

Agenda

Trafford Locality Board Meeting

Date: Tuesday, 17 March 2026

Time: 1.00 pm

Venue: Meeting Room 9, Trafford Town Hall and via MS Teams

Item No.	Time	Duration	Subject	Paper/ Verbal	For Approval/ Discussion/ Information	By Whom
1a	1.00	5 mins	Apologies for Absence		Info	Chair
1b			Declarations of Interest		Info	Chair
1c			Minutes of the Meeting Held on the 17th February 2026	3 - 10	Approval	Chair
1d			Action Log & Matters Arising	11 - 12	Discuss/Info	Chair
2			Forward Plan	13 - 14	Info	Chair
3	1.05	5 mins	Public Questions	15 - 16	Discuss	Chair
4	1.10	10 mins	NHS Reforms		Discuss/Info	GJ
5	1.20	10 mins	NHS GM Trafford Finance report	17 - 28	Discuss/Info	JF
6	1.30	10 mins	Trafford Locality Scorecard - March 2026	29 - 44	Discuss/Info	TM
7	1.40	10 mins	Risk Register	45 - 54	Discuss/Info	TM
8	1.50	10 mins	Governance Review	55 - 60	Discuss/Info	TM

9	2.00	15 mins	Community Services Review: Decommissioning of Community Ear Care Service and realignment of investment	61 - 88	Approval	AC
10	2.15	15 mins	Trafford Participation Strategy 2026-2028	89 - 114	Approval	TM
11			PCCC Highlight Report	115 - 116	Info	GJ
12			Any Other Urgent Business			Chair

Minutes

Trafford Locality Board

Date: Tuesday, 17 February 2026

Time: 1.00 pm

Venue: Meeting Room 9 and via MS Teams

Present	Apologies
<p>Jane Wareing (JW) GP Board Representative and Co-Chair Helen Gollins (HG) Director of Public Health, Trafford Council Maggie Kufeldt (MK) Corporate Director of Adults & Wellbeing Gareth James (GJ) Deputy Place Lead for Health & Care Integration, NHS Greater Manchester Integrated Care - Trafford Heather Fairfield (HF) Healthwatch Darren Banks (DB) Group Director of Strategy, MFT Sara Todd, Place Based Lead NHS GM Trafford & Chief Executive of Trafford Council</p> <p>In attendance:</p> <p>Patricia Davies (PD) LCO Chief Executive Cllr Jane Slater (JS) Trafford Councillor Ian Bett (IB) LCO Director of Performance and Operations Pippa Dewhirst, Governance Manager, NHS GM Trafford Jennifer Clarke, Programme Manager, Health & Care, Trafford Council for item 3 Member of the Public - Samantha Young</p>	<p>Tom Rafferty (TRa) Acting Chief Strategy Officer, MFT Tom Ross (TR) Leader of Council and Co-Chair (in the Chair) Elizabeth Calder (EC) GMMH Charlotte Bailey (CB) Chief People Officer NHS GM Cllr Karina Carter (KC) Trafford Councillor Manish Prasad (MP) Associate Medical Director Thomas Maloney (TM) Programme Director Health and Care Zahid Ahmed (ZA) GP Board Representative Bernadette Ashcroft (BA), VCFSE Representative Julie Flanagan, Finance Lead, NHS GM Trafford</p>

Item No.	Topic	Action
1a	<p>APOLOGIES FOR ABSENCE</p> <p>Apologies for absence were received from Tom Ross, Tom Rafferty, Elizabeth Calder, Karina Carter, Tom Maloney, Charlotte Bailey, Manish Prasad, Bernadette Ashcroft and Julie Flanagan.</p>	
1b	<p>DECLARATIONS OF INTEREST</p> <p>There were no declarations of interest.</p>	
1c	<p>MINUTES OF THE MEETING HELD ON 20 JANUARY 2026</p> <p>RESOLVED: the minutes of the meeting held on 20 January 2026 were approved as an</p>	
1d	<p>ACTION LOG & MATTERS ARISING</p> <p>The action log was reviewed and it was noted all actions were either complete or not yet due.</p>	
1e	<p>FORWARD PLAN</p> <p>RESOLVED: the forward plan was noted.</p>	
2	<p>NHS REFORMS</p> <p>The NHS Greater Manchester Organisational Change stakeholder briefing was shared with the agenda for information. GJ noted whilst the operating model had been agreed work continued to agree the detail that would support the model. GJ advised that staff were currently being consulted on the proposed staffing structures and had an opportunity to provide feedback until the 27th February. GJ confirmed the first iteration of the voluntary redundancy scheme had been completed and the staff had left the organisation. GJ highlighted the opportunity to apply for the second window of voluntary redundancy (VR) was due to end and it was expected a smaller number of staff would leave through this VR window.</p> <p>RESOLVED: the nhs reform update was noted.</p>	
3	<p>DRAFT TRAFFORD NEIGHBOURHOOD PLAN 26/27</p> <p>The report contained Trafford's Draft Neighbourhood Plan submission. GJ introduced the plan noting the draft NHS Planning Guidance for 2026/27 introduced a new national requirement for Neighbourhood Plans, reflecting priorities in the NHS 10-Year Plan. In Greater</p>	

Manchester (GM) localities already had Locality Plans and Delivery Plans, so all Neighbourhood Plans developed in localities had been integrated into these existing plans and structures to maintain coherence. Trafford's Neighbourhood Plan responded to the NHS 10 Year Plan and incorporated our Live Well approach, covering health, public services, and community support, guided by Live Well Hallmarks.

GJ highlighted the draft plan responded to a centrally commissioned GM template and was sectioned into the five areas below, covering current elements of our neighbourhood model and proposed the priorities and areas of congruence for our plan in 26/27:

- Locality Neighbourhood Structure
- Neighbourhood Governance
- Neighbourhood Operating Model
- Local Delivery Priorities 2026/27
- Local Delivery of GM Commissioning Priorities 2026/27

HG confirmed following submission of the draft plan a further review of priorities would be undertaken to further refine and quantify deliverables, creating credible plans behind each of the stated priorities. JC noted partners would be engaged to complete this work.

HG advised NHS GM had committed to collating learning from the 10 Locality Neighbourhood Plans and sharing via the established GM Coordination Group and the outputs would be shared within locality governance. HG noted it was anticipated there would be a final submission following publication of the NHS Neighbourhood Health Planning Guidance.

Members gave thanks for the work of the PMO team supporting drafting the plan and provided feedback as below.

Governance: The governance was too complex and required clearer articulation.

Vision: A concise overarching vision was needed to anchor the plan.

Prioritisation: With 76 priorities, a prioritisation framework was required to identify the core deliverables for 2026/27.

Accessibility: An easy-read version should be produced to support resident engagement.

Clinical and Professional Leadership: References to CPAG/TCAPs need to be checked for completeness.

National Guidance: National guidance was expected shortly and the

	<p>plan may require revisions.</p> <p>Children’s Services: A reference to Family First reforms should be included.</p> <p>PD joined the meeting at this point.</p> <p>GJ noted the feedback and confirmed a governance review had been initiated and a further update would be brought to the Board. Members supported the submission noting the plan would be developed and the above feedback incorporated for the final submission expected in May.</p> <p>RESOLVED: Trafford Locality Board:</p> <ol style="list-style-type: none"> 1. Acknowledged the co-production, support and contributions from all partners in developing the draft Trafford Neighbourhood Plan. 2. Approved the draft Neighbourhood Plan, subject to amendments, and submit to NHS GM (17th February 26). 3. Continued to develop draft content and respond collaboratively to NHS Planning Guidance, once issued, ahead of resubmission of our final plan in approximately May 26. 	<p>ACTION</p> <p>ACTION</p>
<p>4</p>	<p>NHS GM TRAFFORD FINANCE REPORT</p> <p>The report presented the financial position for the ICS overall and the locality delegated budgets by NHS GM for December 2025. As at Month 9 the total ICS year to date deficit was £76m, a £10m adverse variance against the plan, an improvement of £2.8m from the previous month. The Locality position was overspent £1.9m YTD with a forecast outturn of £2.39m overspent. The improvement in the YTD reflected amendments resulting from the transition to the new ledger as indicated in the M8 report. The forecast position showed a slight improvement on the previous month. Actions being taken to address the forecast variance for individual packages of care were underway however this did not deliver a breakeven position. The locality YTD CIP position was ahead of plan by £482k and was forecast to deliver the target of £2.92m. Due to the transition to a new finance ledger in October the analysis of expenditure across all sectors was excluded again from this report. An increased financial control framework remained in place with the system required to demonstrate and provide assurance there was a credible plan to deliver the forecast to secure the remainder of the deficit support funding.</p> <p>GJ highlighted that whilst it was anticipated deficit support funding would be received for the final quarter of the year there was still some risk in the system particularly in relation to the cost of packages of care. GJ noted whilst there had been a slight improvement there would</p>	

	<p>still be an overspend in that area due to the increase in fees and number of patients. GJ noted work was on going as to how the market could be managed to support care home fees and a further update would be brought back to the Board confirming what mitigations could be put in place once an action plan was approved with GM.</p> <p>RESOLVED: The Locality Board:</p> <ul style="list-style-type: none"> • Noted the Month 9 year to date reported financial position for GM ICS of £76m deficit, against a planned deficit of £66m, resulting in a variance against plan of a £10m deficit. • Noted the breakeven forecast outturn position in line with NHSE reporting requirements. • Noted a Locality YTD variance of £1.9m overspend for commissioned services and a forecast variance of £2.4m. • Noted the workstreams in place targeting the cost pressure and the increased grip and control measures for the locality • Noted the delivery of ICS CIP as at Month 9 of £445.8m against a plan of £422.1m, an overachievement of £23.8m • Noted the locality CIP delivery of £2.45m against a plan of £1.97m an • overachievement of £482k and forecast to achieve full delivery. • Noted the risk of the Q4 deficit support funding being clawed back if the system did not deliver the forecast position. • Noted the continuation of the increased financial control framework including local recovery plans. 	ACTION
5	<p>TRAFFORD LOCALITY QUALITY REPORT Q3</p> <p>The report was provided to give TLB a summary of the work undertaken to improve the quality of patient care and experience that had taken place since the last update. The report included updates that had already been considered throughout various locality governance and presented issues in an alert, assure and advise format for the benefit of the Board.</p> <p>GJ introduced the report, noting the Locality Quality Group and been stood down as per direction from the central team and in line with the other localities. GJ noted the quality issues would be escalated through GM quality and contract management routes though the exact locality role required further clarification. Members expressed concern about the potential loss of local scrutiny and influence and GJ agreed a balance was needed as providers potentially felt the meeting was a duplication as they were held to account at a GM level.</p> <p>PD provided an update on progress with District Nursing improvements and advised that whilst the financial envelope was still being discussed with GM, MFT and LCO had started to recruit to reduce the clinical risk. PD confirmed that mutual aid was being provided from South Manchester team and urgent calls were being dealt with in a timelier manner. PD noted that deferrals had reduced from more than 200 a week to a 100 and whilst that was still high, they had all been triaged to ensure urgent treatment was not required. PD</p>	

reported good news that there had been no reportable pressure sores over the last quarter. GJ gave thanks for the update and advised that a report was due to be considered at Health Scrutiny with regards to potentially reducing the ear care service to bring Trafford in line with other localities and reprioritizing funds to support district nursing and palliative care. HF urged the impact on the local population was considered if changes to the ear care service were being considered and GJ confirmed a quality impact assessment would be completed. Members thanked PD for the update and the focus on improving district nursing for Trafford.

RESOLVED: Trafford Locality Board noted the report.

6 BETTER CARE FUND PROGRAMME QUARTER 3 RETURN

The BCF sits within the Section 75 framework partnership agreement between Trafford Council and NHS GM. The report provided the national return in Q3 which was required to be submitted by close of play on 30th January 2026 The Quarter 3 submission focused on:

- an update on the delivery against the BCF metrics for the period of 1st April -31st October 2025; and
- Confirmation of income and expenditure of the BCF 25/26 Programme and actual expenditure for Q3 25/26.

The full BCF return to NHS England was attached alongside the paper MK provided a summary of the key highlights as per the paper. MK advised all the key metrics were on track to meet target except the emergency admissions to hospitals for people 65+. MK confirmed this target had been on track until NHS England updated Health and Wellbeing boards population data which changed the target. MK noted the mitigations as per the report. MK advised at the end of Q3 the expenditure position was due to be 74% of planned incomes so there were no budgetary concerns.

DB queried how value for money was assessed, MK advised patterns and trends were reviewed but a funding review was due to consider if investments provided best value. HG noted the BCF would be considered at the Health and Wellbeing Board and noted public health maybe able to align to support in terms of prevention. PD queried the BCF governance. GJ advised the BCF was formally signed off at the Health and Wellbeing board and was considered at the Locality Board due to its links with the locality plan.

RESOLVED: Trafford Locality Board:

- Noted the content of the final BCF return including mitigating actions where performances was challenged;
- Supported submission that was submitted to NHS England on 30th January 2026 and would be retrospectively approved by Health and Wellbeing Board on 13th March 2026; and
- Noted that the date for the next submission has yet to be released. However, in line with previous submissions this was anticipated to be in April.

7	ANY OTHER URGENT BUSINESS Antimicrobial Resistance (AMR) – HG took the opportunity to update on Trafford’s current AMR position, noting Trafford had been 106th nationally and were now 54th showing a positive change.	
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Trafford Locality Board - Action Log 25/26

Action No.	Date of Meeting	Agenda Item Ref.	Action	Update	Lead	Target Date	Status
176	16/12/25	Early diagnosis cancer strategy	AH to bring an update on MFT capacity to support early diagnosis cancer strategy.		AH	21/04/26	In Progress
182	17/02/26	Draft Neighbourhood plan	TLB feedback to be incorporated into final submission in May including vision statement etc.		TM	19/05/26	In Progress
183	17/02/26	Draft Neighbourhood plan	TM to produce easy to read version to support resident engagement.		TM	19/05/26	In Progress
184	17/02/26	Governance Review	Report to be brought to the Board confirming governance review arrangements.		PDe/TM	17/03/26	Completed
185	17/02/26	Finance	Action plan on managing packages of care pressures to be brought back to the Board once agreed with GM.	Verbal update to be provided at the meeting.	GJ	17/03/26	Completed

In Progress
Overdue
Completed

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Agenda Item 2

Date & Time of Meeting	21 April 1pm	19 May 1pm	16 June 1pm
Agenda and Papers Sent out	14-Apr	12-May	09-Jun
Deadline for Papers	13-Apr	11-May	10-Jun
Chair			
Part 1 – GM ICB Committee (Trafford)			
	Locality Update and Governance	Locality Update and Governance	Locality Update and Governance
	Reform Update	Reform Update	Reform Update
	Task and Finish Group	Task and Finish Group	Task and Finish Group
	Finance, Performance and Sustainability	Finance, Performance and Sustainability	Finance, Performance and Sustainability
	Finance Report	Finance Report	Finance Report
		Locality Scorecard	
	Risk	Risk	Risk
			Risk Review
	Quality	Quality	Quality
	Primary Care	Primary Care	Primary Care
		Primary Care Highlight	
	Childrens	Childrens	Childrens
	ND Pathway		Childrens Update
	TCAPS	TCAPS	TCAPS
		TCAPs Highlight Report	
	Trafford Provider Collaborative	Trafford Provider Collaborative	Trafford Provider Collaborative
	Workwell	Changing Futures	
	Trafford Workforce Group	Trafford Workforce Group	Trafford Workforce Group
	Trafford Participation Group	Trafford Participation Group	Trafford Participation Group
	Partner Update	Partner Update	Partner Update
	Healthwatch 26/27 Forward Plan	Healthwatch 25/26 Annual Review	Healthwatch Performance Report
	Community Collective Annual Review 25/26		
Part 2 – Section 75 Committee			
			s75 yearly review 25-26
		BCF 26/27 Submission	

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Public Question Time – Trafford Locality Board

This item is time limited to 5 minutes.

Public Questions

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

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

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

Name:

Contact Details:

Question:

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

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Name of Committee / Board		Trafford Locality System Board		
Date of Meeting		17 March 2026		
Report Title		NHS GM Trafford Finance report		
Report Author & Job Title		Julie Flanagan NHS GM Trafford		
Organisation Exec Lead		Gareth James		
OUTCOME REQUIRED <i>(please highlight)</i>	Approval	Assurance X	Discussion	Information X
EXECUTIVE SUMMARY				
<p>The attached slide deck presents the financial position for the ICS overall and the locality delegated budgets by NHS GM for January 2026.</p> <p>As at Month 10 the total ICS year to date deficit is £75.7m, a £24.8m adverse variance against the plan, a deterioration of £14.8m from the previous month.</p> <p>The Locality position is overspent £2.37m YTD with a forecast outturn of £2.4m overspent. The deterioration in the YTD reflects the volatility in the activity and expenditure within packages of care however this is not expected to materially impact the forecast position which remains broadly in line with the previous month overall. Actions being taken to address the forecast variance for individual packages of care are underway however this does not deliver a breakeven position</p> <p>The locality YTD CIP position is ahead of plan by £322k and is forecast to deliver the target of £2.92m.</p> <p>An increased financial control framework remains in place with the system required to demonstrate and provide assurance there is a credible plan to deliver the forecast to secure the remainder of the deficit support funding.</p>				
RECOMMENDATIONS				
<p>The Locality Board is requested to:</p> <ul style="list-style-type: none"> • Note the Month 10 year to date reported financial position for GM ICS of £75.7m deficit, against a planned deficit of £50.9m, resulting in a variance against plan of a £24.8m deficit. • Note the breakeven forecast outturn position in line with NHSE reporting requirements. • Note a Locality YTD variance of £2.37m overspend for commissioned services and a forecast variance of £2.4m. • Note the workstreams in place targeting the cost pressure and the increased grip and control measures for the locality • Note the delivery of ICS CIP as at Month 10 of £500.8m against a plan of £496.6m, an overachievement of £4.1m • Note the locality CIP delivery of £2.61m against a plan of £2.29m an overachievement of £322k and forecast to achieve full delivery. • Note the risk of the Q4 deficit support funding being clawed back if the system does not deliver the forecast position. 				



<ul style="list-style-type: none"> Note the continuation of the increased financial control framework including local recovery plans. 	
<p>CONSIDERATIONS – these must be completed before submission to the Board – Reports with incomplete coversheet information will not be accepted and shared with the board</p>	
<p>Risk implications <i>(Please provide a high-level description of any risks relating to this paper, including reference to appropriate organisational risk register)</i></p>	<p>The volatility in the expenditure of individual packages of care expenditure continues to be the main risk to the financial position. Actions are underway targeting several aspects of this area of spend, however impact in 2025/26 will be limited to Q4.</p>
<p>Financial implications and comment/approval <i>(Please detail which organisation(s) will be impacted, and if not required, please briefly detail why)</i></p>	<p>Name/Designation:</p>
	<p>Actions to address the in year cost pressures within individual packages of care in the second half of the year are crucial to stabilising the expenditure and provide an improved foundation for 26/7.</p>
<p>Comment by Trafford Clinical and Practitioner Senate (TCAPS) and/or Clinical Lead <i>(If not required, please briefly detail why)</i></p>	<p>N/A</p>
	<p>Name/Designation: (If appropriate)</p>
	<p>Comment:</p>
<p>What is the impact on inequalities? <i>(Please provide a high-level description of any known impacts)</i></p>	<p>N/A</p>
<p>Equality Impact Assessment / Quality Impact Assessment Outcome <i>(If not appropriate at this stage please state if an EIA or QIA is necessary)</i></p>	<p>N/A</p>
<p>People and Communities: Communications & Engagement <i>(Please detail relevant patient/public engagement completed and/or planned, and if not required please briefly detail why)</i></p>	<p>N/A</p>
<p>Trafford’s Carbon Footprint <i>(Please provide a high-level description of any known positive and/or negative impacts – consider the following topics: energy usage; staff or public transport; waste or materials used. Include steps that could be taken to reduce carbon within relevant plans)</i></p>	<p>N/A</p>
<p>Links to Measurement / Outcomes <i>(Please detail if this is included within the report)</i></p>	



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

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Trafford Locality Finance Report Month 10 January 2026

Trafford

Integrated Care Partnership



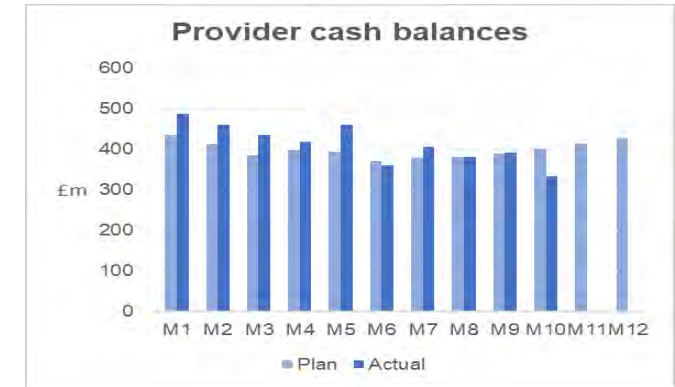
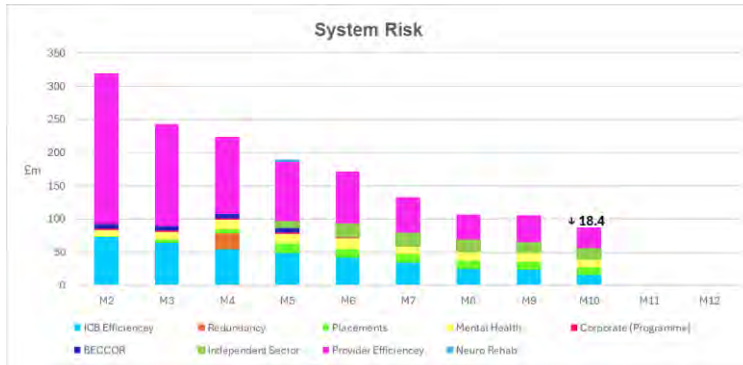
At Month 10 the total ICS year to date deficit is £75.7m, a £24.8m variance behind plan (Month 9: variance of £10.0m), which is a deterioration of £14.8m compared to last month.

M10 2025/26 ICS Surplus/(Deficit) £m	In Month Plan	In Month Actual	In Month Variance	YTD Plan	YTD Actual	YTD Variance	Full Year Plan	Full Year Forecast	Full Year Variance
GM NHS Providers	£15.7	£0.9	-£14.8	-£44.6	-£69.5	-£24.8	£7.5	£7.5	£0.0
NHS GM	-£0.6	-£0.6	-£0.0	-£6.3	-£6.3	£0.0	-£7.5	-£7.5	£0.0
ICS Total	£15.1	£0.3	-£14.8	-£50.9	-£75.7	-£24.8	£0.0	-£0.0	-£0.0

Key points of note for Month 10 are:

- Whilst an overall deficit continues to be reported, there has been:
 - a reduction in the extrapolated run rate for the GM providers of £9.7m (excluding IA costs)
 - a reduction in system reported gross risk of £18.4m
 - and a further reduction in net risk of £8.4m for NHS GM this month as a result of the on-going delivery of recovery plans
- The YTD provider position is now £24.8m behind plan, a deterioration of £14.8m in month, with the remaining reported pressures still mainly relating to the delay in CIP delivery. Whilst there has been a £16.1m adverse performance against the in-month recovery plan forecast trajectory for providers (£13.2m attributed to MFT, £1.6m to NCA), all trusts have confirmed directly with NHSE they will deliver the plan and manage any remaining financial risk.
- NHS GM is reporting a £6.3m YTD deficit this month, which remains in line with the plan. Pressures continue relating to ADHD, Autism and s117 within Mental Health, due to the continuing issue of backdated invoices being submitted by new providers under Right to Choose. All Age Continuing Care has deteriorated this month, due to new backdated high-cost complex cases, and pressures associated with Independent Sector elective activity and delays in delivery of savings also continue to be reported. Finance Recovery Plans continue to be monitored, and updates indicate that whilst the recovery actions have reduced the level of spend compared to earlier in the year, they haven't delivered the original planned reductions.
- On a YTD basis, CIP delivery is £4.1m ahead of target as a system (£0.2m behind plan by NHS GM, offset by a favourable provider variance of £4.3m). Whilst it is forecast that there will be over-delivery against CIP targets, there continues to be a risk to delivery reported by a number of organisations.
- Deficit Support Funding (DSF) has been received up to and including Q4, but there remains a risk that this is subject to clawback if a balanced position for the system is not delivered.
- An increased financial control framework of enhanced grip and control still remains in place to ensure only essential additional expenditure is committed, and on-going scrutiny of the financial position and delivery of CIP through the System Improvement process continues.

The below table outlines key areas to note for Month 9:



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System Risk

- The total gross risk has been estimated at £87.6m at M10. This is a further decrease of £18.4m from M8. Of the total:
 - £31.0m relates to providers.
 - £56.6m relates to NHS GM.
- The majority of this relates to risk associated with the delivery of efficiency targets.
- The GM system is currently reporting that all risk will be fully mitigated, resulting in zero net risk.

System Efficiency

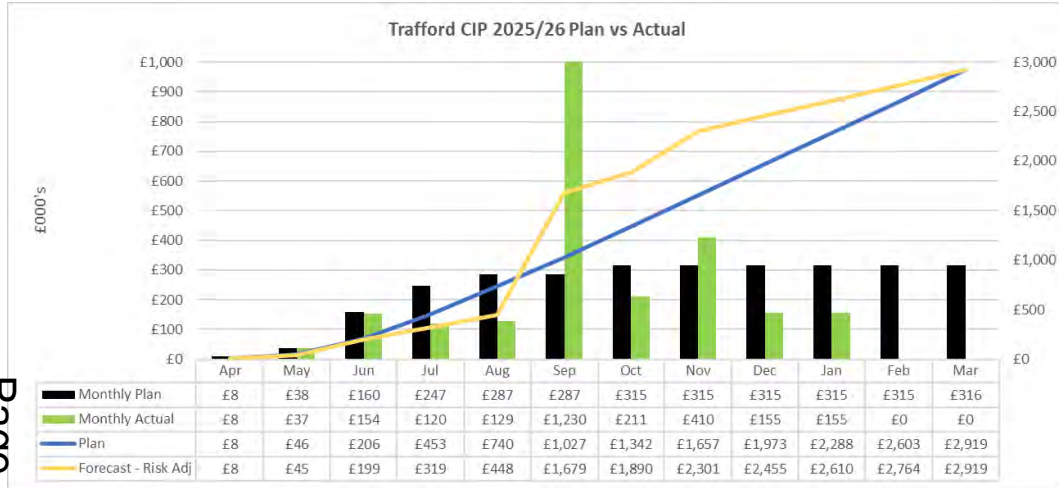
- The chart above details the savings delivered against an overall system savings target of £656.0m
- YTD savings of £500.8m have been delivered against a target of £496.6m, of which 58.4% has been delivered recurrently. Delivery is currently £4.1m ahead of plan YTD.
- The full year target of £656.0m is forecast to be exceeded by £0.9m, albeit with risks still being reported.

Cash

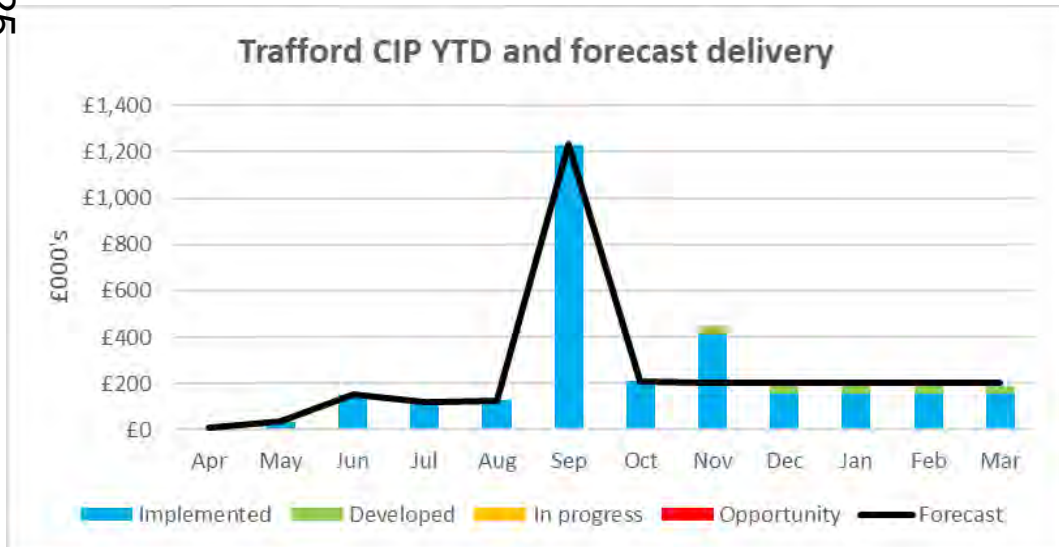
- GM providers (as shown in the chart above) are £68.9m below the planned cash balance (plan: £402.5m, actual: £333.5m).
- At M10 NHS GM had drawn down cash largely in line with the expected straight-line profile (83.3%), which is due to internal processes to ensure that the ICB meets the cash limit at year end. The allowable cash balance at the end of M10 equated to £8.5m, with an actual closing balance of £0.5m.
- The cash position remains challenging for the rest of the year, and NHS GM will continue to actively manage the system working capital position, promoting prompt invoicing and collection of debtors, and utilisation of payment terms with creditors.

Summary Financial Position as at Month 10				M9	In Month	Forecast			In Month
	Budget	Expenditure	Variance	Variance	Movement	Budget	Expenditure	Variance	Movement
	£'000	£'000	£'000	£'000		£'000	£'000	£'000	
Commissioned Services									
Mental Health Services	3,978	3,965	13	10	↑	4,804	4,788	15	↑
Community Services	10,460	10,416	44	36	↑	12,552	12,487	65	↑
Personalised Packages of Care	36,498	39,104	-2,605	-2,080	↓	43,757	46,485	-2,729	↓
Primary Care Locally delegated	5,845	5,855	-11	-39	↑	7,260	7,260	0	↓
Estates void & subsidy	1,834	1,817	17	8	↑	2,200	2,200	0	→
Capacity & Discharge Fund	1,536	1,360	176	156	↑	1,843	1,628	215	→
Total Commissioned Services	60,151	62,517	-2,366	-1,908	↓	72,415	74,848	-2,433	↓

- The volatility in individual packages of care expenditure has impacted the year to date variance however this is not anticipated to materially impact the forecast.
- The forecast is a deficit of £2.43m a slight deterioration on the previous month.
- The forecast assumes full delivery of CIP, performance year to date is £2.45m with a NHSE risk adjusted outturn of £2.92m being in line with the target.



- Forecast achievement of £2.919m is in line with the target.
- YTD performance is £322k ahead of plan.
- The recurrent / non recurrent split of the schemes for in year delivery is 76%/24%.
- Contract slippage within primary care and mental health are the main contributors to the non recurrent savings.
- Workstreams to address the financial recovery plan will be considered to support the recurrent full year effect of this year's target.





- Progress update on actions to address packages of care spend:
 - Joint review of LD packages of care with the LA – phase 2 delay to commencing this work due to staff changes and NHS reform organisational change.
 - End of life task and finish group – analysis of the activity and referral data nearing completion.
 - Market management CHC framework rate – in discussion with central GM colleagues with regards to the next steps on engaging with Trafford care homes.
 - CareCubed software package training and engagement with local providers complete.
 - BAU review of care plans on-going
- Enhanced grip and control measures for the locality will be in place
 - Additional escalation local assurance meetings to be scheduled with a specific focus on financial performance
 - Individual package of care deep dives incorporating finance and quality to provide further assurance
 - Increased scrutiny of STAR requests



The Locality Board is requested to:

- Note the Month 10 year to date reported financial position for GM ICS of £75.7m deficit, against a planned deficit of £50.9m, resulting in a variance against plan of a £24.8m deficit.
- Note the breakeven forecast outturn position in line with NHSE reporting requirements.
- Note a Locality YTD variance of £2.37m overspend for commissioned services and a forecast variance of £2.4m.
- Note the workstreams in place targeting the cost pressure and the increased grip and control measures for the locality
- Note the delivery of ICS CIP as at Month 10 of £500.8m against a plan of £496.6m, an overachievement of £4.1m
 - Note the locality CIP delivery of £2.61m against a plan of £2.29m an overachievement of £322k and forecast to achieve full delivery.
 - Note the risk of the Q4 deficit support funding being clawed back if the system does not deliver the forecast position.
 - Note the continuation of the increased financial control framework including local recovery plans.

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Name of Committee / Board		Trafford Locality Board		
Date of Meeting		19 March 2026		
Report Title		Trafford Locality Scorecard – March 2026		
Report Author & Job Title		Thomas Maloney Programme Director Health and Care, NHS GM (Trafford) / Trafford Council, Phil Jefferson, GM ICB Intelligence Analyst (Trafford)		
Organisation Exec Lead		Gareth James, Deputy Place Lead for Health and Care Integration, NHS GM (Trafford)		
OUTCOME REQUIRED	Approval	Assurance X	Discussion X	Information X
EXECUTIVE SUMMARY				
<p>The purpose of this paper is to present the current version of the Trafford Locality Scorecard and provide an update on progress. The Trafford Locality Scorecard aligns with Trafford's 7 Delivery Ambitions. To help identify priority areas, a set of focus metrics have been identified for discussion at Locality Board and, where available, narrative from Service Leads is included.</p> <p>The detail this month focuses on areas where the locality has made significant improvements over the past few years.</p>				
RECOMMENDATIONS				
<p>The Board is asked to:</p> <p>a) Note the update related to the Trafford Locality Scorecard (March 2026) and accompanying narrative.</p>				
CONSIDERATIONS – these must be completed before submission to the Board – Reports with incomplete coversheet information will not be accepted and shared with the board				
Risk implications <i>(Please provide a high-level description of any risks relating to this paper, including reference to appropriate organisational risk register)</i>		There is a general risk that if we don't mobilise adequate performance arrangements in the locality, we will be unable to have the correct levels of assurance specifically at our Locality Board of the localities delegated responsibilities.		
Financial implications and comment/approval <i>(Please detail which organisation(s) will be impacted, and if not required, please briefly detail why)</i>		<p>Name/Designation: Thomas Maloney, Programme Director Health and Care, NHS GM (Trafford) / Trafford Council</p> <p>Comment / Approval: Finance can be linked directly and indirectly to performance and therefore its imperative finance and performance together inform our efforts on sustainability in its broadest sense.</p>		
Comment by Trafford Clinical and Practitioner Senate (TCAPS) and/or Clinical Lead <i>(If not required, please briefly detail why)</i>		<p>Date of TCAPS / Clinical Lead comment: 11-Nov-25</p> <p>Name/Designation: Thomas Maloney, Programme Director Health and Care, NHS GM (Trafford) / Trafford Council</p> <p>Comment: There are various targets relating to clinical and practitioner practice and therefore not understanding</p>		



	our performance in these areas poses a risk. It is important the correct forums are engaged in managing performance in relation to appropriate health and care services.
What is the impact on inequalities? <i>(Please provide a high-level description of any known impacts)</i>	Without robust performance arrangements we will be unable to understand if we are tackling inequalities successfully. There are clear and obvious links with the work of the HWBB and Trafford Fairer Health For All Partnership to strengthen work in this area.
Equality Impact Assessment / Quality Impact Assessment Outcome <i>(If not appropriate at this stage please state if an EIA or QIA is necessary)</i>	N/A
People and Communities: Communications & Engagement <i>(Please detail relevant patient/public engagement completed and/or planned, and if not required please briefly detail why)</i>	N/A
Trafford's Carbon Footprint <i>(Please provide a high-level description of any known positive and/or negative impacts – consider the following topics: energy usage; staff or public transport; waste or materials used. Include steps that could be taken to reduce carbon within relevant plans)</i>	Impact on our carbon footprint is monitored through different governance but it is important we understand our performance in relation to appropriate services and schemes through our locality performance arrangements in health and care.
Links to Measurement / Outcomes <i>(Please detail if this is included within the report)</i>	Contained within the paper
Enabler implications	Legal implications: N/A
	Workforce implications: N/A
	Digital implications: N/A
	Estates implications: N/A
Sub-Board Sign-Off / Comments <i>(i.e. Trafford Provider Collaborative Board, H&SC Delivery Steering Group)</i>	A version of this paper has been shared with the Finance, Performance & Sustainability distribution list for comment and feedback.
Organisation Exec Lead Sign off	Gareth James, Deputy Place Lead for Health and Care Integration, NHS GM (Trafford)



1. Introduction

- 1.1 The purpose of this paper is to share the current version of the Trafford Locality Scorecard (March 2026) and provide a progress update on developments.

The Trafford Locality Scorecard aligns with Trafford's 7 Delivery Ambitions and includes metrics covering both NHS and Local Authority priority work areas. It is in addition to the existing GMICB Scorecards and dashboards available from the GM Intelligence Hub.

GM Intel Hub > Home Page > Corporate > Performance & Quality

GM Intel Hub > Home Page > Locality

Link here: [GM Intelligence Hub](#)

2. Recommendations

- 2.1 The Board is asked to:

- a) Note the progress update related to the Trafford Locality Scorecard (November 2025) and accompanying narrative.

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Trafford Locality

Monthly Locality Scorecard Update

March 2026



Locality Scorecard



Greater Manchester
Integrated Care

Priority	Code	Metric	Latest	Nat/Loc	Target	Aim	Prev	Curr	Perf	TA	GM	Focus
CYP & Maternity	CYP001	First EHC Plans issued	Jan-2026	Loc	60.0%	Higher	58.8%	46.0%	↓	R		N
	CYP003	Family Help Assessments completed	Jan-2026	Loc	60.0%	Higher	57.1%	74.1%	↑	G		N
	CYP004	Age 0-5 hospital dental extractions due to tooth decay - 12M Rate per 100,000	TBC									N
Prev. & Protection	PP001	Proportion of physically active adults	Mar-2024	Nat	67.6%	Higher	68.3%	65.7%	↓	R	3	N
	PP002	National Screening Programme - Bowel Age 50-59 (Every 30 months, being phased in)	Jan-2026	Nat	70.0%	Higher	45.6%	46.7%	↑	R	4	N
	PP003	National Screening Programme - Bowel Age 60-74 (Every 30 months)	Jan-2026	Nat	70.0%	Higher	78.3%	78.4%	↑	G	2	N
	PP004	National Screening Programme - Breast Age 50-70) Every 36 months)	Jan-2026	Nat	70.0%	Higher	74.3%	74.6%	↑	G	3	N
	PP005	National Screening Programme - Cervical - Standard Age 25-49 (Every 42 months)	Jan-2026	Nat	80.0%	Higher	73.5%	73.6%	↑	R	2	Y
	PP006	National Screening Programme - Cervical - Extended Age 50-64 (Every 66 months)	Jan-2026	Nat	80.0%	Higher	79.1%	79.1%	↑	R	2	N
	PP007	Childhood Immunisations Age 2 MMR First Dose	Feb-2026	Nat	95.0%	Higher	91.3%	91.4%	↑	R	3	N
	PP008	Childhood Immunisations Age 5 MMR Second Dose	Feb-2026	Nat	95.0%	Higher	92.6%	92.6%	↑	R	2	N
	PP009	NHS Health Checks Age 40-74 (Received a health check in last 5 years)	Feb-2026	Loc	36.0%	Higher	49.0%	49.3%	↑	G	5	N
Community Care	ASCOF_2A	% New care users who received short-term support (did not need follow-up support)	Jan-2026	Loc	60.0%	Higher	59.3%	59.0%	↓	R		N
	ASCOF_2C	Rate of permanent admissions to residential and nursing placements (65+)	Jan-2026	Loc	484.0	Lower	362.2	385.7	↓	G		N
	ASCOF_3D	% People using social care in receipt of direct payments	Jan-2026	Loc	61.0%	Higher	18.9%	18.7%	↓	R		N
Mental Health	MH001	MH Inappropriate OAPS (Bed Days)	Dec-2025	Nat	0	Lower	265	185	↑	R	5	Y
	MH002	MH Patients No Criteria to Reside	Feb-2026	Nat	0	Lower	10	6	↑	R	4	Y
	MH003	MH Long Length of Stay (% with LOS 60+ Days)	Dec-2025	Nat	0.0%	Lower	27.3%	30.0%	↓	R	7	Y
	MH004	Dementia Diagnosis Rate	Jan-2026	Nat	66.7%	Higher	70.4%	70.7%	↑	G	10	N
Planned Care & Long Term Conditions	LTC001	% of patients with >=20% 10-year CVD risk score treated with statins	Sep-2025	Nat	60.0%	Higher	67.4%	67.1%	↓	G	5	N
	LTC002	% of diabetic patients received all 8 diabetes care processes	Mar-2025	Nat	100.0%	Higher	43.5%	58.8%	↑	R		N
	LTC003	CKD QOF Registers (Currently Annual Only)	Mar-2025	Loc	4.41%	Higher	5.05%	5.39%	↑	G		N
Primary Care	PC001	GP appointments - percentage of regular appointments within 14 days	Dec-2025	Loc	81.6%	Higher	82.6%	83.9%	↑	G	3	N
	PC003	Antimicrobial resistance (% broad-spectrum antibiotic prescribing)	Jun-2025	Nat	10.0%	Lower	8.5%	8.6%	↓	G	9	N
Urgent Care	UC001	A&E 4-hour Performance	Feb-2026	Nat	78.0%	Higher	70.6%	73.0%	↑	R	1	Y
	UC002	A&E Attendance Rate per 1,000	Feb-2026	Loc	38.7	Lower	39.0	34.2	↑	G	3	N
	UC004	2 Hour Urgent Community Response (First Care Contacts)	Jan-2026	Nat	70.0%	Higher	99.4%	98.7%	↓	G	1	N
	UC006	Hospital admissions for alcohol-specific conditions (12M Rate per 100,000)	TBC									N

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Latest = Latest data | Nat/Loc = National or Local Target | Aim = Activity direction for better performance | Prev = Previous position | Curr = Current position | Perf = Performance direction | TA = Target Achievement | GM = Rank 1(Better) 10(Worse) | Focus = Further investigation

Achieving or Above Target Metrics

To provide a balanced view of performance to the Locality Board, metrics which are achieving or above target have now been included within an additional subset.

Priority	Code	Metric	Latest	Nat/Loc	Target	Aim	Prev	Curr	Perf	TA	GM	Focus
Prev. & Protection	PP003	National Screening Programme - Bowel Age 60-74 (Every 30 months)	Jan-2026	Nat	70.0%	Higher	78.3%	78.4%	↑	G	2	N
Prev. & Protection	PP004	National Screening Programme - Breast Age 50-70) Every 36 months)	Jan-2026	Nat	70.0%	Higher	74.3%	74.6%	↑	G	3	N
Prev. & Protection	PP009	NHS Health Checks Age 40-74 (Received a health check in last 5 years)	Feb-2026	Loc	36.0%	Higher	49.0%	49.3%	↑	G	5	N
Community Care	ASCOF_3D	% People using social care in receipt of direct payments	Jan-2026	Loc	0.6	Higher	0.2	0.2	↓	G		N
Mental Health	MH004	Dementia Diagnosis Rate	Jan-2026	Nat	66.7%	Higher	70.4%	70.7%	↑	G	10	N
Planned Care & LTC	LTC001	% of patients with >=20% 10-year CVD risk score treated with statins	Sep-2025	Nat	60.0%	Higher	67.4%	67.1%	↓	G	5	N
Planned Care & LTC	LTC003	CKD QOF Registers (Currently Annual Only)	Mar-2025	Loc	4.41%	Higher	5.05%	5.39%	↑	G		N
Primary Care	PC001	GP appointments - percentage of regular appointments within 14 days	Dec-2025	Loc	81.6%	Higher	82.6%	83.9%	↑	G	3	N
Primary Care	PC003	Antimicrobial resistance (% broad-spectrum antibiotic prescribing)	Jun-2025	Nat	10.0%	Lower	8.5%	8.6%	↓	G	9	N
Urgent Care	UC002	A&E Attendance Rate per 1,000	Feb-2026	Loc	38.7	Lower	39.0	34.2	↑	G	3	N
Urgent Care	UC004	2 Hour Urgent Community Response (First Care Contacts)	Jan-2026	Nat	70.0	Higher	1.0	1.0	↓	G	1	N

Latest = Latest data | Nat/Loc = National or Local Target | Aim = Activity direction for better performance | Prev = Previous position | Curr = Current position | Perf = Performance direction | TA = Target Achievement | GM = Rank 1(Better) 10(Worse) | Focus = Further investigation

Broad-Spectrum Antibiotic Prescribing continues to reduce
 Dementia Diagnosis Rate moved above target for the first time in February 2025 and continues to increase.
 Bowel and Breast Screening Programmes above target and amongst highest coverage rates in GM

Focus Metrics and Narrative

- From the Locality Scorecard we can show a smaller subset of “focus metrics”. These are metrics which are not improving, statistically significantly different and/or below target and are therefore of interest to analyse further:

Priority	Code	Metric	Latest	Nat/Loc	Target	Aim	Prev	Curr	Perf	TA	GM	Focus
Prev. & Protection	PP005	National Screening Programme - Cervical - Standard Age 25-49 (Every 42 months)	Jan-2026	Nat	80.0%	Higher	73.5%	73.6%	↑	R	2	Y
Mental Health	MH001	MH Inappropriate OAPS (Bed Days)	Dec-2025	Nat	0	Lower	265	185	↑	R	5	Y
Mental Health	MH002	MH Patients No Criteria to Reside	Feb-2026	Nat	0	Lower	10	6	↑	R	4	Y
Mental Health	MH003	MH Long Length of Stay (% with LOS 60+ Days)	Dec-2025	Nat	0.0%	Lower	27.3%	30.0%	↓	R	7	Y
Urgent Care	UC001	A&E 4-hour Performance	Feb-2026	Nat	78.0%	Higher	70.6%	73.0%	↑	R	1	Y

Latest = Latest data | Nat/Loc = National or Local Target | Aim = Activity direction for better performance | Prev = Previous position | Curr = Current position | Perf = Performance direction | TA = Target Achievement | GM = Rank 1(Better) 10(Worse) | Focus = Further investigation

Refreshed: 04 March 2026

- Based on the identification of focus metrics we will coordinate a response from lead officers across the partnership and include narrative and mitigation that’s in place, in the monthly report for FPS and/or TLB.
- The following slides highlight metrics with significant improvements.

Significant improvement National Screening Programme - Bowel Age 50-59 (Every 30 months, being phased in)

Rationale

These slides highlight metrics which have shown significant improvement over the past couple of years



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- Consistent improvement from 12.3% in August 2023 to 46.7% today



Significant improvement National Screening Programme - Bowel Age 60-74 (Every 30 months)

Rationale

These slides highlight metrics which have shown significant improvement over the past couple of years

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- Consistent improvement from 74.7% in August 2023 to 78.3% today
- Continue to meet target
- Trafford is 2nd in GM



Significant improvement National Screening Programme - Breast Age 50-70) Every 36 months)

Rationale

These slides highlight metrics which have shown significant improvement over the past couple of years

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- Consistent improvement from 61.5% in August 2023 to 74.6% today
- Have been meeting target since April 2025
- Trafford is 3rd in GM



Significant improvement NHS Health Checks Age 40-74 (Received a health check in last 5 years)

Rationale

These slides highlight metrics which have shown significant improvement over the past couple of years

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- Consistent improvement from 32.5% in September 2023 to 49.3% today
- Have been meeting target since July 2024



Significant improvement Dementia Diagnosis Rate

Rationale

These slides highlight metrics which have shown significant improvement over the past couple of years

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- Consistent improvement from 64.7% in March 2024 to 70.6% today
- Have met target every month since April 2025



Significant improvement Antimicrobial resistance (% broad-spectrum antibiotic prescribing)

Rationale

These slides highlight metrics which have shown significant improvement over the past couple of years



- Slight upward trend recently, but has improved from 11.2% in January 2023 to 8.6% today.
- Have met target every month since January 2024



Significant improvement 2 Hour Urgent Community Response (First Care Contacts)

Rationale

These slides highlight metrics which have shown significant improvement over the past couple of years



- Have improved from 84.7% in January 2024 to 98.7% today
- Have consistently met target.
- Trafford are first in GM.



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Name of Committee / Board		Trafford Locality Board		
Date of Meeting		17 th March 2026		
Report Title		Trafford Strategic Risk Register 2025/26		
Report Author & Job Title		Pippa Dewhirst, Governance Manager, NHS GM ICB		
Organisation Exec Lead		Thomas Maloney, Programme Director Health and Care, Trafford Council / NHS GM (Trafford)		
OUTCOME REQUIRED <i>(please highlight)</i>	Approval	Assurance X	Discussion X	Information
EXECUTIVE SUMMARY				
<p>The purpose of this report is to present the Locality Board with an overview of the strategic risks for the 2025/26 Trafford Locality Board Strategic Risk Register and provide assurance that risks are effectively identified, monitored and managed.</p> <p>There are currently 10 strategic risks on the Locality Board register, seven of the risks are rated extreme (red), two rated high (orange) and one rated moderate risk (yellow).</p> <p>Since the risks were last presented to the Locality Board in October 2025, one new risk has been added (SR18) and one of the risks (SR08) have been closed. The other risk scores remain the same and are all detailed in Appendix 1.</p>				
RECOMMENDATION				
<p>Trafford Locality Board is asked to:</p> <ol style="list-style-type: none"> note the content of this report and supporting appendix for assurance purposes; and review the strategic risk position and confirm that the current level of risk, risk scores, controls, gaps in control and action plans are acceptable and in line with risk treatment plans. 				
CONSIDERATIONS – these must be completed before submission to the Board – Reports with incomplete coversheet information will not be accepted and shared with the board				
Risk implications <i>(Please provide a high-level description of any risks relating to this paper, including reference to appropriate organisational risk register)</i>	<p>Risk is requested to be on meeting agendas' to further embed risk management activities. Risk management is an integral part of the organisation's statutory requirements.</p> <p>Risks considered and mitigated in the body of the report.</p>			
Financial implications and comment/approval <i>(Please detail which organisation(s) will be impacted, and if not required, please briefly detail why)</i>	Name/Designation: N/A			
	Comment / Approval: N/A			
Comment by Trafford Clinical and Practitioner Senate (TCAPS) and/or Clinical Lead <i>(If not required, please briefly detail why)</i>	Date of TCAPS / Clinical Lead comment: N/A			
	Name/Designation: N/A			
	Comment: N/A			
What is the impact on inequalities? <i>(Please provide a</i>	N/A			



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

1.0 Introduction and Background

- 1.1 The Locality Board has a responsibility to maintain an on-going risk profile of the Trafford locality through the Locality Board Strategic Risk Register as set out in NHS GM's Risk Management Strategy. Accountability for each of the strategic risks recorded on the risk register is assigned to an Executive Lead and managed by a risk Lead Manager. The strategic risk register provides evidence and ensures that a systematic process for identifying Trafford locality's strategic objectives as well as its associated strategic risks, towards the achievement of its objectives, is in place. It is a key document for the Locality Board and should be used to monitor key risks and to assure itself that the risks are being managed and mitigated.
- 1.2 The Locality Board should; challenge the risk ratings and target risk scores; assess the robustness of the controls and actions plans identified and ensure that progress is made to reduce the gap between the current risk rating and the target score. Other Boards and Working Groups that report into the Trafford Provider Collaborative Board (TPCB) and/or the Locality Board will have oversight of individual risks recorded on the register, in accordance with the terms of reference of each Board and/or Group.
- 1.3 The Locality Board has been working in an integrated manner with partner organisations and other stakeholders under the established Trafford Integrated Care Partnership. Joint priorities and work areas for the health and social care system have been developed to address challenges that have been identified. These are set out in the aspirations of the Trafford Locality Plan.

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

- 2.1 There are currently 10 strategic risks identified on the 2025/26 Locality Board strategic risk register which align and directly link to the strategic priorities and objectives of NHS GM. All the risks have been reviewed and updated.
- 2.2 There has been some changes to the strategic risks since they were last presented to the Locality Board in October 2025. The changes are detailed below:
- One new risk has been added.
 - SR18 is a new risk on the strategic risk register which has been added to recognise the risk of the proposed reduction of the Clinical Leadership capacity at place which could reduce clinical oversight and potentially effect strategic delivery and patient safety assurance. Feedback has been given to the NHS GM Central team to highlight Locality concerns and further workshops are expected to be scheduled to consider the detail of service specific operating models.

- One risk is recommended to close as the risks have been mitigated and they have reached their target score.
 - SR08 related to the risk that the neighbourhood programme may not be able to deliver person centered and community based care in neighbourhoods if all partners could not commit to providing capacity, funding , engagement and commitment in relation to the Neighbourhood programmes strategic objectives. The risk has now been reduced and reached its target score as the risk has been successfully mitigated. The Neighbourhood plan has been developed with partners and has confirmed priorities. Governance is in place to support and the Neighbourhood model is aligned with Live Well approach. Trafford Senior Leadership Team are satisfied that there is no current risk to the success of Neighbourhood programme and recommend it is closed.
- All other risks have been reviewed by their risk leads and the scoring has remained the same, the risk register in appendix 1 provides further detail about action plans in place to mitigate the risks.

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

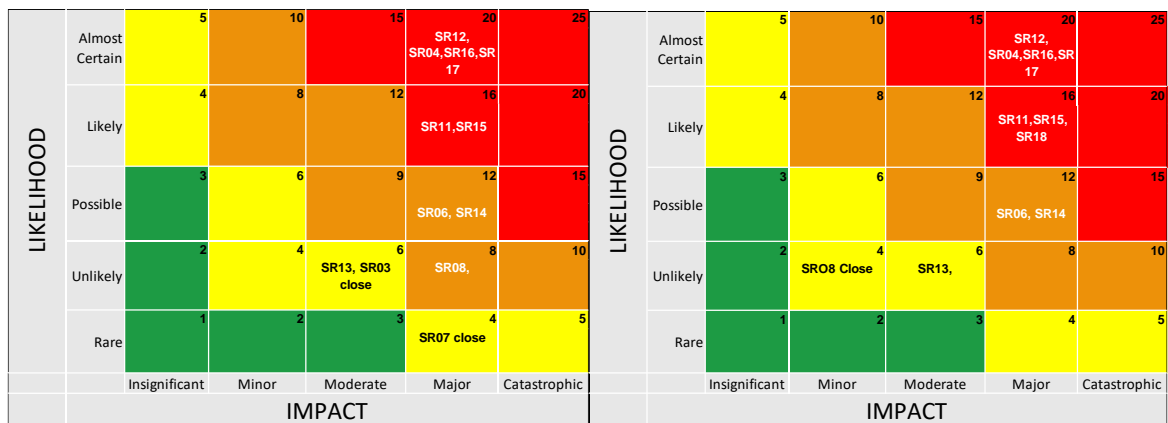


Figure 1: Heat Map (October 2025)

Figure 2: Heat Map (March 2026)

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

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



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

3.0 Future Risk Management

3.1 As Locality Governance is updated in upcoming months in response to the NHS reforms the risk management process will be considered and agreed with partners. The guidance and support of the NHS GM Central team will be utilised to ensure consistency to place risk approach. TLB have previously agreed to initiate a task and finish group and this forum will be utilised to engage with partners. The group will consider how place and system risk can effectively be monitored to ensure appropriate risk management is embedded.

4.0 Recommendations

4.1 Trafford Locality Board is asked to:

1. note the content of this report and supporting appendix for assurance purposes; and
2. review the strategic risk position and confirm that the current level of risk, risk scores, controls, gaps in control and action plans are acceptable and in line with risk treatment plans.

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NHS GM Priorities	Risk ID	Date Added	Executive Lead	Risk Description	Lead Manager	Committee Oversight	Likelihood	Impact	Initial Risk Rating (L x I)	Key Controls in place	Gaps in Control	Likelihood	Impact	Current Risk Rating (L x I)	Action Plans (Action owner, Expected date of completion)	Progress against Actions Plans	Assurance	Gaps in Assurance	Likelihood	Impact	Target Risk Rating (L x I)	Risk Movement	Last Reviewed Date	Estimated Closure Date	Status
Achieve Financial sustainability. We will manage public money well to achieve our objectives.	SR12	10/05/24	Gareth James	Risk - Failure to deliver the financial plan for 2025/26 for GM ICS as agreed with NHSE. Cause - Failure to develop and / or deliver recurrent saving schemes across the ICS or operational cost pressure above planned level of expenditure. Impact - Further scrutiny and intervention by NHSE unable to deliver GM ICS strategy health of GM population worsens inequalities and variation in health and care continued	Julie Flanagan	Trafford Locality Board Trafford Finance, Performance & Sustainability Group	4	5	20	<ul style="list-style-type: none"> Financial Performance Recovery Oversight Group, Provider Oversight meetings and Locality Assurance meetings established which include financial assurance and scrutiny. ICB CIP groups established reporting to EMT/ Chief Officers meeting/ Finance Committee, Finance Recovery Oversight Group which in turn reports to Finance Committee and ExeC Committee All organisations report financial and operational performance to their respective Finance Committees and Boards Continuation of the grip and control measure implemented in 2023/24 including expenditure >£10k for ICB proposals and >£100k for NHS provider proposals is subject to review and approval by the ICB Exec team via the STAR process All ICB contract renewals or extensions must also be submitted to the STAR process If approval is granted via STAR then the governance route as identified in the SoRD is followed for ICB incurred costs or via NHS provider internal governance 	<ul style="list-style-type: none"> In year financial reporting of the Trafford system partner position still to be developed to provide insight to Trafford Locality board of the challenge 	5	4	20	<ul style="list-style-type: none"> Grip and control measures e.g. STAR process and Business Critical Post panel remain in place to control expenditure. CIP plans are further being developed and implemented to realise efficiencies along with commissioning intentions that will deliver efficiencies while improving services. Work ongoing through PMO All budgets reviewed to identify non recurrent slippage opportunities on a monthly basis Financial reporting and monitoring taking place on monthly basis Provider oversight and ICB locality assurance meetings either monthly or quarterly dependent on level of risk To develop in year financial reporting of the Trafford system partner position to provide insight to Trafford Locality board of the challenge Red lines - GM developed trigger points that will require corrective actions. ICB is adopting a new reporting pack with a focus on run rate to allow identification of potential issues so a mitigation plan can be implemented to address the risks on in year delivery 	<ul style="list-style-type: none"> ICB Locality CIP plan developed and on track to deliver 4% target Schemes shared with ICB Locality report and high level ICS position reported to Locality board monthly Locality Assurance meetings in place First draft of a locality partnership finance report shared via FPS but further work required by all partners. Trafford system reporting paused due to organisational change within partners. Red line trigger points for ICB locality variances developed and shared 	<ul style="list-style-type: none"> ICB finance Committee Each NHS Organisation reports via their internal finance committee and board meeting NHS GM reviews NHS provider performance as well as ICB financial performance at their EMT, finance committee and board Trafford Locality Board to oversee financial performance of the ICB locality delegated budgets Trafford Finance Performance And Sustainability Group established 	In year financial reporting of the Trafford system partner position still to be developed to provide insight to Trafford Locality board of the challenge	4	3	12	↔	03/03/26	31/12/26	Active
Help people stay well and detect illness earlier. We will work together to prevent illness and reduce risk and inequalities.	SR04	17/10/23	Gareth James	There is a risk that children and young people will suffer from adverse healthcare due to insufficient funding and capacity across health services to meet the surge in demand. This could lead to delayed diagnosis/treatment and care resulting in poorer outcomes for children and young people especially in delayed access to mental health services and delays in the assessment and diagnosis of Autism and ADHD Waiting times for Autism and ADHD continue to increase, with high presentation of CYP waiting for diagnosis across multiple services across education, health and social care.	Cathy O'Driscoll	Trafford Locality Board	5	4	20	<ul style="list-style-type: none"> NHS Long Term Plan Trafford All Age Mental Health Strategy GM Mental Health Strategy GM Autism Minimum Standards Trafford SEND Ambition Plan ND Triage and Assessment meeting Childrens Commissioning Board 	<ul style="list-style-type: none"> Workforce challenges across providers SEND commissioning Strategy needs to be developed Trafford All Age Mental Health Strategy is currently being refreshed Significant increase in demand across all CYP health services Workforce to support the wider ND needs led offer and work through the waiting lists for both ASH and ADHD 	<ul style="list-style-type: none"> 1.1 Review of CYP Community Health Services 1.2 Redesign VCSE mental health service offers to meet demand within financial envelope 1.3 Develop a SEND Commissioning strategy and mental health strategy to progress system approach to reducing health inequalities 1.4 Developing a support offer for families whilst they are waiting for services 1.5 Implementation of the GM ND Pathway transformation programme. 1.6 Implications of the SEND white paper in 2026 1.7 ASD/ADHD Needs led offer development and changes to waiting list referral criteria clarification around comms for ASD/ADHD from GM needed 	<ul style="list-style-type: none"> A support whilst you are waiting included pre/post diagnostic offer has been developed and implementation has commenced through a staged approach. The support will be delivered from a 'system' approach across Education, health and social care teams'. There has been a focus on broadening the universal offer initially. Recurrent funding has been secured to improve the early intervention and prevention mental health offer. Proposals are currently being drafted. The review of community services has commenced focussing initially on the Physiotherapy and Occupational Therapy Service. A SEND commissioning strategy has been developed and is going to SEND board at the end of March for sign off. Barnardos have been commissioned to provide ND Hub and triaging of patients in Trafford on waiting lists has commenced. Comms provided to GPs by GM and awaiting clarification for wider comms and complaints for system sharing 	<ul style="list-style-type: none"> All Age Mental Health Board CYP Commissioning Board SEND Board Locality Board 	Routine performance data and transparency around finances from providers to support commissioning of services.	2	4	8	↔	03/03/26	01/09/26	Active			
Strengthen our communities. We will help people, families and communities to help each other and manage their own health.	SR16	06/10/25	Gareth James	Risk : There are several Community Services that are in a very challenging position due to lack of capacity / long waits and challenging shortages of funding for staff to meet the increasing demand. Most notably District Nursing Service / Specialist Palliative Care / OT waits / Bladder and Bowel Service / Childrens Autism pathway / SWMS Cause : Historic investment in the services and increasing demand on all services in some cases increase in activity by 42% Impact : Poor patient outcomes affecting the continuity and quality of patient care, / deterioration in condition / poor staffing morale due to significantly increased workloads and financial impact due to the requirement for additional investment. Additionally potential for delays in discharge due to lack of community service provision.	Cathy O'Driscoll	Trafford Locality Board	5	4	20	<ul style="list-style-type: none"> MFT Contract and Contract Governance Locality Board Provider Collaborative Trafford Locality Assurance Meeting Trafford Quality Group Trafford Health Scrutiny GM Strategic Commissioning Trafford Childrens and Young People Commissioning Board 	<ul style="list-style-type: none"> Sustainable workforce sustainable funding model lack of data and oversight on service capacity and delivery 	<ul style="list-style-type: none"> A paper outlining the implications of the gaps in community services has been to the Trafford Senior Leadership Team to outline the risks and implications and the financial requirements. Further discussions and Trafford Provider Collaborative / Trafford Locality Board / MFT Execs have been undertaken. Ongoing concerns have been raised raised at monthly MFT GM led contract meetings. GM improvement funding to be provided for the early help pathway 	<ul style="list-style-type: none"> Ongoing risks in relation to the community Services and discussed at Trafford Locality Assurance Meeting TLCO assurance and mitigation plans for services have been received specifically in relation to OTAT service giving assurance and increased capacity into the service and the reduction in the waiting list. A full business case has been developed for the Trafford District Nursing service which is being considered at Locality Board, including the proposal for the mitigation of the financial gap. 	<ul style="list-style-type: none"> SLT TPCB Health Scrutiny Committee Trafford Locality Assurance Meeting TLB 	To be reviewed and agreed	2	2	4	↔	25/02/26		Active			
Achieve Financial sustainability. We will manage public money well to achieve our objectives.	SR17	01/10/25	Gareth James	Risk - Failure to deliver a breakeven financial position on ICB locally delegated budgets. Cause - Failure to develop and / or deliver recurrent saving schemes to meet the target or operational cost pressure above planned level of expenditure. Impact - Increased scrutiny by NHS GM, increased constraints on investment and spending plans, health of Trafford population worsens inequalities and variation in health and care continued	Julie Flanagan	Trafford Locality Board Trafford Finance, Performance & Sustainability Group	4	5	20	<ul style="list-style-type: none"> Locality Assurance meetings established which include financial assurance and scrutiny. Trafford CIP groups established reporting to Locality leadership team which in turn reports to Trafford Locality Board Monthly reporting to the GM All Age Continuing Care group and separate deep dives on all individual packages of care spend Continuation of the grip and control measure implemented in 2023/24 including expenditure >£10k for ICB proposals - approval by ICB Exec team All ICB contract renewals or extensions must also be submitted to the STAR process If approval is granted via STAR then the governance route as identified in the SoRD is followed for ICB incurred costs or via NHS provider internal governance 	<ul style="list-style-type: none"> No local (GM) commissioned service specification for ADHD NH providers requiring rates out with the contracted level / limited contract management of care home market 	<ul style="list-style-type: none"> CIP plans have been reviewed and alternate proposals agreed by the board to significantly reduce the risk of CIP delivery. This includes non recurrent slippage All care home providers to be contacted to finalise 24/5 statement of accounts Financial reporting and monitoring taking place on monthly basis Proposals to slow in year packages of care spend presented to the Locality Board in August and September and action groups to address the demand / spend to progress in Q3 Senior meeting between ICB locality and LA adult social care / commissioning colleagues to be scheduled to work through escalated issues 	<ul style="list-style-type: none"> Locality CIP plan updated to meet delivery of in year target All care home providers contacted regarding 24/5 statement of account finalising the position on cross year accruals. Reconciliation meeting scheduled with LA colleagues Locality Assurance meetings in place LD task and finish group completed phase 1 of the review to establish the baseline of cases and annual spend. Phase 2 deep dive into cases to be undertaken in 26/7; EoL packages of care analysis underway and target to complete by end of March 26; 4 blocked EoL beds in place at competitive rate. Meeting scheduled with CCO re the based rate for CHC packages 	<ul style="list-style-type: none"> Trafford Locality Board Trafford Locality Assurance Meeting NHS GM All Age Continuing Care Group and locally packages of care deep dives Trafford Finance Performance And Sustainability Group established 		3	4	12	↔	02/03/26	31/03/26	Active			
Help people stay well and detect illness earlier. We will work together to prevent illness and reduce risk and inequalities.	SR11	17/10/23	Gareth James	There is a risk that the capacity of the Designated team at place will be unable to fulfil the requirements of the three delivery group functions adequately. This will lead to gaps in oversight and assurance of contracts, statutory functions, training, and abilities to embed new requirements such as the serious violence duty.	Sarah Owen	Trafford Strategic Safeguarding Partnership	4	4	16	<ul style="list-style-type: none"> Safeguarding Quarterly report to GM and 6 weekly flash reports including situation report on workforce to reflect MIAA review. Prioritisation of work streams. Regular review of work streams to assist with the task of prioritisation through team meetings. Engagement with all Partner agencies. Maintaining virtual meetings where possible to maximise time available to team. Statutory functions matrix is being established through the delivery groups to map minimum statutory requirements. Mutual aid protocol to be designed for GM cover across the wider safeguarding workforce to assist with cover where possible. 	<ul style="list-style-type: none"> Business continuity and associated workstreams are not secure due to vacant posts in the Adult Named GPs and the Designated Doctor for child deaths not in post. The current team capacity limits availability to engage in quality and service improvement. Examples of this can be seen in relation to: - domestic abuse, provider assurance visits, review of GP assurance tool kit, limited audit and assurance activity, - evidence gathering with provider organisations, - oversight of safeguarding within contracts, particularly since the changes to the quality team support. The reduced capacity directly impacts the teams ability to be proactive. The Named and Designated professionals have approximately half of the recommended allocation of time set out in the intercollegiate guidance and by definition can therefore only carry out half of the necessary aspects of the role. Attendance at Named and Designated National Networks to facilitate awareness and alignment of wider workstreams throughout GM. The Designated Nurse - Safeguarding Children and Cared For Children has a dual role, this limits ability to engage fully in either role. In addition, one day per week is dedicated to the NHS EGA leadership Masters which reduces available time for locality work. 	<ul style="list-style-type: none"> 1.1 Arrangement to recruited Adult Named GP. 1.2 Further discussions around the GM Safeguarding Model 	<ul style="list-style-type: none"> 1.1 Recruitment to Adult GP role is not currently progressing - business critical form completed - not authorised due to wider GM capacity and possibility of mutual aid. 1.2 Deputy Designated Nurse post remains vacant due to interim arrangements within the organisation. Rationalisation of workload - sticking to prioritisation plans. 1.3 Following the presentation of the Safeguarding compliance to the intercollegiate guidance and Trafford locality safeguarding budget at SLT 15.10.24, authorisation was provided to commence applications to the business critical panel for the advertisement of vacant posts. The Designated Team are currently completing this process. 06.03.2025 - 1.1 The current Named GP has resigned with a 12 week notice period. The Designated Safeguarding team are currently completing TRAC application and associated BCF authorisation. 1.2 Deputy Designated Nurse post has been successfully recruited to, expected start date June/July 2025. 26.06.25 The Designated Nurse for LAC is now in post- making the team compliant with intercollegiate guidance and improving capacity to engage in both GM and locality work. vacancy freeze remains in place across the organisation, pending structural reform of the ICB, therefore There are no plans to recruit to the Named GP post for adults and Children, which is a significant gap for Primary Care. This also means that key functions will not be deliverable for the ICB within the locality as the business continuity / mutual aid offer does not extend to periods exceeding 1 month. The Designated Dr for child death post also also remains vacant, posing a challenge for the current CDOP model. 18.09.2025 - The Designated Nurse for LAC has served notice on the post. The Designated Dr for LAC is currently on longterm sick. Mutual aid has been requested and Manchester and Trafford have scheduled a meeting to discuss any mutual aid opportunities, it is worth noting that Manchester and Trafford share the Designated Dr for LAC who in on longterm sick and Manchester have also gaps in workforce. 25.02.2026 Update The draft consultation safeguarding structure is now available with a wider NHS GM meeting scheduled with the Clinical Chief Officer to raise the currentTrafford workforce risk. This is also monitored via the monthly sit rep and mutual aid requests have been sent to GM. 	<ul style="list-style-type: none"> Trafford Locality Board 	None identified yet	3	4	12	↔	25/02/26	31/03/26	Active			

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Achieve Financial Sustainability. We will manage public money well to achieve our objectives.	SR15	01/07/25	Gareth James	Risk: The cost of Nursing Home care is difficult to control, across NHS GM ICB, as private care providers are demanding rates higher than the agreed contract rate. Cause: Risks mainly stem from the development and management of the market infrastructure, including pricing frameworks, standard contract and the ongoing spot purchase of specialist or out-of-area services. Impact: There is a financial impact as Personalised Care teams across NHS GM ICB may be paying above the budgeted cost to support CHC eligible patients. High provider costs may result in care needing to be sourced out of area, potentially affecting the continuity and quality of patient care.	Sarah Owen	Trafford Locality Board	5	4	20	The Service has access to a pricing framework negotiated with key providers of nursing and homecare services within the borough. This offers an agreed weekly/hourly rate for services rather than variable or spot pricing. Spot purchase is still used in situations where care need cannot be met on-framework due to market saturation or a requirement for specialist services.	Market management and contract monitoring are now within NHS GM centrally, with the ongoing need for all staff to review KPI's when reviewing care packages. LA spot purchase costs for D2A become difficult for the service to resolve, with health becoming responsible for the ongoing costs of placements they have not procured or been involved in the procurement of beds.	4	4	16	1.1 CIP programme with identified schemes to ensure adherence to the CHC framework and quality reviews of packages of 1.2 Procurement of Care Cubed to provide an evidence base to support negotiation with the care home market 1.3 Improved data/dashboard metric via CHS	1.1 CIP plan is monitored monthly via SLT oversight and reported 1.2 ILED project plan - market management and care cubed implementation plan 18.09.25 Care Cubed training planned in September and October. 1.3 CHS have created a tailored dashboard 25.02.26 Update Care Cubed training has been completed and the joint LA and ICB launch of the tool was completed in Feb 26. Reporting and governance will be developed following the consultation, there is a scheduled meeting in March for the locality to discuss the risk with the Chief Officer for Healthcare Commissioning.	Senior Leadership Team All Age Continuing Care (AACC)	Progress of ILED workstreams	4	3	12	↔	25/02/26	01/07/26	Active
Recover core NHS and care services. To improve access to high quality services and reduce long waits.	SR18 New	26/02/26	Gareth James	Erosion of Clinical "DNA": 80% cut in medical leadership sessions over last 5 years (28-->18-->5) There is a risk that the proposed reduction of clinical leadership capacity at Place (from 18 sessions to 5 sessions) will result in a total loss of clinical oversight, Patient safety assurance, and strategic delivery. This is compounded by an unsubstantiated reliance on external provider organisations to fulfill leadership functions without formal agreements, funding, or prior engagement	Manish Prasad	Trafford Locality Board	4	4	16	TCAPS - local clinical effectiveness group in place and this is being reviewed in light of reform changes CPAG - recently formalised CPAG into trafford governance which will continue post reform as hosted by MFT Clinical Leads - are still in post and support the locality with the delivery of objectives/strategy and reactive issues	Issues that were previously managed locally by experienced clinicians will now escalate directly to a light management structure or, worse, go undetected until a patient safety incident occurs This creates a high risk of strategic paralysis where no meaningful reform actually happens at the Place level. Reliance on providers for clinical leadership without formal agreements AMDs challenged to deliver GM strategy while handling Place operational fires. The organisation shifts to a "reactive" state, where clinical risks are only identified after a serious incident (S) has occurred Clinicians transferred to host organisations without legal indemnity clarity	4	4	16	Mandate a minimum session count for Place-based leads to ensure strategic clinical leadership continuity Develop a MOU with providers - Formal agreements with Trusts and PCNs defining their contribution to place clinical leadership. Clarity needed on Place clinical indemnity usually covered by NHS crown indemnity and if affected by Host/transfer arrangements	To be commenced	To be commenced	None identified yet	2	4	8	New	02/03/26	01/04/27	Active
Recover core NHS and care services. We will continue to improve access to high quality services and reduce long waits.	SR06	17/10/23	Gareth James	There is a risk to the delivery of a sustainable and clinically safe model of Intermediate Care due to: - longstanding financial challenges and complex governance and delivery arrangements. - the challenges in obtaining system agreement for longer term redesign and transformation of services to enable more sustainable provision.	Cathy O'Discoll	Home First Board.	4	4	16	<ul style="list-style-type: none">NHS GM and Trafford Council- S75 GroupLocality BoardMFT Contract and Contract GovernanceBetter Care Fund Programme Funding and Governance.Improving Lives Everyday Programme Governance, including IMC Transformation Programme.IMC Executive GroupPause in one bedded unit to lower costs in year.	<ul style="list-style-type: none">Agreement of 26/27 Finance which will be included with new Place Grant Agreements. Agreement of the investment envelope for future development .	3	4	12	1.1 System buy in and implementation of the recommendations of the Independent Changeology Review of IMC and D2A Pathways in Trafford, undertaken in 2024. 1.2 Development of IMC strategy and new models of care inc. delivery plans, and supporting governance to drive delivery. 1.3. Agreement to align work to Care Closer to Home, to ensure no double counting of benefits or decisions that could impact other programmes are not made in isolation.	1.1 26/27 BCF planning discussions are underway within S75 Steering Group and supporting working to undertake key actions to develop new Place Grant Agreements. 1.2. IMC Programme well underway - including design framework developed with staff and high level recommendations shared with Execs in March. Next phase of development of costed bed model in development, working towards May. 1.3. Agreement to align work to Care Closer to Home, to ensure no double counting of benefits or decisions that could impact other programmes are not made in isolation.	Better Care Fund Programme. Provider Collaborative Locality Board. Improving Lives Everyday Programme	Developed of costed new models of care which are agreed by all key partners (in progress). Finalising of the new Place Grant Agreement and hosting arrangements and full understanding of the implication of this on this particular programme (in progress)	3	3	9	↔	03/03/26	01/09/26	Active
Support our workforce and our carers. We will ensure we have a sustainable, supported workforce including those caring at home.	SR14	25/06/25	Sara Todd	Risk - NHS Reforms announced in mid-March '25 will have a significant impact on the level of ICB resource and the ability to deliver against GM strategy; due to the resource reductions and the current uncertainty there are risks to the delivery of the Trafford locality plan. There are further risks to the morale and wellbeing of ICB staff in the locality. It feels inevitable that we will enter a period of business continuity. Following agreement of the operating model and associated structures there is significant concern about the level of support afforded to the 10 places along with the lack of detail underpinning the proposed hub and spoke models. In particular, but not limited to the following areas: <ul style="list-style-type: none">Clinical leadershipSafeguarding and SENDsupport functions such as finance, estates, BIPackages of care and CHC Cause - likely that the delivery of 39% corporate cost reductions will have a wide ranging impact, during the transition design phase there is a high degree of uncertainty for staff and partners. Impact - slow-down of delivery of locality delivery and sustainability plans, potential lack of improvement against issues raised in the most recent staff survey, a period of business continuity with further risk to delivery of statutory duties. Although the GM operating model has been agreed there are a number of services where it remains unclear how the model will work, in particular, the interface between GM and the 10 places.	Gareth James	Trafford Locality Board	3	4	12	<ul style="list-style-type: none">Robust GM design governanceSignificant level of engagement ensuring locality colleagues have opportunity to contribute to the design of the new operating modelDevelopment of Trafford locality people and culture action plan - co-produced with locality colleaguesPrioritisation of locality team workloadsEnsure that locality colleagues are given time and opportunity to take advantage of programme management capacity for 24/25Engagement at locality level - part 3 TLB conversationsRegular and honest communication with locality teamDetailed PIA undertaken to support VR and FOP processesWorkshops have been implemented to work through the detail of service specific operating modelsDPLs and service matter experts are completing a 'responsibility matrix' to provide clarity of roles between GM and placerecognition that the operating model will not be fully implemented on 01/04/26	<ul style="list-style-type: none">Lack of detail underpinning the operating modelLack of clarity on the availability of a voluntary redundancy offerLocality team capacity during the vacancy freeze periodLack of consistency in messaging between design groupsImpact on staff moralecontinued lack of detail on numbers of VR/CR requiredcontinued lack of detail for highly sensitive services such as safeguarding and SENDlack of clinical support in place	1 A detailed Trafford people and culture action plan is being co-designed with locality team colleagues, covering the following 3 key areas: <ul style="list-style-type: none">supporting staff throughout the period of reform - including time for wellbeing, regular appraisals, regular and honest communicationsprioritisation of workloads - to address issues raised in staff survey and to manage current capacity issuescommunication - regular face-to-face time together and flexible timing of comms 2 Ensure Trafford locality colleagues are embedded throughout GM design process 3 Regular locality partnership engagement 4 GM operating model workshops 5 development of responsibilities matrix 6 GM workshops - IPOC, safeguarding and SEND	1 Detailed actions agreed by SLT across the 3 areas and shared with staff at locality briefing - final plan agreed at time together at end of July. SLT will undertake prioritisation process in September (part of a pilot of GM framework) and continued monthly Trafford locality briefings. 2 SLT colleagues have been attending design forums and specific work-streams. Other Trafford partners also part of design phase. Current pause on implementation of operating model, Trafford colleagues taking part in detail model testing. Also a Trafford colleague working with GM colleagues to agree engagement activities planned for October. 3 TLB part 3 workshop held in May and follow up discussions in June and July (standing item on TLB) also, conversations with key locality partners and neighbouring localities. Further discussion at TLB in September led by Charlotte Bailey, Part 3 discussions at TLB in February and agreement to establish a T&F group in Trafford 4 partners invited to essential workshops - more in depth conversations at Exec committee group 5 Outputs due by 11/03/26 6 IPOC workshop undertaken and others planned w/b 16/03	SLT TPCB TLB GM ELT Reform Board Exec Committee Trafford Task and Finish group	Lack of new information to share with colleagues lack of information on HR framework Staff uncertainty during 'pause' period - demonstrated in pulse check results Impact of VR exits on the local team	3	3	9	↔	16/03/26	On-going	Active			

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Support our workforce and our carers. We will ensure we have a sustainable, supported workforce including those caring at home	SR13	17/10/23	Gareth James	There is a risk that without adequate resource, planning and controls we will fail to attract and retain our workforce; this may lead to a critical shortage of skills which could result in the organisation failing to deliver on its strategic priorities.	Tom Maloney	Trafford Locality Board	3	3	9	<ul style="list-style-type: none"> GM Joint Forward Plan GM People and Culture Strategy Completed a organisational self assessment of existing practice against the 10 aims of the GM People and Culture Strategy Organisational Strategy, Policy and Work Programmes in place for the different operational teams within Locality Board member organisations (i.e. Adult Social Care Policy) Trafford People and Culture Action Plan - coproduced with staff via face to face engagement NHS GM SLT 'Prioritisation' of key deliverables (Nov 25) Continued engagement with staff via face to face staff briefings and Time Together sessions and GM led Live Leadership Briefings in place, plus staff support schemes as we go through reform 	<ul style="list-style-type: none"> Trafford Workforce Group has been stood down - governance review in February 26 to pick up Feasibility study regarding the adoption and spread of good practice not fully completed and has since been stood down - agreed by the working group prior to it being stood down Regular usage of data and information from Virtual Workforce Information System (VWIS) to aid strategic and operational workforce planning not yet mobilised and stood down as a priority due to competing priorities Inclusion of wider workforce metrics from independent adult social care and other sectors into VWIS to aid true collaborative workforce planning. SRO for VWIS has retired and gap in senior leadership to progress the proposed work SRO for Integrated Career Pathway priority has been affected by organisational changes and capacity remains an issue - work programme has been postponed pending system reform conversations Ability to recruit is paused whilst NHS reform continues, responding to the NHS 10 Year Plan. Creation of new operating model across NHS GM has led to VR Phase 1 and Phase 2 (TBC) Step down of the LAM and the One Workforce Committee so no repring into GM currently 	2	3	6	<p>1.1 Integrated Induction, has been mobilised (July 25), a task and finish group has been established (July 25) and learning from Stockport has been shared and will be utilised to form the core elements of the model. Planned pilot Q4 of 25/26.</p> <p>1.3 This priority has been tentatively progressed throughout 25/26. An agenda for a stakeholder T&F Group has been produced and administrative support is being sought to arrange the necessary logistics. Q3 stakeholder meeting took place to look at piloting the new model in Q4 of 25/26 but it has been agreed this will now be delivered as part of our priorities in 26/27. As part of the strategic governance review the priority on the concept of an integrated induction may shift to sit under the governance of Trafford Live Well - all options will be explored and suitable governance arrangements enacted with partners support.</p>	Trafford Locality Board	None identified yet	2	2	4	↔	25/02/26	01/08/26	Active	
Strengthen our communities. We will help people, families and communities feel more confident in managing their own health.	SR08 (to be closed)	17/10/23	Patricia Davies	There is a risk that the neighbourhood programme may not be able to deliver person-centred and community-based care in neighbourhoods if all partners don't fully commit to providing capacity, funding, engagement, and commitment in relation to the Neighbourhood Programme's four strategic objectives.	Tom Maloney (Interim)	Trafford Provider Collaborative Board	2	4	8	<ul style="list-style-type: none"> System commitment encompassed in the Trafford Locality Plan 2025-28 and additional complimentary partnership strategies Draft Neighbourhood Plan developed through codesign with partners in response to the draft NHS Planning Guidance - comprehensive and encompassing all aspects of neighbourhood working including neighbourhood structure, operating model, governance, and proposed delivery of local and GM priorities. This has been supported by all partners through their own governance routes and ratified by Trafford Locality Board (Feb 26) The above guidance places a requirement for localities to develop and implement effective neighbourhood models, which is why this action has been recommended for closure as there is structure and rigour provided around neighbourhood working in the guidance, as well as a clear requirement which our partners have already responded enthusiastically to in the codesign of the draft Neighbourhood Plan for 26/27. Neighbourhood Health & Care SRO, programme manager, project manager and administrative support in place (current arrangements set to end in July 2026 pending final NHS GM consultation on structure, with new arrangements present to replace the current in the proposed structure as it stands today). Neighbourhood connectivity and governance is aligned to Live Well including the expansion of existing groups and repurposing others - this ensures system wide alignment and connectivity Trafford Live Well programme structure and full team complement with Project Manager and Project Coordinator is now in place; in addition to the stand up 	<ul style="list-style-type: none"> Sustainable funding model for general practice participation in the integrated neighbourhood teams - being actively worked on, various funding sources being explored including BeCoRR Conclusion of NHS Reform activity including changes to Place Partnership structure yet to conclude, and impact of changes yet to be understood. 	2	2	4	<p>Original actions listed below - the responses and developments surrounding these actions have evolved due to the emergence of new arrangements due to NHS reform and the enhanced maturity of neighbourhood working detailed within our draft Neighbourhood Plan.</p> <p>1.1 Ongoing partnership discussions and curation of Neighbourhood Programme and Trafford Live Well priorities for 25/26 (and beyond). Development of investment principles to utilise the Live Well grant allocation (25/26)</p> <p>1.2 Dynamic review of performance metrics in-year related to the neighbourhood plans. Adoption of population and cohort level measures in our recently agreed TLB Performance Arrangements for 25/26</p> <p>1.3 Establishment of a VCFSE Community Engagement model across Trafford.</p> <p>1.4 Establish Trafford's response to GM Live Well, including vision, mission statements, centres, spaces, offers, VCFSE sustainability, prevention</p>	<p>1.1 Neighbourhood model connectivity and governance with Live Well if fully aligned, with a 'Live Well Integrated Neighbourhood Team model developed and in the process of refinement partners in a codesign approach. Parallel Trafford Live Well conversations have earmarked specific priorities for 26/27 including sustainability of the VCFSE sector, mobilisation of live well spaces and centres - including two flagship centres in Partington and Urmston. Investment proposal for the allocated monies for 26/27 has been drafted, using agreed investment principles and additional sites for Live Well Phase 2 to be decided (March 26)</p> <p>The Trafford Neighbourhood Plan developed in partnership and with commitment from system partners sets out a set of joint delivery priorities for Neighbourhoods, as well establishing a collective aim and ambitions.</p> <p>1.2 Continued review of agreed performance metrics and associated products through Finance, Performance and Sustainability and the Neighbourhood Impact and Evaluation Group - flex as and when required and nuance reporting products as the neighbourhood priorities evolve and change. Neighbourhood Proformas have been developed with support from neighbourhood Leads to support wider Locality Scorecard, and are currently in testing (Q4).</p> <p>1.3 As of November 2025, the Trafford Community Collective are funded by Trafford Council to act as the Local Infrastructure Organisation (initial 3.5 years of funding) and leading on the VCFSE Engagement Model - 2 years effective March 2026. Co-designed work programme is developed and managed in the Trafford Participation Group.</p> <p>1.4 Live Well programme structure in place with full team complement and associated governance (Steering Group, Infrastructure group and two Operational Groups for each of the flagship sites in Sale and Partington), required 'Programme Implementation Plan' has been developed and is being operationalised. Phase 2 for 26/27 is actively being developed with a paper being developed outlining options for future Live Well Ecosystems to build on the success of Phase 1.</p>	Trafford Locality Board Trafford Health And Wellbeing Board Trafford Provider Collaborative Board Trafford Live Well Steering Group (and associated groups) Neighbourhood Health and Care Group (and associated groups)	None identified yet	1	4	4	↓	26/02/2026	10/03/26	Active

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Name of Committee / Board		Trafford Locality Board		
Date of Meeting		17th March 2026		
Report Title		Governance Review		
Report Author & Job Title		Pippa Dewhirst, Governance Manager, NHS GM		
Organisation Exec Lead		Thomas Maloney, Programme Director Health and Care, Trafford Council / NHS GM (Trafford)		
OUTCOME REQUIRED <i>(please highlight)</i>	Approval X	Assurance X	Discussion X	Information
EXECUTIVE SUMMARY				
<p>The purpose of this report is to present the Locality Board with an overview of the proposed Governance Review, its remit and details of the Task and Finish Group that has been enacted to support the process.</p>				
RECOMMENDATION				
<p>Trafford Locality Board is asked to:</p> <ul style="list-style-type: none"> • Note the content of this report • Agree to the process described in the report. 				
CONSIDERATIONS – these must be completed before submission to the Board – Reports with incomplete coversheet information will not be accepted and shared with the board				
Risk implications <i>(Please provide a high-level description of any risks relating to this paper, including reference to appropriate organisational risk register)</i>		Effective governance arrangements will support future risk management.		
Financial implications and comment/approval <i>(Please detail which organisation(s) will be impacted, and if not required, please briefly detail why)</i>		Name/Designation: N/A		
		Comment / Approval: N/A		
Comment by Trafford Clinical and Practitioner Senate (TCAPS) and/or Clinical Lead <i>(If not required, please briefly detail why)</i>		Date of TCAPS / Clinical Lead comment: N/A		
		Name/Designation: N/A		
		Comment: N/A		
What is the impact on inequalities? <i>(Please provide a high-level description of any known impacts)</i>		N/A		
Equality Impact Assessment / Quality Impact Assessment Outcome <i>(If not appropriate at this stage please state if an EIA or QIA is necessary)</i>		N/A		



<p>People and Communities: Communications & Engagement <i>(Please detail relevant patient/public engagement completed and/or planned, and if not required please briefly detail why)</i></p>	N/A
<p>Trafford’s Carbon Footprint <i>(Please provide a high-level description of any known positive and/or negative impacts – consider the following topics: energy usage; staff or public transport; waste or materials used. Include steps that could be taken to reduce carbon within relevant plans)</i></p>	N/A
<p>Links to Measurement / Outcomes <i>(Please detail if this is included within the report)</i></p>	N/A
<p>Enabler implications</p>	<p>Legal implications: N/A</p>
	<p>Workforce implications: N/A</p>
	<p>Digital implications: N/A</p>
	<p>Estates implications: N/A</p>
<p>Sub-Board Sign-Off / Comments <i>(i.e. Trafford Provider Collaborative Board, H&SC Delivery Steering Group)</i></p>	<p>A version of this paper has been discussed by members of the Trafford Strategy and Planning Hub (6th March 2026) and also shared with the membership of the first Governance T&F Group (10th March 26) – a summary from the T&F Group has been included in this paper.</p>
<p>Organisation Exec Lead Sign off</p>	<p>Thomas Maloney, Programme Director Health and Care</p>

1.0 Introduction and Background

- 1.1 Trafford Integrated Care Partnership (TICP) Governance arrangements are regularly reviewed to ensure they are comprehensive and support effective decision making. We regularly adapt our governance to suit emergent requirements and continuously learn from ‘what works’ resulting in changes to our arrangements as and when needed – a Cooperative Commitment in Trafford’s Locality Plan 2025-28.
- 1.2 Due to the ongoing NHS reforms, we will be undertaking a locality governance review to ensure our place partnership governance is fit for purpose, in line with the new operating model and responds appropriately to any centrally issued guidance from NHS GM. We are in the mobilisation stage of the review, with this paper outlining key considerations and some practical next steps.

2.0 Context

- 2.1 We are now entering a phase of place partnership mobilisation as principles evolve from theory and design into operational delivery and as such, place partners at Trafford Locality Board have been asked to consider key components of our new arrangements, including:
- The Place Partnership Agreement;
 - Place Funding;
 - Place Team; and
 - Place Transfer.
- 2.2 We will also consider the wider partnership governance arrangements that will enable the effective deployment of the new operating model allowing local insight-led planning, integrated delivery at place and facilitating partners to co-ordinate resource to achieve shared outcomes.
- 2.3 The Partnership Agreement will be of particular importance as it will form an agreement that reflects shared priorities and ensures Trafford is a space for collaboration and integrated working. It will also be pivotal to ensure that place funding is thoroughly reviewed to establish a financial framework that enables place delivery within the new operating model.
- 2.4 For context, we have already started to make some adjustments to our governance arrangements responding to strained capacity, GM instruction, emergent need and feedback from stakeholders. An example would be the stepping down of our Locality Primary Care Commissioning Committee. We have rerouted the responsibilities of this group via our NHS GM Senior Leadership Team Meeting and then onward to Trafford

Locality Board as required, acknowledging staff changes as part of phase one of NHS reform. As per guidance from central NHS GM we have also stood down the Locality Quality Group and are considering how staffing changes may impact other locality governance in the immediate future.

- 2.5 It is anticipated the central team in NHS GM will provide governance guidance to ensure consistency at place and this will be considered and where appropriate embedded locally when received. We are active participants in the NHS GM Governance Leads meeting which will be utilised as a forum to share best practice and receive updates from the central GM team, sharing pertinent updates into relevant Trafford forums thereafter.

3.0 Governance Review and Next Steps

- 3.1 To support and structure this work and in pursuit of formalising new governance arrangements, Trafford Locality Board have initiated a Task and Finish Group (T&F Group). Members of Trafford Locality Board were invited to nominate representatives for the T&F Group. The membership of the Task and Finish Group is detailed below:

- Gareth James, Deputy Place Based Lead, NHS GM
- Thomas Maloney, Programme Director for Health and Care representing NHS GM
- Heather Fairfield, Chair of Healthwatch Trafford
- Bernadette Ashcroft, Chief Executive Officer, Trafford Community Collective
- Dr Jane Wareing, GP Board Representative
- Darren Banks, Group Director of Strategy, MFT
- Ian Bett, Director of Operations and Performance, Trafford Local Care Organisation
- Adam Hebden, Acting Chief Director of Strategy, MFT
- Dominique Sykes, Director of Legal and Governance, Trafford Council
- Michelle Richards, Associate Director of Performance and Strategic Development, GMMH
- Maggie Kufeldt, Corporate Director of Adults & Wellbeing, Trafford Council

The inaugural meeting will be held on the 10th March 2026 and a summary of the meeting is provided at section five below for information. The T&F group will meet monthly and report progress to the Board in a timely manner – separate time limited thematic group meetings maybe convened to discuss specific elements of the overarching review.



- 3.2 Initially the group will focus on the place partnership agreement and locality grant. The remit of the group will then develop into considering the wider governance options to successfully enact the place partnership agreement. Feedback from the T&F Group will be reviewed at Trafford Locality Board meetings and fed into GM appropriately, with work continuing in the 26/27 financial year to solidify arrangements, noting an extended period of transition.
- 3.3 To assist the T&F Group the H&SC PMO led by the NHS GM Governance Lead have commenced a review of existing arrangements. The team have started to map and consider our current governance arrangements and highlight if they expect it to be:
- Retained in its current format and structure;
 - Change – could include updates to membership, scope or reporting arrangements; or
 - Stood down.
- 3.4 We will be reaching out to Chairs and Co-Chairs, Senior Responsible Officers, Subject Matter Experts (SME) and other key officers for their initial input on future arrangements and will compile a comprehensive report in due course of these findings which will inform a future options paper which will be curated in the T&F Group and latterly presented to Trafford Locality Board.
- 3.5 To progress at pace and where feasible we have already started the initial phase of the review and engagement. The outputs of the planned engagement will periodically be reviewed by NHS GM Trafford Senior Leadership Team ahead of being considered at both the T&F Group and more formally via Trafford Locality Board.
- 3.6 Other organisational forums may benefit from bespoke briefings and will assist in us gathering additional insight and feedback to any options developed over the coming weeks and months and these will be scheduled as and when needed.

4.0 Governance Task and Finish Group Summary

- 4.1 The Task & Finish Group met on 10th March 2026 to mobilise the agreed governance review required - focussing on the 4 aspects highlighted in section 2.1.

The focus of the initial meeting was the draft Place Partnership Agreement (PPA). This was considered with members expressing ongoing concern about the lack of clarity around GM and Place responsibilities and the limited incorporation of locality



feedback to revised versions of the draft PPA. The group highlighted issues in the PPA, including contradictory and unclear terminology, minimal revisions between drafts that have been shared with members, and missing schedules such as the responsibility matrix and funding arrangements. Members also noted the absence of meaningful reference to lived experience and public engagement, despite its prominence in GM and Trafford strategies. A series of actions and escalations into GM were agreed, some of which have been formally enacted.

The group recognised dependencies across the four workstreams and agreed to continue refining the PPA in parallel with GM developments. Key actions, in addition to escalating initial concerns to GM, were as follows:

- Requesting clearer engagement processes
- Strengthening Trafford-specific content
- Preparing an interim “good-enough” agreement for April/May.

A host of additional practical actions were also agreed in-principle which are being considered by the Group for sign off. A verbal update on support for the draft actions will be verbalised in the Locality Board appropriately.

5.0 Recommendations

5.1 Trafford Locality Board is asked to:

- Note the content of this report
- Agree to the process described in the report.

Name of Committee / Board		Trafford Locality Board		
Date of Meeting		17th March 2026		
Report Title		Community Services Review: Decommissioning of Community Ear Care Service and realignment of investment.		
Report Author & Job Title		Alex Cotton, Head of Transformation and Delivery, NHS GM (Trafford) Phil Brown, General Manager, Trafford and South Manchester, Trafford and Manchester Local Care Organisation.		
Organisation Exec Lead				
OUTCOME REQUIRED <i>(please highlight)</i>	Approval X	Assurance	Discussion X	Information
EXECUTIVE SUMMARY				
<p>Trafford's challenges regarding community nursing capacity have been subject to a number of papers and Executive to Executive discussion within locality and with NHS Greater Manchester Central Executive Team. The outcome of discussions held in December 2025 was an agreement for:</p> <ul style="list-style-type: none"> the LCO to embed an improved triage model releasing £315k in internal savings which can be realigned to increase Community Nursing capacity. a joint review of Trafford Community Services by the LCO and Locality Team to determine any potential services of lower clinical value which could potentially be decommissioned and investment realigned to increase Community Nursing capacity. Continued discussion with partners and NHS GM Executive team in regards to the remaining funding gap in funding for core and speciality nursing provision. <p>This paper is in response to our second commitment and the outcome of the joint review of current service. This process identified one service, Community Ear Care, which is not routinely commissioned across GM localities and systems across the country and can be considered of low clinical value.</p> <p>This paper outlines a proposal to decommission Trafford's Community Ear Service and includes key considerations of the potential impact on Trafford people and the system; alongside the contribution the repurposing of this funding could have on community nursing capacity should this proposed be approved.</p>				
RECOMMENDATIONS				
<p>Trafford Locality Board is asked to:</p> <ul style="list-style-type: none"> Note the content of this report and the risks and opportunities in closing Trafford's Ear Care Service and realigning investment to increase District Nursing capacity. Approve the recommendation to close Trafford's Ear Care Service and realign investment to increase District Nursing capacity. To agree to the proposed next steps and advise of any additional actions required, not contained within this report. 				
CONSIDERATIONS – these must be completed before submission to the Board – Reports with incomplete coversheet information will not be accepted and shared with the board				
Risk implications <i>(Please provide a high-level description of any risks relating to this paper, including reference to</i>	<ul style="list-style-type: none"> No community ear care service means that any residents requiring this intervention will need to self-fund this intervention, which may result in expanding health inequalities within more deprived areas of Trafford. 			



<p>appropriate organisational risk register)</p>	<ul style="list-style-type: none"> • There is a risk of increase in otherwise avoidable referrals to hospital-based ENT. • There is a risk of increase referrals to Adult Hearing Service provided by the Independent Sector, which is currently subject to NHS GM CIP Programme. <p>However, as this is the only service identified as part of this review, the risks of not commissioning the service and realigning investment to community nursing include:</p> <ul style="list-style-type: none"> • Continuation of a staffing model that doesn't reflect population need (number or complexity) • Continued growth in deferral of patients and delays to review and treatment. In December 2025, this figure was 200 deferrals each week which in turn contributes to a high number of reported incidents, including 178 community acquired pressure ulcers and multiple safeguarding and medication issues over the last 12 months. • High staff sickness • High number of contacts per staff, above national average and recommendation. National benchmarking shows Trafford's community nursing spend per head is in the lower quartile nationally, with validated caseloads three times the national average. • 38% less time spent at each visit compared to national average.
<p>Financial implications and comment/approval <i>(Please detail which organisation(s) will be impacted, and if not required, please briefly detail why)</i></p>	<p>Name/Designation: Julie Flanagan, Associate Director of Finance (Trafford), NHS GM and XXX</p> <p>The annual commissioning budget for Trafford's Community Ear Care Service is £328k. It is proposed that this investment is realigned to contribute funding gap in District Nursing.</p>
<p>Comment by Trafford Clinical and Practitioner Senate (TCAPS) and/or Clinical Lead <i>(If not required, please briefly detail why)</i></p>	<p>Date of TCAPS;</p> <p>Name/Designation:</p> <p>Comment: Due to the timescales associated with the delivery of this paper it was not possible to present to TCAPs ahead of Trafford Locality Board. However, potential clinical implications of decommissioning Ear Care Service are described within Quality Impact Assessment (Appendix A)</p>
<p>What is the impact on inequalities? <i>(Please provide a high-level description of any known impacts)</i></p>	
<p>Equality Impact Assessment / Quality Impact Assessment Outcome <i>(If not appropriate at this stage please state if an EIA or QIA is necessary)</i></p>	<p>A full EQIA has been completed by Trafford LCO as part of this proposal and can be found as appendix to this report (Appendix A).</p>



<p>People and Communities: Communications & Engagement <i>(Please detail relevant patient/public engagement completed and/or planned, and if not required please briefly detail why)</i></p>	<p>Trafford Locality is currently working with NHS Greater Manchester Communications and Engagement Team to develop an engagement plan, should this proposal be agreed by Locality Board. Communications to key stakeholders will be developed and agreed in partnership with Trafford LCO.</p>
<p>Trafford's Carbon Footprint <i>(Please provide a high-level description of any known positive and/or negative impacts – consider the following topics: energy usage; staff or public transport; waste or materials used. Include steps that could be taken to reduce carbon within relevant plans)</i></p>	<p>There are no anticipated positive or negative impacts on Trafford's Carbon Footprint as a result of this proposal.</p>
<p>Links to Measurement / Outcomes <i>(Please detail if this is included within the report)</i></p>	<p>The proposal to realign this investment to increasing District Nursing capacity would:</p> <ul style="list-style-type: none"> • fund and addition 6.5 WTE band 5 nurses, costed at midpoint with weekend enhancements. • Based on 10 visits per day, this would equate to capacity for 325 visits per week, or 13,520 per year, which includes a 20% allowance for annual leave and training etc. • Move from an average of 198 deferrals per week to no deferred visits. • This would also reduce the average visits per registered nurse down from the current average of 16, closer to the QNI recommendations of 10 visits per registered nurse. Which in turn could reduce the rates of staff sickness. • Significantly reduce the number of incidents which can arise due high level of deferrals i.e. number and severity of pressure ulcers.
<p>Enabler implications</p>	<p>Legal implications: TLCO has a legal responsibility to undertake a consultation with any staff member effected by the decommissioning of this service, if approved.</p>
	<p>Workforce implications: Should the proposal to decommission Trafford's Ear Care Service be supported, there will be implications for 3 members of TLCO staff which currently deliver this service. TLCO will lead staff consultation including opportunities for deployment to other appropriate services.</p>
	<p>Digital implications: None identified as part of this proposal.</p>
<p>Estates implications: None identified as part of this proposal.</p>	
<p>Sub-Board Sign-Off / Comments <i>(i.e. Trafford Provider Collaborative Board, H&SC Delivery Steering Group)</i></p>	<p>This proposal as reported into and considered at:</p> <ul style="list-style-type: none"> • NHS GM and TLCO Joint Community Service Review Programme Group (weekly) • LCO CIA Panel –Approval of EQIA (Appendix A) March 2026 • This proposal was considered and supported by NHS GM (Trafford) and TLCO Senior Leadership Team meetings in February 2026. • This proposal was considered and supported by Trafford Provider Collaborative on 26th February 2026.



	<ul style="list-style-type: none"> This proposal was presented to Trafford Health Scrutiny Committee on 4th March. While Health Scrutiny Committee understood why this proposal has been developed, concerns were raised by members regarding Trafford residents who are unable to resolve their issues via self-management or over the counter prescriptions and are unable to fund ear care (ear dewaxing) privately and the impact this could have on their long-term hearing.
<p>Organisation Exec Lead Sign off</p>	<p>Gareth James, Deputy Place Lead for Health and Care Integration (Trafford) NHS Greater Manchester; Adam Hebden, Director of Strategy, Manchester University Hospitals NHS Foundation Trust (MFT)</p>

PLEASE ENSURE THAT YOU “SAVE AS” BEFORE BEGINNING YOUR REPORT, THE TEMPLATE SHOULD REMAIN UNCHANGED. (please delete once read)

Follow on with the Main body of the report (new page – do not change formatting) DO NOT EMBED DOCUMENTS, include links where necessary to longer/lengthy documents for reference

1.0 Introduction

1.1 Challenges in Trafford’s community nursing capacity are substantial and longstanding and remain so despite significant work being undertaken by MFT and locality partners in 2024/25 and 2025/26. This included the completion of a detailed business case and revised community nursing specification, including a redesign of the adult core and specialist community nursing services in Trafford.

1.2 This work has also been shared through the NHS GM community services programme to support progression of a standardised model for core district nursing across all Greater Manchester localities.

1.2. In Q3 2025, this accumulated in a number of Executive-to-Executive discussions with Locality partners and NHS Greater Manchester Executive Team. The outcome of these discussions was a commitment for:

- the LCO to embed an improved triage model releasing £315k in internal savings which can be realigned to increase Community Nursing capacity.
- a joint review of Trafford Community Services by the LCO and Locality Team to determine any potential services of Low Clinical Value which could potentially be decommissioned and investment realigned to increase Community Nursing capacity.
- continued discussion with partners and NHS GM Executive team in regards to the remaining funding gap in funding for core and speciality nursing provision.

1.3 This paper is in response to our second commitment and the outcome of the joint review of current service. This process identified one service, Community Ear Care, which is not



routinely commissioned across GM localities and systems across the country and can be considered of low clinical value.

- 1.4 This paper outlines a proposal to decommission Trafford’s Community Ear Service and includes key considerations of the potential impact on Trafford people and the system alongside the contribution the repurposing of this funding could have on community nursing capacity should this proposed be approved.

2.0 Trafford Ear Care Service

- 2.1 In 2022, as part of Trafford’s Community Services Review Programme, a joint TLCO/ ICB review of the Ear Care service was undertaken to establish a ‘right-size’ service and contribute to cost pressures. This resulted in the implementation of a new service specification which included a change to the criteria and a reduction of capacity in the service.
- 2.2 The service is commissioned for patients aged 16 and over with a GP in Trafford and aims to treat all patients eligible for ear clearance within one community service using either irrigation, instrumentation or micro-suction techniques. The service is available for housebound patients, those who can attend clinic and also for those in a residential care home. The exclusion criteria for ear irrigation are cleft palate, mastoidectomy, recent perforation or mucus discharge from the ear. For micro suction, the exclusion criteria are patients who have had recent ear surgery or a mastoidectomy.
- 2.3 The service does not presently prescribe medications or work under a Patient Group Directive. The service assesses, diagnoses and either signposts to a pharmacy for over-the-counter medications or refers to a GP sending symptoms and recommends a prescribed medication.
- 2.4 The service is delivered by 1.0wte Band 6 nurse, 1.0wte Band 5 Nurse and 1.0wte Band 4 Assistant Practitioner.
- 2.5 The service accepted 7,281 referrals in 2025, an average of 607 referrals per month. In total the service had 6,596 patient contacts in the same period, which is an average of 550 contacts per month. There is no waiting list, patients are booked in to next available appointment, which is approximately 4 weeks.

3.0 Potential risks and impact of decommissioning Trafford Community Ear Care Service on People and Place.

- 3.1 A full EQIA can be found in Appendix A, with the following providing an overview of this assessment.
- 3.2 **Health inequalities**
- 3.2.1 Vulnerable Groups – National statistics inform that impacted earwax is present in one in 20 adults and over 30% of older people and more than 30% of people with learning disabilities (1) Compacted ear wax causes “a sizeable burden” on the healthcare resources of a country if left untreated.



3.2.2 Affordability - As the only commissioned service for ear clearance, the decommissioning of this service will end NHS funded provision for Trafford residents, resulting in residents requiring to self-fund this intervention, if required. The general cost range for ear irrigation to be undertaken privately is £50 to £80 and may vary depending on provider and location. Local research indicates an average of £60 for this intervention, with many providers offering home visits and free hearing tests. However, this cost may be prohibitive to some Trafford residents.

3.3 Clinical Considerations

3.3.1 Hearing Loss- Wax impaction can have safety issues for patients and an untreated buildup can lead to hearing loss. Research has dictated that if impacted ear wax is left untreated in the canal for too long, it can potentially lead to permanent hearing loss.

3.3.2 Dementia -- Hearing loss causes an increased risk of people developing dementia and exacerbating established dementia. It was found that the cognitive function of people with dementia improved once they had impacted earwax removed (Nakashima et al 2016).³

3.3.3 Mental Health - Hearing loss has been shown to increase the risk of isolation, confusion, and depression (Harkin 2020)

3.3.4 Other related Ear Care implications- Tinnitus is when the brain provides a sound to compensate for hearing loss. Impacted earwax causes hearing loss and earwax related tinnitus is treated regularly and successfully in Trafford ear care service. Earwax can also cause dizziness increasing a person's risk of falling.

3.4 System Considerations

3.4.1 Without a community Ear Care service and with some residents unable to self-fund this intervention, there is a risk of an increase of referrals to secondary care ENT.

3.4.2 Without an ear irrigation there is a risk of long-term hearing loss, which could result in an increase referral to Adult Hearing Service, which is currently a focus of NHS GM CIP Programme in light of increase of activity and costs in recent years.

4.0 Alternative Treatments and Mitigations

4.1 **Online support and self-management:** The vast majority of ear wax impaction can be managed via self-care and resolved within 5 days. There is substantial advice online in terms of self-care in the management of Ear Wax management including on NHS Patient facing websites and independent and voluntary/advocacy group websites.

4.2 **Consultation with a Pharmacist:** Free consultation with a pharmacist is available, who can offer advice and treatments, including over-the-counter ear drops and guidance on safe ear wax techniques. A pharmacist will also be able to advise when professional intervention is required.

4.3 **General Practice:** GPs will continue to be able refer patients to NHS audiology services if a person meets the following:

- Has documented underlying hearing loss that is directly linked to ear wax build-up



- Ear wax issue is part of a broader medical condition requiring specialist intervention
- They meet specific clinical criteria determined by local NHS Trusts

4.4 As part of a joint engagement and communication plan, information will be made readily available to residents to support their informed decisions. We will use our communication tools to signpost patients to available services and advice can also be available from their local pharmacists and to national advice that is available NHS and national groups where there is a huge amount of information available.

5.0 Commissioning of Ear Care Services Nationally and within Greater Manchester

5.1 Community Ear Care services have largely been decommissioned across the UK. In September 2020, UK Minister of State at the Department of Health and Social Care, Edward Argar, officially reclassified ear wax removal as an "enhanced service" rather than a core NHS service. Due to the number of financial pressures in the NHS, most CCGs/ICBs have had to make the decision to discontinue free Ear Care.

5.2 Nationally, the impact has been managed as the private sector has increased significantly with this invention being available in a number of well-known national high street providers such as Boots, Specsavers and including other regional/local providers. In local GM areas that we have discussed this with; there hasn't been a significant impact reported in decommissioning these services.

5.2 As part of this review, Trafford ICB sought information as to whether other localities in GM commission community Ear Care Services. While not all localities provided a response, the following provided their position:

- **Manchester** – No longer commission this service.
- **HMR**- Recently agreed to stop their DN service delivering this intervention. Syringing is available via audiology where required for fitting hearing aids.
- **Salford**- while ear syringing is currently part of the DN specification due to capacity issues and pressures within the team, the ear syringing service was temporarily put on hold in October 2025. The team are still delivering ear syringing clinics to Care Home and housebound patients, but all other patients are not currently covered and will be asked to self-manage, pay for private treatment or the GP should refer to audiology if hearing is impaired. Salford are in the process of reviewing the DN services across all of the NCA footprint to bring them into line and are aware that other areas do not provide this service and therefore, things may change in Salford further in the future.

5.3 In terms of available private providers of ear care provision within Borough, 11 different providers have been identified and there is presence across all neighbourhoods. All private providers of Ear Care services must be registered with CQC.

6.0 Potential opportunity and impact on realignment of investment on People and Place

6.1 Following the review of community services provision, Trafford Ear Care Service was the only service identified as of lower clinical value, with all others falling within core requirements. Decommissioning this service and realigning the commissioning budget to increase District



Nursing capacity and resilience could provide an opportunity to make significant inroads into addressing the challenges, as demonstrated below.

- 6.2 The following has been determined based on a conservative budget of £312k:
- This fund and addition 6.5 WTE band 5 nurses, costed at midpoint with weekend enhancements.
 - Based on 10 visits per day, this would equate to capacity for 325 visits per week, or 13,520 per year, which includes a 20% allowance for annual leave and training etc.
 - In January 2026, there were 794 recorded deferred visits, an average of 198 deferrals per week. Based on this the reinvestment of the £312k from Ear Care would have ensured there were **no deferred visits**.
 - This would also reduce the average visits per registered nurse down from the current average of 16, closer to the QNI recommendations of 10 visits per registered nurse. Which in turn could reduce the rates of staff sickness.
- 6.3 While this is a significant improvement in District Nursing, it is important to highlight that this would not resolve all of the issues within the Community Nursing Business case and additional funding would still be required to address existing challenges in Specialist Palliative Care, treatment room, Bladder & Bowel and Diabetes services.

7.0 Recommendations

- 7.1 It is recommended that Trafford's Ear Care Service close and for the investment to be realigned to increase District Nursing capacity.
- 7.2 The closure of Trafford's Ear Care Service would not be without impact to Trafford residents who require an intervention in the future, as they would be required to self-manage or self-fund this care. However, as a realignment of this funding could enable a move from an average 198 DN deferrals per week to no deferrals per week, it is felt that benefit of doing so is such that this is required and would be better utilised to support Trafford's population need.
- 7.3 Should Trafford Locality Board support this recommendation the following actions would be undertaken:
- Staff Consultation: To be led by the LCO with 3 members of staff impacted by the closure of the Ear Care Service.
 - Development of exit plan and closure of the service by TLCO.
 - Process to initiate recruitment of additional DN capacity to be initiated by TLCO.
 - Improvement plan to be developed – providing estimated trajectory for when improvements will be seen within DN service. While this will be subject to recruitment, this will provide an outline timeframe for 26/27.
 - Joint communication to system partners and key referrers such as General Practice.
 - Reconciliation within Finance and Contracting.



- 7.4 Continued discussions will also be required with regard to specialist nursing such as Specialist Palliative Care, treatment rooms, Bladder and Bowel and Diabetes as this will not be addressed via the closure of this service.

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Appendix A:

Quality Impact Assessment Tool – Decommissioning of TLCO Ear Care Service

In healthcare, ‘quality’ includes patient safety, patient experience and clinical effectiveness. These domains include Equality and Diversity, Dignity and Respect and the effects of planned changes on workforce.

What is Quality Impact Assessment (QIA)?

This is a tool to help develop service change. It should be used at the beginning of a process to inform the development of the service change, ensuring that the core pillars of quality are considered and that the service is developed in a comprehensive way, based on rounded data and intelligence.

Why undertake a QIA?

When a change to a service or care pathway is proposed, the relevant **Quality and Safety Committee** must ensure that the proposal has positive effects on patient safety and patient experience, is evidence based and delivers best practice. Only then can we be assured of high quality care. The QIA also needs to demonstrate that issues of workforce planning, and skills transfer, together with education and training have been appropriately considered. This tool will enable the Quality and Safety Committee to be assured that all essential factors are being considered and addressed through the development of service design.

Who should undertake a QIA?

The team responsible for service design should begin the QIA at an early stage, to ensure compliance with statutory requirements.

Stage 1 Initial Assessment

Assess each answer as potentially positive, neutral or adverse (P/N/A) against each criterion and describe your rationale below: -

Area of Quality	Impact Question: Trafford Community Ear Care Service to be decommissioned?	P/N/A
		A
Duty of Quality	Could the proposal impact on any of the following - compliance with the NHS Constitution, partnerships, safeguarding children or adults or the duty to promote equality?	A
Patient/Staff Experience	Could the proposal impact on any of the following - positive survey results from patients and staff, patient choice, personalised and compassionate care?	A
Patient Safety	Could the proposal impact on any of the following – safety, systems in place to safeguard patients to prevent harm, including infection?	N
Clinical Effectiveness	Could the proposal impact on evidence-based practice, clinical leadership, clinical engagement and high quality standards?	A
Prevention	Could the proposal impact on promotion of self-care and improving health equality?	A
Productivity and Innovation	Could the proposal impact on - the best setting to deliver best clinical and cost-effective care; eliminating any resource inefficiencies; low carbon pathway; improved care pathway?	A

Please describe your rationale for any potentially adverse assessment:

Closing the Trafford Ear Care Service would impact adversely on all areas identified above.

Assessment completed by: Phil Brown and Deb Smith

Date: February 2026

Stage 2 Full Assessment

- A. Assess each potential impact of the change to a service or care pathway, providing information to inform the assessment.
- B. Using **Appendix 1**: “*Risk Management measure of severity and consequences, likelihood and scoring risk matrix*” carry out a risk assessment of all identified potential adverse effects.

A. Assessment of each potential impact of the change

PATIENT SAFETY		
1. What is the potential impact of the service development on patient safety?	Use these prompts to help you comprehensively evaluate the plans	Information to inform assessment/understanding of potential adverse effects
<p>What are the known patient safety issues within the current service? (as identified by national/local audits, SIs, incident trend analysis, concerns and complaints, CQC and other external inspections, staff observation/feedback)</p>	<p>Has the current safety of the service been evaluated and known patient safety risks identified? Prompts to consider:</p> <ul style="list-style-type: none"> • Specific safety issues within this pathway or service, • Analysis of available data/information to identify themes and trends. • The way in which the planned changes will address the identified patient safety issues. • Impact on preventable harm. 	<p>Impacted earwax is present in one in 20 adults and over 30% of older people and more than 30% of people with learning disabilities (1) Compacted ear wax causes “a sizeable burden” on the healthcare resources of a country if left untreated.</p> <ul style="list-style-type: none"> • Hearing loss has been shown to increase risk of isolation, confusion, increased accidents at home and depression. • There is conclusive evidence of the association between hearing loss and social isolation (3) and between earwax impaction and reduced cognitive function (4) Elderly people and those with a learning disability can have ear wax so hard that it had eroded into the ear canal, causing extreme pain and often requiring a general anesthetic to be removed (5) <p>The following are significant symptoms that can adversely affect patient’s health outcomes, safety and quality of life. Approximately 70% of patients come under the bracket of ‘elderly’ or they are a ‘hearing aid user’. Both of these categories would be at risk without ear clearance.</p>

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	<p>Hearing loss - Wax impaction can have safety issues for patients and an untreated buildup can lead to hearing loss. Research has dictated that if impacted ear wax is left untreated in the canal for too long, it can potentially lead to permanent hearing loss, which is a cost implication for audiology.</p> <p>Dementia - Hearing loss causes an increased risk of people developing dementia and exacerbating established dementia. It was found that the cognitive function of people with dementia improved once they had impacted earwax removed (Nakashima et al 2016).</p> <p>Unaddressed midlife hearing loss was the most significant risk factor for dementia, being responsible for 9.1 per cent of people developing dementia. (NHS England 2017).</p> <p>Mental Health - Hearing loss has been shown to increase the risk of isolation, confusion, and depression (Harkin 2020).</p> <p>Prolonged problem Earwax can cause Otitis externa and then GP intervention and medication will need providing at an added cost or possible ENT referral.</p> <p>Earwax can also cause dizziness which makes people high risk of falling.</p> <p>Tinnitus is when the brain provides a sound to compensate for hearing loss. Impacted earwax causes hearing loss and earwax related tinnitus is treated regularly and successfully in Trafford ear care service. The average cost of tinnitus treatment per patient per year is £717, equating to an NHS healthcare bill of £750 million per year. Some of this figure would be attributable to wax related tinnitus.</p> <p>Between 1/2/25 and 31/01/26, the service submitted 9 incidents, all were no harm incidents under the categories Infrastructure – Cleaning (6), Safeguarding (1), Aggressive Behaviour (1), Access, Admission and Transfer (1)</p>
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<p>Have staffing, skill mix and workload issues been considered within the plans?</p>	<p>What impact will the plan have on staffing requirements? Prompts to consider:</p> <ul style="list-style-type: none"> • New ways of working • Skill mix 	<p>This QIA relates to the closure of the service.</p>
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	<ul style="list-style-type: none"> • Recruitment activity • Vacancy levels 	
Do the plans include changes to treatment involving medications, (including prescribing, administration or security)	<p>What impact will the plans have on medicines security and how will any identified risks will be mitigated?</p> <p>Prompts to consider:</p> <ul style="list-style-type: none"> • Patient safety • Competency in medicines administration • Systems in place to ensure appropriate monitoring of patient outcomes/safety 	The service does not presently prescribe medications or work under a Patient Group Directive. The service assesses, diagnoses and either signposts to a pharmacy for over-the-counter medications or refer to a GP sending symptoms and suggest a prescribed medication.
Will the plans impact positively or negatively on the organisation's duty to protect children, young people and adults?	<p>Protocols to consider include:</p> <p>The NHS Constitution, Partnership working, Safeguarding children or adults</p>	<p>The service is commissioned for patients aged 16+, so no impact on children.</p> <p>There would be a negative impact on patients who would have to seek alternate provision, which would likely incur a cost to the patient and this may be a barrier in sourcing the treatment.</p>
Do the planned changes require ratification through a governance process?	<p>In the event of a legal challenge, how thorough is the ratification process?</p> <p>Prompts to consider:</p> <ul style="list-style-type: none"> • Current statutes / professional standards e.g. Mental Capacity Act, Mental Health Act, Dangerous Drugs Act, Children's' Act, No Secrets, GMC, NMC etc. • Responsible committees within each hospital/MCS/LCO and across the pathway 	Ratification would be required via the LCO QIA Panel, Trafford Provider Collaborative, Trafford Locality Board and Scrutiny Committee.

CLINICAL EFFECTIVENESS		
2. What is the potential impact of the service development on effectiveness?	Use these prompts to help you comprehensively evaluate the plans	Information to inform assessment
Are the planned changes or service re-design in line with the most up-to-date guidance ensuring the business case is evidence-based?	Does the plan reflect Quality Standard Indicators? Are there gaps? If there are gaps, how will these be addressed?	<p>NICE (Hearing Loss in Adults: Assessment and Management NG98, 2018) states that adults with earwax that is contributing to hearing loss or other symptoms or preventing ear examination or ear canal impressions being taken, have earwax removed.</p> <p>NICE guidelines advise on management of earwax that wax softeners should be used for 3-5 days and if the problem persists then wax removal is necessary by irrigation or microsuction.</p>
What plans are in place for clinical audit or evaluation	Audit against standards outlined in NICE guidance or professional standards. Use the NICE clinical audit tool where available www.nice.org.uk	N/a
Health Outcomes for patients	What are the expected health outcomes for patients? How will the success against the expected health outcomes be measured? How do these compare with other available treatment or care pathway alternatives?	<p>Health outcomes could be worse if the service is no longer provided. This could specifically affect the elderly or low income earners that could not afford to have the treatment privately.</p> <p>There could also be negative impacts on services such as Audiology and ENT departments, that may experience a rise in demand.</p>

PATIENT EXPERIENCE AND INVOLVEMENT

3. What is the potential impact of the service development on patient experience and involvement?	Use these prompts to help you comprehensively evaluate the plans	Information to inform assessment
What do patients and carers say about the current service?	Use positive and negative feedback from: <ul style="list-style-type: none"> • PALS and complaints • Local surveys • Real time feedback eg FFT • Focus groups • Healthwatch 	FFT – Between 1/2/25 and 31/01/26, 193 responses were received with 192 “very good” and 1 “good”. There has been 1 complaint in the previous 12 months due to 3 week waiting time for an appointment.
How will patients, carers and key stakeholders be involved in the decision-making process around the development of this service?	At what point in the decision-making process will patients and public have a chance to influence the service development? What methods will be used to involve patients, public and stakeholders?	Proposal will be presented to scrutiny committee.
How will the service development improve the patient experience?		Closure of the service provision will not improve the patient experience.
How will the patient experience of the new service be monitored?	How will feedback be collected? Who will be analysing it and when?	N/a
What level of public support for this service development is anticipated?	Do you expect people to be supportive, be a little concerned or contact their MP or the press as a result of their objections?	Public support is anticipated to be negative if the service was stopped.

OPERATIONAL EFFECTIVENESS		
4. What is the potential impact of the service development on operational effectiveness?	Use these prompts to help you comprehensively evaluate the plans	Information to inform assessment
Will the plan eliminate or reduce inefficiency or waste?	<p>What is the impact on the workforce?</p> <p>Does the plan support better utilisation of staff?</p> <p>Does the plan facilitate improvements in care pathways?</p> <p>Will the plan impact operational performance?</p>	<p>Closure of the service would impact on the workforce, who would require redeployment or else potential redundancy..</p> <p>The funding for the service would be reinvested into District Nursing service, where an increase in resource is required to meet current demand.</p> <p>The care pathway is likely to be negatively impacted as patients attend secondary care appointments and are not able to receive treatment due to requiring wax removal prior to this taking place, although patients would be required to source this elsewhere, prior to attending secondary care..</p> <p>N/a</p>

REPUTATION		
5. What is the potential impact of the service development on the Trust reputation?	Use these prompts to help you comprehensively evaluate the plans	Information to inform assessment
Will patient choice be affected?	<p>Will choice be reduced, increased or stay the same?</p> <p>Will the plans influence waiting times, access to service and clinical outcomes?</p>	<p>Patient choice would be negatively affected if the service is closed as the service would no longer be available in the community, and patients would have to seek alternate provision, which would likely be at a cost to the patient.</p>

Does the plan align to the Trust strategic plan	What impact will the plan on the delivery of the Trust Strategic plan? Have key stakeholders been involved in the development of the plan?	The proposal aligns to the strategic objective of making best use of resources and achieving financial stability.
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B. Risk Assessments

Date	Risk Type	Risk Title	Hazard/s - <i>what could cause the risk to occur</i>	Risk Description - If (what could happen) then this would/could result in (potential impact)	Impact	Likelihood	Score	Owner	Existing Controls / Mitigation	Actions
6/2/26	Patient Safety	Risk of patient harm	Closure of Ear Care service could result in patient harm if compacted ear wax is not addressed.	If the Ear Care Service closes this may result in patient harm caused by compacted ear wax.	2	3	6		Alternate provision to be sourced by patients.	
6/2/26	Reputation	Negative impact on reputation	Closure of service could have negative impact on LCO/ MFT reputation.	If the Ear Care service closes, this could have a negative impact on the reputation of LCO/ MFT which could result in an increase in patient complaints.	2	3	6			
6/2/26	Clinical Effectiveness	Impact on secondary care	Closure of service could have negative impact on efficiency of secondary care services.	If the Ear Care service closes, this could have a negative impact on the efficiency of secondary care services, resulting in increased demand and inefficient use of secondary care services if patients are not ready to receive treatment and require a second appointment.	2	2	4		Alternate provision to be sourced by patients.	

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Full Assessment completed by: Phil Brown and Deb Smith	Date: 6/02/26
Requires review at Group Quality and Safety Committee:	YES/ NO
Date considered at Group Quality and Safety Committee:	
Approval from Group Quality and Safety Committee to proceed with plan:	YES/ NO

Appendix B: Risk Management measure of severity and consequences, likelihood and scoring risk matrix²

Score	1	2	3	4	5
Descriptor	No Harm/Insignificant	Low/Minor	Moderate	Severe Harm/Major	Death/Catastrophic
Risk of Patient/Staff/Public harm	Minimal injury requiring no/minimal intervention or treatment	Minor injury or illness	Moderate injury requiring professional intervention	Major injury with long-term/permanent incapacity or disability	Risk of death or an event which would impact on a large number of patients/staff/public
Patient Safety Incidents potential harm (Severity) and actual physical/psychological harm	Impact Prevented – any patient safety incident that had the potential to cause harm but was prevented resulting in no harm to people receiving NHS funded care	Patient experienced minor injury or illness as a result of the incident, patient requiring extra monitoring or minor intervention e.g. bruising, skin tear, psychological harm due to a delayed surgery	Patient Safety Incident that resulted in moderate increase in treatment and which caused significant but not permanent harm to one or more persons receiving NHS funded care e.g. broken wrist, ankle or unexpected return to theatre Hospital acquired PE or DVT (avoidable) including within 3 months' of admission	Major injury leading to long-term or permanent incapacity or disability requiring extensive rehabilitation Mismanagement of patient care with long term effects Serious sexual assault of a patient	Incident leading to death
Control of Infection Healthcare Acquired Infection (HCAI)	Non-compliance of infection control policy	Non-compliance with isolation of patients with: Hospital acquired colonisation or infection affecting one or more patients, staff or public or bay closure Diarrhoea due to possible infection	Outbreak of Noro-likevirus NLV in one ward within a directorate MRSA/VRE/CPE Bacteraemia with eventual recovery Hospital acquired infection affecting a whole ward	HCAI with associated morbidity Pseudo-membranous colitis with associated morbidity Closure of two or more wards due to Noro-like virus NLV within a directorate	Loss of multiple services in critical areas due to infection MRSA or CPE bacteraemia as cause of death Hospital acquired infection detailed under Part 1 of cause of death Death due to pseudo-membranous colitis

² Australian/New Zealand Risk Management Standards, AS/NZA 4360:1999

http://www.wales.nhs.uk/ihc/documents/A.4.1.4_Australia_and_New_Zealand_Methodology_AS_NZ%204360_1999.pdf

Score	1	2	3	4	5
Descriptor	No Harm/Insignificant	Low/Minor	Moderate	Severe Harm/Major	Death/Catastrophic
					related to <i>Clostridium difficile</i> infection
Impact on staff	No time off work	Staff first aid/minor treatment requiring time off work for 1-7 days	RIDDOR reportable event >7 days off work (or on light duties) as a result of the accident or specified injury e.g. fractures (other than fingers, thumbs and toes)	Permanent/long term incapacity >6 months e.g. amputations Loss of or reduction in sight	Incident leading to unexpected death
Needlestick injury	Cleans sharps injury	Used sharps injury/body fluid splash to eyes/mouth	RIDDOR Used sharps injury or body fluid splash from patient with known blood borne virus	RIDDOR Seroconversion following sharp injury/body splash	
Patient experience	Unsatisfactory patient experience which is able to be resolved locally	Unsatisfactory patient experience – minimal risk to patient safety in the short term	Mismanagement of patient care – short term effects Impacting on a small number of patients but could significantly impact on patient safety if unresolved Mixed sex accommodation	Mismanagement of patient care – long term effects, unsatisfactory patient outcome or experience Mixed sex accommodation for >24 hours	Totally unacceptable patient experience which impacts on a large number of patients
Quality, complaints and audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (Stage 1 – green) Local resolution Minor implications for patient safety if unresolved Reduced performance rating	Treatment or service has significantly reduced effectiveness Formal complaint (Stage 2 – amber) complaint Local resolution Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Formal complaint (red) Multiple complaints/independent review Critical report	Totally unacceptable level or quality of treatment/service Inquest/Ombudsman inquiry Gross failure of patient safety if findings not acted on Large scale cervical screening errors

Score	1	2	3	4	5
Descriptor	No Harm/Insignificant	Low/Minor	Moderate	Severe Harm/Major	Death/Catastrophic
Human Resources, OD&T, staffing and competence			Late delivery of key objective due to lack of staff (recruitment, retention or sickness) Low staff morale Poor staff attendance mandatory training	Uncertain delivery of key objective due to lack of staff/loss of key staff Very low staff morale No staff attending mandatory training	Non-delivery of key objective due to staff shortage/loss of key staff
Staffing levels	Low staffing level impacting on the quality of service delivery for 1 shift	Low staffing level impacting on the quality of service delivery 1-2 days	Low staffing level impacting on the quality of service delivery >2 days or only one trained nurse on duty for a shift		
Service/business interruption	Loss/interruption Minor loss of non-critical service	Loss/interruption in a number of non-critical areas	Service loss in critical area	Extended loss of essential service in 1 or more areas	Loss of multiple services in critical areas
Statutory duty/inspections	No or minimal impact or breach of guidance/statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/improvement notice	Multiple breaches in statutory duty Enforcement action Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty Prosecution Very low performance rating or deteriorating in performance rating Severely critical report
Adverse publicity/reputation of organisation	Rumours: Minimal Impact Local Press <1	Regular Concern Local Media 1 to <7 days	Moderate loss of confidence National Media <3 days	Major loss of confidence National Media >3 days	International adverse publicity Severe loss of confidence Public inquiry
Financial impact	Minimal impact	<300,000 – 0.5% of turnover of the Trust	>300,000 – 0.5% to 1% of Trust turnover	>600,000 – 1% to 2% of Trust turnover	>1.2 million – over 2% of Trust turnover
Objectives/projects	Insignificant cost increase/schedule slippage. Barely noticeable reduction in scope or quality	<5% over budget/schedule slippage. Minor reduction in quality/ scope	5-10% over budget/schedule slippage. Reduction in scope or quality requiring client approval	10-25% over budget/schedule slippage. Key objectives not met	>25% over budget/schedule slippage. Key objectives not met

Score	1	2	3	4	5
Descriptor	No Harm/Insignificant	Low/Minor	Moderate	Severe Harm/Major	Death/Catastrophic
Litigation – claim	Risk of claim remote	Claim less than £10,000	Claim(s) between £10,000 and £100,000	Claim(s) between £100,000 and £1 million	Claim(s) >£1 million
Target/standard impact	Minimal impact on Trust targets or standards	Local risk of non-achievement of Trust targets or standards Single failure to meet internal standards	HOSPITAL SITE/MANAGED CLINICAL SERVICE/MLCO GROUP risk of non-achievement of Trust targets or standards Repeated failure to meet internal standards	HOSPITAL SITE/MANAGED CLINICAL SERVICE/MLCO GROUP risk of non-achievement of one or more Trust targets or standards – risk posed to overall Trust compliance	Trust failure to meet national standards
Non-physical or physical assault	Non-physical or physical assault which causes negligible offence or harm	Non-physical or physical assault that causes minor offence or harm	Non-physical or physical assault that causes significant offence or harm	Physical assault that causes major harm or non-physical assault which causes major offence and may be criminal (racially or religiously aggravated)	Physical assault that results in death
Fire incidents	False alarm	Minor fire, no injury or loss of service	Fire: minor injury or minor loss of services	Fire: major injuries or significant loss of services	Death as a result of fire incident

Level	1	2	3	4	5
Descriptor	Rare	Unlikely	Possible	Likely	Almost Certain
Frequency of event	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Probability of event	<1%	1-5%	6-20%	21-50%	>50%
	May only occur in exceptional circumstances	Could occur at sometime	Will occur at sometime	Probably will occur	Expected to occur

The final step in quantification is to combine the measures of severity and likelihood in a Risk Matrix

Risk Matrix

	Likelihood				
Severity	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Certain Almost
1 Low	1 Very Low	2 Very Low	3 Very Low	4 Very Low	5 Very Low
2 Slight	2 Very Low	4 Very Low	6 Low	8 Low	10 Medium
3 Moderate	3 Very Low	6 Low	9 Low	12 Medium	15 High
4 Major	4 Very Low	8 Low	12 Medium	16 High	20 High
5 Catastrophic	5 Very Low	10 Medium	15 High	20 High	25 High

Appendix C - Supporting documents and statements

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Name of Committee / Board		Trafford Locality Board		
Date of Meeting		17th March 2026		
Report Title		Trafford Participation Strategy 2026-2028		
Report Author & Job Title		Thomas Maloney, Programme Director Health and Care, Trafford Council and NHS GM		
Organisation Exec Lead		Gareth James, Deputy Place Lead, NHS GM (Trafford)		
OUTCOME REQUIRED	Approval X	Assurance	Discussion X	Information
EXECUTIVE SUMMARY				
<p>In 2023 an 'Trafford Integrated Care Partnership Engagement Paper' was supported at Trafford Locality Board which set out a series of recommendations to develop a 'strategy' and practical toolkit to help Trafford stakeholders improve their individual and collective efforts in listening to the voice of our people and using this to help plan, design, deliver and improve health and care services.</p> <p>Shortly after in 2024 NHS GM produced its 'People and Communities Participation Strategy' and we committed in the refresh of our Locality Plan in early 2025 to develop our own local response to the GM Strategy and embedded this within a specific 'Cooperative Commitment'.</p> <p>This Strategy and Framework provide helpful clarification on what we mean by participation, why it is so important and includes practical applications of how this could work in practice. It highlights the journey we have been on to develop this document, acknowledges some important developments which will help shape our actions moving forward and provides examples of how we are doing this already – so we can build from our examples of success.</p> <p>We have developed a set of building blocks which need to be in place to enable our organisations, departments, teams and people to deliver meaningful participation. This strategy and framework are therefore a 'call to action' to ensure we are individually and collectively doing our utmost to fulfil our cooperative commitment and provides some practical advice as to what processes, infrastructure, resourcing and policy need to be in operation to do this.</p> <p>Key changes from the draft version shared in the Board in December 2025 include, a proof read and minor narrative changes to reflect partner feedback, stronger referencing to engagement work being delivered in Children and Young People services and inclusion of a case study and aligning the timeframe for the strategy to the lifespan of the Trafford Locality Plan (2028).</p>				
RECOMMENDATIONS				
<p>The Board are asked to:</p> <ol style="list-style-type: none"> a) Suggest any changes or additional content to the strategy. b) Pending changes, approve the publication of the strategy. 				



<p>c) Partners and where appropriate departments/divisions, agree to provide bi-annual updates on implementation of the strategy via Place Partnership governance arrangements (tbc).</p>	
<p>CONSIDERATIONS – these must be completed before submission to the Board – Reports with incomplete coversheet information will not be accepted and shared with the board</p>	
<p>Risk implications <i>(Please provide a high-level description of any risks relating to this paper, including reference to appropriate organisational risk register)</i></p>	<p>There are various risks if we do not deliver effective methods of participation in health and care such as poor health outcomes, less honesty and transparency between services and residents, services meeting the needs of our diverse communities and deterioration of community resilience</p>
<p>Financial implications and comment/approval <i>(Please detail which organisation(s) will be impacted, and if not required, please briefly detail why)</i></p>	<p>Name/Designation: N/A</p>
	<p>Comment / Approval: N/A</p>
<p>Comment by Trafford Clinical and Practitioner Senate (TCAPS) and/or Clinical Lead <i>(If not required, please briefly detail why)</i></p>	<p>Date of Clinical Lead comment: N/A</p>
	<p>Name/Designation: N/A</p>
	<p>Comment: N/A</p>
<p>What is the impact on inequalities? <i>(Please provide a high-level description of any known impacts)</i></p>	<p>Resident participation in health and care is essential for creating systems that are responsive, equitable, effective and well positioned to tackle inequalities. This strategy aims to tackle current challenges by ensuring meaningful participation is delivered by all partners making up TICP.</p>
<p>Equality Impact Assessment / Quality Impact Assessment Outcome <i>(If not appropriate at this stage please state if an EIA or QIA is necessary)</i></p>	<p>N/A at this stage</p>
<p>People and Communities: Communications & Engagement <i>(Please detail relevant patient/public engagement completed and/or planned, and if not required please briefly detail why)</i></p>	<p>The strategy has been created and tested in a variety of forums throughout its life course to date, some of which are captured in the draft strategy itself.</p>
<p>Trafford’s Carbon Footprint <i>(Please provide a high-level description of any known positive and/or negative impacts – consider the following topics: energy usage; staff or public transport; waste or materials used. Include steps that could be taken to reduce carbon within relevant plans)</i></p>	<p>N/A</p>
<p>Links to Measurement / Outcomes</p>	<p>Although the draft strategy doesn’t have a prescriptive outcomes measurement approach at this time, there is a strong commitment in the strategy to codesign this with</p>



<i>(Please detail if this is included within the report)</i>	stakeholders so we have shared accountability and ownership of the strategy and the framework
Enabler implications	Legal implications: We have a legal obligation in health and care to engage and enable meaningful participation, and this strategy enhances our individual and collective commitment to the agenda
	Workforce implications: Our workforce will have to be adequately trained and developed to ensure meaningful participation – this will form part of organisational responses to the draft framework
	Digital implications: Part of our strategy and addressing the framework may require stronger digital connections and solutions
	Estates implications: N/A
Sub-Board Sign-Off / Comments (i.e. Trafford Provider Collaborative Board, H&SC Delivery Steering Group)	The draft strategy document has been co-designed by the Trafford Participation Group, it has also been through a variety of partnership forums including ASC's Lets Talk Participation workshops, Improving Lives Every Day Board, Strategy and Planning Group, Neighbourhood Programme Steering Group, etc.
Organisation Exec Lead Sign off	Gareth James, Deputy Place Lead, NHS GM (Trafford)

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Trafford Participation Strategy 2026

March 2026

Trafford

Integrated Care Partnership



Trafford Participation Strategy | Introduction

This strategy sets out in broad terms **why participation is important** and how we intend to work with our partners and communities in neighbourhoods and localities

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Having a **systematic approach to participation** across our locality will support the strategic objectives of **Fairer Trafford** in reducing the health inequalities that are embedded within our communities.

We will work with and **invest time and resources into our Voluntary, Community Faith and Social Enterprise (VCFSE) sector** to help us reach those people and communities.

Relationships are central to successful participation. They form the foundation for trust, confidence, collaboration, and shared decision-making and the success of this strategy will be based on the people involved and their relationships.

Strong relationships help build trust, which is essential for people to feel safe contributing ideas, experiences, and feedback.

We will use **clear communication and variety of methods** to help bridge gaps in language, culture, and perspective between people and stakeholders.

This strategy contains a **Framework containing a series of fundamental ‘building blocks’** – for us to deliver against our ambition of systematic participation in health and social care we must first ensure we have solid foundations from which to build our delivery model.

Ensuring **all partners have a clear strategic approach,** robust governance, adequate infrastructure and efficient systems and processes will enable us to build trusted relationships with people and communities and embed an ongoing dialogue that leads to positive change.

Trafford Participation Strategy | Background



Trafford published a **Communications and Engagement Strategy in October 2020** supported by the now disestablished Trafford Local Care Alliance. This strategy was to help focus the efforts of system partners in two specific areas:

- Covid-19 recovery and outbreak management
- Longer term strategy for health and social care reform

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The strategy contained a set of co-designed commitments aiming to cement effective partnership working through ensuring effective and joined up communication efforts and the further development of an engagement model which permeated into communities of Trafford allowing a true codesign and where feasible coproduction approach to health and care services



Trafford Participation Strategy | Background & Context



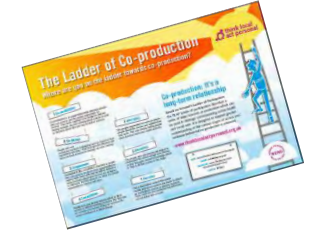
Trafford Participation Strategy |

What is Participation?



- We have taken guidance and counsel from the **Greater Manchester People and Communities Participation Strategy** in developing our local definition of participation:
 - Participation in this sense means including the voices, ideas and capacity of residents and communities in our work.
 - Enabling active involvement of individuals, patients, service users, carers, and communities in shaping the services they receive, and influencing decisions that affect their health and well-being – Put simply it means finding out what matters to people and using that intelligence to plan, design and deliver services.
 - Meaningful participation is central to person-centred care and health equity.
 - It provides opportunities for the health and care system to work with people and communities to realise solutions together – beyond what is required by law.
 - This strategy sets out how we will build on our existing strong foundations to create a systematic model for continuous participation -always with a purpose, involving partners, local Healthwatch, the VCSE sector and communities.
- Resident participation in health and care is essential for creating systems that are **responsive, equitable, and effective**

Defining what we mean.....



In defining participation in its broadest sense, we have made significant progress – however we acknowledge there is a continuum of participation ranging from basic communications to coproduction. We will work together to define our individual and collective efforts

Trafford Participation Strategy |

The importance of authentic participation

Builds Trust and Transparency

- Involving residents:
 - Fosters trust in health and care systems and providers.
 - Encourages open communication and shared decision-making.
 - Reduces mistrust and misinformation, especially in marginalised communities.

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Improves Health Outcomes

- When residents are actively involved in their care:
 - They are more likely to self-care and follow treatment plans
 - They can identify early signs of complications.
 - They feel empowered, which can improve mental and physical health.

Ensures Services Meet Needs

- Residents bring lived experience and local knowledge:
 - Helps tailor services to cultural, social, and economic contexts.
 - Identifies gaps in care that professionals might overlook.
 - Encourages co-design of services that are more accessible.

Enhances Accountability

- Resident participation:
 - Holds providers and policymakers accountable for quality and equity.
 - Encourages feedback loops that drive continuous improvement.

Strengthens Community Resilience

- Engaged communities:
 - Are better prepared to respond to public health crises.
 - Can mobilise peer support networks.
 - Promote health literacy and preventive care.



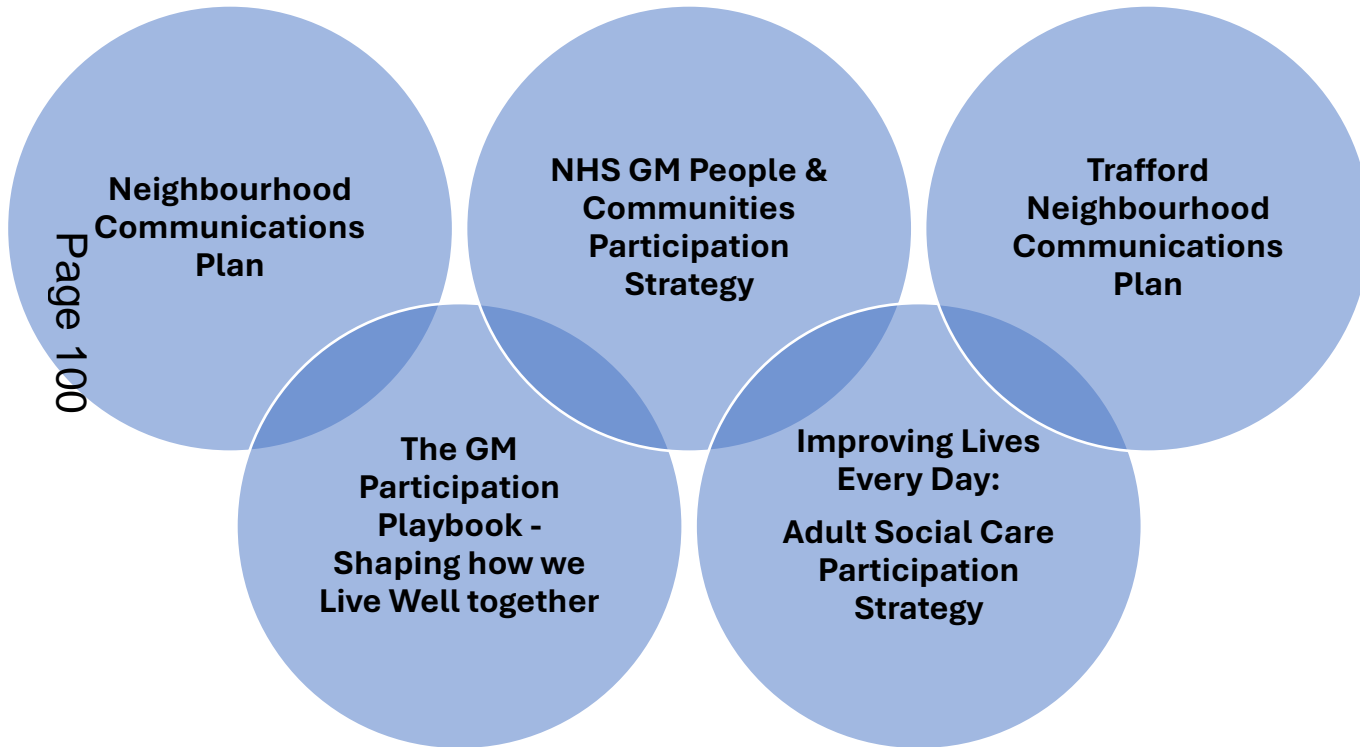
Trafford Participation Strategy | GM and National Strategy

The work of Trafford's Participation Group is guided by National, Greater Manchester and Local strategies and principles

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Communications and Participation | Contributing Strategies and Plans



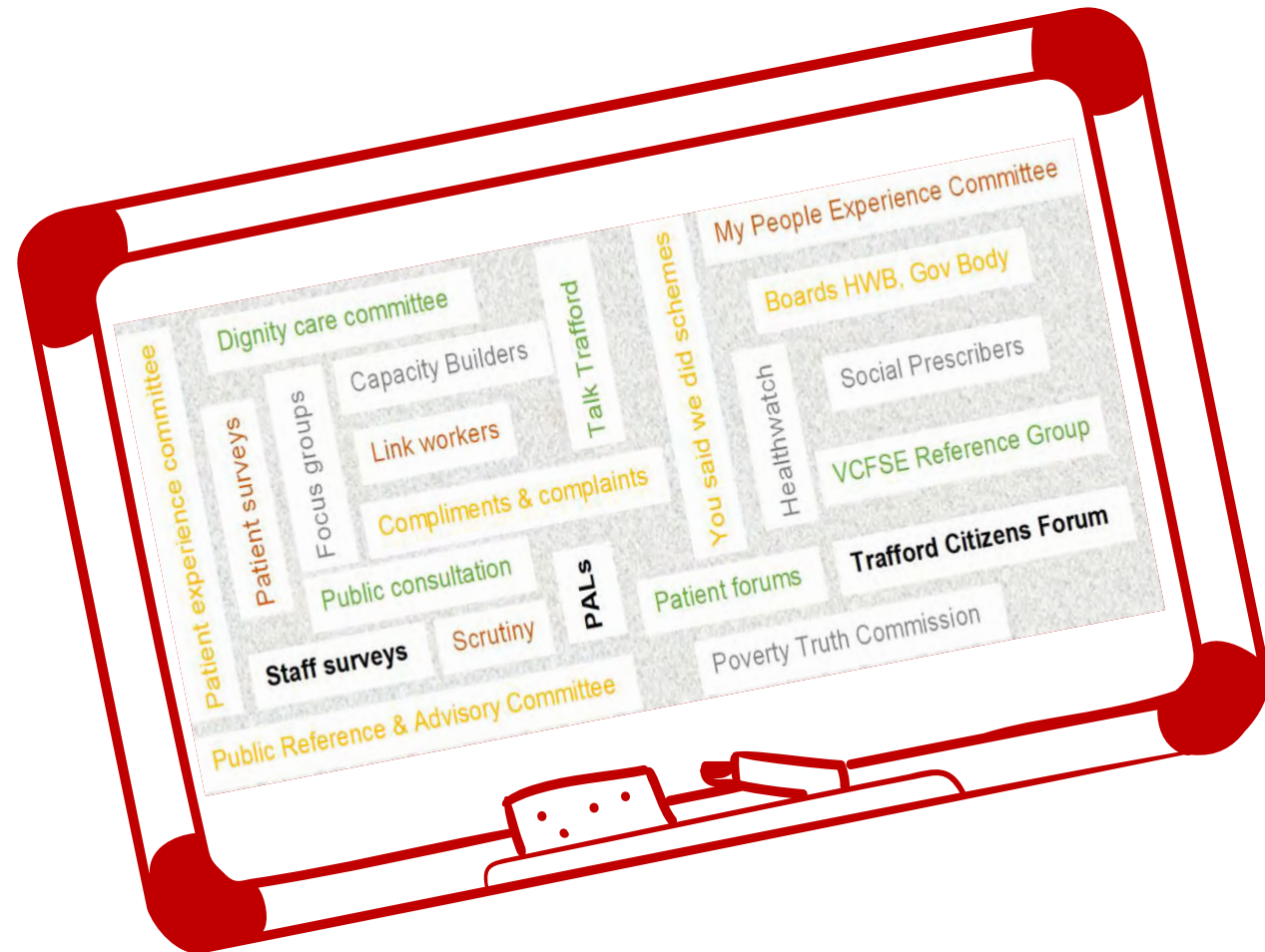
- **NHS GM People & Communities Participation Strategy:** This strategy sets out in broad terms why participation is important and how we intend to work with our partners and communities in neighbourhoods and localities.
- **The GM Participation Playbook:** This inspiring resource brings together tools and examples of participatory methods from citizens' assemblies and participatory budgeting to co-production and digital democracy.
- **Trafford Neighbourhood Communications Plan:** Structures how we promote public participation and effectively communicate to stakeholders regarding our neighbourhood plans and model
- **Adult Social Care Participation Strategy:** Taking guidance from this strategy and under the stewardship of the Improving Lives Every Day (ILED) programme the strategy will set out how adult social care shapes services that reflect the needs of the people we support by ensuring meaningful participation and coproduction where possible.

Key Challenge: Bringing these strategies and plans together effectively to guide our work

Trafford Participation Strategy | Self exploration

- Trafford has embarked on developing a refreshed engagement model across Health and Social Care. This approach would directly **address structural inequalities by allowing power to be shared and fostering greater community resilience and control** – a key and underpinning principle of the Trafford Locality Plan. We recognise the excellent work and approaches already in operation, and we wish to build our model from existing best practice.
- **Trafford Participation Group** has evolved to support a wide agenda focusing on service change and transformation and has been responsible for the development of this strategy and its associated work programmes.
- To inform this strategy and identify areas for improvement, a **self-assessment exercise** was conducted. The following areas of focus were identified...

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Trafford Participation Strategy | Our journey towards improvement



Trafford Participation Group took the following measures to improve:

Exploration Phase

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Semi-structured interviews with Mastercall, Healthwatch Trafford, Trafford Community Collective, Manchester Foundation Trust (Group), Trafford Local Care Organisation, Trafford Council (Youth Services). Exploratory conversations were also completed with Trafford GP Board.

Briefings

Conversations on emerging models were verbally communicated to TLB, TPCB, Trafford GP Board and the H&SC Delivery and System Reform Steering Groups, and NHS GM Trafford Senior Leadership Team to keep abreast of developments.

Multi-Agency Workshop

Facilitated by AQuA in March 2023, this workshop provided an opportunity for attendees to:

- Understand the current picture across GM, England and beyond when supporting the engagement of people and communities.
- Capture what currently happens in Trafford and where the resources to deliver this are held.
- Understand how Trafford can deliver a positive approach to engaging people and communities under the new landscape.
- Develop potential options for engagement.

Trafford Participation Strategy | Building on Good Practice



Trafford Autism Partnership Board

A new Trafford Autism Partnership Board has been launched to improve services and make Trafford a more autism-friendly place to live, work and visit. The board brings together autistic residents, carers, community groups, health and care providers, housing and employment services, the police, and the voluntary, community and faith sectors. The partnership is co-chaired by Mark Simpson, a Trafford resident with lived experience of autism and an Autism Peer Mentor



Trafford Youth Needs Analysis & Engagement 2025

Engagement

Over 5,800 11–19-year-olds, responded to the Youth Offer and Bee Well surveys.

Results

Young people (YP) made the link between activities and good mental and physical wellbeing

YP either were not aware of the full offer or were not sure it interested them

Cost was a barrier for YP but even more so for parents

YP wanted better access to 4G pitches, U16 gyms, dance and to use their local parks and greenspaces and to feel safe doing so.

Actions

Relaunch Trafford Youth Service with a neighbourhood-based model

Working with partners to improve access to facilities/activities

Work with Friends of Parks groups and AMEY to improve park facilities



Shaping our Adult Social Care Future

Bringing together people who draw on social care to live their lives, community members, care professionals, and local leaders to co-create real solutions for adult social care.

- 🗨️ Sharing experiences and ideas
- 👥 Collaborating with others in your community
- 🛠️ Helping design future service.
- 🌍 Be part of a movement for change



Trafford Participation Strategy | Principles



- Trafford stakeholders developed a set of key features for our model of participation. The feedback centred on having a set of common approaches or principles, such as:

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Have a **common purpose** of people and communities being at the heart of all our individual and collective engagement endeavours

Listen, act, learn, empower, share and do it together

Have **honest and transparent** conversations

Always be **inclusive**

Use lived experience to plan, design, deliver and improve services

Be **equitable**

- The above statements reinforce the previously agreed principles that were coproduced as part of the original Communications and Engagement Strategy (2020). This feedback and subsequent input from working group colleagues have been merged to form a series of **'We Will'** statements which aims to solidify our collective efforts in ensuring the best model of participation.
- Meaningful participation cannot exist without the firm foundation provided by our underpinning principles.

Trafford Participation Strategy | Principles



Be open and transparent in our communications and engagement and use clear language and information that is accessible for our different communities

Listen, act, learn, empower, share and do it together

Engagement will predominantly be positioned in neighbourhoods, where people live

Strive towards co-production and co-design where feasible

Use lived experience to plan, design, deliver and improve services

We will...

Listen to individuals, families and communities of Trafford – having honest and transparent conversations

Ensure any engagement is meaningful and we track actions and outcomes - People should understand how their contributions have impacted proposals and decisions

Utilise existing organisational and sector infrastructure and coordinate our collective engagement efforts

Adopt a continuous improvement approach, learning from best practice

Be always inclusive

Comply with legislative frameworks and national / regional policy and guidance

Be equitable

Trafford Participation Strategy | Trafford Participation Framework

In the Trafford Locality Plan we committed to communicate, engage, co-design, coproduce and consult (appropriately) with our partner organisations, communities and people. To help strengthen this approach we have developed our ‘Participation Framework’ – collaboratively produced by the Trafford Participation Group.

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Locality Plan Cooperative Commitment

“We will continue our collective journey towards meaningful participation through effective communications, codesign, and co-production , guided by our agreed Participation Framework”

Trafford Participation Strategy | Building Blocks and Our Commitment



Trafford Participation Strategy: Building Blocks | Strategy and Vision, Our Commitment



Having a clear strategy and vision is crucial for creating health and care services that are not only effective but also equitable, person-centred, and sustainable. A strategy empowers people with lived experience and ensures that people who use services, carers, and communities are not just consulted, but are active partners in shaping the services they rely on. There are various trusted sources including NHSE, SCIE and NICE which highlight the following as core elements of a strong participation strategy and vision:

Joint Objectives and Shared Purpose

- Aligns with legal and policy requirements (Care Act 2004, Health and Care Act 2012, CQC)
- Define the vision of your organisation and/or team
- Define the goals of participation (e.g., improving services, shaping policies, co-design)
- Set expectations about the scope and influence of service user involvement
- Provides clear direction and accountability for stakeholders and wider partners

Inclusive Participation Framework

- Identify diverse groups and ensure methods to reach and involve all communities, especially marginalised voices
- Use a mix of engagement approaches tailored to different needs and preferences
- Remove barriers to participation (e.g., language, accessibility, digital divide)
- Shared principles for participation – ensuring all efforts are mobilised, working towards agreed goals in the correct manner and with the right values

Strategy Into Action

- Development/delivery of tangible action plans, responding to the aims and aspirations of your strategy
- Practice Frameworks supporting better use of resources and helps reduce duplication and inefficiencies



Trafford Participation Strategy: Building Blocks | Shared Principles, Our Commitment

Having a set of shared principles around co-production is fundamental for effective participation. These principles guide how professionals and service users work together as equals to design, deliver, and evaluate services.

When Trafford’s Engagement Model was developed in 2023, extensive work was undertaken to gather a broad range of partner views, resulting in a set of shared system principles also referred to as “We Will” Statements. Building on these strong foundations, Trafford’s aim now is to gather the views of individuals with lived experience, to develop an updated set of principles that our people can truly buy into. Through co-production, other areas have identified the following key principles:

Below are two examples of co-produced participation principles from other areas:

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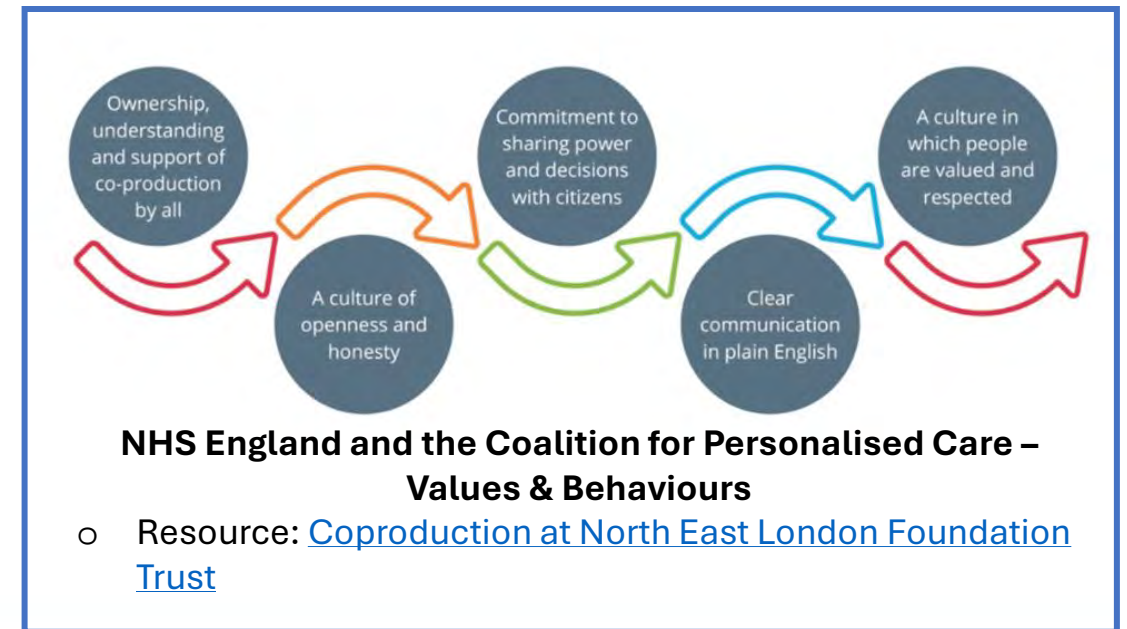


A diagram showing ten numbered principles on sticky notes arranged in two rows. The principles are:

1. Create positive change
2. Bring the voice of lived experience
3. Encourage collaboration & allyship
4. Expose the system challenges
5. Create and use resources for citywide improvement
6. Develop training & share learning
7. Encourage adoption & spread to other services/cities
8. Advocate & campaign for change
9. Ensure sustainability and legacy of Brighton & Hove Common Ambition
10. Recognise and understand our work and its value

Brighton & Hove Common Ambition Co-Produced Principles

- Resource: [Brighton & Hove Common Ambition \(Co-Produced Support for People Experiencing Homelessness\)](#)



A circular diagram with five interconnected nodes representing values and behaviours. The nodes are:

- Ownership, understanding and support of co-production by all
- Commitment to sharing power and decisions with citizens
- A culture in which people are valued and respected
- Clear communication in plain English
- A culture of openness and honesty

NHS England and the Coalition for Personalised Care – Values & Behaviours

- Resource: [Coproduction at North East London Foundation Trust](#)

Trafford Participation Strategy: Building Blocks | Good Governance, Our Commitment

Strong governance arrangements are pivotal to effective participation, helping to build trust, accountability, and a structure where the voices of service users can genuinely influence decision-making. The following core elements of good governance must be in place:

Transparency and Accountability

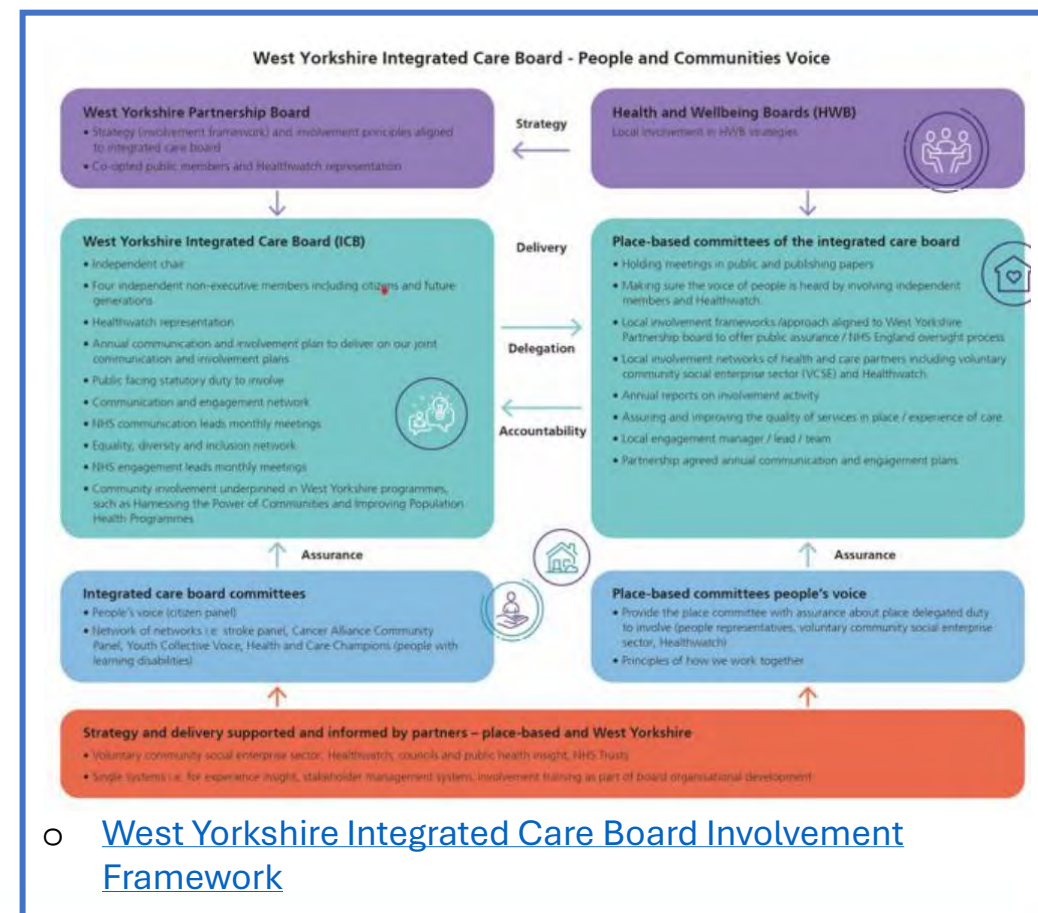
- Clear communication on how decisions are made and how input is used
- Mechanisms to demonstrate how feedback influences outcomes – ensuring lived experience input is visible in decision-making and service redesign.
- Responsibility for acting on service user contributions, compliments and complaints

Leadership and Culture

- Strong leadership commitment to participation and co-production
- Respect for lived experience as a form of expertise
- Embedding a culture of lived experience into planning, design, delivery, and continuous improvement of services

Structures and Resources for Meaningful Involvement

- Clear, purpose-driven engagement processes and participation structures
- Ongoing support, training, and fair compensation for service users
- Regular evaluation and adaptation of participation practices



- [West Yorkshire Integrated Care Board Involvement Framework](#)

Trafford Participation Strategy: Building Blocks | Infrastructure, Our Commitment

To ensure the voice of lived experience is meaningfully involved in shaping health and care services, a robust and multi-layered infrastructure is required. Below is a list of key components, some covered in the other ‘building blocks’ of this strategy, but reinforced to ensure adherence to the research and evidence base for deploying meaningful participation:

Structural & Organizational Infrastructure

- Dedicated ‘Participation Teams’ and/or ‘Lived Experience’ roles
- Coproduced and embedded engagement/participation strategies – considered at organisational level and mobilised appropriately in teams/departmentally

Digital Participation Tools

Physical & community infrastructure such as patient participation groups, participation hubs, community surgeries, information and advice hubs, lived experience panels, etc

Data, Feedback & Learning Infrastructure

- Feedback mechanisms which in turn allow for structured learning & adaptation

Capacity Building and Resources

- Provide training and support for both service users and staff to engage effectively
- Allocate sufficient funding, time, and tools to sustain participation activities
- Ensure fair recognition or compensation for service users’ contributions
- Collaboration and empowerment of VCFSE organisations who often act as trusted intermediaries and can facilitate inclusive engagement

NHS
Manchester University
NHS Foundation Trust

Working with People and Communities Toolkit

This online toolkit is intended to provide guidance for colleagues who wish to work closely in participation with patients and communities on how we devise, design, deliver and develop service provision across our Hospitals and Community Services.

Toolkit Resources

GM People and Communities Participation strategy	Health Inequalities Dashboard- Power BI	A guide to quality improvement and PDSA	Tips for making participation activities work
Understanding and mapping your stakeholders	Engagement planning form 2024	How to run focus groups	Developing survey questions
How to hold individual conversations	Running an online event	EqIA Approach and Template	Guide to consultation activity

Trafford Participation Strategy | Have we made a difference?

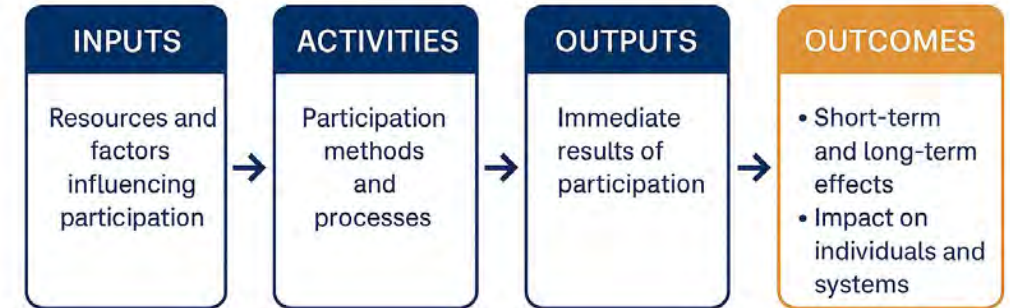
- Evaluating the implementation of our participation strategy involves assessing how well service users (patients, carers, communities) and professionals work together to design, deliver, and evaluate services
- Although we haven't an agreed model to assess impact, we are committed to developing an 'Evaluation Framework' working with partners such as Think Local Act Personal (TLAP)

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We will work together to define clear outcomes such as:

- Improved service outcomes (e.g. better health, satisfaction, access)
 - Enhanced user experience (e.g. feeling heard, respected, involved)
 - Stronger relationships (e.g. trust between professionals and users)
 - Organisational change (e.g. policies, culture, staff attitudes)
- We will assess outcomes at individual (e.g. patient empowerment) and service level (e.g. improved quality or efficiency) and systemic (e.g. policy influence, sustainability)
 - We will evaluate the quality of our processes looking at key indicators such as:
 - Inclusivity: Were diverse voices involved?
 - Transparency: Was decision-making open?
 - Reciprocity: Were contributions valued equally?
 - Sustainability: Is the approach embedded in practice?

Participation Evaluation Framework



**Think Local
Act Personal**

Trafford Participation Strategy |

Powered by.....



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A big thank you to all the partners who contributed to Trafford's codesigned Participation Strategy



able / Unacceptable - Trafford PCCC cancelled, updates from Operational Group and SLT

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

primary medical providers to sign up to the COVID vaccination service for the coming Spring, service as opposed to PCN.
 Commissioned to provide primary medical services to the residents of Trafford Waters.
 5/27 is being developed at GM. Trafford hopes to retain the 25-26 HIU and SMI schemes, M.
 have confirmed their intention to continue contracting arrangements with PCIT in 26-27, footprint.
 have commenced, with the first face to face one being held on 12 March 2026.
 n 3 members of the Primary Care Team leaving the organisation (contracts, head of primary care) – this is having significant impact on the teams capacity
 are in progress and utilisation is positive we will be providing a summary and analysis post
 for another two years with STAR application submission.
 a further year
 re-active way to support any quality issues due to capacity in the PC team. Weekly MDT's in place to solve as they arise. Pro-active quality monitoring on hold until NHS reform arrangements are in place.
 e LFPSE system and have started to upload any relevant incidents where system learning is identified.
 y quarterly and we are aware of their inspection schedule in Trafford which is based around the same across GM. For Trafford, we were assured that there are currently no significant inspection issues, but we are aware that a number of practices have aged ratings (going back as far as 12 months) in the coming months.
 on hold until capacity and remit for the team following reform has been clarified.

- Priority actions in coming period:**
- Analysis of winter schemes following end of Q4 to consider impact and value for money of investment
 - Locality and GM winter planning meetings in place.
 - Linking in with GM Vaccs Team to ensure provision of the Covid and Flu vaccinations for all eligible patients
 - To ensure all GP Practices are compliant with any contract changes as a result of modern general practice contracts
 - Digital Facilitator continues to work with practices to ensure compliance with Modern General Practice contracts
 - Locality colleagues continue to work with GM primary care colleagues to clarify BeCCor asks for primary care

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Agenda Item 11

	Mitigating Actions	Likelihood	Impact
outside of practice boundary and lack of primary	Engagement with provider of home and engagement with Primary Care providers across Trafford	4	

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