ONESTOCKPORT
Health and Care Board

Agenda
ONE Stockport Health and Care Board

Date: 29 July 2026
Time: 14:00 – 16:30 pm
Venue: Upper Ground Floor Conference Room, Stopford House

Item No.	Time	Subject	Paper / Verbal	For Approval/ Discussion/ Information	By Whom
Meeting Governance					
01.	14:00	Welcome and Apologies:			Chair
02.		Notification of items of Any Other Business			
03.		Declarations of Interest	Pages 02 - 05	To Note	Chair
04.		Minutes of previous meeting – 27 May 2026	Pages 06 - 20	**For Approval**	Chair
05.		Actions and Matters arising	Page 21	For Discussion	Chair
Leadership Updates					
06.	14:10	Place Based Lead and Deputy Place Based Lead Update / NHS Reform	Verbal	For Discussion	Michael Cullen / Philippa Johnson
07	14:20	NHS GM Acting CEO update	Pages 22 - 33	To Note	Philippa Johnson
Partnership Working					
08.	14:30	Carers Board – Flash report	Pages 34 - 35	To Note	Sarah Dillon Steve Gear and Katy Frankland
09.	14:50	Community Voice Partnership	Pages 36 - 49	For discussion	Kathryn Rees
Assurance Updates					
10.	15:10	Place Mobilisation: • Partnership Agreement • Place Fund • Outcomes Framework • Place Team	Pages 50 - 153	For Discussion	Philippa Johnson
Updates from other Boards / Committees / Partnerships					
11.	16:00	Workforce Group – Flash report	Pages 154 – 156	To Note	Kathryn Rees
Meeting Governance					
12.	16:10	Questions from the public:	Verbal	For Discussion	Chair
13.	16:15	Any Other Business	Verbal	To Note	Chair
Date and time of next meeting: **Wednesday 30 September 2026, 14:00 – 16:30 pm, Upper Ground Floor Conference Room, Stopford House**					
For Information: None					

ONESTOCKPORT
Health and Care Board

NAME	Current position(s) held in the NHS GM i.e. Governing Body member; Committee member; Member Practice; NHS GMIC employee or other	NAME OF INTEREST	NATURE OF INTEREST	TYPE OF INTEREST				Interest		ACTION TAKEN TO MITIGATE RISK	DATE SIGNED
				Financial Interest	Non-Financial Professional	Non-Financial Personal	Indirect Interest	From	To		
Buckley, Paul	Director of Strategy & Partnerships, Stockport NHS FT, Member of ONE Stockport Health and Care Board	None declared						Apr-24	Present		02/05/2024
Burgess-Allen, Jilla	Director of Public Health, Stockport MBC, Member of ONE Stockport Health and Care Board	None declared						Apr-23	Present		26/04/2024
Chambers, Carmel	Chief Executive, Stockport Homes, Member of ONE Stockport Health and Care Board	CEO Stockport Homes	CEO - advocating on behalf of the housing sector representing particular groups of NHS patients		×			Apr-26	Present		
CULLEN, Michael	Chief Executive, Member One Stockport Health and Care Board	Stockport MBC employee	Stockport MBC Employee	×				30-Oct-06	Present	N/A	29/04/2024
		GMPF Local Pension Board	Member	×				16-Jun-19	Present		
Dalby, Natalie	Chief Superintendent (Stockport), GMP, Member of One Stockport Health and Care Board	None declared									14/11/2025
Dillon, Sarah	Director of Adult Social Care, Stockport MBC, Member of ONE Stockport Health and Care Board	None declared									07/05/2024

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				Financial Interest	Non-Financial Professional	Non-Financial Personal	Indirect Interest	From	To		
Graham, John	Chief Finance Officer - Tameside & Glossop IC NHS FT & Stockport NHS FT, Deputy Chief Executive - Stockport NHS FT, Member of ONE Stockport Health and Care Board	Lydiate Learning Trust	Chair/Director	×				2011			29/05/2024
		CIMA (Accountancy Body) Council	Elected Member		×			2016			29/05/2024
		Las Calas Time Share Committee	Elected Member			×		2018			29/05/2024
		New Directions (Sefton)	Non-Executive Director				×	2023			29/05/2024
HASSALL, Anthony	CEO Pennine Care NHS FT, Member of ONE Stockport Health and Care Board	None declared									19/04/2024
JAMES, Karen	Member of ONE Stockport Health and Care Board	None declared									22/04/2024
	Chief Executive Tameside and Glossop Integrated Care NHS Foundation Trust	None declared									22/04/2024
	Chief Executive Stockport NHS Foundation Trust	None declared									22/04/2024
Johnson Philippa	Deputy Place Based Lead, Member of ONE Stockport Health and Care Board	None declared									23/04/2024
McDougall, Tim	Executive Director of Quality, Nursing & Healthcare professionals, Pennine Care NHS Foundation Trust, Member of ONE Stockport Health and Care Board	None declared									22/04/2024

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				Financial Interest	Non-Financial Professional	Non-Financial Personal	Indirect Interest	From	To		
McGrath, Jo	Sector 3, Member of ONE Stockport Health and Care Board	Sector 3	CEO - advocating on behalf of the VCSFE sector representing particular groups of NHS patients	×				Jul-19	Present	Recusal from situations where interests are declared. Ensure Sector 3 enters competitive bidding arrangements with NHS to mitigate appearance of bias. Commitment to full transparency, disclosing my position with NHS and decision-making organisations.	15/07/2024
McLoughlin, Chris	Executive Director People and Neighborhoods, Stockport MBC, Member of ONE Stockport Health and Care Board	None declared									13/11/2024
MEHTA, Viren Dr	Primary Care Representative - ONE Stockport Health and Care Board	Cheadle Medical Practice	GP Partner	×				Aug-06	Present		29/04/2024
		Stockport GP Board	Chair		×			Aug-22	Present		
		Viaduct Care CIC	GP Chief Officer & Director	×				May-23	Present		
		Stockport Primary Care Board & Stockport GP Board	Chair		×			Aug-22	Present		
		Alvanley Family Practice	Partner	×				Jul-24	Present		
		Greater Manchester GP Board	Vice-Chair		×			Jun-23	Present		
		Jinendra Trust Charity	Trustee			×		Jul-12	Present		
		Dorothy Bulkeley Charity	Trustee			×		Jun-14	Present		
		VNV Solutions Ltd	Director			×		Mar-23	Present		
REES, Kathryn	Member of ONE Stockport Health and Care Board	Royal Mencap	Trustee			×		Jan-22	Present	Make the Board aware should any conflict arise	19/04/2024
	Director of Strategy, Stockport MBC	Stockport MBC employee	Employee	×				2019	Present		22/04/2024
Roberts, Mark Cllr	Leader of Stockport Council, Chair of ONE Stockport Health and Care Board	None declared									
Shaw, Heidi	Stockport MBC, Member of ONE Stockport Health and Care Board	None declared									22/04/2024

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				Financial Interest	Non-Financial Professional	Non-Financial Personal	Indirect Interest	From	To		
Woodworth, Simon Dr	Associate Medical Director, Member of ONE Stockport Health and Care Board	Beech House Medical Practice	Partner	x				Jun-16	Present	Make the Board aware should any conflict arise	23/04/2024
		East Cheshire NHS Trust	Wife employed by the Trust				x	2005	Present	Make the Board aware should any conflict arise	23/04/2024

Draft Minutes

ONE Stockport Health and Care Board – Public Meeting

Date: 27 May 2026
Time: 15:45 – 16:45 pm
Venue: Upper Ground Floor Conference Room, Stopford House

Present	Apologies
Present: Cllr Mark Roberts, Leader of Stockport Metropolitan Borough Council **(Chair)** Jilla Burgess-Allen, Director of Public Health, Stockport Metropolitan Borough Council Michael Cullen, Chief Executive and Place Based Lead, Stockport Metropolitan Borough Council Natalie Dalby, Chief Superintendent, Stockport District Commander, GMP David Dolman, Associate Director of Finance, NHS Greater Manchester (Stockport) Philippa Johnson, Deputy Place Based Lead, NHS Greater Manchester (Stockport) Carmel Chambers, Chief Executive, Stockport Homes Dr Viren Mehta, GP Partner, Cheadle Medical Practice & Alvanley Family Practice, GP Chief Officer, Viaduct Care, Chair, Stockport GP & Primary Care Board, Vice-Chair, GM GP Board Karen James, Chief Executive, Stockport NHS Foundation Trust Heidi Shaw, Director, Family Help and Integration, Stockport Family – Education, Health and Care, Stockport Metropolitan Borough Council Jemma Billing, Associate Director of Quality, CHC and Safeguarding, NHS Greater Manchester (Stockport)	**Apologies:** John Graham, Chief Finance Officer, Deputy Chief Executive, Stockport NHS Foundation Trust Anthony Hassall, Chief Executive, Pennine Care NHS Foundation Trust Katherine Sheerin, Chief Commissioning Officer, NHS Greater Manchester Tim McDougall, Director of Quality, Nursing and Healthcare Professionals, Pennine Care NHS Foundation Trust Jo McGrath, Chief Executive, Sector 3 Dr Simon Woodworth, GP & Associate Medical Director, NHS Greater Manchester (Stockport) Paul Buckley, Director of Strategy and Partnerships, Stockport NHS Foundation Trust Kathryn Rees, Executive Director, Corporate and Support Services, Stockport Metropolitan Borough Council Chris McLoughlin, Executive Director, People and Neighbourhoods, Stockport Metropolitan Borough Council Sarah Dillon, Director of Adult Social Care, Stockport Metropolitan Borough Council
In attendance	
Matt Walsh, Mental Health Network Director of Quality, Nursing and AHPs, Pennine Care NHS Foundation Trust Kim Roberts, (Senior Programme Manager, Primary & Community Care & Neighbourhoods) NHS GM (Stockport) for item 11 Cath Comley Senior Project Manager for Cancer and End of Life Care, NHS GM (Stockport) for Item 12 and item 13	

Gareth Lord, Senior Strategy, Planning & Performance Manager, NHS GM (Stockport), for item 13 Fiona Smith, Strategy, Planning and Performance Programme Manager, NHS GM (Stockport) for item 14 Chris Harland, Head of SEND, Access and Admissions, Stockport MBC, for item 15		
1.	**Welcome & Apologies**	**Action**
	The Chair welcomed members to the meeting of ONE Stockport Health and Care Board. Apologies were noted as listed above.	
2.	**Notification of items of Any Other Business**	
	There were no other items of business to discuss, in addition to the items listed on the agenda.	
3.	**Declarations of Interest**	
	The Chair asked members of the Board to declare any interests held that would impact on the business conducted or changes to a previous declaration. There were no declarations of interest received.	
4.	**Minutes from previous meeting**	
	The Chair asked members if there were any amendments to the minutes or if they could be confirmed as a true record. M Walsh asked that reference to Mental Health Neighbourhood plans in agenda item 06 be changed to Mental Health Assertive Outreach plans. No further comments were received on the accuracy of the minutes. **RESOLVED:** **Subject to the change of wording noted above, the minutes of the ONE Stockport Health and Care Board meeting held on 25 March 2026 be APPROVED as a correct record.**	
5.	**Actions and Matters Arising**	
	An update was provided on open actions: LB15: Discussion on resource allocation across the system to take place at a future Board Development session. It was noted that a discussion on resource allocation across the system is due to take place after NHS Reform is completed and therefore the action will remain on the log. **Action to Remain Open.** LB20: Right Care Right Person update to Board: H Shaw informed the Board that the last update to the Safeguarding Partnership took place in June following the standing down of the local Right Care Right Person Oversight Group, due to the successful implementation of the process. The Chair thanked H Shaw for the update but added that it would be useful to	

	get an understanding of the consequences on other service areas. P Johnson responded that N Dalby had reported the positives from a GMP perspective at the previous meeting, but we need to understand the impact on other system partners particularly the mental health and acute providers as we know that there have been some issues in these areas. P Johnson added that there may be a GM system approach to this, so we need to work out whether there is something taking place across all system providers or if it needs to be Stockport specific. **Action to remain Open.**	**PJ / HS**
6.	**Place Based Lead and Deputy Place Based Lead Update**	
	M Cullen highlighted two regulatory updates since last meeting. Regulator of social housing awarded C1 grading means that the council and Stockport Homes Group are meeting the required consumer standard for tenants across different areas including safety and quality of homes, safety, quality, repairs and maintenance, complaints, and residents engagement, provides assurances of the strength of our housing services and joint working Last week we received the outcome of the CQC inspection of Adult Social, where we were rated as good. This is recognition of the hard work, compassion, dedication and professionalism of colleagues across the health and care system and across the partnership as a whole, showing a real ONE Stockport achievement. The service focusses on people needs, choice and dignity. Central to the offer is helping residents live independently, ensuring lived experience is at the heart of what we deliver and a shared commitment to working together. P Johnson informed the Board that the locality team are still moving through ICB reform process. The majority of colleagues have been slotted in across NHS GM but there still 87 people across GM who will be going through ring fenced interviews in June. Quarter one is viewed as transition period, with 01 July being the planned date when people will move into their new posts. There will be a significant impact on the team as the moves take place, particularly in the Senior Leadership Team at Stockport. We will publish a structure with names against the roles when we are in a position to do so. It is expected that we will end up with 2 vacancies out of the 17 roles in the new structure at Stockport. This is a much smaller team than previous which is causing some anxiousness across the system, however, the plan is to operationalise the new ICB operating model, particularly the strategic commissioning function delivered by the pan GM functions, working closely with the new Place Health and Care Partnerships in each locality. We will shortly be receiving a new suite of documents, which we have talked about previously, consisting of a Partnership Agreement; Outcome Framework, Place Fund, and Place Team Model. The Place Fund will operate in shadow form for 2026/27 but will consist of the Better Care Fund but with additional service lines which support Intermediate Care and Out of Hospital work. Discussions on the employment model for Stockport are still in progress. There is a 6 week time period to provide a response to the ICB on preferred employer (NHS Trust or Local Authority). There will be a period of consultation with staff in due course with a view to a decision by the end of the calendar year.	

	P Johnson advised the Board of two significant pieces of work since last reporting. The first area is Send Reforms. We have been getting our Local Area Resource Plans together in response to the National Reform Programme for SEND. The second area is Neighbourhood health. We recently participated in a NHS GM Extended Leadership Team workshop. Stockport presented at the session and demonstrated mobilisation of tests of change; working with partners and PCNs; responding to need; with an overall theme of supporting people with frailty, dementia and end of life. As part of the programme we have been able to identify people with greatest need from the data, to design responses to improve health and care using a proactive approach. We have been able to see the burden on the Acute Trust and the opportunity we have to wrap around people differently to help them be well and independent at home. We have also been able to see that 2000 people attended the Emergency Department more than 5 times in the year and need to challenge ourselves as to how we support people more effectively closer to their home. Overall, there has been some great work, noting these are small tests of change, on frailty; conveyances to hospital; and improved end of life, which has been really positively received in NHS GM. P Johnson added that a report on Neighbourhood working will be brough back to future board meeting. RESOLVED: The ONE Stockport Health and Care Board NOTED the Place Based Lead and Deputy Place Based Lead Update.	
7.	**NHS GM Acting CEO update**	
	P Johnson presented the update and highlighted the following areas: Recruitment to the Chief Executive post has paused whilst appointment to the role of Chair takes place. Colin Scales has been asked to remain as Acting Chief Executive during this period. NHS GM is investing in ADHD and Autism support for Children and Young People and is progressing with the implementation of a needs led model GM wide programme. This is a live topic for Stockport, with a complex programme of transformation across all areas, overseen by the SEND board and working with families to co-design the model. P Johnson flagged that Stockport has had initial positive response to a bid to secure capital for our Town Centre Health Hub and are developing the business case with partners. Finally, Stockport Foundation Trust have recently received an award for the Catering Services. **RESOLVED:** **The ONE Stockport Health and Care Board NOTED the NHS GM Acting**	

	CEO update.	
8.	**Stockport Families Partnership update**	
	H Shaw set out the priorities since last time which were to respond to ILACS inspection through the Continuous Improvement and Impact Plan (CIIP) and to ensure the implementation of reforms for children services. For the CIIP that was submitted to Ofsted last October 90% of actions are completed and the remaining 10% are linked to transformation and reforms and will be included in the refreshed plan. The Plan is overseen by Continuous Improvement and Impact Board which is chaired by a LGA independent chair The Children services reforms come under the Children Wellbeing & Schools Act and are challenging and will change the way we work. The overarching messages from the reforms are around early intervention, reducing escalation and improving outcomes for Children and Young Persons. H Shaw added that the key message is that the reforms are not Local Authority reforms but are system wide reforms and as partners we need to implement the right local models. **RESOLVED:** **The ONE Stockport Health and Care Board NOTED the Stockport Families Partnership update.**	
9.	**Finance Report**	
	D Dolman presented the finance report noting that Stockport reported an underspend of £0.687m (M11 £0.697m underspend) for the financial year ended 31 March 2026. The £0.687m underspend was primarily driven by reduced continuing healthcare expenditure, in line with recovery plan initiatives, alongside lower spending on mental health packages of care. This was mainly due to a reduction in the number of patients requiring observations and a decrease in the level of observations needed. Favourable movements in activity-based community contracts and primary care contracts also contributed to the underspend. Cost Improvement Plan savings for the year totalled £5.958m, which was £1.468m above the full year plan of £4.490m mainly due to additional savings from individualised packages of care reviews aligned to the financial recovery plan. In terms of the recovery plan, the locality exceeded the recovery plan trajectory presented at M4, which resulted in the locality reporting a £0.687m underspend. The Chair informed the Board that this would be David's last Board meeting, as he was leaving NHS GM at the end of May and expressed his thanks for all his hard work. The Chair noted that NHS GM will continue to support the	

	Locality Finance and asked if he could give any further details on the new arrangements. D Dolman responded that no dedicated finance lead at each locality, going forward there will be a more advisory role input to localities. Associated Directors are now covering two localities each. **RESOLVED:** **The ONE Stockport Health and Care Board NOTED the Finance update.**	
10.	**Stockport Quality Group Report**	
	J Billing informed the Board that the Stockport Quality Group was paused in December 2025, due to the work happening as part of NHS reform. The Quality function has now moved to a central function rather than being locality based. Work is on-going that will in-reach and support localities, and we expect a written plan will come to a future Board. Quality Meetings with the larger providers are starting in June, so Pennine Care and Stockport Foundation Trusts will be part of that, then we can start to understand how that will look for other providers. The plan is for the first meeting of the GM Quality group to take place in July with the first Locality Quality Group around September time. **RESOLVED:** **The ONE Stockport Health and Care Board NOTED the Quality update.**	
11.	**Six-month report / deep dive on Long Term Conditions: Diabetes / Cardio Vascular Disease (CVD)**	
	V Mehta explained that the report brings together two streams of work which we originally started through the provider partnership where it was recognised that there was a need to decide on priorities to give focus to key areas. As a result the areas of Diabetes and Cardio Vascular Disease were agreed and now sit under the Live Well Collaborative Health and Care pillar. Diabetes and CVD were picked because over past 10 years we have seen both prevalence and outcomes going the wrong direction and they both differentially impacted particularly groups. There is so much synergy between the two areas that we decided to bring both together into a single report. The report shows how we have tried to take a cross system approach including VCSFE and all system partners and to look at end to end prevention, community care, to complex specialist care. K Roberts provided more information on the programmes noting that strong collaborative relationships have been built to bring together to consider how services provided differently and meet the needs of people within their own community. In the paper there are two case studies, which show how we have been challenging ourselves to think about what difference is it making and how are we empowering and supporting residents. Our involvement in the National Neighbourhood Health Implementation Programme (NNHIP) allows us to bring some of that learning into all programmes. It was recognised that people don't just have Diabetes / CVD but usually have other long term conditions, so we needed to think more holistically and not just the condition.	

	In terms of new initiatives, the structured education programme in Cheadle neighbourhood was based on a strong engagement and feedback programme from Greater Manchester that found we need to work harder to tailor programmes to population needs including delivering in the community with their peers. We tested this approach in Urdu language and found that uptake and engagement was really strong with family members also being brought along. The challenge now is how we make this the normal way we provide services to support our residents. The report also describes deprivation and how we ensure that those living in deprived communities access services and get the support they need. There is a focus on digital technology across the locality with good uptake but we need to look at the impact that is having is the different neighbourhoods. The next step is to think about the quality of services delivered and are they having the impact we want, strengthening our neighbourhood approach and taking it to the next level so that this becomes the standard in our services and involving all partners including the voluntary sector. V Mehta then highlighted the risks to the programmes including increase in demand and cost pressures for GLP-1 which are newer treatments for weight management but can also be used for the treatment of diabetes. V Mehta noted an opportunity for weight management and how we work with communities, healthy eating, keeping active as well as the wrap around support. There are also particular challenges around transition from young people moving to adulthood and how people are navigated through the system so that there is a real all age approach with no hard cut off. With a reduction in resources available across Greater Manchester there is a challenge around capacity and V Mehta questioned how many priorities could be achieved. The Chair noted that the strength of a partnership approach to work on the challenges comes across in the report and the risks are set out well. H Shaw commented that she was interested in the transition for Children and Young People and the risk around securing the youth worker role which is critical in integrating pathways and asked if there was any way that we can secure that funding. V Mehta acknowledged the comments and added that the inability for longer term planning can have a damaging effect on our services. In Primary prevention the work we are already doing such as healthy weight pathway, active schools programme needs to be more visible. Through the live well strand we need to do further work for all age as we still have 33% children overweight. V Mehta agreed that good practice needs to be set at a young age as the impact of childhood obesity in the future will be significant. J Burgess-Allen added that it feels like there is tension between the benefits of a whole system integrated approach and traditional single disease approach which needs to be joined up. We are really good at partnership working in Stockport but that doesn't mean that everything will work if upscaled across the	

	Borough. The learning is how we approach the design our service models and interventions with our community. **RESOLVED:** **The ONE Stockport Health and Care Board NOTED the progress made on Diabetes / Cardio Vascular Disease (CVD)**	
12.	**Cancer update (Including National Cancer Plan and implications for Stockport)**	
	C Comley presented the Cancer update bringing the NHS Cancer Plan to the attention of the Board. The key areas to highlight are early diagnosis, screening uptake, reducing inequality, community models of care workforce and capacity, and data integration. Within Stockport we have a really good record of collaborative working. There is an emerging cancer strategy, which we need to make sure aligns with the national and GM priorities. There is a focus on continuing work on early diagnosis and strengthening our community models of care, reducing inequalities and adopting innovation. In Primary Care the Direct Enhanced Services focusses on early diagnosis, barriers to screening uptake; and supporting standardisation across the borough to ensure equity of access. Public Health is key to early diagnosis, so a dedicated Primary Care Engagement Officer (Public Health), has been working with practices to improve screening uptake through targeted engagement, follow up of non responders, education and pathway support. Work is on-going on Lifestyle services, supported by Public Health and includes weight loss, promoting healthy style of living; HPV catch up vaccinations and the Healthy Stockport Hub. In secondary care, Stockport Foundation Trust has a cancer improvement programme, which includes key workstreams that will help achieve aims of NHS Cancer Plan. The second De Vinci robot is coming on line which will speed up surgery, reduces risk of complications and reduces length of stay. There is an expanded use of AI to read chest x-rays, and flags those needing urgent radiology input. The is a pilot for AI and MR scans for Prostate Cancer which Stockport will be part of. We are developing Pancreatic Case finding and Bladder Cancer finding pilots. In terms of the VCSFE organisations, Beechwood is crucial for providing counselling to patients who have cancer and their families. The Moya Cole hospice who has specialist services which can be personalised to patient's needs. The Trust will soon be opening their McMillan centre to provide information and which will have counselling rooms and quiet areas. GM is a pioneer for the lung cancer screening programme. A self request lung Xray programme is starting in June in Stockport – whereby anyone over 40, registered with a Stockport GP with a long term cough can present directly to Xray. In Brinnington there has been a prostate cancer screening pilot, which had good uptake and picked up some cases which wouldn't otherwise have been identified, leading to a better outcome for patients.	

	The Chair noted that there appeared to be a lag in the screening data being from 23/25 and 24/25. C Comley responded that this is the latest information available due to the intervals between screening. V Mehta commented that with regard to screening uptake there is a spread of achievement and uptake across population, so working with the practices to improve uptake and understand the local population is key. In terms of Cervical Cancer data more up to date information is available from GP systems. V Mehta noted we have been ahead of curve in communications but with the recent reforms this resource is becoming more stretched so as partners we need to make sure we have capacity in place for when we need it. Similarly, in terms of education & training of public and staff, it could fall away so we need to think about how we keep that focus as our workforce becomes more stretched. Finally, V Mehta added that we are amongst the biggest workforce in Stockport, so as partners we need to challenge ourselves to look at our own workforce and what we are doing to encourage out staff to undertake screening and allowing them time to do so. P Johnson informed the Board that she was aware of two concerns that had been flagged. The first one was from the Cancer Alliance who run the programme for GM, regarding traction in localities. We have assured the GM Alliance that Cancer remains on our agenda. We are building a new system, different from the old one so we have to think across whole system post reform so that we don't let progress slip. The second area was from the Stockport Cancer Board who has concerns about there no longer being a GP Cancer lead on their meeting. Following NHS Reform we need to be looking how we make the required connections recognising the resource constraints across the system. J Burgess-Allen commented that there is a significant percentage of the cancers which are preventable we shouldn't forget that being overweight and obesity is a factor affecting 12 – 15 cancers and is a compelling reason for whole system approach. The Tobacco and Vape Bill has recently passed through Parliament and is in legislation now, which is significant step in protecting our children from the risk of tobacco and lung cancer. C Comley added that GM cancer will be continuing with their communication campaigns. **RESOLVED:** **The ONE Stockport Health and Care Board NOTED the Cancer update**	
13.	**2025/26 End of Year programme delivery update**	
	G Lord presented the report informing the Board that this is an end of year report which sets out how we performed against ONE Stockport Health and Care Delivery Plan in year 2 of the plan. Of the 43 aims there were 73 deliverables, 60% of which have been marked as complete, 24% are in progress. Flash reports have been included for each of the programmes, presented by the programme leads: (i) M Walsh gave the following update for Mental Health, Learning Disabilities	

and Autism:

The Adult Crisis Resolution Home Treatment Team Expansion Programme demonstrates strong progress across mobilisation, workforce implementation and pathway design, with delivery remaining on track. Completed actions include consultation closure and establishment of governance structures; however, a key dependency remained on GM-wide service specification sign-off. 35/42 staff have been recruited and we are awaiting further investment and the Executive Finance Group will ratify this at the forthcoming meeting.

Saffron is in the Pennine Care NHS Foundation Trust (PCFT) Stockport business plans that actively consider how Saffron will be utilised in the future and how this aligns to both the system's needs but also consider PCFTs wider needs and use of estate.

There are zero acute out of area placements for adults at this moment in time.

The Trust continues to work to drive down the long length of stay and work closely with adult social care partners and independent providers to get patients into the right community setting as soon as possible.

All new mental health referrals now come to the central Neighbourhood Mental Health Teams (NMHT). The huddle consists of a range of clinical staff and our VCFSE partners.

There was a significant delay in the recruitment of the VCFSE practitioners that were separately commissioned for NMHT. They are all recruited now, apart from the manager and one worker and are currently being inducted, and we will be organising an away event to fully launch and align.

Each of the 6 Primary Care Networks (PCNs) will have 1 Peer Support Worker and 1 Recovery Worker. Centrally there will also be a Neurodiverse Worker, Co Occurring Conditions Worker and an Age UK Worker.

As part of the inpatient transformation work PCFT are in the process of aligning dedicated community Consultants into the PCN catchment areas. This is being done alongside the Single Medical Model. Following this the Specialist Teams (Community Mental Health Team) will be aligned to PCNs. This will mean there will be a fully aligned and seamless neighbourhood team working from primary to specialist.

In Child and Adolescent Mental Health Services (CAMHS), PCFT have introduced the screening tool and a Neuro-diverse profiling tool. There have been no issues for the Stockport element of this. Enhanced support is in place for schools now including the up to the age of 18 years offer. We continue to work with the CAMHS waiting list. As a Trust, there has been a rise in complaints which will be examining thematically for Stockport Families, making changes if required.

(ii) C Comley gave the following update for Cancer and End of Life:

The good news stories were covered in the earlier agenda item.

EPACCS for advanced care plans for people in end of life has been paused as it is included in NNHIP and awaiting learning outcomes.

Frailty work has been paused as it is included as part of NNHIP but also to do more collaborative work around end of life and advanced care planning.

This van can is an initiative across NHS GM to talk to people about Cancer giving information out and helping people. They have just won an award at the GM Cancer Awards.

(iii) P Johnson gave the following update for Safe and Timely Discharge:

One of our providers of community beds exited the market, which we planned to mitigate by securing further commissioned beds. Unfortunately, that wasn't possible as the market didn't respond, so we had to spot purchase beds that potentially slows the process down and makes it more difficult for staff to support patients. We are working hard to mitigate the loss. We are driving a strong home first agenda, in partnership, to get people home with right support which is aligned with our strategy. There have been a number of initiatives to support people getting home.

There has been a focus on admission avoidance and supporting people in the community to take pressure of the system and keeping people well in their own home.

There have been improvements in the Single Point of Access with care co-ordination and a big programme of work around Urgent Neighbourhood Services to ensure the right pathways are in place and there's joined up care. Part of that is the Community UTC continued all year achieved about 4-5% against the 4hour standard performance. The plan is for this to continue.

St Thomas plans are being developed for an 82 bedded facility that is due to go live in January - slightly ahead of schedule.

(iv) H Shaw gave the following update for Connected Communities and Spaces:

We are developing spaces as part of the Live Well offer, developing the Stockroom offer at Cornerstone as the main Live Well centre, as well as libraries, and family hubs as Live Well spaces. There has been a programme of training over the last 3 months and making every contact count to engage residents. The comms plan is being rolled out next week.

The next phase is for VCFSE to become Live Well spaces (not sure the VCFSE will become spaces but I could be wrong? Perhaps leave it in and see if anyone contests it), which will coincide with the implementation of the Live Well Innovation Fund.

The Independent Stockport Suite at Fred Perry House is set up as realistic home environments allowing people to explore technology and equipment and will be open to the public in June. Live Well have been involved in training sessions and an on-line padlet is also available for training.

A good new story of impact is that Stockroom has noticed an increase in footfall in families and children since introducing registration of births.

(v) P Johnson gave the following update for Collaborative Health Care:

Most of this has been covered previously in the agenda.

A huge amount of work is going on around Neighbourhood Health through Area Leadership Team focussing on frailty, end of life and dementia as well as work on modern general practice and access to GPs.

(vii) V Mehta gave the following update for Improving Access to Primary and Community Care and Medicines Optimisation:

For Primary Care access - over 1 million appointments were delivered in the last year, which is enough for everyone in Stockport 6 times each, masking that some people need to be seen multiple times whereas others are not seen at all.

Pharmacy, Dental, Optometry - Improvements in dental access, and a new national contract for dental care. Optometry have led the way in a pilot for blood pressure checks as well as blood pressure checks in pharmacies.

Community services are still resetting teams, with Stockport leading the way in some of this reform. We are building these services in neighbourhoods and the Live Well offer and looking at how we deliver care tailored to population.

Medicines optimisation is embedded in Primary Care Networks, improving our reach. Stockport prescribing savings are the highest in GM.

(viii) J Burgess-Allen gave the following update for Cost of Living and Anti-Poverty:

A reminder that poverty is a fundamental driver of health inequalities.

The alliance has helped over 45,000 residents access £27 million helping to lift them out of poverty.

The Household Support Fund has now ended and replaced with the Crisis and Resilience Fund that will be used to continue to shift from crisis support to prevention. There is a smaller pot of money, but a delivery plan has been developed.

There's been a delay in poverty awareness training but this is about to be rolled out.

Anti -poverty lived experience network is being managed by Disability Stockport and coming together and meeting regularly.

(ix) H Shaw gave the following update for Maternity, Children, Young People and SEND:

	The balanced system methodology that looks at how professions are required to meet the needs of population, has been rolled out for Speech and Language Therapy and is receiving positive feedback. The same methodology is now being rolled out in Occupational Therapy and Physiotherapy. This is really important in terms of the expert and support for young people. Successful expansion of the Funded Child Programme and development of the Healthy Child Programme have resulted in the number of contacts above North West and national averages. Strong breastfeeding performance, with the infant feeding team achieving the prestigious UNICEF Baby Friendly Award. Enhanced Maternity Pathway with midwifery embedded. The Family Nurse Partnership offer is being expanded to work up a 3 tier pathway offer for all parents in Lancashire Hill and Brinnington. (x) S Wilson provided the following update for Adult Social Care: The main focus has been reducing delays in our Care Act duties to support people to live independently. Tech and digital have been a focus. We've appointed Senior Tech Officers and people with lived experience to advisory roles to help embed Tech Enabled Care in everyday life. This approach will continue to be pushed throughout the year. We have continued funding for Making Every Adult Matter working with Supported Housing with Stockport Homes Group partners. We have a Supported and Specialist Housing Strategy, that sets out how we will help people to live independently. The opening of Brookhead Lodge extra care housing scheme will enable people to remain independent and prevent residential / nursing care. We have managed to accommodate 10 patents from residential services into this facility. The One Health and Social Care Career Academy drives forward how we support the workforce for care and health in Stockport and looks at challenges in vacancies and quality of services. **RESOLVED:** **The ONE Stockport Health and Care Board NOTED the End of Year programme delivery update**	
14.	**Interim Governance Arrangements for ONE Stockport Health & Care Board (Terms of Reference)**	
	F Smith explained that the new NHS GM Operating Model became effect from 01 April 2026, however, implementation of the model within localities relies on the development of a formal Place Agreement between system partners.	

	The Place Agreement is likely to confirmed around July 2026 and until this time localities have been advised to continue with their existing Locality Board arrangements. Our current Terms of Reference have a review date of April 2026 and therefore these need to be extended until later in the year. It is proposed that the Terms of Reference are extended until July 2026, with the understanding that if the Place Agreement is operational before that date an earlier review can take place. In addition, with the closure of Healthwatch, Board representation in the Terms of Reference has been amended to reflect that there will be representation rather than specifically the Chief Executive. **RESOLVED:** **The ONE Stockport Health and Care Board APPROVED the amendments to the Terms of Reference.**	
15.	**SEND update (Including schools white paper and SEND Reform)**	
	C Harland gave the update and explained that there are five key points to highlight: Demand is still too high but as a partnership we have adapted and throughput has increased, backlogs are reducing, and performance in timeliness and statutory compliance at key transition points is strengthening and getting better, but there is still more to do. We are starting to lift out of the short term recovery phase to a more sustainable system way of working. In terms of Education, Health and Care Plans (EHCP) that means the right capacity in the right place, new roles have been created looking at quality assurance, dispute resolution, and feedback loops into the SEND function to capture lived experience and areas which can be improve. Reflection of the system as a whole is that we have so many good areas, that other partnerships don't have such as inclusion service, SEN support, we are close to all therapies being delivered through a balanced system, and we have the Neurodiversity (ND) team which is going to evolve into the ND hub. From here we need to scale, develop and mature what we do to make it robust. The next point is preparation for adulthood, Stockport Council has consulted on and adopted a Strategy, the next stage is the co-design of a delivery / action plan with workstreams stood up as soon as possible so that we can start moving on our ambitions. The final area is around SEND reforms, which is major opportunity for partners and Stockport residents. The Department for Education (DFE) has asked for local area plans to align to SEND reforms. There was an initial deadline for submission of the plans of 19th May with a final deadline of 19th June. If the plan is accepted the DFE has committed to write off 90% of debts for the cumulative deficit for high needs block, which currently stands at	

	around £70m. For the local area there are so many opportunities to do things differently. The DFE has asked us to reflect on four key areas: • Strengthening partnership and practice • Experts at hand • Sufficiency of Place Planning • Dispute Resolution and co-production V Mehta referred to EHCP and the positive progress made against the backlog but in terms of the upward trajectory of EHCP requests it would be interesting to see how we benchmark against others. In terms of the backlog there can be a differential impact in high areas of deprivation so do we have any neighbourhood data to look at this, Finally, V Mehta asked if there was any information on young people Not in Education, Employment or Training (NEET) and older young people's ability to access to good quality work after being through the system. C Harland responded that we are benchmarked on each of the areas. Stockport is an outlier mainly due to the funding level at schools and the Council, we are around 500 / 600 plans adrift from our neighbours. In terms of deprivation and the prevalence / complexity of SEND this is acknowledged in the data, follow up data and analysis, which can be provided in a future update to Board. In the outcomes framework Stockport performs favourably for NEET in relation to send learners. H Shaw confirmed that we have a focussed NEET careers team which is looking for the NEET learners post age 16. **RESOLVED:** **The ONE Stockport Health and Care Board NOTED the SEND update**	
16.	**Questions from the Public**	
	There were no questions from the public.	
17.	**Any Other Business**	
	There was no Any other Business.	

Date & Time of Next Meeting: Wednesday 29 July 2026: 13:30 – 16:45 pm, Upper Ground Floor Conference Room, Stopford House

ONESTOCKPORT
Health and Care Board

OSHCLB ACTION LOG

Action Ref	Meeting Date	Current Status	Action Description	Action Lead	Target Date	Comments
LB15	03/09/2025	in progress	Discussion on resource allocation across the system to take place at a future Board Development session	DD	25/03/2026	To be scheduled after NHS Reform completes
LB20	28/01/2026	in progress	Schedule a Board discussion on Right Care, Right Person (RCRP)	HS / PJ	25/03/2026	To determine whether there is GM wide piece of work looking at the impact of RCRP on wider partners.

NHS
Greater Manchester

Acting CEO's Report to the Board

July 2026

Part of Greater Manchester
Integrated Care Partnership

Board

15 July 2026

Report for Information

Required information.	Details.
Title of report.	Acting CEO's Report to the Board
Author.	Jenny Noble on behalf of Professor Colin Scales
Presented by.	Professor Colin Scales
Contact for further information.	gmhscp.gmicb.corporate@nhs.net
Executive summary.	The paper details updates from the Acting CEO with reference to the national, regional and local system positions.
The benefits that the population of Greater Manchester will experience.	The NHS Greater Manchester (GM) response to NHS Reform, with consideration being made through the necessary due diligence.
How health inequalities will be reduced in Greater Manchester's communities.	Proactively responding to the independent review into maternity and neonatal services at Nottingham University Hospitals NHS Trust.
The decision to be made and/or input sought.	The Board is asked to note the contents of the CEO's Report to the Board. Also, disseminate and cascade the necessary key messages and information as appropriate.
How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	Delivering key messages in the context of NHS Reform which is BAF SR10.

Key milestones.	Key messages in the context of NHS Reform.
Leadership and governance arrangements.	For consideration and dissemination by the Board.
Engagement* to date. ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	Engagement has already commenced with the GM system's key stakeholders and NHS GM staff in response to NHS Reform. Any formal decisions to be taken, will proceed through the necessary governance routes.
Financial or Legal Implications	NHS GM proceeding with the organisational change programme in response to NHS Reform.

Public engagement	Clinical engagement	Sustainability impact	Financial advice	Legal advice	Conflicts of interest	Report accessibility
No	No	No	No	No	No	No

Introduction

1.1. The paper details updates from the Acting CEO with reference to the national, regional and local system positions.

National and Regional Updates

1.2. This section of my report is aimed to update the Board on the key areas of development from a national and regional position, since the last Acting CEO's Report to the Board in May.

1.3. Board members will be aware that Donna Ockenden has published the independent review into maternity and neonatal services at Nottingham University Hospitals NHS Trust.

1.4. This is a deeply distressing report. It describes years of serious and repeated failures in care, including poor leadership and culture, a lack of accountability, unacceptable racism and discrimination and women and families being disbelieved or dismissed. It also describes extremely serious failings in post death care – failures that caused grieving families further pain and trauma at a time when they should have been treated with the utmost care, dignity and compassion.

1.5. All of our thoughts are with the women, babies and families who were harmed, bereaved and let down, and with those who have fought for years to be heard. Every woman, baby and family has the right to safe, compassionate, personalised and equitable care, and to be listened to and taken seriously when they raise concerns.

1.6. The review has taken a continuous learning approach. Nottingham University Hospitals NHS Trust has responded to findings as they emerged and has already taken steps to improve care. However, the report shows the scale of what still needs to change.

1.7. One of the most important steps the Trust has taken is to listen to women and families, and every service in the NHS must do the same. Previous reviews have repeatedly shown that women and families must be heard, believed and have their concerns taken seriously and acted on. It is more important than ever that you work closely with your maternity and neonatal voices partnerships lead and local communities to ensure your services are set up to do this well to achieve this.

1.8. The Government has announced immediate action in response to the review including roll out of Martha's Rule to all maternity and neonatal settings in England, strengthening candour and cooperation in future reviews, and Human Tissue Authority (HTA) action requiring all Trusts to review mortuary records.

1.9. I've attached a Stakeholder Briefing with an update on work to improve neonatal care services in the North West, issued on behalf of North West Safe and Sustainable Specialised Health Services for Babies & Children programme which will be reviewed by Chief Officers at their meeting on 8th July and a verbal update will be provided at Board.

Office for Pan ICB Commissioning (OPIC) – National Context and North West Arrangements

1.10. The Office for Pan ICB Commissioning (OPIC) is a new national model mandated by NHS England (NHSE) and the Department of Health and Social Care (DHSC) to be led by Integrated Care Boards (ICBs) in regions in taking on a wider strategic commissioning role. As confirmed in national guidance and the 2 March 2026 letter (Direct commissioning update), the majority of NHSE's direct commissioning functions—including specialised services, health and justice services, and vaccination and screening—are expected to transfer to ICBs from April 2027, subject to legislation.

1.11. To enable this transition to an ICB-led OPIC model while maintaining consistency and expertise, NHSE requires the establishment of seven OPICs, one in each NHS region. OPICs will operate as regional centres of commissioning excellence, enabling

collaboration between ICBs to plan and commission services at scale, improve equity and outcomes, and ensure resilience in delivering complex and high cost services. National requirements specify that each OPIC must be hosted by a single ICB on behalf of all ICBs in the region, operate through formal joint ICB governance arrangements (such as a joint committee), and support both ICB strategic and operational commissioning in a region. While OPICs will facilitate collective decision making, statutory accountability will remain with individual ICBs.

1.12. In the North West, NHS Lancashire and South Cumbria (LSC) ICB has been collectively agreed as the host organisation for OPIC, working in full partnership with NHS Greater Manchester (GM) ICB and NHS Cheshire and Merseyside (CM) ICB, which was formalised in May this year. The three ICBs, supported by the NHSE North West regional team, have established a collaborative programme to design and implement OPIC arrangements. This includes the North West OPIC Programme Development Board, which brings together senior leaders across the partner organisations to oversee delivery, linking with ICB Executive level oversight and governance arrangements. ICB Boards and related Transition Committees have been regularly informed of these developments.

1.13. The North West OPIC will initially focus on delivering the nationally mandated “OPIC Core” functions, including specialised commissioning, health and justice services, vaccination and screening, and Child Health Information Services, with the potential to extend to additional “OPIC Plus” services where this adds value in the region. The OPIC ICB partnership aims to strengthen strategic commissioning capability in line with the Model ICB Blueprint of May 2025, improve consistency and equity of services, and maximise the effective use of public resources across the region, aligned to the national NHSE Strategic Commissioning Framework.

1.14. Implementation will follow a phased approach. A “shadow” OPIC is planned to be in place by autumn 2026 to test governance, operating models and ways of working, ahead of the formal transfer of functions and staff from NHSE North West Specialised Commissioning to LSC as host ICB in April 2027 in partnership with CM ICB and GM ICB. New joint governance arrangements will also be established to reflect the expanded scope of commissioning responsibilities with consideration of revised arrangements through the current North West Specialised Commissioning Joint Committee.

1.15. Overall, the establishment of OPIC represents a significant step in enabling ICBs to act as strategic commissioners for their local populations, supported by strong regional collaboration and national standards, with the North West partnership working collectively to deliver these ambitions.

Greater Manchester (GM) System Updates

2.0 This section of my CEO Report is specifically focussed on what is happening here within the GM system.

The NHS GM Board

2.1. Since the last Board meeting in May, Sir Richard Leese has retired as Chair of NHS GM's Board. Since taking up the role of Designate Chair on 1 November 2021, and subsequently being appointed as substantive Chair on the establishment of NHS Greater Manchester ICB on 1 July 2022, he has provided committed and thoughtful leadership through a period of significant change. He has played a central role in establishing the Board, appointing and developing a diverse membership, and creating the conditions for strong partnerships with local government, the voluntary, community and social enterprise sector, and wider system partners.

2.2. He has also led the organisation through a demanding period of formal undertakings, organisational reform and financial challenge, providing steady leadership and constructive challenge at a time when the system has needed clarity, resilience and a continued focus on its responsibilities to the Greater Manchester population. His consistent focus on the wider determinants of health, joined-up care and support within neighbourhoods and communities has helped establish a strong foundation for the next phase of delivery, including implementation of the 10 Year Health Plan. I am sure the Board will join me in thanking him for his leadership, commitment and the time he has dedicated to supporting health and care across Greater Manchester.

2.3. Recruitment to appoint Sir Richard's successor is still under way. As announced earlier this year, this role is expected to also take on the Health Commissioner responsibilities for Greater Manchester, working closely with the Mayor. In light of the recent Makerfield by-election and upcoming election for the Mayor of Greater Manchester, the recruitment process has paused temporarily noting that we're in the pre-election period right now. In the interim, our Deputy Chair and Non-Executive Director, Jackie Njoroge, has stepped into the role of Acting Chair. Jackie joined the NHS GM Board in January and brings over 20 years' senior strategy and data leadership experience, alongside a strong record of public sector non-executive governance.

2.4. There is another change to notify the Board of, which is in relation to Kathy Roe, who has been appointed as Acting Deputy Chief Executive, as well as being our Chief Finance Officer. This will provide invaluable support to me as Acting Chief Executive.

2.5. New Board and Committee arrangements have now been operational for three months and a governance and leadership review is currently underway as well as Committee Development. Board development has largely been paused until we have a substantive Chair and Chief Executive in post.

NHS Reform

2.6. The 1st July marked an important milestone in our reform journey, with the vast majority of colleagues taking up their new roles in the structures. This means that we are now much more materially able to work in ways which align to our new operating model. Although it is important for the Board to recognise that there is still change taking place for colleagues, as they settle into new teams and new roles. Our 2 year OD plan is in place to support our organisation through this period. We also must stay aware to the fact that a small number of staff have now entered a significantly unsettled period where they are displaced and are currently being supported to find suitable alternative employment. Every effort is being made to find alternative roles for these colleagues, but we must not under-estimate the impact this has on individuals and on line managers.

2.7. Another milestone was reached in June, when we created a set of documents that will support the bringing to life of our Place Health and Care Partnerships (PHCPs). Known as the 'document suite', the documents collectively provide the practical framework for bringing PHCPs together around our shared priorities to improve healthy life expectancy, close the HLE gap and raise the healthiest generation of children. The document suite includes a partnership agreement, an outcomes framework, the place fund, the place team and a governance options appraisal. We have entered a period of engagement on these documents to ensure that final drafting responds to feedback from partners and stakeholders.

Neighbourhood Health

2.8. We had a successful System Leaders Group event on 29th June on Neighbourhood Health as part of Live Well. This was the culmination of our system engagement on Neighbourhood Health over the last two months. Over that period, we have met with a range of partners from across the Greater Manchester system to discuss how we can accelerate our progress on Neighbourhood Health. This included a visit from the NHS England National Lead on Neighbourhood Health (Dr Claire Fuller) on 11th June.

2.9. The key action from the engagement was for us to produce a Strategic Commissioning Framework for Neighbourhood Health – and we will take a first draft of this to NHS GM Executive Committee on 8th July and follow this up with an item at today's Board.

2.10. Over the summer, Place Leads will lead the work to finalise Neighbourhood Health Implementation Plans for each of the 10 localities – set in the context of the new Strategic Commissioning Framework. As per the National Framework , these plans will run through to March 2028 in line with the national framework with clear stepped improvements and quantifiable impact. This will include a commitment for a GM-wide launch of Integrated Neighbourhood Teams in all 10 places from the start of Q3. We will present the outputs of this work to September Board.

#NoSpaceforRacism campaign launches

2.11. The second phase of the Greater Manchester-wide No Space for Racism campaign has now launched publicly, featuring health and care staff from across our system sharing their personal experiences of racism in the workplace.

2.12. The campaign has been developed in response to evidence that around one in four health and care staff in Greater Manchester report experiencing racism at work. Incidents range from racist language and exclusion to threats and, in some cases, physical abuse. These experiences can come from patients, visitors and colleagues and can have a profound impact on wellbeing, confidence and staff's ability to provide the best possible care.

2.13. At the heart of this phase is a public-facing film featuring staff from a range of professions across health and social care, including general practice, nursing, surgery, ambulance services and social care. By sharing their lived experiences, the campaign aims to increase public understanding of the impact of racism, encourage respectful behaviour towards staff and empower colleagues and members of the public to challenge racism when they witness it.

2.14. However, the awareness campaign is only one element of a much wider programme of work. As with many of our campaigns, it is the action that sits behind the communications that will ultimately deliver lasting change.

2.15. Across Greater Manchester, partners are working together to strengthen and simplify reporting mechanisms for staff who experience racism, building on the significant progress many organisations have already made. There is also a collective commitment to present a clear and consistent anti-racism position across the health and care system, ensuring that staff, patients and communities receive the same message wherever they access services.

2.16. Work is also underway to improve how incidents that meet the threshold for hate crime are identified and escalated, with closer collaboration taking place with Greater Manchester Police. Alongside this, enhanced training and support are being developed to help staff respond confidently to incidents, whether they are directly affected or acting as active bystanders supporting colleagues.

2.17. This work complements and builds on the recommendations of the Mann Review, supporting a coordinated system-wide approach to creating a more inclusive and supportive working environment for all staff.

MenB vaccine to be offered to thousands of young people

2.18. Thousands of young people will receive protection against MenB vaccination through a one-off programme launching ahead of the 2026 academic year.

2.19. Eligibility includes those born between the 1 September 2007 and the 31 August 2008, students turning 25 after 31 December 2026 entering higher or further education for the first time, and international students under 25 starting university.

2.20. The programme will start later this month with the first dose being offered from mid-July and the second being offered in August. A new Q&A blog and eligibility asset are available, with a full communications toolkit to follow before England's booking system opens on Monday 13 July.

Health Innovation Manchester (HInM) Update

2.21. As reported at the last meeting, the HInM Strategy has recently been refreshed to respond to national and local strategic drivers in health and life sciences and HInM colleagues were invited to attend our Board strategy session in June to present this including how their plan relates to the Strategic Commissioning Strategy which was well received.

Health and Safety Oversight

2.22. I have previously committed to updating the Board on matters relating to health and safety through a standing item within my report. Since the last update to the Board, there has not been a further meeting of the Health and Safety Oversight Group. However, work on reviewing how our health and safety arrangements are delivered following organisational reform is ongoing.

2.23. Progress has also been made in implementing the outstanding recommendations from the Mersey Internal Audit Agency (MIAA) Health and Safety Audit – this includes further progress on the implementation of our new incident reporting system, which we hope to have in place by the summer, as well as reviewing our first aider and fire warden coverage following changes to our organisational structures as part of reform. Implementing these recommendations remains an important area of focus as we continue to strengthen our organisational arrangements and respond to the changes arising from reform.

2.24. The next meeting of the Health and Safety Oversight Group is scheduled to take place in August, following which a further update will be provided to the Board.

Recommendations

3.0 The NHS GM Board is asked to:

3.1. Note the contents of the Acting CEO's Report to the Board.

3.2. Provider feedback on any future topics they wish to be covered within the Acting CEO's Report to the Board in September 2026.

Stakeholder Briefing - Update

2 July 2026

An update on improving neonatal care services in the North West

Background

The NHS has been looking at how to improve neonatal care for babies and their families across the North West. This work is being led by the North West Safe and Sustainable Specialised Health Services for Babies and Children programme, on behalf of the three NW ICBs including NHS Cheshire and Merseyside, NHS Greater Manchester, and NHS Lancashire and South Cumbria.

Although neonatal staff are working hard and provide lots of great care, at the moment the majority of neonatal units in the region do not meet national minimum activity standards in terms of the number of babies they care for.

This matters because evidence shows that babies receive better health outcomes and are less likely to develop life-long disabilities when their neonatal care is provided by a very specialised team, who perform the same procedures more frequently.

There is also too much variation in the levels of specialist care being provided by different neonatal units in the region, and the number of cots provided does not match current or expected future levels of demand for care.

The NHS wants to improve the quality and consistency of neonatal services to ensure that they are sustainable for the future, and that all babies and families receive the same high quality of care, wherever they live or are treated in the North West.

What has happened so far?

Although it's likely that changes will need to be made as a result of this review work, it's important to stress that this improvement work is still at an early stage of development, and there are no plans or proposals for any service changes just yet.

An updated Case for Change document was developed and published in December 2025, which describes the challenges facing the region's neonatal services in more detail.

You can read the full version of the Case for Change, as well as a summary version and an Easy Read version here: NHS England — North West » Improving neonatal services in the North West

Staff and parent/carer engagement

Following the publishing of the Case for Change, a staff engagement period was held between January and March 2026.

A series of staff listening sessions were delivered, which focused on hearing from NHS staff with experience of working in or alongside neonatal care services in the North West, in order to understand their thoughts and views on the issues set out in the case for change.

In March and April 2026, the programme also held a series of focus groups and one-to-one discussions with parents and carers who have used neonatal services in the North West, in order to hear their reflections on the case for change, and learn more about their own experiences of care – including what currently works well, and what could be better for families.

The findings highlighted a broad level of support for the case for change and the principle of delivering more centralised care from fewer, more specialist units, especially if it meant that care was made better, safer and more consistent for babies.

However, most parents felt that careful thought needed to be given to how changes could be made without disadvantaging families or requiring them to carry extra burdens such as further travel and accommodation costs, or more separation.

The findings of this insight work have been summarised into a report, which is available to read on NHS England North West's website here:

North-West-Neonatal-Critical-Care-Review-Parent-Carer-Engagement-June-2026-FINAL.pdf

Next steps

Feedback gathered from these staff, parent and carer discussions will be used to help inform the next phase of planning and development.

This will include a number of workshop events which will be held over summer to help develop a long-list of potential options for how neonatal services could look in the future, and then refine this into a short-list.

We continue to be committed to involving staff, families and wider stakeholders at every stage as this work progresses – and we will keep you updated about further key developments.

If you have any further questions in the meantime, please contact the programme team via: england.nw-specialisedbabieschildren@nhs.net

Note*:* On Amos Report

We also note the publication of the Baroness Amos report this week and welcome its findings. Whilst many of the recommendations fall outside the scope of this programme of work, we are committed to considering any relevant findings where appropriate. Responsibility for taking forward improvements to neonatal services will sit with Operational Delivery Networks (ODNs) and provider Trusts, who are best placed to implement changes at a service level.

Flash Report from Carers Partnership Board

Report To (Meeting):	One Stockport Health and Care Board		
Report From: (Committee Chair)	Bethan Kelly & Steve Gear (Co-Chairs)		
Drafted by: (SRO)	Sarah Dillon		
Date:	29 July 2026	**Agenda Item No:**	08

Decision		**Assurance**		**Information**	**X**

Date of meeting
Summary of all meetings in the past 12 months
Summary of updates provided during meeting
The Carers Partnership Board was established three years ago to provide strategic leadership and strengthen the identification, recognition and support of unpaid carers across Stockport. Bringing together senior representatives from health, adult social care, primary care, the voluntary, community and social enterprise (VCSE) sector, and local authority services, the Partnership provides a coordinated approach to influencing system-wide change and ensuring unpaid carers remain a priority across strategic decision-making. The Board receive regular updates on intelligence gathered through the Carers Network, where carers with lived experience share the challenges they face and identify opportunities for improvement. This insight is presented in the form of an ongoing “issues list” which is RAG rated and regularly updated at each Board meeting and continues to inform the Partnership's priorities and drive collaborative action across organisations. Progress in the last 12 months has been significant on several key initiatives, including the development and launch of the Carers Portal, which provides a single point of access to information, advice and support, particularly for newly identified carers, and the Carers Charter which is being developed to establish a shared commitment across organisations to recognise, involve and support carers consistently which is approaching final sign off with a view to being indorsed by leaders of SMBC and associated services to demonstrate a service wide commitment. The Partnership has recently been exploring how we can collectively improve carers' consent processes, helping professionals across health and care services engage more effectively with carers, while respecting confidentiality and enabling carers to advocate on

behalf of the people they support where appropriate, we have created consent letters for many different scenarios for services to use to ensure consistency, which is both trauma informed and transparent across services.

Members have also regularly received an update on the commissioning of Short Breaks, to develop a more sustainable offer that enables carers to access meaningful respite, recognising its importance in preventing carer burnout and supporting people to remain living independently at home. This has been a strong example of collaboration with carers and is now launched for Stockport carers and their cared for to access.

The continued expansion of Think Carer training has also been a highlight, supporting professionals, employers and community organisations to identify unpaid carers earlier, improve awareness of carers' rights and needs, and embed a more carer-aware culture across Stockport. Since its launch in June 2025, we have created over 350 Carer Champions within Stockport across all sectors and provided additional support and signposting to many organisations who have requested further support including creating their own employee networks for unpaid carers.

The Partnership is committed to collaborative working across health, social care and the VCSE sector, recognising that improving outcomes for unpaid carers requires a whole-system approach. Volunteers with lived experience of caring continue to play a vital role in shaping priorities, co-producing solutions and ensuring that carers remain at the heart of service design, delivery and continuous improvement of our offer and support to Stockport Unpaid Carers.

Key decisions taken

• Carers' voices continue to held in the highest regard directly influencing system improvements through the Carers Network and Partnership Board, having established a strong feedback loop to inform decision making.
• Development continues on the Carers Portal to improve access to information and support as and when additional information, resources, support or feedback is received to continue to enhance the quality of information and support available to Carers via the portal.
• Think Carer training continues expand across Stockport to raise awareness across workplaces and community settings, creating a carer friendly place to live and work with Thanks to Live Well Funding.
• Partnership representation continues across GP, Primary and Secondary Care, Adult Social Care, VCFSE and wider system groups alongside experts by experience to embed carers' needs within strategic programmes and decision making.

Matters referred to the Locality Board for approval, debate or further consideration

To continue to endorse and support the Partnership.

Risks and mitigations raised

Decline in representation and input across the key partners.

ONESTOCKPORT
Health and Care Board

Community Voice Partnership Update

Report To (Meeting):	ONE Stockport Health and Care Board		
Report From (Executive Lead)	Sarah Dillon, Executive Director Adult Social Care and Health and Statutory DASS Kathryn Rees, Executive Director Corporate and Support Services		
Report From (Author):	Richard Currie, Adult Social Care Co-production Lead Carolyn Anderson, Children's Transformation Lead		
Date:	29 July 2026	**Agenda Item No:**	09
Previously Considered by:	ONE Stockport Health and Care Executive Group		

Purpose of the report:

To provide an update on coproduction, participation and community engagement activity over the last 12 months.

Key points (Executive Summary):

Over the last year, Stockport has continued to strengthen its commitment to coproduction, participation and community-led decision making across the partnership. This report is not exhaustive of all of the work undertaken by partners but provides some highlights from Adult Social Care, Stockport Family and Live Well.

People with lived experience have played a central role in shaping services, governance and strategic priorities, contributing to Stockport's 'Good' CQC assessment in Adult Social Care, where coproduction across the council was recognised as a particular strength. We have embedded lived experience leadership across partnership boards, expanded opportunities for residents, children, young people and families to influence decisions, introduced innovative approaches such as paid Technology Enabled Care leadership roles, and strengthened mechanisms for engagement through Equity Networks, Live Well Neighbourhood Networks and Pride in Place.

This work is increasingly translating into tangible change. People with lived experience are influencing commissioning, safeguarding, housing, technology-enabled care and service improvement; children, young people and families are shaping strategies, community safety initiatives, SEND reform and participation approaches; and neighbourhood and equity networks are helping under-represented communities influence local priorities and services. Across the system, the focus has shifted from consultation towards a more mature model of shared design, decision making and community leadership, helping to strengthen prevention, independence, community connection and resident voice.

Our ambition is to drive coproduction as a golden thread across public services and partnerships in Stockport. Our priorities include strengthening the diversity and reach of participation, improving how we measure impact, ensuring lived experience remains central to decision making and resource allocation, and supporting greater community power. Achieving this will require continued commitment from all partners to create the conditions for genuine power-sharing with residents, communities and people who draw on support.

BACKGROUND PAPERS
Enc. Full report.
Anyone requiring further information on the full report should contact Richard Currie richard.currie@stockport.gov.uk (Adults) or Carolyn Anderson (CSS, Stockport Family) carolyn.anderson@stockport.gov.uk

What is required:

The ONE Stockport Health and Care Board is asked to:

- **Note** the update

Decision	**X**	**Discuss/Direction**	**X**	**Information/Assurance**	

Aims (please indicate x)		
Which integrated care aim(s) is / are supported by this report:	People are happier and healthier and inequalities are reduced	**X**
	There are safe, high-quality services which make best use of the Stockport pound	**X**
	Everyone takes responsibility for their health with the right support	**X**
	We support local social and economic development together	**X**

Conflicts of Interests	
Potential Conflicts of Interest:	None

Risk and Assurance:	
List all strategic and high-level risks relevant to this paper	This report covers all aspects of the ONE Stockport Health & Care Board remit and therefore all locality risks are relevant to this paper.

Consultation and Engagement:	
Local People / Patient Engagement:	N/A
Workforce Engagement:	N/A

ONESTOCKPORT
Health and Care Board

STOCKPORT COUNCIL UPDATE ON COMMUNITY VOICE PARTNERSHIP

Report of the Executive Director of Adult Social Care & Health and Executive Director for Corporate and Support Services

Coproduction Across Stockport Adult Social Care 2025–26

1. What have we done in the last 12 months?

1.1 People with lived experience were key partners in preparing and presenting evidence for Stockport's CQC assessment. The assessment recognised Adult Social Care as 'Good' and identified coproduction as an area of strength. We have strengthened lived experience leadership across partnership boards, with co-chairing arrangements in place across all our boards, i.e. Making It Real, Adult Safeguarding, Safeguarding Quality Assurance, Mental Health and Wellbeing, Autism, Learning Disability and Age Friendly Partnership Boards.

1.2 The Making It Real Board has increased in size and diversity and has supported wider priorities, including development of the Housing Subgroup and work to promote the Live Well Directory through co-created videos and written stories.

1.3 We established and embedded a Coproduction Remuneration and Payments Policy, enabling the Council to formally recognise and appropriately compensate people for their time, expertise and contribution.

1.4 As part of the Year of Technology Enabled Care, two paid TEC Lead roles were created. Both roles are held by people with direct lived experience of Adult Social Care and are based at the 'Living Independently in Stockport Suite', working with colleagues to promote technology that supports independence at home.

1.5 People with lived experience have contributed to key service and governance activities, including the interview, selection and onboarding process for the new Chair of the Adult Safeguarding Partnership Board.

1.6 We have continued to co-deliver our practice model training based on Gloriously Ordinary Lives with the co-chair of the Making It Real Board and used wider forums, including the Preparing for Adulthood workshop, to promote the benefits of coproduction.

1.7 The Coproduction Lead has supported practice development by attending peer review meetings with social workers and social care officers, creating space to positively challenge, think creatively and promote more person-centred approaches.

1.8 The Stockport Coproduction Lead continues to build regional and national relationships through Think Local Act Personal, ADASS, Social Care Future, the Social Care Institute for Excellence and an informal national network of Coproduction Leads.

1.9 The Executive Director of Adult Social Care and Heath and the Coproduction Lead have worked with Think Local Act Personal (TLAP) and Doncaster colleagues to deliver two national webinars sharing Stockport's approach to coproduction.

2. What difference has it made?

2.1 People with lived experience are having greater influence over decisions that affect them, including policy, commissioning, housing, technology-enabled care, safeguarding prevention and wider service improvement.

2.2 Coproduction is becoming more visible and expected across Adult Social Care and wider partnerships, supporting a shift from consultation towards shared design and decision-making where appropriate.

2.3 Partnership board arrangements create opportunities for people to build confidence, skills and leadership experience, with coproduction acting as a route into wider participation and, in some cases, paid roles.

2.4 Work linked to Live Well and Technology Enabled Care is strengthening community connection, promoting independence and supporting a greater focus on prevention and early help.

2.5 Regional and national engagement has enabled Stockport to share practice, learn from others and contribute to wider improvement in coproduction across Adult Social Care.

3. How do we know?

3.1 Evidence is drawn from CQC assurance activity, feedback from people with lived experience, partnership board activity, surveys, engagement work and the delivery of specific coproduced projects.

3.2 People with lived experience provided direct feedback to CQC, contributing to the positive assessment of Stockport's approach and supporting the view that coproduction is an established strength.

3.3 Partnership boards, co-chairing arrangements and project delivery provide evidence that lived experience is influencing priorities, service development and decision-making across a wider range of programmes.

3.4 Stockport's remuneration approach has also influenced practice beyond the borough, with other local authorities seeking support to develop their own policies and processes.

3.5 We recognise the need to strengthen how impact is measured. The next phase will develop a clearer mix of qualitative and quantitative measures to demonstrate outcomes, learning and value.

4. Where next?

4.1 Embedding coproduction as a consistent "golden thread" across the Council, NHS, schools, housing providers, the voluntary sector and wider One Stockport partnerships.

4.2 Further strengthen the use of lived experience in service design, commissioning, technology-enabled care and safeguarding prevention, ensuring people remain central to decision-making and resource allocation.

4.3 Expand the reach and diversity of coproduction by drawing on strengths, assets and lived experience across communities and voluntary sector organisations, including global majority and LGBTQ+ communities.

4.4 Develop clearer impact measures so the connection between coproduction activity, improved outcomes, greater independence and effective use of public resources can be demonstrated more consistently.

4.5 Encourage our own leaders and leaders across partner organisations to embrace coproduction principles, move beyond consultation where appropriate and create opportunities for genuine power-sharing with residents, communities and people who draw on support.

4.6 Work with North West ADASS to explore a lived experience parliament for coproduction, drawing on the model used in the West Midlands.

4.7 Ensure people with lived experience have a key role in the award of the contract for the public access space within the St Thomas' development.

Coproduction Across Stockport Family 2025–26

5. What have we done in the last 12 months?

5.1 Over the last year, Stockport Family has strengthened its approach to participation and co-production as part of the Continuous Improvement and Impact Plan, Families First reforms and wider transformation activity. A participation audit was completed across the partnership, mapping existing engagement activity, identifying gaps and establishing a shared approach to participation and coproduction. A Participation Delivery Plan has been developed alongside the creation of governance arrangements to coordinate and oversee activity across the system.

5.2 The Stockport Co-production Charter has been refreshed through extensive engagement with children, young people, parent carers, practitioners and voluntary sector partners. This included co-design with L!sten (Youth Alliance), participation from a young person with lived experience of SEND as part of the core project team, feedback from around 1,500 young people and more than 180 parent carers.

5.3 We have continued to strengthen and connect participation routes including Youth Alliance, Young Inspectors, Children in Care Council, SK-Inc, Care Leavers Forum, Parent Reference Groups, PACTS and Empowering Parents Empowering Communities. Work has also begun to align participation activity across Family Help, SEND Reform and Families First Partnership Programme workstreams.

6. What difference has it made?

6.1 There is now greater consistency and visibility of participation across Stockport Family. The refreshed charter provides a shared language and expectations for how professionals work alongside children, young people and families.

6.2 Young people and families have influenced priorities for the charter refresh, informed SEND reform planning, contributed to service reviews and shaped improvement activity. The work has also strengthened our ability to identify where voices are under-represented and target future engagement activity more effectively.

7. How do we know?

7.1 Evidence includes participation audit findings, engagement data from the charter refresh, increasing alignment of participation activity across programmes and feedback from children, young people and families gathered through established forums and surveys. The partnership now has a clearer understanding of participation activity, gaps and opportunities through the completed audit exercise.

8. Where next?

8.1 Next steps are focused on embedding participation and co-production as a consistent expectation across all services and programmes. This includes implementing the Participation Delivery Plan, establishing the Voice and Experience Steering Group, developing workforce capability, strengthening feedback loops and introducing clearer measures of impact so that children, young people and families can see how their involvement has influenced decisions and services.

8.2 Young people's views are gathered through the annual Youth Summit, the L!sten Youth Alliance, Young Inspectors, children in care participation activity, SEND participation arrangements and ongoing engagement through schools, youth providers and community organisations. Feedback is used to influence strategy, commissioning, service design and delivery.

8.3 The examples below demonstrate how issues raised by young people have resulted in tangible action across Stockport.

What young people told us	**What we have done**
Young people want to be listened to and involved in decisions that affect them.	Established a **Youth Advisory Board** and are developing a new **Youth Strategy** directly informed by young people's views. Young people have also helped shape the refreshed **Coproduction Charter**, ensuring expectations around listening, communication and accountability are embedded across services.
Young people want professionals to work with them	Through the Coproduction Charter refresh, over **1,500 young people** helped identify the values and behaviours they expect from professionals. Young people were involved in designing the

in a more open, honest and respectful way.	survey, shaping findings and testing proposals. The resulting charter emphasises kindness, empathy, honesty, regular communication and accountability.
Young people wanted participation to include children and young people with SEND and lived experience.	A young person with lived experience of SEND was employed as part of the Coproduction Charter task and finish group. Engagement also included specialist colleges, SEND Connections partners, children with complex needs and care experienced young people.
Young people wanted more safe places to go and positive activities in their communities.	Warm Spaces were established across Lancashire Hill, Reddish, Adswood, Offerton and Brinnington. Following feedback from young people, the programme was extended beyond its planned end date and will continue through to the end of the academic year. Twelve summer holiday activities will also be delivered in local community locations.
Some young people reported feeling unsafe in parts of the borough.	Detached youth workers have been deployed in neighbourhoods experiencing higher levels of anti-social behaviour and where young people report concerns about safety. Additional targeted youth work has taken place around Stockport Interchange and railway station.
Young people wanted more support around risk, exploitation, substance misuse and community safety.	Outreach has been undertaken jointly by detached youth workers and Mosaic Young People's Substance Misuse Workers at Stockroom, Lancashire Hill and the transport interchange, providing harm reduction advice, education and access to support. Young people identified through police activity can also be referred through the **PIED (Prevention, Intervention, Education and Diversion) Panel** to provide early support and diversion from risk. Police-led disruption activity and interventions to tackle exploitation and criminality have also been strengthened.
Young people highlighted concerns about knife crime, hate crime and online safety.	Schools-based delivery has been expanded covering knife crime, hate crime and online safety. Virtual Reality intervention programmes are also being used to deliver targeted knife crime education and prevention work.

Transport can prevent young people accessing education, activities and opportunities.	Practical solutions have been implemented where barriers have been identified, including supporting a young person moving from Year 6 to Year 7 in Brinnington to access an IGO pass to improve travel and participation.
Young people wanted more opportunities to be active and take part in local activities.	Additional football activity has been developed through the voluntary and community sector and new football and boxing provision has been commissioned in response to local demand.
Young people wanted more opportunities to develop skills, influence services and prepare for adulthood.	The Young Inspectors programme enabled eight young people with SEND to undertake an eight-week programme and carry out quality assurance visits of HAF provision. In addition, HAF and VST worked together to support seven care leavers into employment opportunities during the summer programme.
Young people with SEND wanted more inclusive opportunities and better access to activities.	SEND-specific HAF places have been increased and additional provision commissioned. Inclusion training has been delivered through Seashell, SEND Connection Days have been held with families, and support has been provided to activity providers to increase inclusion and accessibility.
Care leavers told us that moving into independent accommodation can feel isolating and that they do not always feel safe when living independently for the first time.	In response to feedback from care leavers, Stockport introduced an offer of a Ring doorbell for young people moving into independent accommodation. This practical change was developed directly from care leaver feedback about safety, reassurance and confidence when living independently. Alongside wider support from Personal Advisers and accommodation services, this demonstrates how young people's experiences are influencing the support offer available to care leavers.
Young people told us they wanted support to develop positive activities in their community and improve local spaces that matter to them.	A group of young people with an interest in fishing at Sykes Reservoir, Edgeley, approached the North West Anglers Alliance for support. Working alongside the young people, Stockport Council has supported funding applications aimed at improving the reservoir and creating opportunities for local young people. One of the young people attended Task Day training and has since taken on a leadership role coordinating and supervising maintenance activities, enabling wider

	participation from young anglers and volunteers whilst ensuring work can be undertaken safely. The longer-term ambition is to secure a lease arrangement for the reservoir, enabling the group to access external funding and take greater ownership of the site for the benefit of the local community.

Equity Networks, Neighbourhood Networks and Engagement Through Live Well

9. What have we done in the last 12 months?

9.1 Over the last year, Stockport has continued to invest in and develop its Equity Networks and Live Well Neighbourhood Networks as key mechanisms for community engagement, co-production and resident influence. Equity Networks now bring together communities including Young People (L!sten), LGBTQ+, SEND, Stockport Race Equality Partnership and the Multi-Faith Network, all chaired by people with lived experience and supported to identify and influence priorities that matter most to their communities.

9.2 Alongside this, Live Well Neighbourhood Networks have been established and embedded across Stockport's neighbourhoods, bringing together residents, VCFSE organisations, public services, schools, health partners, businesses and councillors to identify local priorities, build relationships and coordinate action. Network meetings, community conversations and neighbourhood intelligence have informed emerging neighbourhood action plans and delivery priorities.

10. What difference has it made?

10.1 The networks have created stronger connections between communities, voluntary organisations and public services. They have improved opportunities for under-represented communities to influence strategy and service design whilst providing routes into support, information and neighbourhood-based activity. Through Live Well, networks are increasingly acting as a bridge between resident voice, community assets and statutory services.

10.2 Neighbourhood Networks have evolved from relationship building to identifying priorities and supporting coordinated delivery around issues such as health inequalities, digital inclusion, community wellbeing and access to support.

11. How do we know?

11.1 Attendance and engagement levels across neighbourhood networks have remained strong, with evidence of sustained participation from VCFSE organisations, residents and statutory partners. Feedback highlights the value of networking, shared learning and improved collaboration across sectors. Community conversations,

neighbourhood profiles and network intelligence are increasingly informing local planning and priorities.

11.2 The Equity Network review has also provided a clearer understanding of the contribution networks make in amplifying lived experience, improving engagement and influencing strategic priorities.

12. Where next?

12. 1 The next phase is focused on moving from engagement to delivery and influence. This includes strengthening links between Equity Networks, Family Hub Networks, Live Well Neighbourhood Networks and partnership governance; embedding community voice in neighbourhood action plans; improving feedback loops; and ensuring engagement activity translates into visible change for residents.

Pride in Place

13. What have we done in the last 12 months?

13.1 Stockport has been selected as part of the national Pride in Place programme, bringing long-term investment and community-led decision-making into Brinnington. During the last year significant preparatory work has taken place, including stakeholder mapping, partner engagement, governance development and progression through the government's early adopter programme. Work has also focused on aligning Pride in Place with the wider Live Well neighbourhood approach.

13.2 The programme has begun establishing arrangements for a community-led Neighbourhood Board, resident engagement and future investment planning, with the council acting as the accountable body whilst supporting local leadership and community ownership.

14. What difference has it made?

14. 1 Although the programme remains in its establishment phase, it has already strengthened conversations about community power, local leadership and resident-led decision-making. Pride in Place has provided an opportunity to connect regeneration, community development and Live Well ambitions around a shared focus on belonging, neighbourhood improvement and resident influence.

14.2 Early work has also helped build local momentum and engagement around long-term investment opportunities in Brinnington.

15. How do we know?

15.1 Evidence includes successful progression through programme milestones, engagement activity with partners and residents, application to the early adopter programme and the establishment of governance arrangements to support community-led delivery.

16. Where next?

16.1 The focus for the coming year will be establishing the resident-led Neighbourhood Board, developing shared priorities with local communities and beginning implementation of the long-term investment programme. Close alignment with Live Well, neighbourhood networks and wider community development activity will help ensure investment is shaped by residents and connected to existing strengths and priorities within Brinnington.

Pride in Place brings £20 million in funding over the next decade to Brinnington. We have successfully recruited a Chair of the Pride in Place Board – Nicola Thompson, a passionate resident who was born-and-bred in Brinnington. Recruitment to the Pride in Place board is currently underway, the board will be made up of people who live or work in Brinnington who will shape local priorities, influence decisions and support improvements in the area.

Healthwatch Stockport Update

17. What have we done in the last 12 months?

17.1 Previous service ceased operation on 31st March and Healthwtach Bury have been commissioned as a new provider to establish Healthwatch Stockport Borough (HWSB), with work commencing from 1st June 2026.

17.2 Since launching 6 weeks ago, HWSB has focused on building a foundation for the new contract.

- Team Building: Recruited 2 Community Engagement Officers to lead outreach.
- Strategic Engagement: Held key introductory meetings with strategic partners (e.g., ICB, Council) to align our work with the One Health and Care Plan.
- Attended the Health and Wellbeing Board meeting in June and linked in with other local boards to plan attendance
- Volunteer Mobilisation: Recruited 6 new volunteers who have already supported our engagement work.

What difference has it made & how do we know? (Last 6 Weeks)

- Reached Vulnerable Communities: Healthwatch has conducted 6 pop-up events and 2 listening events in locations where the 'least heard' communities and individuals frequent, gathering 60+ pieces of feedback.
- Impact: Heard experiences from older residents, families, the homeless, and vulnerable migrants.
- Evidence: Feedback captured, showing a spectrum from excellent care to concerns about maternal care and GP access.
- Established a Visible Presence: A soft launch at the "Live Well Independently" facility allowed networking and promoted the service to professionals and the public.
- Appointed 3 part time community engagement officers to work across Stockport borough (starting mid July 2026)

Impact for People, Organisation & System

- People: HWSB is giving voice to "seldom heard" groups, directly addressing health inequalities as required by the service specification.
- Organisation: HWSB is building a credible, independent voice and demonstrating ability to "influence commissioning and local service provision."
- System: HWSB is strengthening the "Live Well" model by ensuring resident feedback is heard by decision-makers.

What next?

- Targeted Engagement & Priority Projects: Use insights from recent events, coupled with more insight yet to be gathered, to identify and deliver priority projects (for example it could be GP waiting times and access, maternity and neonatal care, mental health). We will develop an Annual Workplan setting out clear priorities based on local evidence, with regular progress monitoring against KPIs.
- Strategic Influence & System Integration: Embed HWSB work within the One Health and Care Plan framework to influence commissioning. We will:
- Continued attendance at Health and Wellbeing Board meetings and evidence contribution to decision-making.
- Engage with Stockport ICB structures and contribute to the Joint Strategic Needs Assessment (JSNA) .
- Collaborate with other Healthwatch providers across the ICS to share best practice and intelligence.
- Expand Volunteer Capacity: Continue growing the HWSB volunteer network to support engagement activities. We will:
- Recruit, train, and support volunteers, building on the initial cohort of 6.
- Develop a volunteer training programme to build skills and experience.
- Ensure volunteers are involved in governance and decision-making where appropriate.
- Deepen Insights & Reach: The new Engagement Officers will focus on reaching diverse groups to fulfil our statutory duties. We will:
- Develop a Communications and Engagement Strategy that actively involves all residents, with specific approaches for marginalised and seldom-heard communities.
- Align engagement methods with the Public Sector Equality Duty and ensure they are inclusive and accessible.
- Deliver 'Enter and View' Programme: Plan and deliver Enter and View visits to health and social care settings (e.g., GP practices, care homes) to observe service delivery and gather evidence on patient experiences. We will:
- Agree visit priorities with commissioners.
- Publish reports with recommendations for improvement following each visit.
- Strengthen Signposting & Information: Develop a comprehensive signposting and information service to support residents in making informed decisions. This will include:
- A visible presence across Stockport through community drop-ins and events.
- Clear contact routes, including a local rate telephone number.
- A 'no wrong door' approach, assisting with all health and social care enquiries.

- Publish Annual Report: By 30 June 2027, publish a statutory Annual Report setting out how HWSB has fulfilled its responsibilities, engaged with diverse communities, demonstrated impact, and spent allocated funding. This will be shared with Healthwatch England, the Council, ICB, CQC, and other statutory bodies.
- Complete Healthwatch Quality Framework: Undertake the Healthwatch Quality Framework self-assessment within year one and develop an action plan to drive continuous improvement, with annual review thereafter.

Place Health and Care Partnership Board Document Suite

Report To (Meeting):	ONE Stockport Health and Care Board		
Report From (Executive Lead)	Philippa Johnson, Place Partnership Director, NHS GM (Stockport)		
Report From (Author):	Fiona Smith, Place Partnership Lead, NHS GM (Stockport)		
Date:	29 July 2026	**Agenda Item No:**	10
Previously Considered by:	ONE Stockport Health and Care Executive Group		

Purpose of the report:

To engage Stockport system partners in discussions to inform the final drafting of the Place Health and Care Partnership (PHCP) document suite.

Key points (Executive Summary):

NHS GM has developed a suite of documents designed to describe how we will continue to lead through reform, respond to national policy change and deliver locally for the people and communities we service. The intention is that following a period of engagement and feedback a final iteration will be signed up to and adopted by all partners at each Place.

The document suite consists of the following five documents:

- Place Partnership Agreement
- Place Outcomes Framework
- Place Fund
- Place Team Framework
- Place Governance Options:

The ONE Stockport Health and Care Board reviewed and discussed a previous draft iteration of the PHCP document suite at its February 2026 meeting.

Initial feedback from localities has helped to shape later iterations, with the current version, as included in this paper, discussed at NHS GM Executive Committee on 10th June 2026. It has been agreed that to allow meaningful discussions at Place, engagement will take place through July and August with a final date for submission of feedback of Friday 21st August 2026. It is envisaged that the suite will then be finalised in September, with formal sign off by all required partners in Places happening in October.

The timeline for completing this work is summarised in the table below: -

Time period	What	Lead	Purpose
22nd July 2026- 21st August 2026	Period of engagement on the 'Final Draft'	PBLs , PP Directors (locally), Chief Officers, Programme Director (Pan-GM)	Ensure all partners are fully sighted, can influence the refinement of the document suite ready to sign off.
24th August- 25th Sept	Outcome report and finalisation	Sprint team; • Programme team • Lead DPLs	Collate all feedback into a single refined and finalised document suite ready for sign off.
Oct	Formal signatures	Place Leads and PP Directors	Formal sign up from all partners. (inc NHS GM as a partner in each place)
Nov	NHS GM IC Board (Public)	Charlotte Bailey	Confirmation to NHS GM ICB that all places have signed up and any amends constitution.

What is required:

The ONE Stockport Health and Care Board is asked to:

- **Note and provide feedback** on the suite of Place Health and Care Partnership Documents, to allow for the collation and submission by 21st August.

Decision	**X**	**Discuss/Direction**	**X**	**Information/Assurance**	

Aims (please indicate x)		
Which integrated care aim(s) is / are supported by this report:	People are happier and healthier and inequalities are reduced	**X**
	There are safe, high-quality services which make best use of the Stockport pound	**X**
	Everyone takes responsibility for their health with the right support	**X**
	We support local social and economic development together	**X**

Conflicts of Interests	
Potential Conflicts of Interest:	None

Risk and Assurance:	
List all strategic and high-level risks relevant to this paper	This report covers all aspects of the ONE Stockport Health & Care Board remit and therefore all locality risks are relevant to this paper.

Consultation and Engagement:	
Local People / Patient Engagement:	N/A
Workforce Engagement:	N/A

NHS
Greater Manchester

Place Health and Care Partnerships Summary Slides

Part of Greater Manchester Integrated Care Partnership

About This Document and Contents

This document sets out the Place Health and Care Partnership (PHCP) proposals in NHS Greater Manchester, explaining how strategic commissioning, place-based working, governance, funding, teams and outcomes fit together to deliver improved population health and reduced inequalities. It provides a single, coherent framework to clarify roles, decision-making and accountability within the PHCPs and across Place and GM-wide partners.

NHS
Greater Manchester

Executive Summary and Introduction

Part of Greater Manchester
Integrated Care Partnership

Foreword

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

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

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

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

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

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

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

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

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

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

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

Professor Colin Scales
Acting Chief Executive
NHS Greater Manchester

NHS
Greater Manchester

Describing how strategic commissioning and PHCPs will work in future

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

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

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

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

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

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Introducing the PHCP Document Suite

A diagram to show the relationship between the documents in the suite

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Partnership Agreement

The overarching document that sets out the shared intent, principles and formal basis for Place Health and Care Partnership working. It sets the tone, expectation, describes the behaviours and guide rails for how PHCPs will be taken forward. It holds the overall framework together and is the primary document for sign-off by colleagues at place.

Place Fund

Sets out how financial decision-making, commissioning and investment will support place ambitions

Describes the 2026/27 Shadow Year and the journey toward the desired future state.

Outcomes Framework

Articulates what the PHCPs are uniquely accountable for delivering.

Describes interdependencies with other partners and strategies.

Place Team

Role, purpose and core capabilities of Place Teams within GM Place Partnerships

Sets out how multi-partner teams work together to deliver

Describes flexible models for how Place Teams can be structured and operate in different local contexts

Place Governance Options Appraisal

Is a working document currently being finalised.

Describes governance options for NHS GM's relationship with Place Partnerships

Compares mechanisms for managing Place Fund, Place Team, and outcomes delivery

Logic Model - Place Delivery

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Inputs

Governance inputs:

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

Investments into:

- Place Teams
- Place Grants
- Neighbourhood services through contracts

Key Activities

Integrated Neighbourhood Team Activity

Demand Management Initiatives

Activity in Live Well Centres and Spaces

Primary Care activity

Community Services Activity and Access

Metrics and Outcomes

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

Delivery Measures: Uniform across the 10 localities

Place Specific

Supported by measures to show cost avoidance and demand reduction

Contributing to GM Strategy

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

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

Leading to Change in Place and System

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

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Partnership Agreement

Part of Greater Manchester
Integrated Care Partnership

Partnership Agreement

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Acts as the **overarching agreement** for the PHCP document suite

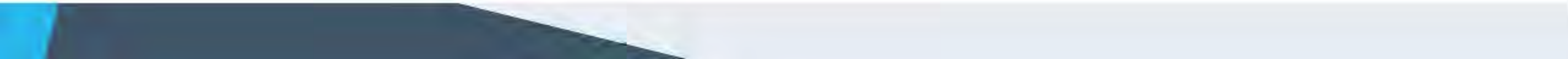
Sets the **shared intent and principles** for Place Partnership working

Provides **a stable, common foundation** for collaboration across the system

Aligns partners to **collective action that adds value beyond single organisations**

Is a formal document but **does not create a legal entity** or alter statutory accountability

Is the **primary document for formal place sign-off**



Partnership Agreement: Structure by section

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

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

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

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

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

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

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

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

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

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

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

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

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Place Outcomes Framework

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Integrated Care Partnership

Place Outcomes Framework

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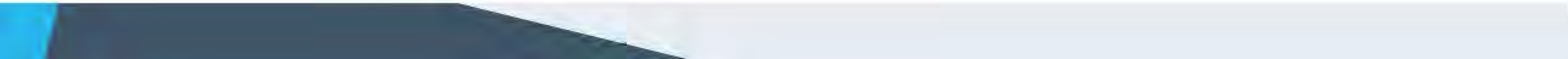
Defines **what success looks like** for the Place Health and Care Partnership

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

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

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

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



Place Outcomes Framework – Linking delivery measures to outcomes

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Outcome 1
Keeping people healthy and preventing ill health

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

Outcome 3
Supporting staff wellbeing and retention

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

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

Uniform across all 10 PHCPs

Delivery measures

PHCP Specific

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

Outcomes Framework composition

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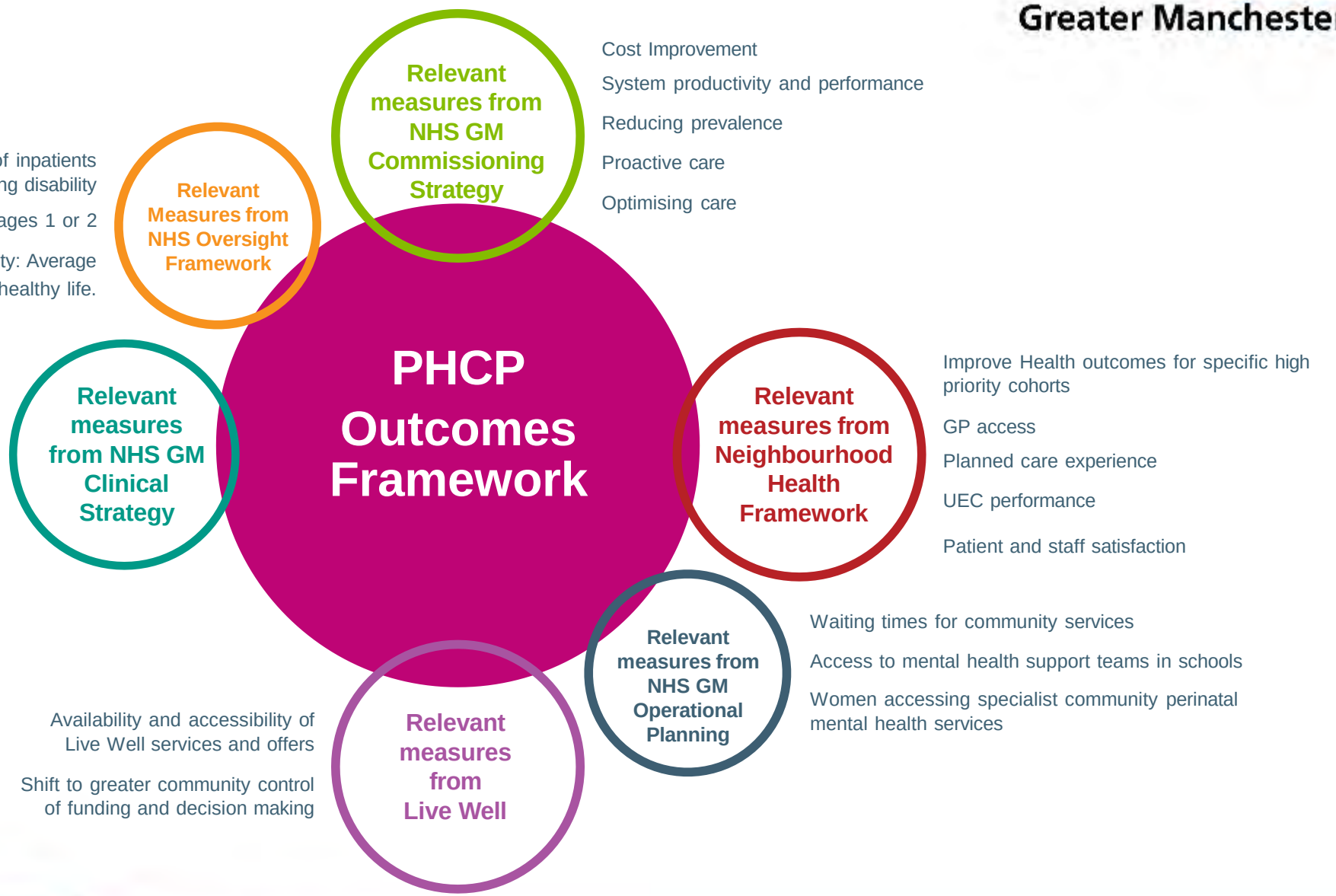

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Place Fund

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Integrated Care Partnership

Place Fund

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Brings together **place-based resources** to support delegated decision-making aligned to population need and agreed outcomes

Enables **collective financial stewardship**, neighbourhood health and prevention, with decisions closer to communities

Supports a **whole-system view of local resources,** helping shift from reactive to preventative investment

Operates in **shadow form in 2026/27** to test and strengthen arrangements

Sits within GM's **shared stewardship of ~£9bn**, focusing on managing demand, risk and outcomes - not budget transfer

A **core component of the Place operating model**, alongside the Partnership Agreement and Outcomes Framework

Wider than the Better Care Fund – starting with BCF but aligning broader place-relevant spend

The Place Fund exists within a wider context featuring the totality of investment in Place and Neighbourhood Health through contracts such as primary care, VCFSE, Foundation Trusts etc.

What is included in the Place Fund?

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Core Place Fund
- Initial scope

Better Care Fund (BCF) – aligned spend on **integration, hospital avoidance and flow**, creating a **single baseline** to reduce fragmentation across BCF, acute, community and local authority contracts

Includes:

- Community equipment *(incl. digital & telehealth)*
- Intermediate care *(bed-based & home-based)*
- Discharge to Assess & reablement
- Adult social care protection
- Carer support
- Community nursing
- Hospices
- Care coordination
- Integrated neighbourhood teams

Wider Place Fund scope
- Aligned Place Level Expenditure

Aligns **place-relevant spend beyond BCF**, including centrally held budgets, enabling Places to **see, understand and influence full pathway costs**, reduce duplication, manage risk and improve outcomes

Includes:

- Community health & out-of-hospital services *(neighbourhood models, prevention, admission avoidance)*
- Intermediate care, discharge & community pathways *(currently fragmented across contracts and organisations)*
- Locally commissioned services supporting **hospital avoidance, flow and community alternatives**
- Prevention & early intervention with a **clear link to reducing future acute and specialist demand**

Future alignment into the Place Fund

Over time, and subject to agreed processes, additional budgets to be aligned into the Place Fund using a consistent GM-wide methodology.

This aligns with the Strategic Financial Framework's emphasis on:

- Stronger risk and gain-sharing arrangements
- Reducing fragmentation in contracting
- Managing risks collectively to unlock future investment

The focus is on shifting future funding growth, rather than destabilising existing acute, primary or mental health provision, maintaining necessary acute spend while redirecting growth into neighbourhood and preventative models.

Place Fund: How this works in 2026/27

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2026/27: Shadow Year for the Place Financial Framework

2026/27 will operate as a shadow year, in line with the Strategic Financial Framework

The ICB will continue to hold Place Fund budgets centrally

Places will work against the full financial picture, including wider aligned spend across partners

Places will influence and shape financial decisions within agreed rules, respecting contractual commitments, quality requirements and control totals

This approach maintains financial stability while enabling Places to operate as if the model were live and to build confidence in the arrangements

Commitment to Development in Year

2026/27 is an active development year. Alongside delivery, partners will:

Finalise the technical design of the Place Fund, including scope, hosting, governance and financial controls

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

Strengthen transparency, assurance and reporting, ensuring outcomes, value and impact are visible

The place fund will launch in April 2027.

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Place Team

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A Place Team is a multidisciplinary team drawn from across Place partners, providing shared capacity to turn collective ambition into action by connecting strategy to neighbourhood-level delivery, connected through shared purpose and accountability to the Place Lead.

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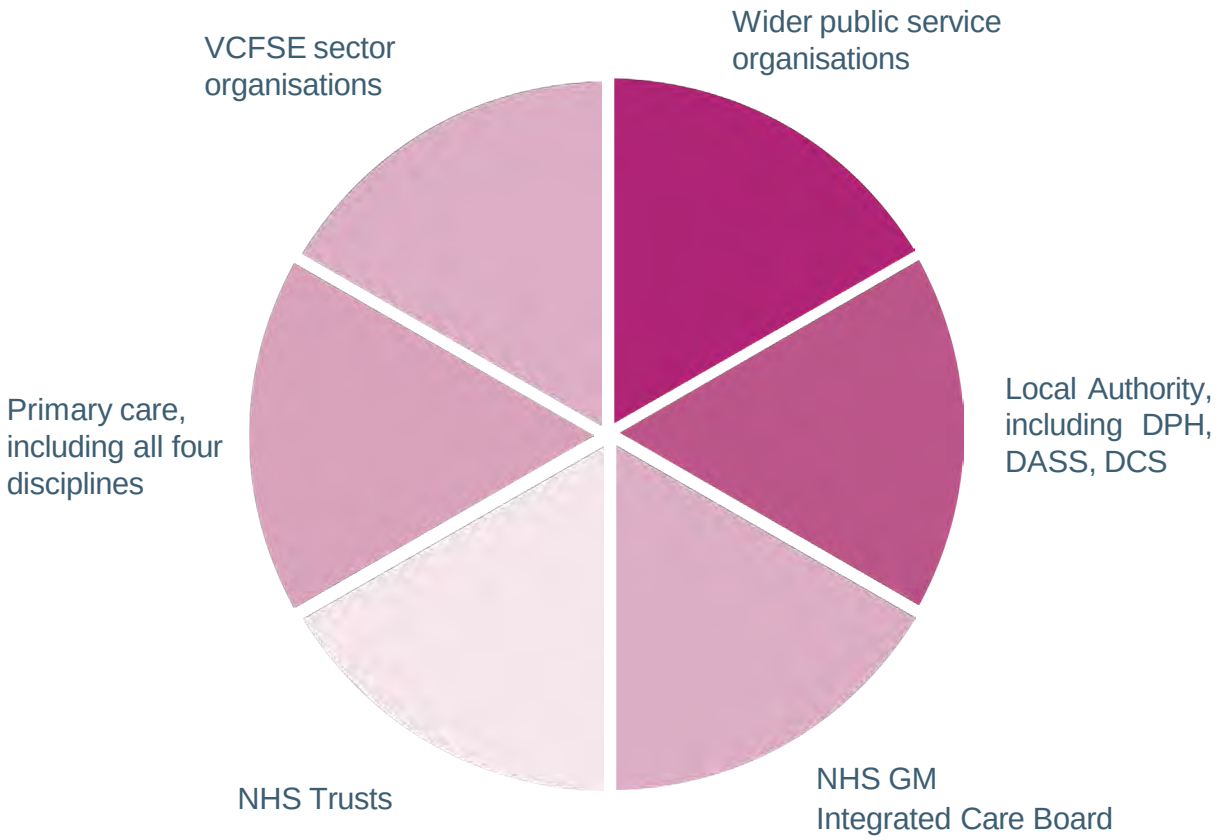

Creating success through:

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

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

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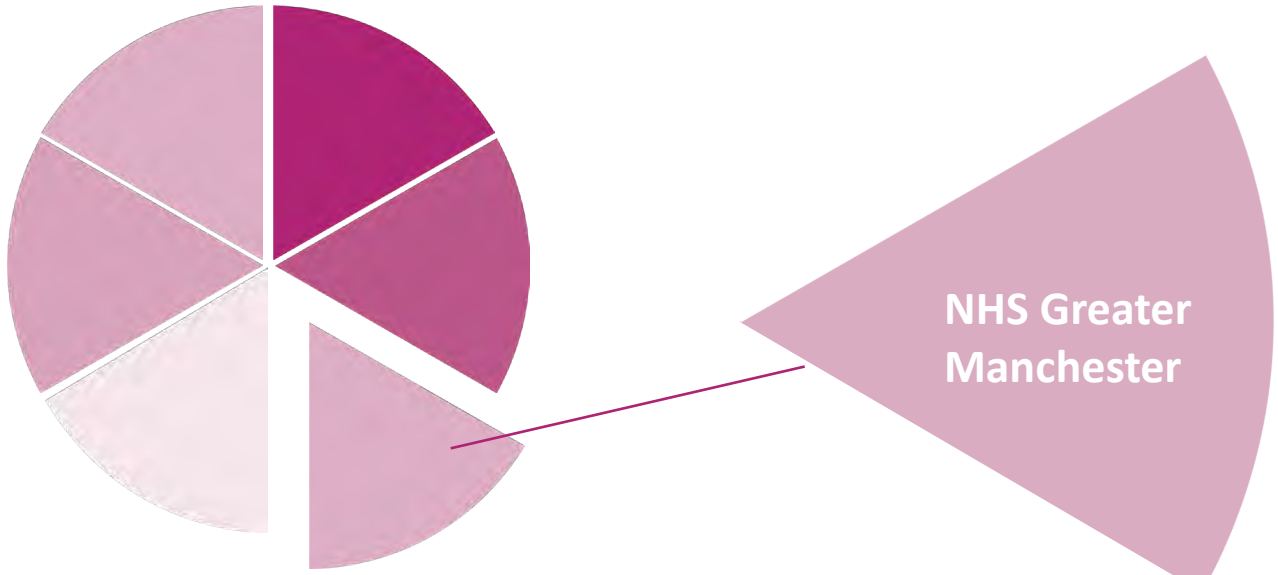
NHS GM contributes alongside all partners

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

Components of the NHS GM Model Place Team



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

Setting up Place teams will be informed by context in each place rather than a one-size-fits-all.
A series of potential scenarios is featured below:

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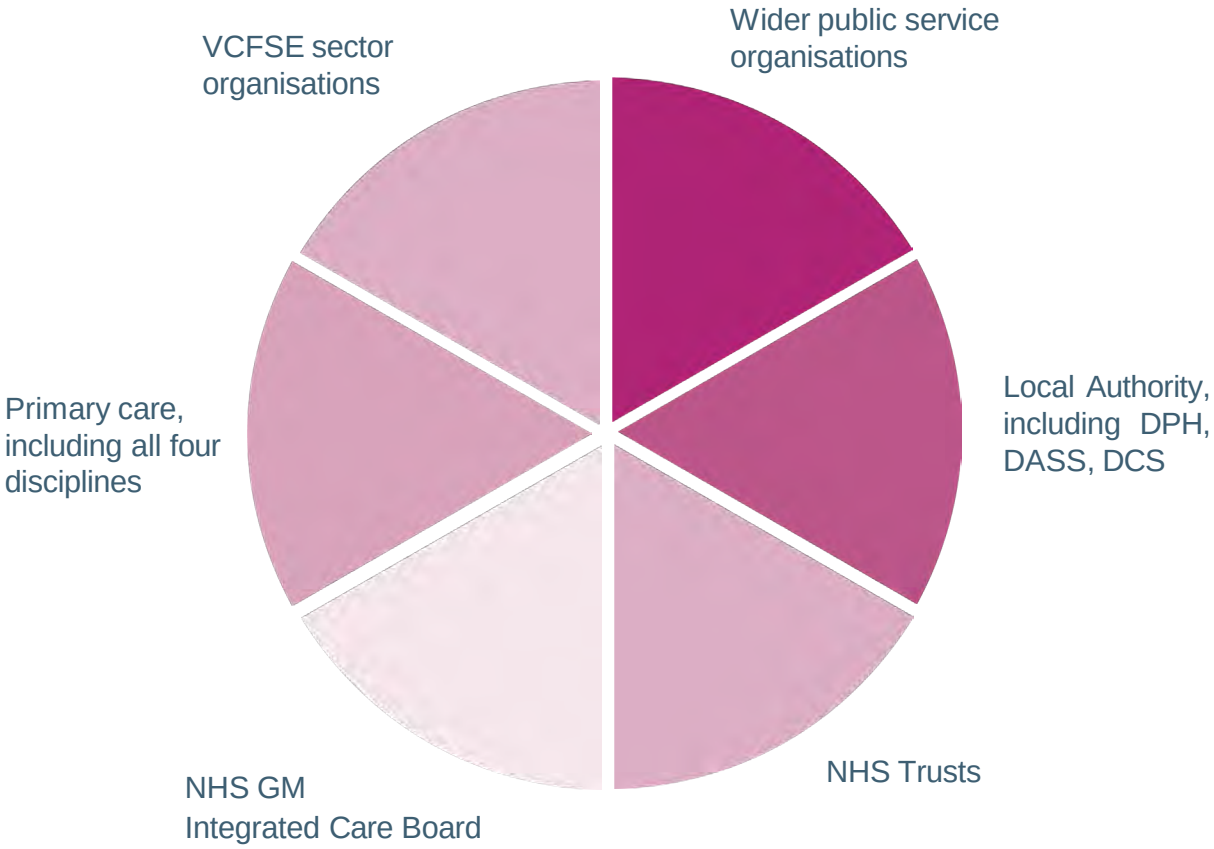
Model	Scenario Summary
Fully Integrated	A single, fully integrated Place Team hosted and line-managed by one organisation, with staff from all partners collectively accountable to the Place Lead and Place Partnership, enabling clear ownership, strong leadership and rapid, joined-up delivery.
Hybrid	A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



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Governance

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Integrated Care Partnership

Place Governance Options Appraisal

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- NHS GM's role is to create the conditions for successful Place Health and Care Partnerships. This is achieved through the setting of the outcomes framework, provision of the place fund and funding of the place teams.
- Arrangements and governance options to achieve this have been considered in detail and are described in the below table:

Element	Arrangement	Governance
Outcomes Framework	Set by NHS GM	Formalised through partnership agreement
Place Fund	Provided by NHS GM Preferred host: Local Government	Section 75 (added to existing BCF S75s)
Place Team	Funded by NHS GM Preferred host: NHS Trust	Contract (added to existing NHS contract)
	Alternative host – Local Government	Section 75 (added to existing BCF S75s)

- Broader work is progressing to develop a model place-based governance structure and set out GM system governance more clearly. Implementation will follow once hosting arrangements are finalised.

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Appendix

Part of Greater Manchester
Integrated Care Partnership

Engagement & Sign Off Plan

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1 May
Chief Officer and DPL Check in

6 May
Chief Officer Update

12 May
DPL Session

20 May
Chief Officers – sign off

11 June
Executives Committee – sign off

21 -22 May
Reiteration and Amends

Appendix 1 – Table to show which relationship each document relates to

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Though each document is presented as part of a single suite, the different framework components are more directly relevant to different relationships associated with the place partnerships, being:

- Between composite partners within the PHCP
- Between the PHCP and GM structures.

This table signifies which documents and frameworks are most relevant to each relationship.

Document	Between partners in the PHCP (Including NHS GM as a partner)	Between the PHCP and NHS GM as a strategic commissioner
Partnership Agreement	✓	
Outcomes Framework	✓	✓
Place Fund	✓	✓
Place Team	✓	
Governance Framework Options Appraisal		✓

Appendix 2: Place Outcomes Framework – Linking delivery measures to outcomes with descriptions

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Outcome 1

A narrowing of the healthy life expectancy gap between the most and least advantaged communities, with better outcomes for all residents, measured through locally meaningful indicators of inequality, prevention, and early years, grounded in what matters to people, while supporting NHS sustainability and economic growth.

Outcome 2

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

Outcome 3

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

Outcome 4

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

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

Uniform across all 10 PHCPs

Delivery measures

PHCP Specific

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

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

Part of Greater Manchester Integrated Care Partnership

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Narrative Overview: Place Partnership Agreement

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

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

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Definitions and Glossary

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

"Accountability"

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

"Agreement"

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

"Best for Place"

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

"Best for GM"

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

"Commissioning Organisation"

The organisation holding statutory or delegated responsibility for commissioning functions relevant to this Agreement (e.g. NHS GM). For the purposes of dispute resolution, the Commissioning Organisation may act corporately and separately from its representative(s) within the Place Health and Care Partnership.

"Delivery Board"

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

"GM Operating Model"

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

“Greater Manchester (GM) Strategy”

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

“Integrated Neighbourhood Team (INT)”

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

“Local Care Organisation (LCO) / Provider Collaborative”

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

“Neighbourhood”

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

“Place Outcomes Framework”

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

“Partner” or “Partners”

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

“Partnership Board”

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

“Place”

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

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“Place Funding Framework”

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

“Place Neighbourhood Plan(s)”

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

“Place Health and Care Partnership”

The Partners working together in accordance with this Agreement.

“Population Health Management”

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

“Reserved Matters”

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

“Responsibility”

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

“VCFSE”

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

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Change Log

Change ID	Change Description	Status
001	Update within 1.2 Parties to change "PCN" to recognise more the breadth of "Primary Care"	Completed
002	Formatting Changes around "Place Partnership" wording	Completed
003	Section 4.1 additional clarity to the context of Place Outcomes Framework	Completed
004	Section 4.5 inclusion of the structure to the Place Outcomes Framework	Completed
005	Definitions : consideration to "Place" being defined and therefore not needing to be replaced throughout the whole document	Completed
006	Definitions : rewording of Place Funding Framework	Completed
007	Section 5.4 strengthening of clarity around the Place Team construct	Completed
008	Definitions : ensured clarity on "Best for Place" and consideration to Partner organisational priorities	Completed
009	Definitions : clarity added to ensure clear understanding and application of accountability, responsibility and stewardship	Completed
010	Section 7.4 moved link to Schedule 2 for Place Funding Framework	Completed
011	Section 11.3 strengthening of Formal Dispute Resolution process	Completed
012	Section 11.4 strengthening of Commissioning Level Dispute resolution	Completed
013	Definition : deletion of "Sovereign Organisation" as description more appropriate in latter section	Completed
014	Section 1.3 strengthening of Status of Agreement to ensure appropriate for the scope and terms	Completed
015	Section 1.2 Mechanism for agreeing new Partners	Completed
016	Section 1.3 "Agreement Supplements" consideration to precedence and alignment	Ongoing
017	Section 2.2 Mechanism for "early termination" of Agreement to be added	Completed
018	Schedule 4 inclusion of draft/sample Terms of Reference for Partnership Board	Completed
019	Section 8.3 Conflict of Interest principle to be added	Completed
020	Section 4.4 improved wording and clarity	Completed
021	Section 6 needs to have a clear link to the Responsibility Matrix within Schedule 3	Completed
022	Section 6.3 addition to align and coordinate resources "where appropriate and/or possible"	Completed
023	Section 7.2 updated to include "the statutory duties and sovereign governance of each Partner"	Completed
024	Section 10 standardised use of ICB and NHS GM, to use NHS GM consistently	Completed
025	Schedule 1 inclusion of current iteration of the Place Outcomes Framework - linking together NHS Neighbourhood Health Framework, GM Live Well, Prevention Demonstrator and NHS Outcomes Framework cohesively	Completed
026	Section 11.4 consideration to be given as to whether different "commissioning scenarios" work through the process	Completed
027	Section 10.1 removed some duplication in purpose within the section to support clarity	Completed

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028	Section 75 considerations need to be made either as part of the Agreement, Terms of Reference or as a connected document	Ongoing
029	Updated following Chief Officer Feedback – Jonathan to make some further additions following consultation with Mills&Reeve and place colleagues (Trafford).	Completed
030	Section 7.5 added to strengthen the connection and approach to decision making with regards Place Fund, and follow the principles set out in section 8	Completed
031	Updates to bring consistency across Accountability, Responsibility and Stewardship	Completed
032	Rewording to section 1.1 based on feedback to strengthen the context and purpose of this work	Completed
033	Section 1.3 and 1.4 swapped around to support the flow of the document	Completed
034	Expansion of aligned, complimentary and supporting documents within section 1.4	Completed
035	Further additions/changes are flagged in the feedback tracker on the SharePoint	Completed
036	Inclusion of sections 5.5 and 6.5 to support opportunities around place team approaches	Completed
037	Section 1.5 adjustment made to working “Governance Framework” to Terms of Reference	Completed
038	Inclusion of Section 6.2 to outline the role of the Place Lead	Completed
039	Section 8.3 added to demonstrate the close connection and relationship to Health and Wellbeing Boards	Completed
040	Section 10.3 removed to recognise the elements included in previous sections covering the breadth of connection into Clinical	Completed
041	Section 9.2 updated the ordering to recognise the importance of the commitment to stakeholders and communities	Completed
042	Consideration to moving “variable” elements of the agreement into a schedule for a cleaner approach to individual place changes	Ongoing

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1. Purpose, Parties and Status of the Agreement

1.1 Context and Purpose

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

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

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

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

1.2 Parties

This Agreement is made between the following Partners:

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

1.3 Principles of Partnership

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

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

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1.4 Status of the Agreement

- The Place Health and Care Partnership (PHCP) is not a legal partnership or a legal entity and cannot bind Partners or enter into contracts.
- This Agreement is not an NHS Contract, nor is it a legal binding contract. However, the Partners do intend for it to be formally adopted as a clear expression of shared intent, setting out the commitments, behaviours and governance arrangements that all Partners agree to follow in exercising their respective roles within the Place Health and Care Partnership.
- Each Partner remains a sovereign organisation, retaining its own statutory duties, legal responsibilities, accountabilities, governance arrangements and decision-making authority.
- This Agreement supplements and aligns with:
    - Greater Manchester Strategy
    - NHS GM Strategic Commissioning Strategy
    - NHS GM Clinical Strategy
    - Place Neighbourhood Plan(s)
    - Services contracts
    - Section 75 agreements
    - Partnership Board and LCO / Provider Collaborative Terms of Reference

1.5 Inclusion of New Parties

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

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

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

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2. Commencement and Term

2.1 Context

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

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

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

2.2 Term

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

2.2 Early Termination

A Partner may withdraw from this Agreement by giving written notice to the Partnership Board, with the period of notice and any transition arrangements agreed collectively to ensure continuity of Place responsibilities and avoid operational disruption.

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3. Shared Vision, Purpose and Strategic Context

3.1 Why this matters

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

3.2 Greater Manchester Strategic Context

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

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

It also supports the wider Greater Manchester Combined Authority vision:

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

3.3 Place Vision

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

3.4 Purpose of the Agreement

This Agreement exists to:

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

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4. Strategic Priorities and Place Outcomes Framework

4.1 Context

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

4.2 Strategic Priorities

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

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

4.3 Place Outcomes Framework

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

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

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

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

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

4.4 How the Place Outcomes Framework will be used

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The Place Outcomes Framework will:

- provide the mechanism through which Partners translate strategic priorities into coordinated delivery. It will guide how programmes are planned and sequenced, ensuring that activity across organisations is aligned to the outcomes we have collectively agreed.

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

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

- through clear and transparent reporting, strengthen accountability to residents and partners, demonstrating how Place activity is contributing to improved outcomes.

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

4.5 Place Outcomes Framework Principles

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

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

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- providing one version of the truth via a balanced scorecard

4.5 Place Outcomes Framework Structure

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

1. **A narrowing of the healthy life expectancy gap between the most and least advantaged communities, alongside a general uplift for all residents,** measuring this through locally meaningful indicators of inequality, prevention, and early years development, anchored in what matters to people, such as "I feel supported to live a healthier life where I live.", and also ensuring the future sustainability of the NHS and support economic growth.
2. **Increased proportion of care delivered in neighbourhood settings, reducing health inequalities, reliance on emergency services and enabling earlier support.**
3. **Improved staff wellbeing and retention across sectors, as a marker of a compassionate, sustainable and inclusive local system.**
4. **More effective use of local partners' collective resource to achieve shared outcomes; evaluating impact and taking an approach of continuous improvement.**

Delivery Measures: Uniform across the 10 Locations

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

Delivery Measures: Place Specific

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

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5. System Characteristics, Leadership and Culture

5.1 Context

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

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

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

5.2 Leadership Characteristics

Partners commit to leadership behaviours that:

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

5.3 Cultural Characteristics

Partners will foster a culture that:

- **Places outcomes and tackling inequalities at the centre of decision-making**, ensuring all actions contribute to improved health, wellbeing and equity.
- **Recognises and addresses wider social, economic and commercial determinants of health**, working with partners beyond traditional health and care boundaries.

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

5.4 The Place Team

The Place Health and Care Partnership (PHCP) will operate through a Place Team; a virtual, multi-disciplinary team drawn from across all Partners. The Place Team:

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

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

5.5 Hosted and Ringfenced Roles

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

These roles may:

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

Where roles are designated as ringfenced, Partners commit to ensuring that:

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

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

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

5.6 Application

These characteristics will be reflected in:

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

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6. Roles, Responsibilities and Collective Capability

6.1 Context

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

6.2 Place Lead

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

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

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

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

6.3 Shared Responsibilities of All Partners

All Partners will:

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

6.4 Collective Resource and Capability Commitments

Partners agree that the Place Health and Care Partnership (PHCP) is the primary forum through which we will:

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

6.5 Operationalising Shared Capability

To make this real, Partners will:

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

6.6 Hosted, Assigned and Ringfenced Workforce Arrangements

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

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

- roles that are formally hosted by one Partner on behalf of the PHCP;
- staff who are assigned, seconded or functionally aligned to Place delivery while remaining employed by their substantive organisation;

- capacity that is ringfenced, in full or in part, to support agreed Place programmes or functions; and
- the establishment of joint teams or shared functions, drawing on staff from across multiple organisations.

In all cases:

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

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

- agree the intended contribution and outcomes associated with the role;
- ensure alignment with the Place Outcomes Framework and Place Neighbourhood Plan(s);
- review the effectiveness of the arrangement as part of ongoing performance and capability discussions; and
- adjust deployment over time in response to changing needs.

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

6.7 Commitment to Continuous Development

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

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

6.8 Responsibilities Matrix

The PHCP will be supported by a clear and consistently applied Responsibility Matrices, which provide a shared understanding of how functions, duties and activities are distributed across the system. The matrix are a practical tool that

translate the principles of shared accountability into an operational framework, ensuring that all Partners understand their respective roles.

- Clarifies who leads, who supports and who assures each functional area, enabling transparency and reducing ambiguity in day-to-day working.
- Reflects the sovereign duties of each Partner, ensuring that statutory responsibilities remain with the appropriate organisation while enabling coordinated system delivery.
- Supports integrated neighbourhood delivery, by showing how responsibilities flow from GM-level frameworks through Place and into Neighbourhoods, consistent with the commitment to “support integrated delivery at neighbourhood level”.
- Enables effective planning and prioritisation, ensuring that the right capabilities are aligned to the right functions, and that shared resources are deployed where they add most value.
- Provides a single reference point for understanding how functions are exercised across NHS GM, the Local Authority, Providers, Primary Care and the VCFSE sector.
- Strengthens accountability, supporting the Partnership Board and Delivery Board to oversee delivery, monitor progress and identify gaps or overlaps in responsibilities.
- Supports continuous development, enabling the Partnership to review and adapt responsibilities as the system matures, in line with the commitment to “regularly reviewing the skills, capacity and capability required to deliver the Place Outcomes Framework”.

The Responsibility Matrix are not a static document. They will be reviewed periodically to ensure they remain aligned with the GM Operating Model, delegated functions, and the evolving needs of residents and communities. Updates will be agreed collectively through the Partnership’s governance arrangements and reflected in the Terms of Reference.

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7. Place Funding

7.1 Context

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

7.2 The Place Funding Framework

Partners agree to operate within the shared Place Fund Framework [Schedule 2], which:

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

7.3 Principles of Place Funding

The Place Funding Framework is underpinned by the following principles:

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

7.4 Application

The Place Funding Framework will be used to:

- inform the development of the Place Neighbourhood Plan(s);
- support joint planning and prioritisation;
- enable pooled or aligned budgets where appropriate;
- support investment in prevention, community assets and neighbourhood delivery;
- monitor financial performance and risk at Place level.

7.5 Decision making

Decision-making relating to the Place Fund will follow the shared governance principles set out in this Agreement, with formal processes described in Section 8.

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

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

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

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8. Governance and Decision-Making

8.1 Context

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

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

8.2 Governance Structure

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

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

These components operate as a single, coherent governance system. The detailed governance diagram, membership, reporting lines and operating model will be set out in the appropriate Terms of Reference.

8.3 Health and Wellbeing Board

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

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

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

8.4 Decision-Making

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

- **Consensus is the default**
  Decisions will be made by consensus wherever possible, reflecting the shared commitment to act in the best interests of residents and the system as a whole.
- **Best for Place principle**
  Partners will act in accordance with the Best for Place principle, ensuring that decisions are guided by outcomes, equity and the needs of communities.
- **Respect for statutory duties**
  No Partner may be required to act unlawfully, contrary to statutory duties, or in a way that compromises its organisational responsibilities.
- **Reserved matters**
  Certain decisions remain the responsibility of individual Partners, as sovereign organisations. These Reserved Matters will be respected and handled transparently within the governance process.
- **Clarity of escalation**
  Where consensus cannot be reached, issues will be escalated in line with the dispute resolution process set out in Section 11.
- **Conflicts of interest**

  All actual or potential conflicts of interest will be declared and managed in accordance with the Partnership's agreed process, ensuring impartiality and protecting the integrity of decision-making.

8.5 Accountability

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

- **The Partnership Board is collectively accountable**
  The Partnership Board is accountable to all Partners for the delivery of the Place Outcomes Framework, the Place Neighbourhood Plan(s) and the effective oversight of resources.
- **Sovereign accountability remains unchanged**
  Each Partner remains accountable to its own Board or Cabinet for the discharge of its statutory duties, financial responsibilities and organisational performance.
- **Accountability for hosted and ringfenced roles**
  Where staff or functions are hosted by a Partner or ringfenced to support Place delivery, Partners agree that:
  - statutory and organisational accountability remains with the employing organisation, unless explicitly varied through formal arrangements;

  - individuals may operate to Place-aligned objectives and priorities, agreed through the Partnership's governance structures;
  - governance arrangements will ensure clarity of reporting, decision-making and escalation routes, avoiding duplication or ambiguity; and
  - no arrangement under this Agreement shall be interpreted as transferring statutory duties, legal accountability or employer liability between Partners.
- **Mutual assurance**
  Partners will provide assurance to one another through transparent reporting, shared intelligence and open dialogue, ensuring that risks, issues and performance concerns are surfaced early and addressed collectively.

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9. Transparency, Information and Learning

9.1 Context

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

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

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

9.2 Commitments

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

- **Communicate transparently with stakeholders and communities**
  Ensure that information about performance, outcomes and progress is communicated clearly and accessibly to residents, staff and partners, supporting accountability and trust.
- **Share information openly and proactively**
  Provide each other with timely, accurate and relevant information required to deliver the Place Outcomes Framework, monitor performance, manage risk and support effective planning.
- **Ensure compliance with legal and regulatory requirements**
  Handle all information in accordance with data protection legislation, information governance standards, Freedom of Information requirements, and competition law.
- **Protect commercially sensitive information**
  Identify and manage commercially sensitive information appropriately, ensuring it is shared only where necessary, with suitable safeguards, and in a manner that does not compromise legal or competitive obligations.
- **Promote a culture of learning and improvement**
  Foster an environment where learning is openly shared, mistakes are used constructively, and insights from residents, staff and partners inform continuous improvement.
- **Use shared data and intelligence to drive decision-making**
  Work collaboratively to develop and maintain shared analytical capability, ensuring that decisions are informed by robust evidence, population health insight and real-time system intelligence.

- **Support joint review and reflective practice**
  Participate in joint reviews, after-action learning, peer support and cross-organisational improvement activity, recognising that shared reflection strengthens system resilience.

9.3 Safeguards and Responsibilities

Partners acknowledge that:

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

9.4 Commitment to System Learning

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

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

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10. Clinical Strategy

10.1 Clinical Governance

The Place Health and Care Partnership (PHCP) will operate in full alignment with:

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

Partners agree to work together to:

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

Clinical governance at Place will focus on:

- Supporting the delivery of the GM Clinical Strategy at neighbourhood and Place level.
- Facilitating multi-professional clinical leadership and engagement in the development of pathways, redesign work and preventative models.
- Ensuring clinical quality, safety and learning are embedded in transformation and commissioning decisions.
- Supporting INTs with structured clinical input and clear professional leadership connections to provider and NHS GM governance.

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

- Not duplicate provider clinical governance committees or NHS GM governance structures.
- Provide a shared space for coordination, visibility and joint action on cross-system clinical issues.

- Ensure a coherent two-way link with NHS GM's Clinical Governance Framework to support escalation, learning, risk management and clinical leadership.

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

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

10.2 Quality Oversight & Assurance

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

Place quality arrangements will be fully aligned with:

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

The PHCP will support quality by:

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

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

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

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

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11. Problem Resolution and Escalation

11.1 Context

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

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

11.2 Principles

When managing disagreements, Partners will:

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

11.3 Place Approach

If a disagreement arises between Partners:

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

- The relevant Board will consider the matter in line with the Place Health and Care Partnership's principles and agreed priorities.

4. **Escalation to Statutory Bodies**
   - Where the issue relates to statutory responsibilities, legal obligations, or matters that cannot be resolved within Place governance, the matter may be escalated through existing governance routes within:
     - NHS GM;
     - [Name] Council;
     - or other relevant statutory bodies.
   - Partners will notify each other in writing if such escalation is required.
5. **Formal Dispute Resolution**
   - If the issue remains unresolved after the above steps, the matter may be escalated through the formal dispute resolution process as follows:

a. Independent Facilitator

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

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

b. Mediation

If the independent facilitator cannot resolve the issue, the Partners may submit the issue to mediation by CEDR or other independent body of organisation agreed between the Partners in all other cases.

The mediation will follow the mediation process of CEDR or other independent body as may be agreed between the Parties.

c. Exit, termination or non-resolution

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

- that the Partner(s) involved in the dispute can withdraw from the Place Health and Care Partnership;
- to terminate this Agreement in whole or in part; or

- that the issue need not be resolved.

11.4 Commissioning Level Disputes

Where a Commissioning Organisation is both:

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

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

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

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

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

11.5 Commitment to Learning

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

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12. Review, Variation and Evolution

12.1 Context

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

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

12.2 Commitments

Partners agree that:

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

- adapt to changes in the scope or ambition of the PHCP.

12.3 Transparency and communication

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

14. Signatures

(Signature blocks adapted for each Place.)

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Schedule 1 - Place Outcomes Framework

Schedule 2 - Place Fund

Schedule 3 - Place Team Approach

Outcomes Framework: Narrative Introduction

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

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

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

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

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

Metric Ref	National framework/GM framework/ICB team	Metric Description	Rationale	Metric Type
		Access to General Practice		
Live Well/ EX4	Live Well	% residents who say it is easy to contact their GP practice (GP Patient Survey)	Improve access to general practice so people can see their GP in a timely, high-quality way	Delivery Metric - consistent across place
Nat8	National Neighbourhood Framework	90% of clinically urgent patients on the same day by March 2027	Improve access to general practice so people can see their GP in a timely, high-quality way	Delivery Metric - consistent across place
		CHC		
OF00XX	NHSOF	Percentage of continuing healthcare referrals completed in 28 days	Better co-ordination of care for high-priority cohorts	Delivery Metric - consistent across place
		Children and Young People		
Nat6	National Neighbourhood Framework	Reduce acute outpatient appointments for children under the age of 16 by 10%	Improve quality and access to care for children and young people by enhancing paediatric expertise across the pathway, including primary care	Delivery Metric - consistent across place
Nat7	National Neighbourhood Framework	Reduction of community waits for children, as part of delivering Medium Term Planning Framework success measures	Improve quality and access to care for children and young people by enhancing paediatric expertise across the pathway, including primary care	Delivery Metric - consistent across place
		Community		
Nat18/OF0025	National Neighbourhood Framework / NHSOF	For those adult patients not discharged on their DRD, the average (mean) number of days from the DRD to discharge	Ensure there is better co-ordination of discharge process and capacity planning across health and care services, enabling patients to be discharged efficiently and effectively. Contribute to an improvement in the average length of discharge delay for all acute adult patients.	Delivery Metric - consistent across place
Nat17	National Neighbourhood Framework	The proportion of adult patients discharged from acute hospitals on their discharge ready date (DRD)	Ensure there is better co-ordination of discharge process and capacity planning across health and care services, enabling patients to be discharged efficiently and effectively. Contribute to an improvement in the average length of discharge delay for all acute adult patients.	Delivery Metric - consistent across place
E.D.25	Op Plan	Increased utilisation of Pharmacy First, Hypertension Case Finding, Contraception services	Better access in community and reduce reliance on others services	Delivery Metric - consistent across place
OP1	Op Plan	Reduction of community waits for adults, as part of delivering Medium Term Planning Framework success measures	Better access in community	Delivery Metric - consistent across place
		Elective		
EL1	ICB Team	A&G: deliver a 10% increase in requests for Advice & Guidance over 25/26 baseline in 2026/27	Improve experiences of planned care and support delivery of the referral to treatment (RTT) standard	Delivery Metric - consistent across place
EL2	ICB Team	Community: work with elective programme and local trust to design and implement a local community / Tier 2 provision for ENT and Gynaecology specialties in 2026/27 [Suggested Change to expand scope and longevity - Work with Elective programme and Trust to implement community/Tier 2 provision through 2026/27]	Deliver more follow-up outpatient care in neighbourhoods	Delivery Metric - consistent across place
EL5	ICB Team	Referral rates: reduce referrals by 5% across 10 specialties in 2026/27 vs 2025/26 baseline, in line with BeCCoR EQIS scheme	Improve experiences of planned care and support delivery of the referral to treatment (RTT) standard	Delivery Metric - consistent across place
Nat12	National Neighbourhood Framework	Follow-up appointments: work with local Trust to redesign outpatient model to support reduction in follow-up appointments by at least 10% by March 2027	Improve experiences of planned care and support delivery of the referral to treatment (RTT) standard	Delivery Metric - consistent across place
		End of Life		
Nat2	National Neighbourhood Framework	Better identify people coming to the end of life and improve access to services so people can die in a place of their choosing by increasing the number of people identified as approaching end of life by 10%	Better identify people coming to the end of life and improve access to services so people can die in a place of their choosing	Delivery Metric - consistent across place
Nat3	National Neighbourhood Framework	Reduce non-elective admissions and bed days of one day or over by 10% for the end of life cohort by March 2029	Better identify people coming to the end of life and improve access to services so people can die in a place of their choosing	Delivery Metric - consistent across place
		Harm		
PC4	ICB Team	Reduction in medicines related harm through neighbourhood approaches	Improve safety of care	Delivery Metric - consistent across place
		Long Term Conditions		
Nat4	National Neighbourhood Framework	Improvement of at least 10% in evidence-based clinical outcomes, measured through quality and outcomes framework standards for CVD, diabetes, COPD, mental health conditions and dementia	Better diagnosis and treatment for people with long-term conditions	Delivery Metric - consistent across place
PC3	ICB Team	Reduction in those with high/very high unmet need (CVD, Diabetes, Asthma, COPD) through neighbourhood approaches (beccor)	Improve health outcomes for people with long term conditions	Delivery Metric - consistent across place
OF0052 / Nat5	NHSOF / National	Percentage of diabetes patients to receive all eight care processes	Better diagnosis and treatment for people with long-term conditions	Delivery Metric - consistent across place
MH3	Op Plan	Reducing the number of admissions to inpatient settings and reducing length of stay for people with learning disability and/or autism	Improved provision and co-ordination of care people with mental illness. Ensure there is better co-ordination of discharge process and capacity planning across health and care services, enabling patients to be discharged efficiently and effectively.	Delivery Metric - consistent across place
OF0034	NHSOF	Percentage change in the number of inpatients who are autistic or have a learning disability	Improving lives of those with LD and/or autism	Delivery Metric - consistent across place
EK.5.a and b	Op Plan	Reduce admission rates to mental health hospitals for people with a learning disability and autistic people	Improving lives of those with LD and/or autism	Delivery Metric - consistent across place
		Mental Health		

OV1	SCGCSINAWG	Average LOS (physical and mental health) to be improved	Improved provision and co-ordination of care people with mental illness. Ensure there is better co-ordination of discharge process and capacity planning across health and care services, enabling patients to be discharged efficiently and effectively.	Delivery Metric - consistent across place
MH2 Also Live Well/AD5	ICB Team	Reducing the number of people presenting to A&E in mental health crisis (all age)	Improved provision and co-ordination of care people with mental illness. Ensure there is better co-ordination of discharge process and capacity planning across health and care services, enabling patients to be discharged efficiently and effectively.	Delivery Metric - consistent across place
MH1	ICB Team	Reduction in CRFD for adults, older adults and rehab patients in MH inpatient settings	Improved provision and co-ordination of care people with mental illness. Ensure there is better co-ordination of discharge process and capacity planning across health and care services, enabling patients to be discharged efficiently and effectively.	Delivery Metric - consistent across place
		UEC		
Nat16	National Neighbourhood Framework	Reduce category 3 and 4 ambulance conveyances in high-priority cohorts (those with mid to severe frailty, in a care home or housebound and end of life) by March 2029	Have fewer ambulance call-outs for the least urgent cases, with appropriate diversion to relevant urgent care provision in the community.	Delivery Metric - consistent across place
Nat1	National Neighbourhood Framework	Reduce non-elective admissions and bed days of one day or over by 10% for people with mild to severe frailty, in a care home or housebound by March 2029	Help people with mid to severe frailty, in a care home or housebound, to stay healthier, manage escalating conditions and maintain greater independence for longer.	Delivery Metric - consistent across place
Nat13	National Neighbourhood Framework	Keep growth flat and work towards an overall reduction in non-elective admissions for high priority cohorts	Better co-ordination of reactive care for high-priority cohorts (those with mid to severe frailty, in a care home or housebound and end of life), increasing use of urgent care provision in the community. For example, by making use of a single point of access, urgent community response, hospital at home, and virtual wards.	Delivery Metric - consistent across place
Nat15	National Neighbourhood Framework	Contribute to an overall reduction in type 1 ED attendances for high priority cohorts	Better co-ordination of reactive care for high-priority cohorts (those with mid to severe frailty, in a care home or housebound and end of life), increasing use of urgent care provision in the community. For example, by making use of a single point of access, urgent community response, hospital at home, and virtual wards.	Delivery Metric - consistent across place
		Live Well infrastructure		
Live Well/WOW1	Live Well	% of neighbourhoods in each locality with a Live Well access point (Centres and Spaces) % LW centres offering: I. Employment support pathway II. Housing support and advice **III. Mental health & wellbeing support** **IV. Primary care** V. Debt advice & income support*	The ambition through LW is for residents to be able to access support in their local area, with “priority offers” available through their local access points. The metric reflects the five proposed priority offers at the time of writing	GMS Implementation monitoring

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

Metric Ref	National framework/GM framework/ICB team	Metric Description	Rationale	Metric Type
		Workforce		
Live Well/WOW3	Live Well	% of frontline workers in Live Well roles reporting feeling fully integrated into the wider health, care and other public services in their area	Improve staff satisfaction	Delivery Metric - consistent across place
OF0082	NHSOF	Staff sickness rate	Improve staff satisfaction - drawn from across the entire partnership from several inputs to provide the most accurate picture	Delivery Metric - consistent across place
OF0061	NHSOF	Staff survey – raising concerns sub-score	Improve staff satisfaction - drawn from across the entire partnership from several inputs to provide the most accurate picture	Delivery Metric - consistent across place
OF0084	NHSOF	Staff survey engagement theme score	Improve staff satisfaction - drawn from across the entire partnership from several inputs to provide the most accurate picture	Annual Oversight
Ref TBC	NHSOF	Staff survey - We are compassionate and inclusive headline metric score	Improve staff satisfaction, wellbeing and retention drawn from across the entire partnership from several inputs to provide the most accurate picture	Annual Oversight
Ref TBC	WRES	WRES indicator 5 - %staff experiencing harrassment, bullying or abuse from patients/relatives/public	GM agreement via the ICP to combat racism and support staff and communities.	Annual Oversight
Ref TBC	WRES	WRES indicator 6 - %staff experiencing harrassment, bullying or abuse from colleagues, managers	GM agreement via the ICP to combat racism and support staff and communities.	Annual Oversight
Ref TBC	WRES	WRES indicator 8 - %staff experiencing discrimination at work from managers, team leaders, colleagues	GM agreement via the ICP to combat racism and support staff and communities.	Annual Oversight
Ref TBC	NHSOF	Staff mix - agency spend as % of total temporary staffing/ Bank vs agency spend split	Improve staff retention	

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

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

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Place Fund

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Place Fund: Narrative Overview

This is the Place Fund document, an underpinning document in the Place Health and Care Partnerships (PHCP) document suite as referred to in slides 20-23 in the overarching summary slide deck. The Place Fund document sets out how financial stewardship, accountability and decision-making will operate as Greater Manchester (GM) enters a period of significant financial and operating-model transition. It is designed to support neighbourhood health and ensure that the system continues to deliver value for money despite continued pressure on resources.

The framework recognises the risk that financial grip will be weakened if accountability is unclear or fragmented across organisations and geographies. It therefore reinforces the importance of strong collective stewardship, with finance understood as a shared responsibility across leaders, clinicians and system partners, not solely budget holders or finance professionals.

Background and Strategic Context

Greater Manchester's strategic direction requires a deliberate shift in investment and delivery models over time. The system is committed to moving resources away from a predominantly acute, hospital-based focus towards out-of-hospital care, with greater emphasis on community services, prevention and neighbourhood-based models of support.

This transition must be managed carefully. The system continues to experience significant operational and financial pressures, particularly within acute services. The framework therefore balances the need to manage immediate constraints with the ambition to unlock medium-term transformation, while also aligning with anticipated national policy and funding changes.

The Financial Opportunity

The GM Integrated Care Board (ICB) is responsible for managing approximately £9bn of public funding on behalf of GM residents. These resources are allocated and managed through a combination of pan-GM budgets and Place-based budgets. Management of the funding is structured through a GM "jigsaw" framework, which provides insight into the relationship between the quantum of spend in an area compared to outcomes and where there may be some unwarranted variation

While individual budgets are held and managed at different levels of the system, ownership of a budget does not remove collective responsibility for outcomes, financial sustainability or value for money. Every role within the system has an influence on how resources are used and the outcomes that are achieved for citizens.

Fragmented budgets and contracting arrangements can drive inefficiency and create misaligned incentives across the system. This is particularly evident in areas such as individual packages of care, where funding and accountability can sit across multiple

NHS and local authority budgets, acute contracts, private providers and community service arrangements.

The framework seeks to enable the development of, standardise and strengthen risk- and gain-sharing arrangements, reduce duplication, and enable GM to better leverage its scale. This will support more integrated commissioning and delivery approaches. Existing arrangements, such as the Mental Health Integrated Fund, demonstrate how shared financial risk can be effectively managed and provide a practical model for wider adoption.

The Place Fund

The Place Fund is a core element of the GM operating model. It is intended to support delegated financial authority at Place level and is directly linked to agreed outcomes and population needs.

By bringing resources together and devolving decision-making closer to communities, the Place Fund will enable faster, more locally driven decisions while maintaining system-wide stewardship. During 2026/27, the Place Fund will operate in shadow form, allowing arrangements to be tested, refined and strengthened ahead of fuller implementation. What this means in practice will be described in a later section in this document.

The Better Care Fund (BCF) provides the foundation of the Place Fund. On its establishment, the ICB inherited ten separate BCFs, each with significant local variation. In several areas, existing arrangements were not fully aligned with national BCF objectives or with the emerging GM operating model.

To address this, the framework establishes a requirement for greater standardisation ahead of anticipated BCF reforms in 2027/28. A consistent set of ten categories of spend has been applied across all ten BCFs, enabling consolidation of activity that previously sat in different budgets, such as intermediate care.

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

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

This common categorisation supports transparency, consistency and comparability across Places, and establishes a clearer platform for future financial and service integration.

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

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

It is important to note that none of this funding or activity will stop. Funding has been repositioned to align more appropriately with commissioning responsibilities and contractual arrangements, while remaining within the overall ICB financial envelope.

Draft Finances

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

The draft financial position reflects the first systematic application of the agreed Better Care Fund (BCF) categorisation and the early transition towards Place-based financial arrangements. As a result of this work, an additional £81m has been consolidated into the BCFs across Greater Manchester, using the ten standard categories of spend.

While two locality spend categories have reduced as part of this reclassification, all Places continue to operate above the national minimum contribution requirements. The overall position demonstrates increased coherence and transparency in how resources supporting community, intermediate care and neighbourhood services are identified and managed.

This early position should be understood as an initial step rather than a fixed endpoint. Further funding is expected to move into the Place Fund and BCFs as financial flows are reviewed in a structured and phased way during 2026/27. This will be undertaken alongside the shadow operation of the Place Fund, allowing the system to test and refine arrangements without destabilising services.

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

Overall, the draft finances provide a stronger baseline for future Place-based financial planning, support the shift towards integrated neighbourhood delivery, and establish the foundations for more effective collective stewardship across the GM system.

Shadow Year

To support a safe and phased implementation of the Place Fund, 2026/27 will operate as a shadow year. During this period, the ICB will continue to hold the Place Fund centrally, noting that Place teams will continue to work against the full financial picture, including wider aligned spend, they will also influence and shape financial decisions within agreed rules - respecting contractual commitments, quality requirements and control totals. This approach will allow for technical design work to be completed to the standard required for the following year and beyond.

2026/27 is an active development year, not a pause. Alongside delivery, there is a clear commitment to:

- Finalise the technical design of the Place Fund, including scope, hosting, governance and controls
- Develop and test neighbourhood investment and left-shift mechanisms, including risk and gain-share approaches
- Strengthen transparency, assurance and reporting so that outcomes, value and impact are visible
- Use learning from the Place Health and Care Partnership (PHCP) sprint approach to refine partnership agreements and decision-making ahead of future delegation

A strengthened governance approach will be established in 2026/27 to oversee progress, manage risks, and ensure transparent and consistent communication across partners. A dedicated technical process workstream will design the technical, operational and financial processes required for smooth implementation of the Place Fund in future years.

Future Planning

A central measure of success for the Place Financial Framework will be the extent to which investment shifts proportionately over time towards neighbourhood and community-based services (Left Shift).

Over the medium term and in line with plans, additional budgets will be aligned into the Place Fund using a consistent methodology to help address the needs of the population and improve outcomes. This aligns with the GM Strategic Financial Framework's emphasis on:

- Stronger risk and gain-sharing arrangements
- Reducing fragmentation in contracting
- Managing risks collectively to unlock future investment

It is important to note that we do not need to wait for these arrangements to be 'live' to glean opportunities to manage expenditure and mitigate risks more effectively. If we can reduce the cost of our demand now, it will increase the 'left shift' or neighbourhood health investment opportunity both in-year and from the planned investment in this area from 27/28, though a commitment is required to establish pan GM governance to fully enable this approach.

This focus is on shifting future funding growth, rather than destabilising acute, primary or mental health provision. The framework acknowledges the continued demand and national performance pressures faced by acute providers, including those driven by targets such as Referral to Treatment (RTT). However, it establishes a clear expectation that future funding growth should increasingly be directed towards services that support early intervention, prevention and care closer to home.

The framework is not static. It will be reviewed, engaged on with the system and updated as the GM operating model matures, national policy develops, and learning emerges from the shadow operation of the Place Fund. This iterative approach will ensure that the framework remains relevant, effective and aligned to the overarching ambition for neighbourhood health and sustainable system stewardship.

NHS
Greater Manchester

Place Team Framework
DRAFT V1

Part of Greater Manchester
Integrated Care Partnership

NHS Greater Manchester

Place Team: Narrative Overview

This is the Place Team document, and underpinning document in the Place Health and Care Partnerships (PHCP) document suite as referred to in slides 24-27 of the overarching slide deck. It sets out a comprehensive narrative for the development and operation of Place Teams as a central mechanism for delivering the ambitions of PHCPs across Greater Manchester. It forms part of the wider Place Mobilisation approach, alongside the development of Place Agreements and outcomes, place funding arrangements, and consideration of future employment models for NHS Greater Manchester (NHS GM) place teams.

Together, these elements aim to establish a coherent and sustainable model of place-based working that enables partners to improve health, reduce inequality, and support wellbeing in ways that reflect local need and context.

Background and strategic context

Significant progress has already been made in establishing the foundations for place-based working. There is shared agreement on a set of principles that underpin a new model of working at place, and clarity about the role of PHCPs within the overall health and care system. These partnerships are understood as the primary forum through which NHS organisations, local authorities, the voluntary, community, faith and social enterprise sector, and wider partners come together to plan and deliver for their populations.

National policy continues to reinforce this direction. The Neighbourhood Health Framework places renewed emphasis on local decision-making, prevention, and community-based approaches, under the leadership of Health and Wellbeing Boards. This reinforces the importance of place as the level at which population health outcomes can be most effectively shaped and delivered.

Within this context, the contribution of NHS GM has been defined as one partner within place, bringing specific skills, capacity, and system responsibilities. This contribution complements, the leadership and resources of other place partners.

It is recognised that places differ in history, geography, population need, and organisational maturity. As a result, this document does not prescribe a single structural model for Place Teams. Instead, it sets out the broad functions, capabilities, and ways of working required, alongside an illustrative ‘menu’ of scenarios that show how these might be configured in practice.

The purpose of a Place Team

A Place Team exists to enable partners to turn shared ambition into coordinated action. Place is not a programme or a delivery unit; it is a dynamic system of relationships, capabilities, behaviours, and shared purpose. The Place Health and Care Partnership

provides the space where this system is mobilised, bringing together leadership, professional expertise, and community insight.

Place working enables partners to connect physical and community assets through a One Public Estate approach, supporting care, prevention, and wider support to be delivered in familiar and trusted local settings. It promotes leadership across the life course, encouraging integrated approaches that respond to the needs of children, working-age adults, and older people, while actively addressing health inequalities.

Critically, place creates the conditions for intelligence to inform action. Data, lived experience, and population health insight are used to shape decisions, prioritisation, and improvement, rather than reporting performance alone. Most importantly, Place Teams support a shift towards prevention and early intervention by helping partners align investment and resources upstream, reducing reliance on reactive services over time.

Underlying all of this is a focus on collaborative leadership. Place Teams help align NHS, local authority, VCFSE and other partners where appropriate, such as housing and education, around shared priorities, while empowering residents to shape solutions through co-production and community action.

Core place capabilities

The effectiveness of a Place Team rests on a set of interdependent capabilities drawn from across the partnership. System leadership and alignment enable shared purpose to be translated into action, supported by trust, strong relationships, and clear governance. Data, intelligence, and improvement functions ensure that decisions are grounded in local insight and that learning is continuous.

Frontline service integration supports the delivery of proactive, multidisciplinary, and inclusive models of care that respond to lived experience and neighbourhood need. Place planning and resource logic bring together commissioning, finance, and transformation to align investment with long-term outcomes and sustainability.

Engagement and co-design capabilities ensure that change is shaped with residents, not just for them, while community activation extends the reach of place working into the wider determinants of health. The collective nature of these capabilities is fundamental. Place is strongest when it operates as a shared system, rather than working as a single teams or organisations.

Skills and expertise across the partnership

Delivering place-based working requires a blend of technical, relational, and adaptive skills. These include the effective application of population health data, meaningful community engagement, service and pathway design, programme management, and financial planning. Strong communication, relationship-building, and influencing skills are essential to support matrix working across organisational boundaries.

Clinical leadership, population health literacy, and change management expertise provide credibility and momentum, enabling partners to redesign services, manage complexity, and sustain improvement. These skills do not sit neatly within one organisation; instead, they are contributed by partners and brought together through the PHCPs.

Membership of the Place Team

Place Teams are inherently multi-organisational. They include colleagues from:

- Local authorities,
- NHS providers across acute, community, mental health, and primary care,
- NHS GM
- The VCFSE sector.

Strong links are also required with:

- Schools
- Further and higher education
- Housing providers
- Leisure services
- Emergency services,
- Commissioned partners, including those from the independent sector.

At the heart of this model is a commitment to working with people who use services, carers, and local residents. Their insight, experience, and leadership are essential to effective place-based change.

How Place Teams operate

Successful Place Teams share a number of common features. They are built on a positive and collaborative culture, underpinned by a shared vision and clear goals aligned with the locality plan. The outcomes framework, featuring uniform and place specific measures, supports focus and accountability, ensuring progress can be measured at individual, service, and population level.

Partners agree a limited number of priority areas where collective effort can deliver the greatest impact, supported by clear plans and well-defined responsibilities. Effective governance arrangements provide clarity on decision-making and accountability from strategy through to delivery. Crucially, all partners commit both operational and enabling capacity to the place endeavour.

Place Health and Care Partnership leadership

The PHCP Leadership Teams provide the strategic and operational leadership for place. While their composition reflects local context, they share a common purpose: to mobilise the full breadth of partnership resource around agreed priorities. Their

strength lies not in uniformity of structure, but in their ability to harness diversity of contribution and sustain collaboration.

Early engagement has demonstrated strong appetite across partners to align resources and co-own delivery, creating momentum for the next phase of place development.

NHS Greater Manchester's contribution as a partner at place

NHS GM plays a distinct system role within PHCPs. It aligns place plans with system and national priorities, provides population health intelligence, shapes resource allocation and incentives, supports provider collaboration, evaluation and assurance.

In practical terms, NHS GM commits funded capacity to each place across five core competency areas:

- Place leadership and integration
- Live well and neighbourhood health and care
- Pathway development and demand management
- Place governance and administration
- Clinical and care leadership.

This capacity is intended to enable and support place partners to deliver shared ambitions.

In time all place partners will need to be able to define their individual organisation's contributions to the Place Team.

Approaches to Place Team configuration

Given varying local contexts and ways of working, levels of integration and maturity, different approaches to organising Place Teams are appropriate. These range from fully integrated teams hosted and line managed by a single organisation, to hybrid, fluid, or dispersed models relying on matrix working. Each approach involves trade-offs between stability, flexibility, control, and partner engagement. A table to show the benefits and principles associated with each potential model is shown on the next page.

Decisions about contributions, configuration and accountability should be taken locally by PHCP, informed by context and readiness, and kept under review as arrangements mature.

	Fully Integrated Team	Hybrid Model	Dispersed Model	Fluid Model
Definition	All place partners formally commit staff to a single, integrated Place Team, hosted by one organisation. Colleagues work under one line-management structure and are fully accountable to the Place Lead and PHCP, regardless of their original employer.	A core group of Place Team staff (including NHS GM roles) is hosted and line-managed through a single organisation, while additional partner roles contribute capacity without being formally line-managed by the host. Accountability remains with the PHCP.	Place Team members remain fully employed and line-managed within their own organisations. They work together in a matrix arrangement against agreed place objectives, with senior leaders accountable to the PHCP rather than a single host	The PHCP agrees shared plans and priorities, and partners align and "offer in" staff capacity for defined programmes or time-limited work. Roles remain employed and managed by partner organisations, similar to a consultancy or pooled-resource model.
Benefits	• Strong signal of shared ownership and commitment to place • Clear accountability, decision-making and leadership • Faster coordination and delivery due to unified management • Builds a strong shared culture and system identity • Enables deeper integration of planning, finance and delivery	• Balances integration with organisational autonomy • Creates a strong coordinating platform for place work • Easier to secure early buy-in from partners • Maintains flexibility while improving coherence • Reduces risk for partners compared to full integration	• Lowest structural change and organisational risk • Preserves strong organisational identity and control • Easier to implement quickly • Sustains clear links back into partner organisations • Appropriate where partners must retain significant internal capacity	• High flexibility to respond to changing priorities • Encourages early engagement and partner buy-in • Makes best use of specialist skills when and where needed • Minimises structural disruption for organisations Useful for targeted transformation or early mobilisation

Principles	• Shared sovereignty at Place • System before organisation • Single point of accountability • Commitment = Credibility • Culture as important as structure	• Strong core with flexible edges • Clarity of contribution for each member • Progressive integration • Transparent decision making • Parity of esteem	• Matrix working with intent • Leadership alignment > Line Management • Explicit trade offs • Consistency through governance	• Purpose drives resource (not structure) • Time Bound Mutual Commitment • Negotiated accountability • High Trust, High discipline • Value exchange

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Implementation and next steps

Agreement on the Place Team approach is best achieved alongside other mobilisation elements, including place outcomes, place agreement, funding arrangements, and potential employment transfer options. Once agreed, each place will lead local implementation.

Place Teams will continue to develop through 2026 and 2027, with the expectation that effective, mature arrangements will be embedded from April 2027. Their success will depend on sustained collective commitment, shared leadership, and a willingness to work differently in pursuit of better outcomes for local people.

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DRAFT – FOR COMMENT

Governance Options Appraisal: NHS GM to Place Partnership

Part of Greater Manchester Integrated Care Partnership

NHS Greater Manchester

Place Governance Options Appraisal: Narrative Overview

This is the Place Governance Framework document, an underpinning component of the Place Health and Care Partnerships (PHCP) document suite as referenced in the overarching slide deck. It sets out an options appraisal for how governance arrangements between NHS Greater Manchester (NHS GM) and Place Health and Care Partnerships will operate, describing a series of mechanisms through which outcomes, resources, and accountabilities are agreed and managed at place. It forms part of the wider Place Mobilisation approach, alongside the development of Place Agreements and outcomes, Place Team arrangements, and place-based funding models.

Together, these elements aim to underpin the agreement of a coherent and consistent governance framework that supports effective partnership working at place, enables shared decision-making and accountability, and creates the conditions for partners to collaboratively improve health outcomes, reduce inequalities, and deliver sustainable, locally responsive services.

1. Introduction

1.1 The landscape is complex and changing with the introduction of the national Neighbourhood Framework. NHS GM is both a partner in each place 'delivery partnership' and a commissioner of outcomes (setting the outcomes framework). NHS GM is contributing resources to the partnership (staffing funding and delivery funding). The outcomes framework is WHY we are here (the impact and performance we want), the resourcing is HOW the partnership chooses to deliver the outcomes (the activity, interventions etc). In the new world of strategic commissioning, NHS GM sets outcomes (Impact), allocates resource, oversees governance, shares best practice - creating the conditions for local delivery.

1.2 The purpose of this paper is to outline the governance options for the NHS GM specified objectives/responsibilities/outcomes and support. The support comprises the two elements of NHS GM funded Place Fund and Place Team – both of which require the delivery of objectives/responsibilities/outcomes also. The purpose of this paper is not to cover the Place Partnership agreement between all partners within each of the 10 Place Partnership across GM. The focus is to be clear on preferred governance for the place fund, place team and outcomes.

1.3 This paper has been drafted with the intention of providing clarity on governance from NHS GM to Place, drawing together:

- 1.3.1 Existing legal and governance mechanisms available to NHS GM and partners
- 1.3.2 Greater Manchester's devolved history and operating model
- 1.3.3 Feedback from system leaders

1.4 There is common understanding that the Place Partnership Agreement is focused on the delivery of outcomes. As such this is not considered further, as this alternative workstream covers that element. The Place Partnership Agreement pulls together all partners with the common aim of improving these outcomes through shared endeavour. These outcomes are set by NHS GM as the strategic commissioner, though they are set with strong engagement across all partners and are well supported outcomes that are in the interests of our population and our health and care system.

1.5 This options appraisal outlines the governance options to support the delivery of Place Partnership responsibilities set by and supported by NHS GM in relation to the place fund and place team, in partnership with others.

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1.6 The options considered within this paper are:

1.6.1 Internal delegation within NHS GM
1.6.2 Section 75 between NHS GM and each local authority
1.6.3 Contractual arrangement
1.6.4 Non legal agreement (e.g. Memorandum of Understanding)

1.7 It is not possible to specify a single recommended preferred option because a range of information remains unknown, for example which organisation will be the host in each place for the place fund and place team. However recommended options are outlined for a range of potential scenarios. NHS GM is clear that both the place fund and team must be hosted by a statutory organisation, as such that limits the place partners options to NHS Trusts and Local Authorities, therefore wider place partners are not considered within the options.

1.8 It may be more helpful for NHS GM with the GM system to be clear with regards to how it wants to operate, and then to confirm which governance route is most suitable for that scenario. This paper confirms that there are appropriate governance mechanisms to allow NHS GM to enact the hosting of a place fund and a place team by a place partner on behalf of a Place Partnership.

2. Governance Options

Option 1. Internal delegation within NHS GM

NHS GM can formally create a committee or sub-committee mapped to the specific geographical "place" footprint.

The ICB retains ultimate legal accountability but delegates formal decision-making powers and budgets to this committee via its Scheme of Reservation and Delegation (SoRD).

Legislation offers significant flexibility, allowing the ICB to appoint members to this committee who are not ICB employees (such as local authority, VCSE, or local provider representatives).

Benefits

- **Simple Use of Funds** – funds can be more easily managed within a single organisation's arrangement; however this may limit flexible ways of using funding to meet shared goals.
- **Simple implementation –** this would avoid any risk of procurement challenge or the need to seek more complex legal advice.
- **Minimal Staffing Changes** – this would be easy to implement.
- **Ability to Amend arrangements** – only single organisation agreement needed to change arrangements.
- **Governance and Accountability** - while partnership is a strength, it can blur the lines of accountability. If the place team does not deliver, NHS GM can manage internal performance directly.

Risks

- **Not aligned with GM Strategy** – not in line with Greater Manchester's history of health and care integration.
- **Promotes single organisation operating** - not in line with health and care integration ambitions within 10 year health plan and neighbourhood framework and would not support joint decision making or governance.
- **Financial Risk Share –** does not support ability to share financial risks or benefits or support flexibility in the use of place level funding from multiple organisations.
- **Financial requirements –** does not support meeting reduced headcount, as required by NHS

GM.

Option 2. Section 75 Agreement (NHS Act 2006)

A Section 75 agreement is a formal, legally binding partnership arrangement between an NHS body and a local authority, enabled by Section 75 of the National Health Service Act 2006. This mechanism allows NHS and council partners to integrate resources and management structures, reallocate functions and use pooled budget.

In this scenario, NHS GM and the chosen host local authority could enter a Section 75 agreement to deliver population health objectives. For example, NHS GM could contribute its Place Fund and/or Place Team budget into a pooled fund, and the local authority (on behalf of the Place Partnership) could be designated to lead on the commissioning and delivery of the agreed programmes of work within the place, using that funding and/or staff.

The agreement could also specify that the local authority will host the NHS GM funded Place Team and provide the services to the place using the resources provided. Importantly. Section 75 explicitly allows a local authority to commission or provide health services on behalf of an NHS commissioner (and vice versa).

Benefits

- **Promotes and Enables Collaboration and Integration** - a Section 75 agreement frames the arrangement as a partnership rather than a traditional purchaser-provider contract. This is likely more congruent with the collaborative relationship around place.
- **Shared Governance and Oversight of Deliverables** – the agreement can establish joint governance structures. For example, a Partnership Board with representatives from NHS GM and place partners could be created to oversee the pooled funding and programme delivery.
- **Flexible Use of Funds** - funds can be used in more flexible ways to meet shared goals. The agreement can allow places to directly commission third parties or deploy resources across the place as needed without separate NHS procurement each time, if this is described within the scope of the partnership plan.
- **Avoidance of Procurement Challenge** - Section 75 arrangements between public bodies are generally not viewed as a procurement of services, but rather a co-operative agreement under statutory powers. This means NHS GM can transfer responsibilities and funding without going out to tender in the open market, and an external provider challenge is unlikely since this is seen as an in-house or joint arrangement, and not a commercial contract award.
- **Phase-in of Staffing Changes** - staff deployment can be handled more gradually. Initially, NHS GM staff can be seconded into the arrangement (remaining employed by NHS but working under the direction of the place). The Section 75 agreement might specify management arrangements for these staff (e.g. day-to-day management by place leadership, while employment policies remain with NHS GM). Because the organisations are partners, this is akin to an internal secondment in support of the partnership. There is less of a sense that a service has been outsourced to a third party – which helps avoid immediate TUPE concerns. Over time the agreement could be varied to facilitate a formal staff transfer.
- **Ability to Build in Break Clauses and Exit** - a Section 75 agreement can be written with term and termination provisions that suit all parties. For example, the initial term could be one year (shadow year) with an automatic review and option to extend to a full five-year or even ten-year term. Either party could have the right to terminate with notice (e.g. if objectives aren't being met or if the host can no longer fulfil the role), providing a formal exit route. If a host withdraws after Year 1, the agreement can simply lapse or be terminated, and NHS GM can then form a new Section 75 with whichever local government body takes on hosting in Year 2. This ability to reconstitute the partnership relatively smoothly is an advantage of the model.
- **Alignment with Wider GM Strategy** – as Greater Manchester has a history of health and care

integration (e.g. through devolution agreements and pooled budgets in localities), a Section 75 at place level aligns well.

- **Ease of Implementation** - Section 75s already exist between NHS GM and each of the 10 local authorities across GM to facilitate the Better Care Fund. So, expansion of these to cover the Place Fund and/or Place Team would be relatively straight forward.
- **Link to Existing Governance** – This approach would require a Joint Committee, this is currently the Locality Board in each place which is expected to evolve into the Place Partnership Committee. This already has a clear relationship to the Health and Wellbeing Board of each place.

Risks

- **Governance and Accountability** - while partnership is a strength, it can blur the lines of accountability. If the place team does not deliver, NHS GM cannot "enforce" performance in the same way as under a contract; instead, it must work through the agreed partnership governance to apply pressure or make changes, which could potentially slow down corrective action. Therefore, it is crucial to include clear performance indicators and monitoring requirements (mirroring the Place Outcomes metrics proposed) and to jointly agree on consequences or improvement actions if these are missed.
- **Financial Risk Share -** the agreement should spell out how financial risks are handled. For instance, if there is an overspend on a program or a shortfall in savings, is NHS GM expected to bail it out, or will the council cover it upfront? Typically, Section 75 agreements define how overspends/underspends in the pooled fund are managed. If not carefully done, NHS GM might inadvertently bear more risk than intended, or vice versa. There is also the question of VAT and budget handling – transferring NHS funds to a council can have VAT implications and different financial rules, which need expert input to avoid inefficiencies.
- **Legal Limitations -** Section 75 can only be used for certain functions and it must be checked that the activities in scope are eligible as defined in regulations. Our high level review of this suggests that this is not a risk, however this would need due diligence confirmation.
- **Limitation of Parties –** A Section 75 can only be entered into between a NHS statutory body and a Local Authority. Therefore should a place wish a different local partner to the host of the Place Fund and/or Place Team, such as an NHS Trust, this mechanism could not be used. This could therefore result in different governance between different places, which may not be welcomed from a consistency perspective as it could add complications associated with variation.

Option 3. Formal Contract (Legally Binding Service Contract)

Under this option, NHS GM would enter a formal contract for services with a provider organisation to deliver the agreed place health responsibilities.

The contract could specify the deliverables, outcomes, funding, and staffing arrangements in detail, alternatively it could take a more outcomes based commissioning approach with less of a focus on inputs. NHS GM would be the "Commissioner", a local authority or NHS Trust would be the "Provider." This model treats the "host" as an external provider for contract purposes.

There are a number of variations that could be considered within the remit of "Contractual mechanisms", for example outcomes-based commissioning or lead provider models.

Benefits

- **Clarity and Enforceability -** a formal contract provides clear definitions of each party's obligations, performance targets, and financial terms. It is legally enforceable – if either side fails to meet obligations (e.g. host/place partnership not delivering outcomes or NHS GM not paying), there is legal recourse available.
- **Financial Accountability -** payment terms, use of funds, and recovery of staff costs can be

precisely defined.

- **Managed Change -** the contract can incorporate break clauses or review points to allow termination or variation if the model isn't working or if the host needs to change. This provides flexibility while still maintaining a formal agreement.
- **Familiar Framework -** both NHS and local authority partners are familiar with contract management. This option treats the arrangement akin to commissioning a service, establishing a clear commissioner-provider relationship, which can help in performance management and escalation of issues, but is generally not common between commissioning organisations.
- **Staffing and TUPE Issues** - formally contracting out services would be interpreted as a "service provision change" in law, meaning TUPE (Transfer of Undertakings) would automatically apply, and place staff assigned to this work would legally transfer to the new provider at contract commencement. This is in line with the current intent of Chief Officers.

Risks

- **Risk of Procurement Challenge** - entering a multi-million services contract with a host local authority or NHS Trust would be required to be published on Find a Tender. Alternatively, NHS GM would need to justify a direct award (e.g. on grounds that the host is uniquely qualified) and document the decision as per procurement regulation criteria (transparency, value, etc.). There is a risk of legal challenge from other providers if the direct award is not clearly permissible, although the partnership nature here makes a challenge less likely.
- **Inflexibility/Relationship Dynamics -** a strict contract could be seen as transactional and potentially undermining the spirit of collaboration, with a preference for a partnership ethos over a commissioner-provider relationship. Additionally, once signed, a contract can be inflexible - changes to scope or funding usually require formal variations and must adhere to procurement rules. Without careful drafting, this could limit flexibility and adaptability.
- **Time, Complexity and Cost –** engaging with external legal services required to draft a bespoke agreement, negotiating and finalising a multi-year contract in a short timeframe is challenging. Contracts of this scale (length and value) typically take significant effort to draft, review and approve. The tight timeline poses a risk that the contract may not be ready for launch, or that details could be rushed and leave gaps. The costs of engaging external legal firms to draft a bespoke agreement should also be considered.
- **VAT** – expert advice would be required to understand any VAT implications of a contractual arrangement.

Option 4: Memorandum of Understanding (MOU)

A Memorandum of Understanding is a non-legally binding, collaborative agreement that outlines the parties' intentions, roles, and shared goals. This could outline a consultative or advisory forum arrangement.

In this option, NHS GM and the host organisation for the place fund and team would sign an MOU documenting how they will work together on place delivery. The MOU could cover the broad objectives, governance structure, and the plan to deploy staff and resources, effectively serving as a "good faith" agreement. However, any movement of staff would require parallel legal instruments (e.g., secondment agreements or separate workforce deployment contracts).

The ICB can task a place partnership to act purely in a stakeholder, advisory, or consultative capacity. The place partnership operates as a non-statutory "Place Board" or alliance. It brings together local leaders to co-design strategy, assess local population needs, or recommend service changes. The forum itself cannot make binding financial or legal decisions. It feeds its recommendations back to partners, including NHS GM, for formal sign-off.

Benefits:

- **Speed and Flexibility -** MOUs can be drafted and agreed relatively quickly since they are less formal. The content can be high-level and principles-based. This is advantageous given the tight timeline – the parties could, for instance, write an MOU in a few weeks, capturing the essence of the collaboration.
- **Avoidance of Procurement Challenge -** because an MOU is not legally binding and involves no commercial contract award, it avoids the requirement for procurement processes in the immediate term.
- **Collaborative Culture -** an MOU sets a collaborative tone. It emphasises mutual understanding, trust, and shared commitment, which can be valuable in the context of integrating teams. The place host may respond better to an approach that doesn't immediately impose contractual terms on their partnership.
- **Adaptability and Simplicity in Documentation -** since it's not legally binding, the MOU can be easily modified as circumstances change.

Risks:

- **Non-Enforceability -** an MOU cannot be enforced in court if one party doesn't deliver what was expected.
- **Accountability and Audit -** from a governance perspective, an MOU might be viewed as too "light" for the scale of change and value involved.
- **Need for Supplementary Agreements -** in practice, even with an MOU, certain things will still require formal agreement, including the formal transfer of funding and staffing.
- **Legal Classification -** while an MOU is not a legally binding contract, if money flows and services are provided, there's a risk that it could be challenged as a de facto contract in disguise if a third party were inclined to do so. Although unlikely, NHS GM should be cautious to ensure the MOU does not contain language that looks like a binding service contract.

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3. Conclusions

3.1 Internal NHS GM governance is not considered a feasible option for Place Partnerships, as this approach does not embody the collaborative nature of this work across arrange of partners. It retains too much control within NHS GM in relation to funding and staff, and does not support the head count reduction required in relation to staff.

3.2 Using an informal or advisory route, such as an MoU, is not considered a feasible option either as it provides no enforceable basis for service delivery, accountability, or staff and funding arrangements. As with option 1, it retains too much control within NHS GM in relation to funding and staff, and does not support the head count reduction required in relation to staff.

3.3 A formal contract is a feasible option. It is the preferred option if the host is an NHS Trust. It offers strong enforceability and delivery assurance but is less suited to integrated place functions where joint working, shared staffing, and flexible delivery models are required. Where Local Care Organisations are already in place, this is a particularly attractive option and potentially in line with future strategic direction such as IHOs. Procurement exposure make it less agile or holistic than a Section 75 partnership model.

3.4 A Section 75 agreement is a feasible option. It is the preferred option if the host is the local authority. It provides a statutory basis for NHS and local authority integration, enabling shared governance, staff deployment and flexible multi-year collaboration. It aligns with BCF, and avoids triggering procurement under PSR for in-scope place activity and offers the flexibility required for Place Fund and Place Team hosting. It supports the long-term transformation goals, while de-risking both staffing and financial arrangements for NHS GM. This approach is tried and tested across integrated commissioning models and aligns with the collaborative vision of place within GM.

3.5 This appraisal concludes different preferred governance routes depending on host. Whilst it is not necessarily favoured by NHS GM to vary the governance route, if different hosts are permitted, this will be the preferred. Otherwise the only possible option for both NHS Trust and local authority hosts is the contractual route. This is likely however to result in VAT implications for local authority hosts, which pose both an unacceptable and unaffordable cost. The alternative if the same governance route was required, would be to insist that all Place Funds and Place Teams are hosted by the same organisation type, thereby not giving each place full chose in this matter. Indeed there is strength in one organisation type hosting the Place Team and another the Place Fund, as this provides – distributed leadership and helps glue partnership.

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3.6 A high level appraisal scoring is provided in appendix 1, which in summary shows:

Governance mechanism	Place Fund	Place Team
Internal delegation within NHS GM	**Not recommended – does not achieve operating model intent**	**Not recommended – does not achieve operating model intent**
Section 75 Agreement (NHS Act 2006)	**Recommended for local government host, as most in line with place partnership approach of operating model and easy to implement given existing BCF arrangements Not possible for NHS Trust host**	**Recommended for local government host, as most in line with place partnership approach of operating model and easy to implement given existing BCF arrangements Not possible for NHS Trust host**
Formal Contract (Legally Binding Service Contract)	**Recommended for NHS Trust host, because preferred s75 not possible and easy to implement given existing contractual arrangements Possible, though not recommended for local government host as less aligned to partnership approach of operating model and potential VAT implications**	**Recommended for NHS Trust host, because preferred s75 not possible and easy to implement given existing contractual arrangements Possible, though not recommended for local government host as less aligned to partnership approach of operating model and potential VAT implications**
Memorandum of Understanding (MOU)	**Not recommended – does not effectively achieve formal transfer of resources and responsibility to host**	**Not recommended – does not effectively achieve formal transfer of resources and responsibility to host**

4. Outstanding risks / issues

4.1 If direction of travel, as set out in the neighbourhood Framework suggests that single or multi neighbourhood providers and/or Integrated Health Organisations (IHOs) are likely to be led by acute provider organisations in the future, then should this influence our GM decision making. This could suggest a more sensible direction of travel would be towards NHS Trusts as hosts of the place fund and place team, rather than local government.

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4.2 Clarification required with regard to *section 65Z5 delegation and 65Z6 joint exercise arrangements and also "conferral of discretions" powers* which whilst included in legislation, have been on hold as determined by NHSE. Should that change we will consider any benefits these may bring.

4.3 Clarity of timelines. It is currently understood that the earliest the governance would need to be in place for these arrangements would be 1 January 2027 for the place team and 1 April 2027 for the place fund.

5. Recommendations

5.1 The Place Outcomes will be set by NHS GM and governed through the Place Partnership Agreement.

5.2 The preferred host for the Place Fund is now understood to be the Local Authority. A Section 75 agreement is the preferred governance route for the Place Fund when hosted by a Local Authority.

5.4 The preferred host for the Place Team is now understood to be an NHS Trust. A contractual agreement is the preferred governance route for the Place Team when hosted by an NHS Trust.

5.5 Regardless of governance mechanism, it will be explicit that the host is required to manage the place fund and/or place team via the Place Partnership. As such the decision making in relation to the place fund and/or place team will not sit within the host organisation, but rather the Place Partnership.

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Appendix 1 - Governance options scoring

Governance option	Funding	Staff
Internal ICB governance – delegation to an internal ICB group via Scheme of Reservation and Delegation	Strategic alignment – 2 (partners are able to be members of governance but does not reflect spirit of partnership) Deliverability/effectiveness – 3 (already in place, or will be established anyway but only as single organisation) Cost – 5 (within existing resources, as exists already) Total - 10	Strategic alignment – 2 (partners are able to be members of governance but does not reflect spirit of partnership) Deliverability/effectiveness – 2 (doesn't achieve staff transfer) Cost – 5 (within existing resources, as exists already) Total - 9
Section 75 – governed through a joint committee between NHS GM and a Local Authority	Note – not possible for NHS Trust therefore score of 0 Strategic alignment – 5 (in line with place partnership approach of operating model) Deliverability/effectiveness – 5 (already in place, or will be established anyway) Cost – 5 (for LA within existing resources, as exists already for BCF) Total – 0 for NHS Trusts as not possible **Total – 15 for LAs**	Note – not possible for NHS Trust therefore score of 0 Strategic alignment – 5 (in line with place partnership approach of operating model) Deliverability/effectiveness – 3 (TUPE requirements more complex to non NHS employer) Cost – 5 (for LA within existing resources, as exists already for BCF) Total – 0 for NHS Trusts as not possible **Total – 13 for LAs**
Contract mechanism – through the NHS standard contract	Strategic alignment – 4 (able to reflect place partnership approach of operating model) Deliverability/effectiveness – 5 (already in place)	Strategic alignment – 4 (able to reflect place partnership approach of operating model) Deliverability/effectiveness – 5 (already in place)

	Cost – 5 for NHS Trusts (within existing resources, as exists already), 2 for LA (due to potential VAT issues) **Total – 14 for NHS Trusts** Total – 12 for LAs	Cost – 5 for NHS Trusts (within existing resources, as exists already), 2 for LA (due to potential VAT issues) **Total – 14 for NHS Trusts** Total – 12 for LAs
Informal route – such as a consultative or advisory forum, potentially through an MOU	Strategic alignment – 2 (partners are able to be members of group but informal nature doesn't put sufficient weight behind arrangement) Deliverability/effectiveness – 1 (easy to implement but not clear or firm enough for delivery) Cost – 5 (not costly) Total - 8	Strategic alignment – 2 (partners are able to be members of group but informal nature doesn't put sufficient weight behind arrangement) Deliverability/effectiveness – 1 (easy to implement but not clear or firm enough for delivery and doesn't achieve staff transfer) Cost – 5 (not costly) Total - 8

Flash Report from Workforce Group

Report To (Meeting):	One Stockport Health and Care Board		
Report From: (Committee Chair)	Kathryn Rees – Executive Director, Corporate and Support Services		
Drafted by: (SRO)	Jennie Neill, Assistant Director – HR &OD		
Date:	29 July 2026	**Agenda Item No:**	11

Decision		**Assurance**		**Information**	**X**

Date of meeting
Annual update
Summary of updates provided during meeting
• Workforce development activity has concentrated on the places, partners and resources most likely to shape resident conversations. • Welcome to Live Well: ○ 24 bespoke training sessions delivered ○ 10 team meetings ○ 450 attendees. ○ 60+ organisations/groups. ○ The training has been refreshed to reflect where the programme is now and to incorporate feedback from colleagues and partners. Making Every Contact Count (MECC) remains a key part of the delivery programme. ○ Delivery moving forward will be a blended model. There will still be an in-person session each month, but there will also be an online session. ○ Training will be delivered by the neighbourhood coordinators, with support from a colleague from a partner organisation, for example VCFSE. ○ Team-based sessions will be delivered by HR/OD teams in the council, with tailored content to match the needs of the team. ○ 7-minute briefings will be developed in response to feedback from GMP and to meet the needs of local businesses. ○ There is an aspiration to align delivery of Welcome to Live Well training to Neighbourhood Networks; however, room availability is preventing this at the moment. This will be resolved by booking further in advance.

- Update by setting:
    - **Family Hubs:** 3 resident-welcoming teams; 3 team meetings; prior MECC knowledge; Padlet shared; upcoming tablets in receptions.
    - **Libraries**: neighbourhood coaching engaged; MECC in place; Padlets shared.
    - **Life Leisure:** input requested to share active-wellbeing practice.
    - **Cornerstone:** spaces/offers pack to be refined for consistent onboarding.
    - **Online/Padlet:** Padlet links reshared and SharePoint resources used for update

- Live Well training content
    - What we have done so far:
        - Centres, Spaces and Offers; Neighbourhood profiles; Family Hubs; Digital Tools; Neighbourhood and Work Well co-ordinators; Independence and Care; NNHIP & ALTs
    - What's next
        - Next phase Centres, Spaces, Offers; LWIF Grants; Virtual Live Well Centres; Neighbourhood Action Plans; Opening of Independent Living Centre
    - Next steps on agreeing content:
        - Review content with ICB colleagues
        - Feedback from locality workforce leads – workshop planned to compile what is happening in our partner organisations, how Live Well is being communicated and how colleagues are being trained – need partnership commitment for this
        - Work with partners to encourage colleagues from across the locality to attend training
        - Restart training as soon as possible and reach a wider audience across our partnership
        - Develop 7-minute briefings

Key decisions taken

- Partner commitment, rollout, governance and support needs remain the key areas for development.
- A priority for the next phase is to agree which resources will support partners to roll out Live Well across their workforce or volunteers.
- However, there are a number of challenges to ongoing delivery – the issues for consideration below highlight these

Matters referred to the Locality Board for approval, debate or further consideration

Areas for consideration:

- What commitment can your organisation make now — and what would make it stronger?
- What will teams do differently in resident, customer or community conversations?
- Where does Live Well sit in planning, reporting and decision-making?
- What resources, facilitation or evidence would help you move from intention to rollout?

Risks and mitigations raised	
Risk	Mitigation
Partners not embedding Live Well in their organisations and it remains to be perceived as “council led” instead of “partnership delivered”	One Stockport Workforce Group Live Well Workshop coming up with partner HR and OD leads to agree how delivery will commence in partner organisations
Room availability may limit alignment of Welcome to Live Well training with Neighbourhood Networks	Booking rooms further in advance to support neighbourhood-based delivery.
Inconsistent adoption if the Live Well story is not made practical for each setting, including conversations, signposting and escalation.	Tailoring training materials as required for the setting and incorporating feedback
Delivering culture change	Need all partners on board delivering Live Well training, through supervision, communications etc so it becomes fully owned and embedded as how we work in Stockport – case studies of Working the Live Well Way to be shared to embed learning