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HMR Integrated Care Partnership Committee

Meeting information

Date and time of meeting: Thursday, 23 April 2026 at 10.00 am
Venue: Hollingworth A, First Floor, Number One Riverside, Smith Street, Rochdale, OL16 1XU

Agenda items

1. **APOLOGIES**
To receive any apologies for absence.

2. **URGENT ITEMS OF BUSINESS**
To determine whether there are any additional items of business which, by reason of special circumstances, the Chair decides should be considered at the meeting as a matter of urgency.

3. **DECLARATIONS OF INTEREST**
Members are required to declare any disclosable pecuniary, personal or personal and prejudicial interests they may have and the nature of those interests relating to items on this agenda and/or indicate if S106 of the Local Government Finance Act 1992 applies to them.

4. **ITEMS FOR EXCLUSION OF PRESS AND PUBLIC**
To determine any items on the agenda, if any, where the public are to be excluded from the meeting.

5. **MINUTES (Pages 6 - 10)**
To approve the minutes of the Heywood, Middleton and Rochdale Integrated Care Partnership Committee meeting held on 17th March 2026.

6. **PUBLIC QUESTIONS**
To note public questions received since the last meeting of the Committee.

7. **GM VERBAL UPDATE**
To receive a verbal update from the NHS GM Integrated Care Representative and the Place Based Lead – Item for information.

8. **FINANCE, PERFORMANCE AND RISK**

8a. **2025/26 Quarter 4 Locality Strategic Risk (Pages 11 - 53)**
To consider a report from the Assistant Director of Commissioning Adult Social Care and Prevention – Item for assurance.

9. **DELIVERY**

9a. **Local Care Organisation Business Plan 2025-2026 Quarter 4 Review (Pages 54 - 78)**
To consider a report from the Assistant Director of Commissioning Adult Social Care and Prevention – Item for assurance.

10. **STRATEGY AND DEVELOPMENT**

10a. **Development Session - Place, Governance and Focus**
A Committee development session – Item for discussion.

Committee Members

Mrs. Chris Mayer CBE (Independent Chair)
Councillor Iftikhar Ahmed (Portfolio Holder for Adult Care and Wellbeing) (voting s75/non1section 75)
Councillor Carol Wardle (Portfolio Holder for Finance and Growth) (voting s75/non-section 75)
Councillor Rachel Massey (Portfolio Holder for Children's Services and Education) (voting s75 /non-section 75)
Councillor Daalat Ali (Portfolio Holder for Health) (voting s75/non-section 75)
Nichola Thompson (NHS GM HMR Locality Representative) (voting s75/non-section 75)
Rochdale Borough Council Chief Executive (voting s75/non-section 75)
NHS Greater Manchester Integrated Care Representative (non-voting)
Maddy Hubbard (Voluntary, Community Social Enterprise Representative) (voting non section 75)
Kate Jones (HealthWatch Rochdale) (non-voting)
Dr Shona McCallum (Local Care Organisation Independent Chair) (voting non-section 75)
Gertie Nic Philib (Northern Care Alliance NHS Foundation Trust Representative) (voting non-section 75)
Dr Salman Shahid (Associate Medical Director for HMR) (voting s75/non-section 75)
Nicola Tamanis (Pennine Care NHS Foundation Trust Representative) (voting non-section 75)
Zeph Curwen (Local Care Organisation Representative) (voting non-section 75)
Dr Zahid Chauhan - (Chief Executive BARDOC) (voting non-section 75)

Contact information

Contact: Governance and Committee Services
Phone: 01706 924872
Email: Governance.Committees@rochdale.gov.uk
www.rochdale.gov.uk

Quick Guide to Declaring Interests at Rochdale Borough Council Meetings

This is a summary of the rules around declaring interests at meetings. It does not replace the Member's Code of Conduct, the full description can be found in RBC Constitution Part 9 Councillors and Co-opted Members Code of Conduct

Within 28 days' of becoming a councillor or co-opted member, you must notify the Monitoring Officer of any 'disclosable pecuniary interests'.

You are also legally bound to disclose Disclosable Pecuniary Interests relating to:

1. You, and your partner's business interests (eg employment, trade, profession, contracts, or any company with which you are associated).
2. You and your partner's wider financial interests (eg trust funds, investments, and assets including land and property).
3. Any sponsorship you receive.

Failure to disclose this information is a criminal offence.

In addition to the disclosable pecuniary interests notifiable, you must, within 28 days of becoming a councillor notify the Monitoring Officer in writing of the details of your **other personal interests.**

You have a **personal interest** in any business of your authority where it relates to or is likely to affect:

1. Any bodies of which you are in a position of general control or management and to which you are appointed or nominated by the Council.

2. Your membership of bodies exercising functions of a public nature, including charities, societies, political parties, trade unions including one of whose principal purposes includes the influence of public opinion or policy (including any political party or trade union), of which you are in a position of general control or management.

The interests of any person from whom you have received a gift or hospitality with an estimated value of at least £50

Step One: Establish whether you have an interest in the business of the agenda

1. If the answer to that question is ‘No’ then that is the end of the matter.

2. If the answer is ‘Yes’ or Very Likely’ then you must go on to consider if that personal interest can be construed as being a prejudicial interest.

Step Two: Determining if your interest is prejudicial

A personal interest becomes a prejudicial interest:

1. Where the wellbeing, or financial position of you, your partner, members of your family, or people with whom you have a close association (people who are more than just an acquaintance) are likely to be affected by the business of the meeting more than it would affect most people in the area.

2. The interest is one which a member of the public with knowledge of the relevant facts would reasonably regard as so significant that it is likely to prejudice your judgement of the public interest.

For a non-prejudicial interest, you must:

1. Notify the committee officer for the meeting as soon as you realise you have an interest.

2. Inform the meeting that you have a personal interest and the **nature of the interest.**

To note: You may remain in the room and speak and vote on the matter.

For prejudicial interests, you must:

1. Notify the committee officer for the meeting as soon as you realise you have a prejudicial interest (before or during the meeting).
2. Inform the meeting that you have a prejudicial interest and the **nature of the interest.**
3. Leave the meeting while that item of business is discussed.

4. Make sure the interest is recorded on your annual register of interests form if it relates to you or your partner's business or financial affairs. If it is not on the Register update it within 28 days of the interest becoming apparent.

To note:

Where you have a prejudicial interest in any business of the Council, you may attend a meeting but only for the purpose of making representations, answering questions or giving evidence relating to the business, provided that the public are also allowed to attend the meeting for the same purpose, whether under a statutory right or otherwise and you leave the room where the meeting is held immediately after making representations, answering questions or giving evidence.

You must not:

1. Participate in any discussion of the business at the meeting.
2. Participate in any vote or further vote taken on the matter at the meeting.

Interests arising in relation to overview and scrutiny committees:

If at the time a decision was made or action was taken, you were a member of the executive, committee, sub-committee, joint committee or joint sub-committee and you were present when that decision was made or action was taken, you may attend the meeting of the overview and scrutiny committee for the purpose of explaining the reasons for the decision, or answering questions or giving evidence relating to the business, but you cannot participate otherwise in the discussion or in any vote on the matter.

Assistants to Portfolio Holders may not be members of an Overview and Scrutiny Committee when that Committee is considering business relating to the responsibility of their Portfolio Holder.

Where an Overview and Scrutiny Committee is scrutinising an executive decision made by a Township Committee or Sub-Committee, any Member of that Township Committee or Sub-Committee present when the decision was made shall not be involved in the scrutiny of that decision, in accordance with the Code of Conduct for Councillors.

HMR INTEGRATED CARE PARTNERSHIP COMMITTEE

MINUTES OF MEETING
Tuesday, 17 March 2026

PRESENT: Mrs. Chris Mayer CBE (Independent Chair), Councillor I. Ahmed, Councillor C. Wardle, Councillor R. Massey, Councillor D. Ali, N. Thompson (NHS Greater Manchester Heywood, Middleton and Rochdale Locality representative), M. Hubbard (Voluntary, Community Social Enterprise representative), G. Nic Philib (Northern Care Alliance NHS Foundation Trust), N. Tamanis (Pennine Care NHS Foundation Trust) and Z. Curwen (Local Care Organisation – substitute representative).

OFFICERS: K. Thompson (Director of Public Health and Communities / Deputy Chief Executive Rochdale Borough Council (Interim), G. Davies (Assistant Director Finance), H. Ashall (Assistant Director of Commissioning Adult Social Care and Prevention), N. Dove (Associate Director of Transformation and Delivery (HMR), NHS Greater Manchester Integrated Care), S'O Hare (Associate Director of Finance, HMR), K. Gregg (Programme Manager, Bridging Team – Heywood, Middleton and Rochdale Local Care Organisation, Northern Care Alliance NHS Foundation Trust), W. Townsend (Public Health Development Manager), F. Todde (Public Health Commissioning and Improvement Manager), R. Fardon (Public Health Registrar), and J. Jenkinson (Senior Governance and Committee Officer).

ALSO IN ATTENDANCE: Councillor B. Sheerin (Assistant to Portfolio Holder for Adult Care and Wellbeing)

203 APOLOGIES

Apologies for absence were submitted on behalf of S. Taylor, K. Jones and Dr S. Shahid.

In addition, Councillor I. Faisal (Assistant Portfolio Holder, Health) had submitted apologies for absence.

204 URGENT ITEMS OF BUSINESS
There were no urgent items of business.

205 DECLARATIONS OF INTEREST
There were no declarations of interest.

206 ITEMS FOR EXCLUSION OF PRESS AND PUBLIC

Agenda Item Nos. 10a, 10b and 11a were to be considered following the exclusion of the press and public.

207 MINUTES

Resolved: That the Chair be authorised to sign, as a correct record, the minutes of the HMR Integrated Care Partnership Committee meeting held on 24th February 2026.

208 PUBLIC QUESTIONS

There were no public questions for consideration.

STRATEGY AND DEVELOPMENT

209 DEVELOPMENT SESSION - NEIGHBOURHOOD HEALTH AND CARE PROGRAMME DELIVERY PLAN

Consideration was given to a presentation that outlined work underway to develop the Neighbourhood Health and Care Programme Delivery Plan.

Progress towards the Neighbourhood ambition and delivery of the Co-operative Communities Model had been undertaken as part of the delivery of the 'Strengthening Our Communities' priority.

A Neighbourhood Programme Group development session had been held on 3rd March 2026 to consider the future approach. During the session, the following five risks were identified as priorities for the next 12 months:

1. Develop a clear and realistic vision for neighbourhoods that enables a long-term vision. Our governance arrangements need to be simplified and facilitate better alignment between programmes.

2. Ensure our enabler and technical functions are truly integrated including data, IT, IG at a strategic and operational level.

3. Fully embed a community-led model with co-production deeply rooted into our approach and support the growth of joy and agency in our communities.

4. Address inequalities through inclusion and structural racism.

5. Develop our financial flows model to ensure investment into prevention, addressing our risk averse approach.

Resolved:

1. That the Neighbourhood Health and Care Programme Delivery Plan presentation be noted.

2. That the neighbourhood priorities 1-5 as set out above, and in slide 8 of the presentation, be supported as the focus of the neighbourhood programme 2026/27.

3. That the proposed scoping work during Quarter 1, 2026/27 to identify synergies of the key neighbourhood programmes, as set out in slide 11 of the presentation be supported.

210 HMR INTEGRATED CARE PARTNERSHIP COMMITTEE PROPOSED GOVERNANCE

Consideration was given to a presentation that set out the role and remit of the Heywood, Middleton and Rochdale (HMR) Integrated Care Partnership Committee and the Health and Wellbeing Board.

It was agreed that the proposed next steps to develop the governance relationship between the two bodies be discussed at the HMR Integrated Care Partnership Committee meeting on 28th April 2026.

Resolved:

1. That the HMR Integrated Care Partnership Committee Proposed Governance presentation be noted.

2. That a report outlining governance proposals and an operating model be submitted to the Heywood, Middleton and Rochdale Integrated Care Partnership Committee meeting to be held on 28th April 2026.

FINANCE, PERFORMANCE AND RISK

211 FINANCIAL FLOWS

Consideration was given to a presentation regarding the National Financial Flows pilot.

It was explained that Financial Flows was a national piece of work testing better ways to fund care, to enable teams across organisations to work together more easily. The new funding approaches provided a focus on prevention, community support, and keeping people well, rather than responding only when things went wrong (failure demand).

The proposed initial pilot cohort was End of Life. Data indicated that whilst there were some areas of good practice, there were also areas for improvement, and often activity around end of life was driven by failure demand.

On behalf of the Committee, the Chair welcomed the presentation and commended the work underway.

Resolved:

1. That the Financial Flows presentation be noted.

2. That the proposed next steps, as set out in slide 12 of the presentation be supported.

3. That an update report be submitted to the Heywood, Middleton and Rochdale Integrated Care Partnership Committee meeting in July 2026.

212 EXCLUSION OF PRESS AND PUBLIC

Resolved: That, in accordance with the provisions under Section 100(A) (4) of the Local Government Act 1972, as amended, the press and public be excluded from the meeting during the consideration of the following items of business. Reason for the Decision: Should the press and public remain during consideration of the items, there may be a disclosure of information that was deemed to be exempt under Part 3 of Schedule 12A of the Local Government Act 1972.

FINANCE, PERFORMANCE AND RISK

213 NHS GREATER MANCHESTER LOCALITY BUDGET 2026/27: POSITION STATEMENT

The Associate Director of Finance provided a verbal update regarding the 2026/27 locality budget.

It was reported that a budget underspend was forecast for the current financial year.

Proposed changes for 2026/27 included the transfer of funding for proactive and preventative care, starting with the Better Care Fund, through a section 75 agreement, as had been the case in the locality for several years.

Discussions with NHS Greater Manchester would continue over the next six months to support the strategic allocation of resources and ensure delivery of locality priorities.

Resolved: That the NHS Greater Manchester Locality Budget 2026/27: Position Statement update be noted.

214 SECTION 31 GRANT FOR DRUG, ALCOHOL, ROUGH SLEEPER AND SMOKING CESSATION SERVICES (SECTION 75)

Consideration was given to a report that sought approval in relation to Section 31 Public Health grants and ringfenced funding for drug, alcohol, rough sleeper and smoking cessation services.

During the discussion it was requested that information in relation to young people’s use of the services be included in future reports.

Resolved:

1. That the recommendations set out in the report be approved.

2. That information regarding young people's use of the drug, alcohol, rough sleeper and smoking cessation services be included in future reports submitted to the Heywood, Middleton and Rochdale Integrated Care Partnership Committee.

Reason for decision
The decisions ensured the Council maximised the potential of the ringfenced funding over the next three years and remained compliant with contract procedure rules in relation to the relevant services.

Alternatives considered
Details of the options considered and rejected were set out in section four of the report.

ASSURANCE

215 NATIONAL NEIGHBOURHOOD HEALTH IMPLEMENTATION PROGRAMME OVERVIEW AND UPDATE

The Assistant Director Commissioning and Prevention, Adult Social Care, introduced a presentation that outlined progress of the Programme to date, future developments, risks and opportunities.

Resolved: That the National Neighbourhood Health Implementation Programme Overview and Update presentation be noted.

216 CHAIR'S ANNOUNCEMENT

The Chair announced that Simon O'Hare would be leaving his role on 31st March 2026. On behalf of the Committee, the Chair expressed heartfelt thanks to Simon for his invaluable support to the HMR Integrated Care Partnership Committee.

Members echoed the Chair's appreciation and extended their best wishes to Simon for his future endeavours.

Report title: 2025/26 Quarter 4 Locality Strategic Risk

Report to: HMR Integrated Care Partnership Committee

Date of meeting: 23rd April 2026

Cabinet Portfolio Holder: Cllr Daalat Ali, Portfolio Holder for Health and Cllr Iftikhar Ahmed, Portfolio Holder for Adult Care and Wellbeing

Report of: Assistant Director of Commissioning Adult Social Care and Prevention

Public or Private: Public

Key Decision: No

Published on the Forward Plan: No

1. Report summary

1.1 This report details the Heywood Middleton and Rochdale (HMR) locality Q4 risk position for 2025/26 and includes:

- An overview of the strategic context driving our key risk.
- Proposed escalations to Greater Manchester Integrated Care Board (GM ICB) (table 2), and updates from risk escalated in Q2 (table 1).
- An overview of all strategic risks and aligned operational risks with a risk score of 15 or above.
- Full risk detail in the appendices.

1.2 This report has been developed by LCO programme groups and LCO Board subgroups as per the agreed HMR Risk Management Framework.

1.3 The full risk position is reported quarterly to LCO Performance Group, LCO Board and HMR Integrated Care Partnership Committee (ICPC).

1.4 Following discussion at ICPC the agreed escalations are sent to GM ICB.

2. Recommendations

ICPC is asked to:

2.1 Discuss the strategic and operational risks and whether this is an accurate reflection of the key challenges facing the system.

2.2 Discuss and approve the overall risk position as detailed in the appended report.

2.3 Recommend the risks that are important to escalate to GM where specific support is needed to mitigate in Table 1.

3. Key information

Key challenges and risk themes

3.1 NHS reform remains a significant driver of many risks, particularly as NHS GM colleagues operate under Business Continuity arrangements during ongoing organisational changes.

3.2 The Q4 risk review highlighted clear themes as we prepare for reduced staff capacity linked to the voluntary redundancy process.

3.3 In early Q4, new organisational structures were released, which will affect locality functions and capacity across GM, although the operational impact remains uncertain. These changes are giving rise to three main risk themes:

- **Skills and Capacity** – the ability to deliver key priorities and the resulting impact on quality, performance, and finance.
- **Uncertainty around the operating model –** uncertainty about how reforms will affect operational functions like financial decision making and contracting at a local level.
- **Performance and Outcomes for residents** - the effect of NHS reform changes on the ability to maintain and improve services.

3.4 Due to the level of uncertainty, the high scores for many of our risks remain and will continue to be monitored, mitigated were possible and reported via LCO Governance and ICPC.

Update on the risks escalated to GM ICB in Q3.

3.5 There were no risks escalated to GM in Q3; however, the full risk report was submitted for information.

3.6 There are no escalations to GM for specific action this quarter, however as in Q3 this report will be submitted to GM for information.

4.7 The following table provides an overview of all the locality strategic risks and underpinning operational risks scored 15+.

Strategic Risk	Exec Lead	Monitoring Committee	Aligned Locality Objective(s)	Q1 Score	Q2 Score	Q3 Score	Q4 Score
SR1 – Quality & Safety - Contractual Standards and Incidents IF we do not have contractual standards in place for providers operating across the system and fail to learn from incidents, THEN it could result in a decline in patient safety leading to patient harm.	Alison Kelly	Quality, Safety & Safeguarding Strategic Group	Helping people stay well and detecting illness earlier. Recovering core NHS and care services	**16 (4X4)**	**16 (4X4)**	**16 (4X4)**	**16 (4X4)**

Key points to note

- Staffing gaps in the CHC team, particularly Learning Disabilities nurse capacity, which may affect statutory performance and case management
- Following the departure of the Children's health lead there is a gap in resource which has the potential to impact our ability to respond to a SEND inspection, interim measures are in place, but recruitment is constrained by NHS reforms.
- Additionally, the NHS Reform could impact contract and procurement capacity for 2026/27, which may affect performance oversight. Current mitigations are progressing, but assurance remains limited. A Strategic Lead post has been advertised, and interviews are due to take place in Mid-March 2026.

Aligned Operational Risks (Scored 15+)

- **406-Impact of ICB Restructure on 2026/27 contracts and procurement 20** (Nadia Dove) - IF changes to ICB structures result in insufficient staff capacity to issue new contracts and carry out procurements for 2026/27, THEN NHS GM and the locality as part of that, may not have the resources to deliver the pieces of work to allow contracts to be put in place:
  1. Inability to effectively manage performance and quality which may impact outcomes for residents
  2. Increased risk of legal challenge
  3. Potential for payment dispute
  4. Delays in CIP where procurement is required
- **405- Staffing Gaps in the Continuing Health Care (CHC) Team 16** (Kristy Wild) - IF the current shortage of Learning Disability (LD) Nurse capacity is not addressed, THEN we will be unable to meet statutory performance requirements, provide adequate case management, and maintain assurance to NHSE and the ICB, this increases the risk of non-compliance and poor outcomes for individuals.
- **424 - SEND Inspection Resource Gap (Children's Commissioning) 20** (Alison Kelly / Nadia Dove) – IF a SEND CQC inspection is announced THEN there is a risk that the system will not have adequate resources in relation to Children's commissioning to support the inspection.

Strategic Risk	Exec Lead	Monitoring Committee	Aligned Locality Objective(s)	Q1 Score	Q2 Score	Q3 Score	Q4 Score
SR2 - Impact of NHS reform on Performance Management IF performance management is not effectively coordinated, with clearly defined roles and responsibilities aligned across the GM system, THEN there is a risk that we will not achieve key strategic aims, including: 1. Improving health and care outcomes for residents. 2. Reducing inequalities across neighbourhoods. 3. Enhancing quality and safety of services. 4. Increasing efficiency and productivity across the system.	Steve Taylor	Performance Group	Helping people stay well and detecting illness earlier. Recovering core NHS and care	**16 (4X4)**	**16 (4x4)**	**16 (4x4)**	**20 (5x4)**

Key Points to note

The risk score has increased from 16 to 20 due to performance meetings being stood down since February 2026 due to NHS Reform, and there being no locality performance lead due to NHS Reforms. Therefore, our oversight of performance in Locality is currently challenged.

- The Mental Health IMC unit is expected to be ready from Mid-March 2026.
- Locality Assurance Meetings have been stood down in Q4, therefore reporting for this has stopped.
- Children's service challenges: Autism and ADHD waiting times, CAMHS specification changes, and Speech Language Therapy (SLT).
- Most actions are in progress, but some solutions depend on GM-level decisions and funding allocations.

Aligned Operational Risks (Scored 15+)

- **193-Non-Contract Mental Health Beds utilisation 16** (Nadia Dove) IF effective pathways are not in place to enable HMR residents to be admitted to contracted mental health beds, THEN residents will be admitted to non-contract beds, resulting in out of area placements, increased financial pressure and limited assurance around the quality of care.
- **187-Monitoring performance outside of locality responsibility 16** (Nadia Dove) - IF we do not continue to monitor performance, for those areas outside of localities control (e.g. elective waits) and escalate areas of inequality in access to services THEN HMR residents may continue to face inequitable access, longer waits for treatment, and poorer health outcomes.
- **406-Impact of ICB Restructure on 2026/27 Contracts and Procurement 20** (Nadia Dove) - IF changes to ICB structures result in insufficient staff capacity to issue new contracts and carry out procurements for 2026/27, THEN NHS GM and the locality as part of that, may not have the resources to deliver the pieces of work to allow contracts to be put in place:
  1. Inability to effectively manage performance and quality which may impact outcomes for residents
  2. Increased risk of legal challenge
  3. Potential for payment dispute

4. Delays in CIP where procurement is required

- **402-Talking Therapies Performance Improvement 16** (Nadia Dove) - IF we do not see improvements in the Talking Therapies Service THEN we will fail to improve performance and therefore outcomes for our residents.
- **416-Funding for Children's Speech and Language Therapy (SLT) Service 16** (Nadia Dove) IF there is not sufficient investment in Children's Speech and Language Therapy service THEN this will impact our ability to meet the needs of children in a timely way, improve performance and school readiness outcomes in line with our locality plan outcomes.
- **417-Changes in CAMHS specification 16** (Nadia Dove) IF we do not develop a system plan to address the changes in the CAMHS specification that requires community services to carry out ADHD and autism assessments for children without comorbidities THEN there will be a gap in provision as this is currently not commissioned and this will impact already high waiting lists.
- **420 - Delay related harms in ED 16** (Zeph Curwen) - IF we do not increase UEC services for our population that are alternatives to attending ED THEN our population will continue to experience delay related harm in ED's.
- **421- Autism and ADHD waiting time 16** (Nadia Dove) - IF Rochdale is unable to show progress against Autism and ADHD waiting time recovery, THEN this not only impact Children and Young People's outcomes (including transition age) but in turn will impact upon SEND Inspection outcome which is a risk for the LA and the HMR ICS.

Strategic Risk	Exec Lead	Monitoring Committee	Aligned Locality Objective(s)	Q1 Score	Q2 Score	Q3 Score	Q4 Score
SR3 - Financial Sustainability If in response to significant system-wide challenges, we do not manage financial performance collaboratively and strategically, there is a risk that we will: 1. Fail to achieve financial balance and deliver value for money 2. Overlook or inadequately mitigate the impact of funding decisions on residents and partners 3. Undermine investment in prevention, primary, and community care, limiting our ability to deliver early intervention and reduce long term demand.	Simon O'Hare/ Mina Patel	Finance & Efficiencies Group	Achieving financial sustainability Helping people stay well and detecting illness earlier Strengthening our communities	**20 (5x4)**	**20 (5x4)**	**20 (5x4)**	**16 (4x4)**

Key Points to note

The overall risk score has reduced in Q4 from 20 to 16, as the locality are unlikely to have significant NHS GM budgets locally.

The System Locality Finance and Efficiencies Group continues to be the main forum where detailed discussions take place to manage the system's collective financial position. Other key points include:

- Details around the Fair Funding Formula outcome and national business rate changes have now been received.
- Non-recurrent funding for frailty SDEC service is badged as being funded through capacity monies in 2026/27 planning, as it is has been in previous years and there is no reason to believe that there will be any change made to this.
- The impact of NHS reform has meant that the Finance and Efficiencies Sub Group has been stood down
- CIP delivery for 2025/26 is largely on track but future planning may be affected by reform-related resource constraints.
- Visibility of partner CIP plans is improving but remains a gap and will be challenging for 2026/27 due to NHS Reform and CLM changes
- Medicines optimisation capacity is being strengthened, and leadership recruitment is ongoing.

Aligned Operational Risks (Scored 15+)

- **406-Impact of ICB Restructure on 2026/27 contracts and procurement 20** (Nadia Dove) IF changes to ICB structures result in insufficient staff capacity to issue new contracts and carry out procurements for 2026/27, THEN NHS GM and the locality as part of that, may not have the resources to deliver the pieces of work to allow contracts to be put in place:
  1. Inability to effectively manage performance and quality which may impact outcomes for residents
  2. Increased risk of legal challenge
  3. Potential for payment dispute
  4. Delays in CIP where procurement is required
- **412-Visibility and alignment of partner CIP plans 15** (Simon O'Hare) The level of savings required across the system is now impacting service delivery. IF we do not have clear visibility of each organisations CIP plans, THEN this could lead to:
  1. Unidentified and unmitigated impacts for our residents and/ or partners
  2. Duplication of effort and double counting
  3. Missed opportunities for collaboration
- **387- Medicines Optimisation Capacity 16** (Mina Chowdhury) IF the Medicines Optimisation Team are unable to increase capacity, THEN the CIP target will not be achieved for 2025/26.
- **423 – SDEC Frailty Funding 16** (Zeph Curwen) - IF the frailty SDEC service is non recurrently funded THEN the patient cohort will be likely to conveyed to ED and admitted to hospital which will impact on patient outcomes and harm and increase pressures in acute hospitals.
- **425- Potential Residential Market Failure due to inability to agree a fee rate that market requires 16 (Hayley Ashall / Nichola Thompson) -** IF the borough is unable to agree a residential care market fee rate with providers, THEN it may lead to residential market failure resulting in:
  1. Providers exiting the market.
  2. Reduced care options for residents.
  3. Increased care costs for individuals.
  4. An overall increase in the borough's care budget.

Risks closed since last report

- **404 - National Business Rate increases 16** (Sam Smith/Simon O'Hare) IF as a result of national business rate changes there is an increase in cost for the health and care system THEN this will impact the level of funding available for the delivery of services.
- **422-Impact of Fair Funding Formula changes on the Local Authority 20** (Sam Smith) **-** IF the Fair Funding Review results in a reduced settlement, THEN the local authority may face increased financial pressure and service delivery challenges over the next three years

Both the above risks are closed due to the final settlement being received in February 2026, noting the outcome was better than expected.

Strategic Risk	Exec Lead	Monitoring Committee	Aligned Locality Objective(s)	Q1 Score	Q2 Score	Q3 Score	Q4 Score
SR4 – Impact of NHS reform on locality resource IF, as a result of NHS GM and NHS provider reforms, the locality lacks sufficient resources, namely capacity, capability, and funding, THEN there is a risk we will be unable to deliver key strategic priorities effectively and / or have sufficient resource to allow this	Nichola Thompson	Strategic Commissioning Group	All	**20 (4X5)**	**20 (4X5)**	**20 (4X5)**	**20 (4X5)**

Key Points to note

To achieve the ambitions set out in the Locality Plan, we need the right level of investment and capacity and skills within locality which is currently at risk due to:

- Resource constraints linked to NHS reform are affecting commissioning and clinical capacity, particularly in children's services and medicines optimisation. Decisions for support services such as finance and BI are being made by those directorates at GM and not within locality.
- VR will also impact on locality specific finance knowledge across senior and operational posts.
- Children's Speech Language Therapy and CAMHS specification changes that require additional planning and support.
- Contracting capacity for 2026/27 continue to be a concern, with work underway to explore longer-term solutions.

Aligned Operational Risks (Scored 15+)

- **387- Medicines Optimisation Capacity 16** (Mina Chowdhury) IF the Medicines Optimisation Team are unable to increase capacity, THEN the CIP target will not be achieved for 2025/26.
- **406-Impact of ICB Restructure on 2026/27 contracts and procurement 20** (Nadia Dove) IF changes to ICB structures result in insufficient staff capacity to issue new contracts and carry out procurements for 2026/27, THEN NHS GM and the locality as part of that, may not have the resources to deliver the pieces of work to allow contracts to be put in place:
  1. Inability to effectively manage performance and quality which may impact outcomes for residents
  2. Increased risk of legal challenge
  3. Potential for payment dispute
  4. Delays in CIP where procurement is required
- **416-Funding for children's speech and language therapy service 16** (Nadia Dove) IF there is not sufficient investment in Children's Speech and Language Therapy service THEN this will impact our ability to meet the needs of children in a timely way, improve performance and school readiness outcomes in line with our locality plan outcomes.
- **417-Changes in CAMHS specification 16** (Nadia Dove) IF we do not develop a system plan to address the changes in the CAMHS specification that requires community services to carry out ADHD and autism assessments for children without comorbidities THEN there will be a gap in provision as this is currently not commissioned and this will impact already high waiting lists.

Strategic Risk	Exec Lead	Monitoring Committee	Aligned Locality Objective(s)	Q1 Score	Q2 Score	Q3 Score	Q4 Score
SR5 - Impact of NHS reforms on our locality operating model and strategic planning IF ongoing NHS reforms continue to generate significant uncertainty without a clearly defined and approved strategic direction, THEN this will hinder our ability to articulate the role of localities, align system-wide planning, and effectively deliver our key strategic priorities.	Nichola Thompson	ICPC	All	**20 (4x5)**	**20 (4x5)**	**20 (4x5)**	**20 (4x5)**

Key Points to note

Our locality operating model continues to be recognised as an example of best practice at both regional and national levels. However, we face significant uncertainty due to the ongoing GM ICB reorganisation and the implementation of the NCA Clinical Leadership Model. Whilst progress is being made to provide further clarity to support planning, and GM ICB reorganisation has entered its final stage and NCA CLM has now been enacted there is still a significant amount of uncertainty with regard to the implication on our existing operating arrangements. The role and resources available in locality has significantly reduced due to these changes and work is underway to determine our future operating model. Whilst this uncertainty still stands there is a risk in the ability to deliver our strategic objectives. This evolving context continues to be a key driver behind the high-risk rating across our strategic risks.

Aligned Operational Risks (Scored 15+) - None

Strategic Risk	Exec Lead	Monitoring Committee	Aligned Locality Objective(s)	Q1 Score	Q2 Score	Q3 Score	Q4 Score
SR6 - Neighbourhoods Development and delivery IF we do not deliver our neighbourhood model at pace and ensure resource is aligned across the system THEN this will impact: 1. Our ability to reduce inequalities and improve outcomes for our residents. 2. Our ability to attract any potential additional transformation funding 3. Our ability to remove duplication 4. Delayed and ineffective implementation	Kuiama Thompson	Neighbourhoods Programme Group	All	**16 (4x4)**	**16 (4x4)**	**16 (4x4)**	**16 (4x4)**

Key Points to note

The HMR Locality Plan outlines our ambition to improve outcomes for our residents over the next five years. Central to this is a fundamental shift toward prevention and proactive care, delivered through our neighbourhood approach. This transformation is essential to ensuring the long-term sustainability of our health and care system. We continue to participate in the National Neighbourhood Health Implementation Programme bringing increased national visibility and a heightened expectation for rapid delivery. Additionally, it has been confirmed that we will receive a further 3 years funding for the Live Well Implementation Programme with an expectation to further embed Live Well approaches within the locality. The national neighbourhood framework guidance has now been released, and we will be expected to provide our neighbourhood plan and ensure we resource our plans effectively. In this context, it is critical that we address key operational risks primarily driven by capacity and resource challenges across the system.

Aligned Operational Risks (Scored 15+)

- **409-Resource to deliver the neighbourhood model 16** (Kuiama Thompson) IF we do not have leadership, operational and project management resource to support the implementation of the neighbourhood model and development of the neighbourhood partnerships and Live Well THEN, we will be unable to deliver at the pace and scale required to deliver improved outcomes and the requirements from GM.
- **410-Neighbourhood data and insight 16** (Kuiama Thompson) IF we do not have data and insight at a neighbourhood level THEN we will be unable to deliver targeted work to address inequalities and improve outcomes
- **419 - People Strategy 16** (Clare Nott/ Ann Ridyard) IF we do not deliver our People Strategy in line with the neighbourhood Model and NHS reform then we will fail to foster a culture of integration and prevention at all levels which is fundamental to delivering our locality plan.

Strategic Risk	Exec Lead	Monitoring Committee	Aligned Locality Objective(s)	Q1 Score	Q2 Score	Q3 Score	Q4 Score
SR7 - Strengthening our VCSFE sector If we do not adopt a strategic and coordinated approach to strengthening the VCSFE sector, there is a risk to the sectors long-term sustainability, which could undermine our ability to: 1. Shift the system focus from treatment to prevention 2. Reduce demand on statutory services 3. Improve outcomes and wellbeing for residents	Hayley Ashall	Strategic Commissioning Group/ Neighbourhood Programme Group	All	**16 (4x4)**	**16 (4x4)**	**16 (4x4)**	**16 (4x4)**

Key Points to note

- VCFSE Sector leaders across 3 neighbourhoods and boroughwide to undertake the Live Well Leadership Collaborative to strengthen leadership within the sector.
- Financial Flows programme underway as one of 4 pilot areas nationally which will identify opportunities for funding into the VCFSE sector.
- Live Well Grants are currently being delivered and expected to be distributed by May 2026.+
- Action Together 'Home from Hospital grants continue to be delivered to fund local community provision.
- Adult Social Care – Day opportunities framework being explore in collaboration with e VCFSE sector to look at working differently and removing barriers to joining the future framework for day opportunities.

Aligned Operational Risks (Scored 15+) - None

Appendix 1 – Full Strategic Risk Register

Risk No. & Title	Risk Description	Controls	Gaps in Controls	Current Risk Score			Further Actions	Progress Against Actions	Completion Date for actions	Assurances	Gaps in Assurances
SR1 - Quality & Safety - Impact of NHS Reform on Contractual Standards and Incidents	IF we do not have contractual standards in place for providers operating across the system and fail to learn from incidents, THEN it	1. Quality, safety & safeguarding team have robust processes in place for the oversight of all commissioned providers. This is	1. Potential changes in GM as a result of NHS Reform that affects operational capacity to meet and advise	4	4	**16**	1. Fulfilling Statutory Quality Framework and Safeguarding Matrix which are implemented locally and feed into the wider	1. Fulfilling Statutory Quality Framework and Safeguarding Matrix which are implemented locally and feed into the wider	1. Ongoing 2. Q2	1. HMR Quality, Safety and Safeguarding Strategic Group in place providing assurance to HMR ICPC (Local) 2. System Quality Group (GM)	None

Risk No. & Title	Risk Description	Controls	Gaps in Controls	Current Risk Score			Further Actions	Progress Against Actions	Completion Date for actions	Assurances	Gaps in Assurances
	could result in a decline in patient safety leading to patient harm	underpinned by statute. 2. Continue to provide challenge to the system to ensure that quality, safety and safeguarding statutory responsibilities are met.	providers on statutory responsibilities. Clarification of roles and responsibilities for the quality team across GM which may impact locally. 2. Potential impact of GM ICB staff reductions.				GM System. 2. Interpretation of the ICB reform and how this impacts us in GM and locally.	GM System. 2. Interpretation of the ICB reform and how this impacts us in GM and locally.		3. Quality Performance Committee (GM) 4. Safeguarding Leadership Group 5. Safeguarding Partnership (Police/ICB/Council)	
SR2 - Impact of NHS reform on Performance Management	If, performance management is not effectively coordinated, with clearly defined roles and responsibilities aligned across the GM system, then there is a risk that we will not achieve key strategic aims, including: 1. Improving health and care outcomes for residents 2. Reducing inequalities across neighbourhoods	1. Approved Locality Plan (2025–2030) Sets strategic outcomes for HMR residents, informed by data and insight. Includes commitment to review data by neighbourhood, deprivation, and GM/National benchmarks to address inequalities. 2. Approved LCO Business Plan (2025–2026)	1. Developing Local Data Capacity - Ongoing need to strengthen locality-level capacity and capability to generate and interpret high-quality data and intelligence. 2. Enhancing Data Quality - Continued focus required on improving data accuracy, completeness, and consistency	4	4	20	1. Develop Strategic Dashboards - Develop and refresh performance and outcome dashboards to reflect Locality Plan priorities, enabling clearer tracking of progress and impact. 2. Launch Neighbourhood Intelligence Tools - Create tailored neighbourhood dashboards to	1. Develop Strategic Dashboards - Develop and refresh performance and outcome dashboards to reflect Locality Plan priorities, enabling clearer tracking of progress and impact. 2. Launch Neighbourhood Intelligence Tools - Create tailored neighbourhood dashboards to	1. Phased plan Q1-4 2. Q4 3. TBD 4. Q1 25/26	1. Monthly Performance Oversight - A structured monthly reporting rota is in place, with Programme Groups providing detailed performance updates to the System Performance Group, enabling timely insight and action. 2. Quarterly Governance Reporting - Performance is formally reported on a quarterly basis through the LCO Board and ICPC, ensuring	1. Further assurance is needed from Greater Manchester on the specific actions being taken to address inequalities across localities and how these align with HMR priorities. 2. Not all agreed priorities currently have dedicated programmes or

Risk No. & Title	Risk Description	Controls	Gaps in Controls	Current Risk Score	Further Actions	Progress Against Actions	Completion Date for actions	Assurances	Gaps in Assurances
	3. Enhancing quality and safety of services 4. Increasing efficiency and productivity across the system	Operational delivery plan aligned to Locality Plan outcomes, with clear performance improvement measures. 3. GM LAM Process in place Refreshed indicators support monitoring and assurance to NHS GM. 4. System-wide Performance Group Provides collective oversight, insight, and coordination of mitigating actions to improve system performance.	to support robust decision-making. 3. Resource Constraints for Programme Delivery - Limited resources may impact the pace and scale of delivery for performance improvement initiatives. 4. Evolving Policy - National and regional policy changes may affect strategic priorities and delivery timelines, requiring adaptive planning. 5. Distributed Accountability Across GM System - Performance outcomes influenced by GM-wide structures and		support targeted interventions and deepen understanding of local needs and impact 3. Co-produce neighbourhood priorities using neighbourhood insight and intelligence to drive improved outcomes, reduce inequalities, and tackle key performance challenges on a neighbourhood footprint. This will be a key focus for the locality as part of the refreshed GM operating model.	support targeted interventions and deepen understanding of local needs and impact 3. Co-produce neighbourhood priorities - Work to co-produce neighbourhood priorities will formally commence in Q1 2026/27. Work has commenced as part of the neighbourhood programme to lay the foundations to support their development such as the development of our neighbourhood operating model.		strategic oversight and accountability. This process has been adapted so that during the Business Continuity phase, we are managing performance for services/areas of greatest risk. 3. Locality Assurance with GM-Quarterly Locality Assurance Meetings with Greater Manchester ICB provide a system-level forum for review, challenge, and alignment on performance and delivery. No confirmation as to whether the LAM process will be stood down as a result of Business Continuity.	governance structures in place, limiting assurance on delivery and impact.

Risk No. & Title	Risk Description	Controls	Gaps in Controls	Current Risk Score			Further Actions	Progress Against Actions	Completion Date for actions	Assurances	Gaps in Assurances
			provider-level accountability, limiting direct local control and impact.								
SR3 - Financial Sustainability	If, in response to significant system-wide challenges, we do not manage financial performance collaboratively and strategically, there is a risk that we will: 1. Fail to achieve financial balance and deliver value for money 2. Overlook or inadequately mitigate the impact of funding decisions on residents and partners 3. Undermine investment in prevention, primary, and community care, limiting our ability to deliver early	1. Locality Plan (2025–2030) -The approved Locality Plan provides a strategic framework for achieving financial sustainability over the next five years, with a clear focus on prevention 2. LCO Business Plan (2025–2026) - The approved Business Plan outlines a detailed financial delivery plan for the next 12 months, establishing a strong foundation for the transformational ambitions set out in the Locality Plan. 3. System-wide Financial	1. Uncertainty Around Long-Term Funding - Lack of assurance regarding the continuity of non-recurrent funding 2. The locality's financial position is heavily influenced by the wider NHS GM and HMR Rochdale partners, which are subject to change and may impact local decision-making and stability. 3. Changes in national policy may affect local priorities, funding allocations, and delivery models, requiring adaptive planning	4	4	**16**	1. Continued monitoring of existing system savings schemes for 25/26 2. Build on the existing baseline of spend to include prevention 3. Understand the drivers of our expenditure across the health and care system to support planning for 26/27 onward. 4. Expand the contract register to include PCFT contracts	1. Savings schemes are being actively monitored. F&E Subgroup is stood down, with a view to convening Task & Finish Groups where required/agreed to complete specific pieces of work. Spend against budgets continue to be monitored as part of business as usual and escalations are raised with the Finance & Efficiencies Group where required. 2. A system-wide 'Spectrum of Prevention' Public Health team to	1. Ongoing 2. Q3 3. Q3 4. Q3	1. Regular financial reporting to the Integrated Care Partnership Committee (ICPC) Financial position is reported verbally on a monthly basis, with a comprehensive written report provided quarterly to ensure transparency, oversight, and informed decision-making. 2. Finance & Efficiencies Group established for system-wide financial oversight - A dedicated Finance & Efficiencies Group is in place to provide strategic oversight of HMR's financial position, including monitoring of in-year performance and	1. Lack of reliable data to confirm impact of funding effectiveness 2. Attendance at meetings from all system partners

Risk No. & Title	Risk Description	Controls	Gaps in Controls	Current Risk Score			Further Actions	Progress Against Actions	Completion Date for actions	Assurances	Gaps in Assurances
	intervention and reduce long-term demand	Oversight- Identified savings for 2025/26 are actively monitored through the HMR Finance & Efficiencies Group and its Subgroup, with regular reporting to the LCO Board and ICPC to ensure transparency and accountability. 4. Integrated Contract Register - A comprehensive contract register has been developed, covering health, children's services, public health, and adult social care. This ensures alignment with strategic priorities and supports more coordinated commissioning and resource planning.	and response. 4. Budgets delegated from GM in 2026/27 may limit local flexibility and autonomy and create challenges for partner organisations – this work is still under discussion, but any changes made to budget delegations needs to be understood and risk assessed by all partners.					lead on the development of a 'Spectrum of Prevention' to classify services by their contribution to prevention. This will help us identify which services should be considered prevention and included in the left-shift strategy whilst acknowledging that many services that deliver prevention also deliver treatment. Hold initial discussions at LCO SMT to agree next steps. 3. Understanding the drivers of prevention will require collaboration across finance, commissioning,		delivery of system efficiency savings.	

Risk No. & Title	Risk Description	Controls	Gaps in Controls	Current Risk Score			Further Actions	Progress Against Actions	Completion Date for actions	Assurances	Gaps in Assurances
								and analytics teams, and is contingent on capacity within the new operating model. 4. PCFT has been requested to submit relevant contract information. A follow-up is required			
SR4 - Impact of NHS reform on locality resource	IF, as a result of NHS GM and NHS provider reforms, the locality lacks sufficient resources, namely capacity, capability, and funding, THEN there is a risk we will be unable to deliver key strategic priorities effectively and / or have sufficient resource to allow this	1. Place Design Group and Locality Structures - A dedicated Place Design Group was established to define the function of place and map resources across localities. Although progress has temporarily paused due to Treasury approval processes linked to redundancy support, the group remains a critical mechanism for shaping future	1. Uncertainty across the system may contribute to reduced productivity and staff attrition. 2. System-wide Financial Pressures across GM may constrain funding available to localities. 3. Efforts to ensure consistency across GM Place-based models may mean a levelling down for	4	5	**20**	1. Keep stakeholders informed about the emerging Place Model, with a focus on clarifying and embedding locality budget responsibilities for 2026/27. 2. Continue collaborative development of the NCA Clinical Leadership Model (CLM), including support in the creation of an	1. Preparations for the October engagement launch are progressing, with ongoing discussions involving Place leadership teams and staff. This engagement will provide greater clarity on the implications for HMR. Locality leaders are also actively contributing to NHS Greater Manchester-wide	1. Q2 2. Q4	1. The Place Lead and Deputy Place Lead actively contribute to regional and national forums, ensuring HMR's voice is represented in shaping system-wide reform and priorities. 2. Updates are provided monthly to ICPC from GM ICB and locality leads on how the work is progressing and key risks	1. Very fast moving and little time for handovers. 2. Decisions for support services (finance, BI etc) made by those directorates and not by the locality.

Risk No. & Title	Risk Description	Controls	Gaps in Controls	Current Risk Score	Further Actions	Progress Against Actions	Completion Date for actions	Assurances	Gaps in Assurances
		locality roles and resource alignment. In parallel, draft locality structures (designed to avoid redundancy implications) have been developed and will be shared with staff for engagement in October. 2. Clinical Leadership Model Co-Design: The Northern Care Alliance (NCA) has formally committed to co-designing the Clinical Leadership Model in partnership with localities, ensuring alignment with place-based priorities. A dedicated workshop has been convened to initiate this process, which will	HMR in some areas. 4. Timescales for implementation of NHS reform as these are guided by national approval. 5. Decision making for Provider reorganisation sits outside of integrated locality system 6. Loss on locality specific finance knowledge across senior and operational posts through voluntary redundancy – this will reduce locality retained knowledge and relationships which may make future intra-organisation more challenging, plus the loss of this specific		NCA wide place strategy. 3. Locality Budgets: Clarify the financial and governance implications of NHS reforms by determining: a. the level of budget retained at locality, b. our autonomy and influence over that budget, and c. the governance arrangements between the locality and providers that would be in place to enable decision-making at a local level.	discussions on Place-based allocations for 2026/27. 2. Work continues to define a clear and consistent way of working with Place, with an agreed approach expected to be in place by Q4. 3.Locality Budgets - Work is continuing through the NHS GM finance community and is being shared with DPL and PBL for comment and amendments. This only began in November and has not concluded. As this is too late for inclusion in council budget setting this will need agreement from council			

Risk No. & Title	Risk Description	Controls	Gaps in Controls	Current Risk Score			Further Actions	Progress Against Actions	Completion Date for actions	Assurances	Gaps in Assurances
		inform the future configuration of the Provider Leadership Model and clarify the scope of resources currently deployed within localities by NCA.	knowledge will be a challenge.					colleagues before it can be implemented.			
SR5 - Impact of NHS reforms on our locality operating model and strategic planning	IF ongoing NHS reforms continue to generate significant uncertainty without a clearly defined and approved strategic direction, THEN this will hinder our ability to articulate the role of localities, align system-wide planning, and effectively deliver our key strategic priorities.	1. GM ICB Commitment to Place-Based Delivery - Greater Manchester ICB has reaffirmed its commitment to safeguarding the Place-based delivery model. A dedicated Place Design Group, featuring representation from HMR via the Deputy Place Lead, has been established to lead this work. The group has developed a draft model for Place, which will be shared for staff	1. Timescales for implementation of NHS reform as these are guided by national approval. 2. Decision making for Provider reorganisation sits outside of integrated locality system	5	5	20	1. Refresh the Locality Operating Model to incorporate the outcomes of the GM Place Design programme and the emerging Northern Care Alliance Clinical Leadership Model (CLM). This refresh will ensure clarity on roles, responsibilities, and resource deployment across the locality footprint. 2. Assess PCFT Reorganisation Impact to	1. Preparatory work is underway to support the refresh of the HMR Locality Operating Model, including the agreement of core principles that define how we operate locally. These principles were formally approved by ICPC in July. Further discussion at planned through ICPC to review progress on system reform and shape HMR's local response.	TBD	1. Regular updates provided to ICPC and LCO Board	1. It is currently unknown how the planned staffing reductions will be implemented across GM and the impact for localities and whether there will be Treasury approval. 2. Unclear outcome of the Clinical Leadership Model (CLM) 3. Not aligned to PCFT reorganisation

Risk No. & Title	Risk Description	Controls	Gaps in Controls	Current Risk Score			Further Actions	Progress Against Actions	Completion Date for actions	Assurances	Gaps in Assurances
		engagement throughout October. This process will directly inform the refresh of the HMR Locality Operating Model 2. Co-Design of the Clinical Leadership Model - The Northern Care Alliance (NCA) has committed to working in partnership with localities to co-design a Clinical Leadership Model that aligns with Place-based approaches. A dedicated workshop has been convened to initiate this collaborative process, which will help clarify future leadership structures and resource					understand its reorganisation plans and assess the implications for locality-based delivery.				

Risk No. & Title	Risk Description	Controls	Gaps in Controls	Current Risk Score			Further Actions	Progress Against Actions	Completion Date for actions	Assurances	Gaps in Assurances
		deployment across localities.									
SR6 - Neighbourhoods Development and delivery	IF we do not accelerate the delivery of our neighbourhood model and fail to effectively align resources across the system, THEN we risk: 1. Undermining our ability to reduce health inequalities and improve outcomes for residents 2. Missing critical opportunities to secure additional transformation funding 3. Duplication and inefficiencies across services 4. Experiencing delays and fragmentation in implementation, diminishing the overall impact 5. Failing to deliver the National	1. Strategic Ambition: A 5 year vision and ambition has been defined and agreed by system partners through the Neighbourhoods Programme Group. 1. Strategic Oversight: The Neighbourhood Programme Group provides robust strategic oversight of the neighbourhood model, supported by established governance structures to ensure effective delivery. 2. Defined Leadership: Clear and agreed leadership is in place, with the Place Lead acting	1. Uncertainty surrounding the impact of NHS reform on locality structures and the availability of resources to support the effective delivery of the neighbourhood model (linked to Strategic Risk SR4&5).	4	4	16	1. Co-design a Neighbourhood Operating Model that integrates our neighbourhood and Live Well vision, supported by a comprehensive five-year delivery plan. 2. Assess the implications of NHS reforms on locality functions and resource allocation, ensuring future resource is aligned to support the neighbourhood model. 3. Clarify and respond to the requirements of the National Neighbourhood Implementation Programme	1. A high-level vision has been developed, and work is progressing on the operating model, guided by input from the Neighbourhood Programme Group (NPG) in September. The model is being co-produced with system partners and the VCFSE sector, under the oversight of the NPG. 2. The Deputy Place Lead is actively engaged in GM-level developments. Draft structures are expected to be shared in October, which will inform and support local planning.	1. December 2025. 2. TBD 3. Ongoing 4. Ongoing 5. October	1. Progress updates are regularly provided to the Integrated Care Partnership Committee (ICPC) via the Neighbourhood Programme Group (NPG), ensuring strategic oversight. 2. Delivery of the business plan is monitored through regular reporting to the Local Care Organisation (LCO) Board, supporting transparency and accountability. 3. Reporting through the GM Live Well Programme, ensuring alignment with regional priorities and enabling shared learning. 4. Governance arrangements are currently under review to strengthen assurance mechanisms and ensure they	1. Understanding of GM requirements from locality and support to address resource challenges.

Risk No. & Title	Risk Description	Controls	Gaps in Controls	Current Risk Score			Further Actions	Progress Against Actions	Completion Date for actions	Assurances	Gaps in Assurances
	Neighbourhood Implementation Programme to the expected standard, potentially affecting our national reputation and future influence. 6. Failing to deliver the local implementation of GM Live Well	as the Senior Responsible Officer (SRO) for the overall programme, complemented by executive leadership from the Director of Public Health to drive system-wide alignment. 3. Neighbourhood Leadership: Each Neighbourhood Partnership has an appointed SRO, ensuring accountable leadership and consistent delivery. 4. Investment secured: Live Well Implementation Funds have been secured to accelerate delivery. 5. Forward Planning: A comprehensive neighbourhood					4. Implementation of the approved neighbourhood plan 5. Develop and secure agreement on the resource requirements needed to deliver our neighbourhood plan and the National Neighbourhood Implementation Programme. This will include ensuring resources are strategically aligned across the system to maximise impact, reduce duplication, and enable efficient, coordinated delivery.	3. Implementation is underway, with progress being monitored through established governance structures and regular reporting mechanisms. 4. Discussions are underway in regard to resources Discussion planned with senior leaders and some resource has been allocated from the Bridging Team, Public Health & Communities and Action Together. Recruitment is underway for an interim Project Manager, they will establish the Live Well Ecosystem.		remain fit for purpose as the programme evolves. 5. National Neighbourhood Implementation Programme reporting mechanisms have been established, with formal reporting scheduled to commence in October, supporting national-level assurance and visibility.	

Risk No. & Title	Risk Description	Controls	Gaps in Controls	Current Risk Score			Further Actions	Progress Against Actions	Completion Date for actions	Assurances	Gaps in Assurances
		plan for 2025/26 has been developed and formally approved by the Neighbourhood Programme Group, providing a clear roadmap for implementation. 6. Implementation of the approved neighbourhood plan - Subgroups now established to oversee delivery. 6. Clarify and respond to the requirements of the National Neighbourhood Implementation Programme									
SR7 - Strengthening our VCSFE sector	If we do not adopt a strategic and coordinated approach to strengthening the VCSFE sector, there is a risk to the sectors long-term sustainability, which could	1. Baseline Investment Mapping - A comprehensive baseline of current spend with the VCSFE sector has been developed, forming a critical foundation for	1. Impact of NHS Reform on Local Autonomy - Uncertainty around the outcomes of NHS reform may affect the locality's influence over	4	4	**16**	1. Develop a Day Opportunities Framework Developing a Day Opportunities Framework of providers open to the VCFSE to be able to support service delivery	1. Integrated work across health, care and VCFSE to understand what the framework and opportunity looks like. Report taken to ICPC to set out the	1. Q4	1. The VCSFE sector is actively engaged across all governance structures, including Finance and Efficiencies, ensuring their role in shaping investment decisions and delivery priorities.	Assurance around long term funding

Risk No. & Title	Risk Description	Controls	Gaps in Controls	Current Risk Score			Further Actions	Progress Against Actions	Completion Date for actions	Assurances	Gaps in Assurances
	undermine our ability to: 1. Shift the system focus from treatment to prevention 2. Reduce demand on statutory services 3. Improve outcomes and wellbeing for residents	delivering the Locality Plan ambition to increase investment and ensure long-term sustainability. 2. Leadership and Engagement - A Senior Responsible Officer (SRO) for VCSFE has been appointed within LCO governance arrangements, with strong links to the sector through Action Together and the wider VCSFE senior leadership network. 3. Governance - The VCSFE sector is an equal partner across all locality governance structures, ensuring meaningful involvement in decision-making	discretionary spend and decision-making 2. System-wide Financial Constraints - Ongoing financial pressures across the GM system are placing strain on budgets and leading to service reductions, making it increasingly challenging to safeguard and grow investment				as an ongoing sustainable income generation and offer. This will enable us to explore outcome based commissioning and if successful consider what a wider VCFSE Framework for service delivery could look like. 2. VCFSE Sector leaders across 3. neighbourhoods and boroughwide to undertake the Live Well Leadership Collaborative to strengthen leadership within the sector. 3. Financial Flows programme underway as one of 4 pilot areas nationally which will identify opportunities for	proposals and agreed. Next steps co-producing in the services specification attached to the framework to go out to the market. 2. Organising the Live Well Summit is underway.		2. The Neighbourhoods Programme Group and its associated governance arrangements provide a structured forum for oversight, collaboration, and alignment of VCSFE contributions to locality priorities.	

Risk No. & Title	Risk Description	Controls	Gaps in Controls	Current Risk Score			Further Actions	Progress Against Actions	Completion Date for actions	Assurances	Gaps in Assurances
		and strategic planning. 4. Targeted Investment through Live Well Funding - Live Well funding plans have been developed, with the majority of resources strategically aligned to VCSFE delivery. Live Well Grants are currently being delivered and expected to be distributed by May 2026.					funding into the VCFSE sector.				

Appendix 2 – Operational risk detail – score 15+

Risk No. & Title	Risk Description	Controls	Gaps in Controls	Current Risk Score			Further Actions	Progress Against Actions	Completion date	Assurances	Gaps in Assurances
187-Monitoring performance outside of locality responsibility	IF we do not continue to monitor performance, for those areas outside of localities control (e.g. elective waits), and escalate areas	1. Monitoring Performance of Cancer and Elective Care via the Planned Care, End of Life and Cancer	1. Locality is not responsible for hospital waiting times in relation to elective care and cancer services.	4	4	**16**	1. Continue to Report to LCO Governance. 2. Escalate any areas of poor performance to GM where	1. 2025/26 Q2 LAM process complete. The Q3 LAM process will take place in January 2026. 2. We continue	1. Q3 2. Q1-Q4	1. LCO Planned Care, Cancer and End of Life Programme Group. 2. LCO Performance	None

Risk No. & Title	Risk Description	Controls	Gaps in Controls	Current Risk Score			Further Actions	Progress Against Actions	Completion date	Assurances	Gaps in Assurances
	of inequality in access to services THEN HMR residents may continue to face inequitable access, longer waits for treatment, and poorer health outcomes.	Programme Group. 2. Key highlights reported to LCO Performance Group, LCO Board and ICPC. 3. Escalate any areas of concern to GM via the Local Assurance Meeting Process.	2. NHS Reforms impact on staff and clinical leadership 3 Lack of capacity in locality in the new operating model from April 2026 to manage this work leading to reliance on GM Curator and central data sources				required, particularly where Rochdale residents are experiencing longer wait times in comparison to GM peers.	to monitor performance and escalate any areas for concern at LAM. 3 LAM meetings stood down by NHS GM in Q4 and therefore reporting to his has stopped 4 Locality has stood down performance meetings in February and March 2026 due to NHS Reform		Group 3. LCO Board 4. ICPC 5. GM Locality Assurance Meeting Process	
193-Non-Contract Mental Health Beds utilisation	IF effective pathways are not in place to enable HMR residents to be admitted to contracted mental health beds, THEN residents will be admitted to non-contract beds, resulting in out of area placements, increased financial	1. OAP co-Ordinator and MDTs (PCFT). 2. Contract Beds with various organisations across Manchester (priory etc.) 3. Main contract is with Birch Hill. 4. Spot Purchasing (non-	1. Demand for mental Health inpatient beds. 2. Non-contract providers may not discharge when CRFD.	4	4	**16**	1. IMC development and go live	1. Mobilisation plan to be developed, the unit is expected to be ready from Mid March 2026.	1. Q3-Q4	1. Multi-agency Discharge Event (MADE) Focused meetings between the locality and providers to unblock issues which are preventing discharge. issues. 2. GM MADE to	None

Risk No. & Title	Risk Description	Controls	Gaps in Controls	Current Risk Score			Further Actions	Progress Against Actions	Completion date	Assurances	Gaps in Assurances
	pressure and limited assurance around the quality of care.	contracting) beds for patients. 5. Scoping and data analysis has been completed using various methodologies such as rapid reviews of services, data analysis of A&E data, market testing and review of current models in operation within GM. 6. Development of specification which has been co-produced with Home Treatment Team, NCA and PCFT service user feedback. Business case created outlining costs. 7. Proposal to								escalate risks. 3. Mental Health Transformation Group. 4. Complex Lives Group	

Risk No. & Title	Risk Description	Controls	Gaps in Controls	Current Risk Score			Further Actions	Progress Against Actions	Completion date	Assurances	Gaps in Assurances
		continue to implement Mental Health intermediate Care (IMC) was approved by ICPC on 26th August.									
402-Talking Therapies Performance Improvement	IF we do not see improvements in the Talking Therapies Service THEN we will fail to improve performance and therefore outcomes for our residents	1. Options paper submitted to ICPC on the 25th June 2025 - recommended option agreed. 2. Performance Improvement trajectory was agreed at the MHTG on 27th August.	1. It is the responsibility of the provider to implement the changes.	4	4	**16**	1. Monitor progress against the Talking Therapies Trajectory and the national targets. 2. Implement the recommendations from the Talking Therapies Service Review. 3. Quality & Safeguarding team to conduct a site visit of the Big Life premises.	Monthly meeting in place with the provider (Big Life) to: 1. Monitor progress based on the agreed performance improvement trajectory and National targets current performance indicates slow improvement and we expect to see activity by Feb 2026 when the new service delivery plans will be operational. 2. Monitor progress of agreed recommendations implementation e.g. enacting direct	1. Q1-Q4 2. Q1-Q4 3. Q3	1. Mental Health Transformation Group 2. Strategic Planning and Improvement Group. 3. Regular reporting to ICPC via the performance report 4. Provide assurance to the GM Mental Health Commissioners.	None

Risk No. & Title	Risk Description	Controls	Gaps in Controls	Current Risk Score			Further Actions	Progress Against Actions	Completion date	Assurances	Gaps in Assurances
								award arrangements. 3. Completed in October 2025 - outcome was positive no further actions were requested.			
417-Changes in CAMHS specification	IF we do not develop a system plan to address the changes in the CAMHS specification that requires community services to carry out ADHD and autism assessments for children without comorbidities THEN there will be a gap in provision as this is currently not commissioned and this will impact already high waiting lists.	1. An Autism and ADHD Risk paper was submitted to enable strategic level discussion at LCO Board and ICPC in September. 2. The risk was discussed as part of the Q2 Local Assurance Meeting and there was an action to 'co-ordinate a focused HMR discussion outside the meeting to address CAMHS Specification Impact and CYP mental health	1. Challenging financial position across the system 2. GM decision making as this sits outside the locality's control. 3. Initially the changes to the CAMHS specification were due to take effect from January 2026. The GM central team have acknowledged that Community paediatric providers are not in a position to provide this	4	4	16	1. Action arising from the LAM was to set up a GM Workshop to look at how to mitigate this risk across GM. 2. STAR Process approved for CAMHS funding for a Waiting List Initiative across GM. 3. Exploring alternatives to support patients that won't meet the inclusion criteria.	1. A GM workshop took place on the 16th October 2025 with a focus on prioritisation criteria. There are no plans in place, as yet, to address the gap in community services. This is being taken forward by GM colleagues. CAMHS will continue to accept. 2. GM has asked providers to utilise the non-recurrent funding to review all children waiting against the new GM triage tool. This will mean that some children waiting will no longer be eligible for assessment and will be supported	1. Q2-Q4	None	No clear plan on how this will be enacted. The provider does not have the skills or capacity to deliver the assessments. The Multi-agency panel will allow data capturing to inform the development of a 0-18 assessment pathway in community paediatrics. The panel will note the children eligible for assessment who would have received it in community paediatrics if the provision was in place. In the meantime, those children will continue to be added to CAMHS waiting lists for assessment. GM colleagues are reviewing the capacity in Community

Risk No. & Title	Risk Description	Controls	Gaps in Controls	Current Risk Score	Further Actions	Progress Against Actions	Completion date	Assurances	Gaps in Assurances
		concerns and clarify provider engagement.	additional activity. A review of Community paediatrics is being undertaken by GM. CAMHS have been asked to work flexibly and continue to accept referrals without a mental health comorbidity until such time that alternative provision is available in community paediatrics.			into needs-led provision in the borough. This process will allow children with greater needs to be prioritised. The inaugural Multi-agency triage panel meeting will meet on the 17th March 2025. Initially, the panel will consist of NCA and PCFT neurodevelopmental staff, including the Neurodiversity hub, who will triage all new referrals using the new GM triage tool. Colleagues from education, social care and early help will join the multi-agency panel following the initial pilot. 3. Our Neurodiversity Hub offers needs led support to families. We are currently looking at how our services and support			Paediatric teams across GM. A communication briefing for parents and carers has been shared by GM colleagues. This has been shared widely with HMR. A further briefing will be shared describing and signposting to our local needs-led offer.

Risk No. & Title	Risk Description	Controls	Gaps in Controls	Current Risk Score			Further Actions	Progress Against Actions	Completion date	Assurances	Gaps in Assurances
								are aligned to the neurodiversity hub so that we can meet the needs of families in a timely way, without a diagnosis. An MOU has been drafted and shared with services that are planning to collaborate as a 'virtual' Neurodiversity Hub.			
420 - Delay related harms in Emergency Departments (ED)	IF we do not increase UEC services for our population that are alternatives to attending ED THEN our population will continue to experience delay and related harm in ED's.	1. SPOA & Call before you convey went live on 2nd June. 2. Winter Planning summit took place 2nd July. 3. Additional GP Appointments (in and out of hours) planned for Bank holidays. 4. GM CAS 5. Increasing referrals to Alternative to Transfer (ATT)	1. Unable to control overcrowding from other areas like Oldham and Bury. 2. Uncertainty around capacity funding allocation for this year	4	4	**16**	1. Increasing community clinician access to call before convey senior decision makers. 2. Work with NWAS to ensure suitable alternative are explored prior to ED 3. Additional capacity schemes being planned for winter 4. Mental health schemes are planned for	'1. Hospital at home utilisation now on trajectory. 2. More work needed with NWAS colleagues. UEC comms messages have been developed and will be shared with all partners. 3. Approved funding for the following schemes for winter - SDEC and Frailty - UTC Additional Appointments - In hours primary acre - Out of hour hubs	Q3-Q4	UEC Delivery Group UEC Delivery Board System Pressure Calls	None

Risk No. & Title	Risk Description	Controls	Gaps in Controls	Current Risk Score			Further Actions	Progress Against Actions	Completion date	Assurances	Gaps in Assurances
		and UCR team 6. SDEC/Frailty. 7. PCN alternative capacity hubs in place. 8. Recruitment of medical doctors in UTC / extra weekend doctors in UTC. 9. NHS 111 DoS reviews taking place. 10. Return appointments being booked for low acuity patients. 11. GTKWTG comms campaign being socialised. 12. Children's CCNT and PNP in place to deflect suitable referrals from Royal Oldham Hospital ED.					mobilising this winter across acute and community services 5. vaccination programme planned to start late summer to support with flu, covid and respiratory related infections	- Acute Visiting Service 4. Monthly HMR immunisations meeting in place to monitor performance and risks. 5. The Flu and Covid vaccination programmes start from 1st October. The RSV vaccine is available all year round for the eligible cohorts and continues to be offered to these patients.			

Risk No. & Title	Risk Description	Controls	Gaps in Controls	Current Risk Score			Further Actions	Progress Against Actions	Completion date	Assurances	Gaps in Assurances
		13. Hospital at Home capacity for 100 adult patients across; Respiratory, Heart Failure, Frailty and IV therapy.									
406-Impact of ICB Restructure on 2026/27 Contracts and procurement	IF changes to ICB structures result in insufficient staff capacity to issue new contracts and carry out procurements for 2026/27, THEN NHS GM and the locality as part of that, may not have the resources to deliver the pieces of work to allow contracts to be put in place: 1. Inability to effectively manage performance and quality which may impact outcomes for residents 2. Increased risk of legal challenge 3. Potential for payment dispute	1. A process has been defined by the GM team which the locality is currently following. 2. Conversations about the lack of staff capacity to issue contracts for 26/27 because of NHS reforms have already taken place.	1. Impact of NHS Reforms on the locality. 2. Inability to issue long-term contracts for smaller contracts because of the NHS GM financial position and interpretation of the Provider Selection Regime (PSR) rules. 3. Lack of clarity around the new GM operating model	4	5	**20**	1. Discussion across GM with locality colleagues to agree a future process that accounts for reduced staff capacity. The locality will require legal advice. To explore options e.g. having a longer contract term to need to issue contracts every year.	1. Locally Contract Intentions for 2026/27 have been defined and approved at ICPC. How we proceed will be dependent on progress through the STAR, PSR and FSOD processes at NHS GM as well as alignment to the commissioning intentions at NHS GM. 2. Contract intentions were approved at ICPC in October 2025. Progressing with arrangements for 2026/27 is dependent on having signed arrangements in	1. Q4	Limited	Limited assurance on the plan for contracts in future and whether capacity will be sufficient to issue contracts (especially to small providers).

Risk No. & Title	Risk Description	Controls	Gaps in Controls	Current Risk Score			Further Actions	Progress Against Actions	Completion date	Assurances	Gaps in Assurances
	4. Delays in CIP where procurement is required							place for 2025/6 so this has been the initial priority. A clear position will be held by the locality by the end of March			
421-Autism and ADHD waiting times	IF Rochdale is unable to show progress against Autism and ADHD waiting time recovery, THEN this not only impact Children and Young People's outcomes (including transition age) but in turn will impact upon SEND Inspection outcome which is a risk for the LA and the HMR ICS.	1. Performance against GM ICS localities to be reviewed routinely via HMR Mental Health Transformation Group. Risk escalated via HMR Q2 Locality Assurance process. 2. CAMHS team continue to offer staff overtime to work on waiting list initiatives. 3. HMR Neurodiversity Hub and Neuro Padlet are in place which provide significant support to families. 4. Continue to monitor waiting times 5. Promotion that you don't need a	1. Community Paediatrics in HMR are only commissioned to assess autism in children under 5 and are not commissioned for ADHD assessments. 2. No Clear Alternative Assessment Pathways at this time. There is no capacity in community Paediatrics in HMR to undertake this work currently. 3. Unclear Local Impact of Regional Changes. There is no GM funding allocated to enhance	4	4	**16**	1. To ensure that people can continue to get support without a diagnosis. 2. Initial meeting held with providers recently to scope a neighbourhood triage panel. This work will be progressed from January 2026. 3. The Neurodiversity Hub has been enhanced and is continuing to develop new offers to meet the needs of children and families. A graduated response is being developed to include digital, group and individual support. Plans are developing for services supporting neurodiverse	1. ADHD and Autism wait times were discussed at the Performance Group in August, with a request for the Director of Children's Services to present the current position to the LCO Board and ICPC. A draft has been prepared and is scheduled to go through governance in September and October. The aim is to demonstrate that the investment strategy at the GM level has resulted in disparities across localities. 2. Performance meetings stood down in locality in February and March	1. Q2/Q4	ICPC LCO Performance Group, LCO Board, Mental Health Transformation Group ICPC GM Locality Assurance Meeting (LAM). SEND Alliance	None

Risk No. & Title	Risk Description	Controls	Gaps in Controls	Current Risk Score			Further Actions	Progress Against Actions	Completion date	Assurances	Gaps in Assurances
		diagnosis to get support. 6. A new GM clinical triage tool will be implemented in January 2026, along with additional non-recurrent waiting list initiative monies to prioritise CYP with most need and/or who have waited the longest. 7. GM have agreed with CAMHS providers that they will work flexibly to continue to assess CYP without a moderate to severe mental health need until alternative provision is available in Community Paediatrics.	community paediatrics. 4. No alternative triage or coordination mechanism has been identified to manage this volume of referrals. 5. Workforce and Capacity Pressures (Proposed reductions in senior clinical staffing (B7 and above) may affect service delivery, quality, and waiting times.) 6. There has been limited opportunity for local planning or mitigation in response to these proposals. 7. Potential Reduction in School-Based Support				children and families are working collaboratively as a 'virtual' neurodiversity hub.	2026 due to the NHS reform agenda. 3. Reference to risk 424 re SEND 4. Changes made at an NHS GM level around the CAMHS spec and for change to ADHD and ASD assessment which will alter impact on waiting times . 5. Currently providers are in the process of reviewing waiting lists. 6. HMR has a multi-disciplinary panel review process in place to review new referrals moving forwards			

Risk No. & Title	Risk Description	Controls	Gaps in Controls	Current Risk Score	Further Actions	Progress Against Actions	Completion date	Assurances	Gaps in Assurances
422-Impact of Fair Funding Formula changes on the Local Authority	IF the Fair Funding Review results in a reduced settlement, THEN the local authority may face increased financial pressure and service delivery challenges over the next three years.	Formal Consultation Response 1. The Council has submitted a formal response to the national consultation, ensuring its position is recorded and considered which was submitted in August. Lobbying and Political Engagement 2. Ongoing lobbying of Ministry of Housing, Communities and Local Government (MHCLG) and Ministers by Council leaders and elected Members to	1. Rochdale Council will receive the settlement, and we won't know this until December 2025	**CLOSED**	1. Awaiting the outcome of the consultation and the final Fair Funding Formula. 2. Exploring budget efficiencies. 3. Budget Setting process completed by 10th March 2026.	1. Monitoring the position and aim to let the system know the outcome, we will know by December 2025. (first announcement expected on 26/11/25) 2. Work has started to explore budget efficiencies for 2026/27. 3. Meeting will be scheduled for February 2026.	1. Q3-Q4 2. Q3-Q4 3. Q4	Council's Leadership Team Cabinet Finance & Efficiencies Group ICPC	None

Risk No. & Title	Risk Description	Controls	Gaps in Controls	Current Risk Score			Further Actions	Progress Against Actions	Completion date	Assurances	Gaps in Assurances
		influence funding decision.									
409-Resource to deliver the neighbourhood model	IF we do not have leadership, operational and project management resource to support the implementation of the neighbourhood plan THEN we will be unable to deliver at the pace and scale required to deliver improved outcomes and national and regional expectations posing reputational risk.	1. GM Live Well Funding confirmed, plan agreed and implementation underway. 2. Economic Inactivity Trail Blazer activity underway and funding confirmed for further year. 3. Y1 Neighbourhood Delivery Plan agreed and delivery underway 4. Senior leadership arrangements in place 5. NNHIP delivery is underway with identified resource from the system.	1. GM Live Well funding not currently received 2. Existing locality resource not sufficient to meet all requirements as a result of long-term recruitment restrictions. 3. Outcome of NHS Reform on the locality resource available to support delivery of neighbourhood plans 4. Pace of delivery required for NNHIP impacts the degree of engagement	5	4	**16**	1. Agree locality operating model to sustain and deliver on the neighbourhood plan once outcome of NHS reform and NCA CLM is known.	1. Work underway through ICPC to agree place purpose and governance structures.	1. June 2026	1. Neighbourhood Programme Group in place overseeing the development of the work and reporting to ICPC. 2. Neighbourhood Delivery Group 3. Live Well System Group. 4. Place Lead, Deputy Place Lead and Director Public Health and Communities are a key part of regional and national NHS reform discussions	Lack of assurance around the future role of localities and therefore the resource required in locality.

Risk No. & Title	Risk Description	Controls	Gaps in Controls	Current Risk Score			Further Actions	Progress Against Actions	Completion date	Assurances	Gaps in Assurances
			required from senior stakeholders and leads.								
410- Neighbourhood data and insight	IF we do not have data and insight at a neighbourhood level THEN we will be unable to deliver targeted work to address inequalities and improve outcomes	1. Data and intelligence network established that brings together data expertise from across the system and data proposal for neighbourhoods developed and agreed through Neighbourhood Programme Group. 2. Agreement to recruit additional resource to develop the neighbourhood dashboard 3. Engagement and Insight Group in place and realigned to the Neighbourhood	1. Impact of NHS reform on current team developing the data sets 2. Current data alignment at GM to neighbourhoods 3. Access and quality of community services data	4	4	**16**	1. Identify approach for developing the Neighbourhoods Dashboard.	1. A paper proposal was taken to NPG regarding the approach.	1. November	Neighbourhood Programme Group in place overseeing the development of the work and reporting to ICPC. Engagement and Insight Group in place, reporting into the Neighbourhood Programme Group. Data and Intelligence Network established.	Data and Intelligence Network reporting into the Neighbourhood Programme Group

Risk No. & Title	Risk Description	Controls	Gaps in Controls	Current Risk Score			Further Actions	Progress Against Actions	Completion date	Assurances	Gaps in Assurances
		Programme Group 4. Day of Action series underway to inform. 5. Resource confirmed to support NNHIP									
419 - People Strategy Delivery	IF we do not deliver our People Strategy in line with the neighbourhood Model and NHS reform then we will fail to foster a culture of integration and prevention at all levels which is fundamental to delivering our locality plan.	1. People Strategy appraisal taken place with key actions identified to strengthen People Strategy delivery. 2. Revised HMR LPG membership and scope agreed to support alignment and implementation to Neighbourhoods. 3. Development of System Leadership programme to continue to foster a culture	1. Gap in delivery lead for System People workplan. 2. Staff lack capacity to enable them to fully engage with the programme 3. The reduction of resources outlined in Risk SR5 and the lack of clarity regarding this is limiting our ability to plan our delivery. This will also impact our ability to deliver	4	4	**16**	1. Development of an OD and culture plan to facilitate the delivery of the Neighbourhood model and agree support through Live Well fund.	1. Training and OD packaged currently being mapped to support the implementation of neighbourhoods and Live Well Centres, Spaces and Offers.	1. June 2026.	1. Representation on the Neighbourhood Programme Group from HMR LPG 2. Live Well System Group Neighbourhoods Delivery Group 3. Regular updates to LCO SMT and LCO Board	None

Risk No. & Title	Risk Description	Controls	Gaps in Controls	Current Risk Score			Further Actions	Progress Against Actions	Completion date	Assurances	Gaps in Assurances
		of integration and prevention. 4. Identified VCSFE leaders to participate in the Live Well Collaborative. 5. Agreed at Neighbourhood Programme Group to focus on OD and Workforce Development Plan with a specific focus on delivery of NNHIP, Live Well and Families First.	the ambitious plans. 2. Capacity in locality with current restrictions is impacting the ability to align resource and delivery at pace.								
387-Medicines Optimisation capacity and the impact on CIP delivery	IF the Medicines Optimisation Team are unable to increase capacity, THEN the CIP target will not be achieved for 2025/26	1. Continued focus on high savings projects and targeting resource to practices with high spend/apu 2. Strategy implemented to maximise CIP reporting by	Challenging financial position across the system and the requirement for savings without the capacity planned.	4	4	**16**	1. Staff training to support CIP delivery 2. PCN Staff training to support CIP delivery	1. New roles started 15th September and 1st December 2025 2. We have now trained pcn pharmacy team across all 6 PCNs, and good progress in savings	Q4	1. HMR PCOG 2. HMR PCCC 3. GM Medicine Optimisation 4. LCO Performance Group 5. Monitoring of CIP through F&E Subgroup	None

Risk No. & Title	Risk Description	Controls	Gaps in Controls	Current Risk Score			Further Actions	Progress Against Actions	Completion date	Assurances	Gaps in Assurances
		training PCN pharmacy team to report as part of the incentive scheme financial sustainability theme to support with achieving CIP targets.						reporting observed. 3. Currently (Feb 26 Data) shows that we are -£22 k from CIP target 4. At the end of Q4, MOT capacity still at -2.6 WTE (inc Head of role). Furthermore 1.6 WTE unrecruited staff removed from new reform proposed structure			
404-National Business Rate increases	IF as a result of national business rate changes there is an increase in cost for the health and care system THEN this will impact the level of funding available for the delivery of services	1. Local Authority are currently responding to the national consultation 2. Financial planning underway to understand financial impact	Lack of clarity on how the new rates will be implemented	**CLOSED**			1. The Government are expected to finalise their plans by Q4, after which can further plan mitigation	1. Further consultation planned with input from the Local Authority. Thereafter an update will be available.	1. Q4	1. Discussion taking place through Finance & Efficiency Group 2. Monthly discussion at LA treasurers' group	1. The plan and impact is currently unknown
405-Staffing Gaps in the	IF the current shortage of	In the interim, the LA will	Joint funded individuals	4	4	**16**	This to be scoped as part of the	There is no change in this risk. There	March 2026	Reviews are being	Lack of clinical oversight

Risk No. & Title	Risk Description	Controls	Gaps in Controls	Current Risk Score			Further Actions	Progress Against Actions	Completion date	Assurances	Gaps in Assurances
Continuing Health Care (CHC) Team	Learning Disability (LD) Nurse capacity is not addressed, THEN we will be unable to meet statutory performance requirements, provide adequate case management, and maintain assurance to NHSE and the ICB, this increases the risk of non-compliance and poor outcomes for individuals.	continue to: 1. Review the joint funded individuals and share a copy of their assessment with the team. 2. In order to ensure effective case management for individuals funded CHC, this will mean that performance against new referrals will slip.	won't be getting a clinical review of their package though other clinicians will be involved.				design group for individualised commissioning.	continues to be a gap in LD provision but given the changes afoot within the ICB, any new recruitment has been put on hold. GM are aware and there was some discussion a few weeks ago about picking this up at a GM level, but it has been stood down again pending the outcome of the reforms		undertaken but without clinical oversight	
412-Visibility and alignment of partner CIP plans	The level of savings required across the system is now impacting service delivery. IF we do not have clear visibility of each organisations CIP plans, THEN this could lead to: 1. Unidentified and unmitigated	1. Finance and Efficiency subgroup established bringing together system finance and operational leads. 2. Agreement through Finance and Efficiencies	1. Individual organisations attendance at the F&E subgroup 2. The impact of NHS reform has meant that F&E subgroup has been stood down.	3	5	**15**	1. Each partner to bring their CIP plans to the F&E subgroup as/when they are developed to support detailed discussion on impact, interdependencies and mitigations.	1. Highlight report template is being refreshed to capture CIP plans to facilitate discussion at the group. 2. No significant impact for 25/26, need to keep going for 26/27 which will be	1. On-going 2. Q3-Q4	1. Finance and Efficiency Group reporting into ICPC	We are dependent upon organisations sharing their plans and engaging with the meeting. Without that there is no assurance that the collective

Risk No. & Title	Risk Description	Controls	Gaps in Controls	Current Risk Score			Further Actions	Progress Against Actions	Completion date	Assurances	Gaps in Assurances
	impacts for our residents and/ or partners 2. Duplication of effort and double counting 3. Missed opportunities for collaboration	System Wide group to share CIP plans	3. Move to a Clinically Led Model from a Care Org model means it will be more challenging to get HMR / RI specific information.					challenging given NHS reform and NCA Clinical Leadership Model (CLM) changes in NCA and the impact to produce a HMR specific position.			impact of CIP is being mitigated NHS reform and CLM changes in NCA will likely make the production of a HMR specific position challenging
423 SDEC Frailty Funding	IF the frailty SDEC service is non recurrently funded THEN the patient cohort will be likely to conveyed to ED and admitted to hospital which will impact on patient outcomes and harm and increase pressures in acute hospitals.	1. We are monitoring the delivery of service and feeding that through UEC board & LCO to evidence impact. 2. We are linking this service into our NNHIP work.	1. Funding allocations from GM unknown.	4	4	**16**	1. Paper to be submitted to finance group in January 2026.	Unfortunately Capacity monies are by their nature non recurrent but have flowed in to PCTs, CCGs and localities for over 20 years and so there is no reason to assume they will cease. The SDEC service is badged as being funded through capacity monies in 2026/27 planning, as it is has been in previous years and there is no reason to believe that	January 2026	UEC Delivery Group UEC Delivery Board LCO Finance	None

Risk No. & Title	Risk Description	Controls	Gaps in Controls	Current Risk Score			Further Actions	Progress Against Actions	Completion date	Assurances	Gaps in Assurances
								there will be any change made to this.			
424 SEND Inspection Resource Gap (Children's Commissioning)	Gaps in staffing in terms of children's commissioning in terms of preparation for SEND inspection which is a risk to the organisation Following the departure of the health lead for SEND, IF a SEND CQC inspection is announced THEN there is a risk that the system will not have adequate resources in relation to Children's commissioning to support the inspection	1. A group of key leads has been established to ensure all information is collated and that all leads are aware of their roles in relation to an inspection this group will meet regularly to track progress and system readiness. Support has been secured from the Assistant Director for Schools and Health 2. Greater Manchester ICB has been approached to consider	1. Locality is not in a position to recruit due to NHS reform.	5	4	**20**	1. Plans in place to look at a strategic lead for children's employed in a joint role across the local authority and health timescales to be determined.	1. We are awaiting clarification regarding the GM Operating Model. Locally we are seeking to explore interim arrangements. 2. Strategic Lead post has been advertised interviews due to take place in Mid March 2026 3. group has been meeting Jan – March 2026 ensuring up to date information shared across the local system	TBC	Strategic Commissioning Group	None

Risk No. & Title	Risk Description	Controls	Gaps in Controls	Current Risk Score			Further Actions	Progress Against Actions	Completion date	Assurances	Gaps in Assurances
		whether the post could be prioritised for recruitment.									
425 Potential Residential Market Failure due to inability to agree a fee rate that market requires	IF the borough is unable to agree a residential care market fee rate with providers, THEN it may lead to residential market failure resulting in: 1. Providers exiting the market. 2. Reduced care options for residents. 3. Increased care costs for individuals. 4. An overall increase in the borough's care budget.	Care Market Fee setting process. Provider forums, contract monitoring, quality Assurance process and other engagement mechanisms with providers. Scrutinising the available budget and options available to explore.	System-wide Financial Constraints – Ongoing financial pressures across the GM system, national government funding and local funding puts additional pressure on budget available to meet the needs of providers.	4	4	**16**	Care Market Fee consultation process to begin in January 2026	Fee modelling already began, providers have started to submit their requests and considerations. Consultation with care market undertaken and fees reviewing in lien with consultation feedback. Change to care marker provider fee consultation process in future years presented to market to help ongoing dialogue and earlier engagement.		Strategic Commissioning Group Integrated Commissioning Board Provider Forums	None

Heywood, Middleton & Rochdale Integrated Care Partnership

ROCHDALE BOROUGH COUNCIL

Report title: Local Care Organisation Business Plan 2025 - 26 Quarter 4 and End of Year Review

Report to: HMR Integrated Care Partnership Committee

Date of meeting: 23rd April 2026

Cabinet Portfolio Holder: Cllr Daalat Ali, Portfolio Holder for Health and Cllr Iftikhar Ahmed, Portfolio Holder for Adult Care and Wellbeing

Report of: Assistant Director of Commissioning Adult Social Care and Prevention

Public or Private: Public

Key Decision: No

Published on the Forward Plan: No

1. Report Summary

1.1 In May 2025, the Integrated Care Partnership Committee (ICPC) approved the 2025/26 LCO Business Plan. Since then, the system has continued to work collaboratively to deliver the agreed priorities. It should be noted that delivery has been notably affected by the wider pressures associated with NHS reform. These ongoing structural and operational changes have required substantial time, resource, and adaptation across teams, which in turn has impacted the ability to progress some deliverables at the pace originally planned, with some elements being paused or not yet commenced as a result of the ongoing pressures. Consequently, the Q4 review was limited to a light-touch process, providing no opportunity to showcase the impact.

1.2 Despite the ongoing challenges, significant progress has been made on a number of outcomes. Following a number of closures in Q3, only 64 deliverables were due in Q4. 34 of these have been completed, 2 have been paused, 4 have been closed and 24 will remain ongoing into 2026/27.

1.3 Table 1 below provides an overview of the delivery statuses for all the key deliverables due in Q4. Appendix 1 provides further information.

1.4 In Appendix 1, a full review is included which highlights some of the outstanding work that has taken place to date. Areas include cancer, end-of-life, population health, mental health and primary care.

1.5 As the system move into 2026/27, the approach to the LCO business planning will look markedly different from previous years. In light of ongoing NHS reform, the forthcoming Greater Manchester Operating Model and the NHS Neighbourhood Health Framework, there will not be a launch of a new business plan from 1 April 2026. It is anticipated the beginning of the development of the Business Plan will commence in Quarter 2. This is to enable sufficient time for place structures and functions to be finalised, ensuring the plan aligns to local and national plans also positions services better to deliver effectively within the evolving system landscape. Therefore, at this time no recommendations have been made for work to be carried forward into the 2026/27 business plan.

1.6 This timeframe and outlined plan will be reviewed ongoing in line with the local place structure development and any further legislation or policy derived at a local, reginal or national level which may impact on the business plan approach.

Table 1 – LCO Business Plan deliverable status

Status	Description	Total
Complete	Work is complete	**34**
In Progress	Work is underway and will continue in 2026/27	**18**
Closures	Closed	**4**
Total Key Deliverables		**64**

2. Recommendations

2.1 To note the contents of the review and acknowledge the proposal to develop a new business plan in Q2 26/27 which aligns to local and national neighbourhood plans.

4 Reason for recommendation

4.1 To provide assurance on the delivery of the LCO Business Plan.

5 Appendices

5.1 Appendix 1: LCO Business Plan 2024/25 Q4 Review (Full detail)

Strategic Objective 2 – Helping people stay well & detecting illness earlier

Priority	Start Well - Children's Prevention
SRO/ Clinical Lead	Lianne Davies/ Dr Adam Shipp
Governance	Children's Health Alliance

Deliverables	Due	Status	Update
Vaccinations (HPV/MMR Only)			
Targeted engagement in low uptake areas	Q1-Q4	**Complete**	Uptake of MMR 1 has increased from 90.2% in Feb 2024 to 92.5% in Feb 2026. The rate is higher than GM average of 91%. Uptake of MMR 2 has increased from 85.3% in Feb 2024 to 87.8% in Feb 2026. The rate is higher than GM average of 85.3%. This is due to GP surgeries stepping up invitation process and offering extra appointments, Living well doing outreach in areas of low uptake, clinics offered via extended access, Intra health (schools imms team) offering MMR jabs in schools. Overall uptake of HPV vaccine is 70% as of Feb 2026. This is an improvement from 58% seen in October 2024. Intrahealth has worked very hard in schools of low uptake, especially engaging male students.

Strategic Objective 2 – Helping people stay well & detecting illness earlier

Priority	Start Well - Children's Early Support
SRO/ Clinical Lead	Dr Adam Shipp
Governance	Children's Health Alliance

Deliverables	Due	Status	Update
Speech and Language Therapy			
Develop a whole system workforce plan	Q1-Q3	**Ongoing into 26/27**	A paper went to LCO SMT in February to propose; • Merging traded SALT posts into one Local Authority contract • Creating one integrated Children's Services SALT Team • Rebalancing the workforce to improve skill mix and resilience • Maintaining the same financial envelope • Increasing clinical capacity and system impact LCO SMT agreed this in principle.
Service redesign and implementation of 'Can Do'	Q2-Q4	**Ongoing into 26/27**	
Neurodiversity Hub Expansion			
Implementation of full system work programme	Q1-Q3	**Complete**	The Neurodiversity hub is fully established with one vacant post (CAMHS LMHP due to postholder retirement) that is currently being recruited. The additional 0.4 OT and 1.0 Assistant SALT are in post. An MOU has been shared to formalise the partnership arrangements with the Neurodiversity Hub and other services supporting neurodiverse children and families in the borough as a 'virtual' hub. Training is being planned for staff to offer Neuro-profiling. Initially this will be a targeted offer to families. GM assurance meeting took place on 19th February resulting in full confidence of HMR's delivery. GM have asked HMR to pilot a new GM commissioned neurodiversity Chat messaging service, which is being progressed. The multi-agency triage panel meetings are planned to commence weekly from 17th March 2026. There is further work to be undertaken within education settings, and a task and finish group will be set up to take this forward as part of continuous service improvement.

Strategic Objective 2 – Helping people stay well & detecting illness earlier

Priority	Start Well - Children's Targeted Intervention
SRO/ Clinical Lead	Dr Adam Shipp
Governance	Children's Health Alliance

Deliverables	Due	Status	Update
SEND Health Offer			
Develop an integrated service specification for health team aligned to the children with disability team, new homes and respite provision for children with disabilities	Q1 – Q3	**Ongoing into 26/27**	No update was provided in Q4, and therefore it is recommended that this moves into 26/27.

Strategic Objective 2 – Helping people stay well & detecting illness earlier

Priority	Live Well - Diabetes
SRO/ Clinical Lead	Dr Sonal Sharma/ Ben Willmot
Governance	Diabetes Delivery Group

Deliverables	Due	Status	Update
Prevention - Work with key stakeholders, including the VCSE sector to raise awareness of the risk factors of Type 2 diabetes	Q1-Q4	**Ongoing into 26/27**	Action Together have been leading on a VCSFE co-designed and co-delivered Diabetes/CVD prevention project of health festivals in community venues with education on healthy cooking, exercise, and health checks. Completion April 2026. We have set up a new National Diabetes Prevention Programme (NDPP) venue in Kirkholt starting 19th March to improve access for those in Kirkholt to access Diabetes Prevention. We have completed an evidence review into NDPP from national data, and local engagement data to develop a series of recommendations for improving awareness, referral, uptake, and inequalities. We will work with the provider and Diabetes Delivery Group to implement these in 26/27.
Early Detection - Work with partners to increase early detection of Type 2 diabetes in the community	Q1-Q4	**Complete**	Point of Care testing (including blood sugar testing) has been successfully rolled out in the community from September 2025, with a permanent Number 1 Riverside base on Thursdays and outreach across the week.
Management - Take a personalised approach to prevention across the care pathway to prevent exacerbation of Type 1 and Type 2 diabetes	Q1-Q4	**Ongoing into 26/27**	To increase awareness and education on why it is important to attend 9 Care Process Reviews, a video has been filmed, with versions in other languages to come, and will be sent out to eligible patients. We have been utilising ICB Practice Quality Visits to discuss performance of care processes, NDPP, T2D Path to Remission, and Structured Education via intelligence documents. We have completed a review into the Diabetes pathway for patients with Learning Disabilities, with recommendations to investigate differences in GP Practice processes, awareness of programme offerings, and adjusting referral forms. A subgroup will meet to explore this further. HCL patient technology education session planned for April, including podcast.

Strategic Objective 2 – Helping people stay well & detecting illness earlier

Priority	Live Well – Cardiovascular Disease (CVD)
SRO/ Clinical Lead	Dr Sonal Sharma
Governance	CVD Delivery Group

Deliverables	Due	Status	Update
Establish and Review an Ambulatory Blood Pressure Monitoring Pathway	Q1-Q4	**Complete**	ABPM pathway between Living Well (community provider) and primary care is well established. In 2025/26, off the 2100 blood pressures, 460 were referred to primary care for ABPM. Moving forward this pathway will be complimented with home BP monitoring, which will include providing free HBPM kits to residents in need and follow ups before referrals to GPs.
Commission VCSFE to engage high CVD risk residents to raise awareness of prevention and increase primary care intervention uptake.	Q1-Q4	**Complete**	Living well and Action Together have been commissioned to support this work. They have been arranging educational and health checks events in a range of settings across the borough, prioritising areas of high CVD prevalence. Living Well has a nig pool of CVD volunteers they have trained to support events and focus groups. Action Together in partnership with Deeplish community centre is organising healthy cooking events in March/April 26.
Community CVD outreach workers to engage south Asian population to increase uptake of health checks	Q1-Q4	**Complete**	Along with promoting NHS health checks and encouraging 40–74-year-olds to access GPs for checks, Living Well is also offering community health checks that include point of care testing for cholesterol and glucose along with BP and BM etc. Since October they have delivered 570 health checks and identified 230 residents with high risk who were either referred to primary care for more investigations or community lifestyle intervention programmes.
Align local Specialist Advice and Guidance (A&G) offer with GM's Specialist A&G Pathway	Q3-Q4	**Complete**	Work continues on expanding the use of Advice and Guidance and digital triage tools to allow patients to be treated in the most clinically appropriate setting. A shift is planned for all referrals going via Advice and Guidance for the specialties at provider level which have the most potential for this model to be effective. GM continue to encourage that all referrals receive appropriate clinical triage through a single point of access. GM will continue to commission Consultant Connect for the forthcoming financial year.

Strategic Objective 2 – Helping people stay well & detecting illness earlier

Priority	Live Well – Cardiovascular Disease (CVD)
SRO/ Clinical Lead	Dr Sonal Sharma
Governance	CVD Delivery Group

Deliverables	Due	Status	Update
Implementation of GM Heart Failure Toolkit in Primary Care (Possible Pilot on behalf of GM)	Q3-Q4	**Ongoing into 26/27**	The GM Heart Failure Toolkit for primary care is currently being rolled out via a series of Teams sessions being planned to cover the generic aspects of Heart Failure, with a more tailored session for localities to cover local variations. The locality sessions will run from April via our scheduled primary care education events where GM will present a quick and easy guide on the toolkit to support those with Heart Failure from diagnosis through to palliative care using evidence-based guidelines.

Strategic Objective 2 – Helping people stay well & detecting illness earlier

Priority	Live Well - Cancer
SRO/ Clinical Lead	Dr Carolyn Walker
Governance	Cancer Think Tank

Deliverables	Due	Status	Update
Early Diagnosis – Develop and deliver a programme of work which meets the priorities of the Cancer Alliance Engagement Funding	Q1-Q4	**Complete**	We have partnered with local businesses, including Dunstars Farm and Clelland McKever, to deliver an early detection and prevention programme. This has included collaboration with lifestyle services on healthy weight, physical activity, and recognising signs and symptoms, supported by CSILS. We have also delivered four radio shows—two on Roach Valley and two with Crescent. We have worked with mental health services, learning disability teams, and housing providers to deliver training on the signs and symptoms of cancer. This support has enabled staff (i.e. Housing Officers) to confidently share key health messages with residents
Cancer Screening - Define and deliver a targeted work programme to increase uptake in Breast and Bowel Screening and reduce inequalities	Q1-Q4	**Complete**	The final round of deep-dive exercises with selected practices across each PCN to reduce screening exemptions and improve uptake, concluded at the end of March 26.
Emergency Admissions - Undertake a data deep dive to further understand our urgent and emergency admissions for cancer patients and agree a subsequent work programme.	Q2-Q4	**Paused**	This work has been paused due to business continuity arrangements being in place in locality.

Strategic Objective 2 – Helping people stay well & detecting illness earlier

Priority	Live Well - Mental Health
SRO/ Clinical Lead	Nadia Dove/ Claire Maw / Charlotte Mitchell (Children)/ Dr Anirban Roy
Governance	Mental Health Transformation Group/ Children's Health Alliance

Deliverables	Due	Status	Update
Talking Therapies			
Implement pathway improvements for Talking Therapies	Q1-Q4	**Complete**	This work is complete for 25/26 and will become part of BAU for 26/27.
Pathway Review and Developments			
Align our Mental Health Offer at a Neighbourhood Level	Q1-Q4	**Ongoing into 26/27**	This has been included within our Integrated Mental Health Strategy and actions have been developed to enable.
Undertake a review of our crisis and discharge pathways	Q1-Q4	**Complete**	
Integrated Mental Health Strategy (IMHS)			
Phase 1 – Development of Adults IMHS	Q1-Q2	**Complete**	The Integrated Mental Health Strategy was signed off at Integrated Care Partnership on the 26th August 2025.
Phase 2 – Development of Children's IMHS	Q4	**Closed**	This was closed in Q3 due to limited resource/ capacity to undertake this work.

Strategic Objective 2 – Helping people stay well & detecting illness earlier

Priority	Live Well - Mental Health
SRO/ Clinical Lead	Nadia Dove/ Claire Maw / Charlotte Mitchell (Children)/ Dr Anirban Roy
Governance	Mental Health Transformation Group/ Children's Health Alliance

Deliverables	Due	Status	Update
Mental Health for cared for children			
New service specification and delivery model developed	Q1	**Ongoing into 26/27**	Work will continue into 26/27.
Implementation to commence once the new homes are established	Q4		

Strategic Objective 2 – Helping people stay well & detecting illness earlier

Priority	Live Well - Learning Disability (Adults, the children's element can be found in the Children and Young People Plan)
SRO/ Clinical Lead	Barbara Mitchell / Dr Anirban Roy
Governance	Mental Health, Learning Disabilities and Autism Transformation Group

Deliverables	Due	Status	Update
Re-establish Learning Disabilities Health Sub-group	Q1	**Ongoing into 26/27**	Pennine Community Learning Disability Team have agreed to undertake the chairing of the health subgroup. Awaiting confirmation of first meeting.
Co-produce a Learning Disabilities Strategy for HMR	Q1- Q4	**Ongoing into 26/27**	There have been several meetings with people with a learning disability, and the strategy is being drafted based on feedback. Channel 3 are assisting with the development and a first draft has been developed.

Strategic Objective 2 – Helping people stay well & detecting illness earlier

Priority	Live Well - Neurodiversity (Adults, the children's element can be found in the Children and Young People Plan)
SRO/ Clinical Lead	Barbara Mitchell / Dr Anirban Roy
Governance	Mental Health, Learning Disabilities and Autism Transformation Group

Deliverables	Due	Status	Update
Development of an Adults Autism Strategy for Rochdale	Q1-Q2	**Ongoing into 26/27**	Work continues with the strategy, and an event is being scheduled on April 2nd (World autism awareness day) to share the work undertaken so far and agree the action plan. The plan will be taken through the various governance processes in order to ensure there is commitment to the strategy and agreement about how the action plan will be monitored.
Development of an Adults Neurodiversity Strategy for Rochdale	Q1-Q4	**Ongoing into 26/27**	We have phased the approach to developing the LD and Neurodiversity Strategies. We have started the Learning Disabilities Strategy and will move onto developing the Neurodiversity Strategy in phase 2 which we aim to start in Q3.
Increase uptake of Oliver McGowan Training across Health and Care Sector – Phase 1 – Adult Social Care	Q1-Q4	**Complete**	

Strategic Objective 2 – Helping people stay well & detecting illness earlier

Priority	Age Well (1)
SRO/ Clinical Lead	Hayley Ashall/ Zeph Curwen/ Dr Venk Mallya
Governance	Epic Lives Board / Frailty

Deliverables	Due	Status	Update
EPIC Lives			
EPIC Lives Transformation Programme implementation	Q1 –Q4	**Complete**	Work will be ongoing into 26/26 – work has begun for wave 2 implementation.
Frailty Offer			
Scoping: prioritise key areas of focus within the Frailty pathway based on readily available data.	Q1-Q2	**Complete**	Key areas of focus have been agreed, these are 1. Care Home Admission and Avoidance Call Out, 2. Falls, 3.Workforce Roles, 4. End of Life & Palliative Care and 5. Prevention and Proactive Care. These align with the priorities for Enhanced Health at Home.
Data Analysis: Further understand the reasons for frailty related attendance/admissions and conveyances (care and nursing homes) and map the pathways to identify areas of improvement/development.	Q2-Q3	**Complete**	This work has been superseded by the National Neighbourhood Health Implementation Pilot (NNHIP).
Pathway Developments/Redesign: Define recommendations based on the outcome of the data analysis and gain approval (if required).	Q3-Q4	**Closed**	
Implement key recommendations (if approved)	Q4	**Closed**	

Strategic Objective 2 – Helping people stay well & detecting illness earlier

Priority	Age Well (2)
SRO/ Clinical Lead	Hayley Ashall/ Zeph Curwen/ Dr Venk Mallya
Governance	Epic Lives Board / Frailty

Deliverables	Due	Status	Update
Intermediate Care			
Develop the intermediate care offer (Bed based and in a person's home)	Q1	**Complete**	Over 30 system representatives participated in the Intermediate Care (IMC) System Workshop on 4th September. Work is ongoing to refine our plans and vision, including the development of a comprehensive business case for the proposed extra care and IMC scheme in central Rochdale.
Mobilise/implement the intermediate care offer	Q2-Q4	**Ongoing into 26/27**	Work is continuing into 26/27 and will be considered as part of our neighbourhood delivery offer.

Strategic Objective 2 – Helping people stay well & detecting illness earlier

Priority	Die Well – Palliative Care
SRO/ Clinical Lead	Sam Wells / Dr Carolyn Walker
Governance	Planned Care, Cancer and End of Life Programme Group

Deliverables	Due	Status	Update
Develop our 5-year end-of-life vision and phased implementation plan	Q1-Q2	**Complete**	We have developed '10 steps to making HMR the best place to die', which describes our programme of work for 2025-30. This was shared with the LCO Board in 25/26 Q1.
Conduct data analysis to further understand admissions into secondary care for palliative patients within the last year of life.	Q1-Q2	**Ongoing into 26/27**	This work will now be taken forward as part of the End-of-Life Financial Flows Pilot and will continue into 2026/27. The programme will also include analysis of the associated costs for patients accessing services during their final year of life.
Explore opportunities to increase usage of EPaCCS (Electronic Palliative Care Coordination Systems)	Q1-Q4	**Complete**	EPPACS is now fully implemented across all PCN areas, with each PCN having an appointed End-of-Life (EOL) champion. Training continues to be provided by the GM Care Record team, with Health Innovation Manchester continuing to offer light-touch support alongside quarterly locality meetings as we move into 26/27. The National Neighbourhood Health Implementation Programme (NNHIP), has also contributed to increased use of the shared care record/ EPaCCS, particularly within secondary care. As part of the programme, we have also assessed the quality of uploaded records and identified areas for improvement to strengthen quality and improve patient outcomes going forward. Meetings are scheduled with relevant stakeholders to plan the discontinuation of Statements of Intent where EPaCCS are in place.

Strategic Objective 2 – Helping people stay well & detecting illness earlier

Priority	Die Well – Palliative Care
SRO/ Clinical Lead	Sam Wells / Dr Carolyn Walker
Governance	Planned Care, Cancer and End of Life Programme Group

Deliverables	Due	Status	Update
Roll out of the Public Awareness and Perception Questionnaire	Q1-Q2	**Due for completion in 26/27**	The Public Awareness and Perception Questionnaire has been developed, and was signed off at our Planned Care, Cancer and End of Life Programme Group in February 26. We are now identifying the most effective locations for rollout to ensure maximum engagement and response rates. We expected this work to be completed in Q1 26/27.
Review learning from across GM on the use of technologies (ie. The EARLY Tool) to identify palliative patients and the impact this has on the wider system	Q1-Q2	**Complete**	We have reviewed the learning from the EARLY Tool and the benefits it offers, and we are now working with the GM EARLY team to explore its implementation and use across HMR.

Strategic Objective 3 – Recovering core NHS services

	Primary Care
	Dr Aggy York
	Primary Care Operational Group

Deliverables	Due	Status	Update
Improving Access to General Practice			
Self assessment tool completed by 36 practices and supporting action plans developed and agreed	Q1	**Complete**	All 36 practices have completed the self assessment tool and supporting actions plans. The actions plans have been reviewed and agreed.
Action plans delivered & evaluation report completed	Q2-Q4	**Complete**	Practice have been worked through their action plans across the year, with actions being completed and reported on via quarterly reporting. All actions will be completed by 31st March.
Work with practices to validate NHS Digital GP Appointment Data Dashboard (GPAD) data sets including Cloud Based Telephony (CBT)	Q2-Q4	**Complete**	Practice have received training to support validation exercise and will continue to review their data and changes to appointment mapping up until 31st March.
Develop locality capacity, demand and utilisation dashboard	Q1-Q3	**Complete**	Dashboard has been completed; there are however data quality issues due to how the data is reported back to the primary care team which are currently being reviewed.
Scope and develop options appraisal for consolidation of HMR urgent primary care including out of hours offer	Q1-Q2	**Paused**	This work has been paused following discussions by GM ICB central Urgent care team that the intention is to commission a single GP OOH service across all GM ICB footprint. Discussions will restart following conclusion of NHS reform.

Strategic Objective 3 – Recovering core NHS services

	Primary Care
	Dr Aggy York
	Primary Care Operational Group

Deliverables	Due	Status	Update
Primary Care Workforce - Recruitment & Retention			
Validation of datasets and training needs to understand primary care workforce capacity, risks and training needs	Q1	**Ongoing into 26/27**	Work to validate NWRS data feed has been paused due to limited BI resources. Training Needs Analysis has been completed, and further work is progressing to align risks and training needs, and this will inform PCA workplan development for 26/27.
Scope, agree & deliver Practice Management development programme & deliver enhanced student placements offer	Q2-Q4	**Ongoing into 26/27**	Enhanced student placements programme is progressing well. This programme is delivered by PCA in conjunction with the GMTH training hub and January update is as follows; PA 2, Nurse 4, Paramedic 3, Pharmacist 12 and Podiatrist 1. Large scale roll out of full PM programme has been delayed as further work is required to agree scope and scale – this will now be picked up into 26/27 work plan development. Peer support for practice management is in place.

Strategic Objective 3 – Recovering core NHS services

Priority	Community Services
SRO/ Clinical Lead	Hayley Ashall/ Zeph Curwen
Governance	Community Services TBD

Deliverables	Due	Status	Update
Understand our current community services offer, spend and outcomes.	Q1	**Complete**	There has been a baseline review undertaken of 35 services based upon a desk top review. It includes spend and recommendations which include: • Drafting new specifications, • Propose contract and performance processes • Developing a prevention approach • Improving TEC offer and aligning with the NHS 10-year plan • Concluding the NCA vision 10 review and how the outcomes align to the (Strategic Delivery Framework)
Develop a cohesive system plan for community services.	Q2	**Ongoing into 26/27**	This work will continue to progress into 26/27, and will be linked into our wider neighbourhoods work and the GM Operating Model.
Implementation	Q3-Q4	**Ongoing into 26/27**	

Strategic Objective 4 – Address poverty and grow the wealth of our communities

Priority	Address poverty and grow the wealth of our communities
SRO/ Clinical Lead	Dianne Gardner
Governance	Neighbourhood Programme Group/ Anti-Poverty Network

Deliverables	Due	Status	Update
Benefits maximisation targeted work	Q1 – Q4	**Complete**	This year, we've brought in over **£5,000,000** of additional income (by assessing benefit entitlements, encouraging claims and supporting people to challenge their benefit entitlements) for the borough through our core contract with Citizens Advice and Community Advice Organisations.
Advice and support expansion	Q1 – Q4	**Complete**	Using National Household Fund investment, we've embedded holistic welfare advice alongside crisis support, including extra help with benefit forms. This has widened access to welfare and debt support across 10 new community locations, such as debt advice at the Lighthouse Project in Middleton and Money Mentors at Rochdale Foodbank. The learning and good practice developed through this work will directly inform and strengthen our approach to VCFSE grants as part of the new Crisis and Resilience Fund.
Develop and implement a sustainable "Good Food" strategy	Q1 – Q4	**Ongoing into 26/27**	Rochdale became a Sustainable Food Place in May 2024 and has since developed a Sustainable Food Partnership focused on six key themes, including food waste, climate change, and health and wellbeing. The partnership is creating a borough-wide Good Food Strategy, shaped through a recent Good Food Summit and due for publication in 2026. This work builds on a range of existing initiatives such as the BigPan Cooking Programme, Boro Full of Beans, and local efforts to tackle food poverty.
Anti-Poverty Foundation Group development and expansion of influence.	Q1 – Q4	**Complete**	The APFG recently presented at the ICPC meeting, showcasing their work, insights, and system blockages. They were also recently referenced in Parliament for their influence in helping to scrap the two-child benefit cap. They are involved in major initiatives including the £16 million National Lottery Spaces of Hope bid and influencing the GM Live Well blueprint. Their experience in designing and assessing VCFSE Household Fund grants is now helping to shape Rochdale's community-led approach to both the Crisis and Resilience Fund and the VCFSE Live Well Fund, strengthening community led local decision-making and investment.

Strategic Objective 4 – Address poverty and grow the wealth of our communities

Priority	Work and Health
SRO/ Clinical Lead	Lianne Davies / Nadia Dove
Governance	Neighbourhood Programme Group/ Health TBD

Deliverables	Due	Status	Update
Economic Inactivity Trailblazer delivered via the Heywood Neighbourhood Partnership	Q1 – Q4	**Ongoing into 26/27**	This work has so far been focussed on Heywood and Middleton, supporting people that are economically inactive and have health conditions and/or caring responsibilities. Support includes addressing barriers, helping people grow in confidence by learning new things and taking part in activities/training courses, and providing practical support. By the end of this financial year, 287+ people will have been supported to access community-based activities. Activities are led by the community and key to engagement and relationship building when helping people to move into employment. We continue to be drive referrals through health colleagues for them to see that good work, health and skills are essential parts of support that people need to Live Well. Further training available for front line workers inc. health professionals, so they are confident in having the healthy work conversation and have a good understanding of the type of support available to have positive conversations. This Live Well Journey to Employment continues after April and is built into the LA's Single Settlement. Our ambition is to roll this approach out to all neighbourhoods in line with the wider Live Well agenda and build on existing assets and the developing ecosystems.

Strategic Objective 4 – Address poverty and grow the wealth of our communities

Priority	Work and Health
SRO/ Clinical Lead	Lianne Davies / Nadia Dove
Governance	Neighbourhood Programme Group/ Health TBD

Deliverables	Due	Status	Update
Identify pathway to engage people at point of referral onto elective care waiting list.	Q1 – Q4	**Complete**	The MSK partnership are developing digital pathway / triage for MSK referrals. The Work and Skills offer includes the Work Well Vanguard Programme and is one of the pathways of support. This is due to go live early in the new financial year and will hopefully generate consistent referrals from elective waiting lists. Some referrals are currently received albeit the majority from self referrals likely following interaction with a service. This year 121 residents with MSK as a primary of secondary health barrier have been supported. Overall, the Work Well Vanguard Programme has supported over 346 people meeting our agreed target. This has prevented and supported people back into employment and empowered people to understand what reasonable adjustments they need in the workplace and expectations of good employment. We have also supported people to find alternative career opportunities if they are not able to carry out their current job role and we worked closely with employers to help them look at good practice. Through the Education, Work and Skills Single Settlement the Work Well Programme will continue after March 2026 when current funding finishes however, Rochdale we will continue to deliver this preventative approach.

Strategic Objective 5 – Support our workforce and carers

Priority	Workforce Integration, Training and Skills
SRO/ Clinical Lead	Clare Nott and Ann Ridyard
Governance	HMR Locality People Group

Deliverables	Due	Status	Update
Training and Skills			
System Training – Explore and implement wider determinants of health training for our neighbourhood and integrated workforce.	Q1-Q4	**Closed**	It was agreed to close this work programme down and subsume it within the development of the OD programme for our Neighbourhoods model. This will be revised within the 2026/27 following the end of business continuity arrangements.
System Leadership - Undertake the System Leadership Programme test pilot in Middleton	Q1	**Complete**	System Leadership test sessions were undertaken across Middleton neighbourhood partnership, team manager/head of service level and with senior leaders. The tests have informed the development of the programme which is currently being finalised.
System Leadership - Agree mechanism for continued provision of the System Leadership Programme	Q2	**Complete**	It has been agreed to fund the final development and full pilot for the System Leadership programme through the Live Well Implementation Support fund. Additionally, we will be working with the Health Innovation Unit to utilise the GM Leadership Collaborative Programme within the locality and to bolster our local offer.

Strategic Objective 5 – Support our workforce and carers

Priority	Carers
SRO/ Clinical Lead	Hayley Ashall/ N-Compass
Governance	Carers Collaborative

Deliverables	Due	Status	Update
Undertake engagement with Carers through our system networks to support the development of the Carers Strategy Implementation Plan	Q1 – Q2	**Complete**	1. Three Carers collaboration events have taken place: • 9th June – attended by over 50 carers and those supporting carers, with over 20 services promoting their offer. • 10th September – attended by over 100 carers and those supporting carers, with over 24 services promoting their offer. • A third event took place in February 2026 2. The carers coproduction network meets regularly and is feeding into the programme of work to capture further carers views. 3. The carers collaboration have met throughout the year, bringing together people passionate about carers to implement the strategy and contribute to codesigning the carers action plan.
Hold a workshop and carers information day to inform the implementation plan	Q2	**Complete**	
Develop and agree the Carers Strategy Implementation Plan	Q2	**Complete**	Carers collaborative events and coproduction network have undertaken exercises to capture carers voices to shape/ codesign the carers strategy implementation plan.
Deliver the agreed actions for the Carers Strategy Implementation Plan	Q2 – Q4	**Ongoing into 26/27**	This work will continue into 2026/27.