is addressing a legacy of underinvestment that has left a proportion of end-user devices operating beyond their recommended lifecycle.

8.2 Historically, ageing hardware across several practices has resulted in reduced system performance, increased device failure rates, and constraints in supporting current clinical systems, security updates, and modern ways of working. This has contributed to operational disruption within practices and increased pressure on local IT support services.

8.3 Funding has now been secured, and a hardware refresh programme is underway, which will progressively mitigate these risks; however, until refresh activity is fully implemented and embedded as a rolling programme, there remains a residual risk to productivity, staff experience, cyber security posture, and the reliable delivery of digital primary care services.

9. NHS App Onboarding and Engagement

9.1 Across Salford 66% of patients age 13+ are registered with the NHS App.



9.2 The Digital First team maintains a digital maturity matrix to assess and monitor onboarding, used in conjunction with the NHS App dashboard.

9.3 The Digital First team is continuing with a rolling programme of engagement with practices to deliver NHS App events and support patients face-to-face with downloading and installing the app.

10. Artificial Intelligence (AI)

10.1 Early in 2025/26 the Digital First team delivered sessions to introduce practices to the concepts of Robotic Process Automation (RPA) and Artificial Intelligence (AI) with focus on benefits and risks.

10.2 At the GM-level a process was introduced for GP practices to follow when requesting solutions or systems that include AI functionality. This process involves raising a project request via ServiceNow which will then be assessed by an AI Oversight Group.

10.3 The purpose of the AI Oversight Group is to assess the request to ensure that the product can be safely deployed from a technical and cybersecurity perspective and to understand the potential risks presented by AI. The group will then either grant approval to proceed or will feed back reasons that a request is rejected.

10.4 It remains the practice's responsibility to nominate a Clinical Safety Officer who will be responsible for conducting an appropriate Clinical Safety assessment of the practice's intended use of the AI product. This needs to follow a formal process which will be advised by the Artificial Intelligence Oversight Group. Online training is available to support practices' nominees to understand the required approach.

10.5 Further advice and details of training available can be obtained from the Digital Facilitator team.

11. Future Plans

11.1 Digital resources will continue to be made available to Salford as part of ICB NHS reforms and associated reorganisation. This reorganisation is in progress at the time of writing and, although this may affect the modality of delivery of specific projects, the overarching digital themes will remain consistent with current plans.

11.2 The sector IM&T Team and Digital Facilitation team will work together to deliver a range of objectives in the coming year. The broad objectives anticipated for 2026/7 include:

- Engagement and inclusion with key locality meetings and stakeholder groups.
- Ensuring digital workflows and information sharing at the locality and sector level continue to develop in tandem with the Northern Care Alliance footprint and wider GM ecosystem.
- Supporting delivery of the NHS Blueprint through improving digital process and provision of patient access.
- Supporting any practices changing Online Consultation products using the GM framework.
- Continued support to practices implementing RPA/AI solutions.
- Continuing to drive NHS App uptake through a communications campaign supported by face-to-face in-practice sessions.
- Website audits and reviews; application of accessibility standards.
- Educating and supporting practices in appointment slot mapping to ensure accurate provision of GP Appointment Data to NHS England.
- Online Access to Records – continued support to practices.
- Working with the Northern Care Alliance to deploy LIMS.

Helping practices to optimise Cloud Based Telephony systems and capitalise on smart telephony functionality focusing on patient satisfaction and resource optimisation.

12. Recommendations

12.1 The Salford Integrated Care Partnership Committee is asked to:

- note the contents of this report and support the broad aims of delivering digital themes to primary care services in the Salford locality.

Chris Upton
Head of IT and Assurance/North-East Sector Lead

Salford Integrated Care Partnership Committee
26 February 2026
Item 6 (a) - Update on Urgent & Emergency Care and Winter Planning

Item for: Decision/Assurance/**Information**

Report of:	Associate Director of Delivery & Transformation	
Date of Paper:	16 February 2026	
In case of query, please contact:	Stephen Tilley stephen.tilley@nhs.net	
System Priorities: (Please tick as appropriate)	Physical activity and movement	
	Thriving families	
	Live and age well	
	Preventable illness - CVD and Diabetes	
	Urgent and emergency care	✓
	Mental health and emotional wellbeing	
	Triple aim – population health, performance recovery, financial sustainability	
	Other system enabler i.e. Workforce, Estates, Digital etc.	

Purpose of Paper:

Information on Urgent & Emergency Care (UEC) performance and assurance on winter plans for the Salford Locality system.

Further information

How will this benefit the health and wellbeing of Salford residents, or the Integrated Care Partnership?	Ensure that the systems services are resilient this winter.
How does this paper address health inequalities and promote inclusion?	N/A
What risks may arise as a result of this paper and how will they be mitigated?	N/A
Does this address any existing high risks facing the organisation and how does it reduce them?	Failure to achieve system performance measures is a risk and the report provides information on plans over winter that help to mitigate that risk.
Are there any possible conflicts of interest associated with this paper?	No
Will any current services or roles be affected by issues within this paper and what are they?	No

Note: Where appropriate, please ensure detail is provided.

Document Development

Has there been Public Engagement?	N/A
Has there been Clinical Engagement?	N/A
Has the impact on Salford socially, economically and environmentally been considered?	N/A
Has an Equality Impact Analysis been completed?	N/A
Has legal advice been obtained?	N/A
Has this been to any groups or committees for engagement, comments, or approval?	No

Note: Where relevant, please provide detail and ensure that it is clear how and when particular stakeholders were involved in this work, that there is clarity of what the key message/decision was, and whether amendments were requested about any part of the work.

Salford
Integrated Care Partnership

Update on Urgent & Emergency Care (UEC) and Winter Planning

1. Executive Summary

This report outlines current UEC performance and provides updates on programmes that support UEC performance and provides assurance on winter planning.

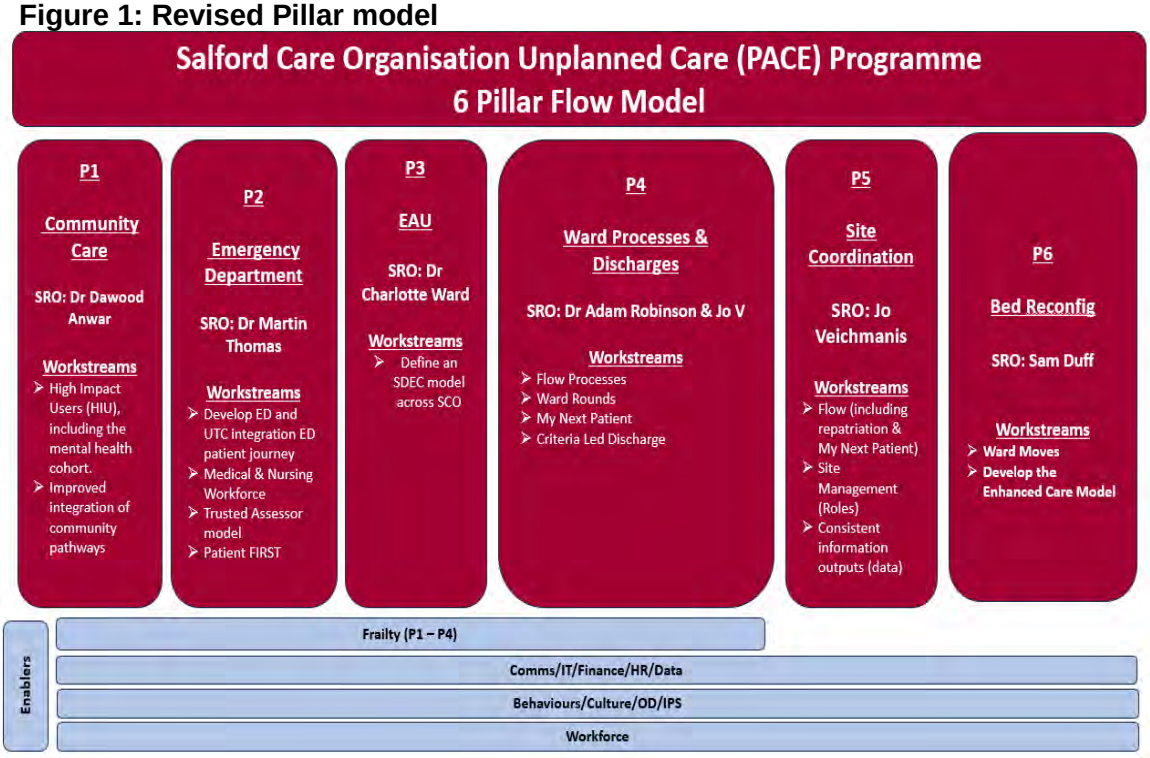
The report covers:

- *the review and refocusing of the UEC Excellence Programme*
- *current UEC performance*
- *the Urgent Care Recovery Fund*
- *UEC Transformation*

2. The Review and Refocusing of the UEC Excellence Programme

2.1 To help achieve the required UEC performance across the Northern Care Alliance (NCA), Salford Care Organisation (SCO) established the UEC Excellence Programme in 2024/25 which saw the creation of 6 strategic and operational pillars. There has been a recent review and refocusing of this original pillar model (see Figure 1 below) to ensure that the activity is properly focused on the areas of challenge that Salford need to meet.

Figure 1: Revised Pillar model



2.2 In October 2025 all programmes were reviewed to identify key areas of focus as the original brief was felt to be too wide to enact real change. The review was further supported by a bed reconfiguration workshop in November 2025 to look at the future co-locating of specialties across the site. An Emergency Dept (ED) transformational workshop was held in December 2025 with key stakeholders from all divisions and locality partners. It explored clinical scenarios currently coming through the ED that could be streamed to other services, focusing on Right Care, Right Time, Right Place. Additional meetings will be held in Quarter 4.

2.3 These workshops have helped shape clear areas of focus for the pillars with actions reviewed at every pillar meeting. Since October there has been a steady improvement in performance and a belief that this will continue to the end of the year.

2.4 The high impact areas of focus are in Table 1 below.

Table 1: High Impact Areas of Focus

Pillar 1 focus areas	Improved integration of community pathways High Impact Users (HIU), including the mental health cohort Call before Convey has been implemented through Salford Primary Care Together (SPCT)
Pillar 2 focus areas	Trust assessor model Front Door Integration (Urgent Treatment Centre & ED) Minor Injuries/EPR Front Door Processes,1st & 2nd Assessment Process/Same Day Emergency Care (SDEC2) Capital Front Door Redesign Update Workforce, Medical Demand & Capacity, Nursing Turnover Recruitment
Pillar 3 focus areas	Increase Hot Clinics being worked through Pillar 3 Define an SDEC model across Salford Care Organisation Review community provision for Deep Vein Thrombosis (DVT) pathway
Pillar 4 focus areas	Flow Processes Ward reviews in line with Getting It Right First Time (GIRFT) principal Number 9 Clear escalation processes to support flow/discharges Criteria Led Discharge
Pillar 5 focus areas	Development of site management within Pillar 5 Streamlining flow meetings Escalation processes
Pillar 6 focus areas	Enact agreed ward moves Develop the enhanced care model across the SCO

2.5 Each Pillar meets fortnightly (except Pillar 2 which meets weekly) with representation from across the Salford locality and reports into the newly formed Planned and Acute Care Enhancement programme (PACE). This monthly steering group has senior representatives from each Pillar and key directors/senior managers from across the Salford system, and monitors progress of the whole pillar programme.

3. UEC Performance

3.1 There are three key NHS indicators UEC metrics in Greater Manchester (GM). The first is the 4-hour target which measures the percentage of Accident & Emergency (A&E) attendances that wait less than 4 hours before admission, discharge or transfer. The second is the number of attendances at A&E. The third is No Reason / Criteria to Reside, now commonly referred to as Days Kept Away from Home (DKAFH). This is to reflect the fact that this indicator shows when patients are medically fit to be discharged but, for various reasons, remain in a hospital bed.

3.2 Quarter 3 in 2025/26 continued to present challenges across Salford and the Greater Manchester footprint with high levels of flu/ Respiratory Syncytial Virus (RSV) cases, staff sickness and recent outbreaks of Norovirus in some wards of the SCO closing wards/beds. Despite this, the 4-hour target continues to steadily improve on the previous year's performance. All three months of Quarter 3 were above 65%: October 66.6%, November 66.7% and December 67.0%. In what has been an extremely busy and difficult January, the percentage is similar with 66.8%. However, this is below the GM average of 67%. The NCA as a whole is still working towards a target of 72% by the end of March 2026. This is recognised by the NCA as challenging, but the pillar refocus is designed to get closer to this target.

3.3 Attendance at the ED was slightly up in January 2026 against January 2025, 9974 and 9401 respectively. This was also reflected in Quarter 3 – see Table 2 below.

Table 2: ED attendances

Month	2025	2024
December	9652	9434
November	10,069	9765
October	10,547	10,091

This reflects a similar increase across Greater Manchester, but unlike other localities, there is not the same wide fluctuation in attendance month to month as our alternative pathways to ED continue to have an impact.

3.4 Days Kept Away From Home continues to be challenging but there has been a steady decrease in beds occupied by someone fit for discharge. October saw 19.4%, November was 16.6% and December was 16.1%. This trend continues in January 2026 with 15.7%. This reduction has been facilitated with the introduction of weekly DKAFH meetings in the SCO to support reducing length of stay and a Board Round Steering Group has been established. Salford continues to support the GM Discharge and Flow meeting to help ensure patients who do not need to be in hospital can be discharged safely if appropriate to other localities.

4. UEC Recovery Funds

4.1 The Salford Provider Collaborative Board and Locality Board originally agreed a plan to utilise the available UEC Recovery Funds (UECRF) in 2023/24 to support the delivery of a number of schemes across the system. Both Boards agreed to extend the plans into 2024/25 and again in 2025/26. These funds, in line with guidance and planned locality expenditure, were expected to have an impact on achieving the three key ambitions of the national UEC Recovery Strategy.

These are:

- The achievement of 76% of patients being admitted, transferred, or discharged from ED within 4 hours (this has recently been decreased to 72% for all NCA member organisations).
- A reduction in hospital bed occupancy to 92%.
- A target of 30-minute ambulance handover times.

4.2 For the sake of simplicity, and in the context of broader work within the city, this report focuses on programmes funded via NHS GM allocations. The present range of programmes are outlined in Table 3 below. Providers of the schemes were written to in January 2026 to request spend, activity and outcomes data from April – December 2025 to determine the impact of the programmes, and this is summarised in the table below.

Table 3: UEC Recovery Fund Schemes

Scheme	Provider	Activity and Outcomes
Home First - Admission Avoidance	NCA	The purpose of the team is to support admission avoidance in the ED. The service sees an average of 83 patients a month and supports discharge before admission, or earlier discharge following admission by continuing planning started in ED. UECRF funding supports additional capacity for the team.
Independent Living Services admission avoidance (Occupational Therapy service)	NCA	The funding supported recruitment to 4 additional Occupational Therapy (OT) posts to secure additional workforce capacity in the community OT service to maintain people living independently in their own home. The number of referrals into the service have significantly increased, with the complexity and acuity also increasing.
Reablement at home service	NCA	The service sees over 1200 patients a year and aims to get them independent at discharge from the service so that they do not require further statutory support (72%) or in receipt of a package of care (18%) or other support (10%). UECRF funding supports additional capacity for the team.
Home First - Acute Flow & Discharge	NCA	Additional Flow Facilitators and Patient Pathway Managers are funded; they enable flow by supporting discharge planning arrangements with the ward teams. Since the enhancement of the teams, there has been a consistent decline in super-stranded patients on medical wards and a reduction in average length of stay.
(EPIC) GP pre-registration ED streaming and UTC support	SPCT	The core Extended Integrated Primary Care (EPIC) service is, in part, funded from this budget. It has supported over 18,000 deflections from ED, with patients being discharged for diverted to SDEC pathways.
Home from Hospital Service	Voluntary, Community & Social	Age UK Salford & Trafford provide a wraparound support package for older adults with low support needs being discharged from SCO, for those that cannot access formal

	Enterprise (VCSE)	care support services. Salford Council for Voluntary Services (CVS) provide support to individuals discharged from hospital and step down reablement. This includes community connectors and a hospital support worker, with approximately 200 referrals and 1500 interventions/contacts so far. There is also a befriending service and check and support via Salford CVS offering a daily check-in for the 7 days following discharge and regular on-going telephone contact to individuals experiencing loneliness, isolation, or reduced wellbeing. There have been over 70 referrals to this so far.
Additional General Practice (GP) Capacity	Primary Care Networks (PCNs)	Resources have been used to create additional appointments in primary care (over 24,000) to enable patients to be seen closer to home and avoid unnecessary ED attendances.
Greater Manchester Mental Health (GMMH) Schemes	GMMH	In Salford this has supported For Housing with reserved tenancies, the remainder has contributed to the provision of 28 beds supporting flow across the wider system (23 step-down, 3 crisis and 2 Psychiatric Intensive Care Unit), and a personalisation fund, focussed on discharge support for individuals with over 70 individuals supported.

4.3 Final analysis will be available at year end, but it is important to demonstrate the ongoing impact of the programmes. At its meeting in May 2023, the Integrated Care Partnership Committee (ICPC) agreed to commission the EPIC 24 model on a recurrent basis, in part funded by UECRF. NHS GM Salford has also agreed to honour the VCSE Compact with respect to a Well Being Matters social prescribing post which represents part of the VCSE programme, i.e. at least a commitment to the end of September 2026. The locality team are seeking to clarify the contracting arrangements around the GMMH schemes with colleagues from NHS GM. Historically some UECRF was allocated to support a GM-wide decision regarding hospice provision, Salford can now honour that GM commitment without needing to use UECRF. No decision has been taken to make a recurrent financial commitment of UECRF monies funded via NHS GM allocations to any of the other programmes listed.

5. UEC Transformation

5.1 Work continues to develop and implement programmes to support Salford achieving its UEC targets and meet areas of focus outlined by NHS England.

5.2 There are currently Medical, Surgical and Frailty SDECs. 24-hour opening has been tested and is being evaluated. They continue to develop closer working relationships with specialities to aid the faster movement of patients to appropriate support.

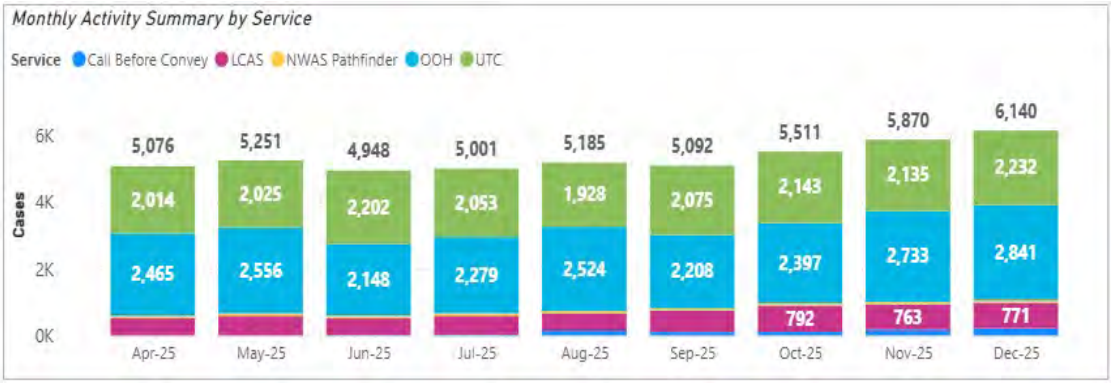
5.3 Frailty remains a key focus and the Salford UEC system tested the placement of a geriatrician in the Urgent Community Response team between 26 January and 6 February. The geriatrician undertook a board round twice a day and provided senior decision support to Advanced Clinical Practitioners (ACPs) on duty. The initial benefits identified are in Table 4 below. The outcomes of the test are being reviewed but it is intended that a further test will be carried out in Quarter 4.

Table 4 – Frailty Identified Benefits

The opportunity for closer Multi-Disciplinary Team (MDT) working between geriatricians and Urgent Community Response (UCR)
Definition of the inclusion and exclusion criteria for patients appropriate for UCR, along with escalation processes
Ways to formalise/standardise development of a clinical plan within UCR
Calculation of the UCR service overall 'frailty burden'
Definition of pathways for those over 65 with frailty in the integrated neighbourhood teams
Closer working with adult social care

5.4 A variety of alternatives to ED have been developed working closely with Salford Primary Care Together (SPCT). These have seen a 33% increase year on year on contracted activity across a variety of integrated urgent care services, where patients are triaged and offered alternative pathways to ED, if appropriate. These services include Locality Clinical Assessment Service, Urgent Treatment Centre (co-located with Salford ED), GP Out-of-Hours, North West Ambulance Service (NWAS) Pathfinder (crew on scene) and Care Before Convey, see Figure 2 below.

Figure 2: Monthly activity by alternative to ED service



5.5 In addition, SPCT are testing a Single Point of Access model in line with the implementation requirements of NHS England. Through this service, health professionals are encouraged to contact the SPCT hub before conveying a patient to ensure the correct endpoint is achieved. These calls are assessed through the digital hub, allowing timely clinical validation and redirection to services such as the Urgent Treatment Centre (UTC), GP Out-of-Hours, or community-based pathways. This approach not only reduces unnecessary ED attendances but also supports improved patient experience and system efficiency (see Table 5 below).

In January the SCO are reporting a daily average of 56 ambulances arriving as opposed to the usual average of 78. Opportunities continue to be explored, and to this end, from 16 February SPCT will be supporting the hospital in a proof of concept test providing an Advanced Nurse Practitioner (ANP) to support minor injury pathways (e.g. minor burns, wounds, dressings etc), fully integrated with the ED and UTC. The objective is to reduce the workload on the ED, reduce 4-hour breaches caused by minor injury waits and improve the patient experience. Ultimately the intention is to generate evidence to inform future scaling, including potential off-site Minor Injury Unit provision.

Table 5: Single Point of Access usage

Month	Total Number of Calls	% referred to ED	Number of patients who avoided ED
April 2025	73	15.1	62
May 2025	75	18.6	61
June 2025	88	15.9	74
July 2025	99	23.6	71
August 2025	221	35.3	143
September 2025	169	20.1	135
October 2025	179	21.2	141
November 2025	239	23.4	183
December 2025	278	26.9	203

6. Recommendations

6.1 The Salford Integrated Care Partnership Committee is asked to:

- note the content of the report.

Stephen Tilley
Service Transformation Lead (Salford), NHS GM

Salford Integrated Care Partnership Committee
26 February 2026
Agenda Item 6 (b) – Adults Social Care Overspend

Item for: Decision/**Assurance**/**Information**

Report of:	Strategic Head of Finance for People (Children's and Adults)	
Date of Paper:	16 February 2026	
In case of query, please contact:	Samuel Russell samuel.russell@salford.gov.uk	
System Priorities: (Please tick as appropriate)	Physical activity and movement	
	Child Friendly City	
	Live well, Neighbourhoods and Communities	
	Adults and Ageing Well	
	Preventable illness - CVD and Diabetes	
	Urgent and emergency care	
	Mental health and emotional wellbeing	
	Triple aim – population health, performance recovery, financial sustainability	✓
	Other system enabler i.e. Workforce, Transformation, Digital etc.	

Purpose of Paper:

This paper provides the Salford Integrated Care Partnership Committee (ICPC) with:

- An overview of the financial position within the Adult Social Care contract delivered by the Northern Care Alliance utilising Month 9 (end of December 2025) information.
- A clearer explanation of how the contract is funded, alongside the key factors contributing to the current overspend position.
- An outline of the potential year-end financial contributions required from commissioning partners, should the forecast overspend materialise under the existing risk-share arrangements.

Further information

How will this benefit the health and wellbeing of Salford residents, or the Integrated Care Partnership?	Ensuring public funding is spent appropriately. Achieving Value for Money, ensuring that funding is available to protect core services.
How does this paper address health inequalities and promote inclusion?	Financial and performance pressures associated with the Integrated Fund services. Through management of committed developments and holding providers to account for performance.
What risks may arise as a result of this paper and how will they be mitigated?	As outlined in section 4.
Does this address any existing high risks facing the organisation and how does it reduce them?	The Adults Social Care contract is the largest pressure on the Integrated Fund (IF) in 2025/26. If agree to fund, will support IF balancing by year-end.
Are there any possible conflicts of interest associated with this paper?	N/A
Will any current services or roles be affected by issues within this paper and what are they?	N/A

Note: Where appropriate, please ensure detail is provided.

Document Development

Has there been Public Engagement?	N/A
Has there been Clinical Engagement?	N/A
Has the impact on Salford socially, economically and environmentally been considered?	N/A
Has an Equality Impact Analysis been completed?	N/A
Has legal advice been obtained?	N/A
Has this been to any groups or committees for engagement, comments, or approval?	Been referenced verbally in Integrated Care Partnership Committee in January 2026.

Note: Where relevant, please provide detail and ensure that it is clear how and when particular stakeholders were involved in this work, that there is clarity of what the key message/decision was, and whether amendments were requested about any part of the work.

Adults Social Care Overspend Report

1. Executive Summary

This finance report provides the ICPC with an in-year update in relation to the Adult Social Care Contract delivered by the Northern Care Alliance on behalf of commissioners (Greater Manchester Integrated Care Board and Salford City Council).

Section 2 – Provides an overview of the Adult Social Care contract in relation to the Integrated Fund.

Section 3 – Outlines the budget setting processes for Salford City Council and how the contract is funded by both commissioners.

Section 4 – Explains the key variances in relation to the Adult Social Care contract budget delivered by the Northern Care Alliance.

2. Adults Social Care Contract Overview

2.1 Health and Adult Social Care (HASC) services in Salford are currently delivered by the Northern Care Alliance (NCA) under a Section 75 Partnership arrangement between Salford City Council (SCC) and Greater Manchester Integrated Care Board (GM ICB) funded through the Integrated Fund (IF). The purpose of joint commissioning was to deliver integrated health and social care services to Salford residents through a closely aligned and collaborative model.

2.2 This report sets out how the Health and Adult Social Care contract is funded through the Integrated Fund and explains how those resources are allocated across service delivery. It provides an overview of the main areas of expenditure supported by the contract, including workforce costs, third-party care provision, and associated operational and overhead costs. The report also summarises the current in-year financial position and sets out the forecast outturn for the end of the financial year, highlighting key cost pressures, variances, and risks that may impact the overall funding position.

3. Health and Adults Social Care (HASC) Contract Funding

3.1 As part of the annual budget setting process, the Integrated Fund is reviewed in a similar way to the council's budget, taking account of available funding across partners and planned service expenditure. This includes consideration of expected cost pressures such as inflation, pay awards, and increasing demand for services. A balanced budget for the Integrated Fund is agreed and set at the start of the financial year, providing a baseline against which in-year performance is monitored.

3.2 To balance the budget, this required partners, through their respective annual budget-setting processes, to identify and agree the level of additional funding to be allocated to support the HASC Contract in 2025/26. Salford City Council (SCC) identified c.£14m to support service pay award, foundation living wage raises, and manage cost and demand pressures. Further details follow from paragraph 3.4 on how

these additional funding streams have been allocated to the contract throughout the year.

3.3 When the 2025/26 Integrated Fund budget position for the Salford Locality was established, £140.457m was allocated to the Health and Adult Social Care contract. Partner contributions were jointly agreed, taking account of the funding requirements for each individual service or element within the contract. The start of year budget, including the Better Care Fund (BCF), reflects contributions from the Greater Manchester Integrated Care Board (GM ICB) and Salford City Council (SCC) were £35.376m (25%) and £105.081m (75%) respectively. These contributions are subject to further validation through a detailed financial review to confirm the accuracy of funding allocations.

3.4 As outlined above, the council agreed to increase the funding allocation to the HASC contract by approximately £14m and this was made up of:

- The £4.3m increase reflects rising Adult Social Care costs and demand pressures, driven by a 4% increase (148 cases) in the number of care packages during 2024/25, together with an average 5% increase in package costs after applying fee-rate uplifts.
- An estimated £8.6m to support the impact of the Foundation Living Wage and the potential increase in employer National Insurance contributions for Adult Social Care providers, required to be met through the Integrated Fund in 2025/26.
- A provision of £1.026m to fund the anticipated pay award for Adult Social Care staff employed by the NCA, which is funded by the council through the annual contract uplift.

3.5 To ensure effective financial management across Health and Adult Social Care services, the additional funding is only released when the NCA can evidence increased costs against the agreed and eligible categories of expenditure. Please refer to Table 1 below, which sets out the funding the NCA is forecast to receive from the Integrated Fund commissioning partners.

Table 1: Forecast Contract Income expected from NCA

HASC Contract Income	SCC £'000	ICB £'000	Total £'000
Health and Adults Social Care Contract - Opening Value	(105,081)	(35,276)	(140,457)
Agreed Provider Fee Rate Uplift	(7,630)	(676)	(8,306)
Adjustment for The Limes Recharge	872	0	872
National Insurance Uplift	(446)	0	(446)
Annual Pay Award	(649)	0	(649)

Pay Re-alignment to Salford City Council Pay Scales - Effective from April 2024	(1,134)	0	(1,134)
Priory Placement Uplift	0	(53)	(53)
Aging Well	0	(533)	(533)
Independent Living Service	0	(294)	(294)
Grand Total	**(114,068)**	**(36,932)**	**(151,000)**

** This table reflects forecast income expected from Commissioning Partners and is subject to change*

3.6 The table sets out the total contract funding expected from the NCA by the end of March 2026, broken down by commissioning partner. From Salford City Council's perspective, £112.934m has been incorporated within the Integrated Fund to date. A further £1.134m relating to pay re-alignment is currently being held corporately, pending the submission of evidence to demonstrate associated additional expenditure.

3.7 Of the total fee rate requirements across commissioners referenced in Table 1 above, the total allocation to NCA providers is £8.306m based on known information at period 9. This is split between Salford City Council and GM ICB as split in the table. Following a detailed review of Section 117 packages of care, the GM ICB contribution is expected to reduce their fee rate contribution to £383k.

3.8 A contract variation will be required before any additional funding can be released to the NCA. Completion of this variation is dependent on agreement and approval from all commissioning partners. This process must be completed by March 2026 to enable the funding to be applied within the 2025/26 financial year.

4. HASC Contract Expenditure Overview

4.1 Following confirmation of Integrated Fund partner contributions to the HASC contract, the NCA have developed a budget that incorporates current expenditure trends, demand growth and inflationary adjustments. In addition, the budget will need to recognise expected changes in Adult Social Care spending, such as increasing complexity of care, higher package costs, and planned service developments that may impact activity levels across the contract.

4.2 The NCA budget-setting approach used the 2024/25 forecast outturn based on the Quarter 3 position. This was then adjusted to reflect known changes, including staffing updates, hospital placement requirements, and other areas of financial realignment.

4.3 The proposed opening budget presented by the NCA reflected a gap of £3.829m. In line with usual NHS practice, this was established as a savings target through Cost Improvement Programmes (CIPs), leading to the development of business cases identifying efficiencies and opportunities to reduce expenditure in-year. However, because the target was set at the start of 2025/26, there was limited lead time to design, approve and embed these programmes into operational practice, reducing the likelihood of realising full-year benefits.

4.4 To date, £0.752m of efficiencies have been identified as achieved, mainly relating to reduced costs due to Strength Based annual reviews, leaving an anticipated in-year pressure of £3.077m. A summary table of achieved and expected cost avoidance has been transacted within the current year budget.

Table 2: Cost Improvement Programme Achieved

CIP Schemes	Category of CIP	SCC £'000
Admin post review	Pay	13
Great Places cohort 2	Non-Pay	110
Review of discretionary spend	Non-Pay	30
Strengths Based Reviews	Non-Pay	599
Grand Total		**752**

4.5 NCA Financial Management has identified a potential further cost avoidance of £332k that could be achieved by the end of the financial year bringing the overall CIP total to £1.084m. This has not been reflected in the forecast position.

4.6 Presuming that all forecast contract income is assumed to be confirmed with commissioning partners based on the Quarter 3 forecast, this will provide an expected HASC contract budget of £151m. This is reflected below in Table 3 presenting a high level subjective spend analysis.

Table 3: HASC Subjective Spend Analysis

HASC Contract	Annual Budget £'000	Actual Year to Date £'000	Forecast £'000	Total £'000
Pay	26,248	18,901	25,262	(986)
Non-Pay	8,368	6,545	8,752	384
Packages of Care	121,303	93,327	125,967	4,664
Other Non-Pay	1,726	1,741	2,323	597
Pay CIP	(636)	0	0	636
Non-Pay CIP	(2,440)	0	0	2,440
Divisional Income	(3,569)	(2,348)	(3,127)	442
Grand Total	**151,000**	**118,166**	**159,177**	**8,177**

4.7 Pay is expected to underspend by £0.968m once the re-alignment of pay scales from April 2024 onwards has been reflected across the relevant service budgets. This adjustment corrects historical variances and ensures that social workers across Salford are receiving equitable and consistent rates in line with updated pay structures.

4.8 However, this underspend has reduced in 2025/26 due to the NCA applying a standardised 5% vacancy factor across all services following agreement from commissioning partners, equating to £1.111m referenced as supporting affordability.

The introduction of this vacancy factor increases the level of assumed savings within budgets and therefore offsets part of the benefit previously associated with pay realignment.

4.9 Adult Social Care packages across the overall service is anticipated to overspend by £4.664m after taking account of Fee Rate and National Insurance uplifts. Further work is required to quantify the financial position across each service area and to support an effective placement budget being established for 2026/27.

4.10 The main reasons for the package of care overspend position relates to increased cost of packages rather than volume of clients supported. Overall, the average weekly costs of placements have increased by 4.67%, up to £599 based on overall packages. There has been a net increase in additional placements, between April to December has been 18 but has shown a transition from nursing and residential services to home care. The volume of packages is increasing in Care at Home (1.4%) and Supported Tenancies (2.8%) and is referenced that average costs are rising above Foundation Living Wage fee rate uplift is due to availability of services and complexity.

4.11 Further work is required to understand placements expenditure across Adult Social Care services, and this will be undertaken as part of budget setting. The overview in paragraph 4.10 has been quantified using Table 4 below.

Table 4: Packages of Care Overview

	April-25		Oct-25		Nov-25		Dec-25		Change from April	
Package Type	No.	Weekly Value (£)	No.	Weekly Value (£)	No.	Weekly Value (£)	No.	Weekly Value (£)	No.	Weekly Value (£)
Care At Home	1,802	515,654	1,827	531,058	1,816	524,640	1,828	534,239	26	18,584
Direct Payments	397	185,515	394	182,899	394	184,692	390	185,077	(7)	(438)
Nursing	276	368,032	290	402,838	289	402,030	275	389,461	(1)	21,429
Residential	678	656,607	682	684,601	670	681,097	662	681,777	(16)	25,170
Supported Tenancies	576	408,976	579	444,002	587	443,893	592	454,715	16	45,739
Total	**3,729**	**2,134,785**	**3,772**	**2,245,400**	**3,756**	**2,236,352**	**3,747**	**2,245,268**	**18**	**110,483**

4.12 The Cost Improvement Programme (CIP) position has been mentioned above in paragraph 4.2 to 4.4, outlining an expected pressure of £3.077m.

4.13 Further investigative work is being undertaken to understand the non-pay, other non-pay and divisional income elements of the HASC contract. These elements of the budget have not been highlighted in monthly monitoring reports, limiting visibility of the underlying cost drivers. Initial review indicates that, when taken collectively, these budget lines are contributing to £1.423m overspend. This includes understanding any grants or additional funding outside of the Integrated Fund that is supporting the HASC contract.

4.14 The NCA has indicated that there may be scope to improve the current £8.177m forecast overspend, noting that the actual position at the end of December was £4.767m, inclusive of a £2.307m in-year CIP gap. This will be monitored and scrutinised very closely up to the end of March 2026.

4.15 This assessment will also be strengthened by the forthcoming Ernst & Young financial due diligence review, which was expected to commence in late January. The findings from this independent review will support a more robust understanding of underlying cost drivers and help validate the forecasted position ahead of year-end.

4.16 It is also worth noting that any overspend on the HASC contract will be managed through the Integrated Fund risk-share arrangements. Under this mechanism, financial risk is proportionately shared between the two commissioning partners, with Salford City Council contributing 73% and NHS Greater Manchester contributing 27% of any deficit. If the forecast overspends materialise amounting to £8.177m, the contributions to the commissioning partners based on the current risk-share and taking account of performance in the fund would be £5.642m and £2.087m respectively.

4.17 The forecast financial position will change up until end of March 2026. The position will continue to be monitored closely across the locality finance teams up to year-end.

5. Recommendations

5.1 The Salford Integrated Care Partnership Committee is asked to:

- note the finance position of the Adults Social Care contract based on the month 9 (end of December) forecast from the NCA.
- note the finance risk to both commissioning partners through the risk-share arrangement within the Integrated Fund.

Samuel Russell
Strategic Head of Finance for People Services (Salford City Council)

Salford Integrated Care Partnership Committee
26 February 2026
Item 6 (d) - Place Partnership Development

Item for: Decision/Assurance/Information

Report of:	Delivery Lead for Health and Care Integration (Salford)	
Date of Paper:	13 February 2026	
In case of query, please contact:	Emma Popoola Emma.Popoola@nhs.net	
System Priorities: (Please tick as appropriate)	Physical activity and movement	✓
	Thriving families	✓
	Live and age well	✓
	Preventable illness - CVD and Diabetes	✓
	Urgent and emergency care	✓
	Mental health and emotional wellbeing	✓
	Triple aim – population health, performance recovery, financial sustainability	✓
	Other system enabler i.e. Workforce Transformation, Digital etc.	✓

Purpose of Paper:

The purpose of this paper is to provide the Integrated Care Partnership Committee (ICPC) with an update in relation to ongoing place partnership development work and seek views in relationship to the proposals around future place funding, place teams and closer alignment with Health and Wellbeing Board.

Further information

How does this paper address health inequalities and promote inclusion?	Tackling inequalities is fundamental to all place partnership development work.
What risks may arise as a result of this paper and how will they be mitigated?	None.
Does this address any existing high risks facing the organisation and how does it reduce them?	This paper does not seek to address any existing high risks. However, risk management will form a key part of our place partnership development, to ensure we can effectively identify, assess, and mitigate any risks to the delivery of our integrated care partnership work.
Are there any possible conflicts of interest associated with this paper?	None.
Will any current services or roles be affected by issues within this paper and what are they?	All Salford locality roles and services are affected by the development of our place partnership.

Note: Where appropriate, please ensure detail is provided.

Document Development

Has there been Public Engagement?	Not Applicable.
Has there been Clinical Engagement?	Not at this stage.
Has the impact on Salford socially, economically and environmentally been considered?	Not Applicable.
Has there been an analysis of any impacts on equality?	Not at this stage.
Has legal advice been obtained?	Not Applicable.
Has this been to any groups or committees for engagement, comments, or approval?	Not at this stage.

Note: Where relevant, please provide detail and ensure that it is clear how and when particular stakeholders were involved in this work, that there is clarity of what the key message/decision was, and whether amendments were requested about any part of the work.

Place Partnership Development

1. Executive Summary

The purpose of this paper is to provide the Integrated Care Partnership Committee (ICPC) with an update in relation to ongoing place partnership development work.

This committee is asked to:

- *Note the contents of this report and agree to the proposals outlined in **section 3.4** of this paper.*
- *Provide comments in relation to the proposals outlined around future place funding, place team arrangements and closer alignment with IPCP and Health and Wellbeing Board.*

2. Background and Context

2.1 The Greater Manchester Health and Care Partnership and NHS Greater Manchester (NHS GM) was formed in July 2022. In November 2023, NHS GM introduced an operating model that delegated significant responsibilities to its 10 localities, supported by dedicated locality teams and strengthened system leadership through Locality Boards. Salford's Integrated Care Partnership (ICP) agreed its locality operating model in January 2024.

2.2 In March 2025, national policy set out that Integrated Care Boards (ICBs) would transition towards becoming strategic commissioning organisations and reduce their running costs by up to 50%. NHS GM has since outlined its revised operating model, published in October 2025, and retaining a significant role for place partnerships and smaller NHS GM resourced place teams.

2.3 Salford completed a review of its Integrated Commissioning arrangements in March 2025 to ensure local governance and delivery arrangements could remain fit for purpose. The future of the Salford Integrated Fund, including the associated risk-share, has now been considered also in light of these wider developments.

2.4 Alongside these strategic shifts, organisational, performance and financial pressures across the system have intensified. In August 2025, the Northern Care Alliance (NCA) and Salford City Council (SCC) announced that the provision of Adult Social Care would transfer from the NCA back to the council, bringing the long-standing Section 75 agreement (in place since 2016) to an end. NHS GM is also progressing its organisational change programme to deliver a 39% reduction in running costs by April 2026, while NHS providers have implemented significant management cost reductions during 2025/26 in line with national expectations. The underlying deficit position across GM's NHS system remains extremely challenging with, for example, massive cost improvement plans required again for the NCA in 2026/27.

2.5 Both the NCA and Greater Manchester Mental Health NHS Foundation Trust (GMMH) are implementing new, clinically led group-wide arrangements, and the Voluntary, Community, Faith and Social Enterprise (VCFSE) Accord is undergoing a refresh across Greater Manchester.

2.6 These system-wide developments are unfolding at a time when the operational, performance and financial context across the local health and care system remains very challenging. In this context, the Salford Integrated Care Partnership is considering how best to align its future approach with national policy, regional operating models and local priorities, while maintaining its focus on improved outcomes for Salford residents.

3. Proposals

3.1 Despite the significant organisational and system-wide developments taking place across Greater Manchester and Salford, the core purpose and operating principles of the Salford Integrated Care Partnership will remain unchanged. Our commitment to "one system, one Salford" continues to guide how we work, ensuring that the people we serve remain at the centre of everything we do. The partnership will continue to be grounded in strong relationships, clarity of approach and a shared focus on enabling our workforce and organisations to have the greatest impact on improving health and reducing inequalities.

3.2 Salford will remain a place-based partnership within the Greater Manchester Integrated Care Partnership, bringing together all health, care and wider public-sector partners through a population health management approach. Everyone working for, or on behalf of, a partner organisation will continue to be part of this collective effort, operating in line with our agreed principles such as valuing community strengths, prioritising prevention, promoting integration, tackling inequality and maintaining transparent, collaborative and accountable ways of working.

3.3 As part of an ongoing programme of development, the partnership will need to:

- Reaffirm and strengthen its culture of collaboration, reflecting on whether behaviours and decisions align with our shared values, how organisational interests are balanced with collective priorities and whether further action is required to maintain the positive, inclusive culture that underpins effective partnership working in Salford.
- Strengthen how it plans together, with clearer shared areas of focus, where there is a collective advantage.
- Gain a better understanding of the capacity available across partners to deliver plans.
- Agree how the workforce is deployed in a way that balances organisational responsibilities with shared system aims.
- Create sufficient capacity in place to deliver on shared ambitions.
- Refresh arrangements for managing quality and performance so they reflect the broader system, support joint accountability and align with national shifts in responsibilities.

- Review and update the partnership's governance and leadership arrangements, including reviewing the roles and relationships between key groups, considering how clinical and professional leadership is embedded, and ensuring arrangements support delivery at neighbourhood and city-wide levels.
- Refresh informal leadership forums to ensure they provide the right space for collaboration and shared direction-setting.

3.4 In order to meet these local requirements and in line with the GM Place Mobilisation Programme, it is proposed that:

- A 'place team' is developed with commitment from all organisations/sectors (pending system reforms and conclusion of organisational changes).
- A 'place agreement' is adopted based on the GM development in this area with shared outcomes agreed (pending national and regional guidance around outcomes and metrics).
- Salford's place partnership is relaunched with a new name and improved governance arrangements.
- We move to create a 'sister committee' arrangement where Health and Wellbeing Board (HWB) and ICPC are aligned under a new name with 4 x HWB meetings per year and 4 x ICPC meetings per year together with flexible space together. Assuming we retain the monthly meeting pattern, the additional 4 meeting slots each year can be used flexibly. For example this might allow for a citizen assembly, development sessions or lay months (e.g. in August). There will be joint agenda setting between the ICPC and HWB.
- If agreed, move to this approach from March 2026, using the existing March ICPC meeting slot for a HWB meeting.

3.5 Further detail on progress and next steps of the Greater Manchester Place Mobilisation programme – including work on the Place Agreement, Place Team, Place Funding and the potential Place Transfer approach – is provided in the Place Mobilisation Highlight Report at **Appendix 1**.

3.6 There are emerging clearer proposals in relation to place funding and place team – the details of these are provided in **Appendix 2** and **Appendix 3**. Members of the committee are invited to share comments with regard to these proposals as part of the engagement phase of this work.

4. Recommendations

4.1 The Salford Integrated Care Partnership Committee is asked to:

- note the contents of this report.
- agree to the proposals outlined in **section 3.4** of this paper and specifically around the creation of a 'sister committee' approach.
- provide comments in relation to the proposals outlined around future Place Funding and Place Team arrangements.

Emma Popoola
Head of Planning and Projects

NHS
Greater Manchester

Place Mobilisation: Highlight Report

6th February 2026

Part of Greater Manchester Integrated Care Partnership

Place Mobilisation: Highlight Report

NHS Greater Manchester

Overall Status	SRO	Workstream Lead	Date
On Track	Charlotte Bailey	Jonathan Kerry	6th February 2026

Overall progress

We are now at a point in place mobilisation where the foundations are genuinely taking shape. The core design principles are clear, the intent is shared, and we have a growing alignment across partners about what a mature place model needs to look like.

We have moved beyond abstract design into the early stages of practical mobilisation: understanding the implications for people, funding flows, governance, and partnership behaviours.

We are not underestimating the scale of the task, but we are making steady, thoughtful progress, and we are doing it together. This is complex work, but being approached it with realism, collaboration, and a strong commitment to getting it right.

Key Milestone Progress

We will be continuing to use the Place Mobilisation Oversight Group, with Charlotte Bailey as SRO as the Chair and strong representation from DPLs, function leads and partners, to maintain positive progress on the mobilisation.

Across all elements of the programme (see subsequent pages) good progress is being made in delivery against milestones, bringing partners together and evolving the model, along with existing capabilities, into Place Partnerships to support our collective ambitions.

Risk/ Issues to be escalated

For many of the portfolios, mobilisation sits largely within the control and gift of the Chief Officer and the ICB, with only a small number of clearly defined teams or services potentially transferring out.

Mobilising our place model, however, is an entirely different order of complexity. It requires not only the movement of staff into a fundamentally different place-based structure, but also the potential transfer of those staff out again. It involves shifting funding through expanded mechanisms, alongside significant changes to governance, accountability, and partnership ways of working.

Delivering this will demand a substantial OD effort and a level of system alignment that cannot be achieved through our actions alone.

So, while we are doing everything we can, and doing it with real commitment, we do need clarity and visible support from our ICB COs to make this achievable.

Place Agreement (inc Outcomes)

NHS Greater Manchester

Overall Status	Workstream Lead
On Track	Jonathan Kerry / Mike Barker

Overall progress

The Place Agreement Development Group has been established with a multi disciplinary and organisational approach to rapidly advancing the drafting of Partnership Agreement and aligning to GM Outcomes Framework development to have clear outcomes and metrics for Place.

An initial draft has been developed and feedback received to include/refine prior to progressing with broader engagement.

The group will support in being able to bring together both sector based and locality-based feedback, to ensure strength and depth in final product.

The services of Mills & Reeves (legal oversight) is being explored, not to legalise the agreement, but to ensure to robustness and precision of the agreement.

Next Steps

Work continues on the development of the Agreement, placeholders to support input from Place Funding and Place Team, and the underpinning Outcomes Framework and Metrics.

Discussions will also progress with partners to support as broad a degree of input and feedback as possible.

Aligning to NHS GM governance evolution, work will also progress to ensure Place Partnerships connect in the right way from 1st April 2026.

Milestones

Establish Development Group	19/01/2026	
Initial Draft Agreement	30/01/2026	
High Level Outcomes Framework	30/01/2026	
Stakeholder Draft Circulation / Feedback	09/01/2026	
Outcomes Framework underpinned by Metrics	16/01/2026	
Review from Legal (Mills & Reeves)	23/01/2026	
FINAL DRAFT Agreement include Funding, Outcomes and Team	02/03/2026	

COMPLETE ON TRACK AT RISK DELAYED NOT STARTED

Place Funding

NHS Greater Manchester

Overall Status	Workstream Lead
On Track	Gareth James / Naomi Ledwith

Overall progress

Work on the "Grant" has now moved from design into active mobilisation. The proposal has been fully drafted and refined through extensive co-production with Localities, providers, s151 officers and NHS GM colleagues, resulting in a clear articulation of scope, exclusions, governance principles and the phased glide path.

Engagement materials are now in use across all stakeholder groups, ensuring consistent messaging and enabling Localities to test the model, challenge assumptions and shape the final version.

Technical workstreams are progressing the detailed components of the Grant, including Left Shift methodology, Primary Care LCS standardisation, and gain/risk-share design.

Next Steps

The immediate priority is to complete February's engagement cycle and incorporate feedback into the final Chief Officers paper for March.

This will confirm the scope, hosting model and glide path, enabling the proposal to progress to ICB approval in April.

Once approved, the focus shifts to operational readiness: issuing Partnership Agreement templates, supporting Local Authorities through their statutory governance routes, and establishing the pooled-fund and reporting arrangements required for hosting.

In parallel, technical workstreams will continue to refine the Left Shift allocation and measurement approach, standardise reporting packs, and finalise the in-scope components for the Grant.

Milestones

Draft Locality Grant proposal	12/01/2026	
Stakeholder engagement launched	09/02/2026	
Slide pack issued to support consistent messaging	30/01/2026	
Final paper to Chief Officers for approval	16/03/2026	
Local Authority governance: S75 checks, setup and sign-off.	30/09/2026	
Joint ICB–LA monitoring begins	01/10/2026	
Full handover / Quarterly assurance.	01/04/2027	

COMPLETE ON TRACK AT RISK DELAYED NOT STARTED

Place Team

NHS Greater Manchester

Overall Status	Workstream Lead
On Track	Hannah Dobrowolska / Jonathan Kerry

Overall progress

The Place Team element of the programme has moved from early design into development.

The purpose, principles and core capabilities of Place Partnerships are now clearly defined, and partners share a consistent understanding of what Place Teams are expected to deliver.

NHS GM's contribution model, including the five competency areas and associated funding, has been agreed, giving each Place a clearer foundation for shaping its local team.

Engagement across January and February has tested the emerging model, with strong support for a collaborative, multi-agency approach rather than a prescriptive structure.

Next Steps

Continue to convene the Place Team Group as the central forum for shaping and testing the emerging model, refining the example scenarios so they provide a clear, realistic blueprint for how place-based functions will operate.

Broaden engagement with wider stakeholders to draw in their insight and challenge.

Strengthen links with localities so that the developing place model is grounded in real operational experience and supports their ongoing development work.

Milestones

Place Team group established	19/01/2026	
Initial scenarios drafted	06/01/2026	
Place Team discussion document drafted	06/01/2026	
Final feedback on Place Team Pack received from stakeholders	11/02/2026	
Place Team Pack Finalised	16/02/2026	
Ongoing work with Localities to support/share development learning	31/03/2026	

COMPLETE ON TRACK AT RISK DELAYED NOT STARTED

Place Transfer

NHS Greater Manchester

Overall Status	Workstream Lead
On Track	Tom Hinchcliffe / Will Blandamer

Overall progress

Work has progressed to establish a clear and credible foundation for the Place transfer programme.

A structured due-diligence approach has now been developed, setting out the legal, HR, financial, operational and governance domains that must be examined to support any future employment model.

This framework will ensure NHS GM can meet its statutory responsibilities as the current employer while enabling a balanced appraisal of the options available.

Alongside this, a consistent and neutral set of employment model options is being defined, each described in a way that allows for like-for-like comparison and avoids any implicit preference.

Next Steps

Engagement design will be completed, with a targeted approach agreed to gather insight from Place leaders, NHS GM leadership, workforce representatives and Trade Unions.

The work will focus on validating the final set of options, completing the planned engagement activity, and undertaking a structured assessment of each model.

Each option will be assessed against the agreed criteria, including strategic alignment, workforce impact, legal and HR considerations, operational feasibility, financial implications, cultural fit and overall risk.

This analysis will lead to a comparative view of the options and the development of clear recommendations.

Milestones

Initial scoping, document review and due-diligence framework established	29/01/2026	
Approval of proposal costs	09/02/2026	
Final confirmation of options and engagement approach	13/02/2026	
Stakeholder engagement launched	16/02/2026	
Completion of engagement and thematic analysis	06/03/2026	
Full appraisal, comparative analysis and final report submitted	16/03/2026	

COMPLETE ON TRACK AT RISK DELAYED NOT STARTED

Locality Funding Flow Proposal: Establishing the GM Locality Grant Framework (V4) 5.2.26

This is a partnership engagement draft, not a final document.

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Please Disregard all previous versions

Version Control

Version	Contributors	Date	Section	Change summary
V1	Place Funding Working Group	12.1.26	Whole document	Initial working draft.
V2	Stephen Downs; Sam Evans	13.1.26	Operationalisation	“Staff Transfer” → Employment model; clarified locality responsibility from April 2026.
V2	Phillipa Johnson	13.1.26	Safeguarding integrity of grant	Clarified host does not control the grant; governance clarified.
V2	Tom Rafferty	13.1.26	Appendix 3	Added options appraisal for hosting decision.

V2	Stephen Downs	13.1.26	Safeguarding integrity	Added safeguards for integrity of the grant.
V2	Jonathan Kerry	16.1.26	Scope	Clarified scope boundaries.
V2	Financial Flow Working Group	16.1.26	Appendix 5	Added FAQs including BCF definition.
V2	Financial Flow Working Group	16.1.26	Purpose / Scope / Strategic Context / Next Steps / Governance / FAQ / Risk	Clarified relationship between scope and glide path; phasing; GM spend alignment; standardisation vs bespoke; contract management; grant–staffing headlines. Defined where grant budgets flow now; clarified risks in and out of scope.
V2	Naomi Ledwith	19.1.26	Appendix 5	Restructured and polished FAQ; added Left Shift, neighbourhoods, weighted per capita, Jigsaw, outturn vs need, staffing ring-fence clarifications.
V2	Naomi Ledwith	19.1.26	Whole document (tone and clarity)	Narrative system-reform rewrite: language for mixed audiences; no change to scope, policy or figures; terminology standardised to “Locality Grant”; FAQs aligned to main body.

V3	Sam Evans	20.1.26	Appendices 1, 3 and 4	Updated Jigsaw; updated grant illustrative table; updated risks to hosting arrangements.
V4	Financial Flows Working Group; Manisha Kumar; Claire Lake	2.2.26	Appendix 5 (FAQ)	Added outcomes–quantum linkage, evaluation cycle, and “what if outcomes are not achieved?”. Expanded overspend/risk liability and benchmarking fairness. Clarified GM consistency vs local flexibility; Left Shift incentives beyond finance. Added host statutory powers, reporting across 10 Localities, and rollover controls. Included dispute/escrow pathway for stalemate/veto. Provided worked examples.
V4	Financial Flows Working Group	2.2.26	Appendix 3 (Options Appraisal)	Updated scoring rationale and statutory alignment. Clarified FT reporting as a current system capacity consideration. Added locality-level reporting and rollover requirements. Strengthened

				risks/mitigations and streamlined narrative.
V4	Financial Flows Working Group	2.2.26	Appendix 6	Worked examples of host responsibilities.
V4	Financial Flows Working Group	2.2.26	Whole document	Reflected that discharge funding is in the BCF.
V4	Naomi Ledwith	2.226	Whole Document	Next Steps after engagement move to Appendix 7 Conclusion and recommendations added

Contents

Purpose of this paper

We propose a Locality Grant that enables NHS Greater Manchester (GM) and Locality Partnerships to target investment where it makes the most difference to outcomes and demand: prevention, early help, and neighbourhood-level delivery. The Locality Grant is a system reform designed to unlock earlier action, make best use of public money, and improve the health and wellbeing of our residents.

- Define what the Locality Grant is—and is not.
- Set out the principles and financial governance that underpin the model.
- Describe the phased implementation (the glide path) and hosting arrangements.
- Clarify scope and exclusions, including the relationship with Left Shift funding and gain/risk-share mechanisms.
- Set governance and cultural principles for transparency and accountability.
- Identify risks and mitigations to ensure operational readiness.
- Outline stakeholder engagement to build confidence across sectors.

Out of scope: the employment model, staffing, and the hosting of staff. The Locality Grant does not fund staff by default, and the host organisation of the Grant does not automatically host staff. These decisions will be taken separately via the employment model workstream. This document must not be interpreted as determining employment arrangements.

Introduction: Why this change, why now

Greater Manchester has strong foundations in place-based working. Yet too much spend is still driven by historic outturn and reactive demand, rather than population need and early intervention. The Locality Grant changes that by giving Localities clear, ring-fenced resources—with shared rules and strong partnership governance—to act earlier, reduce avoidable demand and unwarranted variation, and improve outcomes.

This is more than a finance exercise. It is a way of working that places local problem-solving and neighbourhood teams at the heart of delivery, while retaining GM-wide consistency where that adds value. It is deliberately an evolution, not a revolution—building on delegated arrangements to make them simpler, fairer, and more effective.

- Local financial autonomy with shared accountability.
- Place partners are collectively accountable for decisions on Grant spend and for delivering Locality outcomes through best use of the Grant and aligned partner budgets.

- Place partners will agree locally how to apportion risk and gain when aligning or pooling budgets for common goals.
- Place partners will influence spend beyond the scope of the Grant to support Left Shift.

This flexibility enables innovation while maintaining financial discipline, balancing local bespoke approaches with standardisation at scale to reduce unwarranted variation. The approach builds on learning from the management of delegated Locality budgets in recent years—this is an evolution, not a revolution.

The Place Grant proposal stands apart from future changes to the employment model. Once the employment model is agreed for staff aligned to the Place operating model, a decision will be taken on how funding will flow. Therefore, for the purposes of this proposal, funding for staffing is not considered.

Strategic context: Making the system work as one

Set against total NHS and Local Authority spend, the Grant can only influence a small proportion of the factors that drive demand. Evidence shows clinical care explains only a minority of health outcomes, while social and economic conditions—such as housing, income, and employment—account for a much larger share. This makes it essential that we use the Jigsaw to align our influence across wider system spend rather than relying on interventions confined to the Grant alone.

Reviews of integrated care consistently find that the most meaningful improvement in outcomes comes from coordinated cross-sector action, not from health-only approaches or organisational activity structured around clinical models operating across multiple Localities. When NHS influence is expressed primarily through such models, there is a risk of siloed efforts—limiting impact on upstream drivers of demand.

By contrast, aligning NHS and Local Authority levers through the Jigsaw creates greater system-wide ability to reduce demand and improve outcomes than any single organisation or funding stream could achieve on its own.

Success requires an explicit balance: GM-wide/provider-level standardisation, Place-based alignment, and bespoke neighbourhood action. Local Authorities hold key levers for housing, employment, early help and social care; the most impactful delivery occurs at 30,000–50,000 population neighbourhood footprints, where teams act with precision based on relationships, assets and local context. GM-set standards and provider-level standardisation should apply where they

add value, while Places and neighbourhoods retain flexibility to tailor interventions to local needs.

Evolution: What is different in this proposal

The proposed Grant payment is predominantly composed of budget commitments already agreed and flowing through delegated Locality budgets, which are closely aligned to out-of-hospital care.

Volatile budgets—such as Continuing Healthcare (CHC), Individual Packages of Care (IPoC) and Mental Health—will be managed at GM level, with Locality influence rather than ownership. This enables greater standardisation and economies of scale at the appropriate spatial level.

All in-hospital budgets (Acute and Independent Sector contracts, and Medicines Management) have been managed at GM level with Locality influence for some time and will continue to be so.

The primary principle behind the Locality Grant is to give Localities direct budgets they can manage to support and deliver hospital and care avoidance and demand management, while recognising that Localities continue to influence spend they do not directly control.

A new element is the proposed investment in Left Shift development, integral to the ICB sustainability plan and five-year commissioning strategy (being finalised as part of the 2026/27 planning process).

This funding will be sourced through Pan-GM efficiencies and planning. A key lever will be gain/risk-share arrangements, which sit outside the Place Grant (e.g., IPoC, CHC, Mental Health). The success of these arrangements will influence how much funding can be invested in-year and recurrently into the Locality Left Shift / Neighbourhood Development Fund.

Scope of the Locality Grant

Included

- From October 2026: Better Care Fund (BCF); Live Well programmes; Left Shift funding.
- From April 2027 (subject to technical work): Primary Care locally commissioned services; out-of-hospital services; VCFSE services; Capacity funds.

The Locality Grant does not replace or disrupt provider funding—it provides shared tools, intelligence, and governance to make changes together where they improve outcomes and value for the people we serve.

See Appendix 2 for Locality-level financial detail (in refinement).

Out of scope (Pan-GM): Locality team costs (until the employment model is agreed); staff support costs (IT licences, storage); Acute contracts not within BCF; Independent Sector activity-based contracts; Mental Health contracts; CHC; Individual Packages of Care; Medicines Management.

Contract management for in-scope Grant services will be administered at Pan-GM level.

Governance: Clear roles, shared decisions

The host organisation acts solely as the administrative and financial vehicle for the Grant. Hosting does not confer ownership, control, or unilateral decision-making rights over the Grant. The Grant remains a ring-fenced system resource, and all decisions on its use are made collectively through the Place Partnership Agreement—not by the host.

The host fulfils defined functions—such as holding the pooled fund, processing transactions, and ensuring compliance with Section 75 and grant conditions—on behalf of the system. The host therefore operates the Grant but does not direct, repurpose, or amend its use; this authority rests with the Place Partnership acting under agreed governance.

Each Place Partnership will have a formal Place Partnership Agreement describing hosting responsibilities and the collective approach to decision-making and governance.

Finance is used as an enabler to improve health outcomes and reduce demand, supported by Place governance.

- The host is the administrative and financial operator of the Locality Grant. Hosting does not confer control over the Grant's purpose or priorities.
- The Locality Grant remains a ring-fenced system resource; decisions are made collectively through the Place Partnership Agreement.
- The host holds the pooled fund, processes transactions and ensures Section 75 and audit compliance on behalf of the system.
- The Place Partnership sets priorities, directs spend and owns the outcomes.

- Protection and probity: the host maintains the ring-fence, processes, audit and reporting.

Safeguarding the integrity of the Grant

Financial principles:

- Collective accountability for delivering the Locality Outcomes Framework.
- Budget alignment across partners using the Jigsaw.
- Transparency: all Locality Grant streams visible to partners.
- No cost shunting: open-book accounting and oversight.
- Integrated delivery: a multi-agency workforce focused on prevention and demand management.
- Weighted per capita: apply universal proportionalism to support Left Shift.
- Place Partnership governance: decisions taken together to protect trust and stability.

Grant controls:

- No reduction or diversion of the Grant without formal system agreement.
- No repurposing for ineligible spend or overheads.
- Ring-fenced Left Shift and prevention budgets remain dedicated to early help and neighbourhood development.
- Section 75 audit and GM assurance apply.
- Outcome-based oversight: funding decisions linked to the Locality Outcomes Framework; KPIs monitored quarterly.

Consistent with current arrangements and to minimise disruption, it is anticipated that Local Authorities will host the out-of-hospital services within the Locality Grant, enabling Section 75 pooled fund arrangements (see Appendix 3 for the hosting options appraisal).

Operationalisation: From principle to practice

Localities will remain accountable for delegated budgets (including the BCF) as now, and these will transition into the Grant. Recognising Q4 statutory timelines and Local Authority governance cycles, we propose a glide path for hosting that allows current processes to continue until early 2027/28.

Glide path: phased, safe, and sequenced

- Phase 1 (April 2026): Refine the Grant (technical work); align to Locality monitoring hosted by GM ICB.

- Phase 2 (by October 2026): Partnership Agreements finalised; monitoring by host with GM ICB joint responsibility; final refinement of Grant components (technical work).
- Phase 3 (April 2027): Full handover to the host organisation.

How scope and glide path fit together:

The scope describes the end-state Locality Grant; the glide path safely transitions budgets and accountability. From April 2026, only technically ready components flow (e.g., BCF, Live Well, early Left Shift). As other streams are standardised, the Grant grows through Phases 2 and 3. Formal accountability is enacted through Partnership Agreements (by October 2026). From April 2027, accountability for the revised Grant transfers fully to the host and decision-making moves from STAR to Locality governance.

Risks and issues (with mitigations)

The Locality Grant introduces a major shift in the way funding, governance and outcomes are aligned across Greater Manchester. As with any system-wide reform, a number of technical, operational and governance-related risks and issues require management. To support clarity and decision-making, risks fall into two categories:

"In Scope" Risks and Issues

These are risks directly related to the design, technical development, and implementation of the Locality Grant itself. They require action through the Locality Grant workstream and its supporting technical groups. They affect the ability to deliver the Grant safely, consistently and on time.

(These require action within the Locality Grant workstream.)

Theme	Risk / Issue	Implication	Mitigation / Required Action
Technical Design	Grant components need further technical refinement	Scope unclear at early implementation stages	Task-and-finish groups to finalise financial modelling and operational
Primary Care Standardisation	Lack of clarity on which LCS budgets move into Localities	Delay in including Primary Care into the Grant	Continue Pan-GM work through 2026/27 to define scope and ensure consistency
Left Shift Funding Flow	Allocation and measurement approach not yet finalised	Inconsistent application of Left Shift investment	Establish a GM-level workstream; integrate financial and non-financial datasets for value measurement

Theme	Risk / Issue	Implication	Mitigation / Required Action
Gain/Risk-Share	Models for IPoC, CHC and MH risk-share incomplete	Risk of cost-shift or misaligned incentives	Technical workstream to produce method, governance and escalation frameworks
Financial Transparency	Open-book reporting and standard reporting packs not yet embedded	Variation in Locality oversight and assurance	Implement open-book arrangements through Partnership Agreements; standardise reporting pack

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"Out of Scope" Risks and Issues

These are risks that affect the wider operating model, workforce, governance or GM-level design, but are not part of this specific workstream. While important, they will be addressed via dedicated system programmes (e.g., employment model, Partnership Agreement, outcomes framework). They are deliberately excluded to avoid conflating multiple system reforms.

(These are owned by other workstreams and not part of the Locality Grant design.)

Theme	Risk / Issue	Why Out of Scope	Where It Is Managed
Employment Model	Staff hosting, grading, JD/PS and redundancy approach unresolved	The Grant does not determine employment arrangements	Employment model workstream (separate HR/OD programme)
Partnership Agreement Readiness	Governance documentation and hosting agreements require development	These documents govern Locality operations beyond the Grant	Dedicated governance & hosting workstreams [
Outcomes Framework	Finalisation of KPI set and trajectories still needed	Outcomes apply system-wide, not specific to Grant technicalities	Outcomes Framework programme (ERO Charlotte Bailey)
GM–Provider/Place/Neighbourhood Delivery Model	Need for clarity on where each level operates and how decisions flow	Broader operating model issue beyond the Grant mechanics	GM–Provider Footprint & Neighbourhood Ways of Working programme

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See Appendix 7 for Next steps following agreement

Conclusion and Recommendations

The Locality Grant represents a significant step forward in simplifying funding flows, strengthening partnership governance, and enabling the shift toward prevention, early help and neighbourhood-level delivery. It brings together existing delegated budgets into a single, ring-fenced and transparent

mechanism, while maintaining GM-level oversight for volatile or scale-dependent budgets such as CHC, IPoC, Mental Health and medicines optimisation. This model provides Localities with greater flexibility and accountability, supported by clear safeguards, open-book reporting, and evidence-based decision-making.

The engagement to date has confirmed strong support for the direction of travel and the principles underpinning the Grant—particularly weighted per capita allocation, clarity of scope and exclusions, strengthened hosting arrangements, and alignment with the Left Shift ambition. Partners also endorse the glide path as a pragmatic, safe and sequenced approach to implementation, recognising the statutory and operational timelines facing both the NHS and Local Authorities.

To ensure the Locality Grant delivers on its intended outcomes—reducing avoidable demand, improving population health and increasing system sustainability—the following recommendations are proposed for agreement

1. Proceed with Local Authority hosting as the preferred model

Local Authorities provide the strongest statutory fit for pooled funds and community-based grant mechanisms, with the capacity, audit frameworks and governance structures required to safeguard public funds. This approach also offers the least disruption to existing BCF flows and maximises readiness for the proposed glide path.

2. Endorse the phased glide path to full implementation by April 2027

Phasing ensures stability, maintains service continuity, and allows time to refine technical components, finalise standardisation work, and secure appropriate local and GM governance approvals. This provides clarity for partners while avoiding unnecessary risk.

3. Confirm the scope boundaries and maintain the distinction between Grant components and Pan-GM budgets

Clear delineation between Locality-managed, ring-fenced Grant lines and GM-managed volatile budgets protects system integrity, avoids cost shunting, and provides the structure needed to deliver Left Shift at scale.

4. Strengthen governance through consistent Partnership Agreements and open-book reporting

Formal Partnership Agreements should define roles, risk/gain-share mechanisms, and escalation routes, ensuring transparency, accountability and shared ownership of outcomes. A standard GM reporting pack will provide comparability and maintain confidence in financial integrity.

5. Embed the Locality Outcomes Framework as the anchor for decisions and assurance

Linking Grant spend to a clear, evidence-based outcomes framework ensures consistency of purpose across all Localities and creates a meaningful basis for monitoring, evaluation and future allocation decisions.

6. Resource and coordinate the technical workstreams required to support implementation

This includes finalising in-scope components, defining the Left Shift methodology, completing gain/risk-share design, standardising Primary Care LCS and out-of-hospital elements, and expanding the Jigsaw to include LA and wider determinants spend. Dedicated capacity and clear governance will be essential to deliver these components at pace.

Locality Grant – Governance & Approvals Timeline (Forward Plan)

February 2026 – Engagement

- Engagement with Localities, s151s, Directors, Executive Leads and partners on the draft proposal.
- Feedback captured and used to shape the final version.

March 2026 – Final Paper to Chief Officers

- Updated paper presented to **Chief Officers** for final agreement to proceed.
- COs confirm scope, glide path and hosting model.

April 2026 – ICB Governance

- Final paper submitted to the **ICB Board** for formal approval.
- Board agreement releases the next phase: formalising hosting arrangements and issuing Partnership Agreement templates.

May–October 2026 – Local Authority Host Governance

Each host LA completes its statutory governance route:

- **Internal officer review** (Directors, Finance, Legal, s151).
- **Section 75 checks** and preparation for pooled-fund setup.
- **Cabinet/Executive decision-making** on hosting and Partnership Agreement.
- **All Local Authorities complete sign-off by October 2026.**

October 2026 – Partnership Agreements in Place

- Each Place signs its **Partnership Agreement** and confirms hosting responsibilities.
- Joint ICB–LA monitoring arrangements start (shadow or partial operation).

October 2026 – March 2027 – Implementation Readiness

- Technical work finalised (scope, reporting pack, Left Shift method).
- Hosts set up pooled-fund arrangements and reporting.
- Places prepare for full operational transfer.

April 2027 – Full Handover

- Hosting arrangements go live.
- Hosts operate the Locality Grant; Places direct spend under agreed governance.
- Quarterly assurance begins under the new model.

Appendix 1 – Stakeholder Engagement Plan

Structured engagement to be completed by end of February includes:

Stakeholder	Working group link	Responsible for brief	Forum for engagement	Date
s151 Officers	Tom Wilkinson; Lisa Butcher	Gareth James		
Directors of Strategy	Gary	Naomi Ledwith		
ICB Executive Directors	Sam Evans	Gareth James		
Place Leads	Gareth James; Naomi Ledwith	Naomi Ledwith		
Deputy Place Leads	Gareth James; Naomi Ledwith	Gareth James		
Directors of Adult Services	Tom Wilkinson; Lisa Butcher	Naomi Ledwith		
Directors of Children's Services	Tom Wilkinson; Lisa Butcher	Gareth James		
Council Leaders and Portfolio Leads	Tom Wilkinson; Lisa Butcher	Naomi Ledwith		
Primary Care Board	Tracy Vell	Gareth James		
Senior Finance Leads	Sam Evans	Naomi Ledwith		

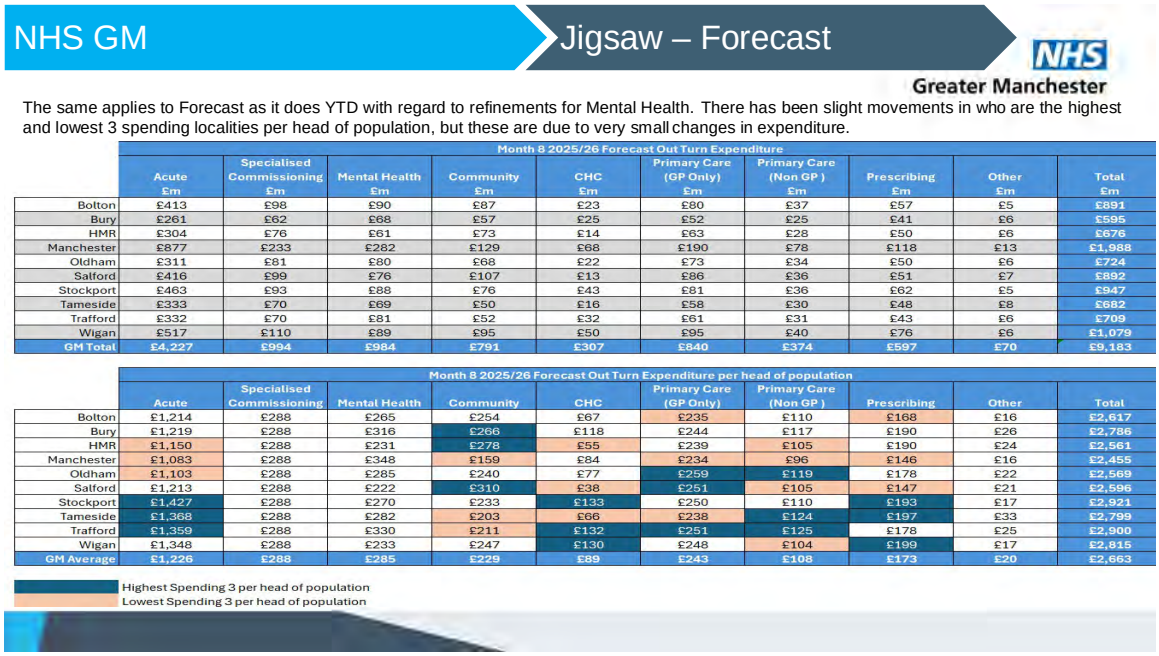
Appendix 2 – Jigsaw (high-level draft illustration)

The Jigsaw approach gives Localities across Greater Manchester a clearer picture of how health and care resources are spent on their populations.

It pieces together whole-system spend—acute, community, mental health, primary care, prescribing and other services—into a single view to enable: shadow monitoring of total spend across GM populations; benchmarking against GM peers to identify variation and opportunities; strategic alignment of investment with GM priorities and population health needs; and better insights about whether spend supports the shift towards prevention and integrated care.

This should be expanded to include appropriate Local Authority spend on care and the wider determinants.

The approach supports the GM ambition for a Left Shift—moving resources and focus from reactive hospital-based care to proactive, preventative, community-based models that address the wider determinants.



The same applies to Forecast as it does YTD with regard to refinements for Mental Health. There has been slight movements in who are the highest and lowest 3 spending localities per head of population, but these are due to very small changes in expenditure.

	Month 8 2025/26 Forecast Out Turn Expenditure									
	Acute £m	Specialised Commissioning £m	Mental Health £m	Community £m	CHC £m	Primary Care (GP Only) £m	Primary Care (Non GP) £m	Prescribing £m	Other £m	Total £m
Bolton	£413	£98	£90	£87	£23	£80	£37	£57	£5	£891
Bury	£261	£62	£68	£57	£25	£52	£25	£41	£6	£595
HMR	£304	£76	£61	£73	£14	£63	£28	£50	£6	£676
Manchester	£877	£233	£282	£129	£68	£190	£78	£118	£13	£1,988
Oldham	£311	£81	£80	£68	£22	£73	£34	£50	£6	£724
Salford	£416	£99	£76	£107	£13	£86	£36	£51	£7	£892
Stockport	£463	£93	£88	£76	£43	£81	£36	£62	£5	£947
Tameside	£333	£70	£69	£50	£16	£58	£30	£48	£8	£682
Trafford	£332	£70	£81	£52	£32	£61	£31	£43	£6	£709
Wigan	£517	£110	£89	£95	£50	£95	£40	£76	£6	£1,079
GM Total	£4,227	£994	£984	£791	£307	£840	£374	£597	£70	£9,183

	Month 8 2025/26 Forecast Out Turn Expenditure per head of population									
	Acute	Specialised Commissioning	Mental Health	Community	CHC	Primary Care (GP Only)	Primary Care (Non GP)	Prescribing	Other	Total
Bolton	£1,214	£288	£265	£254	£67	£235	£110	£168	£16	£2,617
Bury	£1,219	£288	£316	£266	£118	£244	£117	£190	£26	£2,786
HMR	£1,150	£288	£231	£278	£55	£239	£105	£190	£24	£2,561
Manchester	£1,083	£288	£348	£159	£84	£234	£96	£146	£16	£2,455
Oldham	£1,103	£288	£285	£240	£77	£259	£119	£178	£22	£2,569
Salford	£1,213	£288	£222	£310	£38	£251	£105	£147	£21	£2,596
Stockport	£1,427	£288	£270	£233	£133	£250	£110	£193	£17	£2,921
Tameside	£1,368	£288	£282	£203	£66	£238	£124	£197	£33	£2,799
Trafford	£1,359	£288	£330	£211	£132	£251	£125	£178	£25	£2,900
Wigan	£1,348	£288	£233	£247	£130	£248	£104	£199	£17	£2,815
GM Average	£1,226	£288	£285	£229	£89	£243	£108	£173	£20	£2,663

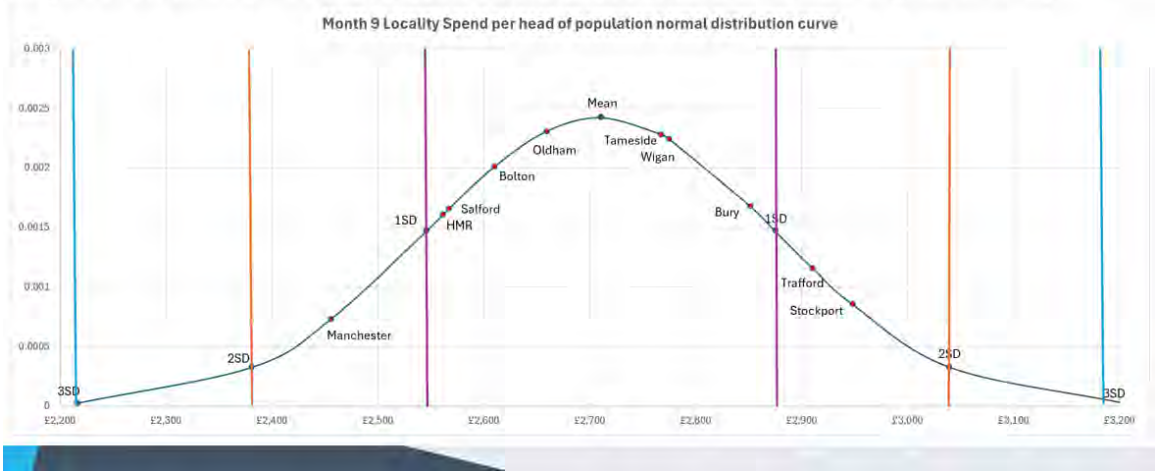
Highest Spending 3 per head of population
Lowest Spending 3 per head of population

NHS GM

Jigsaw – Normal distribution

NHS Greater Manchester

A normal distribution curve is used across a range of fields to show statistical significance to highlight outliers and anomalies. Data within 1 Standard Deviation (SD) of the Mean is within 68% of the mean, 2 SDs 95% and 3 SDs 99.7%. For this data set, 5 localities are less than the mean, 5 above; 1 is more than 1 SD below the mean and 2 are more than 1SD above the mean. No localities are 2 or 3 SDs from the mean, it is generally accepted that being more than 2SD from the mean is statistically significant. Further work will take place in month 10 to refine the approach and usability.



Appendix 3 – Hosting options appraisal

A host organisation is required for the Locality Grant to enable pooled arrangements, transparent financial governance, year-end processing, and compliant administration of multiple funding streams (BCF, VCFSE grants, Live Well/prevention, Primary Care LCS, out-of-hospital budgets). Two options were considered: (A) Local Authority host; (B) NHS Foundation Trust host. The recommended option is Local Authority hosting due to statutory fit, grant-making competence, alignment with existing flows, and readiness to deliver to all 10 Localities without disrupting current arrangements.

Background and problem definition

The Locality Grant brings together multiple funding streams with differing legal, financial and audit requirements, including statutory pooled budgets (BCF), grant-type expenditure (VCFSE), prevention spend aligned to Local Authority functions, and NHS non-contractual allocations.

Legal and policy framework

- Section 75 of the NHS Act 2006 allows NHS bodies and Local Authorities to pool budgets and delegate functions; a host must hold the pooled fund.
- The Local Government Act 1972 and the Localism Act 2011 (General Power of Competence) give Local Authorities powers to issue grants to community groups, charities, businesses and—in specific circumstances—individuals.
- Managing Public Money and GovS 015 apply to all hosts, requiring eligible expenditure controls, clawback mechanisms, year-end reporting, transparency and audit.
- NHS Trusts have no general statutory power to give community grants and typically rely on charitable arms for such activity.

Options analysis

Option A: Local Authority host

Strengths: statutory fit for administering grants (BCF, VCFSE, prevention, community-based allocations); mature grant governance frameworks including s151 oversight, audit processes, competitive grant mechanisms and clawback; ability to roll over unspent funds (subject to S75 and Managing Public Money); established systems for VCSE and non-NHS providers; already host BCF pooled budgets (minimal disruption); demonstrable ability to report by Locality across all ten areas; capacity exists today—no transition risks for April/October handover.

Risks / issues: integrating NHS performance, finance and activity reporting requirements into LA systems (addressed through a joint GM–host finance reporting pack); clarity on S75 configuration and pooled fund boundaries (addressed through standard NHSE S75 templates).

Overall assessment: strong statutory fit, minimal disruption, high readiness.

Option B: NHS Foundation Trust host

Strengths: strong financial governance culture and NHS audit regime; capacity for managing large NHS budgets and transactional activity; ability to adopt shared reporting standards.

Risks / issues: no statutory power to issue community grants; current inability to report at all Locality footprints without additional investment; disruption to existing flows given the majority currently run through LA-hosted BCF arrangements; more complex to manage VCFSE/community grant-type expenditure under NHS SFIs; potential delay to the glide path due to SFI amendments and assurance requirements; need for new governance for rollover and S75 transactions.

Overall assessment: possible in principle but would require major redesign and delay implementation.

Decision criteria

Criteria	**Local Authority (score)**	**Rationale (LA)**	**Foundation Trust (score)**	**Rationale (FT)**
Statutory fit (S75, grant powers)	3	LA has explicit statutory authority to give grants and host S75 pooled funds.	1	FTs cannot issue community grants directly; limited statutory basis.
Administrative capacity	3	Existing grant teams, s151, BCF hosting, VCSE grant mechanisms already operational.	2	Capacity constraints in locality-level reporting and grant processes; can improve but not in time for glide path.
Alignment with existing flows	3	Most grant-type funding already flows through LAs; minimal disruption.	2	Moving BCF to FT would require significant rerouting and

				governance change.
Governance & audit readiness	3	Mature systems for grants, S75, year-end controls, rollover.	3	Strong NHS audit regime but incomplete for grant-making environment.
Grant-making competence	3	LA grant mechanisms and legal powers well established.	1	No general statutory power; limited experience in VCFSE/community grant operations.
Pooled budget operations	3	Already operate BCF pooled budgets with NHS partners.	2	Would require new S75 constructs and revised SFIs.
Practicality (speed, readiness, 10-Locality reporting)	3	Fully able to implement quickly; Locality footprints embedded.	2	Capacity limitations; would require system change and investment.
TOTAL	24		15	

Why the overall scoring favours LA hosting: LA hosting is least disruptive to existing BCF and prevention flows; requires minimal system redesign, ensuring the glide path is achievable; LAs hold broad legal powers to issue grants; LAs already manage grant governance, S75 administration and VCSE payments; FT reporting constraints are capacity issues, not capability or willingness; scoring does not imply FTs lack financial competence—only that grant-making is not a core statutory function.

Key risks: Locality-footprint reporting for all ten places; year-end rollover of unspent funds (particularly prevention/Left Shift); grant control compliance under Managing Public Money/GovS 015; ensuring “no overspend” discipline does not conflict with operational delivery; integrating NHS reporting with LA finance systems.

Mitigations: joint GM–host finance reporting pack standardising NHS-required reporting; clear rollover rules within S75 and the Partnership Agreement; escalation pathway for dispute resolution, including GM-level oversight; open-book accounting and quarterly assurance via the Partnership Agreement.

Recommendation: the preferred option is Local Authority hosting—statutory authority to give grants; ready-made infrastructure and s151 assurance; established pooled-budget and community grant experience; no disruption to BCF and prevention flows; ability to support reporting across all 10 Localities; faster implementation aligned to glide path timelines. FT hosting is viable only with substantial redesign work, causing delay and introducing material risk.

Appendix 4 – Financial detail by Locality (illustrative)

August 2025 draft for illustration only (being refreshed).

Through Operating Model development, an initial proposal indicated the potential of Place funding (the term “grant” was commonly used) aligned with continuous investment in neighbourhood health and Live Well, hosted by a statutory Place partner, utilising local financial governance through the partnership, and operating on an outcomes-based arrangement.

January 2026 draft for illustrative purposes only.

Area	Bolton	Bury	HMR	Manchester	Oldham	Salford*	Stockport	Tameside	Trafford	Wigan	TOTAL
BCF Minimum Values	31,600,519	19,577,112	25,006,338	61,951,118	26,081,512	30,535,029	30,621,034	24,530,503	22,721,698	35,917,248	308,542,113
Pop Health - LIVE WELL	516,000	338,000	390,000	962,500	422,000	470,500	514,000	403,000	410,000	574,000	5,000,000
Left shift Strategic funding	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
Other	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
Total	32,116,519	19,915,112	25,396,338	62,913,618	26,503,512	31,005,529	31,135,034	24,933,503	23,131,698	36,491,248	313,542,113

Appendix 5 – Frequently Asked Questions (FAQ)

1) In simple terms, what is the Locality Grant trying to achieve?

It provides ring-fenced, flexible investment for prevention, early help and neighbourhood delivery—so Localities can act earlier on demand, reduce unwarranted variation and improve outcomes. It complements Pan-GM management of volatile budgets (e.g., CHC, IPoC, Mental Health, medicines) to reduce duplication and transaction costs.

2) How does the Grant simplify funding flows?

Localities set spend priorities within the Grant through the Place Partnership Agreement (no STAR for those elements), while Pan-GM holds volatile/scale budgets for consistency. Contract management for in-scope Grant services is administered Pan-GM.

3) Why isn't the employment model part of the Grant Agreement?

Employment model decisions (hosting of staff, JD/PS, grading, redundancy approach) are being taken via a separate workstream, to avoid conflating complex workforce issues with the financial mechanism. This allows us to start the Left Shift/prevention benefits now, while the employment model is developed with staff/union engagement.

4) What components are in scope—and when?

From Oct 2026: BCF; Live Well programmes; Left Shift funding (subject to technical work). From Apr 2027: Primary Care locally commissioned services; out-of-hospital services; VCFSE services; Capacity (subject to technical work). Items such as CHC, IPoC, Mental Health contracts and medicines remain Pan-GM (Locality influence, not ownership).

5) How does the Grant relate to Packages of Care and other "big ticket" areas?

NHS Packages of Care do not sit in the Grant at present (Pan-GM). However, Localities can influence and build cases for change using Jigsaw insight, benchmarking and gain/risk-share mechanisms to support Left Shift and standardisation where it improves outcomes and value.

6) What does "hosting the Grant" actually mean?

The host is the administrative/financial operator: holds the pooled fund, processes transactions, and ensures Section 75 and audit compliance. Hosting does not confer control over priorities or allocations; decisions sit with the Place Partnership through the Partnership Agreement.

7) Who is the recommended host—and why?

Local Authority hosting is recommended due to statutory fit with BCF and prevention spend, mature grant-making capability, and alignment with existing flows; NHS Foundation Trusts have robust SFIs but more limited statutory ability to issue community grants.

8) What statutory powers enable Local Authorities to host/administer grants?

Local Authorities have explicit powers to give grants to community groups, charities, businesses and, in some circumstances, individuals, via legislation such as the Local Government Act 1972 and the Localism Act 2011 (General Power of Competence). NHS Trusts lack a general statutory power to issue grants and typically rely on charitable arms for that function.

9) How will the host meet NHS reporting needs across all 10 Localities?

A joint GM–host finance pack will standardise reporting for every Locality, including whole-system visibility of in-scope Grant streams, open-book arrangements and outcomes tracking, as part of the Partnership Agreement assurance.

10) Will the host be able to roll over unspent funds between years?

Yes—subject to the Partnership Agreement, Section 75 conditions, and Managing Public Money/GovS 015 rules—so long as rollover supports ring-fenced purposes (e.g., Left Shift/prevention) and is transparently reported. Local options appraisals should include confirmatory checks on rollover arrangements.

11) How was "administrative capacity" scored in the host options appraisal?

Scoring reflected existing grant-making infrastructure, governance/audit readiness, and practical speed of implementation without disrupting current flows. The narrative rationale will be included in the report to avoid undue focus on line-by-line scoring differentials.

12) Who ultimately owns the outcomes and decisions?

The Place Partnership sets priorities, directs spend and owns outcomes; the host safeguards probity, reporting and ring-fence integrity.

13) What do we mean by "Left Shift"?

Moving resource and activity from reactive, high-cost responses into prevention, early help and neighbourhood-based support, underpinned by standards at scale where they add value.

14) What is a "Neighbourhood" and how does it relate to Left Shift?

Neighbourhoods are footprints of roughly 30–50k residents aligned to Primary Care Networks (PCNs) and local community structures—the delivery engine for integrated, early support.

15) What is the Jigsaw and why does it matter?

The Jigsaw is a single view of whole-system spend (NHS—and, as feasible, relevant LA and wider determinants) by population. It enables shadow monitoring, benchmarking and case-for-change development to shift investment upstream where the outcome impact is greatest.

16) Which elements will require GM-level consistency—and which are local?

Where evidence shows benefit from scale/standardisation (e.g., MAS, IAPT, some MH VCFSE, some winter schemes), GM-level consistency will apply via a dedicated workstream. Localities retain flexibility to tailor neighbourhood delivery within the agreed standards and outcomes framework.

17) How will we incentivise "Left Shift" beyond finance—e.g., workforce and services?

Through the Partnership Agreement, outcomes framework and risk/gain-share, we will align workforce, service models and incentives toward prevention and neighbourhood delivery (recognising many levers sit outside the Grant but can be influenced locally and Pan-GM).

18) Why move away from historic allocations toward weighted per capita?

Historic outturn often mismatches need. Weighted per capita (with universal proportionalism) and Jigsaw insight help target investment fairly and where outcome impact is greatest.

19) How will weighted per capita shape Locality Left Shift allocations?

It defines each Locality's indicative prevention/Left Shift share; the Jigsaw then highlights misalignment with historic spend to inform phasing and the case for change.

20) How will the “no overspend” principle operate in practice—especially versus activity-based commissioning?

The Grant is cash-limited; Localities align budgets across partners, remove duplication and use risk/gain-share to manage pressures. Activity-based drift is controlled through the Partnership Agreement, outcomes-linked oversight and open-book reporting. Noting Pan GM has retained volatile budget such as AACC and S117 initially

21) What is the glide path and when do responsibilities shift?

Phase 1 (Apr 2026): refine Grant technicals; align to Locality monitoring hosted by GM ICB. Phase 2 (by Oct 2026): Partnership Agreements finalised; monitoring by host with GM ICB joint responsibility; final refinement of Grant components. Phase 3 (Apr 2027): full handover to the host organisation (subject to technical readiness). Scope grows through Phases 2–3 as standardisation completes.

22) How will small organisations be protected during transition?

Current arrangements continue until new models are ready; Pan-GM Finance and the host will run a safeguarding escalation at transfer; fair, timely and predictable funding for the VCFSE is a core design principle.

23) What technical work remains before Oct 2026 and Apr 2027?

Finalising in-scope components; standardising Primary Care LCS and out-of-hospital elements; Left Shift allocation method/measurement; and the gain/risk-share operating model (IPoC, CHC, Mental Health).

24) Is Capacity & Discharge funding in the Grant—and how will it flow?

Discharge funding forms part of the BCF and continues to flow via existing mechanisms; Capacity funding will follow the glide path for inclusion and be managed in a transaction-light way aligned to outcomes.

25) How will the relationship between funding (quantum) and outcomes be assessed?

Each Grant heading will state which population outcomes it supports, which indicators are expected to shift, and the activity and financial impacts (including where savings land). Benchmarking and the Jigsaw will be used to ensure proportionality and value for money.

26) How will the Grant’s effectiveness and impact be evaluated?

Through an annual evaluation cycle (with formal evaluation partners where appropriate) that triangulates outcomes, activity shifts and cost impacts, and feeds into allocation decisions, uplifts and improvement support. Quarterly KPI oversight will monitor progress.

27) What happens if outcomes are not achieved?

The Partnership Agreement sets an improvement and escalation pathway: supportive intervention → targeted conditions on spend → (where needed) pause/reprofiling—always seeking to protect residents and providers. Decisions are evidence-based and collectively owned.

28) How will overspend, risk and liability be handled?

“No overspend” is a core design principle. Overspend risk sits with the Place Partnership, managed through open-book monitoring, risk/gain-share, and early intervention via governance. The host provides assurance but does not carry unilateral liability.

29) How will benchmarking prevent inequity between similar schemes in different Places?

The finance pack will include comparators (GM and national where available) and unit-cost views. Decisions must evidence proportionality and avoid materially overfunding like-for-like interventions without justification.

30) Will provider funding flows change overnight?

No. Existing mechanisms remain unless the Place Partnership agrees a change supported by evidence, benchmarking, clinical/professional advice, and alignment to safeguards and the sustainability plan.

31) How will BCF, Live Well, VCFSE, Capacity & Discharge, Primary Care LCS and out-of-hospital services flow under the Grant?

They will continue to flow to the full range of provider sectors (Acute, Mental Health, Community, Primary Care, Local Authority, VCSE, Independent Sector, Care Homes) with stronger collective grip on outcomes and Left Shift impact through the Partnership Agreement and finance pack. Inclusion timing follows the glide path.

32) How will changes to flows be governed and safeguarded?

The Partnership Agreement prevents cost-shunting, requires open-book data, mandates clinical/professional leadership, and protects essential services. Any

proposed change must demonstrate better outcomes, better value, and alignment to the Left Shift/sustainability plan.

33) How will Place Partnerships agree investment priorities and hold each other to account?

Decisions are grounded in Local Operational & Strategic Plans, the population health needs assessment, and the outcomes framework—using open-book finance and performance data, with clinical/professional leadership at the table.

34) What if a Place Partnership reaches stalemate or a veto prevents discharge of responsibilities?

The Partnership Agreement will include a formal escalation route (local → GM mediation → resolution panel as needed) with time-bound steps, ensuring decisions are not unduly delayed and statutory duties are met.

35) Example A – Neighbourhood falls prevention

Problem: rising non-elective admissions for falls among 75+. Insight: Jigsaw shows high costs in downstream care; benchmarking shows variation vs GM median. Action: Grant invests in multi-agency falls/fragility pathway (PCN, community rehab, VCSE home safety); outside-Grant levers adjust therapy slots and housing adaptations. Outcomes: fewer admissions; improved MDT responsiveness; lower conveyance. Finance: activity reduction evidenced in SUS/community datasets; provider impact managed via gain/risk-share; next-year allocation uplift linked to outcome trajectory.

36) Example B – High-intensity users of urgent care

Problem: small cohort drives disproportionate A&E/999/NEL activity. Action: Grant funds proactive case finding, health coaching, and community connectors via VCSE; outside-Grant levers align MH access standards and LA social support. Outcomes/Finance: reduced NELs and attendances; demonstrable cost avoidance; reinvestment case to grow the Locality Left Shift pot.

37) Example C – Children & young people early help

Problem: escalation to specialist services due to late intervention. Action: Grant supports school-based early help, parenting support and digital access; outside-Grant levers align CAMHS pathways and community assets. Outcomes/Finance: earlier resolution; reduced specialist waits; improved attendance; activity shift evidenced in referral patterns.

38) Better Care Fund (BCF)

A statutory pooled budget for integrated health, care and housing-related support; forms a major component of the Locality Grant and already flows to multiple provider sectors.

39) Managing Public Money / GovS 015 (grant controls)

Standards that apply to public funds, including proper controls, eligible expenditure, clawback and audit requirements—relevant to host arrangements and rollover.

40) Section 75 (NHS Act 2006)

Enables NHS bodies and Local Authorities to pool budgets and delegate functions; a host is required for the pooled fund.

Appendix 6 – How the host will operate the Locality Grant

Summary

This appendix explains how the host organisation will operate the Locality Grant day to day, using the BCF to illustrate current flows. It clarifies that BCF is only one part of the Locality Grant, which brings together several existing budget lines into a single pooled mechanism. The Locality Grant changes how budgets are grouped and governed, not how provider payments are made. The host provides administration, assurance and reporting; the Locality Partnership makes all spending decisions.

1. Budget lines included in the Locality Grant

Included from October 2026:

- Better Care Fund (BCF)
- Live Well programmes
- Left Shift / Neighbourhood Development funding

Included from April 2027 (subject to technical readiness):

- Primary Care LCS
- Out-of-hospital community services
- VCFSE-funded services
- Capacity funding

Remain Pan-GM:

- CHC
- Individual Packages of Care
- Mental Health budgets
- Medicines optimisation
- Acute and Independent Sector contracts
- Locality team/staff costs (until employment model agreed)

BCF is only one component of the wider Locality Grant.

2. How BCF funds flow now (illustration for understanding the Locality Grant)

The BCF demonstrates that spend already flows through three distinct routes. Across all three routes, NHS providers (Acute FT, Community, Mental Health) are recipients, alongside Local Authority, VCSE and independent providers.

Route 1: Pan-GM NHS → NHS providers (direct NHS payments)

Some BCF-reported spend is paid directly at Pan-GM level from NHS budgets to NHS providers, using system-wide block or activity contracts and Pan-GM community/urgent care contracts. Although included in Locality BCF reporting, the money does not flow through the Locality or Local Authority.

Typical recipients: Acute NHS Foundation Trusts; Community NHS providers; Mental Health NHS providers.

Route 2: Local Authority → providers (via LA systems)

A large proportion of BCF pooled funds is paid through Local Authority systems under Section 75 arrangements, covering homecare, reablement, intermediate care beds, equipment and adaptations, housing-related support and VCSE services.

Typical recipients: Acute NHS Foundation Trusts; Community NHS providers; Mental Health NHS providers; independent sector beds; homecare; VCSE providers.

Route 3: Locality delegated NHS budgets → providers (Local NHS routes)

Some BCF lines come from NHS delegated Locality budgets, directly funding neighbourhood support, anticipatory care, MDTs, falls and frailty services, and VCSE support.

Typical recipients: Acute NHS Foundation Trusts; Community NHS providers; Mental Health NHS providers; PCNs/GP practices; VCSE organisations.

Combined provider list across all three routes

NHS providers:

- Acute NHS Foundation Trusts
- Community NHS providers
- Mental Health NHS providers
- Primary Care / PCNs / Federations

Local Authority services:

- Reablement
- Social care assessment
- Equipment & adaptations
- Housing support

Independent sector:

- Intermediate care
- Homecare
- Short-stay residential/nursing care

VCSE sector:

- Carers support
- Community connectors
- Wellbeing / early help

Other:

- Equipment suppliers
- Digital/home-monitoring providers
- Community transport/access

3. What changes in Locality transparency and reporting under the Locality Grant

- All in-scope budget lines (including NHS Locality lines) will be reported transparently by the host against the agreed Locality Outcomes Framework.
- All budget lines in one place, instead of NHS and LA reporting separately.
- One standard GM reporting template enabling comparability across all 10 Localities.
- Open-book reporting shared with partners each month/quarter.
- Consistent coding and categorisation of spend across all budget lines.
- Quarterly outcomes-linked reporting showing spend against Locality outcomes and Left Shift priorities.
- Full visibility of whole pathways (instead of partial or split budgets).
- Clearer identification of pressures, risks, underspends and opportunities.
- One shared financial narrative for the Locality Grant, replacing multiple fragmented positions.

4. What happens to NHS Locality budgets under the Locality Grant

NHS Locality budget lines that move into the Locality Grant will be hosted and administered by the host organisation. The host becomes responsible for the full suite of financial management functions, while the Locality Partnership continues to make all decisions.

The host will: hold the budget (as part of the pooled fund under Section 75); process all payments and invoices; maintain ledger accuracy and correct coding; record commitments; run in-month financial monitoring; forecast the financial position; produce open-book reports; manage year-end processes (including permitted rollover); and ensure compliance with S75, Managing Public Money and audit.

- Financial administration
- Transaction processing
- Ledger management
- Budget monitoring and forecasting
- Financial reporting and audit assurance

5. What this means for partners

- One place to view all Locality Grant spend.
- One reporting pack for all in-scope budgets.
- One governance route linking spend to outcomes.
- One financial position, not multiple broken-up views.
- One shared audit trail.
- One consistent basis for planning, prioritisation and Left Shift.

Appendix 7 Proposed next steps after engagement

In scope:

- Confirm the glide path and proposed Local Authority hosting arrangements to begin implementation from April 2026.
- Stand up workstreams under this working group to enable the glide path.

Technical work:

- Grant components and technicalities (financial modelling and operational detail).
- Gain/risk-share design and governance (IPoC, CHC, Mental Health).

Left Shift approach:

- Left Shift allocation methodology and measurement (needs-based, weighted per capita, outcomes).
- Jigsaw expansion (whole-system spend mapping; integration of finance, DII and population health data).

Alignment at Place:

- Locality financial transparency (open-book; reporting templates).
- Stakeholder engagement: s151 Officers (hosting, S75 compliance), Directors of Strategy and Executive Directors (sustainability priorities), Place and Deputy Place Leads, Directors of Adult and Children's Services, Council Leaders/Portfolio Leads, Primary Care Board, ICB Nominated Finance Leads for Place.

Out of scope:

- Gain agreement or firm up delivery timelines for GM-level workstreams for enablers, with agreed Executive Sponsors.
- Partnership Agreement — ERO Charlotte Bailey.
- Outcomes Framework — ERO Charlotte Bailey.
- Employment Model — ERO Charlotte Bailey.
- GM–Provider footprint / Place / Neighbourhood ways of working — ERO Katherine Sheerin.

Place Mobilisation Group: Place Team update

Author(s)	Hannah Dobrowolska Deputy Place Lead (Salford) Hannah.Dobrowolska@nhs.net
Date	19 February 2025
Audience	Place Mobilisation Group members, including sub groups and wider stakeholders for engagement
Meeting/ purpose	Development of Place Team to support the work of the Place Partnerships
Status	Third Draft
Version	1.2

Notes

This presentation outlines proposals for place teams to deliver the requirements of Place Partnerships. This evolves the content of the Place Health and Care Partnerships described in a previous slide set widely circulated (v8.5).

It is designed to support discussions across senior leadership to ensure the right model and ways of working are achieved by:

- Providing a clear narrative for the purpose, outcomes and capabilities of the place team
- Sharing scenarios for consideration about how this could be achieved
- Inviting feedback to help shape further development through lived experience, practical insight, and collaborative dialogue

The slides are intended as an update and stimulus for discussion, offering space to test and refine together.

NHS
Greater Manchester

Health and Care Place Mobilisation
Place Team

19 February 2026 – v1.2

Part of Greater Manchester
Integrated Care Partnership

The story so far:

NHS Greater Manchester

- We have already agreed 9 principles for a new model of place working
- We are able to describe the function of place partnerships for the health and care system
- We know that effective place partnerships require the contribution of all partners
- National neighbourhood health guidance has renewed emphasis on place-based decision making under the leadership of the Health and Wellbeing Board (HWB)
- We have started to describe and agree the role/contribution from NHS GM (as one of the partners) is to each of the 10 place teams in terms of skills and capacity – both within a place team and drawn from the central NHS GM team
- We recognise the precise configuration in each place might be different but, in the end, the operating model needs to be clear about the minimum requirements from other place partners too
- We understand that each place is different, so share examples of how a place team might be arranged rather than pre set options or a prescriptive model. This document focuses on outlining the broad skills and capacity required to achieve the outcome ambitions of our place partnership, rather than detailing any exact make up or arrangements of a place team

NHS
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What does a place team do?

Part of Greater Manchester
Integrated Care Partnership

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

NHS Greater Manchester

System Convenor – to enable delivery of the ICP strategy

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

Strategic Commissioner

Needs Assessment & Outcomes-setting

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

Strategy and Planning

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

Contracting & Evaluating Impact of System

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

Clear Accountability and Trust

Ten Integrated Place Partnerships

Local Insight-led Planning

Develop priorities and plans to address:

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

Integrated Delivery at Place

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

Aligning Partnership Incentives & Resource

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

Enablers: portfolio/s to encompass all of these functions

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

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

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

The relationship between our ten Place Partnerships and our GM-wide teams will be central to our future effectiveness

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GM-wide ICB teams will support our Place Partnerships through…

1. Providing **data-driven insights** via the DII, combined with community knowledge and lived experience, to help shape place priorities, delivery of Live Well and Neighbourhood health and care initiatives.
2. Allocating **funding and resources,** sharing financial insights, supporting clinical leadership, through partnership agreements to enable delivery of Place objectives.
3. Supporting **communications**, in collaboration with place partners.
4. Offering guidance and expertise from **quality assurance, quality improvement, and patient safety** insight to help ensure high-quality community care, including services in primary care and care homes.
5. Commissioning **GPIT and digital solutions** to facilitate local integration and transition from analogue to digital systems. Supporting strategic estates discussions.
6. Providing expert guidance in **equality, diversity, and inclusion** to help ensure that health care services, including general practice and care homes, are inclusive, equitable, and of consistently high quality.

Place Partnerships will support GM-wide teams through…

1. We will **work in genuine partnership with communities**, building on community assets and taking a strengths-based approach where co-design and lived experience are central to everything we do
2. **Demonstrating benefits** and delivering improved health outcomes, reduced inequalities, and enhanced prevention through delivery of Live Well and Neighbourhood Health and Care initiatives.
3. Implementing collaborative approaches to **demand management** by utilising place budgets across partners to test and scale alternative care models to systematically reduce acute expenditure.
4. Providing timely progress **updates and outcome** reports to meet governance requirements, including early escalation and mitigation of risks when necessary.
5. **Securing partner investment and commitment**, including clinical and professional leadership, transformation, and organisational development, to support achievement of key objectives.
6. Acting on strategic commissioning intent locally and **sharing local insights** to help inform strategic commissioning and strengthen performance assurance.

Place in Motion: System Leadership in Action

Place isn’t a programme. It’s a living, breathing network of people, capabilities, behaviours and purpose.

The Place Health and Care Partnership turns shared purpose into powerful, practical change, enabling leaders and communities to shape health and wellbeing together, through...

- 🏘️ Activating a One-Public Estate Strategy : Connecting physical assets to health creation, co-locating care, prevention, and support in familiar, trusted spaces across neighbourhoods.
- 👶 Leading across the Life Course : Designing inclusive models that respond to early years, working-age adults, and ageing well, reducing inequalities through locally connected interventions.
- 📊 Making Intelligence Work : Using place-level data, lived experience and population health tools to inform planning and action, not just reports, but decisions.
- 🧠 Creating Conditions for Improvement : Facilitating planning, policy and culture that enable iterative learning, system change and confidence across teams.
- 🤝 Joining Up Leadership : Building alignment between NHS, Council, VCFSE, housing, education, policing and business, advancing shared priorities through matrix working.
- 🗣️ Empowering Resident Voice & Co-Production : Enabling people to take action on what matters to them, not just what services deliver, from co-design to community activation.
- 🔄 Shifting to Prevention & Early Support : Reshaping investment logic to move resources upstream, reducing reliance on reactive services and strengthening independence.
- 💼 Anchoring Delivery in Collaborative Governance : Integrating joint commissioning, aligned budgets and strategies, tying money to purpose and holding partners accountable.

Place is where energy gathers, galvanising the place health and care system partnership to make the fullest possible contribution to the strategy for the borough/city convened by the council. It’s where resource depth becomes impact. Where professionals and residents problem-solve together, and small wins accumulate into something bigger. It’s collaborative leadership, local intelligence, and system confidence moving in one direction: better health, better wellbeing, delivered together.

Place in Motion: Collective Focus across Partners

NHS Greater Manchester

The strength of Place lies in its diversity, not a single team, but a shared system where all contribute to transformation…

Place Capability	Enables	Enabled By
🤝 **System Leadership & Alignment**	- Translates shared purpose into joined-up action - Steers governance and integration - Builds relational trust and prioritises shared goals	NHS GM, NHS Providers, Primary Care, Local Authority, VCFSE leaders, Elected members, Neighbourhood leaders
📊 **Data, Intelligence & Improvement**	- Turns insight into action and tracks what matters - Builds population health dashboards with local context - Supports real-time learning and adaptation	Public Health, BI teams, NHS & Council analysts, Academic partners, Community Connectors
🛠️ **Frontline Service Integration & Transformation**	- Delivers proactive, multidisciplinary, high quality and inclusive care - Adapts services around lived experience and local needs - Responds swiftly through locally rooted teams	Health & Care Providers, Social Care teams, VCFSE organisations, Housing & community-based services, Neighbourhood leaders
🧭 **Place Planning & Resource Logic**	- Aligns investment with life-course outcomes - Models delivery around long-term sustainability - Anchors programmes in shared value	Transformation teams, Finance leads (NHS & Council), Programme managers, Neighbourhood leads shaping priorities
🗣️ **Engagement, Co-Design & Public Voice**	- Enables people to shape change directly - Centres design around what matters to residents - Builds ownership, trust and resonance	Patient/Resident Voice, Engagement teams, VCFSE navigators, Councillors, Comms leads, Neighbourhood forums, youth and lived experience leaders
🏘️ **Community Activation & Wider Collaboration**	- Tackles wider determinants through a community-first mindset - Aligns education, safety, housing and business with wellbeing - Creates neighbourhoods that promote health	Primary Care, Schools, Housing teams, Police, Local Businesses, Leisure & Sport partners, Universities, Neighbourhood leaders

Core Capabilities in Place

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Building a robust place partnership team hinges on blending technical, relational, and adaptive capabilities that cut across sectors and enable a team to lead with clarity, credibility, and creativity.

The skills of the Place will be drawn from the strength of the whole partnership, bringing resource together from across all partners.

Capability	Skill Example	Why It Matters at Place
Data and Insight Application	Ability to build and interpret population health dashboards within Tableau	Turns intelligence into planning power at the neighbourhood level
Community Engagement	Skilled in facilitation, lived experience inclusion, social marketing techniques	Moves the model from “about people” to “with people”
Co-Design and Service Pathway Mapping	Use of tools to support process and journey mapping	Clarifies responsibilities and simplifies delivery for integrated teams
Programme Delivery	Ability to scope, plan, and execute delivery of multi-agency programmes	Operationalises priorities with pace and accountability
Financial Acumen	Ability to model aligned budgets, monitor spend, and support value-based decision-making	Enables shared investment logic and anchors delivery in sustainability
Strategic Communications	Skilled in crafting key messages, infographics, or briefing packs for diverse audiences	Builds shared understanding across sectors and up/down governance tiers
Relationship Building and Brokering	Ability to build trust and align actions across VCFSE, NHS and local authority	The oil in the system that enables collective problem solving
Negotiation and Influencing	Particularly across matrix structures or with providers	Supports integrated decision-making with buy-in
Population Health Literacy	Understanding inequalities drivers, protective factors, and assets	Reframes delivery to prevention, outcomes and impact, not just service metrics
Clinical Leadership/Influence	Ability to lead strategy, align clinical priorities, and drive service improvement	Ensures credibility, quality, and integration across multidisciplinary teams and delivery models
Change Management	Basic fluency in managing resistance, securing buy-in, leading iterative improvement	Enables adaptation and learning across cycles

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Who is part of a place team?

Health and care place partners

- Local authority (including public health, children's services and adult social care)
- NHS acute and community trusts
- NHS GM
- NHS mental health trusts
- Primary care (GP, pharmacy, dentistry and optometry)
- VCFSE sector

We understand that an effective health and care system is dependent on our connection to a range of other key partners in the place including:

- Schools/colleges/universities
- Housing providers
- Leisure services
- Police
- Private sector partners

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How does a place team work?

Part of Greater Manchester
Integrated Care Partnership

Features of a successful health and care place team

NHS Greater Manchester

- Positive collaborative culture
- Shared place partnership vision and goals to improve local health outcomes in line with Locality Plan
- Clear place outcomes framework based on local population needs and data including process-based, people-based and population-based outcomes (to support goals being measurable)
- Agreed, defined and limited partnership areas of focused effort with collective advantage to maximise impact
- Shared plan to guide action and clarify responsibilities
- Clear approach to engagement with the public, patients and stakeholders
- Clear governance arrangements to ensure effective strategic decision making through to delivery
- Commitment of direct health and care capacity from each place partner
- Commitment of wider enabler capacity from each partner

Place Partnership Leadership Team

While each Place will reflect its own unique context, challenges, and opportunities, a consistent framework will underpin the development of Place Partnership Leadership Teams. This framework is anchored in the contribution of NHS Greater Manchester and shaped through shared principles of integration, collaboration, and purpose.

These leadership teams will be designed to harness the full breadth of partnership resource, spanning NHS, local government, VCFSE, and wider public services, to optimise delivery and drive meaningful outcomes for communities. Their strength lies not in structural uniformity, but in the ability to mobilise collective capability around shared priorities and areas of focused effort with collective advantage.

Early engagement with Place partners has demonstrated a strong appetite to align and deploy resource collaboratively, signalling a clear commitment to co-owning delivery and shaping transformation and improvement together.

This momentum provides a powerful foundation for the next phase of development, where partnership becomes the engine of change.

NHS GM's contribution as "Model" place team (1)

NHS GM is one partner to effective place partnerships. It will discharge pan GM wide strategic commissioning decisions, recognising their impact in place, and will engage with place partnerships in their design. And it will also ensure each place has a small team of NHS GM officers to be the conduit to that pan GM wide working, and to deliver the following 5 particular competencies to the place partnership:

1. Place Leadership & Integration

At the core of place working lies a leadership team that fosters transformation not through command, but through connection, driven by shared values, collaboration, and culture. Place leadership plays a critical role in mobilising financial acumen, driving quality and utilising trusted relationships to unlock system wide transformation.

Working alongside system partners, these roles steer local transformation by aligning priorities, unlocking resources, and creating the conditions for shared delivery. Their strength is in enabling the system to lead collectively, embedding reform in relationships, not just structures.

2. Live Well & Neighbourhood Health and Care

As appropriate and agreed within the place, and with partners, act as the integrator across services and sectors, bringing together partners around population-level challenges. Operating close to communities, they support the alignment of local resource and capability, translating strategic ambition into coordinated action. Their focus is on creating the fabric of trust and connection that allows partners to work as one for the benefit of local people.

Place partners will agree a strategic neighbourhood health plan at place-level within the Joint Local Health and Wellbeing Strategy (JLHWS), working with Primary Care Networks, voluntary sector partners, adult social care, and residents themselves, they support the development of holistic responses to population health needs. The scale of the work spans complex programme management, multiple neighbourhood footprints, and intensive multi-agency engagement. With responsibilities across coordination, facilitation, and operational alignment, these roles are essential to weaving together fragmented systems into one cohesive neighbourhood model.

NHS GM's contribution as "Model" place team (2)

NHS Greater Manchester

3. Pathway Development & Demand Management

NHS GM within place will shape and support the delivery of strategic plans and commissioning decisions, bringing clarity, local variation, engagement, shared interpretation, and activate the right relationships to bring them to life. By convening providers, clinicians, and community partners, they help shape intelligent interventions that reduce avoidable demand and improve flow. Their role is to support change that is coherent, outcome-focused, and truly place-sensitive.

It is essential to drive whole-pathway transformation, starting at prevention, across clinical and care sectors, helping partners co-design sustainable models that reduce avoidable demand and improve flow. From complex diagnostics to service mapping and pressure point analysis, they enable insight-led decision-making and practical redesign across services. Their remit spans all age: prevention, children and young people, physical and mental health, intermediate care, urgent response, and long-term conditions, making their support essential to meeting future demand in a place-sensitive, outcome-focused way.

4. Place Governance & Administration

Strong working relationships within and across local partner organisations are essential for delivering more integrated, joined up services that drive benefit for residents. NHS bodies and local authorities have a statutory duty to cooperate when exercising their functions in order to secure and advance health and welfare, but it is the working environment that will enable the most significant change, innovation and trust.

In line with national guidance, place leadership will be focused on the HWB, which will be responsible for overseeing the development and implementation of neighbourhood health in their local areas. This will the connective tissue that binds the Place model together, coordinating systems, information, and governance in ways that empower partners to act confidently and cohesively. From shaping shared operational structures to ensuring informed decision making, making visible the operational scaffolding needed to turn ambition into action at every level of the partnership, and creating the right conditions to support collaboration.

Their work helps partners to navigate complexity with confidence, embedding clarity, assurance, and relational accountability across the model, requiring capacity to establish the framework as set out within the Place Health and Care Partnership Agreement.

NHS GM's contribution as "Model" place team (3)

5. Clinical and Care Leadership

NHS GM clinical and care leaders within place act as agnostic conveners of clinical expertise from across the partnership to provide insight and credibility, supporting partners to shape productivity and improvement that is grounded in both lived experience and professional expertise. Working alongside civic and system colleagues, roles such as Place Clinical Director and sessional Clinical Leads help connect clinical perspectives to strategic priorities, enabling transformation that reflects what matters most to patients and local populations. Their focus is on fostering alignment across pathways, facilitating consensus, and anchoring decision-making in evidence and local intelligence. They play a vital role in helping the system think differently about care, outcomes, and connection.

Note on the place team contribution from NHS GM

NHS GM has a system convening role. As such it is committing approximately £16m to our 10 place teams, this funding has been allocated based on an agreed formula. This will fund capacity in each of the five competency areas above, with an average of 20 colleagues funded in each place. This ranges from 13 to 40 (TBC). The model team was agreed between all 10 places which guided the development of place specific structures. Both the model team structure and individual proposed place structures will be shared from late January when NHS GM staff consultation commences.

Place set up

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- Place context is fundamental to determining the appropriate place team set up
- An assessment of the current level of integration may help inform a place's approach. There are a number of tools available, including the Neighbourhood healthcare maturity matrix | Good Governance designed for place based neighbourhood boards
- Essentially each place partner will contribute capacity to the place endeavour, how much and how this is managed practically to achieve shared place ambitions must be decided by each place partnership
- Set up might range from a fully integrated team under single management through to a more dispersed arrangement held together through a PMO or coordinating function
- Some places may choose to put a lot of commitment, power, responsibility and capacity into the place arrangements, others may choose to retain more within individual organisations

Scenario 1 – Integrated team

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- All place partners to identify colleagues who will form part of the place team for all or part of their work. This staff capacity will be funded and formally committed by the relevant place partner
- Place team colleagues are hosted by a single place partner organisation
  (note: they will be seconded from their employing organisation to the host)
- Place team colleagues work within a single line management arrangement, reporting through to the Place Lead (regardless of whether they are employed by the host organisation or not)
- Place team colleagues work on behalf of the system in line with agreed objectives determined by the Place Partnership
- The place team, via the Place Lead, is accountable to the Place Partnership
- The hosting place partner is likely to also host the place grant
- When staff who are part of this team leave, the funding will continue to be provided by the place partner, however the place will decide whether the role is employed by the funding place partner or host going forward – there are benefits to each approach

Scenario 2 – Hybrid model

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- All place partners to identify colleagues who will form part of the place team for all or part of their work. This staff capacity will be funded and formally committed by the relevant place partner
- NHS GM and some partner colleagues are hosted by a single place partner organisation
  (note: they will be seconded from their employing organisation to the host)
- These place team colleagues work within a single line management arrangement, reporting through to the Place Lead (regardless of whether they are employed by the host organisation or not)
- Other roles from partners are part of the arrangement and place team capacity but not formally line managed by the host
- Place team colleagues work on behalf of the system in line with agreed objectives determined by the Place Partnership
- The place team, via the Place Lead, is accountable to the Place Partnership
- The hosting place partner is likely to also host the place grant
- When staff who are part of this team leave, the funding will continue to be provided by the place partner, however the place will decide whether the role is employed by the funding place partner or host going forward – there are benefits to each approach

Scenario 3 – Dispersed model

NHS Greater Manchester

- All place partners to identify colleagues who will form part of the place team, these staff will be fully funded by the relevant place partner
- Place team colleagues are employed and line managed within their individual place partner organisations
- Place team colleagues work closely together in a matrix way on behalf of the system in line with agreed objectives determined by the Place Partnership
- Senior leaders from across the Place Partnership take lead responsibility for areas of work, reporting to the Place Lead and accountable to the Place Partnership
- Where this work relates to management of the place grant, senior leaders will also report through to a relevant individual in the place grant host organisation
- When staff who are part of this team leave they will be replaced by their employing organisation
- In this model place team colleagues are more likely to continue to undertake organisation specific work in addition to their place partnership work

Engagement and next steps

NHS Greater Manchester

- Pls share feedback on this proposed approach to place partnership teams with Hannah.Dobrowolska@nhs.net by 11 March
- We would especially welcome comments on:
  - The principle of a shared place partnership team from a range of health and care partners across place
  - The required capabilities outlined (slide 10)
  - The proposed partners involved (slide 12)
  - The features of a successful place partnership team (slide 14)
  - The NHS GM contribution to the place team (slides 16-18)
  - The feasibility of the anticipated contribution from all place partners (slide 19)
  - The approach that the team model can vary and adapt to the context of each place (slide 19)
  - The support that will be required to ensure our place partnership teams are successful, and where this could come from
- Once this document is agreed as a framework, it is expected that each place will take the lead to implement their arrangements locally

Salford Integrated Care Partnership Committee
26 February 2026
Item 7 (b) – Place Lead Report

Item for: Decision/Assurance/**Information**

Report of:	Place Lead	
Date of Paper:	10 February 2026	
In case of query, please contact:	Gina Magson Gina.magson@nhs.net	
System Priorities: (Please tick as appropriate)	Immunisations	✓
	Physical activity and movement	✓
	Child Friendly City	✓
	Live well, Neighbourhoods and Communities	✓
	Adults and Ageing Well	✓
	Preventable illness - CVD and Diabetes	✓
	Urgent and emergency care	✓
	Mental health and emotional wellbeing	✓
	Triple aim – population health, performance recovery, financial sustainability	✓
	Other system enabler i.e. Workforce, Transformation, Digital etc.	✓

Purpose of Paper:

This paper provides a summary of local and national policies, strategies, and relevant news to ensure that members of the Salford Integrated Care Partnership Committee (ICPC) remain up to date on the latest developments relevant to the health and care sector in Salford.

Further information

How will this benefit the health and wellbeing of Salford residents, or the ICS?	By ensuring that members of the Salford Integrated Care Partnership Committee are aware of the most up-to-date information available.
How does this paper address health inequalities and promote inclusion?	N/A
What risks may arise as a result of this paper and how will they be mitigated?	N/A
Does this address any existing high risks facing the organisation and how does it reduce them?	N/A
Are there any conflicts of interest associated with this paper?	As decisions made may affect provider organisations represented on this board, conflicts of interest are not entirely avoidable, and will be managed in line with NHS Greater Manchester (GM) policy.
Will any current services or roles be affected by issues within this paper and what are they?	N/A

Note: Where appropriate, please ensure detail is provided.

Document Development

Has there been Public Engagement?	N/A
Has there been Clinical Engagement?	N/A
Has the impact on Salford socially, economically and environmentally been considered?	N/A
Has there been an analysis of any impacts on equality?	N/A
Has legal advice been obtained?	N/A
Has this been to any groups or committees for engagement, comments, or approval?	Approved by Place Lead and Deputy Place Lead on 19 February 2026.

Note: Where relevant, please provide detail and ensure that it is clear how and when particular stakeholders were involved in this work, that there is clarity of what the key message/decision was, and whether amendments were requested about any part of the work.

Salford
Integrated Care Partnership

Place Lead Report

1. Executive Summary

This paper provides a summary of local and national policies, strategies, and relevant news to ensure that members of the Salford Integrated Care Partnership Committee (ICPC) remain up to date on the latest developments relevant to the health and care sector in Salford.

2 Greater Manchester (GM) and National Update

2.1 NHS GM: Update on Organisational Change

NHS England and the Department of Health and Social Care are driving long-term reform to deliver the ambitions of the 10-Year Health Plan. The focus is on three strategic shifts:

- Treatment to prevention: keeping people well, not just treating illness.
- Hospital to community: moving care closer to home through joined-up services.
- Analogue to digital: using technology and data to make healthcare smarter and faster.

NHS England published the Model ICB Blueprint in May 2025, setting out Integrated Care Board's (ICBs) core purpose and functions. Not all changes will happen immediately, with some responsibilities moving to providers or national teams over time.

What this means for NHS GM

The reforms give NHS GM an opportunity to strengthen how we deliver the 10-Year Health Plan as a strategic commissioner working in partnership across the system. Our renewed focus will be:

- **Thinking ahead:** ensuring the right health and care services are in place for our population now and in the future.
- **Supporting Place-based delivery:** enabling local teams and partners to lead delivery where it makes most sense for communities.
- **Working alongside partners:** collaborating across GM to improve outcomes and experience for citizens.

Over the summer, colleagues from across our GM system helped shape our new operating model and, during October/November, further views were invited, with the operating model due to be implemented from 1 April 2026. We received extensive and thoughtful feedback from staff, partners and wider stakeholders, all of which is summarised in the report available on our website. Thank you to everyone who contributed.

Our finalised operating model sets out how NHS GM works – from teams, systems and processes – and how we'll work with our partners.

What this means for our workforce

As part of the national reforms, all ICBs must reduce running costs to £19 per head. For NHS GM, this requires a £42 million (39%) reduction, achievable only through organisational structural redesign and workforce reductions

NHS GM issued a Section 188 Notice on 19 November 2025, beginning a formal 45-day minimum consultation. As part of this ongoing collective consultation, we have shared proposed future structures and our finalised operating model with our workforce. We are using the national Voluntary Redundancy scheme as a first step to mitigate against potential compulsory redundancies.

We know these changes will affect our people personally and professionally, and we deeply appreciate the uncertainty and concern they may bring.

Our 'People First' approach

We remain committed to a 'people first' approach, supporting colleagues in making choices that work best for them while ensuring the organisation can meet its statutory responsibilities. This means:

- **For those who wish to leave:** we are supporting voluntary exits through the Voluntary Redundancy (VR) scheme wherever feasible within the parameters of the organisational change programme.
- **For those who want to stay:** we are working hard to retain and redeploy colleagues wherever we can, implementing the new operating model and structural changes in a fair and transparent way.
- **For those seeking alternative employment**: we are providing ongoing support through the Transition Hub and will host another careers fair on 27 March 2026.

Next steps

As we move through this period of change, there will be a short interim phase where some colleagues have left through Voluntary Redundancy, but new teams and structures are not yet fully in place. We know this can create understandable pressure and uncertainty for teams who are keeping services running while also navigating change.

We are currently mapping any gaps this may create across our work programmes. Where we identify gaps that may impact partners or service delivery, we will proactively inform you and provide clear advice on alternative contacts or routes for support. Our aim is to minimise disruption, maintain continuity wherever possible, and recognise the strain that temporary gaps can place on both our teams and the colleagues who work closely with us.

We will continue to keep you updated as the programme progresses and thank you for your ongoing support, patience and partnership during this period of transition.

2.2 Major Milestone in NHS Greater Manchester's Improvement Journey

NHS Greater Manchester has reached a significant milestone in its improvement journey, with the organisation successfully strengthening its leadership and governance, and improving performance and quality across the city region's health and care system.

Following a formal review, NHS England has now discontinued the 'enforcement undertakings' it set out in 2024 relating to governance arrangements, performance, quality of care and outcomes, leadership capability, and programme management. The decision reflects the considerable progress made by NHS GM and its partners across the NHS, local authorities, primary care, and the voluntary, community, social enterprise and faith sector (VCSFE) over the past year to stabilise and strengthen the foundations of the Greater Manchester Integrated Care Partnership.

2.3 Greater Manchester Primary Care Portal – Launched this Month

A new NHS Greater Manchester primary care portal launched on 9 February 2026. The portal is a single, secure hub bringing together guidance, updates, templates, contacts and resources from across GM and its 10 localities.

The portal will support colleagues in general practice, pharmacy, dentistry and optometry by providing one trusted place to access information. Since Integrated Care Boards were established, communication with primary care has become more complex, with information currently shared across multiple channels, leading to duplication and the risk of key messages being missed.

A GM-wide survey showed strong support for a single platform offering personalised content by role, locality and topic.

The portal will streamline communications, reduce duplication, and deliver fewer, more relevant updates. Users can set preferences and will receive a tailored fortnightly summary, with urgent issues clearly highlighted.

Primary care colleagues have received an email invitation to register for the portal. Development has been supported by a multi-disciplinary working group and primary care ambassadors.

For more information, contact gmhscp.primarycarecomms@nhs.net

2.4 NHS Excellence Awards 2026 – Entries Open

The NHS Excellence Awards 2026 are now open for entries until 5 pm on Friday 6 March 2026. These national awards recognise and celebrate the innovative work of people, teams and organisations improving health and care across England.

Run by, and for, the NHS, these awards spotlight local projects that are making a real difference to patients and communities, helping deliver the ambitions of the 10-Year Health Plan and inspiring others to adopt proven improvements.

Entry to the awards is free and open to NHS trusts, ICBs, Primary Care, Local Authorities and Partners working with the NHS. A range of categories cover all areas such as:

- Delivering value award
- Digital innovation award
- Improving health outcomes award
- Leadership award
- Neighbourhood health award
- Patient involvement and choice award
- Quality improvement award
- Sustainable healthcare award
- Valuing our people award
- Working in partnership award

We are working in partnership with the NHS Confederation on the awards who are hosting the entry form: Submit your entry now.

2.5 GM Live Well

GM Live Well is Greater Manchester's commitment to ensuring great everyday support is available in every neighbourhood. It will tackle health, social and economic inequalities by changing how public services work with people and communities to grow opportunities for everyone to Live Well. GM Live Well will ensure everyone has the support, control, connections, and resources to lead a healthy and happy life.

Read January's newsletter here.

3. Recommendations

3.1 The Salford Integrated Care Partnership Committee is asked to:

- note the contents of the report.
- disseminate and cascade the necessary key messages and information as appropriate.

Stephen Young
Chief Executive, Salford City Council and
Place Lead for Health and Care Integration, Salford