

Agenda

Locality Board – Meeting in Public (Meeting in Public)

Date: 6th July 2026

Time: 4.00 pm – 6.00 pm

Venue: Committee Rooms A and B, Bury Town Hall, Bury

Chair: Dr Cathy Fines

Item No.	Time	Duration	Subject	Paper Verbal	For Approval Discussion Information	By Whom
1.0	4.00 – 4.10	10 mins	Welcome, apologies and quoracy	Verbal	Information	Chair
2.0			Declarations of Interest	Paper	Information	Chair
3.0			Minutes of previous meeting held on 1 st June 2026 and action log	Paper	Approval	Chair
4.0			Public questions	Verbal	Discussion	Chair
Place Based Lead Update						
5.0	4.10 – 4.20	10 mins	Key Issues in Bury	Paper	Discussion	Lynne Ridsdale Will Blandamer
6.0	4.20 – 4.30	10 mins	VCSE Focus - MotherZen	Paper	Discussion	Tori Johnson
7.1	4.30-4.45	15 mins	SEND Inspection update	Paper	Discussion	Jeanne Richards/Will Blandamer
7.2	4.45-5.00	15 mins	Adults CQC inspection update	Verbal	Discussion	Adrian Crook
Locality Board Priorities						
8.0	5.00-5.10	10 mins	Place Partnership Documentation	Paper	Discussion	Will Blandamer
Integrated Delivery Collaborative Update						
9.0	5.10-5.20	10 mins	Implementation of INTs in Bury	Paper /Video	Information	Hannah Dixon
10.0	5.20-5.25	5 mins	Integrated Delivery Board Update	Paper	Discussion	Will Blandamer
11.0	5.25-5.30	5 mins	BCF Year end Report	Paper	Discussion	Hannah Dixon

12.0	5.30-5.40	10 mins	Bury Mental Health Strategy 2026-2030	Paper	Approval	Adrian Crook
13.0	5.40-5.45	5 mins	NCA undertakings commitment and NHSE letter	Verbal	Discussion	Lorna Allan
Committee/Meeting updates						
14.0	5.45-5.50	5mins	Population Health and Wellbeing update	Paper	Information	Jon Hobday
15.0	5.50-5.55	5 mins	Performance & Quality Group update including risk and performance reports	Paper	Information	Kath Wynne-Jones/Catherine Jackson
16.0	For info	For info	SEND Improvement and Assurance Board minutes	Paper	Information	Will Blandamer
Closing Items						
17.0	5.55	5 mins	Any Other Business	Verbal		
18.0	_____	_____	Date and time of next meeting in public - Monday, 7th September 2026, 4.00 - 6.00pm on Microsoft Teams	_____		
19.0		5 mins	Post Meeting Reflection	Verbal/All		

Meeting: Locality Board			
Meeting Date	06 July 2026	Action	Consider
Item No.	2	Confidential	No
Title	Declarations of Interest		
Presented By	Chair of the Locality Board		
Author	Emma Kennett, Head of Locality Admin and Governance (Bury)		
Clinical Lead	N/A		

Executive Summary
NHS GM has responsibilities in relation to declarations of interest as part of their governance arrangements (details of which can be found outlined in the NHS Greater Manchester Integrated Care Conflict of Interest Policy version 1.2). NHS GM (Bury Locality) therefore, has a requirement to keep, maintain and make available a register of declarations of interest for all employees and for a number of boards and committees. The Local Authority has statutory responsibilities detailed as part of Sections 29 to 31 of the Localism Act 2011 and the Relevant Authorities (Disclosable Pecuniary Interests) Regulations 2012. For other partners and providers, we understand that conflicts of interest are recorded locally and processed within their respective (employing) NHS and other organisations as part of their own governance and statutory arrangements too. Taking into consideration the above, a register of Interests has been included detailing Declaration of Interests for the Locality Board. In terms of agreed protocol, the Locality Board members should ensure that they declare any relevant interests as part of the Declaration of Interest Standing item on the meeting agenda or as soon as a potential conflict becomes apparent as part of meeting discussions. The specific management action required as a result of a conflict of interest being declared will be determined by the Chair of the Locality Board with an accurate record of the action being taken captured as part of the meeting minutes. There is a need for the Locality Board members to ensure that any changes to their existing conflicts of interest are notified to NHS GM (Bury Locality) Corporate Office within 28 days of a change occurring to ensure that the Declarations of Interest register can be updated.
Recommendations
It is recommended that the Locality Board:- • Receive the latest Declarations of interest Register; • Consider whether there are any interests that may impact on the business to be transacted at the meeting on 6th July 2026 and

- Provide any further updates to existing Declarations of Interest within the Register.

OUTCOME REQUIRED (Please Indicate)	Approval ☐	Assurance ☐	Discussion ☐	Information ☐
APPROVAL ONLY; (please indicate) whether this is required from the pooled (£75) budget or non-pooled budget	Pooled Budget ☐	Non-Pooled Budget ☐		

Links to Locality Plan priorities	
Scale our work on Population Health Management - Improve population health and reduce health inequality of those in the most disadvantaged areas	☒
Drive prevention, reducing prevalence and proactive care – supporting Demand Reduction through primary intervention, secondary preventions and tertiary prevention	☒
Transforming Community Care in Neighbourhoods - fully realising the benefit of neighbourhood team working with a focus on the assets of residents and communities and providing proactive care	☒
Optimise Care in institutional settings and prioritising the key characteristics of reform.	☒

Implications						
Are the risks already included on the Locality Risk Register?	Yes	☐	No	☒	N/A	☐
Are there any risks of 15 and above that need to be considered for escalation via an NHS GM Statutory Committee or Board in line with the Risk Escalation process ?	Yes	☐	No	☒	N/A	☐
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☒	N/A	☐
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☒	N/A	☐
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☒	N/A	☐
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☒	N/A	☐
Are there any financial Implications?	Yes	☐	No	☒	N/A	☐
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☒	N/A	☐
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒

Implications						
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☒	No	☐	N/A	☐

Governance and Reporting		
Meeting	Date	Outcome
N/A		

Locality Board

Declaration of interest as per policy
 Declaration is mandatory, where relevant
 Not to be used: papers where conflict
 Not to be included in any decision making where conflict (which may then also include the following action is to take at a meeting)
 Free voting present at the meeting but abstaining from the discussion and voting capacity
 Free voting present at the meeting and participating in the discussion but not included in any voting capacity
 Free voting present at the meeting and participating in the discussion but not included in any voting capacity

1

Meeting: Locality Board			
Meeting Date	06 July 2026	Action	Approve
Item No.	3	Confidential	No
Title	Minutes of the Previous Meeting held on 1 st June 2026 and action log		
Presented By	Chair of the Locality Board		
Author	Emma Kennett, Head of Locality Admin and Governance (Bury)		
Clinical Lead	N/A		

Executive Summary
The minutes of the Locality Board meeting held on 1 st June 2026 are presented as an accurate reflection of the previous meeting, reflecting the discussion, decision and actions agreed
Recommendations
It is recommended that the Locality Board:- • Approve the minutes of the previous meeting held as an accurate record; • Provide an update on the action listed in the log.

OUTCOME REQUIRED (Please Indicate)	Approval ☒	Assurance ☐	Discussion ☐	Information ☐
APPROVAL ONLY; (please indicate) whether this is required from the pooled (S75) budget or non-pooled budget	Pooled Budget ☐	Non-Pooled Budget ☐		

Links to Locality Plan priorities	
Scale our work on Population Health Management - Improve population health and reduce health inequality of those in the most disadvantaged areas	☒
Drive prevention, reducing prevalence and proactive care – supporting Demand Reduction through primary intervention, secondary preventions and tertiary prevention	☒
Transforming Community Care in Neighbourhoods - fully realising the benefit of neighbourhood team working with a focus on the assets of residents and communities and providing proactive care	☒
Optimise Care in institutional settings and prioritising the key characteristics of reform.	☒

Implications						
Are the risks already included on the Locality Risk Register?	Yes	☐	No	☒	N/A	☐
Are there any risks of 15 and above that need to be considered for escalation via an NHS GM Statutory Committee or Board in line with the Risk Escalation process ?	Yes	☐	No	☒	N/A	☐
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☒	N/A	☐
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☒	N/A	☐
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☒	N/A	☐
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☒	N/A	☐
Are there any financial Implications?	Yes	☐	No	☒	N/A	☐
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☒	N/A	☐
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☒	No	☐	N/A	☐

Governance and Reporting		
Meeting	Date	Outcome
N/A		

Draft Minutes

Date: Locality Board – Meeting in Public – 1st June 2026

Time: 4.00pm – 6.00pm

Venue: Microsoft Teams

Title	Draft Minutes of the Locality Board		
Author	Emma Kennett		
Version	0.1		
Target Audience	Locality Board		
Date Created	1 st June 2026		
Date of Issue			
To be Agreed			
Document Status (Draft/Final)	Draft		
Description	Locality Board Minutes		
Document History:			
Date	Version	Author	Notes
	0.1	Mrs E Kennett	Draft Minutes produced
Approved:			
Signature:			 Add name of Committee/Chair

Locality Board

MINUTES OF MEETING

Locality Board
Meeting in Public
Microsoft Teams
1st June 2026
4.00 pm until 6.00 pm
Chair – Dr Cathy Fines

ATTENDANCE

Voting Members

Dr Cathy Fines, Senior Clinical Leader for the Borough (Chair)
Cllr Eamonn O'Brien, Leader of Bury Council
Cllr Tamoor Tariq, Executive Member of the Council for Adult Care and Health
Cllr Lucy Smith, Executive Member of the Council for Children and Young People
Dr Kiran Patel, Medical Director, Bury IDC
Ms Sarah Preedy, Chief Operating Officer, Pennine Care Foundation Trust
Ms Karen Kennedy, Director of Strategy, Manchester Foundation Trust
Ms Marie Wilson, Bury VCFA (Voluntary, Community, Faith & Social Enterprise) (On behalf of Ms Helen Tomlinson).
Mr Will Blandamer, Deputy Place Based Lead, Executive Director of Health and Care (for part)
Mr Adrian Crook, Director of Adult Social Services and Community Commissioning
Ms Jeanette Richards, Executive Director of Children and Young People, Bury Council
Mr Jon Hobday, Director of Public Health, Bury Council
Ms Catherine Jackson, Associate Director for Nursing, NHS Greater Manchester (Bury)
Ms Elaine Vermeulen, Associate Director of Strategic Finance – Bury & Salford
Ms Nicola Hepburn, Executive Lead, NHS Greater Manchester

Non-Voting Members

Ms Kath Wynne-Jones, Chief Officer, Bury IDC
Mr Stuart Richardson, Chief Executive, Bury Hospice

Invited Members and Observers

Cllr Carol Birchmore, Leader, Radcliffe First
Cllr Jack Rydeheard, Leader, Reform UK
Ms Clare Hunter, Project Manager, Bury Integrated Delivery Collaborative
Ms Katy Alcock, Interim Divisional Director of Nursing and AHPs, Community Services, Bury Care Organisation, Northern Care Alliance NHS Foundation Trust
Ms Sarah Cook, Homestart
Mrs Emma Kennett, Place Partnership Lead, NHS Greater Manchester (Bury)
Mrs Chloe Ashworth, Assistant Democratic Service Manager, Bury Council

MEETING NARRATIVE & OUTCOMES

1.	Welcome, Apologies and Quoracy
1.1	The Chair welcomed all to the meeting.
1.2	Apologies were received from Ms Lynne Ridsdale, Place Based Lead and Ms Lorna Allan, Chief Digital and Information Officer, NCA
1.3	The meeting was declared quorate.

2.	Declarations Of Interest		
2.1	NHS Greater Manchester has responsibilities in relation to declarations of interest as part of their governance arrangements (details of which can be found outlined in the NHS Greater Manchester Integrated Care Conflict of Interest Policy version 1.2).		
2.2	NHS Greater Manchester (Bury Locality) therefore, has a requirement to keep, maintain and make available a register of declarations of interest for all employees and for a number of boards and committees.		
2.3	The Local Authority has statutory responsibilities detailed as part of Sections 29 to 31 of the Localism Act 2011 and the Relevant Authorities (Disclosable Pecuniary Interests) Regulations 2012. For other partners and providers, we understand that conflicts of interest are recorded locally and processed within their respective (employing) NHS and other organisations as part of their own governance and statutory arrangements too.		
2.4	Taking into consideration the above, a register of Interests has been included detailing Declaration of Interests for the Locality Board.		
2.5	In terms of agreed protocol, the Locality Board members should ensure that they declare any relevant interests as part of the Declaration of Interest Standing item on the meeting agenda or as soon as a potential conflict becomes apparent as part of meeting discussions.		
2.6	The specific management action required as a result of a conflict of interest being declared will be determined by the Chair of the Locality Board with an accurate record of the action being taken captured as part of the meeting minutes.		
2.7	There is a need for the Locality Board members to ensure that any changes to their existing conflicts of interest are notified to NHS Greater Manchester (Bury Locality) Corporate Office within 28 days of a change occurring to ensure that the Declarations of Interest register can be updated.		
2.8	There were no new declarations of interest from today's meeting 1 st June 2026 and the previous meeting 13 th April 2026.		
ID	Type	The Locality Board	Owner
D/06/01	Decision	Received the declaration of interest register.	

D/06/02	Decision	Noted that declarations for new members of the committee would be added to the register for the next meeting.	

3. Minutes Of the Last Meeting and Action Log

3.1	The minutes from the Locality Board meeting held on 13 th April 2026 were considered as a true and accurate reflection of the meeting.
3.2	Updates were received in respect of the Action Log and the following updates were noted: - - A/02/04 – It was highlighted that the Mental Health gap analysis update would be brought to the Locality Board in September 2026. - A/03/01 – In relation to the availability of local maternity data, the risks around this area had been raised with the ICB and confirmation had been received that this work would be prioritised going forward. It was agreed that this action should remain open on the action log for now until the maternity data issue has been appropriately actioned by the ICB. - A/03/02/A04/01 – It was noted that an update in relation to the Place Partnership agreement was included on today's meeting agenda. It was envisaged that the full suite of final documentation would be submitted to the July 2026 Locality Board meeting for approval. - A/03/04 – The action in relation to the Patient voice and new Greater Manchester Primary Care Commissioning Committee still needed to be addressed. - A/04/02 – It was noted that the governance processes surrounding the Locality would pick up the action around ensuring that reports/agenda items fully cover the neighbourhood and left shift models of work and this action could therefore be closed. - A/04/03 – Mr Crook was endeavouring to obtain an accurate figure in relation to the VCFE funding however needed to further review the different funding mechanisms such as grants. This action should remain open on the log for now.

ID	Type	The Locality Board	Owner
D/06/03	Decision	Accepted the minutes from the previous meeting as a true and accurate reflection of the meeting and noted the updates in respect of the actions from the last meeting.	

4. Public Questions

4.1	There were no public questions received.

ID	Type	The Locality Board	Owner
D/06/04	Decision	Received the update.	

5. Key Issues in Bury

5.1	Mr Blandamer presented the latest Place Based Lead update to the Locality Board in the absence of Ms Ridsdale. It was reported that: - Ms Kennedy was in attendance at today's meeting and would be representing MFT at future meetings. Ms Kennedy reported that she would be happy to provide a brief

update on the North Manchester New Hospital Programme at each meeting as required. In terms of the latest update, discussions were taking place to decide what services would sit where and a communication and engagement plan was being developed in this regard. A 'Preferred Route Forward' which set out the direction for the new hospital had been developed and was planned to have a new main hospital alongside a separate outpatient building, delivered as a single, integrated programme of work. It was important to ensure that proposals were not rigid in terms of not being able to accommodate the left shift strategy and any other key requirements. It was noted that plans would continue to develop as design work progresses and colleagues and teams would be involved in shaping what comes next, to ensure the new hospital meets the needs of those who use it and work in it every day. As part of the national New Hospital Programme, announcements about contractor allocation have been this week. Subject to contract, the proposed delivery partnership was Bovis. An article had been published in the HSJ: <https://www.hsj.co.uk/finance-and-efficiency/new-hospitals-paired-with-builders-for-projects-worth-14bn/7041746.article>

- In relation to the Employment Model for NHS Greater Manchester Staff in Place, at the last Locality Board there was a discussion about potential next steps in proposing a future employer from currently NHS Greater Manchester staff in place teams. It was recognised that in the context of emerging and consistent place partnership arrangements in all 10 localities in Greater Manchester it was a strategic intent of NHS Greater Manchester to transfer of employment where Place-based teams are hosted locally on behalf of the Place Partnership, while remaining focused on the shared outcomes of the partnership rather than any single organisation. Place leads and NHS Trusts in Greater Manchester have been written to by the Chief Executive of NHS Greater Manchester requesting they work together to consider the following:
 1. Whether there is an agreed NHS FT at Place that would be willing, in principle, to act as the receiving employer for the NHS Greater Manchester Place-based workforce on behalf of the partnership.
 2. Whether that organisation has the organisational willingness and capacity to do so, taking account of HR, governance, financial and operational considerations.
 3. Whether there is joint local support for this approach as part of the wider Place operating model and partnership arrangements. NHS Greater Manchester were asking Place Leads and NHS FT CEOs jointly confirm their position in writing within six weeks of this letter being issued.
- In relation to the Bury Council Elections and electoral Purdah, following the local council elections held in May 2026, the Labour group retained overall control of the Council with 30 seats. Radcliffe First have 6 seats as do Reform. The Locality Board will note that the council remains in electoral purdah due to the forthcoming local council election in the Moorside ward following the untimely death of a candidate prior to the recent election. The extended period of electoral purdah has had the effect of delaying the publication of the CQC and Ofsted report into the Bury SEND Partnership, and also the CQC report on the Local Authority Adult Care Services. These will be published as soon as possible and considered in the Locality Board.
- In terms of Integrated Neighbourhood Team Working, the Locality Board was sighted on the significant progress made in developing integrated neighbourhood team working in each of the 5 neighbourhoods in the borough in accordance with the Locality Plan and the Borough Lets Do It Strategy. A video had been produced describing the implementation of INTS in Bury. The purpose of this video was to raise awareness among health and social care professionals about Integrated Neighbourhood Teams in

Bury, who they are, what they do and how they help reduce demand in the wider system. The video highlights the valuable work taking place across our neighbourhoods, showcasing how teams are working collaboratively to deliver person-centred care. It brings to life the impact of integrated working, local relationships and the commitment of colleagues in supporting individuals to remain well, connected and independent within their communities. The video could be viewed here- <https://vimeo.com/1192181988?share=copy&fl=sv&fe=ci>

- In relation to the 'No Space for Racism' campaign video launch [video](#) . The '[No Space for Racism](#)' campaign launched internally in March 2026. The public-facing phase of the campaign has now been developed, with a campaign [video](#) shown at the ICP Board on Friday 29th May 2026 for sign off. Nationally, health and care staff have been reporting a significant increase in experiences of racist and discriminatory behaviours. Around 1 in 4 health and care staff in Greater Manchester have reported that they have experienced racism at work in the past year. This includes racist words, insults, being ignored or left out, being threatened and sometimes even violence. It is coming from the patients they are trying to care for, patients' family and friends and other members of staff. This collective insight shaped the decision for Greater Manchester to develop the system wide '[No Space for Racism](#)' campaign, alongside wider system actions, including improvements to reporting, Active Bystander Training, Right to Withdraw principles, and embedding anti-racist practice through commissioning and leadership. The aim of the '[No Space for Racism](#)' campaign is to reinforce a system-wide, zero tolerance stance on racism and abuse, and to better support staff who experience it.

5.2

The following comments/observations were made by Locality Board members: -

- The Neighbourhood team working video was superb and was commended to members for viewing. It was highlighted that more videos like this were needed. It was noted that there was a lot of activity in the neighbourhood working/ PSR space that needed more publicity and exposure. Colleagues were thanked for bringing this video together.
- It would be helpful for MFT representation on the Integrated Delivery Board going forward to ensure there is connectivity to the relevant work programmes.
- There was a need to be mindful of maternity services/care as part of the North Manchester New Hospital Programme given the current flow of Bury patients to this site.

	Type	The Locality Board	Owner
D/06/05	Decision	Received the update.	

6.	VCFE focus – Homestart
6.1	Ms Sarah Cook from Homestart was in attendance to provide a presentation in relation to the work of Homestart. The presentation highlighted: - - The vision, mission and values of the service which included ensuring that every parent has the support they need to give their children the best possible start in life and support parents as they grow in confidence, strengthen their relationship with their children and widen their links with the local community. - That Homestart was a Federation network of independent charities focussed on the 0-5 period and supported families often classed as 'hard to reach' with a wide range

ID	Type	The Locality Board	Owner
D/06/07	Decision	Noted the update.	

8.	Draft SEND Reform submission		
8.1	Mr Blandamer and Ms Richards submitted a report in relation to the draft SEND Reform plan submission. It was reported that: - • Greater Manchester partners across education, health and care were committed to a consistent, collaborative approach to delivering SEND reform across all ten localities through a joined-up, sustainable system with strong governance, commissioning and delivery mechanisms to maximise shared resources, reduce duplication, and improve outcomes and experiences for children, young people, and families. • Bury's Local SEND Reform Plan set out a three-year transformation programme that built on the progress made over the past 2 years in addressing local systemic deficits to deliver a sustainable, inclusive 0–25 system where needs are identified early, supported rapidly, and children and young people thrive in local mainstream settings wherever possible.		
8.2	The following comments/observations were made by Locality Board members: - • This was a positive piece of work which demonstrated the significant progress made to date and the continued good work still required. • A query as to how the strength based assessments would be coordinated as part of the intention to have will have a fully integrated 0–25 SEND system by 2029/30. Ms Richards commented that this was being picked up as part of the co-production and engagement work.		

ID	Type	The Locality Board	Owner
D/06/08	Decision	Endorsed the submission.	

9.	Integrated Delivery update		
9.1	Ms Wynne-Jones submitted the latest Integrated delivery update to the Locality Board. It was reported that: - • The new neighbourhood planning guidance was released on the 18th March 2026. The timescales for the development of the plan had been agreed to strengthen and deepen the work being undertaken and would be brought back to the Locality Board in September 2026. • Work was underway to review delivery arrangements for the Integrated Neighbourhood Teams. It was noted that given the CLM changes at the NCA and statutory requirements of the council, the single line management arrangements in place were being revisited. • The new BECCOR asks were now clear from Greater Manchester. Neighbourhood leads were currently working on local delivery plans with practices. • An engagement event was held at North Manchester General Hospital in March 2026 with more than 50 people in attendance to consider how to strengthen relationships across our programmes of care, with a particular focus on urgent care. Relationships across all programmes of work with MFT were being strengthened and proposed that MFT were		

invited as members to the IDC Board given the importance of this relationship to deliver the neighbourhood framework ambitions.

An outline of the 4LP programme of work with the NCA has now been agreed.

The team had been invited to an event in Cheshire and Mersey on the 5th June 2026 to share the work we have done in the locality on frailty. Our progress in this area is covered in a separate agenda item

9.2

The following comments/observations were made by Locality Board members: -

There was a suggestion of bringing back the diabetes information to a future Locality Board meeting given the importance of the prevention agenda. It was noted dedicated sessions had taken place in this area so may not be required at this stage.

It was suggested that an update on the BECCOR work/outputs be brought back to a future Locality Board meeting.

Pennine Care would be happy to support with any of the Mental Health programmes of work if not already engaged in those areas.

ID	Type	The Locality Board	Owner
D/06/09	Decision	Noted the update.	
D/06/02	Action	It was suggested that an update on the BECCOR work/outputs be brought back to a future Locality Board meeting. <i>NB</i> – this has been scheduled for the September meeting.	Dr Fines

10.	Older Peoples/Falls Frailty
10.1	Ms Wynne Jones introduced this item and welcomed Ms Hunter, Project Manager, Bury Integrated Delivery Collaborative and Ms Alcock, , Interim Divisional Director of Nursing and
10.2	AHPs, Community Services, Bury Care Organisation, Northern Care Alliance NHS Foundation Trust to the meeting. Ms Hunter and Ms Katy Alcock provided a presentation in relation to the Frailty and Falls Programme. It was reported that: - • Before 2018, Bury lacked the integrated approach seen in other Greater Manchester boroughs, with health and social care often working separately. This began to change in 2019 with the support of the new Council Chief Executive and the creation of the Bury Local Care Organisation (LCO). • The LCO focused on establishing five neighbourhood teams across health, social care and the voluntary sector, and on strengthening intermediate tier services to better support people in crisis and enable safe discharge home. Prior to this, Bury had no neighbourhood teams, no clinical rapid response service and a fragmented set of intermediate services delivered by multiple providers. Investment through the Greater Manchester Transformation Fund enabled us to build these teams, embed clinical support and bring services under unified leadership (single line management). These foundations have since underpinned transformation across the Borough. • Building on these foundations, work had continued to strengthen integration and redesign services to better support the older population. The focus had been on

	promoting independence through self-care and community initiatives, identifying and preventing frailty and falls earlier, and working collectively as a system to ensure older people receive the right care in the right place, with their needs and wishes at the centre. • Choices for Living Well (Killelea) had been awarded an outstanding CQC rating which highlighted Killelea as an exemplary model of integrated intermediate care. • The Local Government Association (LGA) Adult Social Care Peer Review was undertaken to assess Bury's readiness for the new CQC assurance framework and to provide an independent evaluation of the quality, leadership and effectiveness of Adult Social Care services. The review highlighted Bury's integrated approach as a major strength, stating that "integration with health at operational and strategic levels is enviable and exemplary." Peer reviewers recognised the positive impact of partnership working across health and social care, noting that staff could clearly demonstrate the difference integration has made to residents and to adult social care outcomes. This represented one of the strongest endorsements of integrated working seen in any LGA peer review nationally. • The Bury Frailty Programme has been aligned to the Neighbourhood Health Framework, supporting a coordinated system-wide approach to improving outcomes for people living with frailty across Bury. In summary, the strategic priorities established to guide delivery and transformation were Prevention & Early Intervention, Care Closer to Home, Integrated Frailty Care, Personalised & Planned Care and Workforce & System Capability. • The Bury Falls Improvement Plan for 2026/27 was discussed. • The key achievements and successes were outlined.		
10.3	The following comments/observations were made by Locality Board members: - • A query as to whether MFT had been fully engaged as part of this work. It was reported that had been some engagement/meetings however further engagement was required particularly in relation to GPs in the South of the borough. • The need to be clear about the differences between nursing and care homes and levels of support received in the two settings as this could often get confused. • The preventative approach taken by the Falls service was extremely successful in terms of reducing hospital admissions. • The outstanding CQC rating for Killelea was a fantastic achievement which should be commended. • There were 17% fewer admissions in Bury due to falls than Manchester, 22% fewer than if you live in Stockport and 42% less than if you live in Tameside.		
ID	Type	The Locality Board	Owner
D/06/10	Decision	Noted the update.	

11	BCF update
11.1	Mr Blandamer submitted a report to update the Locality Board on the BCF Planning 26/27 which had been co-produced by council and health partners.

11.2	It was reported that the aim of the BCF was to support ICBs and local authorities in designing and delivering more integrated and preventative care, particularly for people with more complex health and social care needs, helping people stay independent for longer		
11.3	In terms of governance, it was important to note that the Health and Wellbeing Board had overall responsibility for the BCF however was important for the Locality Board to have oversight of this information on a quarterly basis.		
ID	Type	The Locality Board	Owner
D/06/11	Decision	Noted the contents of the paper and the attachments regarding the detail of the BCF.	
D/06/12	Decision	Expected quarterly updates on the progress of the 26/27 plans versus metrics and expenditure.	

12.	Population Health and Wellbeing update		
12.1	Mr Hobday presented the latest Population Health and Wellbeing update to the Locality Board.		
12.2	It was reported that: - - the Bury Health and Wellbeing Board took place on 17th March 2026. The agenda included discussions on the Better Care Fund, the Healthwatch annual report, an update on physical activity and the locality model. Further information in relation to eh Physical activity work could be shared with members on request. - The next Health and Wellbeing Board was scheduled to take place on the 11th June 2026 and agenda items would include anti-poverty, food, inequalities and mental health.		
12.3	The following comments/observations were made by Locality Board members: Locality Board members should be encouraged to take part in the run at Burrs Country Park.		
ID	Type	The Locality Board	Owner
D/06/13	Decision	Noted the Highlight report.	

13.	Performance and Quality Group update		
12.1	Members received copies of the latest report from latest Performance and Quality Group meeting		
12.2	The risk paper detailed the locality strategic and programme risks set by the locality Risk and Scrutiny Group as scored 12 and above using the strategic risk descriptors detailed in section 3 of this report. The risks are described in summary and high-level mitigating actions are included. Further detailed information on the risk mitigations is discussed and actioned through the transformation/programme boards and workstreams.		
12.3	The risk register was cross referenced with the ICB risks as presented in the Board Assurance Framework.		

12.4	It was noted that the full Performance report would be brought back to the Locality Board in July 2026.
12.5	The following comments/observations were made by Locality Board members: - - Ms Kennedy updated on the national diabetes (Type 2) work in relation to under 40s women with poor maternal outcomes and suggested linking in with the National Diabetes Programme. Ms Wynne-Jones commented that it would be helpful to have a discussion around the national diabetes work at the Major Conditions Board - Ms Richards referred to the Family First Partnership risk and the need for this to be reviewed. It was agreed that Ms Richards would feedback to Ms Jackson on any risk changes. - This had been really good meeting and a real reflection of the great work Bury were doing. The excellent team working was evident regardless of employing organisation which was really positive.

ID	Type	The Locality Board	Owner
D/06/14	Decision	Noted the update.	
A/06/03	Action	Further discussion on the national diabetes programme to be scheduled for the Major Conditions Board	Ms Wynne-Jones
A/06/04	Action	Any changes to the Family First Partnership risk to be submitted to Ms Jackson	Ms Richards

14	SEND improvement and Assurance Board minutes		
13.1	Members received minutes from the SEND Improvement and Assurance Board meeting held on the 12 th May 2026.		
13.2	It was noted that the minutes from this meeting would continue to be brought to the Locality Board whilst the governance changes in this area are implemented to ensure that the Board are sighted key developments/progress.		
ID	Type	The Locality Board	Owner
D/06/15	Decision	Noted the minutes	

15	Any Other Business		
16.1	There were no items raised.		
ID	Type	The Locality Board	Owner
D/06/15	Decision	Noted the information	

13.	Date and time of next meeting		
17.1	Date and time of next meeting in public - Monday, 6th July 2026, 4.00 - 6.00pm in Committee Rooms A and B, Bury Town Hall.		

Locality Board Action Log – June 2026

Status Rating



- In Progress



- Completed



- Not Yet Due



- Overdue

Date	Reference		Action	Lead	Status	Due Date	Update
2 nd February 2026	A/02/04	Action	Mental Health Gap Analysis to be brought back to future Locality Board meeting.	Ms Preedy/Mr Blandamer		Sept 2026	This is now scheduled for the September Locality Board meeting.
2 nd March 2026	A/03/01	Action	The questions raised as part of the Maternity item to be raised with the LMNS and the particularly the availability of a workplan/timescales for the Bury specific data being available.	Dr Fines		April 2026	Email sent and response received following the March meeting to state: - The current GM dashboard does not have the capability to break down service user by postcode, although this is an ambition that we would like. The new national maternity E&E dashboard also unfortunately does not break down by locality: Maternity and Neonatal Equalities dashboard - NHS England Digital We are currently looking to utilise MSDS data which may give us that functionality.



BURY
INTEGRATED CARE
PARTNERSHIP

							Fingertips is currently the only source I am aware of that provides some specific outcomes for Bury relating to maternity .Child and Maternal Health - Data Fingertips Department of Health and Social Care MNVP are aligned to maternity provider however they will be collecting information from all localities and share the demographic breakdown quarterly with the system group. I have copied in Natalie who can advise whether the North Manchester service user feedback is identifiable by post code. Update April 2026 – Members discussed the current gap in relation to the availability of maternity data for Bury residents and the need to accelerate process given the links to the first 1001 days and setting the foundations for lifelong emotional and physical wellbeing.





BURY
INTEGRATED CARE
PARTNERSHIP

						There was a query as to whether NHS numbers and home post codes could simply be used to extract some of the Bury maternity data given does not have a single maternity provider in the locality. It was highlighted that other localities would also be in this position as residents may choose to go to other areas for maternity care and vice versa so data still include residents from other areas. It was highlighted that there was still a need to obtain some more definitive timescales for this work and availability of the Bury maternity data. There was also a query as to whether this would link into the Population Health work. It was noted that this was the intention. Update June 2026 - In relation to the availability of local maternity data, the risks around this had been raised with the ICB in relation to this issue and confirmation that this area of work would be prioritised had been received. It was agreed that this action



							should remain open on the action log for now until the maternity data issue has been resolved by the ICB.
2 nd March 2026	A/03/02	Action	Mr Blandamer to bring back an updated version of the Partnership agreement to the Locality Board meeting at a later stage.	Mr Blandamer	✓	June 2026	Included on the agenda
2 nd March 2026	A/03/04	Action	Clarity to be obtained in relation to the plans for the 'Patient Voice' being captured as part of the new Greater Manchester Primary Care Commissioning Committee.	Mr Blandamer	▶	April 2026	This still needed to be picked up.
13 th April 2026	A/04/01	Action	A further update/items for approval on the Place Partnership arrangements to be provided to the Locality Board in June 2026. The specific governance arrangements would need to be agreed given the timing of the June meeting.	Mr Blandamer	✓	June 2026	Included on the agenda

13 th April 2026	A/04/03	Action	Mr Crook agreed to check on the exact figure given to the VCFE on an annual basis.	Mr Crook		June 2026	Update to be provided in July 2026
1 st June 2026	A/06/01	Action	Meeting to be arranged with Ms Sarah Cook from Homestart to discuss future opportunities.	Mr Hobday/Ms Richards		July 2026	
1 st June 2026	A/06/02	Action	It was suggested that an update on the BECCOR work/outputs be brought back to a future Locality Board meeting. <i>NB</i> – this has been scheduled for the September meeting.	Dr Fines		Sept 2026	
1 st June 2026	A/06/03	Action	Further discussion on the national diabetes programme to be scheduled for the Major Conditions Board	Ms Wynne-Jones		July 2026	
1 st June 2026	A/06/04	Action	Any changes to the Family First Partnership risk to be submitted to Ms Jackson	Ms Richards		July 2026	

Meeting: Locality Board			
Meeting Date	06 July 2026	Action	Receive
Item No.	5	Confidential	No
Title	Place Lead Report		
Presented By	Lynne Ridsdale – Place Lead, NHS Greater Manchester (Bury) and Bury Council Chief Executive		
Clinical Lead	Dr Cathy Fines		

Executive Summary
To provide an update on key issues in the Health and Care System in Bury
Recommendations
The Locality Board is asked to note the update.

Links to Locality Plan priorities	
Scale our work on Population Health Management - Improve population health and reduce health inequality of those in the most disadvantaged areas.	☒
Drive prevention, reducing prevalence and proactive care – supporting Demand Reduction through primary intervention, secondary preventions and tertiary prevention.	☒
Transforming Community Care in Neighbourhoods - fully realising the benefit of neighbourhood team working with a focus on the assets of residents and communities and providing proactive care.	☒
Optimise Care in institutional settings and prioritising the key characteristics of reform.	☒

Implications						
Are the risks already included on the Locality Risk Register?	Yes	☐	No	☐	N/A	☒
Are there any risks of 15 and above that need to be considered for escalation via an NHS GM Statutory Committee or Board in line with the Risk Escalation process ?	Yes	☐	No	☐	N/A	☒
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☐	N/A	☒
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☐	N/A	☒
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☐	N/A	☒
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☐	N/A	☒
Are there any financial Implications?	Yes	☐	No	☐	N/A	☒

Implications						
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☒
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☒

Governance and Reporting		
Meeting	Date	Outcome
N/A		

1. Adult Care CQC Inspection Outcome

I am delighted to advise that the inspection of Adult Care Services at Bury Council by CQC has resulted in a rating of “Good”. This result reflects years of hard work by staff and leadership in transforming and reforming the model of Adult Care in the borough. It is also a reflection of the commitment of Adult Care to partnership working in the borough, through for example integrated neighbourhood teams and intermediate care, and the reciprocal support received from NHS partners, provider providers, and the Voluntary and Community Sector. Adrian Crook will provide a verbal update later on the agenda on the key themes of the report and the report itself will be circulated widely following consideration by the Council cabinet on 8th July. Adrian will also at a future meeting bring forward the next 3 year development plan for ASC.

Locality Board will note that this “good” outcome follows a CQC rating of “good” for the Falcon and Griffin Extra Care Scheme provided and run by the Council, and a CQC rating of “Outstanding” for the Choices for Living (intermediate care bed provision) at Killalea.

2. Bury SEND partnership CQC and Ofsted Reinspection

I am also delighted to report that the Bury SEND partnership has been judged as taking ‘Effective Action’ in all 6 priority improvement areas in the recent SEND Reinspection by CQC and Ofsted. This has followed 2 years of intensive improvement work led by the independently chaired SEND Improvement and Assurance Board. It should be noted our DFE and NHSE advisors have indicated it is very rare for an area to have had as many as 6 improvement areas and be judged as taking effective action on all of them. This judgement is a testament to the outstanding work across the Council Childrens Services, NHS partners and education partners and other key stakeholders and I would like to thank all colleagues for their commitment to improvement of the SEND system for children, young people and families in the borough.

All partners recognise that while this is a very encouraging outcome there is still a lot of work to do – the circumstances of the lives of many children and young people in the borough and their families remain very challenging and we are committed to work harder. The SEND improvement and Assurance board (SIAB), focused on the delivery of the Improvement plan, will transition to become a SEND partnership board with a wider remit across the whole SEND System.

On behalf of the Locality Board may I thank Deborah Glassbrook for her leadership in chairing the SIAB over the last few years. And may I thank all partners on this board, including colleagues from the VCSE, from NHS GM, NCA, Pennine Care, and Council Childrens and Adults Services for their remarkable contribution.

3. NHS Place Team Hosting

At the last two Locality Board there has been a discussion about potential next steps in proposing a future employer from currently NHS GM staff in place teams. It was recognised that in the context of emerging and consistent place partnership arrangements in all 10 localities in GM it was a strategic intent of NHS GM to transfer of employment where Place-based teams are hosted locally on behalf of the Place Partnership, while remaining focused on the shared outcomes of the partnership rather than any single organisation.

Place leads and NHS Trusts in GM have been written to by the Chief Executive of NHS GM requesting they work together to consider the following:

1. Whether there is an agreed NHS FT at Place that would be willing, in principle, to act as the

receiving employer for the NHS GM Place-based workforce on behalf of the partnership.

2. Whether that organisation has the organisational willingness and capacity to do so, taking account of HR, governance, financial and operational considerations.

3. Whether there is joint local support for this approach as part of the wider Place operating model and partnership arrangements.

NHS GM are asking Place Leads and NHS FT CEOs jointly to confirm their position in writing by 7th July.

I'd like to thank colleagues at NCA and Pennine Care for the consideration of this opportunity. Bury has been working with colleagues in Salford, Rochdale, and Oldham to consider the opportunity of a single position on the NCA footprint and I'm pleased to advise NCA have indicated a willingness to consider being the receiving employer for NHS GM staff on that footprint. Significant further due diligence work is required between NHS GM and NCA. Importantly, and in the context of the place partnership documentation presented at this meeting, hosting does not change the prioritisation or commitment of transformational endeavour across the breadth of the place partnership to the objectives of our locality plan – for example in relation to primary care, mental health services, intermediate care, and public health priorities.

4. Integrated Neighbourhood Team Working

The Locality Board is sighted on the significant progress made in developing integrated neighbourhood team working in each of the 5 neighbourhoods in the borough in accordance with the Locality Plan and the Borough Lets Do It Strategy. At the last meeting we shared the link for the video describing the work of our integrated neighbourhood teams and the video will be shown in this meeting.

A number of Bury partner organisations had the opportunity to attend a GM wide meeting with Dr Clare Fuller who is leading the delivery of the NHS England Neighbourhood Strategy to review progress. GM was recognised as being relatively further ahead in developing the model but there is more to be done. I understand some key themes to emerge were particularly in the areas of

- risk cohort identification and support
- strategic Commissioning intent to create the conditions for further neighbourhood working maturity,
- the extent to which we are consistently implementing the commitments around VCSE investment and collaboration as described in the 10 GM MOU
- the extent to which imminent further guidance on single and multi provider neighbourhood contracting models will add value or not to the relative maturity of working in GM

NHS GM convened a system leadership meeting on Monday 29th June to reflect on next steps and the outcome of the that session will be shared shortly. We will bring this to the locality board.

5. Live Well – Whitefield

The Locality Board will recognise the Live Well programme in Greater Manchester, intended to create the conditions for residents in all parts of the borough to be connected to the support, guidance and community assets to enable them to live well. In Bury the principles of live well - building integrated teams in places, recognising, celebrating and promoting and investing in community capacity, and appreciating the strengths of people and communities is core to our transformation ambitions in health and care and in wider public service reform. In this context I am very pleased to advise that our live well centre in Besses, in Whitefield, will be open in soft launch format from mid-July. The centre will be formally opened on Sunday 16th August from 12-3pm and members of the Locality Board are

welcome.

The centre is a converted disused pupil referral unit and has three elements:

- 1) A safe, welcoming, homely community space supported by a café and with provision for a range of voluntary and public services to bring provision to the centre, supported by navigator roles employed.
- 2) A space for hosting the INT and a range of childrens services connected to the family hub implementation in the area.
- 3) A large indoor sports and activity space.

Importantly our focus in Whitefield is not only on the Live Well Centre, and in VCFA have been co-ordinating the investment in a number of voluntary and community groups in the area.

Funding for the 2nd year of live well implementation has been made available, and the Bury Public Service Reform Group will develop proposals for the future focus of the work across the other 4 neighbourhoods.

I would like to thank Helen Tomlinson and Will Blandamer for the joint SRO leadership of the programme.

6. Uplands Medical Practice

I am delighted to advise that on Wednesday the Council planning committee provided planning permission for the conversion of the old Whitefield library site to become a replacement for the Uplands medical centre. Colleagues who have served in Bury for some time will recognise that addressing the very poor accommodation of the Uplands practice has been a priority for nearly 30 years and we are very pleased to get to this milestone. A date for contractors to start on site this year is awaited. I would like to place on record my thanks to all colleagues across NHS and Council, and the practice itself, for their hard work, with a particular thanks to Clare Postlethwaite in the NHS GM Bury team for her determination and expertise.

Lynne Ridsdale
Place Lead NHS GM (Bury)
Chief Executive Bury Council
3/7/26



Hi, I'm Tori!

Midwife, Mother & Founder of MotherZen!

Mother Zen creates a safe, welcoming community hub where parents can meet, form friendships, and reduce isolation. This directly supports the Let's Do It ambition to build connected, resilient communities where residents feel a sense of belonging and mutual support.



The Why...

Is there anyone for me here?
or is it all about the baby?

In 2022, I had my first baby in a new town, 200 miles away from my family & friends. I was lonely & isolated.

A one hour baby rhyme time at the local library wasn't sufficient for my needs as a new mother. Once we'd flown the parachute, blew bubbles it was time to go home again.

I'd sat in a room full of other mothers and our birth trauma, mental wellbeing and need for real connection was drowned out by the tune of nursery rhymes.





Community Consultaion

"Breastfeeding support, open space for mums to connect. Spaces you can relax & not worry about toddlers causing chaos"

"General support for mums, more focus on mums making friends, not just classes for babies"

"Having a safe space where you can let off steam – whether that be coffee, cake, exercise, meditation, and having somebody on hand to ease the pressure we feel as new mums – would have really helped me when my children were younger"

88.5% of respondents would choose Mother Zen over a more traditional offering.



Our current community offerings

MotherZen currently delivers 6 no – low cost community sessions per week:

- A community living room & play space which served as a warm space last winter
- Maternal wellbeing journalling & peer support sessions
- Birth preparation and education
- Breastfeeding Support group
- Sling Library & Baby bank
- Signposting and connecting to local voluntary and community organisations.



Nurturing parents,
building community
MotherZen

Brownies
£3.20

Millions
Shoreb
£3.20

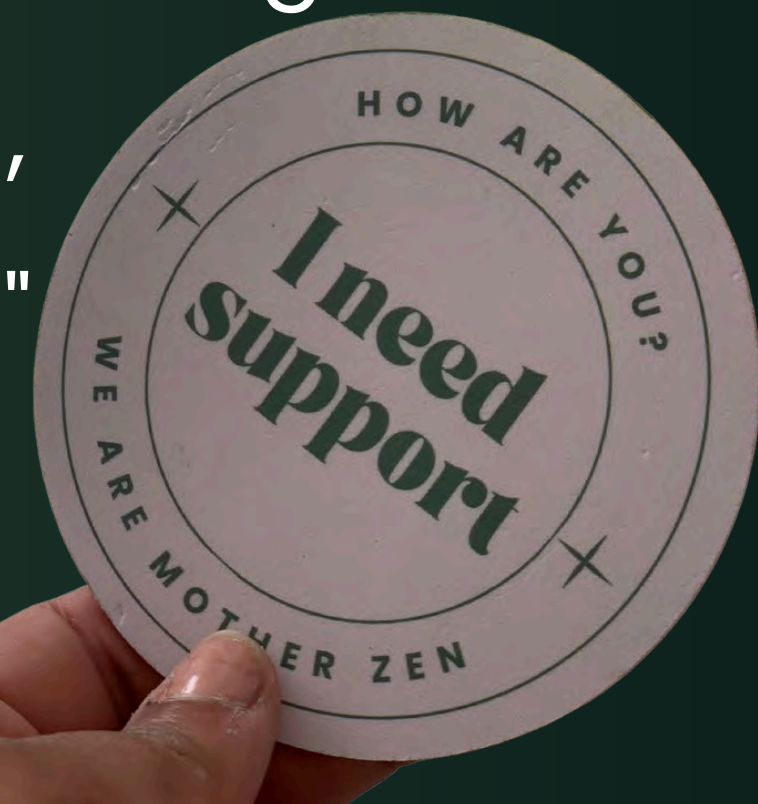
Jammy Dodger
Blondie
£3.20

Community days at our Play Cafe are a haven for local parents,
and have been accessed by 1700 families!



Testimonial

"Honestly, MZ feels like a second home for us. It's been the perfect place for my girl to build confidence before starting nursery. I'm so grateful for this place, for the amazing team, and for the community they've created. They've turned what could have been a lonely season of motherhood into something full of connection, laughter, and comfort. Thank you, MotherZen, for making such a difference in our lives"





What opportunities are there for Mother Zen to work with statutory partners to create a more connected, accessible, and preventative support system for families?

Together, we can create a more connected, accessible, and preventative support system for families across Bury.

Thank you for listening

Meeting: Locality Board			
Meeting Date	06 July 2026	Action	Receive
Item No.	7.1	Confidential	No
Title	SEND Inspection Update		
Presented By	Will Blandamer – Place Partnership Director, NHS GM Jeanette Richards – DCS Bury Council		
Clinical Lead	Dr Cathy Fines, Place Clinical Director, NHS GM		

Executive Summary
Between 9 March 2026 and 11 March 2026, Ofsted and the Care Quality Commission (CQC) revisited Bury, to decide whether effective action has been made in relation to each of the areas for priority action detailed in the inspection report published on 7 May 2024. The inspection was conducted under section 20 of the Children Act 2004. A copy of the SEND Monitoring inspection letter is enclosed which sets out the key findings.
Recommendations
The Locality Board is asked to note the update.

Links to Locality Plan priorities	
Scale our work on Population Health Management - Improve population health and reduce health inequality of those in the most disadvantaged areas.	☒
Drive prevention, reducing prevalence and proactive care – supporting Demand Reduction through primary intervention, secondary preventions and tertiary prevention.	☒
Transforming Community Care in Neighbourhoods - fully realising the benefit of neighbourhood team working with a focus on the assets of residents and communities and providing proactive care.	☒
Optimise Care in institutional settings and prioritising the key characteristics of reform.	☒

Implications						
Are the risks already included on the Locality Risk Register?	Yes	☐	No	☐	N/A	☒
Are there any risks of 15 and above that need to be considered for escalation via an NHS GM Statutory Committee or Board in line with the Risk Escalation process ?	Yes	☐	No	☐	N/A	☒
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☐	N/A	☒
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☐	N/A	☒
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☐	N/A	☒

Implications						
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☐	N/A	☒
Are there any financial Implications?	Yes	☐	No	☐	N/A	☒
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☒
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☒

Governance and Reporting		
Meeting	Date	Outcome
N/A		

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12 May 2026

Jeanette Richards, Executive Director of Children's Services, Bury Metropolitan Borough Council
Colin Scales, Acting Chief Executive, NHS Greater Manchester Integrated Care Board

Area SEND monitoring inspection to Bury Local Area Partnership

Between 9 March 2026 and 11 March 2026, Ofsted and the Care Quality Commission (CQC) revisited Bury, to decide whether effective action has been made in relation to each of the areas for priority action detailed in the inspection report published on 7 May 2024. The inspection was conducted under section 20 of the Children Act 2004.

I write on behalf of His Majesty's Chief Inspector (HMCI) of Education, Children's Services and Skills and the Chief Inspector of Primary Medical Services and the Chief Inspector of Primary Care and Community Services of CQC.

As a result of the findings of the initial inspection and in accordance with the Children Act 2004 (Joint Area Reviews) Regulations 2015, HMCI required the local area partnership to prepare and submit a priority action plan (area SEND) to address the six identified areas for priority action.

The local area partnership has taken effective action to address six of the areas for priority action identified at the initial inspection. This letter outlines our findings from the monitoring inspection.

The inspection was led by one of His Majesty's Inspectors (HMI) from Ofsted, accompanied by an HMI from social care, and a Children's Services Inspector from CQC.

During the inspection, we spoke to local area leaders, parents and carers of children and young people with special educational needs and/or disabilities (SEND), and education, health and social care professionals. We also met with representatives of the parent carer forum (PCF), the Department for Education (DfE) and regional NHS England. We examined relevant documents and correspondence about the performance of the area in addressing the areas for priority action identified at the initial inspection, including the area's priority action plan and self-evaluation.

Findings

Area for priority action 1:

Leaders across the partnership should ensure that the SEND strategy continues to be implemented to improve the lived experiences of children and young people with SEND. This should be overseen by shared strategic governance to ensure that the pace of improvement is maintained.

Outcome: Effective action

Since the previous inspection, the partnership has implemented a range of appropriate actions to improve local services for children and young people with SEND across education, health and social care. Shared strategic governance is stronger, with independent oversight. Performance data is used well to inform and respond proactively to local area priorities. Co-production (a way of working where children, families and those that provide the services work together to create a decision or a service that works for them all) are more effective. For example, a broad range of stakeholders is now involved in strategic decision-making.

Leaders' actions have improved professionals' confidence in the partnership's work to support children and young people with SEND. Systems of support are more self-sustaining and have been shaped by lessons learned from the previous inspection. The co-produced SEND strategy addresses the areas for priority action and progress is checked monthly by the independently chaired SEND Improvement and Assurance Board (SIAB). Leaders' regular reporting to the SIAB helps to maintain effective strategic oversight. Key partners, including the 'Bury2Gether' PCF, contribute to this work effectively.

The PCF provides meaningful support, and challenge, to leaders across education, health and social care. In addition, the PCF contributes to local area decision-making through the SIAB. This strengthened governance has enabled investment in services and staffing. For example, the partnership has expanded educational psychology capacity. However, relationships and communication between the partnership and PCF need further strengthening. Parents and carers do not sufficiently understand the changes taking place in local services. In addition, the PCF experience of co-production is inconsistent. Leaders recognise this and acknowledge that clearer communication and strengthened partnership working are needed.

The partnership has taken reasonable and, in some instances, rapid action to address priority action areas. Leaders understand that there is much work to do. They have identified correctly where further improvement and strengthening of practice is needed. They rightly acknowledge that local area improvements are not experienced equally by children, young people and their families. For example,

primary schools are supported by link speech and language therapy (SALT) therapists. However, secondary schools' access to SALT support is less comprehensive.

Area for priority action 2:

Leaders across the partnership should work collaboratively and effectively to improve the early identification of children and young people's SEND as part of the graduated approach. In particular, they should urgently improve:

- children's access to support from education, health and social care to improve the early identification of needs
- children, young people's and professionals' access to an effective, well-resourced educational psychology service.

Outcome: Effective action

The partnership has prioritised the earlier identification of children and young people's needs. For example, the educational psychology service has been significantly re-designed and expanded. This is providing increased capacity to assess children and young people's needs, and to provide guidance to professionals. In addition, the development of well-understood ways of working together have strengthened multi-agency support in the local area. Practitioners now work in an improved locality model, and these provide an effective role in the early identification of needs by signposting to services for families as part of the graduated approach.

Increased staffing capacity across some services has further supported improvements in the early identification and support available for children and young people with SEND. For example, SALT waiting times for initial assessments have significantly reduced, although long waiting times remain for further intervention, when required. Similarly, the newly established SEND health visiting team has increased capacity for the earlier identification and specialist support for babies and young children with emerging SEND.

The use of evidence-based screening tools is now embedded in universal health visiting practice. This provides improved opportunities for the early identification of speech, language and social communication needs and alerts practitioners to the emerging signs of autism in young children effectively. In addition, babies and young children receive increasingly timely mandated health reviews, through the Healthy Child Programme.

A greater range of multi-agency services coordinate appropriate support for families such as through early help and team around the family meetings. This ensures early help workers provide targeted support and intervention to children, young people and their families. Furthermore, to strengthen help available in education settings,

the partnership has increased the mental health support available to children and young people in schools. More widely, local neighbourhood hubs provide universal, targeted and specialist support to children, young people and their families within accessible community settings. For example, outreach support is delivered in mosques and synagogues. This helps to engage a range of communities in Bury.

School referrals for health support, such as emerging needs relating to neurodiversity, are sometimes closed without notification, frustrating professionals and families. In addition, long waiting times for some services, such as attention deficit hyperactivity disorder (ADHD) or autism assessment, leave professionals and families unsure about next steps and wider available support. Often, special schools, independent special schools and alternative provision (AP) require more specialist support than the tiered support model available to mainstream schools. The support available is limited by specialist expertise, for example educational psychology specialisms, leading many of these schools to commission their own specialist services.

Area for priority action 3:

Leaders across the partnership should improve the quality and availability of support for children, young people and their families while they wait for specialist assessments. This includes:

- children and young people waiting for a speech and language therapy assessment and subsequent intervention
- children waiting for a community paediatric assessment and subsequent intervention
- children and young people on a neurodevelopmental pathway for an assessment of attention deficit hyperactivity disorder (ADHD) or autism.

Leaders across the partnership should also ensure that young people aged up to 25 years old have access to a locally agreed neurodevelopmental diagnostic pathway.

Outcome: Effective action

The partnership has implemented a range of appropriate 'support while waiting' health-led services. These have improved access to help for many children, young people and families. These services provide useful support to reduce the risk of needs escalating while waiting for specialist assessment and/or intervention. Parent-focused programmes, such as specialist family intervention from the SEND health visitor team, and the newly developed 'Neurodiversity Hub' offer individual and group needs-led support to families.

The partnership acknowledges that children and young people in Bury continue to experience lengthy waits for an ADHD and/or autism assessment. In contrast, adult ADHD and autism diagnostic pathways are now fully commissioned. These pathways

provide timely assessments for young people with SEND aged 18–25 years old. Similarly, child and adolescent mental health services are fully commissioned for young people aged up to 18 years old across diagnostic pathways. There are clear and structured transition pathways in place between child and adult mental health services for children and young people as they grow older.

The SEND health visiting team provides enhanced specialist support for babies and children with additional needs. For example, some families with infants and young children, with emerging needs relating to neurodiversity, are offered a 10-week intensive programme of one-to-one support. This uses innovative parent-child video recordings for families to learn strategies to improve interaction and communication.

All referrals to the community paediatric service are triaged. Babies, children and young people who have complex health needs, such as neurological conditions are prioritised. Strong multi-disciplinary team working, and effective information sharing, ensure coordinated support for these children and young people. However, children and young people with needs relating to neurodiversity face longer waits to see a community paediatrician. As a result, some families feel unsupported during this waiting period. Children and young people with deteriorating health, or those where there are significant safeguarding concerns can be prioritised if their needs change, once on the waiting list.

The partnership is working effectively to upskill the broader children's workforce. Professional learning enables earlier identification and improves support for communication needs. This reduces reliance on specialist intervention. In addition, the partnership ensures that families receive support for their child's speech, language and communication development. For example, 'Chat and Play' groups in family hubs, SALT drop-ins and digital offers provide effective early advice and guidance. Primary schools appreciate improved support from allocated link SALT therapists. In addition, SALT therapists now work closely with early years settings, family hubs and education professionals to provide early advice and guidance.

Area for priority action 4:

Leaders across the partnership should improve preparation for adulthood from the earliest ages for all children and young people with SEND in Bury. This should include a well-understood and co-produced strategy to embed preparation for adulthood effectively across the partnership.

Outcome: Effective action

The partnership now ensures children and young people, aged 16 years old, are more effectively supported through a transition pathway to prepare them for adulthood. The transition pathway is underpinned by a co-produced 'Preparing for

Adulthood Standard Operating Procedure' and preparation for adulthood strongly features in the partnership SEND strategy. This improvement work has been supported by professional networking events and redesigned transition processes. Transition planning now starts earlier.

Preparation for adulthood features more strongly in new EHC plans and annual reviews. This typically begins from Year 9 and the partnership annual review documentation places increased expectations that this will be discussed by professionals. For example, educational psychology advice and EHC plan outcomes are increasingly aligned with preparation for adulthood themes and EHC plan case workers are trained to embed preparation for adulthood more consistently in EHC plans. However, the quality of some information remains variable, particularly in older EHC plans. In addition, preparation for adulthood is not reflected consistently well in EHC plans for those children and young people aged under 14.

The partnership's use of data tracking systems has improved. These ensure better oversight of children and young people who are at different stages of preparation for adulthood. Strengthened systems include identifying children moving into post-16 provision, those transitioning from children's social care into adult services and those known to the multi-agency complex case panel.

Young people with complex health or learning needs experience improved transition support to adult health services. In addition, SALT therapists work with young people aged up to 19 years old in college to support their transition to adult learning disability and therapy services. However, the partnership acknowledges that there is limited specialist provision in Bury for young people aged over 19 years old. The transition pathway enables families and professionals to refer children and young people to the preparation for adulthood team. These referrals help multi-agency professionals identify which children and young people, who do not receive social care intervention, may need support in the future.

Leaders recognise that capacity challenges in the preparation for adulthood team mean children and young people with the most complex needs are prioritised for earlier support, and those assessed to have less urgent needs receive reduced support. More work is needed to understand the impact of this on children, young people and their families. To mitigate capacity challenges, the partnership is increasing capacity in the preparation for adulthood team. Embedded practice includes social workers and the preparation for adulthood team jointly visiting families known to social care at the earliest opportunity. This helps professionals to understand children and young people's needs and plan support.

The Bury careers service provides well-regarded careers and next steps guidance for children and young people from Year 9 onwards. The partnership has enabled the careers service to strengthen its support since the previous inspection. This includes

advisors visiting families at home, running support hubs and ensuring children, young people and parents' views are better reflected in EHC plan annual reviews.

Area for priority action 5:

Leaders across the partnership should establish and implement a strategic approach to high-quality transitions for children and young people with SEND from birth to 25.

Outcome: Effective action

The partnership continues to develop, and embed, a strategic approach to transitions through the graduated approach for children and young people with SEND. They have implemented multi-agency oversight at key transition points. As a result, some children and young people experience more coordinated and consistent transition planning across services.

Schools report earlier information sharing at transition points, with improvements in communication between phases. For example, before the early years to primary transition, professionals attend face-to-face and virtual information sharing events. Groups of providers and professionals offer a range of local support for children and young people. This includes staff training from educational psychologists to help schools better prepare to meet children and young people's needs when they transition between phases of education. However, for placements in AP, transition information is frequently incomplete, particularly for children and young people with outdated EHC plans.

Health services have developed robust transition policies and processes to ensure clinicians provide enhanced advice and support for children and young people during unsettling transition periods. This includes some young people with SEND being supported by multi-disciplinary hubs during adult health transitions. However, this strengthened multi-disciplinary transition work is not equally experienced by children and young people with SEND and their families.

The partnership has developed a school transition guide for parents and carers. In addition, the partnership prioritises reviewing EHC plans for children and young people at important school transition points more effectively. New transition arrangements promote more joined-up planning across services, including when preparing for adulthood.

The partnership is focusing on expanding post-16 transition pathways, with more early support. Furthermore, the partnership has identified that the sufficiency of school places for children and young people with SEND, particularly for specialist provision, needs improvement. A SEND sufficiency strategy is being developed but is not yet published.

Area for priority action 6:

Leaders across the partnership should further improve the quality of the statutory EHC plan process. This should include:

- improving the quality of advice received from professionals as part of the needs assessment process
- improving the timeliness and quality of updated EHC plans following annual reviews
- improving appropriate social care contributions to EHC plans so that children and young people's social care needs are reflected more accurately
- improving the focus on preparation for adulthood in children and young people's EHC plans so that their experiences and outcomes improve.

Outcome: Effective action

The quality of children and young people's EHC plans has notably improved. The partnership has implemented better systems and processes to strengthen their overall quality. For example, comprehensive EHC plan templates, with detailed guidance documentation, ensure EHC plans are both compliant and more accurately reflect the needs of children and young people. In addition, new systems to share learning from multi-agency EHC plan audits help to improve the overall quality.

Newer EHC plans include children and young people's voices more clearly and explain their lived experiences more effectively. The partnership has increased EHC plan case worker staffing and implemented more effective processes, such as a tiered quality assurance framework, to improve the quality of EHC plans. Schools acknowledge more responsive EHC plan case work and better communication with the partnership. In addition, stronger management information systems and consistent educational psychology advice contribute to improvements in overall EHC plan quality and accuracy.

Although the backlog of EHC plan annual reviews is reducing, the process remains slow and does not reliably lead to accurately updated plans. A large but steadily decreasing number of existing EHC plans still need updating. This includes EHC plans where an annual review has already taken place. To check progress, leaders monitor EHC plan completion through a detailed data scorecard. This is regularly scrutinised by the SIAB to help drive positive momentum.

The quality of social care advice about children and young people's needs is typically strong, however this information does not always transfer into children and young people's EHC plans when it should. In contrast, health advice is more fully and accurately represented. More generally, outdated information remains common in older EHC plans. Some information is vague and preparation for adulthood is of

inconsistent quality or missing. However, newer EHC plans typically have more complete preparation for adulthood information, usually beginning in Year 9.

Next steps

Inspectors will reach an effective action outcome if, having gathered and evaluated evidence, they find that the local area partnership has taken reasonable steps to address the area for priority action since the full inspection, based on the relevant evaluation criteria.

Effective action does not mean that the area for priority action is no longer a concern or that the local area can stop taking action to address it. Inspections are a point-in-time evaluation. Areas for priority action that receive an effective action outcome may still be identified as areas for priority action in future inspections. This can happen if the local area does not continue to take action and/or the action has not continued to have a positive impact on the experiences and outcomes for children and young people with SEND.

Ofsted and CQC ask the local area partnership to update their priority action plan (area SEND) as a result of this inspection.

I am copying this letter to DfE and regional NHS England.

Yours sincerely

David Mills

His Majesty's Inspector, Ofsted, Lead inspector

Julie Knight

His Majesty's Inspector, Ofsted

Gerry Bates

Children's Services Inspector, CQC

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Meeting: Locality Board			
Meeting Date	06 July 2026	Action	Consider
Item No.	8	Confidential	No
Title	Place Documentation update		
Presented By	Will Blandamer, Place Partnership Director - NHS GM (Bury)		
Author	Will Blandamer, Place Partnership Director - NHS GM (Bury)		
Clinical Lead	Dr Cathy Fines, Place Clinical Director - NHS GM (Bury)		

Executive Summary			
The Bury Locality Board has reviewed draft iterations of Place Health and Care Partnership (PHCP) document suite at its meetings in recent months. The latest version of the Place Health and Care Partnership (PHCP) document suite was discussed at the Executive Committee on the 10th June 2026 and is enclosed for Locality Board discussion/engagement. It was previously anticipated that final sign off of this documentation would be required in July 2026 however formal sign off will be required by partners in Places during October 2026 with the final date for submission of feedback by Friday 21st August 2026. The timeline for completing this work is summarised in the table below: - ☐			
Time period	What	Lead	Purpose
22nd July 2026- 21st August 2026	Period of engagement on the 'Final Draft'	PBLs , PP Directors (locally), Chief Officers, Programme Director (Pan-GM)	Ensure all partners are fully sighted, can influence the refinement of the document suite ready to sign off.
24th August- 25th Sept	Outcome report and finalisation	Sprint team; · Programme team · Lead DPLs	Collate all feedback into a single refined and finalised document suite ready for sign off.
Oct	Formal signatures	Place Leads and PP Directors	Formal sign up from all partners. (inc NHS GM as a partner in each place)
Nov	NHS GM IC Board (Public)	Charlotte Bailey	Confirmation to NHS GM ICB that all places have signed up and any amends constitution.

Recommendations	
The Locality Board are asked to: -	
(i)	Note the revised version of the Place Health and Care Partnership (PHCP) document suite
(ii)	Provide any feedback on this documentation to Mr Blandamer ahead of the 21 st August 2026 deadline.

OUTCOME REQUIRED (Please Indicate)	Approval ☐	Assurance ☐	Discussion ☒	Information ☐
APPROVAL ONLY; (please indicate) whether this is required from the pooled (S75) budget or non-pooled budget	Pooled Budget ☐	Non-Pooled Budget ☐		

Links to Locality Plan priorities	
Scale our work on Population Health Management - Improve population health and reduce health inequality of those in the most disadvantaged areas	☒
Drive prevention, reducing prevalence and proactive care – supporting Demand Reduction through primary intervention, secondary preventions and tertiary prevention	☒
Transforming Community Care in Neighbourhoods - fully realising the benefit of neighbourhood team working with a focus on the assets of residents and communities and providing proactive care	☒
Optimise Care in institutional settings and prioritising the key characteristics of reform.	☒

Implications						
Are the risks already included on the Locality Risk Register?	Yes	☐	No	☐	N/A	☒
Are there any risks of 15 and above that need to be considered for escalation via an NHS GM Statutory Committee or Board in line with the Risk Escalation process ?	Yes	☐	No	☐	N/A	☒
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☐	N/A	☒
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☐	N/A	☒
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☐	N/A	☒
Are there any conflicts of interest arising from the	Yes	☐	No	☐	N/A	☒

Implications						
proposal or decision being requested?						
Are there any financial Implications?	Yes	☐	No	☐	N/A	☒
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☒
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☐

Governance and Reporting		
Meeting	Date	Outcome
N/A		

Place Health and Care Partnerships Summary Slides

About This Document and Contents

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



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1

Page 3 Executive Summary and introduction: Summarises how PHCPs enable Greater Manchester to deliver NHS reform through prevention, neighbourhood care and system-wide collaboration.

2

Page 6 Describing how strategic commissioning and Place Health and Care Partnerships will work in future: How strategic commissioning and Place Partnerships will work together to set priorities, allocate resources and deliver shared outcomes in future.

3

Page 10 Introducing the Place Health and Care Partnerships Document Suite: Describes the relationship between the documents in the suite.

4

Page 13 Partnership Agreement: Sets out the shared intent and principles of mutual accountability for how Place partners work together.

5

Page 16 Place Outcomes Framework: What each PHCP is accountable for delivering and how progress will be measured through a shared outcomes framework

6

Page 20 Place Fund: Explains how place-based resources are brought together to support collective financial stewardship, aligned decision-making and a shift towards prevention and neighbourhood health

7

Page 24 Place Team: The role and purpose of place teams in supporting integration, delivery of outcomes and neighbourhood working within the GM operating model

8

Page 28 Place Governance: An options appraisal describing the relationship how NHS GM confers place fund and place team responsibilities to Place

9

Page 30 Appendix: lists the supporting documents and detailed materials that sit outside the main document and are referenced throughout the suite

Executive Summary and Introduction

Foreword

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

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

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

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

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

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

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

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

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

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



Greater Manchester



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



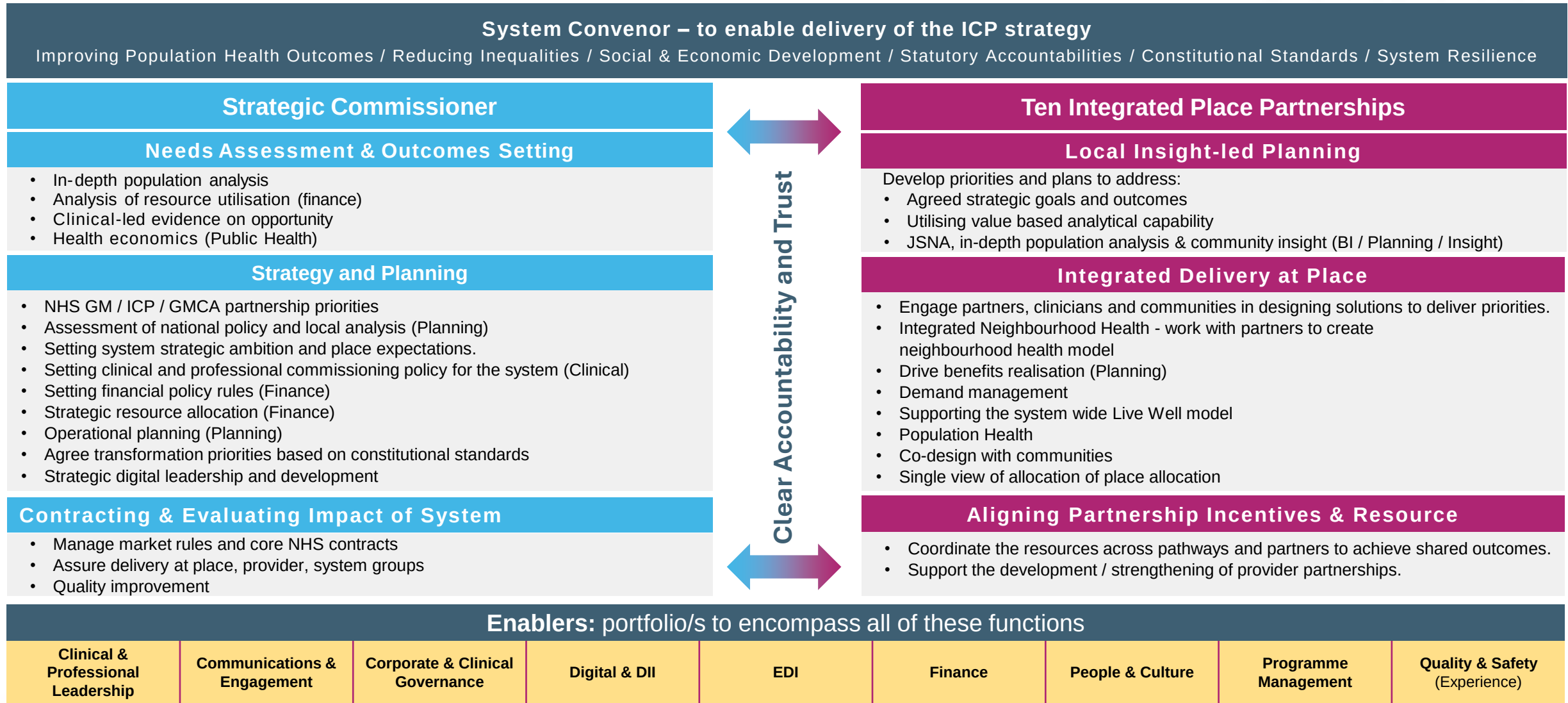
Professor Colin Scales
Acting Chief Executive
NHS Greater Manchester

Describing how strategic commissioning and PHCPs will work in future

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



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

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

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



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



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

Introducing the PHCP Document Suite

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



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Partnership Agreement

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

Place Fund

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

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

Outcomes Framework

Articulates what the PHCPs are uniquely accountable for delivering.

Describes interdependencies with other partners and strategies.

Place Team

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

Sets out how multi-partner teams work together to deliver

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

Place Governance Options Appraisal

Is a working document currently being finalised.

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

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

Logic Model - Place Delivery



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Partnership Agreement

Partnership Agreement



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



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



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



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



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



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

Partnership Agreement: Structure by section

1

Purpose, Parties and agreement status

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

2

Commencement and Term

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

3

Shared Vision, Purpose and Strategic Context

Sets a shared vision and purpose for Place, aligning local priorities with Greater Manchester's wider health and care ambitions.

4

Strategic Priorities and Outcomes Framework

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

5

System Characteristics, Leadership and Culture

Describes the leadership behaviours, culture and ways of working that enable Partners to act as one system while remaining sovereign organisations.

6

Roles, Responsibilities and Collective Capability

Clarifies shared and individual responsibilities and explains how Partners will combine resources, skills and capacity to deliver outcomes effectively.

7

Place Funding

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

8

Governance and Decision Making

Sets out the governance structure, decision making principles and accountability arrangements for Place Partnerships.

9

Transparency, Information and Learning

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

10

Clinical Strategy

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

11

Problem Resolution and Escalation

Provides a clear, proportionate process for resolving disagreements and escalating issues while protecting relationships and continuity of services.

12

Review, Variation and Evolution

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

Place Outcomes Framework

Place Outcomes Framework



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



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



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



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

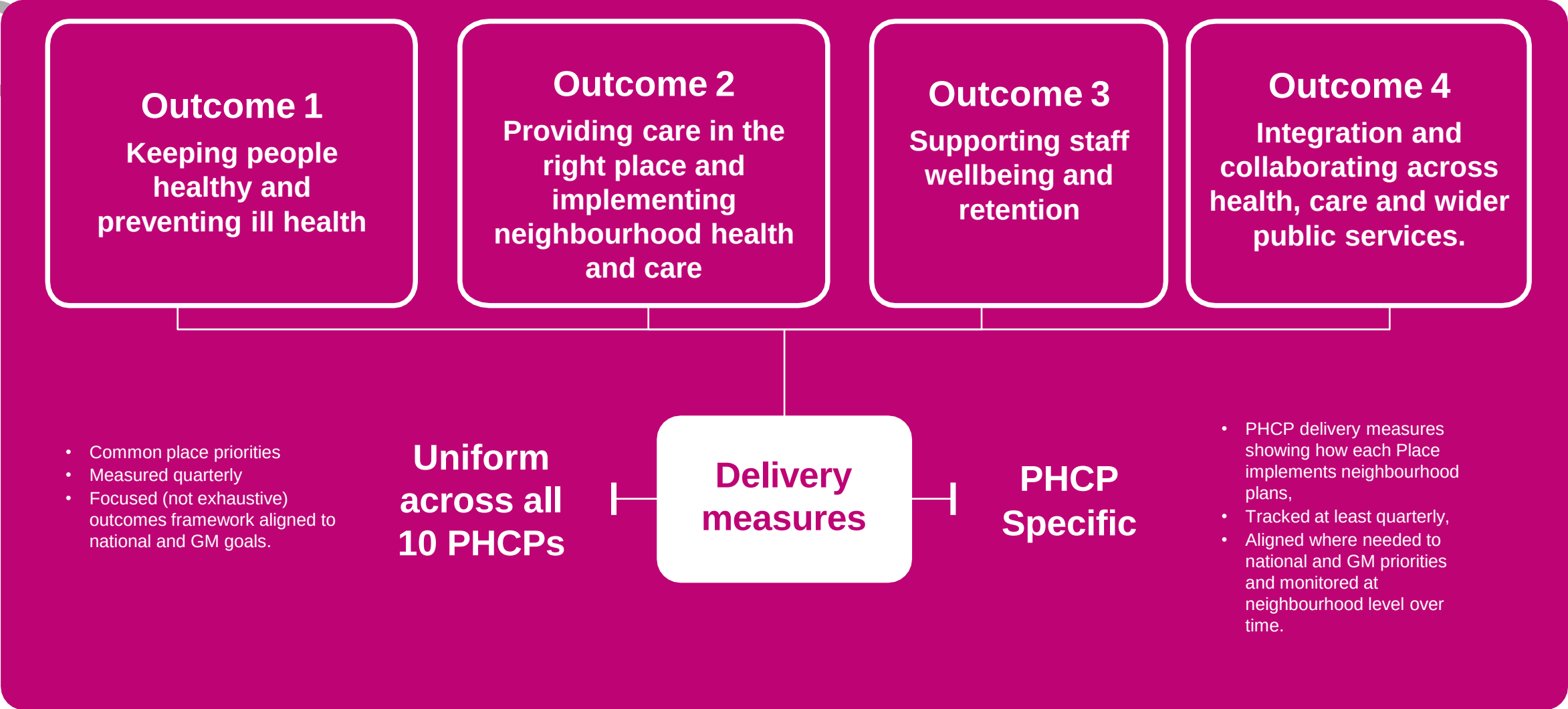


Focuses on **impact rather than activity**, with transparent tracking of progress

Place Outcomes Framework – Linking delivery measures to outcomes



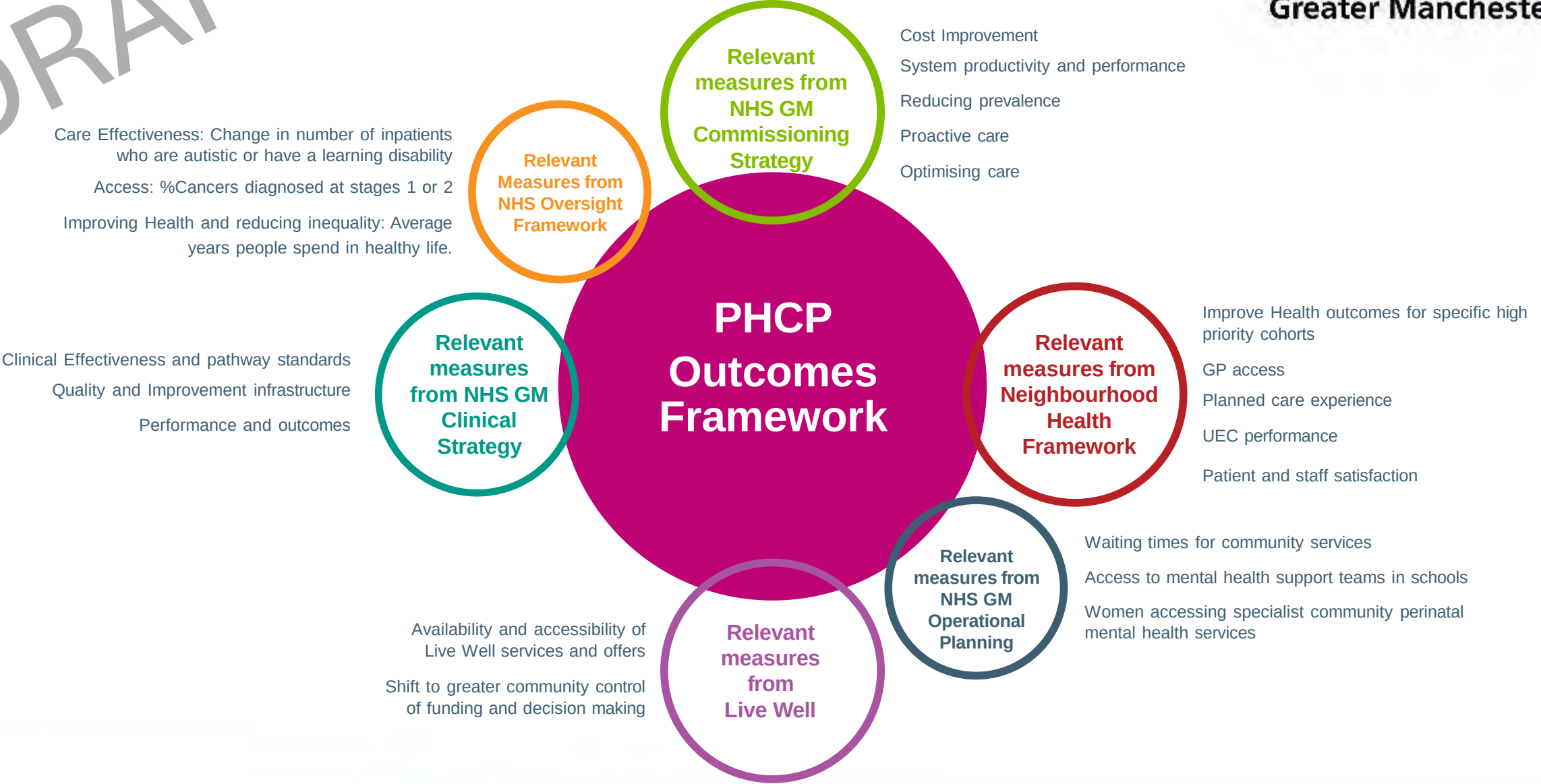
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Outcomes Framework composition



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Place Fund



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

What is included in the Place Fund?



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Core Place Fund

- Initial scope

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

Includes:

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

Wider Place Fund scope

- Aligned Place Level Expenditure

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

Includes:

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

Future alignment into the Place Fund

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

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

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

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

2026/27: Shadow Year for the Place Financial Framework

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

The ICB will continue to hold Place Fund budgets centrally

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

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

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

Commitment to Development in Year

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

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

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

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

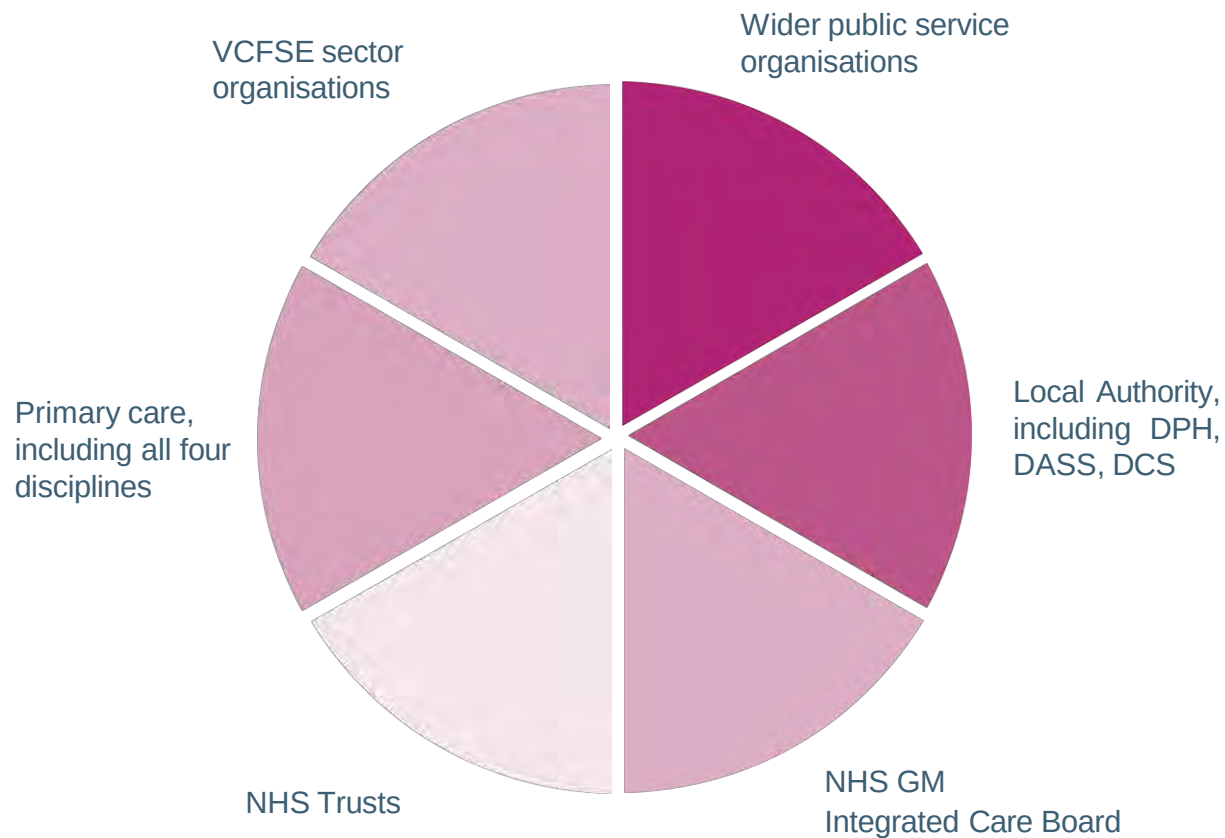
The place fund will launch in April 2027.

Place Team

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



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Creating success through:

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

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



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NHS GM contributes alongside all partners

1 Setting Strategic direction

2 Providing population health intelligence

3 Allocating resources

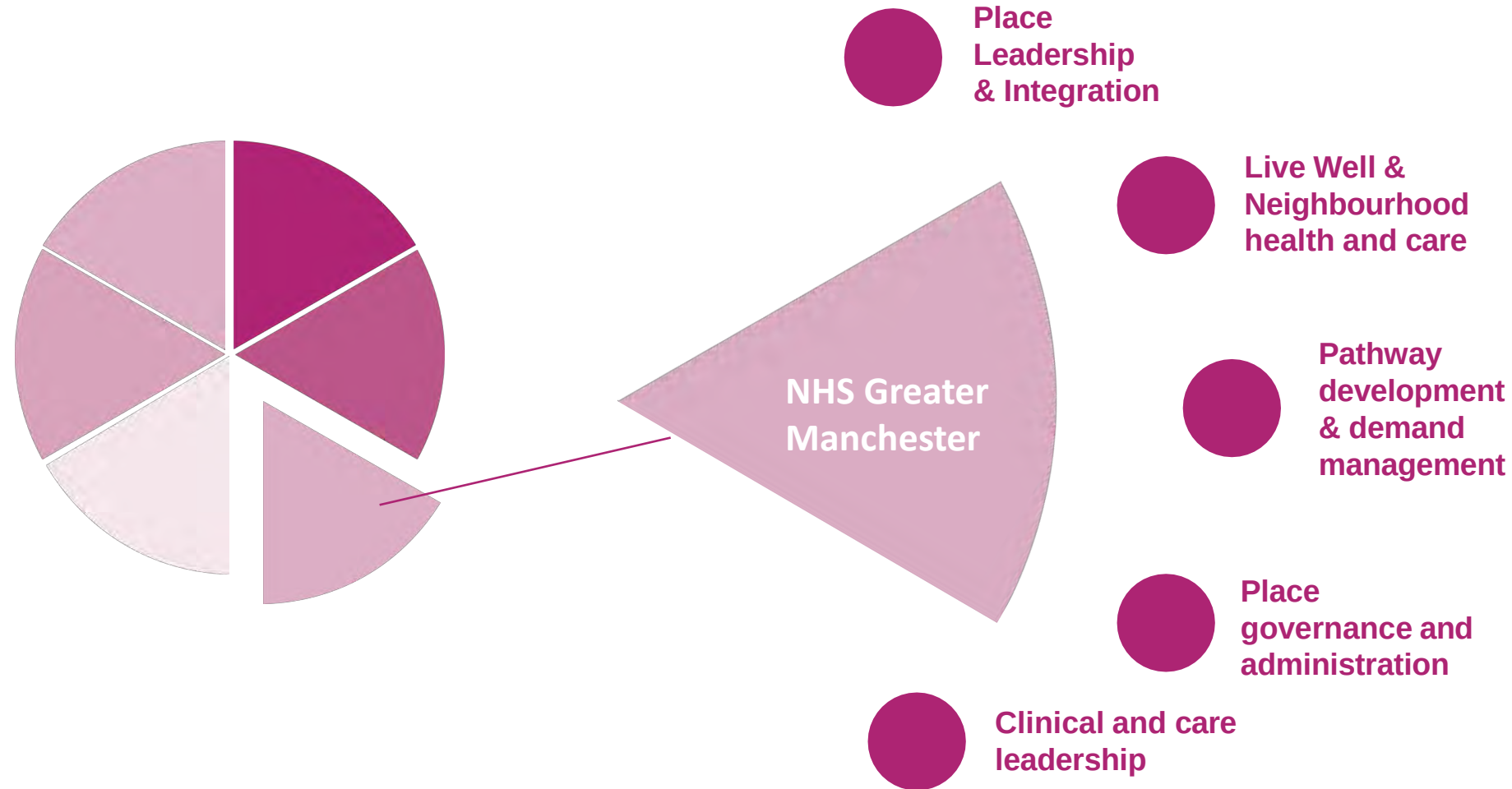
4 Enabling provider collaboration

5 Strengthening cross- sector partnerships

6 Leading system governance

7 Evaluating impact

Components of the NHS GM Model Place Team



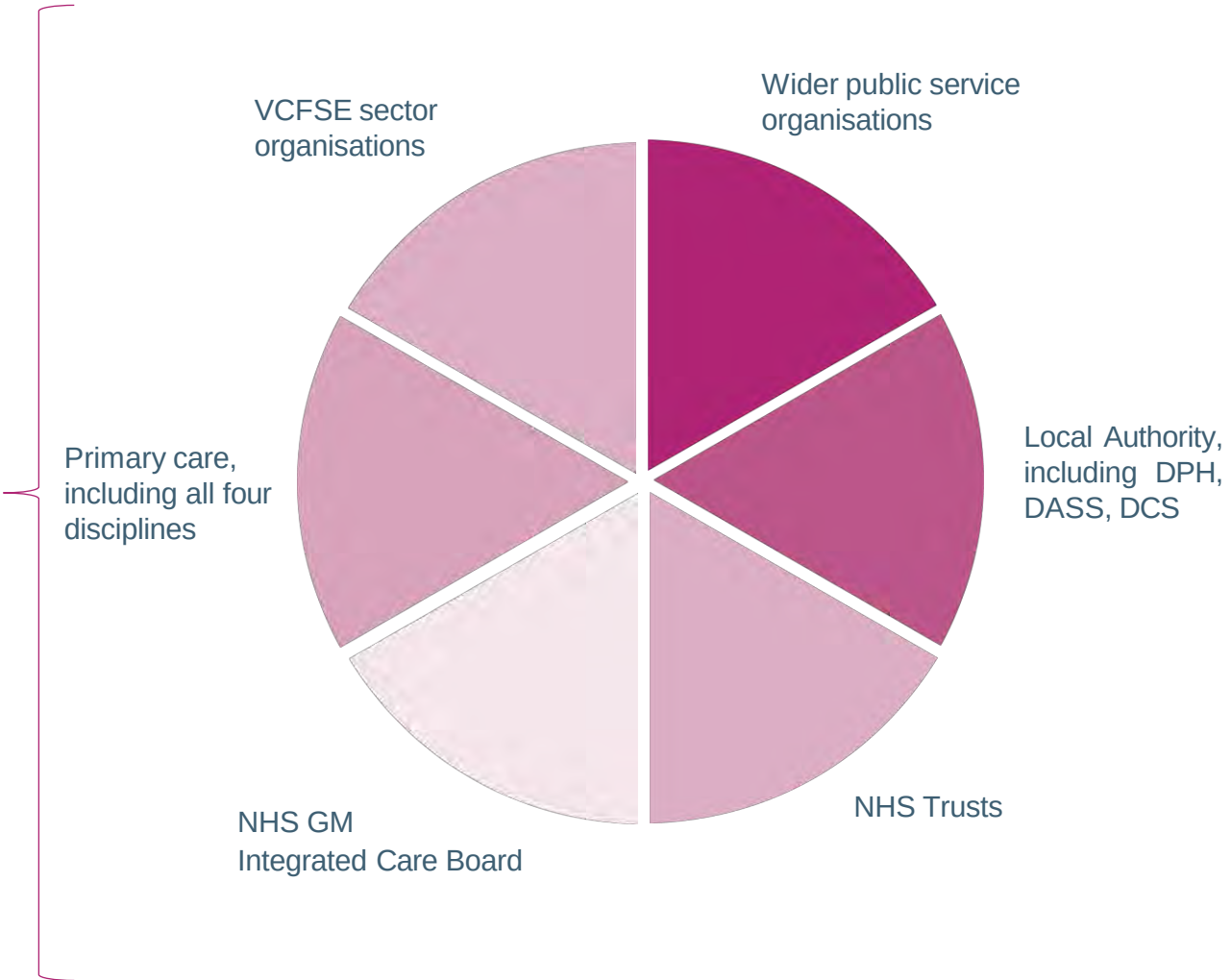
Setting up Place teams will be informed by context in each place rather than a one-size-fits-all.

A series of potential scenarios is featured below:



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



Governance

Place Governance Options Appraisal



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

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

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

Appendix

Engagement & Sign Off Plan



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



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

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

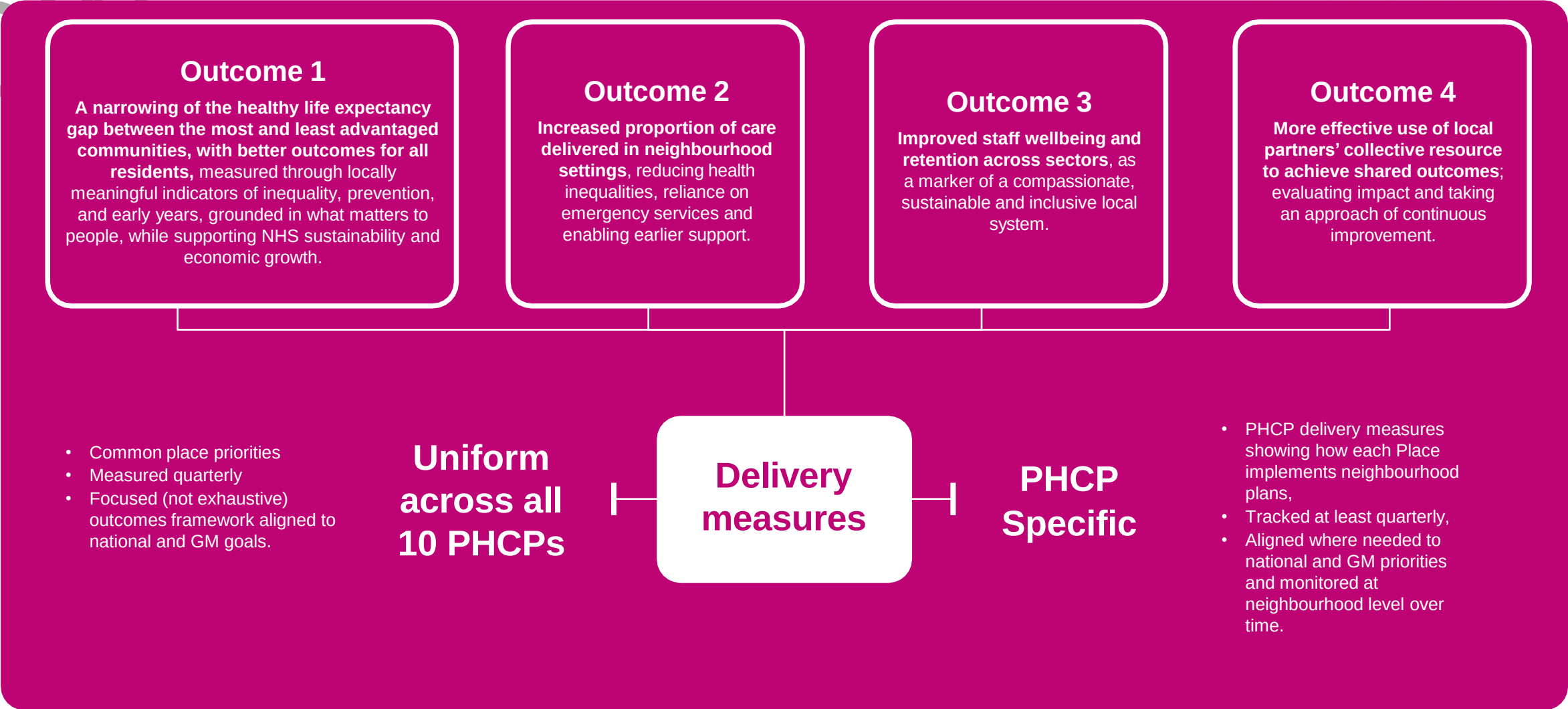
This table signifies which documents and frameworks are most relevant to each relationship.

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

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



Greater Manchester



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



Greater Manchester

Narrative Overview: Place Partnership Agreement

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

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



Definitions and Glossary

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

“Accountability”

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

“Agreement”

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

“Best for Place”

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

“Best for GM”

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

“Commissioning Organisation”

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

“Delivery Board”

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

“GM Operating Model”

**Greater Manchester**

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

“Greater Manchester (GM) Strategy”

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

“Integrated Neighbourhood Team (INT)”

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

“Local Care Organisation (LCO) / Provider Collaborative”

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

“Neighbourhood”

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

“Place Outcomes Framework”

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

“Partner” or “Partners”

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

“Partnership Board”

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

“Place”

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



Greater Manchester

“Place Funding Framework”

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

“Place Neighbourhood Plan(s)”

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

“Place Health and Care Partnership”

The Partners working together in accordance with this Agreement.

“Population Health Management”

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

“Reserved Matters”

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

“Responsibility”

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

“VCFSE”

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

Change Log

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


Greater Manchester

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



Greater Manchester

1. Purpose, Parties and Status of the Agreement

1.1 Context and Purpose

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

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

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

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

1.2 Parties

This Agreement is made between the following Partners:

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

1.3 Principles of Partnership

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

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

**Greater Manchester**

1.4 Status of the Agreement

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

1.5 Inclusion of New Parties

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

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

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

2. Commencement and Term

2.1 Context

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

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

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

2.2 Term

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

2.2 Early Termination

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



Greater Manchester

3. Shared Vision, Purpose and Strategic Context

3.1 Why this matters

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

3.2 Greater Manchester Strategic Context

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

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

It also supports the wider Greater Manchester Combined Authority vision:

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

3.3 Place Vision

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

3.4 Purpose of the Agreement

This Agreement exists to:

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

4. Strategic Priorities and Place Outcomes Framework

4.1 Context

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

4.2 Strategic Priorities

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

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

4.3 Place Outcomes Framework

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

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

4.4 How the Place Outcomes Framework will be used



Greater Manchester

The Place Outcomes Framework will:

- provide the mechanism through which Partners translate strategic priorities into coordinated delivery. It will guide how programmes are planned and sequenced, ensuring that activity across organisations is aligned to the outcomes we have collectively agreed.
- inform decisions about the deployment of resources, supporting Partners to target investment where it can have the greatest impact.
- underpin our shared approach to assurance and improvement, offering a consistent basis for monitoring progress, identifying variation, and supporting collective problem-solving.
- through clear and transparent reporting, strengthen accountability to residents and partners, demonstrating how Place activity is contributing to improved outcomes.
- ensure alignment with the wider Greater Manchester outcomes architecture, enabling coherence across the system while maintaining a strong focus on local priorities and context.

4.5 Place Outcomes Framework Principles

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

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



Greater Manchester

- providing one version of the truth via a balanced scorecard

4.5 Place Outcomes Framework Structure

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

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

Delivery Measures: Uniform across the 10 Locations

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

Delivery Measures: Place Specific

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

5. System Characteristics, Leadership and Culture

5.1 Context

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

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

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

5.2 Leadership Characteristics

Partners commit to leadership behaviours that:

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

5.3 Cultural Characteristics

Partners will foster a culture that:

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



Greater Manchester

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

5.4 The Place Team

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

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

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

5.5 Hosted and Ringfenced Roles

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

These roles may:

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

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



Greater Manchester

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

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

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

5.6 Application

These characteristics will be reflected in:

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

6. Roles, Responsibilities and Collective Capability

6.1 Context

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

6.2 Place Lead

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

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

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

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

6.3 Shared Responsibilities of All Partners

All Partners will:

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

6.4 Collective Resource and Capability Commitments

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



Greater Manchester

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

6.5 Operationalising Shared Capability

To make this real, Partners will:

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

6.6 Hosted, Assigned and Ringfenced Workforce Arrangements

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

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

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

**Greater Manchester**

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

In all cases:

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

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

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

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

6.7 Commitment to Continuous Development

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

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

6.8 Responsibilities Matrix

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

**Greater Manchester**

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

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

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

7. Place Funding

7.1 Context

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

7.2 The Place Funding Framework

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

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

7.3 Principles of Place Funding

The Place Funding Framework is underpinned by the following principles:

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

7.4 Application

The Place Funding Framework will be used to:

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

7.5 Decision making

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

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

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

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

8. Governance and Decision-Making

8.1 Context

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

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

8.2 Governance Structure

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

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

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

8.3 Health and Wellbeing Board

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

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

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

8.4 Decision-Making

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

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

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

8.5 Accountability

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

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

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



9. Transparency, Information and Learning

9.1 Context

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

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

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

9.2 Commitments

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

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

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

9.3 Safeguards and Responsibilities

Partners acknowledge that:

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

9.4 Commitment to System Learning

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

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

10. Clinical Strategy

10.1 Clinical Governance

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

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

Partners agree to work together to:

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

Clinical governance at Place will focus on:

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

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

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



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

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

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

10.2 Quality Oversight & Assurance

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

Place quality arrangements will be fully aligned with:

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

The PHCP will support quality by:

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

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

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

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



11. Problem Resolution and Escalation

11.1 Context

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

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

11.2 Principles

When managing disagreements, Partners will:

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

11.3 Place Approach

If a disagreement arises between Partners:

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



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

a. Independent Facilitator

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

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

b. Mediation

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

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

c. Exit, termination or non-resolution

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

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

- that the issue need not be resolved.

11.4 Commissioning Level Disputes

Where a Commissioning Organisation is both:

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

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

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

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

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

11.5 Commitment to Learning

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

12. Review, Variation and Evolution

12.1 Context

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

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

12.2 Commitments

Partners agree that:

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

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

12.3 Transparency and communication

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

14. Signatures

(Signature blocks adapted for each Place.)



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Schedule 1 - Place Outcomes Framework

Schedule 2 - Place Fund

Schedule 3 - Place Team Approach



Outcomes Framework: Narrative Introduction

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

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

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

Metric Ref	National framework/GM framework/ICB team	Metric Description	Rationale	Metric Type
		Reducing Inequality		
Live Well/EX1	Live Well	% residents who feel confident in knowing where to go in their local area to access support for everyday needs	Deliver equity of access	Annual Oversight
PH2	ICB Team	Reduce smoking rates for adults: a rate of less than 5% by 2030 compared to the 2023 level of 12.5%	Healthy life for longer (relative to England as a whole) and we will reduce the gap in healthy life between the richest and poorest communities	Annual Oversight
LW2	Live Well	Reduce the percentage of adults who are obese	Healthy life for longer (relative to England as a whole) and we will reduce the gap in healthy life between the richest and poorest communities	Annual Oversight
PH1	ICB Team	Reduction in gap between lowest and highest IMDs for age of onset of multiple long term conditions (currently 15yr gap in gm)	To address health inequalities	Annual Oversight
OV8	Strategic Commissioning Plan	To improve Healthy Life Expectancy (HLE) (male/female/all) in GM so that it at least matches the NW of England by 2030	To address health inequalities	Annual Oversight
OV9	Strategic Commissioning Plan	To reduce the gap in HLE between most and least advantaged areas in GM in line with a 10-year ambition to at least halve that gap by 2035 (10 Year Health Plan ambition)	To address health inequalities	Annual Oversight
		Children and Young People		
EX5.1	Live Well	% young people who, through #BeeWell schools survey, agree they have hope and feel optimistic about their future.	Improve health outcomes with specific focus on children and young people as a high-priority cohort	Annual Oversight
E.A.6	Op Plan	Expand coverage of mental health support teams (MHSTs) in schools and colleges (including teams in training)	Improve health outcomes with specific focus on children and young people as a high-priority cohort	Delivery Metric - consistent across place
BH15	Op Plan	Number of women accessing Specialist Community Perinatal Mental Health Services (12-month rolling metric)	Improve health outcomes with specific focus on children and young people as a high-priority cohort	Delivery Metric - consistent across place
Chi1	ICB Team	Reduction in dental extractions in children due to dental cavities	Improve health outcomes with specific focus on children and young people as a high-priority cohort	Annual Oversight
Chi2	ICB Team	Reduction in high/very high unmet need for children with asthma (beccor)	Improve health outcomes with specific focus on children and young people as a high-priority cohort	Annual Oversight
Chi3	ICB Team	Reduction in smoking in pregnancy rates	Improve health outcomes with specific focus on children and young people as a high-priority cohort	Annual Oversight
LW8	Early Years Foundation Stage	School readiness as measured by the proportion of children achieving a GLD	Improve health outcomes with specific focus on children and young people as a high-priority cohort	Annual Oversight
LW2	Live Well	Reduce the percentage of children who are obese	Healthy life for longer (relative to England as a whole) and we will reduce the gap in healthy life between the richest and poorest communities	Annual Oversight
Live Well/AD4	Live Well	(a) No. of children re-referred into children's social care within 12 months (b) No. of children stepped up from Early Help to Social Care*	A successful LW approach will strengthen and enrich existing approaches to early and targeted family help, providing early intervention for families experiencing challenges, helping children thrive within their own homes.	Delivery Metric - consistent across place
		Cancers		
OF009	NHSOF	Percentage of all cancers diagnosed that are diagnosed at stage 1 or 2	Improve health outcomes for people with cancer through early diagnosis and treatment	Delivery Metric - consistent across place
Can1	ICB Team	Cancer Screening rates	Improve health outcomes for people with cancer through early diagnosis and treatment	Delivery Metric - consistent across place
		Long Term Conditions		
LiveWell/AD2	Live Well	% patients with long-term conditions repeatedly not taking up offers of support who are then identified and helped ("Missedness" positively addressed)	Improve health outcomes for people long term conditions - Initial phases focused of cardio-vascular disease, diabetes and respiratory conditions. Scope for wider expansion to a range of other long-term conditions, e.g. dementia	Delivery Metric - consistent across place
OF054	NHSOF	Percentage of patients with GP recorded CVD who have their cholesterol levels managed to NICE guidance	Improve health outcomes for people with CVD through improved diagnosis and treatment	Delivery Metric - consistent across place
OF053	NHSOF	Percentage of hypertension patients treated to target	Improve health outcomes for people with hypertension through improved diagnosis and treatment	Delivery Metric - consistent across place
LD/SM1	ICB Team	Increasing the proportion of people with Learning Disabilities (aged 14 and over) who receive an annual health check and personalised care plan	Improve health outcomes for people with Learning Disabilities through improved access to annual health checks and personalised care plans	Delivery Metric - consistent across place
SM1	ICB Team	Increasing the proportion of people with SMI (aged 18 and over) who receive an annual health check and personalised care plan	Improve health outcomes for people with SMI through improved access to annual health checks and personalised care plans	Delivery Metric - consistent across place
		Imms		
Imms2	ICB Team	Childhood vaccinations	Improve health outcomes with specific focus on children and young people as a high-priority cohort	Delivery Metric - consistent across place
Imms3	ICB Team	Winter illness vaccination rates	Improve health outcomes by prioritising individuals who benefit from vaccination as a key cohort	Delivery Metric - consistent across place

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

Metric Ref	National framework/GM framework/ICB team	Metric Description	Rationale	Metric Type
		Access to General Practice		
Live Well/ EX4	Live Well	% residents who say it is easy to contact their GP practice (GP Patient Survey)	Improve access to general practice so people can see their GP in a timely, high-quality way	Delivery Metric - consistent across place
Nat8	National Neighbourhood Framework	90% of clinically urgent patients on the same day by March 2027	Improve access to general practice so people can see their GP in a timely, high-quality way	Delivery Metric - consistent across place
		Size		
QF00XX	NHSOF	Percentage of continuing health/care referrals completed in 28 days	Better co-ordination of care for high-priority cohorts	Delivery Metric - consistent across place
		Children and Young People		
Nat6	National Neighbourhood Framework	Reduce acute outpatient appointments for children under the age of 16 by 10%	Improve quality and access to care for children and young people by enhancing paediatric expertise across the pathway, including primary care	Delivery Metric - consistent across place
Nat7	National Neighbourhood Framework	Reduction of community waits for children, as part of delivering Medium Term Planning Framework success measures	Improve quality and access to care for children and young people by enhancing paediatric expertise across the pathway, including primary care	Delivery Metric - consistent across place
		Discharge		
Nat38/QF0025	National Neighbourhood Framework / NHSOF	For those adult patients not discharged on their DRD, the average (mean) number of days from the DRD to discharge	Ensure there is better co-ordination of discharge process and capacity planning across health and care services, enabling patients to be discharged efficiently and effectively. Contribute to an improvement in the average length of	Delivery Metric - consistent across place
Nat17	National Neighbourhood Framework	The proportion of adult patients discharged from acute hospitals on their discharge ready date (DRD)	Ensure there is better co-ordination of discharge process and capacity planning across health and care services, enabling patients to be discharged efficiently and effectively. Contribute to an improvement in the average length of	Delivery Metric - consistent across place
E.D.25	Op Plan	Increased utilisation of Pharmacy First, Hypertension Case Finding, Contraception services	Better access to community and reduce reliance on others services	Delivery Metric - consistent across place
QF1	Op Plan	Reduction of community waits for adults, as part of delivering Medium Term Planning Framework success measures	Better access in community	Delivery Metric - consistent across place
		Elective		
EL1	ICB Team	A&E: deliver a 10% increase in requests for Advice & Guidance over 25/26 baseline in 2026/27	Improve experiences of planned care and support delivery of the referral to treatment (RTT) standard	Delivery Metric - consistent across place
EL2	ICB Team	Community: work with elective programme and local trust to design and implement a local community / Tier 2 provision for ENT and Gynaecology specialties in 2026/27 (Suggested Change to expand scope and longevity. Work with Elective programme and Trust to implement community/Tier 2 provision through 2026/27)	Deliver more follow up outpatient care in neighbourhoods	Delivery Metric - consistent across place
EL5	ICB Team	Referral rates: reduce referrals by 5% across 15 specialties in 2026/27 vs 2025/26 baseline, in line with BeCoaR EQIS scheme	Improve experiences of planned care and support delivery of the referral to treatment (RTT) standard	Delivery Metric - consistent across place
Nat12	National Neighbourhood Framework	Follow-up appointments: work with local Trust to redesign outpatient model to support reduction in follow-up appointments by at least 10% by March 2027	Improve experiences of planned care and support delivery of the referral to treatment (RTT) standard	Delivery Metric - consistent across place
		End of Life		
Nat2	National Neighbourhood Framework	Better identify people coming to the end of life and improve access to services so people can die in a place of their choosing by increasing the number of people identified as approaching end of life by 30%	Better identify people coming to the end of life and improve access to services so people can die in a place of their choosing	Delivery Metric - consistent across place
Nat3	National Neighbourhood Framework	Reduce non-elective admissions and bed days of one day or over by 10% for the end of life cohort by March 2029	Better identify people coming to the end of life and improve access to services so people can die in a place of their choosing	Delivery Metric - consistent across place
		Harm		
PC4	ICB Team	Reduction in medicines related harm through neighbourhood approaches	Improve safety of care	Delivery Metric - consistent across place
		Long Term Conditions		
Nat4	National Neighbourhood Framework	Improvement of at least 10% in evidence-based clinical outcomes, measured through quality and outcomes framework standards for CVD, diabetes, COPD, mental health conditions and dementia	Better diagnosis and treatment for people with long-term conditions	Delivery Metric - consistent across place
PC3	ICB Team	Reduction in those with high/very high unmet need (CVD, Diabetes, Asthma, COPD) through neighbourhood approaches (BeCoaR)	Improve health outcomes for people with long-term conditions	Delivery Metric - consistent across place
QF0052 / Nat5	NHSOF / National	Percentage of diabetes patients to receive all eight care processes	Better diagnosis and treatment for people with long-term conditions	Delivery Metric - consistent across place
MH3	Op Plan	Reducing the number of admissions to inpatient settings and reducing length of stay for people with learning disability and/or autism	Improved provision and co-ordination of care people with mental illness. Ensure there is better co-ordination of discharge process and capacity planning across health and care services, enabling patients to be discharged efficiently	Delivery Metric - consistent across place
QF0034	NHSOF	Percentage change in the number of inpatients who are autistic or have a learning disability	Improving lives of those with LD and/or autism	Delivery Metric - consistent across place
EX.5.a and b	Op Plan	Reduce admission rates to mental health hospitals for people with a learning disability and autistic people	Improving lives of those with LD and/or autism	Delivery Metric - consistent across place
		Mental Health		
OV1	SCGCS/NHAG	Average LOS (physical and mental health) to be improved	Improved provision and co-ordination of care people with mental illness. Ensure there is better co-ordination of discharge process and capacity planning across health and care services, enabling patients to be discharged efficiently	Delivery Metric - consistent across place
MH2 Also Live Well/AD5	ICB Team	Reducing the number of people presenting to A&E in mental health crisis (all ages)	Improved provision and co-ordination of care people with mental illness. Ensure there is better co-ordination of discharge process and capacity planning across health and care services, enabling patients to be discharged efficiently	Delivery Metric - consistent across place
MH1	ICB Team	Reduction in CPD for adults, older adults and rehab patients in MH inpatient settings	Improved provision and co-ordination of care people with mental illness. Ensure there is better co-ordination of discharge process and capacity planning across health and care services, enabling patients to be discharged efficiently	Delivery Metric - consistent across place
		MED		
Nat16	National Neighbourhood Framework	Reduce category 3 and 4 ambulance conveyances in high-priority cohorts (those with mid to severe frailty, in a care home or housebound and end of life) by March 2029	Have fewer ambulance call-outs for the least urgent cases, with appropriate diversion to relevant urgent care provision in the community	Delivery Metric - consistent across place
Nat1	National Neighbourhood Framework	Reduce non-elective admissions and bed days of one day or over by 10% for people with mid to severe frailty, in a care home or housebound by March 2029	Help people with mid to severe frailty, in a care home or housebound, to stay healthier, manage escalating conditions and maintain greater independence for longer	Delivery Metric - consistent across place
Nat13	National Neighbourhood Framework	Keep growth flat and work towards an overall reduction in non-elective admissions for high priority cohorts	Better co-ordination of reactive care for high-priority cohorts (those with mid to severe frailty, in a care home or housebound and end of life), increasing use of urgent care provision in the community. For example, by making	Delivery Metric - consistent across place
Nat15	National Neighbourhood Framework	Contribute to an overall reduction in type 1 ED attendances for high priority cohorts	Better co-ordination of reactive care for high-priority cohorts (those with mid to severe frailty, in a care home or housebound and end of life), increasing use of urgent care provision in the community. For example, by making	Delivery Metric - consistent across place
		Live Well infrastructure		
Live Well/WOW1	Live Well	% of neighbourhoods in each locality with a Live Well access point (Centres and Spaces) % LW centres offering: I. Employment support pathway II. Housing support and advice III. Mental health & wellbeing support IV. Primary care V. Debt advice & income support*	The ambition through LW is for residents to be able to access support in their local area, with "priority offers" available through their local access points. The metric reflects the five proposed priority offers at the time of writing	GMIS Implementation monitoring

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

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

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

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

Place Fund

Place Fund: Narrative Overview

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

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

Background and Strategic Context

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

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

The Financial Opportunity

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

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

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



Greater Manchester

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

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

The Place Fund

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

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

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

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

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

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

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



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

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

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

Draft Finances

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

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

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

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

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

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

Shadow Year

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

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

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

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

Future Planning

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

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

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

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

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

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



Place Team Framework

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Place Team: Narrative Overview

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

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

Background and strategic context

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

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

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

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

The purpose of a Place Team

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

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

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

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

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

Core place capabilities

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

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

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

Skills and expertise across the partnership

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

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

Membership of the Place Team

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

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

Strong links are also required with:

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

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

How Place Teams operate

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

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

Place Health and Care Partnership leadership

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

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

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

NHS Greater Manchester's contribution as a partner at place

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

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

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

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

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

Approaches to Place Team configuration

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

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

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

Principles

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



Greater Manchester

Implementation and next steps

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

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



DRAFT – FOR COMMENT

Governance Options Appraisal: NHS GM to Place Partnership

Place Governance Options Appraisal: Narrative Overview

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

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

1. Introduction

- 1.1 The landscape is complex and changing with the introduction of the national Neighbourhood Framework. NHS GM is both a partner in each place 'delivery partnership' and a commissioner of outcomes (setting the outcomes framework). NHS GM is contributing resources to the partnership (staffing funding and delivery funding). The outcomes framework is WHY we are here (the impact and performance we want), the resourcing is HOW the partnership chooses to deliver the outcomes (the activity, interventions etc). In the new world of strategic commissioning, NHS GM sets outcomes (Impact), allocates resource, oversees governance, shares best practice - creating the conditions for local delivery.
- 1.2 The purpose of this paper is to outline the governance options for the NHS GM specified objectives/responsibilities/outcomes and support. The support comprises the two elements of NHS GM funded Place Fund and Place Team – both of which require the delivery of objectives/responsibilities/outcomes also. The purpose of this paper is not to cover the Place Partnership agreement between all partners within each of the 10 Place Partnership across GM. The focus is to be clear on preferred governance for the place fund, place team and outcomes.
- 1.3 This paper has been drafted with the intention of providing clarity on governance from NHS GM to Place, drawing together:
 - 1.3.1 Existing legal and governance mechanisms available to NHS GM and partners
 - 1.3.2 Greater Manchester's devolved history and operating model
 - 1.3.3 Feedback from system leaders
- 1.4 There is common understanding that the Place Partnership Agreement is focused on the delivery of outcomes. As such this is not considered further, as this alternative workstream covers that element. The Place Partnership Agreement pulls together all partners with the common aim of improving these outcomes through shared endeavour. These outcomes are set by NHS GM as the strategic commissioner, though they are set with strong engagement across all partners and are well supported outcomes that are in the interests of our population and our health and care system.
- 1.5 This options appraisal outlines the governance options to support the delivery of Place Partnership responsibilities set by and supported by NHS GM in relation to the place fund and place team, in partnership with others.



Greater Manchester

1.6 The options considered within this paper are:

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

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

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

2. Governance Options

Option 1. Internal delegation within NHS GM

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

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

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

Benefits

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

Risks

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



Greater Manchester

GM.

Option 2. Section 75 Agreement (NHS Act 2006)

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

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

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

Benefits

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



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

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

Risks

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

Option 3. Formal Contract (Legally Binding Service Contract)

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

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

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

Benefits

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

precisely defined.

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

Risks

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

Option 4: Memorandum of Understanding (MOU)

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

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

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

Benefits:



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

Risks:

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



3. Conclusions

- 3.1 Internal NHS GM governance is not considered a feasible option for Place Partnerships, as this approach does not embody the collaborative nature of this work across arrange of partners. It retains too much control within NHS GM in relation to funding and staff, and does not support the head count reduction required in relation to staff.
- 3.2 Using an informal or advisory route, such as an MoU, is not considered a feasible option either as it provides no enforceable basis for service delivery, accountability, or staff and funding arrangements. As with option 1, it retains too much control within NHS GM in relation to funding and staff, and does not support the head count reduction required in relation to staff.
- 3.3 A formal contract is a feasible option. It is the preferred option if the host is an NHS Trust. It offers strong enforceability and delivery assurance but is less suited to integrated place functions where joint working, shared staffing, and flexible delivery models are required. Where Local Care Organisations are already in place, this is a particularly attractive option and potentially in line with future strategic direction such as IHOs. Procurement exposure make it less agile or holistic than a Section 75 partnership model.
- 3.4 A Section 75 agreement is a feasible option. It is the preferred option if the host is the local authority. It provides a statutory basis for NHS and local authority integration, enabling shared governance, staff deployment and flexible multi-year collaboration. It aligns with BCF, and avoids triggering procurement under PSR for in-scope place activity and offers the flexibility required for Place Fund and Place Team hosting. It supports the long-term transformation goals, while de-risking both staffing and financial arrangements for NHS GM. This approach is tried and tested across integrated commissioning models and aligns with the collaborative vision of place within GM.
- 3.5 This appraisal concludes different preferred governance routes depending on host. Whilst it is not necessarily favoured by NHS GM to vary the governance route, if different hosts are permitted, this will be the preferred. Otherwise the only possible option for both NHS Trust and local authority hosts is the contractual route. This is likely however to result in VAT implications for local authority hosts, which pose both an unacceptable and unaffordable cost. The alternative if the same governance route was required, would be to insist that all Place Funds and Place Teams are hosted by the same organisation type, thereby not giving each place full chose in this matter. Indeed there is strength in one organisation type hosting the Place Team and another the Place Fund, as this provides – distributed leadership and helps glue partnership.

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

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

4. Outstanding risks / issues

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



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- 4.2 Clarification required with regard to *section 65Z5 delegation and 65Z6 joint exercise arrangements and also “conferral of discretions” powers* which whilst included in legislation, have been on hold as determined by NHSE. Should that change we will consider any benefits these may bring.
- 4.3 Clarity of timelines. It is currently understood that the earliest the governance would need to be in place for these arrangements would be 1 January 2027 for the place team and 1 April 2027 for the place fund.

5. **Recommendations**

- 5.1 The Place Outcomes will be set by NHS GM and governed through the Place Partnership Agreement.
- 5.2 The preferred host for the Place Fund is now understood to be the Local Authority. A Section 75 agreement is the preferred governance route for the Place Fund when hosted by a Local Authority.
- 5.4 The preferred host for the Place Team is now understood to be an NHS Trust. A contractual agreement is the preferred governance route for the Place Team when hosted by an NHS Trust.
- 5.5 Regardless of governance mechanism, it will be explicit that the host is required to manage the place fund and/or place team via the Place Partnership. As such the decision making in relation to the place fund and/or place team will not sit within the host organisation, but rather the Place Partnership.

Appendix 1 - Governance options scoring

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

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



Place Partnership Document Suite: Executive Overview Guide

Purpose of this guide

This guide provides an executive-level overview of the Place Partnership document suite. Collectively, the documents describe the operating model, governance, financial arrangements, delivery mechanisms and outcomes framework for Place Health and Care Partnerships across Greater Manchester.

The suite is intended to support senior leaders, partners and Place teams to understand how the model fits together, where accountability sits, and how shared priorities will be translated into measurable delivery.

1. PHCP Overview Summary Slides

Document purpose

A high-level presentation that introduces the Place Health and Care Partnership model and explains how the full document suite fits together.

Key content

- Provides an executive overview of Place Health and Care Partnerships and their role in supporting NHS reform.
- Explains how PHCPs support prevention, neighbourhood-based care and system-wide collaboration.
- Clarifies the relationship between the documents in the suite and how each component contributes to the overall model.
- Summarises the key components, including the Partnership Agreement, Outcomes Framework, Place Fund, Place Team and governance arrangements.
- Includes a logic model showing how governance, funding and team arrangements are expected to translate into improved outcomes.

Role in the suite

This is the entry-point document. It enables readers to understand the overall model quickly and provides a clear route into the more detailed documents.

2. Place Partnership Agreement

Document purpose

The core agreement setting out the shared commitments, expectations and operating principles for partners working together at Place.

Key content

- Sets out the shared intent, principles and ways of working for Place-based partnership delivery.
- Defines the role of Place Health and Care Partnerships, population health management, governance and decision-making processes.
- Establishes how partners will align resources and workforce, make collective decisions about priorities and funding, and retain statutory responsibilities while working collaboratively.

Role in the suite

This is the foundation document. It provides the formal basis for partnership working, accountability and sign-off at Place.

3. Outcomes Framework and Place Metrics

Document purpose

A detailed set of measures that supports the Outcomes Framework and enables consistent tracking of progress across Place Partnerships.

Key content

- Provides a comprehensive set of outcome measures and delivery metrics.
- Supports tracking of population health improvement, neighbourhood care delivery, integration and collaboration.
- Includes both standardised measures for consistency across all Places and Place-specific measures to reflect local priorities.

Role in the suite

This is the measurement framework. It defines how progress, impact and success will be tracked and evidenced across Place Partnerships.

4. Place Fund

Document purpose

A document describing the financial model that supports Place-based working and enables greater alignment of resources to shared priorities.

Key content

- Explains how funding will be aligned across organisations and used to support shared outcomes.
- Sets out the approach to collective financial stewardship, including investment in prevention and neighbourhood care.

- Describes the 2026/27 shadow year, during which budgets remain centrally held while Places gain greater visibility and influence over resources.

Role in the suite

This is the financial enabler. It ensures that funding arrangements support Place-based priorities, prevention and wider system transformation.

5. Place Team

Document purpose

A document describing the Place Team operating model and how multi-partner capacity will be organised to support delivery at Place.

Key content

- Defines the role, purpose and contribution of Place Teams within the wider operating model.
- Describes leadership, governance, matrix working, shared priorities and accountability across organisations.
- Emphasises the need for local flexibility in structure, alongside consistency in purpose, outcomes and ways of working.

Role in the suite

This is the delivery mechanism. It explains how Place-level work will be led, coordinated and delivered through multi-partner teams.

6. Place Governance Options

Document purpose

A governance options appraisal document, currently in development, setting out potential approaches to oversight, decision-making and accountability.

Key content

- Explores options for oversight, accountability and decision-making structures at Place.
- Examines how NHS Greater Manchester may delegate or retain responsibilities and how those arrangements relate to Place Partnerships.
- Compares governance options for managing the Place Fund, Place Team and outcomes delivery.

Role in the suite

This is the structural framework. It will determine how authority, oversight and accountability operate in practice across the Place Partnership model.

Meeting: Locality Board			
Meeting Date	06 July 2026	Action	Receive
Item No.	9	Confidential	No
Title	Integrated Neighbourhood Team's Video		
Presented By	Hannah Dixon & Clare Hunter		
Author	Hannah Dixon		
Clinical Lead	N/A		

Executive Summary
A neighbourhood video has been developed to showcase the impact of collaborative working across local partners in improving health and wellbeing outcomes for residents. The video demonstrates the neighbourhood approach in action, highlighting integrated, person-centred support, strong partnership working and community engagement across the locality.
Recommendations
The Board is asked to receive the presentation and video for information.

OUTCOME REQUIRED (Please Indicate)	Approval ☐	Assurance ☐	Discussion ☐	Information ☒
APPROVAL ONLY; (please indicate) whether this is required from the pooled (S75) budget or non-pooled budget	Pooled Budget ☐	Non-Pooled Budget ☐		

Links to Locality Plan priorities	
Scale our work on Population Health Management - Improve population health and reduce health inequality of those in the most disadvantaged areas	☐
Drive prevention, reducing prevalence and proactive care – supporting Demand Reduction through primary intervention, secondary preventions and tertiary prevention	☒
Transforming Community Care in Neighbourhoods - fully realising the benefit of neighbourhood team working with a focus on the assets of residents and communities and providing proactive care	☒
Optimise Care in institutional settings and prioritising the key characteristics of reform.	☐

Implications						
Are the risks already included on the Locality Risk Register?	Yes	☐	No	☐	N/A	☒
Are there any risks of 15 and above that need to be considered for escalation via an NHS GM Statutory Committee or Board in line with the Risk Escalation process ?	Yes	☐	No	☐	N/A	☒
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☐	N/A	☒
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☐	N/A	☒
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☐	N/A	☒
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☐	N/A	☒
Are there any financial Implications?	Yes	☐	No	☐	N/A	☒
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☒
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☒

Governance and Reporting		
Meeting	Date	Outcome
N/A		



BURY
INTEGRATED CARE
PARTNERSHIP

Integrated Neighbourhood Team's Video

Part of Greater Manchester
Integrated Care Partnership



Presentation by:

Hannah Dixon – Commissioning Manager – Bury Council

Clare Hunter – Project Manager – Bury IDC

June 2026

Purpose: To raise awareness among health and social care professionals about Integrated Neighbourhood Teams in Bury, who they are, what they do and how they help reduce demand in the wider system

Audience: Health and Social Care professionals, Community and voluntary sector and service users

Key Messages: How neighbourhoods are working together to:

- Improve health & wellbeing of people in our neighbourhoods
- Make sure services work better together
- Demonstrate neighbourhood values and how this is achieved through partnership

A True Portrait of Integration in Our Neighbourhoods



BURY
INTEGRATED CARE
PARTNERSHIP

A person wearing a blue uniform is seen from the side, holding a large, dark, circular metal drum. They are standing on a paved city street with buildings and a street lamp in the background.

**Integrated Neighbourhood Teams
across Bury are bringing together healthcare
professionals, social care and the
voluntary sector to improve patient care.**

Thank you to all who supported with planning, coordinating and featuring in the video:

<https://vimeo.com/1192181988?share=copy&fl=sv&fe=ci>

Meeting: Locality Board			
Meeting Date	06 July 2026	Action	Receive
Item No.	10	Confidential	No
Title	Chief Officer's Report		
Presented By	Kath Wynne-Jones		
Author	Kath Wynne-Jones		
Clinical Lead	Kiran Patel		

Executive Summary
This paper is intended to provide an update to the Board of progress with the work of the IDC, and progress with the delivery of programmes across the Borough.
Recommendations
The Locality Board are asked to note the content of the report.

OUTCOME REQUIRED (Please Indicate)	Approval ☐	Assurance ☐	Discussion ☒	Information ☐
APPROVAL ONLY; (please indicate) whether this is required from the pooled (S75) budget or non-pooled budget	Pooled Budget ☐	Non-Pooled Budget ☐		

Links to Locality Plan priorities	
Scale our work on Population Health Management - Improve population health and reduce health inequality of those in the most disadvantaged areas	☒
Drive prevention, reducing prevalence and proactive care – supporting Demand Reduction through primary intervention, secondary preventions and tertiary prevention	☒
Transforming Community Care in Neighbourhoods - fully realising the benefit of neighbourhood team working with a focus on the assets of residents and communities and providing proactive care	☒
Optimise Care in institutional settings and prioritising the key characteristics of reform.	☒

Implications						
Are the risks already included on the Locality Risk Register?	Yes	☒	No	☐	N/A	☐



Implications						
Are there any risks of 15 and above that need to be considered for escalation via an NHS GM Statutory Committee or Board in line with the Risk Escalation process ?	Yes	☒	No	☐	N/A	☐
Are there any quality, safeguarding or patient experience implications?	Yes	☒	No	☐	N/A	☐
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☐	N/A	☐
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☐	N/A	☐
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☐	N/A	☐
Are there any financial Implications?	Yes	☒	No	☐	N/A	☐
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☐
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☐
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☒	N/A	☐

Governance and Reporting		
Meeting	Date	Outcome
N/A		



Bury Integrated Delivery Collaborative Update

1. Context

This report is intended to outline to the Board progress which has been made with the key programmes of work within the IDC.

2. Programme Delivery

- An IDC development session has been held to determine the left shift principles by which we will operate to inform future ways of working and risks to be managed
- A test of change in the east neighbourhood has been agreed to create closer links between the INT's and the Mental Health MDT's
- A workshop to create closer connections between adults and children's has been agreed. We are about to commence some shadowing work of different MDT approaches
- The majority of the new ICB Place Based Partnership Team are now in post. We are working to define roles and responsibilities across the totality of the resource we have in Place
- The new neighbourhood planning guidance was released on the 18th March. We have agreed timescales for the development of the plan (see attached) to strengthen and deepen the work we are already doing which will be received by the IDC Board in August and Locality Board in September . Each of the programmes are working up:
 - o Their plan on a page from 2026-2029
 - o Their detailed implementation plans for 2026/27
 - o The governance of their Boards and metrics for which they will be accountable from the place outcomes framework and the neighbourhood health framework
- We are in the process of reviewing our delivery arrangements for our Integrated Neighbourhood Teams. Given the CLM changes at the NCA and statutory requirements of the council, we are needing to relook at the single line management arrangements that are in Place. However, the principle of neighbourhood approach will remain at the heart of everything we do.
- The new BECCOR asks are now clear from Greater Manchester. Our neighbourhood leads are currently working on our local delivery plans with our practices. The initial drafts were shared with NDDG in June
- An outline of the 4LP programme of work with the NCA has now been agreed. We are in the process of scoping the content of these programmes.
- We were invited to an event in Cheshire and Mersey and in GM to share the work we have done in the locality on neighbourhood working.
- We have continued to work with GP Board members and the broader membership to reposition the Board role in the context of ICB governance changes and the neighbourhood plan requirements.
- We have been leading conversations across the 4 localities to determine the arrangements for tier

2 services which will be put in place for ENT and Gynaecology commissioned through the NCA

- A targeted education session on the Pathway to Remission programme (which supports patients to achieve type 2 diabetes remission through structured lifestyle intervention) was delivered to GPs via webinar, contributing to increased awareness and engagement within General Practice.
- The GM Cancer This Van Can roadshow has visited Bury between 30th May and 18th June spreading cancer awareness messaging. Locations were in each of the 5 neighbourhoods which included supermarkets, Bury Pride and Radcliffe Carnival.
- Funding has been made available through the Neighbourhood Cancer Live Well Fund to support localities in developing neighbourhood-based approaches to improving cancer outcomes, with a focus on early diagnosis, supporting patients living with cancer, and reducing health inequalities. In Bury, this funding will be used to facilitate a round of grants to community organisations via the VCFA to support delivery of this activity.
- NCA community services have provided bypass numbers for all services which is a big step forward in improving communication between primary and secondary care

3. Recommendations

The Board are asked to note the progress and risks outlined within this paper.

Kath Wynne-Jones

Chief Officer – Bury Integrated Delivery Collaborative

kath.wynnejones@nca.nhs.uk

June 2026

Meeting:			
Meeting Date	06 July 2026	Action	Receive
Item No.	11	Confidential	No
Title	Better Care Fund (BCF) End of Year (EOY) 2025/26		
Presented By	Hannah Dixon – Commissioning Manager		
Author	Hannah Dixon – Commissioning Manager		
Clinical Lead	N/A		

Executive Summary
This report presents the EOY position for the BCF 2025/26. Overall, delivery against the three nationally mandated performance metrics remains on track, with the locality showing as having achieved all agreed targets. Financially, the report confirms that 100% of BCF funding allocated for 2025/26 has been fully utilised, demonstrating effective deployment of resources in line with programme objectives, which include the left shift strategy and joined up care through neighbourhood working.
Recommendations
For Locality Board members to review the report and receive as information.

OUTCOME REQUIRED (Please Indicate)	Approval ☐	Assurance ☐	Discussion ☐	Information ☒
APPROVAL ONLY; (please indicate) whether this is required from the pooled (£75) budget or non-pooled budget	Pooled Budget ☒	Non-Pooled Budget ☐		

Links to Locality Plan priorities	
Scale our work on Population Health Management - Improve population health and reduce health inequality of those in the most disadvantaged areas	☐
Drive prevention, reducing prevalence and proactive care – supporting Demand Reduction through primary intervention, secondary preventions and tertiary prevention	☒
Transforming Community Care in Neighbourhoods - fully realising the benefit of neighbourhood team working with a focus on the assets of residents and communities and providing proactive care	☒

Links to Locality Plan priorities	
Optimise Care in institutional settings and prioritising the key characteristics of reform.	☒

Implications						
Are the risks already included on the Locality Risk Register?	Yes	☐	No	☐	N/A	☒
Are there any risks of 15 and above that need to be considered for escalation via an NHS GM Statutory Committee or Board in line with the Risk Escalation process ?	Yes	☐	No	☐	N/A	☒
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☐	N/A	☒
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☐	N/A	☒
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☐	N/A	☒
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☐	N/A	☒
Are there any financial Implications?	Yes	☐	No	☐	N/A	☒
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☒
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☒

Governance and Reporting		
Meeting	Date	Outcome
N/A		

BCF EOY 25/26 Report

1. Introduction

- 1.1. The final Better Care Fund (BCF) 2025/2026 Policy Framework and Planning Guidance can be found at: BCF [Better Care Fund policy framework 2025 to 2026 - GOV.UK](#)
This policy framework confirms the conditions and funding for the Better Care Fund (BCF) for 2025 to 2026.
- 1.2. For 2025 to 2026, the objectives of the BCF reflect the government's commitment to reform via a shift from sickness to prevention and from hospital to home. These shifts are also consistent with commitment to reform by developing a 'neighbourhood health service', based on more responsive, preventative and co-ordinated care in people's homes and local communities.
- 1.3. The BCF achieves this by requiring local authorities and integrated care boards (ICBs), to develop and agree plans in collaboration with other local partners to meet the overall objectives of the BCF.
- 1.4. The plan is owned by the Health and Wellbeing Board (HWB) and governed by an agreement under section 75 of the NHS Act (2006). This continues to provide an important framework in bringing local NHS services and local government together to tackle pressures faced across the health and social care system and drive better outcomes for people.
- 1.5. In line with the government's vision for health and care, the Better Care Fund policy framework sets out the vision, funding, oversight and support arrangements, focused on 2 overarching objectives for the BCF in 2025-26:
 - reform to support the shift from sickness to prevention
 - reform to support people living independently and the shift from hospital to home
- 1.6. At the same time, NHS England and the LGA published the Planning Requirements for the BCF. These can be found at: BCF [Planning Requirements 25-26](#)

2. BCF 2025/2026 Conditions, Objectives and Metrics

[Better Care Fund policy framework 2025 to 2026 - GOV.UK.](#)

2.1 National Conditions

Both local authorities and ICBs must comply with the BCF national conditions. Grant conditions for local authorities of each component grant of the BCF will reflect these

national conditions. The national conditions outline steps HWBs must take to deliver on the BCF objectives.

The national conditions for the BCF in 2025/2026 are:

- jointly agreeing a plan
- implementing the objectives of the BCF
- complying with the grant conditions and the BCF funding conditions
- complying with the oversight and support processes

2.2 Objectives

The two objectives for the BCF in 2025 to 2026 are:

- **Objective 1:** To support the shift from sickness to prevention – including timely, proactive and joined-up support for people with more complex health and care needs; use of home adaptations and technology; and support for unpaid carers.
- **Objective 2:** To support people living independently and the shift from hospital to home – including help to prevent avoidable hospital admissions; achieve more timely and effective discharge from acute, community and mental health hospital settings; support people to recover in their own homes (or other usual place of residence); and reduce the proportion of people who need long-term residential or nursing home care.

2.3 BCF metrics for 2025 to 2026

The three metrics to be reported on are below. All 3 metrics are reporting as on track to meet goals:

Metric 4.1: Emergency Admissions - Emergency admissions to hospital for people aged 65+ per 100,000 population – the goal for this target is to be below the target rate set in the plan.

Table 1 shows that metric 4.1 is on track to meet goals – actual data for Jan & Feb 26 and projected data for March was used to inform EOY reporting for this metric as data had not finalised at the time of submission. The final position is as per the below table.

Table 1 - Metric 4.1: Emergency Admissions

	Q1	Q2	Q3	Q4
Target: Rate	1488.6	1461.2	1516	1479.5
Performance	1397.26	1365.3	1452.1	1338.2
Variance	-91.34	-95.9	-63.9	-141.3

Metric 4.2: Delayed Discharge - Average length of discharge delay (LDD) for all acute adult patients (calculates the % of patients discharged after their DRD, multiplied by the average number of days) - the goal for this target is to be below the target rate set in the plan.

Table 2 shows that metric 4.2 is on track to meet goals overall – EOY data is based on Q4 actual data.

Table 2 - Metric 4.2: Delayed Discharge

	Q1	Q2	Q3	Q4
Target: Rate	1.30	1.49	1.00	1.00
Performance	0.94	0.80	1.11	1.24
Variance	-0.36	-0.69	0.11	0.24

Metric 4.3: Residential Admissions - Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population. The actual number of residential admissions has been used in Table 3, the goal for this target is to be below the number of admissions target set in the plan.

Table 3 shows that metric 4.3 is on track to meet goals.

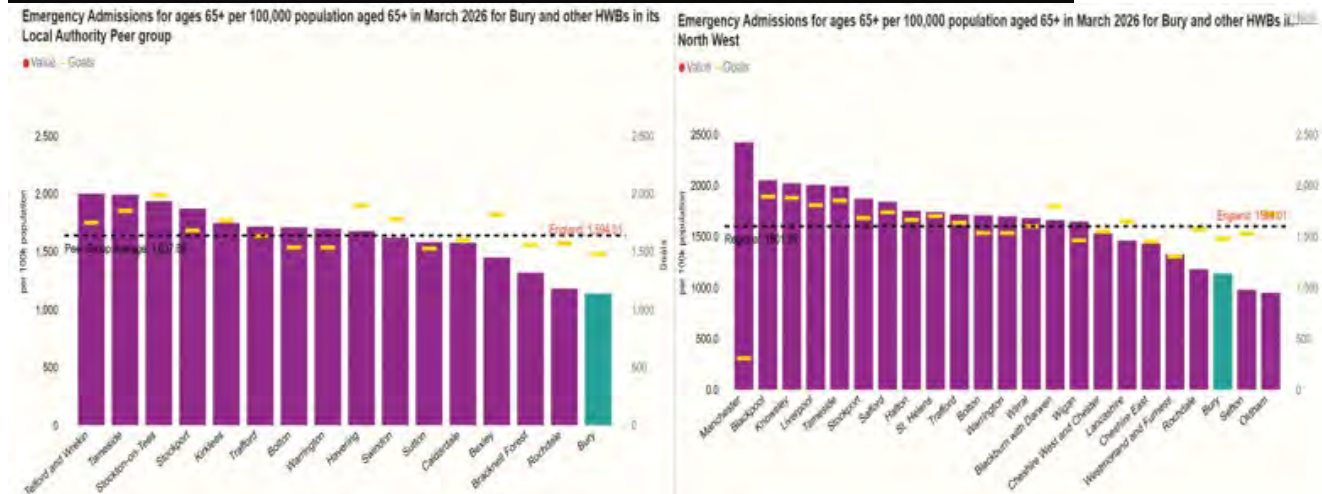
Table 3 - Metric 4.3: Residential Admissions

	Q1	Q2	Q3	Q4
Target: Number of Admissions	62.0	62.0	62.0	62.0
Performance	48.0	43.0	64.0	61.0
Variance	-14.0	-19.0	2.0	-1.0

2.4 Metric Performance Comparison

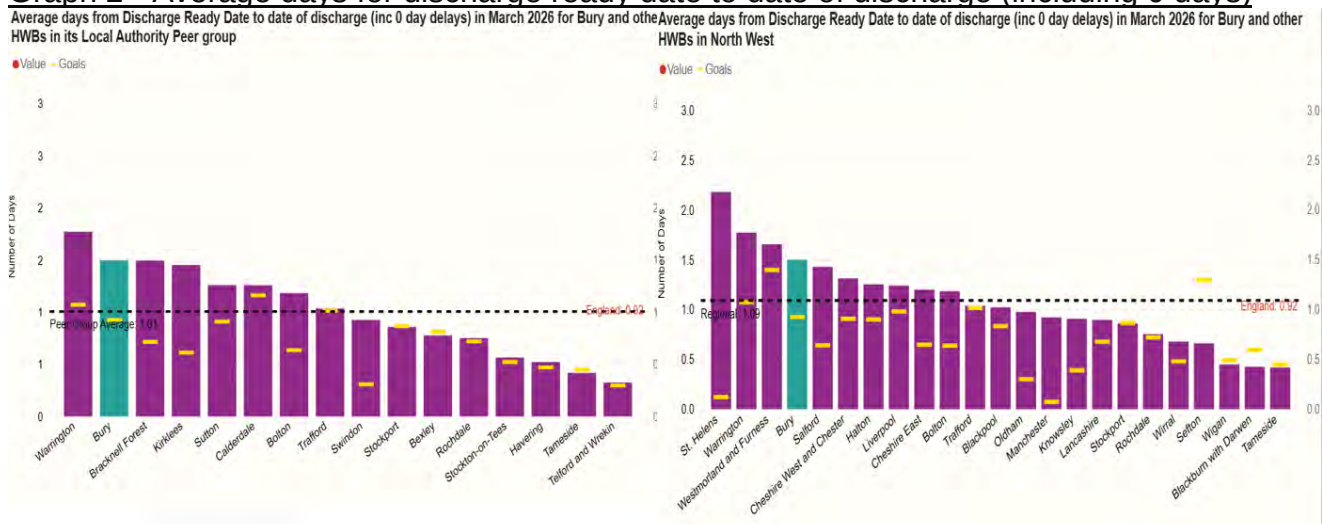
Emergency Admissions for ages 65+ per 100,000 65+ population – Graph 1 shows for the month of March 26, Bury was lower than the region North West, England as a whole and their peer group for this metric.

Graph 1 - Emergency Admissions for ages 65+ per 100,000 65+ population



Average days for discharge ready date to date of discharge (including 0 days) – Graph 2 shows for the month of March 26, Bury was higher than the region North West, England as a whole and their peer group average for this metric.

Graph 2 - Average days for discharge ready date to date of discharge (including 0 days)



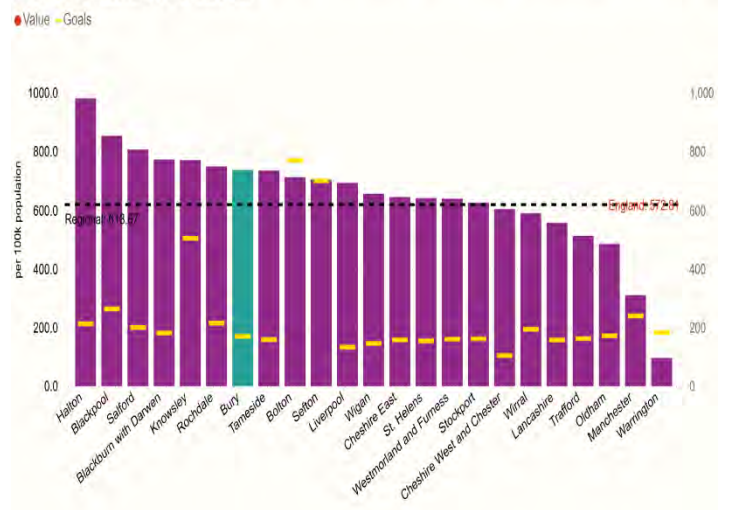
Long-term admissions to residential care homes and nursing homes for people aged 65+ per 100,000 population – Graph 3 shows in the 12 months ending December 2025, Bury was higher than the region North West, England as whole and their peer group average for this metric.

Graph 3 – Long term admissions to residential care homes and nursing homes for people aged 65+ per 100,000 population

Long term admissions to residential and nursing homes for ages 65+ per 100,000 65+ population in December 2024 for Bury and other HWBs in its Local Authority Peer group



Long term admissions to residential and nursing homes for ages 65+ per 100,000 65+ population in December 2024 for Bury and other HWBs in North West



3 Finance Report

3.1 Table 4 demonstrates that 100% of the planned BCF income has been spent up to EOY 2025-26.

Table 4 – Income and Expenditure

Better Care Fund 2025-26 EOY Reporting Template

5. Income & Expenditure

Selected Health and Wellbeing Board:

Bury

	2025-26		
Source of Funding	Planned Income	Updated Total Income for 25-26	DFG EOY Actual Expenditure
DFG (including top-up)	£2,757,942	£2,757,942	£2,757,942
Minimum NHS Contribution	£19,577,112	£19,577,112	
Local Authority Better Care Grant	£9,410,943	£9,410,943	
Additional LA Contribution	£0	£0	
Additional NHS Contribution	£2,136,317	£2,136,317	
Total	£33,882,314	£33,882,314	

End of Year Actual Expenditure	£33,882,314	% of Planned Income
		100%

4 Actions Required

- 4.1 The Locality Board is required to:
- receive this information

Hannah Dixon

Commissioning Manager
Hannah.dixon27@nhs.net
June 2026



Bury HWB BCF
2025-26 EOY.xlsx

Better Care Fund 2025-26 EOY Reporting Template

0

1. Guidance

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements for 2025-26 (refer to link below), which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health and Social Care (DHSC), Ministry for Housing, Communities and Local Government (MHCLG), NHS England (NHSE).

<https://www.england.nhs.uk/long-read/better-care-fund-planning-requirements-2025-26/#introduction>

<https://www.gov.uk/government/publications/better-care-fund-policy-framework-2025-to-2026/better-care-fund-policy-framework-2025-to-2026>

As outlined within the planning requirements, quarterly BCF reporting will continue in 2025-26, with areas required to set out progress on delivering their plans by reviewing metrics performance against goals, spend to date as well as any significant changes to planned spend.

The primary purpose of BCF reporting is to ensure a clear and accurate account of continued compliance with the key requirements and conditions of the fund. The secondary purpose is to inform policy making, the national support offer and local practice sharing by providing a fuller insight from narrative feedback on local progress, challenges and highlights on the implementation of BCF plans and progress on wider integration.

BCF reporting is likely to be used by local areas, alongside any other information to help inform HWBs on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including ICBs, local authorities and service providers) for the purposes noted above.

In addition to reporting, BCMs and the wider BCF team will monitor continued compliance against the national conditions and metric ambitions through their wider interactions with local areas.

BCF reports submitted by local areas are required to be signed off HWB chairs ahead of submission. Aggregated data reporting information will be available on the DHSC BCF Metrics Dashboard and published on the NHS England website.

Note on entering information into this template

Please do not copy and paste into the template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells/Not required

Note on viewing the sheets optimally

To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance tab for readability if required.

The row heights and column widths can be adjusted to fit and view text more comfortably for the cells that require narrative information.

Please DO NOT directly copy/cut and paste to populate the fields when completing the template as this can cause issues during the aggregation process. If you must 'copy and paste', please use the 'Paste Special' operation and paste Values only.

The details of each sheet within the template are outlined below.

Checklist (2. Cover)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'
3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. Once you select your HWB from the drop down list, relevant data on metric goals from your BCF plans for 2025-26 will pre-populate in the relevant worksheets.

2. HWB Chair sign off will be subject to your own governance arrangements which may include a delegated authority.

3. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to:

england.bettercarefundteam@nhs.net

(please also copy in your respective Better Care Manager)

4. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. National Conditions

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2025-26 (link below) continue to be met through the delivery of your plan. Please confirm as at the time of completion.
<https://www.england.nhs.uk/long-read/better-care-fund-planning-requirements-2025-26/>

This sheet sets out the four conditions and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met for the year and how this is being addressed. Please note that where a National Condition is not being met, an outline of the challenge and mitigating actions to support recovery should be outlined. It is recommended that the HWB also discussed this with their Regional Better Care Manager.

In summary, the four National conditions are as below:

National condition 1: Plans to be jointly agreed

National condition 2: Implementing the objectives of the BCF

National condition 3: Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC) (and section 75 in place)

National condition 4: Complying with oversight and support processes

4. Metrics

The BCF plan includes the following metrics (these are not cumulate/YTD):

1. Emergency admissions to hospital for people aged 65+ per 100,000 population. (monthly)
2. Average number of days from Discharge Ready Date to discharge (all adult acute patients). (monthly)
3. Admissions to long term residential and nursing care for people aged 65+ per 100,000 population. (quarterly)

Plans for these metrics were agreed as part of the BCF planning process outlined within 25/26 planning submissions.

Populations are based on 2024 mid year estimates, please note this has been updated from the Q2 template to match the DHSC metrics dashboard.

Within each section, you should set out how the ambition has been reached, including analysis of historic data, impact of planned efforts and how the target aligns for locally agreed plans such as Acute trusts and social care.

The bottom section for each metric also captures a confidence assessment on achieving the locally set ambitions for each of the BCF metrics.

The metrics worksheet seeks a short explanation if a goal has not been met - in which case please provide a short explanation, including noting any key mitigating actions. You can also use this section to provide a very brief explanation of overall progress if you wish.

In making the confidence assessment on progress, please utilise the available metric data via the published sources or the DHSC metric dashboard along with any available proxy data.

https://dhexchange.kahootz.com/Discharge_Dashboard/groupHome

5. Income & Expenditure

This section requires confirmation of an update to actual income received in 2025-26 across each fund, as well as spend to date at Q3. If expenditure by activity has changed since the original plan, please confirm that this has been agreed by local partners. If that change in activity expenditure is greater than 5% of total BCF expenditure, please use this box to provide a brief summary of the change.

On the 'DFG' row in the 'Source of Funding' table, 'Updated Total Income for 25-26' this should include the total funding from DFG allocations that is available for you to spend on DFG in this financial year 2025-26. 'EOY Actual Expenditure' should include total amount that has been spent at year-end, even if the application or approval for the DFG started in a previous quarter or there has been slippage.

The template will automatically pre-populate the planned income in 2025-26 from BCF plans, including additional contributions. Please enter the update amount of income even if it is the same as in the submitted plan. Note that the extra £50m DFG top-up that had been introduced at the start of the year is now included in the total DFG amount therefore please include this in your total actuals expenditure.

Please also use this section to provide the aggregate End of Year Spend. This tab will also display what percentage of planned income this constitutes.



HM Government



Better Care Fund 2025-26 EOY Reporting Template

2. Cover

Version 1.0

Please Note:

- The BCF quarterly reports are categorised as 'Management Information' and data from them will be published in an aggregated form on the NHSE website. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.
- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- All information will be supplied to BCF partners to inform policy development.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Bury	
Completed by:	Hannah Dixon	
E-mail:	hannah.dixon27@nhs.net	
Contact number:	7919963240	
Has this report been signed off by (or on behalf of) the HWB Chair at the time of submission?	No	
If no, please indicate when the report is expected to be signed off:	Thu 11/06/2026	<< Please enter using the format, DD/MM/YYYY

Checklist

Complete:

Yes

Yes

Yes

Yes

Yes

Yes

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'.

Complete

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5. Income & Expenditure	Yes

For further guidance on requirements please refer back to guidance sheet - tab 1.

[<< Link to the Guidance sheet](#)

[^^ Link back to top](#)

Better Care Fund 2025-26 EOY Reporting Template

3. National Conditions

Selected Health and Wellbeing Board:

Bury

Confirmation of Nation Conditions		
National Condition	Confirmation	If the answer is "No" please provide an explanation as to why the condition was not met in the quarter and mitigating actions underway to support compliance with the condition:
1) Plans to be jointly agreed	Yes	
2) Implementing the objectives of the BCF	Yes	
3) Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC) and Section 75 in place	Yes	
4) Complying with oversight and support processes	Yes	

Checklist

Complete:

Yes

Yes

Yes

Yes

Better Care Fund 2025-26 EOY Reporting Template

4. Metrics for 2025-26

Selected Health and Wellbeing Board:

Bury

For metrics time series and more details:

[BCF dashboard link](#)

For metrics handbook and reporting schedule:

[BCF 25/26 Metrics Handbook](#)

4.1 Emergency admissions

Plan		Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan
Emergency admissions to hospital for people aged 65+ per 100,000 population	Rate	1,479.5	1,575.3	1,411.0	1,561.6	1,356.2	1,465.8	1,411.0	1,589.0	1,547.9	1,657.5	1,301.4	1,479.5
	Number of Admissions 65+	540	575	515	570	495	535	515	580	565	605	475	540
	Population of 65+	36,500.0	36,500.0	36,500.0	36,500.0	36,500.0	36,500.0	36,500.0	36,500.0	36,500.0	36,500.0	36,500.0	36,500.0

Assessment of whether goal has been met in Q4:	On track to meet goal
You may use this box to provide a very brief explanation of overall progress if you wish.	4.1: Emergency Admission (Methodology) Nationally reported data on actual performance currently only goes up to December. Locality data has been able to confirmed our actual performance for the whole of 2025-26. Number of admissions 65+ PLAN: 6,510 Number of admissions 65+ ACTUAL: 6,067 (based on Jan/Feb/Mar locality data) REDUCTION ACHIEVED ON PLAN: 443 (6.8% improvement reduction) METRIC – FORCAST TO ACHIEVED FOR 2025-26 (based on locality data)

4.2 Discharge Delays

Original Plan	Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan
Average length of discharge delay for all acute adult patients (this calculates the % of patients discharged after their DRD, multiplied by the average number of days)	1.72	1.09	1.10	1.44	1.27	1.76	1.18	0.89	0.92	1.11	0.98	0.92
Proportion of adult patients discharged from acute hospitals on their discharge ready date	86.0%	89.0%	89.0%	85.0%	87.0%	85.0%	87.0%	89.0%	88.0%	85.0%	86.0%	88.0%

For those adult patients not discharged on DRD, average number of days from DRD to discharge	12.30	9.90	10.00	9.60	9.80	11.70	9.10	8.10	7.70	7.40	7.00	7.70

Assessment of whether goal has been met in Q4:	On track to meet goal
You may use this box to provide a very brief explanation of overall progress if you wish.	4.2: Discharge Ready Date (DRD) (Methodology) Nationally reported data on actual performance currently only goes up to January. The full year performance for the DRD indicators cannot be derived from the monthly figures, as each percentage is based upon a different base number of discharges. However, for the purpose of estimating our full year performance we have taken a crude estimate based on the average of the 12 months' values. Proportion of adult patient discharged from acute hospitals on their DRD: PLAN = FY 87% FORECAST OUTTURN = 88.5% a 1.5% forecast improvement Fro those not discharged on DRD, average number of days from DRD to discharge: PLAN = 9.19 FORCAST OUTTURN = improvement to 8.36 METRIC – FORECAST TO ACHIEVED FOR 2025-26 (based on locality methodology)

4.3 Residential Admissions

Actuals + Original Plan		2023-24 Full Year Actual	2024-25 Full Year CLD Actual	2025-26 Plan Q1 (April 25- June 25)	2025-26 Plan Q2 (July 25- Sept 25)	2025-26 Plan Q3 (Oct 25-Dec 25)	2025-26 Plan Q4 (Jan 26-Mar 26)
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Rate	662.2	838.4	169.9	169.9	169.9	169.9
	Number of admissions	239.0	306.0	62.0	62.0	62.0	62.0
	Population of 65+*	36500.0	36500.0	36500.0	36500.0	36500.0	36500.0

Better Care Fund 2025-26 EOY Reporting Template

5. Income & Expenditure

Selected Health and Wellbeing Board:

Bury

	2025-26		
Source of Funding	Planned Income	Updated Total Income for 25-26	DFG EOY Actual Expenditure
DFG (including top-up)	£2,757,942	£2,757,942	£2,757,942
Minimum NHS Contribution	£19,577,112	£19,577,112	
Local Authority Better Care Grant	£9,410,943	£9,410,943	
Additional LA Contribution	£0	£0	
Additional NHS Contribution	£2,136,317	£2,136,317	
Total	£33,882,314	£33,882,314	

		% of Planned Income
End of Year Actual Expenditure	£33,882,314	100%

If expenditure by activity has changed since the original plan, please confirm that this has been agreed by local partners. If that change in activity expenditure is greater than 5% of total BCF expenditure, please use this box to provide a brief summary of the change.	No change

Checklist

Complete:

- Yes
- Yes
- Yes
- Yes
- Yes

Yes

Yes

Better Care Fund 2024-25 EOY Reporting Template

6. Year End Impact Summary

Selected Health and Wellbeing Board:

Bury

Checklist

Complete:

Confirmation of Statements		
Question statements	Confirmation	If the answer is "No" please provide an explanation:
Overall delivery of BCF has improved joint working between health and social care	Yes	
Our BCF schemes were implemented as planned in 2025-26	Yes	
The delivery of our BCF plan 2025-26 has had a positive impact on the integration of health and social care in our locality.	Yes	

Yes

Yes

Yes

Highlight success and challenges within reference to the most relevant enablers from SCIE logic model:	
Logic model for integrated care - SCIE	
Success and Challenges	Narrative
2 key successes observed towards driving the enablers for integration	Bury has long established shared and collaborative governance through our locality board and our integrated care partnership which delivers the majority of our BCF funded services. Almost all of our BCF funded services are delivered by integrated workforce such as our Urgent Community Response Service, our Intermediate Care Services and our integrated neighbourhood team. Our LGA peer review last year found "exemplary integration with health services". Our integrated care services have helped us keep A and E use and hospitals admissions at some of the lowest in our region and peer group despite population rises and continues to support demand reduction in adult social care. The quality of our care market is now in the top 20 of England and we have not experienced any provider failure of contract hand backs in the last year. Bury has showing as having acheived all goals against the 3 BCF metrics.
2 key challenges observed towards driving the enablers for integration	The ongoing ICB reforms have seen locality resources move into central functions and introduced organisational restructures. As a result, important locality relationships and focus risk being weakened, making it harder to deliver a truly integrated system. Overall, this represents a backward step for the delivery of integrated care.

Yes

Yes

Meeting: Bury Locality Board			
Meeting Date	06 July 2026	Action	Approve
Item No.	Agenda item 12	Confidential	No
Title	Bury Mental Health Strategy 2026 - 2030		
Presented By	Adrian Crook		
Author	Kez Highet / Ian Trafford		
Clinical Lead	Dr. Cathy Fines		

Executive Summary
The Bury Mental Health Strategy 2026–2030 sets out a shared vision and delivery framework for improving mental health and wellbeing across the borough over the next 3 years. Developed in response to evidence from the Joint Strategic Needs Assessment (JSNA), population health data, community engagement and national and Greater Manchester policy priorities, the strategy provides a comprehensive whole-system approach to addressing increasing levels of mental ill-health, inequalities in access, outcome and experience and growing demand on services. The strategy adopts a prevention-led, community-based model of care, aligned to the Greater Manchester Live Well programme and Bury’s whole system Neighbourhood approach set out in the LETS strategy. It aims to improve population mental wellbeing, strengthen early intervention and prevention, improve access to support, reduce inequalities, and deliver more integrated and person-centred care through neighbourhood-based partnerships. Six strategic priorities have been identified for delivery between 2026 and 2030, supported by a phased implementation programme, partnership governance arrangements and an outcomes framework.
Recommendations
The Bury Locality Board is asked to approve the Bury 2026-2030 Mental Health Strategy and support its implementation across the locality.

OUTCOME REQUIRED (Please Indicate)	Approval ☒	Assurance ☐	Discussion ☒	Information ☐
APPROVAL ONLY; (please indicate) whether this is required from the pooled (£75) budget or non-pooled budget	Pooled Budget ☐	Non-Pooled Budget ☐		

Links to Locality Plan priorities	
Scale our work on Population Health Management - Improve population health and reduce health inequality of those in the most disadvantaged areas	☒
Drive prevention, reducing prevalence and proactive care – supporting Demand Reduction through primary intervention, secondary preventions and tertiary prevention	☒
Transforming Community Care in Neighbourhoods - fully realising the benefit of neighbourhood team working with a focus on the assets of residents and communities and providing proactive care	☒
Optimise Care in institutional settings and prioritising the key characteristics of reform.	☒

Implications						
Are the risks already included on the Locality Risk Register?	Yes	☒	No	☐	N/A	☐
Are there any risks of 15 and above that need to be considered for escalation via an NHS GM Statutory Committee or Board in line with the Risk Escalation process?	Yes	☐	No	☐	N/A	☒
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☐	N/A	☒
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☒	No	☐	N/A	☐
Have any departments/organisations who will be affected been consulted?	Yes	☒	No	☐	N/A	☐
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☒	N/A	☐
Are there any financial Implications?	Yes	☒	No	☐	N/A	☐
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☒	N/A	☐
If yes, has an Equality, Privacy or Quality Impact	Yes	☐	No	☐	N/A	☒

Implications						
Assessment been completed?						
If yes, please give details below:						
Extensive engagement has taken place with providers through the Bury MH Programme Board and other fora. A series of public engagement sessions and a survey were undertaken to inform the strategy. The delivery of some elements of the strategy will be reliant on identifying additional investment which is not in place at this time. This represents a delivery risk.						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
High level strategy – any significant services changes will be subject to an Equality, Privacy or Quality Impact Assessment in line with standard commissioning procedures.						
Are there any associated risks including Conflicts of Interest?	Yes	☒	No	☐	N/A	☐
Delivery risks are set out in the Mental Health Programme risk register and are reported to the Bury Mental Health Programme Board with the highest scoring risks reported to the Performance and Quality Group and Locality Board.						

Governance and Reporting		
Meeting	Date	Outcome
Bury Mental Health Programme Board	21/04/2026	Approved

Bury Mental Health Strategy 2026–2030

1. Purpose, scope and development

This document provides a summary of the main priorities and actions set out in the Bury Mental Health Strategy 2026–2030. It includes a more detailed delivery plan for year 1 – 2026.27.

The Strategy builds on the previous one which focused on addressing key gaps in commissioned services and compliance with national frameworks. This work is not fully complete and the new strategy reflects that and more recent regulatory and policy priorities.

The Strategy has been developed with key stakeholders and the priorities reflect the feedback we received from a series of public ‘listening events’ and a public survey with over 200 respondents.

2. Vision, aims and principles

Vision: People in Bury will experience good mental health and wellbeing throughout their lives, with timely, equitable and person-centred support when they need it.

Strategic aim: A prevention-led, community-based mental health system that reduces inequalities, improves outcomes, and supports people to live well.

Delivery principles:

- Prevention and early intervention first
- Equity of access and outcomes
- Person-centred, strengths-based, recovery-focused care
- Community and neighbourhood delivery
- Co-production with people with lived experience
- Integrated partnership working and shared accountability
- Continuing with the Thrive Model principles and incorporating clear service pathways and ‘offers’ for people according to need



3. Strategic and Local Context and Case for Change

Mental health needs in Bury mirrors national and Greater Manchester trends, including increasing prevalence of anxiety and depression, rising demand for children and young people's services, and sustained pressure on crisis and inpatient care.

There are also significant inequalities in access, outcomes and experience with people living in more deprived communities experiencing poorer mental health, higher use of crisis services and greater barriers to accessing support.

This strategy aligns with and supports delivery of:

- Greater Manchester Mental Health & Wellbeing Strategy
- NHS Long Term Plan and Mental Health Implementation Plans
- Pennine Care NHS Foundation Trust Strategy
- Bury Let's Do It! 2030 and the Thriving in Bury framework

The Strategy provides a clear local response that supports neighbourhood working, integration and population health improvement.

Bury Local Context & Need for Change

The Bury Mental Health Strategy 2026–2030 has been shaped by clear evidence of growing mental health need across the population, alongside increasing complexity and inequality in outcomes. The Joint Strategic Needs Assessment (JSNA) highlights that mental health conditions are one of the leading causes of disability in Bury, with around one in four adults and one in ten children experiencing mental illness. Rates of depression and anxiety have risen significantly and are now above national averages, suggesting both increasing demand and previously unmet need.

The evidence also demonstrates that mental health challenges often begin early in life, with half of all long-term mental health problems emerging before the age of fourteen. Rising levels of social, emotional, and mental health needs among children and young people, particularly those with Special Educational Needs and Disabilities (SEND), underline the need for earlier intervention, prevention, and support throughout the life course.

The strategy is also informed by the significant impact of wider determinants on mental health and wellbeing. Population health data highlights strong links between mental health, deprivation, housing, employment, social isolation, and physical health. Bury faces increasing pressures from an ageing population, including growing numbers of people experiencing loneliness, dementia, and caring responsibilities.

There are marked inequalities between neighbourhoods, with higher levels of need concentrated in more deprived communities and among some ethnic minority groups. People living with severe mental illness experience poorer physical health outcomes, higher rates of premature mortality, lower levels of employment, and reduced access to stable accommodation. Housing-related challenges are particularly significant, contributing to delayed hospital discharges and affecting recovery and independence. These findings reinforce the need for a whole-system, place-based approach that addresses both mental health needs and the wider social factors that influence wellbeing.

Community engagement undertaken across Bury provided a strong and consistent message that residents want existing services to work better, be easier to access, and be more joined up.

Through listening events, surveys and discussions with people with lived experience, residents emphasised the importance of community-based, person-centred support that is available early and close to home. Participants highlighted the need for improved communication, coordination and integration between services, alongside greater involvement of people with lived experience in the design, delivery, and evaluation of support.

The engagement findings, combined with the JSNA evidence, demonstrate a need to improve prevention and early intervention, strengthen continuity of care, reduce inequalities, support recovery through housing and employment, and ensure that services are designed around the needs and experiences of Bury residents. Together, these needs form the foundation of the Bury Mental Health Strategy 2026–2030 and its ambition to improve mental health and wellbeing outcomes across the borough.

4. Live Well & Whole System Neighbourhood Approach

Bury's Mental Health Strategy 2026–2030 adopts the GM Live Well and whole system neighbourhood approach as the foundation for delivering prevention-focused, community-based mental health support. Aligned with the Greater Manchester Live Well programme, this model shifts away from reactive, service-led care towards early intervention, community resilience, and integrated neighbourhood support that addresses the wider determinants of mental health such as poverty, housing, employment, social isolation, and inequality. Through Neighbourhood-based Live Well *centres*, *spaces* and *offers*, residents will be able to access holistic, person-centred support in local, trusted settings, with a strong emphasis on co-production, community power and reducing stigma.

The whole system neighbourhood strategy set out in the Government's [Neighbourhood Health Framework](#) provides an aligned delivery framework for this transformation by bringing together health, social care, primary care, housing, voluntary, community, faith, and social enterprise (VCFSE) organisations into integrated multidisciplinary neighbourhood teams. Working collaboratively across organisational boundaries, these teams will focus on prevention, early identification, strengths-based practice and coordinated support, ensuring that services respond to local need and reduce health inequalities. Community-centred delivery, partnership working and investment in local assets will enable residents to shape solutions and access support closer to home.

Together, Live Well and neighbourhood working will provide an opportunity to embed mental health within everyday community life rather than solely within clinical services. This approach has the potential to improve population wellbeing, increase access to preventative support, strengthen community resilience, reduce loneliness and isolation, and decrease reliance on crisis and hospital-based services. By aligning services, commissioning, and resources around neighbourhoods, Bury aims to create a more joined-up, equitable and sustainable system that delivers better mental health outcomes for all residents.

5. Strategic priorities and headline actions (2026–2030)

The Strategy sets six priorities for action. Each priority below summarises the “what” (actions) and “why” (intended impact).

Priority 1 — Prevention and Early Intervention

Objective: Promote positive mental wellbeing and prevent avoidable mental ill-health by acting early and across the life course.

Headline actions:

- Embed mental wellbeing promotion in schools, workplaces and communities (mental health literacy, stigma reduction).
- Strengthen early years and family support, including perinatal and parent–infant mental health pathways and improved support for children with special educational needs and disabilities.
- Expand whole-school approaches and increase coverage and impact of Mental Health Support Teams (MHSTs).
- Grow community-based early support (social prescribing, peer support, Live Well Spaces) to reduce escalation into specialist care.
- Target early intervention for higher-risk cohorts (e.g., domestic abuse, bereavement, bullying/trauma, neurodiversity).
- Deliver suicide prevention and postvention aligned to Greater Manchester approaches.

Intended impact:

- Earlier help-seeking and faster access to appropriate support.
- Reduced demand on crisis and specialist services through prevention and resilience-building.
- Reduced inequalities in mental health outcomes linked to deprivation and other determinants.

Priority 2 — Access, Equity and Timely Support

Objective: Ensure people can access the right support at the right time, regardless of background or circumstance.

Headline actions:

- Reduce waiting times through improved triage, capacity, and flow across key pathways.
- Simplify pathways and implement “no wrong door” access across services and neighbourhoods.
- Provide user-friendly information and navigation about services for residents and professionals (digital and non-digital; accessible formats).
- Offer multiple routes to access support (digital, phone, face-to-face, community; evenings/weekends where needed).
- Strengthen primary care mental health pathways and connections to VCSE and Neighbourhood Teams.
- Target inequalities with culturally competent outreach, reasonable adjustments and community-led approaches.

Intended impact:

- Improved access and experience; reduced deterioration while waiting.
- More equitable outcomes and reduced variation between groups and neighbourhoods.
- Reduced crisis presentations driven by access delays.

Priority 3 — Integrated, Person-Centred and Community-Based Care

Objective: Deliver coordinated, personalised care close to home through neighbourhood-based and community mental health models.

Headline actions:

- Develop/strengthen integrated neighbourhood mental health teams aligned to neighbourhood working.
- Implement holistic, co-produced care planning addressing mental health, physical health and social needs.
- Strengthen step-up/step-down pathways and care coordination for people with complex needs.
- Embed VCSE organisations as core delivery partners; strengthen referral pathways and social prescribing.
- Improve transitions across life stages (16–18/18–25, CAMHS to adult services, older adults).
- Increase trauma-informed and neuro-affirming practice across pathways.

Intended impact:

- Reduced fragmentation and duplication; improved continuity and recovery.
- Greater use of community support; reduced reliance on inpatient care.
- Improved experience: fewer handoffs and less repeated storytelling.

Priority 4 — Crisis Support and Acute System Relief

Objective: Ensure timely, compassionate crisis support in the least restrictive setting possible, reducing reliance on hospital-based care.

Headline actions:

- Strengthen 24/7 crisis response and integration with NHS 111 mental health crisis pathways.
- Expand community crisis alternatives (safe spaces/crisis cafés, home-based crisis treatment).
- Improve crisis handovers and follow-up (7-day/30-day), including post-crisis recovery support.
- Reduce A&E, police and ambulance reliance through joint response models and staff training.
- Strengthen CYP crisis pathways and transitions between child and adult crisis services.
- Address discharge bottlenecks linked to housing and community capacity.

Intended impact:

- Improved crisis experience and safety, faster access to crisis support.
- Reduced A&E presentations, inpatient admissions, and length of stay.
- Improved discharge flow and reduced out-of-area placements.

Priority 5 — Workforce, Partnership and System Strengthening

Objective: Support a skilled, resilient workforce and strengthen partnership working, governance and improvement capability.

Headline actions:

- Implement workforce wellbeing, retention, supervision and reflective practice approaches across partners.

- Build skills and capability (trauma-informed care, cultural competence, neurodiversity, crisis, and suicide prevention).
- Strengthen joint commissioning, pooled approaches where appropriate, and shared leadership/accountability.
- Improve data quality, shared dashboards, and evaluation to support continuous improvement.
- Embed co-production and lived-experience leadership in governance and service redesign.

Intended impact:

- More stable workforce and consistent quality of care.
- More effective partnership delivery and reduced duplication.
- Better system assurance through shared outcomes and performance management.

Priority 6 — Wider Determinants of Mental Health

Objective: Improve mental health by addressing housing, employment, education, safety, and social connection as drivers of wellbeing.

Headline actions:

- Strengthen integration between mental health services and housing/homelessness pathways; increase supported accommodation solutions.
- Expand employment and skills support, including IPS (Individual Placement and Support) pathways.
- Tackle loneliness and isolation through community connection and Live *centres, spaces* and *offers*.
- Strengthen trauma-informed responses to domestic abuse and safeguarding-related drivers of poor mental health.
- Target investment to the most deprived neighbourhoods and underserved groups; embed mental health in local policy.

Intended impact:

- Reduced inequality and improved stability (housing, work, finances) supporting recovery.
- Reduced crisis presentations linked to social and economic stressors.
- Improved community resilience and population wellbeing.

6. Delivery and governance (high-level)

Delivery will be neighbourhood-led and aligned to Live Well, with shared accountability across partners.

- **Oversight and assurance:** Bury Health & Wellbeing Board (strategic) and Bury Locality Board.
- **Delivery:** Mental Health Partnership Board (programme delivery sub-group) with multi-agency workstreams where required.
- **Unit of delivery:** this will vary. Some transformation programmes are GM-wide aligned to the GM Mental Health and Wellbeing Strategy. Others will be led by PCFT across their footprint. Some developments will be at *place* level, in Bury with an emphasis on alignment with our Neighbourhood model..
- **Approach:** phased delivery (Foundation 2026–27; Transformation 2027–29; Consolidation 2029–30).

- **Measurement:** outcomes framework spanning population outcomes, system outcomes, service outcomes and enabling indicators.

Appendix 1: Bury MH priorities / commissioning intentions 2026.27

Strategic priority alignment	Workstream	Overview	Objectives	How - 2025/26 Plans	Indicators
Priority 1 — Prevention and Early Intervention	Coping & Thriving	Describe and promote a core offer of mental wellbeing initiatives and services at a place and Neighbourhood level	Improve access and uptake of mental wellbeing services to provide early help for people with emergent mental and emotional wellbeing issues	1. Describe and promote core offer inc Connect 5, Helping yourself to Wellbeing & Silver Cloud 2. Describe and promote additional provision at a Neighbourhood level as part of wider Live Well offer. 3. Given Funding is available Mental Health prevention to be piloted	Connect 5, Helping yourself to Wellbeing: • Number of sessions delivered • Number of people attending • Participant feedback Silvercloud: • Locality uptake. • KPI's attached
	Suicide prevention	Continued development and implementation of the Bury suicide prevention plan including programme of suicide prevention training.	1. Maintain or increase delivery and uptake of training. 2. Target training at those parts of the workforce / community most likely to be in contact with groups at higher risk inclusive of neurodiversity	1. Shining a Light on Suicide and Zero Suicide Alliance training distributed from GM Leads 2. Face to Face training 1 hour lunchtime learning and 3-hour options. 3. Possible in school provision also from mandatory legislation from central government from April 2026.	• Number of sessions delivered • Number of people attending • Participant feedback
	myHappyMind / myMindcoach	Currently operating in 33 primary schools and 10 high schools. Primary school delivery is part funded by schools and part non-recurrent. High school provision is currently unfunded.	Sustain existing provision in Bury Schools	Plan to be agreed	• Provider impact reporting

		Feedback from teachers, parents and pupils is excellent.			
	Sensory processing	Optimisation of a graduated approach to sensory processing support as part of a redesigned service offer.	Provide early help and bespoke support for children and families with sensory processing needs	1. Recommission existing provider for 2026.27. 2. Review existing pathways. 3. Implement improvement recommendations. 4. Agree commission intentions for 2027.28.	• Numbers of referrals. • Uptake of Sensory toolkit • Waiting times for assessment / consultation. • CYP / parent & carer outcomes & experience.
	Neurodevelopmental [ADHD / ASD] provision for CYP.	Locality implementation of GMICB transformation programme.	1. Enable those in the greatest need / risk to have more timely access to assessment and treatment. 2. Provide early help, guidance and support without the need for a diagnosis. 3. Provide simpler, more consistent pathways for advice, guidance, assessment and support / treatment. 4. Improve outcomes for children and families.	1. Local implementation of multi-disciplinary triage. 2. Review and develop plan for provision of community-based assessments at sufficient capacity. 3. Full implementation of Bury Neurodevelopment Hub. 4. Develop and promote new pathways of care.	• Numbers of referrals. • Waiting times for assessment. • ND hub referral numbers. • CYP / parent carer experience
	Mental Health Support Teams in Schools	Implement the new model of care in line with national guidance. Extend provision to up to 77% of schools [ICB level target]	Extent the provision of evidence-based, accessible early help for CYP with MH issues in school in the context of a whole school approach	Plan / locality actions to be agreed	• School coverage. • Outcome reporting
Priority 2 — Access, Equity	Talking therapies	Comparatively high level of prevalence of depression in Bury.	1. Improve reach of NHS Talking Therapies to people with common MH problems.	Improvement plan TBC with PCFT	• Access rate • 6w wait • 18w wait • Secondary wait

and Timely Support		Access and waiting times for NHS Talking Therapies are below the GM average.	2. Improve timely access of NHS Talking Therapies.		
	Neurodevelopmental [ADHD / ASD] provision for adults.	Implement transformed pathways for neurodevelopmental assessments [ADHD / ASD] for adults.	1. Maintain a managed pathway for transition of young people on shared care [ADHD medication] for young people discharged from CAMHS. 2. Provide access to triage / assessment over time for those patients originally referred to LankUK. 3. Ensure those with the greatest need have more timely access to assessment.	1. Complete commissioning of NES service for 2026.27. 2. Agree arrangements in relation to the remaining LANK UK legacy patients. 3. Agree commissioning arrangements for 2027.28. 4. Support implement GM pathway redesign [ADHD]. 5. Support implementation of new standard service specifications [ADHD and ASD].	• Provider contract KPIs
	Dementia	Current memory assessment pathway delivered by GP practices. Limited MAS provision through delivered by PCFT. Dementia United are undertaking a review of MAS provision with a view to developing a recommended model for the whole of GM.	Work towards having a pathway of care / service model which is compliant with recommended standards.	1. Agree funding arrangements for existing model for 2026.27. 2. Participate in Dementia United review. 3. Agree preferred model and commissioning intentions for 2027.28	
	Domestic abuse support	Provider currently out of contract but with funding committed pending outcomes of wider review of domestic abuse services led by Bury MBC	1. Agree sustainable approach to supporting children and young people who have experienced domestic abuse. 2. Agree sustainable approach to intervening with young people who	1. Review provision as part of wider LA led review of domestic abuse services 2. Develop commissioning intentions	

			exhibit harmful behaviours.		
	Mental health provision for CYP involved in the criminal justice system	The Youth Justice Board is a statutory function currently spanning the Rochdale and Bury authority areas. There is an inequity in provision – in Rochdale there is a designated CAMHS service in relation to Youth Justice – in Bury there is not.	Provide appropriate mental health assessment and support for CYP involved in the criminal justice system.	TBC	
Priority 3 — Integrated, Person-centred and Community-Based Care	Adult community services transformation	Continue to embed and refine the Neighbourhood MH model	1. Ensure effective integration crisis services, specialist services and the wider Neighbourhood model including GPs 2. Ensure clear pathways of care for patients and referrers. 3. Increase overall capacity within community services across PCFT, MBC and VCSE.	1. Develop and implement comms and engagement plan esp with GPs. 2. Review Living well VCSE element of Neighbourhood MH Teams. 3. Agree commissioning intentions for VCSE crisis service for VCSE element of Neighbourhood MH Teams for 2027.28.	To be agreed with PCFT, Bury Council and VCSE partners.
Priority 4 — Crisis Support and Acute System Relief	Adult mental health crisis services	Reduce demand on hospital-based crisis services, specifically MH Liaison, through the provision of safe and effective, community-based crisis resolution and support services.	1. Increase capacity in community-based crisis resolution services. 2. Ensure integration of crisis services with clear pathways for patients and referrers. 3. Reduced A&E attendance [by people in MH crisis] 4. Reduced acute inpatient admissions.	1. Implement locality Crisis Response Team aligned with Home Treatment Team. 2. Ensure local crisis pathways are reviewed and updated. 3. Review existing VCSE crisis service. 4. Agree commissioning intentions for VCSE crisis service for 2027.28. 5. Work with ICB leads and providers on development potential linked to medium term planning guidance inc MH EDs and step-up crisis provision.	• Crisis response team referral numbers • Peer Led Crisis Service referral numbers • MH Liaison referral numbers • 12hr ED breaches

	Patient flow on MH inpatient wards	There has been positive progress in 2025.26 in improving patient flow with reductions in average LOS, OAPs and bed days occupied by people who are CRFD. The emphasis is on maintaining current performance and delivering improvements where possible, largely within existing resources.	1. People are provided with acute inpatient care closer to home. 2. People are discharged from inpatient care in a timely way.	1. Implement inpatient safer staffing levels 2. Implement agreed GM and locality plans for reducing CRFD / OAPS / LOS 3. Days Away from Home Hospital Discharge Pathway Pilot – developing clear discharge pathways on Mental health wards. 4. Map gaps in relation to step-down provision inc MH IMC / enablement to inform commissioning intentions.	• 12hr ED breaches • Inappropriate OAPS. • Bed days occupied by people who are CRFD. • Average LOS – adults & older adults • Patients with a long LOS - over 60 days.

Meeting:			
Meeting Date	01 July 2026	Action	Receive
Item No.	14	Confidential	No
Title	Population Health update		
Presented By	Jon Hobday – Director of Public Health		
Author	Jon Hobday – Director of Public Health		
Clinical Lead	N/A		

Executive Summary
An overview of the work discussed and planned in key population health/public health meetings.
Recommendations
To note the work being discussed.

OUTCOME REQUIRED (Please Indicate)	Approval ☐	Assurance ☐	Discussion ☐	Information ☒
APPROVAL ONLY; (please indicate) whether this is required from the pooled (S75) budget or non-pooled budget	Pooled Budget ☐	Non-Pooled Budget ☐		

Links to Locality Plan outcomes	
To support a local population that is living healthier for longer and where healthy expectancy matches or exceeds the national average by 2025.	☒
To achieve a reduction in inequalities (including health inequality) in Bury, that is greater than the national rate of reduction.	☒
To deliver a local health and social care system that provides high quality services which are financially sustainable and clinically safe.	☐
To ensure that a greater proportion of local people are playing an active role in managing their own health and supporting those around them.	☒

Implications						
Are the risks already included on the Locality Risk Register?	Yes	☐	No	☐	N/A	☒
Are there any risks of 15 and above that need to be considered for escalation via an NHS GM Statutory Committee or Board in line with the Risk Escalation process ?	Yes	☐	No	☐	N/A	☒
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☐	N/A	☒
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☐	N/A	☒
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☐	N/A	☒
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☐	N/A	☒
Are there any financial Implications?	Yes	☐	No	☐	N/A	☒
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☒
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☒

Governance and Reporting		
Meeting	Date	Outcome
N/A		

Population Health and Wellbeing update

1. Introduction

- 1.1. This paper sets out recent population health updates from the Bury health and wellbeing board.

2. Bury Health and Wellbeing Board

- 2.1 Bury health and wellbeing board took place on 11th June, the agenda included discussions on the neighbourhood plans, the anti-poverty strategy, the health inequalities strategy refresh, the Better Care Fund, food and health and mental wellbeing.

2.2 Neighbourhood plans

- Development ongoing until September 2026.
- Focus on aligning programme delivery with priority areas while maintaining strategic oversight

2.2 Anti-poverty strategy

- Strategy nearing final approval stage with strong partner and community involvement.

Key features:

- Built on lived experience and evidence
- Clear actions assigned to stakeholders
- Strong alignment with wider inclusion agenda

Delivery approach:

- Early intervention (e.g. identifying financial risk triggers)
- Use of trusted local organisations (via Crisis & Resilience Fund)
- Proactive outreach to vulnerable groups

2.3 The health inequalities strategy refresh

- Updated framework provides stronger strategic focus, aligned with JSNA evidence.

Emphasis on:

- Place-based data and deprivation insights
- Integration with neighbourhood teams and early years work

2.4 The Better Care Fund

- Strong emphasis on integrated neighbourhood teams to improve prevention, reduce hospital admissions, and join up services across sectors.
- 2026/27 submission approved – meets all national conditions.
- Total value: £41.6m.
- Strong alignment with emerging national priorities.

(2025/26):

- Emergency admissions (65+) performing well
- Delayed discharge and long-term care admissions higher than benchmarks

2.5 Food and Health

- Strong emphasis on integrated neighbourhood teams to improve prevention, reduce hospital admissions, and join up services across sectors.

- Significant progress on Food Strategy and partnership work.
- **Achievements:**
- National recognition and parliamentary engagement
- Gold Food for Life Served Here standard (unique achievement)
- **Challenges:**
- Food inflation and fuel costs
- Some schools opting out
- **Future focus:**
- Breakfast clubs
- Increasing school engagement

2.6 Mental Health and Wellbeing

- Feedback highlights need for:
 - Earlier access and more therapy options
 - Improved support for specific groups (neurodiverse, ethnic minorities, young adults)
 - Better coordination and communication
- **Strategic priorities:**
 - Improve existing services and close gaps
 - Address wider determinants (housing, employment)
 - Strengthen community-based and early support
- **Local Programme Highlights**
- Coping & Thriving programme and mental health mapping
- **Suicide prevention:**
 - Annual conference (next planned Oct 2026 – CYP focus)
 - Audit cycle and stakeholder meetings
- **New targeted support:**
 - Neurodivergent children
 - Suicide survivors

Overall Themes

- Continued focus on integration and prevention across health and care.
- Strong focus on prevention, early intervention, and inequalities
- Increasing emphasis on place-based, data-driven approaches
- Continued system pressures in discharge and long-term care demand
- High-performing areas (e.g. food strategy) acting as national exemplars

Jon Hobday

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Meeting:			
Meeting Date	06 July 2026	Action	Receive
Item No.	15	Confidential	No
Title	Report from the Performance & Quality Meeting – including quarterly risk report and Performance report		
Presented By	Kath Wynne-Jines Catherine Jackson		
Author	Kath Wynne-Jones Catherine Jackson		
Clinical Lead	Cathy Fines Kiran Patel Catherine Jackson		

Executive Summary				
This paper provides an update to the Locality Board on meetings, activity and discussions in relation to performance, IDCB work and quality. The risk paper details the locality strategic and programme risks set by the locality Risk and Scrutiny Group as scored 12 and above using the strategic risk descriptors detailed in section 3 of this report. The risks are described in summary and high-level mitigating actions are included. Further detailed information on the risk mitigations is discussed and actioned through the transformation/programme boards and workstreams. The risk register is cross referenced with the ICB risks as presented in the Board Assurance Framework.				
Recommendations				
The Board is asked to note the report, discuss and consider the risks and make recommendations to the Risk and Scrutiny Group to ensure robust transparency, oversight and mitigation of locality strategic and performance risks.				
OUTCOME REQUIRED (Please Indicate)	Approval ☐	Assurance ☐	Discussion ☐	Information ☒
APPROVAL ONLY; (please indicate) whether this is required from the pooled (S75) budget or non-pooled budget	Pooled Budget ☐	Non-Pooled Budget ☐		

Links to Locality Plan priorities	
Scale our work on Population Health Management – Improve population health and reduce health inequality of those in the most disadvantaged areas	☒
Drive prevention, reducing prevalence and proactive care – supporting Demand Reduction through primary intervention, secondary preventions and tertiary prevention.	☒

Links to Locality Plan priorities	
Transforming Community Care in Neighbourhoods – fully realising the benefit of neighbourhood team working with a focus on the assets of residents and communities and providing proactive care	☒
Optimise Care in institutional settings and prioritising the key characteristics of reform.	☒

Implications						
Are the risks already included on the Locality Risk Register?	Yes	☒	No	☐	N/A	☐
Are there any risks of 15 and above that need to be considered for escalation via an NHS GM Statutory Committee or Board in line with the Risk Escalation process ?	Yes	☐	No	☒	N/A	☐
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☐	N/A	☒
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☐	N/A	☒
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☐	N/A	☒
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☐	N/A	☒
Are there any financial Implications?	Yes	☐	No	☐	N/A	☒
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☒
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☒	N/A	☐

Governance and Reporting		
Meeting	Date	Outcome
N/A		

Performance and Quality Meeting

Summary of Deep Dive into Diabetes

A discussion took place on a range of metrics on diabetes care to understand the activity and impact of diabetes on admission rates.

There was a discussion looking at if practices who completed more of the diabetes 8 care processes in primary care for example managing blood glucose, hypertension, lipid levels and including other physical checks impacts on the risk of an acute admission. The data presented did not provide the correlation but did guide the group to see which practices were completing the care processes. A limitation of the data was that information was provided for the over 65y cohort only.

The group noted uncertainties with the search methodology, including whether admissions were captured by primary or secondary coding and whether codes such as DKA, hypo/hyperglycaemia, wounds, renal or cardiovascular complications were included.

Two actions was taken:

1. To review one of the practices that appeared to be an outlier in their admission rates.
2. To complete a piece of work re-running the data to capture all adults (18y+) rather than over 65y.

Hospital admissions data relating to diabetes which covered the period April 2021- March 2024 was shared. At the time of the analysis, Bury had approximately 760 people with Type 1 diabetes and around 11,500 with Type 2 diabetes. Updated figures shared by the Primary Care team during the meeting were approximately 782 Type 1, 12,279 Type 2, and 216 unknown/other diabetes types as of March 2026. This showed a small increase in Type 1 diabetes likely related to population size and an increase in Type 2 diabetes which was expected.

The analysis was focused on hospital admissions and A&E attendances related to:

- diabetic ketoacidosis (DKA)
- hyperglycaemia
- hypoglycaemia
- insulin overdose/poisoning coding

Bury's A&E attendance and admission activity for diabetes-related reasons appeared relatively lower than some neighbouring areas, including HMR and Oldham.

Non-elective diabetes-related admissions were estimated at just over 100 admissions, with a total cost of around £452,000 and an average cost of approximately £4,300 per admission with DKA identified as the highest-cost admission category.

Admission route analysis suggested many patients came through A&E rather than GP referral routes:

- Ethnicity data suggested variation in attendance/admission patterns, with higher rates noted among Asian populations in Bury and neighbouring areas. Jon Hobday suggested this should be explored further to understand whether targeted education or support is needed.
- Hypoglycaemia admissions were discussed, including existing work with North West Ambulance Service to support treatment at home and rapid response from the community diabetes team.

The Community Service lead highlighted potential opportunities from her previous invest-to-save proposal for example:

- risk stratification with primary care
- increasing access to continuous glucose monitoring
- strengthening the community diabetes duty role to support rapid discharge
- promoting the suspected Type 1 diabetes pathway
- improving education for urgent/emergency teams on direct referral routes
- reviewing the ED/SDEC pathway for suspected Type 1 diabetes

The group agreed there is variation in completion of the diabetes 8 care processes and that this should be reviewed again later in the year, particularly alongside Bury core work and neighbourhood approaches.

It was agreed that diabetes needs to remain a key area of focus because of its links with obesity, CVD, health inequalities and long-term outcomes. Therefore, additional areas for further review included:

- ethnicity and diabetes-related admissions
- paediatric diabetes data
- younger people with Type 2 diabetes
- interface with obesity work
- updated diabetes prevalence figures
- refreshed hospital admission analysis with NCA
- Postpartum follow-up after gestational diabetes
- Non-diabetic hyperglycaemia prevention

CQC Activity

Bankfield Care Home rated as GOOD.

Bankfield is a care home registered to provide personal care to up to 44 older people, some of whom have a diagnosis of dementia. The service does not provide nursing care. There were 40 people living at the service at the time of assessment.

People's experience of this service

Resident feedback - CQC found a culture of kindness, safety and professionalism where members of the management team led by example. People using the service, their relatives and staff all spoke positively about their experiences of the service and the staff team. People reported they were enabled to remain as independent as possible, supported when required by staff who were caring and responsive to their needs. Dietary and hydration needs were met and people told us they enjoyed the food at the service. The registered manager and their team fostered an open culture where everyone's thoughts and feelings were considered.

Radcliffe House Residential Care Home rated as GOOD.

Radcliffe House is a residential care home providing accommodation and support to people who have a mental health condition and have a learning disability or autism. At the time of the assessment, 2 people were living at Radcliffe House.

Staff were safely recruited. Staff said they had completed training and felt supported in their roles and supported to develop. This included relevant training in the complex needs of the young people. Medicines were managed safely. Staff also worked closely with the internal multidisciplinary team as well as other agencies and professionals to help ensure the healthcare needs of the young people were met.

Records and the young people confirmed, they were involved in the planning of their care and how

they wished to be supported in a personalised way. Detailed support and risk management plans were in place to guide staff in managing the young people's complex needs and behaviours, helping to reduce incidents and ensure a consistent approach. Any restrictions in place were lawful. The model of care also considered both short and long-term goals, with a focus on reducing restrictions over time.

People's experience of this service

Both young people said they liked living at Radcliffe House which had a homely feel and had a good rapport with their keyworkers. Staff demonstrated a good understanding of the young people, including their likes and dislikes. Interactions between staff and young people were seen to be polite and good-humoured. This was observed during our visits to the home.

Bury ICP Strategic Risk Report

Introduction

This report updates the Locality Board on the key strategic risks to the delivery of the Locality Plan and Board priorities.

This report updates the Locality Board on the risks considered 12 or greater by the workstreams of the IDCB.

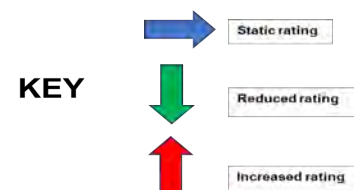
Risks are managed by the relevant IDCB workstreams and this report provides an overview to inform Locality Board members of high risks but does not contain those judged to be under 12 or all the actions that are ongoing in mitigation.

There is a locality Risk and Scrutiny Group who consider all the borough level risks, seeks assurance from the Transformation/Programme Boards and workstreams to advise on the elements of managing, scoring and escalation processes.

There is currently no electronic system for risk management for the borough whilst an agreement is made across the GM ICP and no locality risk manager.

Risk Descriptors

			Likelihood				
			1	2	3	4	5
			Rare	Unlikely	Possible	Likely	Almost certain
Consequence	5	Catastrophic	5	10	15	20	25
	4	Major	4	8	12	16	20
	3	Moderate	3	6	9	12	15
	2	Minor	2	4	6	8	10
	1	Negligible	1	2	3	4	5



No	Theme	Risk description	Initial score							Risk move ment	Risk target	Key control / assurance
			25-26 – 26/27				26/27 – 27/28					
			Q3	Q4	Q1	Q2	Q3	Q4	Q1			
1	<u>Health of GM residents</u> Taken from NHS GM Board Assurance Framework (BAF)	There is a risk that the health of the population will worsen due to wider economic and social conditions deteriorating. This could include societal challenges and structural inequalities that relate to poverty / socio-economic disadvantage, housing and local infrastructure, early years experiences and educational attainment, access to good employment, crime and safety, air quality and transport. This will result in poorer health, unsustainable demand on health and care services and will impede economic growth.	15	15						↔	10	The Greater Manchester Strategy is the main control measure and the deliverability of the strategy including the extent to which the ICB can act as a system influencer and strategic investor is key to mitigating this risk. In the current landscape of NHS reform, it is crucial that the ICB retains the capacity, expertise and ability to act as a collaborative system influencer and co-investor in relation to the building blocks of health which the strategy covers. Alongside the GMS, another key control is the development of a comprehensive strategic approach to NHS 'left shift' which builds upon our GM Population Health Model and comprehensive Prevention and Early Intervention Framework and underpins ICB reform and future transformational operating model. An evidence-based, co-produced and fully costed NHS GM Annual Plan for 2025/26 includes a series of actions relating to reducing the prevalence of poor health and scaling up proactive care. A Fairer Health for All Framework has been agreed by the Integrated Care Board and there are significant

											implementation plans in place for 2025/26 which will seek to embed tackling inequalities as a focus of the system. The GM Housing Tripartite Agreement ensures a collaborative approach to healthy homes across NHS GM, GMCA and Housing Providers.	
2	<u>Quality of Services</u> Taken from NHS GM BAF	There is a risk that key health and care services become unsafe and unstable due to growing and changing demand, pressures faced by other sectors and workforce, estates and technology gaps. This will result in poorer health outcomes for the GM population and a reduction in quality of care and patient safety and an inability to deliver operational delivery standards.	15	15						↔	10	NHS trust provider oversight (POM) in place and well established with plans to further develop and further strengthen. • Exec to exec meetings now a regular occurrence, with Quality KLOES identified. • ICB Provider Oversight Framework established in line with National Guidance. • Quality Assurance Framework established/aligned to meet the National Quality Board Standards. • Work underway to strengthen quality in contractual mechanisms to align with the strategic commissioner aim. • Quality Impact Assessment processes established • GM System Quality Group currently being reviewed in line with wider governance work underway at the ICB). • Reporting, audits and actions in place for safeguarding assurance (aligns to Safeguarding Policy). • MIAA Audit findings/actions • Annual reports (Quality Accounts / Safeguarding Report). • Assurance meetings with NHSE. • Submission to RSQG with escalations as part of business as

											usual. • External audits. • External inspections by regulators	
3	<u>Widening inequalities</u> Taken from NHS GM BAF	There is a risk that health inequalities are widened, and health outcomes are reduced to due to a lack of sustained investment in preventive, proactive and evidence-based services. This will result in increased demand and cost of health and care services and impede economic growth.	16	12						↓	8	Development of a comprehensive strategic approach to NHS 'left shift' which underpins ICB reform and future operating model. Inclusion of 'left shift' investments in the annual plan and budget for 2025/26. Strong oversight of the risk and mitigations through the Population Health Committee (chaired by an NHS GM NED) which has a risk register in place which is reviewed as a standing item at every committee meeting. An evidence-based, co-produced and fully costed NHS GM Annual Plan for 2025/26 includes a series of actions relating to reducing the prevalence of poor health and scaling up proactive care. A Fairer Health for All Framework has been agreed by the Integrated Care Board and there are significant implementation plans in place for 2025/26 which will seek to embed tackling inequalities as a focus of the system. The ICP Strategy and NHS GM Sustainability Plan both have a strong emphasis on improving health and reducing inequalities through prevention. NHS GM has agreed a comprehensive, whole system model for improving health and reducing inequalities in the form of the GM Prevention and Early

											Intervention Framework and co-produced GM Population Health Model. Refresh of the GM Strategy which has a significant impact on the wider determinants of health.
4	<u>Workforce</u> Taken from NHS GM BAF	There is a risk that existing workforce challenges are exacerbated due to the requirement for financial savings and the impact of NHS reforms. This will result in recruitment challenges to key areas, reduced staff wellbeing, lower morale and inequality of opportunity. This will further impact on service delivery and leadership capacity to manage change.	12	16						↑	Direct reporting to NHS GM Board while Committee is stood down. • P&C Governance and supporting TORs • Committee working groups, focus on workforce efficiency, Transforming People Services, Leadership Culture & EDI • Monthly workforce reports • Operational planning rounds and provider oversight meetings, supporting pay bill reduction to support long term financial sustainability. • Regular review of the P&C risk register • Leadership, Culture and EDI; System-level equality impact assessment (EIA) risks noted at P&C; mitigation through electronic systems to increase visibility and assurance
5	<u>NHS Reform Programme disruption of core ICB business service delivery</u> Taken from NHS GM BAF	There is a risk that the NHS Reform Programme could disrupt delivery of core ICB business due to restructure and staffing reductions. This will result in core ICB business being disrupted during the transition. Included in this risk is quality oversight of	16	16						↔	4 GM Transition Programme Team oversees management and updates of the risks for all component programme areas. Transition Operational Delivery Group holds oversight on all the risks within the transition programme and component workstreams. Transition Risk Group to have a grip and oversight over all programme risks. This group will

		commissioned services.									monitor controls, actions and ensure that all work is being done to lower the risk. Chief Officers meeting gives exec level assurance and approval of BAF risks and other high-level risks within the transition needed to be escalated. They will provide periodic updates to ensure progress on mitigations. Executive Committee has exec level assurance and approval of BAF risks and other high-level risks within the transition needed to be escalated. They will provide periodic updates to ensure progress on mitigations. NEDs/Execs Meeting assurance of the high-level risks within the transition programme with monitoring to ensure the risks are correctly being mitigated periodically. NHSE Oversight Meetings report on progress of the reform and any risks that need to be escalated.
6	<u>Finance:</u> <u>System Finance</u> <u>Position</u> Taken from NHS GM BAF	There is a risk that the ICS does not achieve in-year and medium-term financial sustainability due to continued growth in demand, inflationary and cost pressures, inability to deliver CIPs in full and other identified causes such that the financial resources do not meet	20	20					↔	12	The enhanced levels of grip and control and financial assurance established during 2024/25 continue across the GM system, including CIP Governance, Provider Oversight. • NHSE has undertaken a review of both ICB and Provider Trusts exit run rate modelling to ensure consistency and robustness as part of planning. ICB plans submitted to NHSE 12/2/26

		system needs. This will result in the inability to deliver on the ICP Strategy, reducing our ability to invest in preventative care which will drive demand, and continued inequalities and variation in health and care.									showing achievement of plan in 2026/7, 2027/8 and 2028/29. • The medium-term financial plan and financial strategy will be further developed to identify key principles and robust CIPs to support financial sustainability. • ICB has revised the reporting pack with a focus on run rate to allow identification of potential issues and mitigation plans have been implemented to address the risks on in year delivery. Run rates became a focus within the finance item of LAMs from July and are a key item within monthly monitoring for all ICB areas of expenditure. • Recovery plans have been developed for the 4 key areas of overspend: o CIP o Independent Sector o IPoC o ADHD/Autism Each recovery plan has SMART actions in place which will be monitored through the Financial Recovery Group with Committee and Board scrutiny. The ICB Recovery plan is now being accelerated to evaluate and approve new options to mitigate the current risk level with appropriate Board governance. Further schemes were developed including: o Meds Optimisation stretch target o Additional IS contracts activity plans o Primary Care o Non Pay and Workforce • All CIPs are subject to a quarterly deep dive to ensure they remain on track and

											determine if there is any opportunity for stretch. • Productivity pack - GM to continue with the system developed productivity pack that is now used across the NW. This helps to inform opportunities for improved performance and will become part of POMs.	
7	<u>Urgent and Emergency Care</u>	BECAUSE of limited flow of patients out of the ED and hospital, the number of patients in ED can be greater than the staff's capacity to manage within targets, THEN there is a risk that this could lead to a compromised quality of care given to patients. Also, IF the number of patients on the Days Kept Away from Home (DKAFH) list do not reduce, THEN patients will be kept in hospital unnecessarily leading to potential increased harm for those patients (e.g. increased risk of infection, deconditioning) and for other patients attending the emergency department and requiring admission to an acute bed (e.g. reduced ED capacity, trolley waits in ED).	16	16						↔	8	FGH failed the 4-hour target in 2024-25. However, the site is on an improvement trajectory and has seen improved performance month on month since December 2024. This improvement is currently set to continue in May 2025. Further work continues into 2025 -26 including: • Front door streaming review • Re launch of Bury Patient Flow Collaborative • Avoiding needless in patient/emergency care" Deflection from ED • Stroke Rehab -Right Place, Right Time • 7 Day Working More People Home Same Day • Understanding Length of Stay Wards Why not home? why not today? • Increase opening hours on SDEC Staffing review • Consultant Community in reach for Frailty and Dementia • Relaunch Activity rooms on Ward 18 & Ward 8

											• Understand Blockers to be able to Discharge before 10am • Review of services that we can left shift to the community • Implementation booking system to bring patients back the following day for SDEC/UTC June/July 25 • Fall Pilot in the Community • Rochdale Pathways • Weekend SDEC Frailty • Implementation of Hot Clinics • Roll out of Call before your conveyance starting 19th May 25 Review of a 24-hour Assessment area	
8	<u>Services for Children, including SEND</u> Awaiting inspection outcome letter	BECAUSE the Bury system is not delivering in-line with the SEND national framework expectations, THEN there is a risk that the children, young people, families, and carers do not get the right support from health services, Children's Social Care and Education to ensure they reach as good outcomes as all children. The increase in requests for ND assessments is being felt nationally and locally.	16	12						↓	8	Children's Improvement Board in place. Work continues on an improvement journey to strengthen the support for children, young people and families in the borough. External support from national team. Independently chairing a SEND improvement board. Committed £300k investment in the HV service delivered by NCA. mobilised in increasing SEND HV team. Investment into Early Years team. Developing - GM Investment (£200k) in the Neurodevelopmental offer, with the progress of a new model of care pathway. Offering early help to families – this should be fully mobilised by October 25. GM ADHD consultation on adult pathway changes is ongoing. Developing (GM) work is ongoing to

											address reduction in CAMHS waiting lists. Locally focus activity continues to address aspects of the pathway that are under significant pressure. Pathway mapping of the first 1001 days, and the potential roll-out of family hubs. Launch parenting strategy and early years proposition with oversight by the Children’s Strategic Partnership Board. February 2025 – feedback following monitoring visit, positive improvements evidenced. Awaiting inspection letter confirming feedback.	
9	<u>Local Implementation of Families First Partnership</u>	There is a risk that the GM ICB will be unable to fulfill the statutory requirements of the Families First Partnership due to a lack of available funds to sustain the health workforce elements of the programme, following the initial allocation of grant monies in year one. Cause - Each of the 10 localities across the GM ICB footprint has a unique starting position both financially from the FFP grant and with the existing workforce within Provider Safeguarding Teams. Impact - This presents risk	16	12						↓	6	FFP board in place. Good engagement from partners across the system. Funding agreed including split between agencies. Bury has the Family Safeguarding Model as its social work operating model. Family Safeguarding social work teams are aligned to neighbourhoods. Partners contributing to the design of the Early Help and MACPT design; on tract with the MACPT test and learn site. The reforms will build on the existing Family Safeguarding Model, align but not duplicate the MASH.

		that the Multi Agency Protection Teams will not have sufficient input from health to be able to ensure a true multi-agency response to child protection concerns.									
10	<u>Lack of a Plan for Managing the Dynamic Support Register for LDA Children</u>	Dynamic support registers (DSRs) and Care (Education) and Treatment Reviews (C(E)TRs) are essential elements of the pathway providing people with a learning disability and autistic people with appropriate support and care at the right time. There is a risk due to the GM ICB reforms that the staff member responsible locally (DSO) will no longer carry out this function and there will be a gap in this function.	12	12						↔	Locally the Designated Clinical Officer (DSO) for SEND has responsibility for this function. Reform discussion underway with regard to having a centralised GM DSO team with fewer staff. Discussions with GM ICB on the role and responsibilities of the DSO ongoing. Adult DSR managed in Complex Care - no capacity in the team to pick this work up. Support from Complex Care team member to stream line process. No current identified landing place post ICB reforms for the DSR .
11	<u>Safeguarding workforce</u>	There is a risk that the proposed GM ICB Safeguarding Team will be unable to fulfil all of its statutory obligations due to insufficient capacity within the team. Requirements for Named and Designated professionals who have delegated responsibility from the ICB to carry out	12	12						↔	Across GM there are gaps in staff in key safeguarding positions, additionally GM ICB have agreed further VR posts which will create more gaps. Locally the borough has statutory posts filled at the current time. Work on-going with GM ICB on the new proposed model. JDs and responsibilities being developed at GM level without local

		safeguarding duties on behalf of the organisation may not comply with statutory guidance. Impact - Insufficient capacity to deliver the level of assurance and oversight required by the GM delivery model Inability to meet required levels of audit and oversight within the multi-agency strategic safeguarding partnership. Workstreams, support General Practice and provide assurance that learning is adequately embedded across the health economy									input into the design. Mutual aid will be offered where able to as requested.
12	<u>Sustainable General Practice</u>	IF: the apportionment of delegated PC monies is not sufficient enough to cover local elements unique to Bury (such as dementia diagnosis, ring pessaries, bloods etc) THEN: services may need to be stopped limiting what general practice support/deliver LEADING TO: Wider provider pathway pressures which cost more and possible poorer outcomes for the patients	12	12					↔	12	Despite receiving confirmation of funding and budget value for several services which sit outside of BeCCoR, we are being asked to renegotiate contracts with providers at lower rates as part of the STAR/PSR process. This is not only creating additional unnecessary work but is also creating reputational damage between place and providers and is putting these smaller value contracts under significantly greater scrutiny than much larger services funded through other contractual means. Should providers believe these contracts are

		of Bury										no longer deliverable this will result in service loss and a need to redirect patients to secondary care
13	<u>The delivery of the Uplands Practice estate solution</u>	BEAUSE an affordable scheme cannot be achieved to enable move of Uplands practice from current premises, THEN there is a risk that patients will have a poor experience of healthcare due to the condition of the estates. The current facility is becoming increasingly difficult to maintain to an acceptable level and is already impacting on patient experience and staff within the practice.	12	12						↔	8	Financial and contractual discussions are progressing well with all parties, and the agreed site has now been in NHS Property Services for a number of months. National approval has been secured for capital to deliver the scheme on the ex-library site – the planning application has now been submitted with a decision expected in the coming months. The contract is currently out to tender with submissions due back towards the end of May 2026 – the financial approval documents will then need to be updated to reflect prices received. As in all complex projects of this type, until a contract has been awarded and works have started on site, careful management of all known risks continues. Current project plans estimate completion on site around May-July 2027.

14	<u>Mental health programme</u>	If patient flow is not improved in MH inpatient wards this will lead to delayed discharge of patients to more appropriate placements, drive demand for inappropriate Out of Area Placements and increase the risk of 12-hour breaches in ED	12	12						↔	8	Risk score reduced due in Q2 due to progress made. Bury has consistently had an average if between 0 and 1 inappropriate out of area placement and Month on month since April 2025 the number of bed days occupied on acute MH wards by Bury Patients who are clinically ready for discharge has been below target. The YTD position in the last reported month (October) was 817 bed days lost against a maximum target of 1113. LOS for adults and older adults have been on a downward trajectory since the start of the financial year and the number of 12 hour breaches has been consistently below the peak in December 2024. GM, PFT and locality level improvement plan in place. Weekly locality and GM MADE meetings to support flow in MH wards. GM crisis programme to increase / improve community-based crisis provision and pathways. Actively monitored through Bury MH Programme Board.

15	<u>Mental health programme</u>	If the number of referrals for adult neurodevelopmental assessments via the right to choose pathways continues to increase this will lead to potentially inequitable provision and significant financial pressures on the locality budget.	16	16						↔	8	Expenditure is significantly up on the same period last year with significant overspend projected. Budgets for ADHD / ASD provision are being centralised by GMICB and GMICB has taken the decision to suspend funding for new assessments by so called right to choose providers until at least April 2026 to control costs. Expenditure is being closely monitored. Standard service specifications for ASD assessment and ADHD assessment and treatment have been developed and will be implemented with all contracted and right to choose providers in 2026 which should support greater consistency in terms of quality. Plans to implement a triage gateway for adult ADHD assessments have been approved by the GMICB following a public consultation and this will ultimately limit the number of assessment referrals. There has been in principle agreement with GMICB exec to recommission Optimise Healthcare to provide shared care oversight and ADHD / ASD assessment for in 2026.27. This will provide a commissioned alternative to right to choose for patients requiring an

											ADHD or ASC assessment.	
											The transformation of adult ADHD pathways is overseen by the GM Adult ADHD Steering Group with Bury Commissioner representation.	
16	<u>Mental health programme</u>	If demand and waiting times for CYP neurodevelopmental assessments are not reduced this will lead to continued delays in diagnosis and follow up treatment and support for children and families, and risk of further poor OFSTED / CQC inspection outcomes.	16	16						↔	8	Waiting times remain long – further work required to ensure standard routine reporting of waiting times. Progress monitored as part of the SEND improvement programme with regular reporting to SIAB PCFT CAMHS have implemented: - routine check-ins with families on waiting lists. - waiting list initiatives. GM triage / prioritisation criteria for ADHD / ASD assessments due to be implemented within CAMHS and community pediatrics as part of a wider neurodevelopment transformation programme from Jan 2026. CYP with the greatest needs / risks will be prioritised for assessment. The Bury ND Hub has been established to provide early help and needs based support without the need for a diagnosis. This together with other early help initiatives will provide needs led support to children and families and may reduce demand for full assessment in the

												longer term.
17	<u>Mental health programme</u>	If Bury (and the other NES localities) are unable to commission a provider of adult ASD assessment and ADHD assessment and treatment (2025.26) there will be complete reliance on the right to choose pathway for new assessments.	12	9						↓	8	Optimise earlier have now been given approval through the ICB to accept routine adult ADHD and ASD assessment referrals from Bury GPs under their new contractual arrangements. There is a cap on the budget so they will build up a waiting list but it means that we have a fully commissioned provider in place for the first time in over 3 years. The transitions pathway from CAMHS is BAU.

4 Recommendations

The Locality Board are asked to note the progress and risks outlined within this paper.

5 Actions Required

- 5.1 The Locality Board is asked to note the contents of the report and to raise any issues for the IDCB and Risk, Performance and Scrutiny Group.

Catherine Jackson

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NHS GM Bury



BURY
INTEGRATED CARE
PARTNERSHIP

Locality Performance Report June 2026

Part of Greater Manchester
Integrated Care Partnership



Presentation by:

Bury - Oversight Metrics

Show Definitions

Domain	Code	Measure	Frequency	Date	Latest	Previous	Change	Target/Median	Numerator	Denominator	Quartile
Mental Health & Learning Disabilities	N/A	Adult inpatients with autism only	Monthly	Apr 26	2	2	➡	2	N/A	N/A	N/A
	N/A	Adult inpatients with LD and LDA	Monthly	Apr 26	4	4	➡	3	N/A	N/A	N/A
	S030a	% of patients aged 14+ with a completed LD health check	Monthly	Apr 26	3.9%	88.53%	📉	75.0%	47	1,195	Inter
	EH09	Access to Children and Young Peoples Mental Health Services	Monthly	Apr 26	3,665	3,690	📉	5,885 566000.00%	N/A	N/A	Lower
	EAS01	Dementia: Diagnosis Rate (Aged 65+)	Monthly	Mar 26	76.3%	76.50%	📉	66.7%	1,891	2,477	Upper
	S086a	Inappropriate adult acute mental health Out of Area Placement (OAP) bed days (rolling 3 month total)	Monthly	Apr 26	3,605	3,455	📈	0 36250.00%	N/A	N/A	Lower
	N/A	Number of MH patients with no criteria to reside - number of beds occupied by mental health patients who are ready to be discharged	Monthly	May 26	8	14	➡	N/A	N/A	N/A	Inter
	N/A	Percentage of MH patients with no criteria to reside (NCTR)	Monthly	May 26	9.4%	15.73%	➡	N/A	8	85	Inter
	S110a	Overall Access to Community MH Services for Adults and Older Adults with Severe Mental Illnesses	Monthly	Apr 26	3,100	2,375	➡	5,445 442500.00%	N/A	N/A	Inter
	S081a	Talking Therapies: Access Rate	Monthly	Apr 26	290	300	📉	N/A	N/A	N/A	Lower
	S131a	Women Accessing Specialist Community Perinatal Mental Health Services	Quarterly	Apr 26	195	195	↔	N/A	N/A	N/A	Lower
	S125a	Long length of stay for adults (60+ days)	Monthly	Apr 26	25.0%	23.08%	📈	0.0% 25.00%	15	60	Inter
	N/A	Proportion of routine eating disorder referrals cases entering treatment within four weeks, aged 0-18	Monthly	Apr 26	126.0%	126.00%	➡	N/A 8600.00%	126	N/A	Lower
Cancer	N/A	Cancers Diagnosed at an Early Stage (12-month rolling): All Tumours Staged within RCRD	Monthly	Dec 25	59.9%	59.97%	📉	N/A 60.83%	470	785	Inter
Primary Care	S053b	% of hypertension patients who are treated to target as per NICE guidance	Annual	Mar 25	70.6%	69.59%	➡	77.0% 69.69%	22,781	32,267	Inter
	S053c	% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins	Quarterly	Dec 25	65.0%	64.54%	➡	64.07% 63.95%	7,115	10,945	Inter
	S129a	GP appointments - percentage of regular appointments within 14 days	Monthly	Apr 26	80.2%	79.57%	➡	80.49% 82.14%	62,467	77,908	Inter
Quality	S042a	E. coli blood stream infections	Monthly	Apr 26	121	128	➡	N/A	N/A	N/A	Upper
	S044a	Antimicrobial resistance: total prescribing of antibiotics in primary care	Monthly	Jun 25	68.9%	69.78%	📉	87.1% 81.01%	N/A	N/A	Upper
	S044b	Antimicrobial resistance: proportion of broad-spectrum antibiotic prescribing in primary care	Monthly	Jun 25	5.6%	5.57%	📈	10.0% 7.73%	5,314	95,172	Upper
	S037A	% of patients describing the overall experience of their GP practice as good	Annual	Mar 23	71.4%		↔	73.90% 72.96%	N/A	N/A	N/A

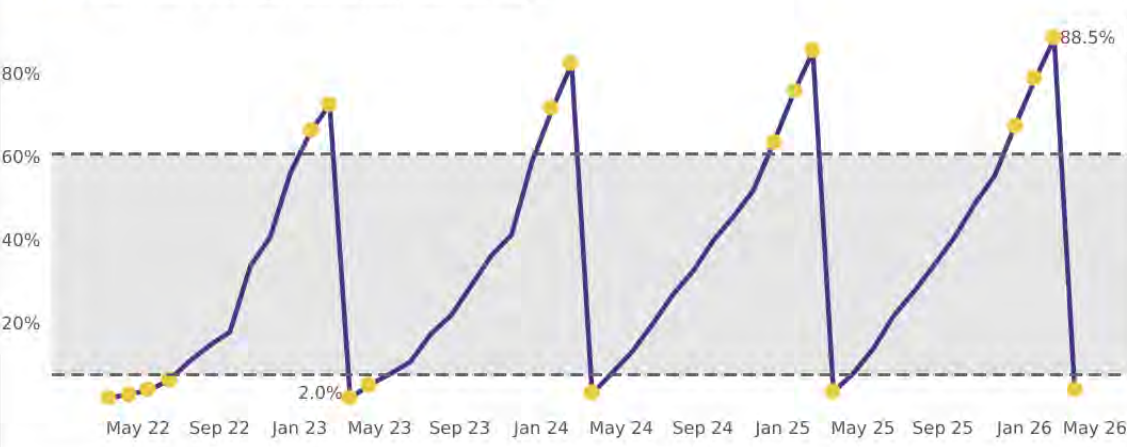
% of patients aged 14+ with a completed LD health check

The % of people on the QOF Learning Disability Register who received an annual health check between the start of the financial year and the end of the reporting period

Source: Learning Disabilities Health Check Scheme (Monthly)



Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	2.0%	3.1%	3.9%	6.5%	10.9%	14.8%	18.0%	33.8%	40.8%	56.4%	66.4%	72.7%
2023-24	2.0%	5.4%	7.9%	10.8%	17.5%	22.0%	29.1%	36.5%	41.3%	58.9%	71.7%	82.5%
2024-25	3.2%	8.1%	13.3%	19.8%	26.9%	32.7%	39.9%	45.8%	52.1%	63.7%	75.9%	85.5%
2025-26	3.6%	8.0%	14.1%	21.9%	27.7%	34.2%	40.7%	48.9%	55.6%	67.7%	79.1%	88.5%
2026-27	3.9%											

Selected measure at April 2026 has continuously decreased for 1 period(s) of time

Latest Value GM Benchmarking
National Rank against other localities

11	Stockport	5.4%
13	Trafford	5.0%
20	Wigan	4.7%
39	Bury	3.9%
44	Rochdale	3.9%
47	Bolton	3.8%
51	Manchester	3.6%
54	Oldham	3.5%
81	Tameside	2.8%
90	Salford	2.6%
14	NHS Greater Manchester Integrated Care Board	3.9%

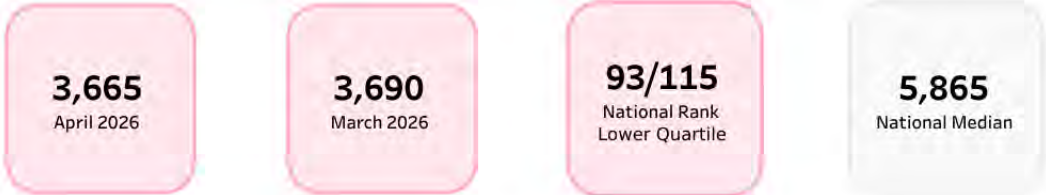
Narrative

- The performance metrics for LD health checks have been reset for the 2026/2027 reporting period, accounting for the significant decline observed in the latest data.
- In April 2026, 3.9% of patients aged 14 and above completed an LD health check, showing an improvement compared to 3.6% in April 2025.
- Bury's performance matches the GM average (3.9%), ranking 4th across localities.

Access to Children and Young Peoples Mental Health Services

Access to Children and Young Peoples Mental Health Services

Source: Published MHSDS (Monthly)



Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23				2,545	2,570	2,565	2,600	2,740	2,790	2,930	2,990	3,075
2023-24	3,100	3,170	3,195	3,230	3,245	3,305	3,345	3,425	3,475	3,545	3,590	3,610
2024-25	3,640	3,680	3,675	3,635	3,570	3,565	3,575	3,560	3,520	3,495	3,500	3,500
2025-26	3,500	3,475	3,470	3,500	3,470	3,515	3,530	3,595	3,600	3,595	3,625	3,690
2026-27	3,665											

Selected measure at April 2026 has continuously decreased for 1 period(s) of time

Latest Value GM Benchmarking

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

Manchester	111.4	16,210 (21)
Tameside	103.3	4,930 (74)
Trafford	94.6	5,045 (70)
Bury	82.1	3,665 (93)
Rochdale	77.4	4,530 (81)
Salford	76.9	5,055 (69)
Stockport	69.1	4,595 (78)
Oldham	67.3	4,240 (84)
Wigan	63.6	4,465 (82)
Bolton	55.3	4,235 (85)

The rate is calculated using the 0-17 registered population figure for each locality | Bury: 45,310

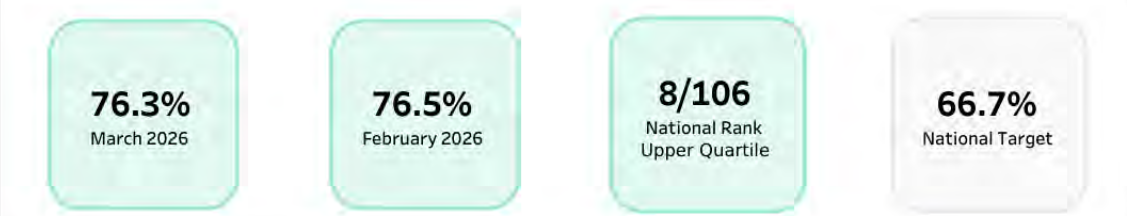
Narrative

- In April 2026, a total of 3,665 attendances for Children and Young People’s Mental Health Services were recorded among patients registered in Bury.
- This represents a decrease compared with the 3,690 attendances reported in March 2026 and is also higher than the 3,500 attendances recorded in April 2025.
- Bury currently reports an access rate of 82.3 per 1,000 population, ranking fourth highest among the Greater Manchester localities.

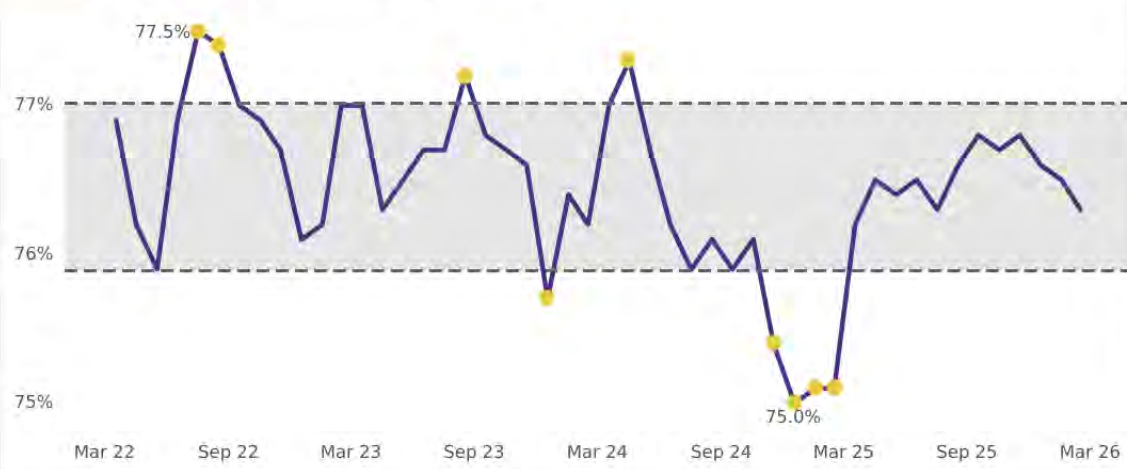
Dementia: Diagnosis Rate (Aged 65+)

Diagnosis rate for people aged 65 and over, with a diagnosis of dementia recorded in primary care, expressed as a percentage of the estimated prevalence based on GP registered populations.

Source: Primary Care Dementia Data (Monthly)



Outliers more than 1 standard deviation from the mean



Selected measure at March 2026 has continuously decreased for 3 period(s) of time

Latest Value GM Benchmarking
National Rank against other localities

7	Manchester	76.4%
8	Bury	76.3%
9	Rochdale	76.2%
11	Oldham	75.8%
12	Salford	75.3%
16	Stockport	74.7%
26	Tameside	72.3%
27	Wigan	72.0%
36	Trafford	70.7%
38	Bolton	70.2%
3	NHS Greater Manchester Integrated Care Board	73.9%

Narrative

- As of March 2026, 76.3% of patients aged 65 and over in Bury have received a dementia diagnosis.
- Bury’s diagnosis rate is higher than the Greater Manchester (GM) average, which stands at 73.9%, and ranks 2nd highest among the GM localities.
- Both Bury and GM exceed the national target for dementia diagnosis, which is set at 66.7%.
- Please note reporting for this metric has changed to quarterly. Next publication is July 2026.

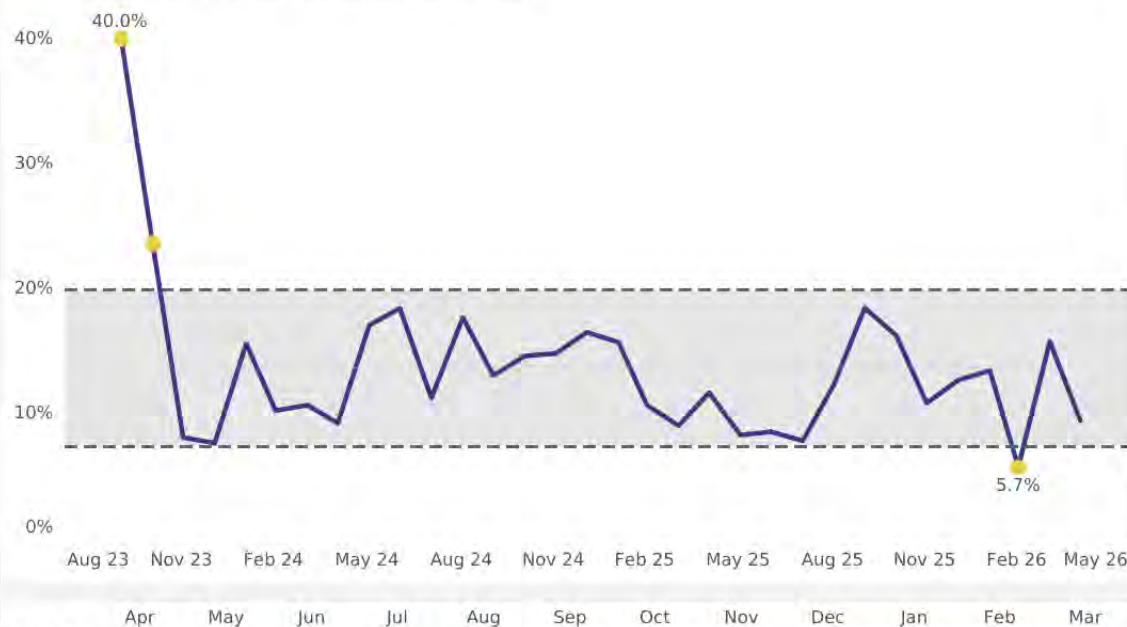
Percentage of MH patients with no criteria to reside (NCTR)

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

Source: GM Admissions - Local (Monthly)



Outliers more than 1 standard deviation from the mean



2023-24	
2024-25	
2025-26	
2026-27	

Selected measure at May 2026 has continuously decreased for 1 period(s) of time

Latest Value GM Benchmarking



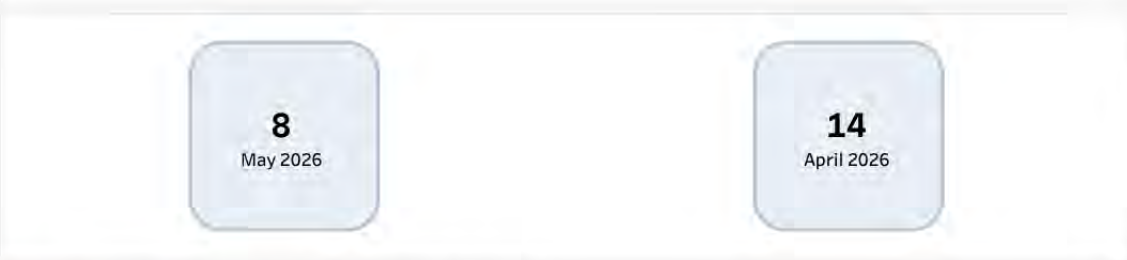
Narrative

- As of May 2026, 9.4% of mental health patients in Bury are reported as having no criteria to reside (NCTR), representing a decrease from 15.7% in April 2026.
- Bury’s performance is above the Greater Manchester (GM) average of 12.0%, with Bury ranking as the third lowest locality across GM.
- Despite this improvement, continued focus is required to sustain progress and maintain performance below the GM average, particularly given historical volatility.

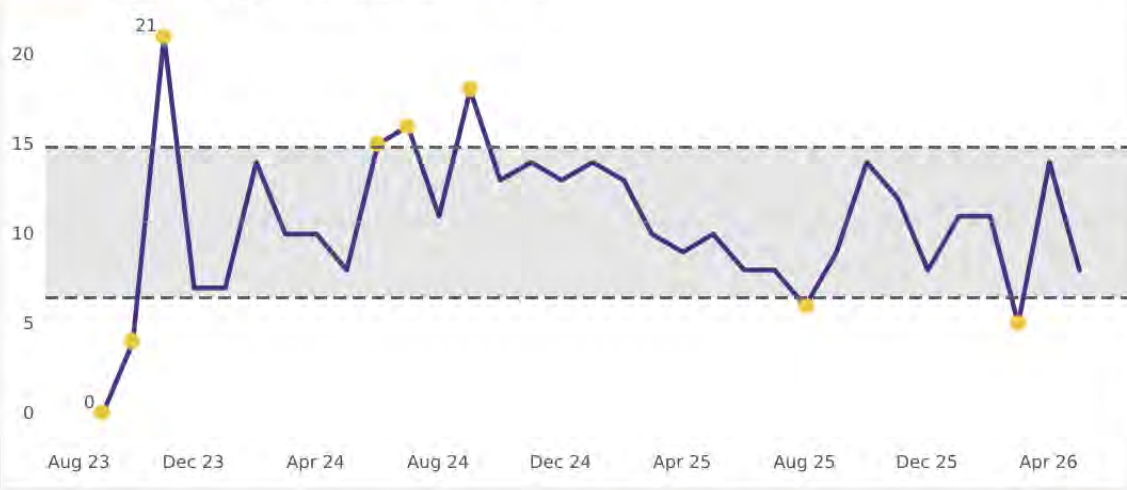
Number of MH patients with no criteria to reside (NCTR)

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

Source: GM Admissions - Local (Monthly)



Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023-24						0	4	21	7	7	14	10
2024-25	10	8	15	16	11	18	13	14	13	14	13	10
2025-26	9	10	8	8	6	9	14	12	8	11	11	5
2026-27	14	8										

Selected measure at May 2026 has continuously decreased for 1 period(s) of time

Latest Value GM Benchmarking
Rate per 1000 | Count

Tameside	0.026	6
Trafford	0.028	7
Bury	0.038	8
Stockport	0.024	8
Rochdale	0.036	9
Oldham	0.045	12
Wigan	0.034	12
Bolton	0.039	13
Salford	0.043	14
Manchester	0.051	38
NHS Greater Manchester Integrated Care Board	0.039	127

The rate is calculated using the registered population figure for each locality | Bury: 211,388

Narrative

- This metric is monitored daily to ensure timely oversight and responsiveness.
- In May 2026, the number of mental health patients in Bury recorded as having no criteria to reside (NCTR) decreased to 8, down from 14 in April (-6 patients month-on-month).
- This equates to a rate of 0.038 per 1,000 population, which is slightly below the Greater Manchester (GM) average of 0.039.
- Bury’s rate is therefore broadly in line with the GM average and comparable with several better-performing localities, indicating relatively strong system performance.

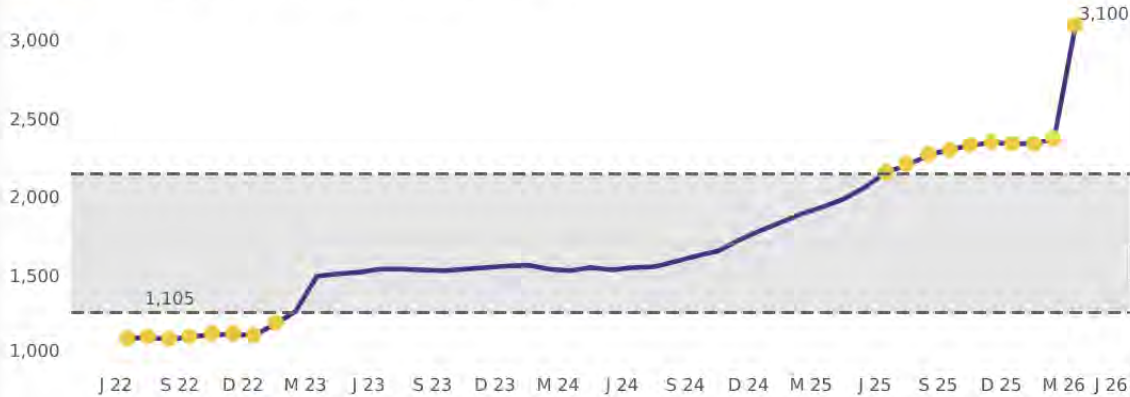
Overall Access to Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses

Number of people who receive two or more contacts from NHS or NHS commissioned community mental health services (in transformed and non-transformed PCNs) for adults and older adults with severe mental illnesses, in a rolling 12 month period

Source: Published MHSDS (Monthly)



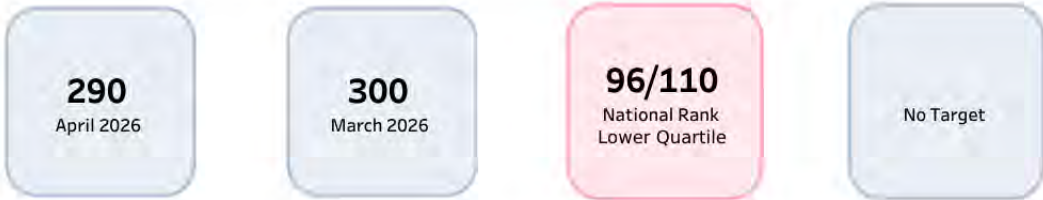
Outliers more than 1 standard deviation from the mean



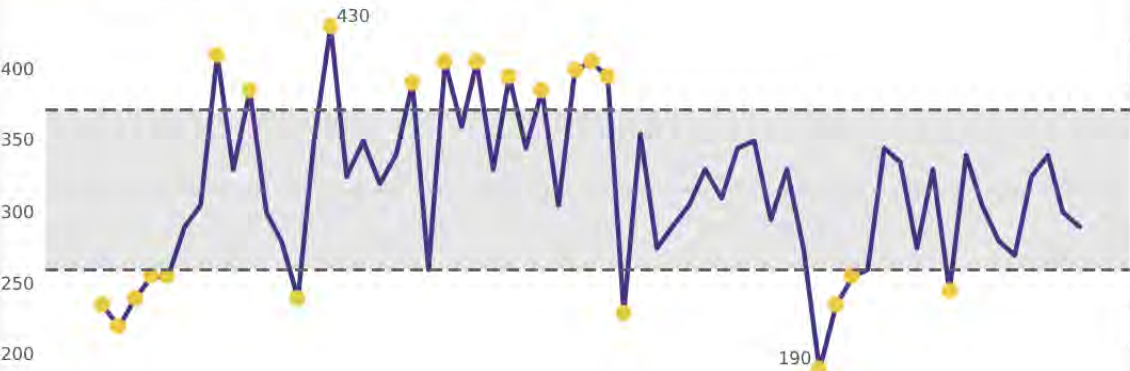
Talking Therapies: Access Rate

This indicator tracks our ambition to expand Improving Access to Psychological Therapies (IAPT) services, also known as NHS Talking Therapies. The primary purpose of this indicator is to measure improvements in access to psychological therapy (via IAPT) for people with depression and/or anxiety disorders.

Source: Improving Access to Psychological Therapies Data Set (Monthly)



Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	235	220	240	255	255	290	305	410	330	385	300	280
2022-23	240	350	430	325	350	320	340	390	260	405	360	405
2023-24	330	395	345	385	305	400	405	395	230	355	275	290
2024-25	305	330	310	345	350	295	330	275	190	235	255	260
2025-26	345	335	275	330	245	340	305	280	270	325	340	300
2026-27	290											

Selected measure at April 2026 has continuously decreased for 2 period(s) of time

Latest Value GM Benchmarking
Rate per 1000 | Count (National rank)

1	Salford	2.5	825 (39)
2	Manchester	2.3	1,715 (19)
3	Trafford	2.0	490 (66)
4	Tameside	1.8	410 (81)
5	Bolton	1.6	550 (60)
6	Oldham	1.6	435 (76)
7	Wigan	1.4	505 (63)
8	Stockport	1.4	465 (72)
9	Bury	1.4	290 (96)
10	Rochdale	1.3	335 (89)

The rate is calculated using the registered population figure for each locality | Bury: 211,388

Narrative

- In April 2026, 290 people in Bury accessed Talking Therapies services, a slight decrease from 300 in March.
- Bury’s rate of 1.4 per 1,000 population is below the Greater Manchester leaders and ranks 9th across GM, indicating comparatively lower access.
- Nationally, Bury is ranked 96th out of 110 systems (lower quartile), highlighting a continued gap to national benchmarks and the need to improve access to psychological therapies.

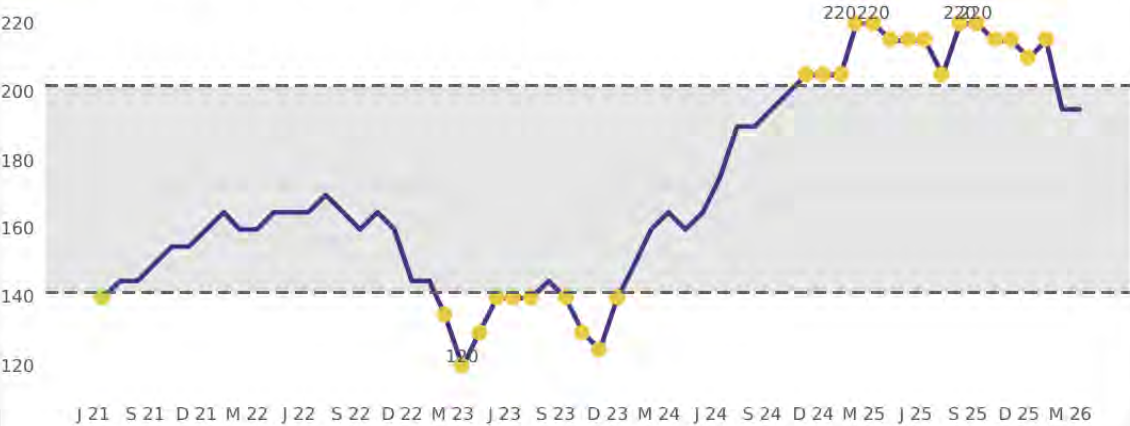
Women Accessing Specialist Community Perinatal Mental Health Services

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

Source: Published MHSDS (Quarterly)



Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22				140	145	145	150	155	155	160	165	160
2022-23	160	165	165	165	170	165	160	165	160	145	145	135
2023-24	120	130	140	140	140	145	140	130	125	140	150	160
2024-25	165	160	165	175	190	190	195	200	205	205	205	220
2025-26	220	215	215	215	205	220	220	215	215	210	215	195
2026-27	195											

Selected measure at April 2026 has continuously for 1 period(s) of time

Latest Value GM Benchmarking
Rate per 1000 | Count (National Rank)

1	Stockport	5.3	335 (59)
2	Bury	4.8	195 (91)
3	Tameside	4.7	215 (84)
4	Rochdale	4.4	225 (79)
5	Trafford	3.9	185 (94)
6	Wigan	3.7	250 (76)
7	Oldham	3.7	200 (90)
8	Bolton	3.1	205 (86)
9	Salford	2.8	220 (81)
10	Manchester	2.6	520 (42)

The rate is calculated using the 15-44 female population figure for each locality | Bury 40,940

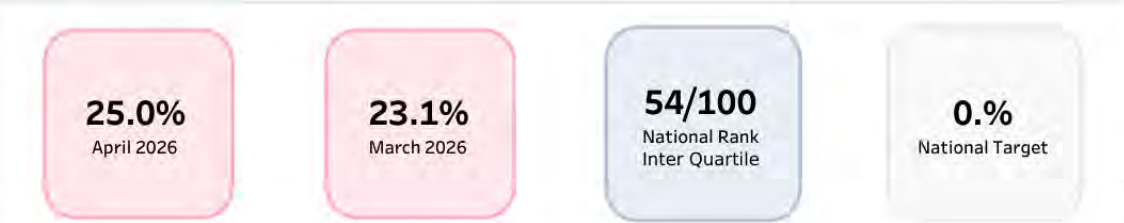
Narrative

- In April 2026, 195 women in Bury accessed specialist community perinatal mental health services, unchanged from March 2026.
- Bury’s rate of 4.8 per 1,000 population is the second highest in Greater Manchester, indicating strong relative performance within the system.
- However, Bury is ranked 91st out of 107 systems nationally (lower quartile), highlighting a continued gap to national benchmarks despite good performance locally.

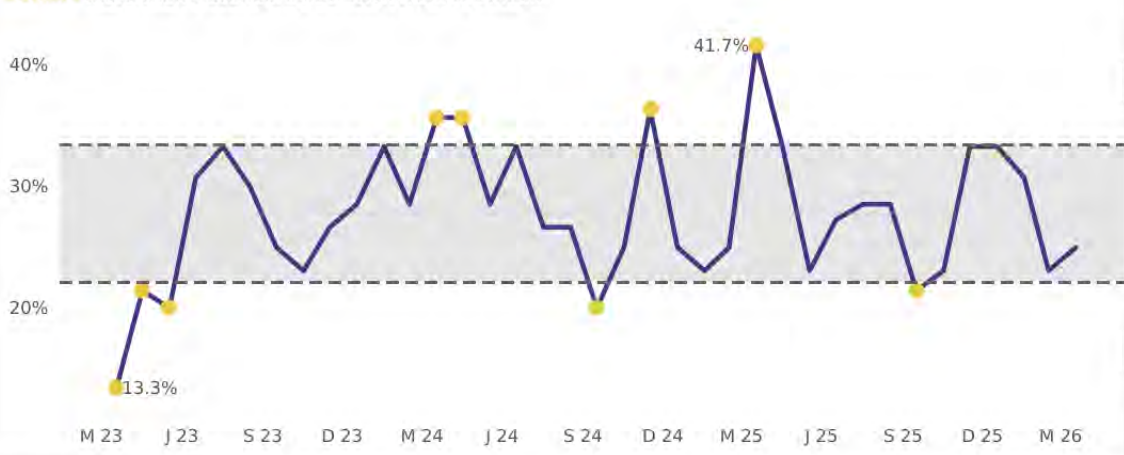
Long length of stay for adults (60+ days) - Mental Health Patients

Proportion of all discharges from adult acute and older adult acute beds, with a length of stay of over 60 days

Source: Published MHSDS (Monthly)



Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023-24	13.3%	21.4%	20.0%	30.8%	33.3%	30.0%	25.0%	23.1%	26.7%	28.6%	33.3%	28.6%
2024-25	35.7%	35.7%	28.6%	33.3%	26.7%	26.7%	20.0%	25.0%	36.4%	25.0%	23.1%	25.0%
2025-26	41.7%	33.3%	23.1%	27.3%	28.6%	28.6%	21.4%	23.1%	33.3%	33.3%	30.8%	23.1%
2026-27	25.0%											

Selected measure at April 2026 has continuously increased for 1 period(s) of time

Latest Value GM Benchmarking
National Rank against other localities

6	Salford	13.3%
26	Rochdale	18.8%
27	Oldham	19.0%
54	Bury	25.0%
62	Wigan	26.7%
65	Tameside	27.3%
71	Stockport	28.6%
95	Bolton	36.4%
98	Trafford	41.7%
99	Manchester	42.4%
28	NHS Greater Manchester Integrated Care Board	28.8%

Narrative

- In April 2026, 25.0% of adult mental health discharges in Bury had a length of stay exceeding 60 days, an increase from 23.1% in March.
- Bury’s performance is below the Greater Manchester average of 28.8% and broadly in line with the national interquartile range (ranked 54th of 100), indicating average comparative performance.
- Despite this, the recent increase highlights continued pressure on discharge flow and the need to reduce long lengths of stay and associated bed occupancy.

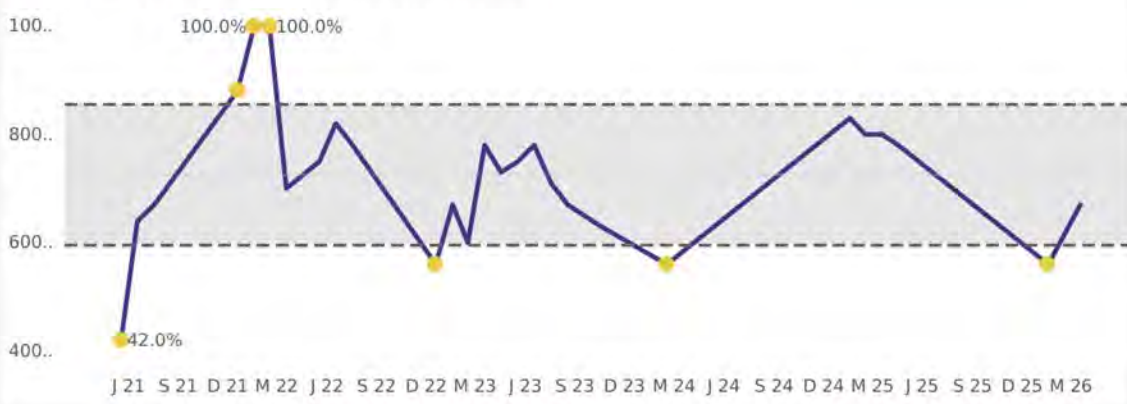
Proportion of routine eating disorder referrals cases entering treatment within four weeks, aged 0-18 - Mental Health Patients

Proportion of all discharges from adult acute and older adult acute beds, with a length of stay of over 60 days

Source: Published MHSDS (Monthly)



Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Nov	Jan	Feb	Mar
2021-22			42.0%	64.0%	67.0%			88.0%	100.0%	100.0%
2022-23	70.0%		75.0%	82.0%	78.0%			56.0%	67.0%	60.0%
2023-24	78.0%	73.0%	75.0%	78.0%	71.0%	67.0%	63.0%			56.0%
2024-25									83.0%	80.0%
2025-26	80.0%	78.0%							56.0%	
2026-27	67.0%									

Selected measure at April 2026 has continuously increased for 1 period(s) of time

Latest Value GM Benchmarking
National Rank against other localities

46	Salford	88.0%
	Wigan	88.0%
56	Stockport	85.0%
	Trafford	85.0%
79	Manchester	73.0%
86	Bury	67.0%
	Tameside	67.0%
102	Bolton	50.0%
	Rochdale	50.0%
107	Oldham	33.0%
27	NHS Greater Manchester Integrated Care Board	73.0%

Narrative

- Performance is stable at 67.0% (February–April 2026) but remains below the GM average (73.0%).
- Trend shows ongoing variability, with recent improvement following a period of decline.
- Delivery remains inconsistent, with performance fluctuating across months.
- Bury ranks 86th nationally (lower quartile), indicating continued poor relative performance.
- Most GM localities continue to outperform Bury, with several achieving ≥85%

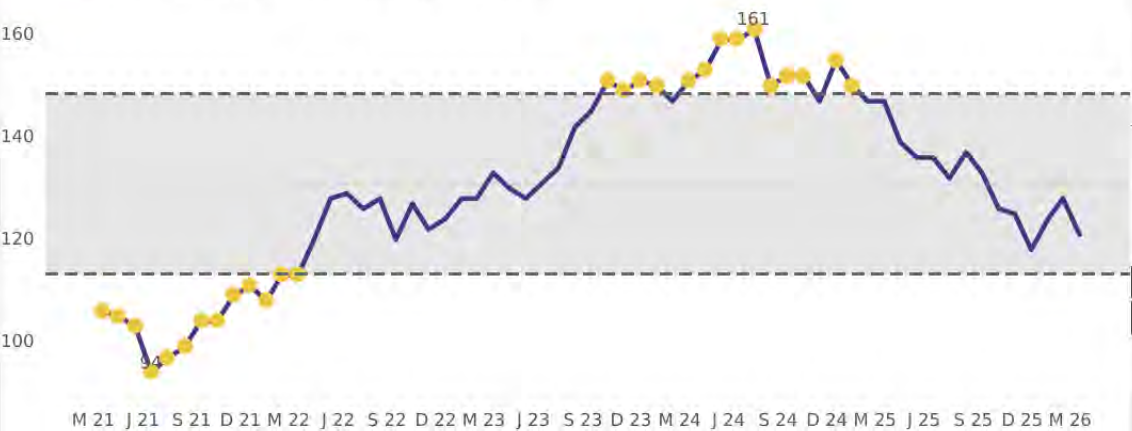
E. coli blood stream infections

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

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



Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	106	105	103	94	97	99	104	104	109	111	108	113
2022-23	113	120	128	129	126	128	120	127	122	124	128	128
2023-24	133	130	128		134	142	145	151	149	151	150	147
2024-25	151	153	159	159	161	150	152	152	147	155	150	147
2025-26	147	139	136	136	132	137	133	126	125	118	124	128
2026-27	121											

Selected measure at April 2026 has continuously decreased for 1 period(s) of time

Latest Value GM Benchmarking
Rate per 1000 | Count (National Rank)

Salford	0.50	163.0 (23)
Wigan	0.55	194.0 (29)
Bury	0.57	121.0 (10)
Bolton	0.58	195.0 (30)
Manchester	0.59	439.0 (68)
Rochdale	0.60	151.0 (20)
Oldham	0.65	174.0 (24)
Stockport	0.78	258.0 (48)
Trafford	0.83	206.0 (32)
Tameside	0.95	218.0 (38)

The rate is calculated using the registered population figure for each locality | Bury: 211,388

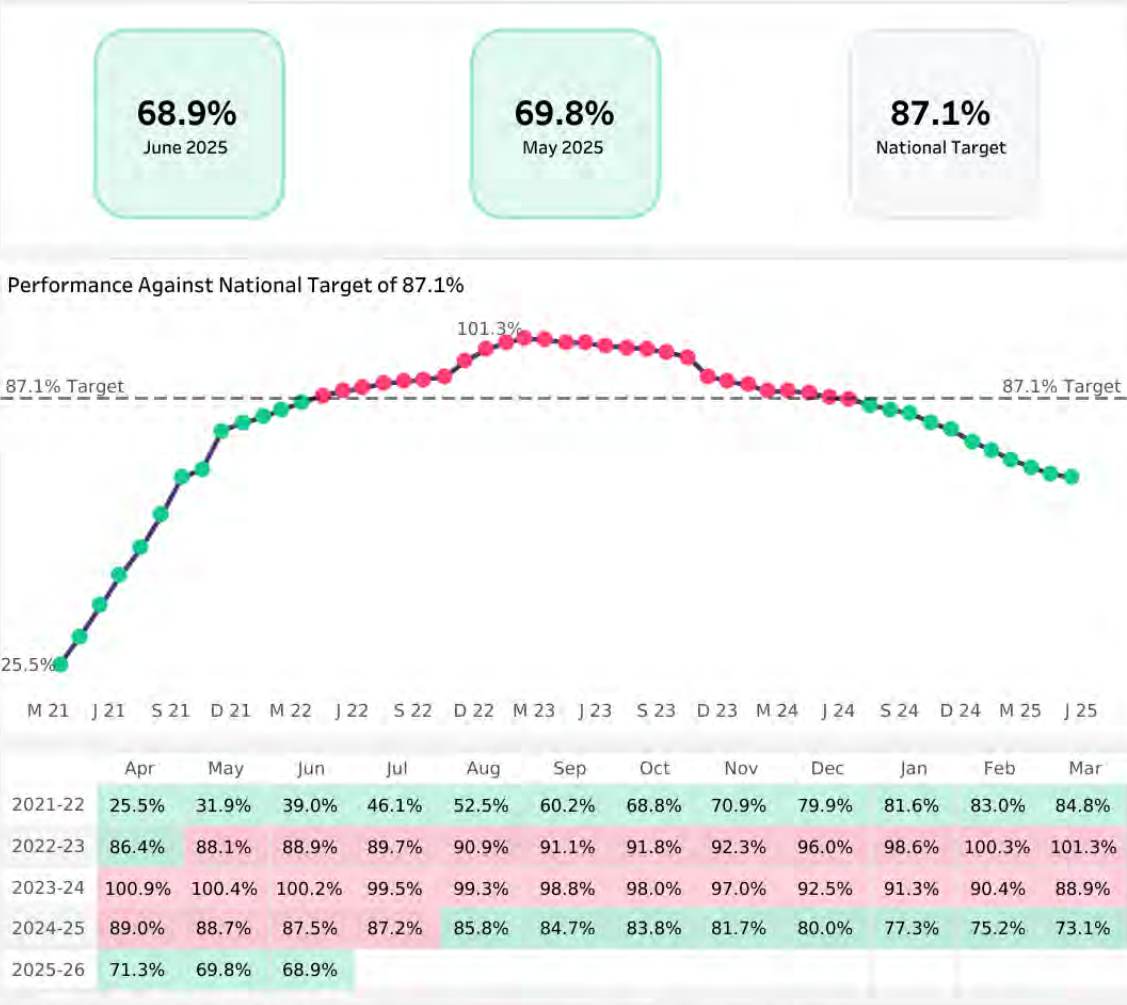
Narrative

- Over the 12-month period ending April 2026, a total of 121 cases of E. coli bloodstream infections were recorded among patients registered in Bury.
- This represents a slight decrease compared with March 2026, when 128 cases were reported, and is notably lower than the 147 cases recorded in April 2025.
- Bury currently reports an infection rate of 0.57 per 1,000 population, ranking as the 3rd lowest rate among the Greater Manchester (GM) localities.

Antimicrobial resistance: total prescribing of antibiotics in primary care

The number of antibiotic (antibacterial) items prescribed in primary care, divided by the item-based Specific Therapeutic group Age-Sex related Prescribing Unit STAR-PU

Source: EPACT Prescribing Data (Monthly)



Selected measure at June 2025 has continuously decreased for 14 period(s) of time

Latest Value GM Benchmarking

Bury	68.9%
Rochdale	74.6%
Salford	77.5%
Bolton	79.4%
Tameside	80.2%
Manchester	80.4%
Trafford	82.3%
Oldham	85.4%
Wigan	87.6%
Stockport	91.4%

Narrative

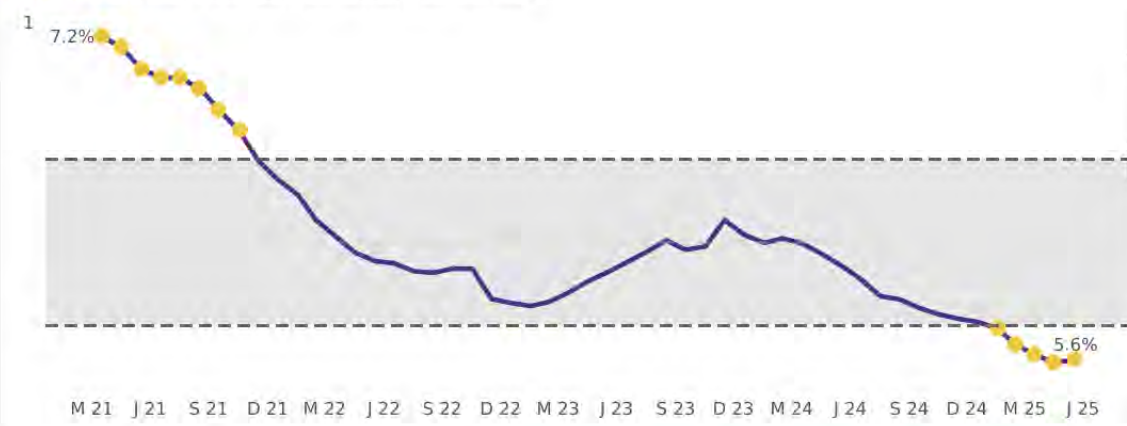
- In June 2025, 68.9% of total antibiotic prescribing in primary care for the Bury population met the relevant criteria, where a lower percentage indicates improved prescribing practice.
- This represents a substantial improvement compared with June 2024, when the corresponding figure was 87.5%.
- Bury currently reports the lowest percentage among the Greater Manchester localities and has successfully met the national target of remaining below 87.1%.

Antimicrobial resistance: proportion of broad-spectrum antibiotic prescribing in primary care
The number of broad-spectrum antibiotic (antibacterials) items from co-amoxiclav, cephalosporin class and fluoroquinolone class drugs as a percentage of the total number of antibacterial items prescribed in primary care.

Source: EPACT Prescribing Data (Monthly)



Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	7.2%	7.1%	7.0%	7.0%	7.0%	6.9%	6.8%	6.7%	6.6%	6.5%	6.4%	6.3%
2022-23	6.2%	6.1%	6.1%	6.1%	6.0%	6.0%	6.0%	6.0%	5.9%	5.9%	5.9%	5.9%
2023-24	5.9%	6.0%	6.0%	6.1%	6.1%	6.2%	6.1%	6.2%	6.3%	6.2%	6.2%	6.2%
2024-25	6.2%	6.1%	6.1%	6.0%	5.9%	5.9%	5.8%	5.8%	5.8%	5.8%	5.7%	5.7%
2025-26	5.6%	5.6%	5.6%									

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

Latest Value GM Benchmarking
National Rank against other localities

14	Oldham	5.5%
15	Bury	5.6%
19	Bolton	5.9%
20	Tameside	5.9%
22	Rochdale	6.0%
43	Manchester	7.4%
51	Stockport	7.6%
74	Salford	8.4%
79	Trafford	8.6%
100	Wigan	9.6%

- Narrative
- Bury’s rate of broad-spectrum antibiotic prescribing in June 2025 is 5.6%, the same as the previous month.
 - The chart shows that the selected measure has decreased continuously over the past 15 reporting periods, highlighting sustained improvement.
 - Bury currently reports the 2nd lowest percentage of broad-spectrum prescribing among the Greater Manchester (GM) localities.
 - This performance is within the national target threshold of less than 10%.

Bury - Sight Metrics

Domain	Code	Measure	Frequency	Date	Latest	Previous	Change	Target/Median	Numerator	Denominator	
Urgent Care	N/A	A&E 4 hour performance	Monthly	May 26	73.8%	74.9%		78.0%	6,999	9,478	N/A
	N/A	A&E Attendances	Monthly	May 26	9,478.0	7,161.0		N/A	9,478	N/A	N/A
	N/A	No Reason/Criteria To Reside patients (NCTR) as % of occupied beds	Monthly	May 26	17.7%	15.6%		N/A	1,813	10,237	N/A
	EM11	Total number of specific acute non-elective spells	Monthly	May 26	1,960.0	2,045.0		N/A	1,960	N/A	Upper
Elective Care	EB26x	Diagnostic 6ww: All	Monthly	Apr 26	11.8%	8.7%		1.0%	627	5,326	Upper
	EB28	Diagnostic 6ww: All	Monthly	Apr 26	11.8%	8.7%		1.0%	627	5,326	Upper
	EB28x	Diagnostic 6ww: All	Monthly	Apr 26	11.8%	8.7%		1.0%	627	5,326	Upper
	EB20	RTT incomplete: 65+ week waits	Monthly	Apr 26	3.000	1.0		0.	3	N/A	Upper
Cancer	S012a	28 Day Wait from Referral to Faster Diagnosis (Monthly): All Patients	Monthly	Apr 26	72.3%	79.9%		80.0%	670	927	Inter
Maternity	S104a	Number of neonatal deaths per 1,000 total live births	Annual	Dec 24	1.9	1.5		1.0%	4	2,077	Lower
	S022a	Number of stillbirths per 1,000 total births	Annual	Dec 24	5.3	5.4		2.5	11	2,077	Lower
Screening and Immunisations	S049a	Breast screening coverage, females aged 53-70, screened in last 36 months	Annual	Dec 25	74.6%	73.3%		N/A	16,689	22,380	Inter
	S046a	COVER immunisation: MMR2 Uptake at 5 years old	Quarterly	Dec 25	86.6%	87.6%		95.0%	511	590	Inter
	S050a	Females, 25-64, attending cervical screening within target period (3.5 or 5.5 year coverage, %)	Quarterly	Jun 24	70.3%	70.6%		80.0%	37,935	53,940	Inter
	S047A	Seasonal Flu Vaccine Uptake: 65 years and over	Monthly	Feb 26	74.0%	73.8%		85.0%	28,892	39,039	Inter

Bury - Sight Metrics

The below metrics are currently missing from the report due to lack of locality level reporting or the measure is currently being built.

Theme	Indicator	
Cancer	Total patients waiting over 62 days to begin cancer treatment vs target	Build in progress
LD and Autism	Inpatients with a learning disability and/or autism per million head of population	Build in progress
Primary Care and Community Services	Proportion of Urgent Community Response referrals reached within two hours	Currently available in the scorecard at trust level but not locality
	Proportion of virtual ward beds occupied	Currently unavailable at locality level due to inaccurate reporting
	Units of Dental Activity delivered as a proportion of all Units of Dental Activity contracted	Build in progress
Screening and immunisation	Bowel screening, aged 60-74, screened in the last 30 months	DQ issues
Urgent and Emergency Care	Reduce adult general and acute bed occupancy below 92%	Currently available in the scorecard at trust level but not locality

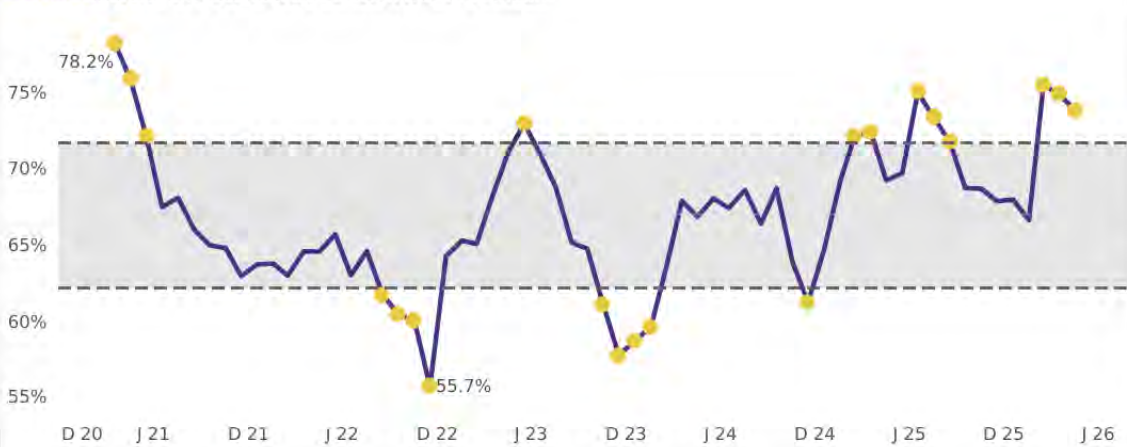
A&E 4 hour performance

Number of attendances at A&E departments, and of these, the number of attendances where the patient spent less than 4 hours from time of arrival to time of admission, or discharge, or transfer.

Source: Emergency Care Dataset (ECDS) (Monthly)



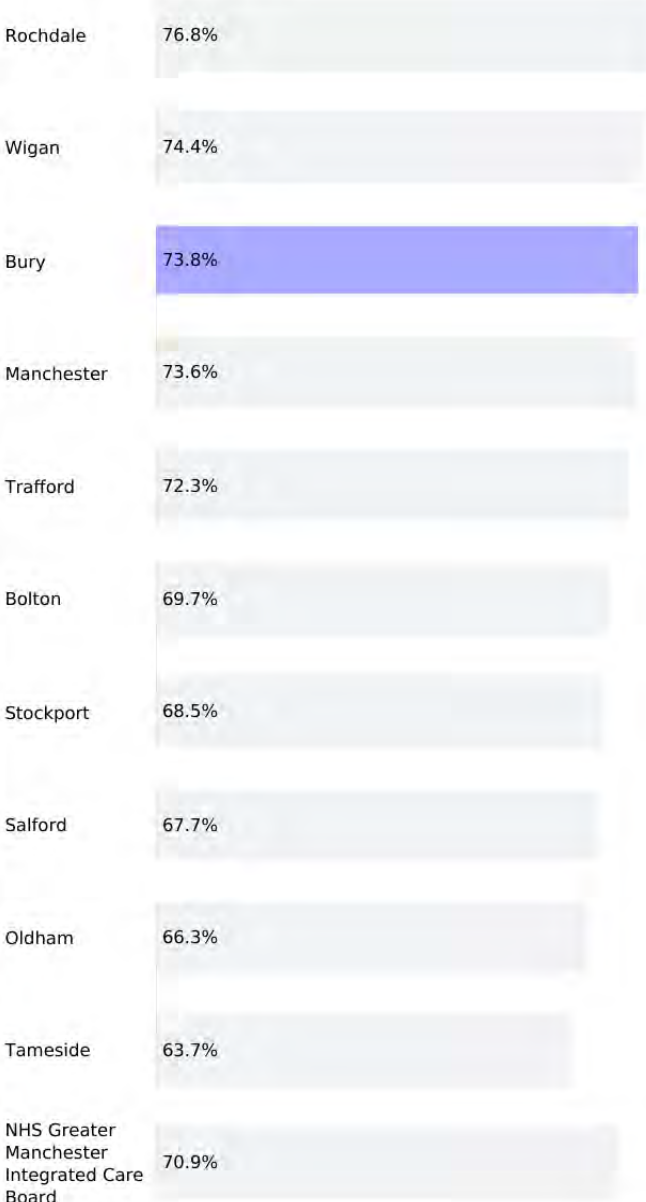
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	78.2%	75.9%	72.1%	67.5%	68.1%	66.0%	65.0%	64.8%	63.0%	63.8%	63.8%	63.0%
2022-23	64.6%	64.6%	65.7%	63.0%	64.6%	61.7%	60.5%	60.1%	55.7%	64.3%	65.3%	65.1%
2023-24	68.2%	71.1%	73.0%	71.1%	68.8%	65.2%	64.8%	61.1%	57.8%	58.7%	59.7%	63.4%
2024-25	67.9%	66.9%	68.1%	67.5%	68.6%	66.4%	68.7%	63.9%	61.3%	64.7%	69.2%	72.2%
2025-26	72.5%	69.3%	69.7%	75.0%	73.4%	71.8%	68.8%	68.7%	67.9%	68.0%	66.7%	75.5%
2026-27	74.9%	73.8%										

Selected measure at May 2026 has continuously decreased for 2 period(s) of time

Latest Value GM Benchmarking



Narrative

- This metric is monitored daily to support timely performance oversight.
- In May 2026, Bury achieved a 4-hour emergency care performance rate of 73.8%, decreasing from 74.9% in April 2026.
- This represents a year-on-year improvement compared with 69.3% in May 2025.
- Bury’s performance exceeds the Greater Manchester average of 70.9%, ranking 3rd highest among GM localities.

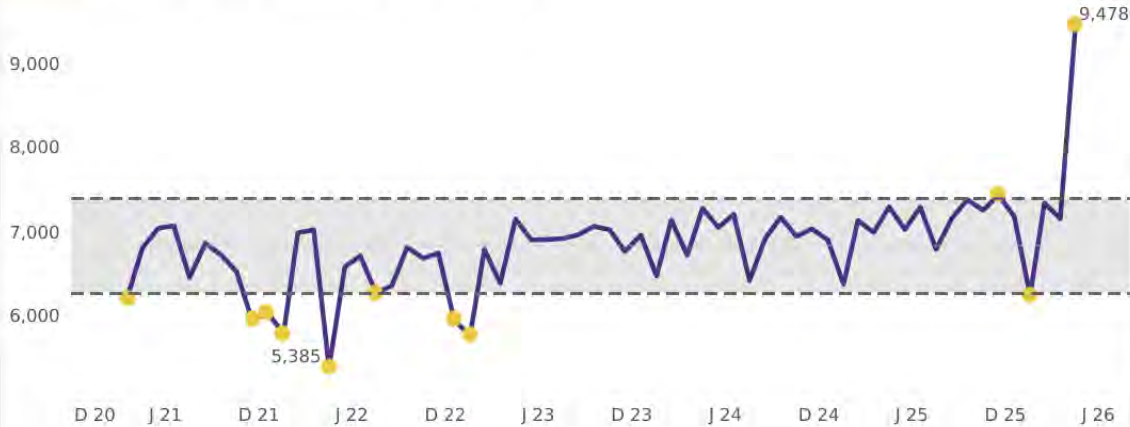
A&E Attendances

Number of attendances at A&E departments

Source: Emergency Care Dataset (ECDS) (Monthly)



Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	6,220	6,816	7,049	7,079	6,459	6,869	6,734	6,532	5,954	6,042	5,791	6,995
2022-23	7,029	5,385	6,589	6,718	6,275	6,363	6,823	6,691	6,750	5,953	5,766	6,793
2023-24	6,394	7,156	6,909	6,914	6,925	6,971	7,070	7,032	6,770	6,966	6,481	7,145
2024-25	6,727	7,285	7,058	7,214	6,426	6,930	7,178	6,952	7,040	6,910	6,382	7,141
2025-26	6,999	7,303	7,034	7,300	6,797	7,168	7,389	7,263	7,450	7,188	6,245	7,348
2026-27	7,161	9,478										

Selected measure at May 2026 has continuously increased for 1 period(s) of time

Latest Value GM Benchmarking
Attendances Rate per 1000 population & Count

Trafford	33.6	8,325
Bolton	34.0	11,371
Manchester	39.2	29,308
Salford	41.7	13,498
Stockport	43.1	14,245
Bury	44.8	9,478
Oldham	51.9	13,909
Wigan	52.8	18,595
Rochdale	54.6	13,843
Tameside	63.3	14,471

The rate is calculated using the registered population figure for each locality | Bury: 211,388

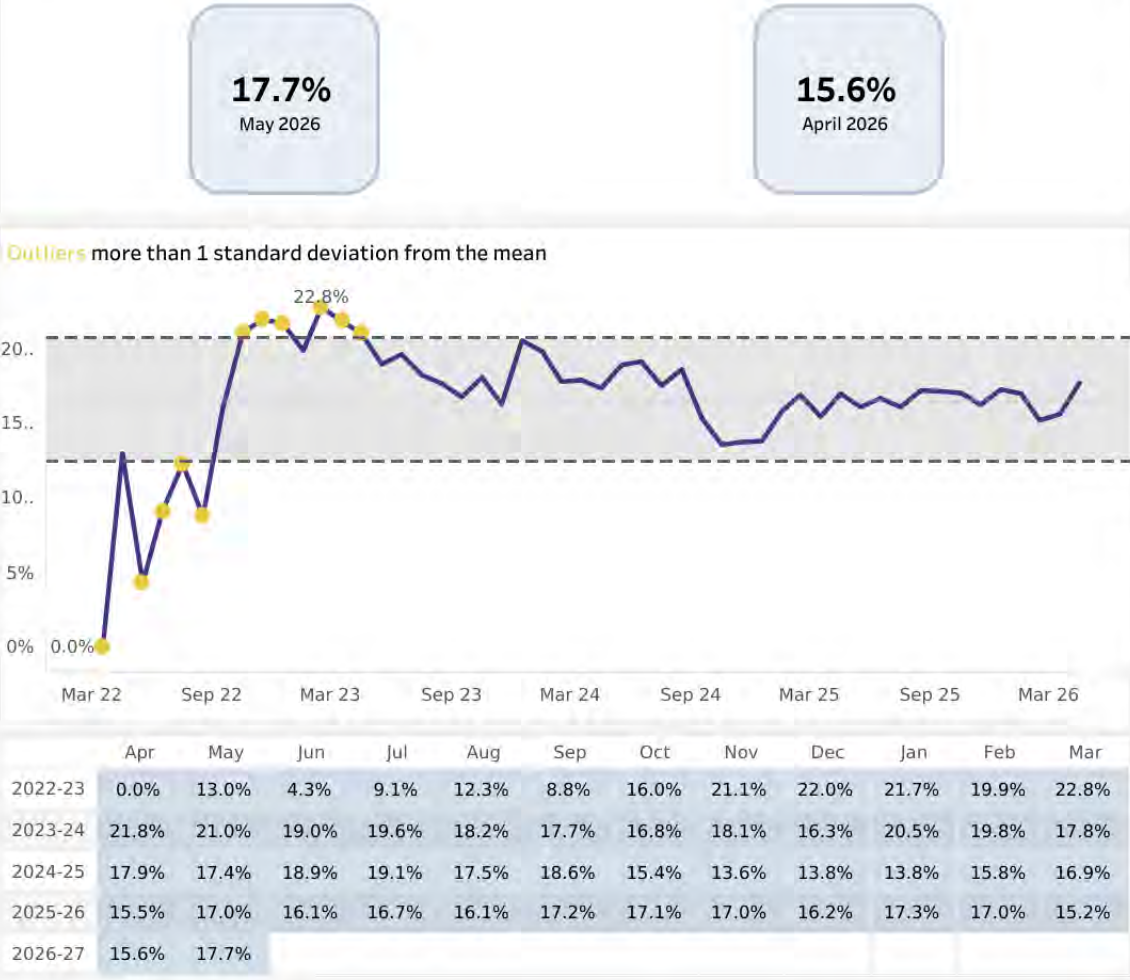
Narrative

- In May 2026, Bury recorded 9,478 A&E attendances, an increase from 7,161 attendances in April 2026.
- Attendances in May 2025 were lower than current levels, with 7,303 attendances recorded.
- Bury’s attendance rate is 44.8 per 1,000 population, ranking 6th lowest across Greater Manchester localities.

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

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

Source: GM Admissions - Local (Monthly)



Latest Value GM Benchmarking

Stockport	9.2%
Oldham	9.5%
Tameside	11.3%
Rochdale	14.5%
Manchester	15.2%
Trafford	15.5%
Bolton	15.5%
Bury	17.7%
Wigan	18.5%
Salford	19.5%
NHS Greater Manchester Integrated Care Board	14.5%

Narrative

- This metric is monitored daily to support ongoing performance oversight.
- NCTR has increased to 17.7% in May 2026 (from 15.6%), indicating a deterioration in discharge performance.
- Bury is performing above the GM average (14.5%) and is among the higher-rate localities.
- Performance has remained consistently elevated throughout 2025/26 (16–18%), reflecting sustained system pressure on flow and discharge pathways.

Selected measure at May 2026 has continuously increased for 2 period(s) of time

Total number of specific acute non-elective spells

Number of specific acute non-elective spells in the period (auto-calculated sum of E.M.11a and E.M.11b)

Source: National Flows APC (Monthly)

1,960

May 2026

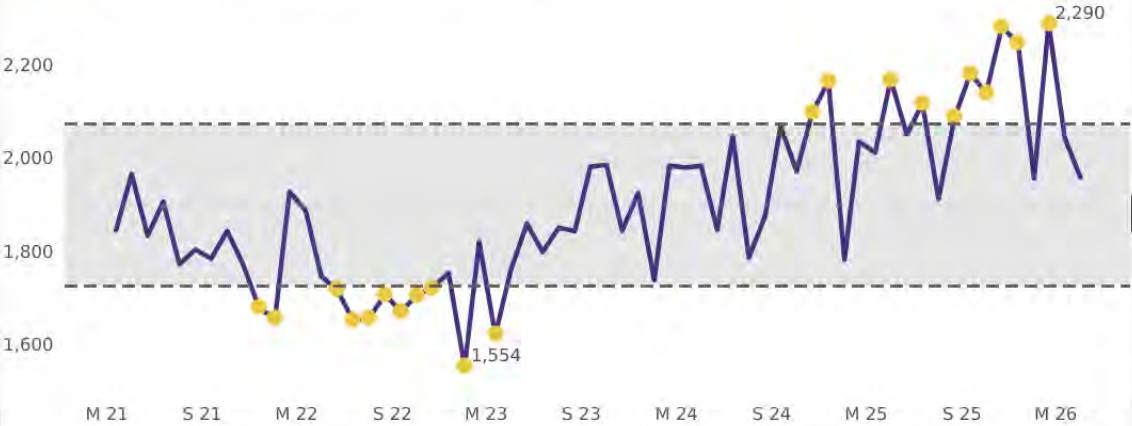
2,045

April 2026

2/10

GM Rank

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	1,847	1,967	1,835	1,908	1,774	1,805	1,786	1,845	1,775	1,681	1,657	1,929
2022-23	1,889	1,748	1,718	1,654	1,658	1,709	1,672	1,707	1,724	1,755	1,554	1,822
2023-24	1,622	1,762	1,861	1,800	1,852	1,845	1,983	1,987	1,846	1,926	1,740	1,985
2024-25	1,981	1,985	1,848	2,049	1,788	1,876	2,070	1,973	2,099	2,166	1,784	2,037
2025-26	2,013	2,170	2,052	2,118	1,914	2,089	2,182	2,142	2,283	2,247	1,958	2,290
2026-27	2,045	1,960										

Selected measure at May 2026 has continuously decreased for 2 period(s) of time

Latest Value GM Benchmarking
Count & Rate Per 1000 Population

Manchester	5.7	4,236
Trafford	6.2	1,539
Oldham	8.9	2,387
Tameside	8.8	2,009
Bolton	9.1	3,047
Bury	9.3	1,960
Salford	9.9	3,210
Wigan	10.4	3,663
Rochdale	10.4	2,627
Stockport	10.5	3,454

The rate is calculated using the registered population figure for each locality | Bury: 211,388

Narrative

- Non-elective activity reduced to 1,960 in May 2026 (from 2,045 in April), indicating a short-term easing.
- However, demand remains elevated compared to prior years, reflecting ongoing system pressure.
- Bury sits mid-ranking within GM (9.3 per 1,000 population), performing better than higher-rate localities (e.g. Salford, Wigan, Stockport) but above the lowest-rate areas (e.g. Manchester, Trafford).

Diagnostic 6ww: All
% of Patients waiting over 6 weeks for a diagnostic test or procedure

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



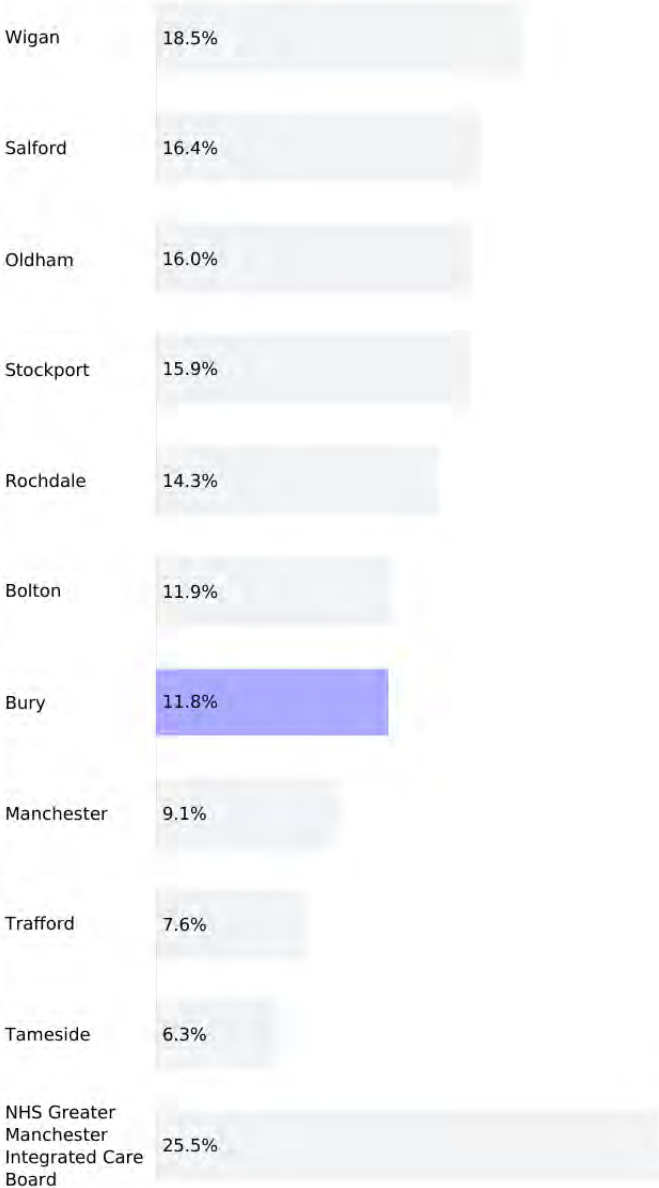
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	36.7%	34.4%	36.7%	40.1%	40.7%	40.6%	45.7%	42.8%	42.9%	46.0%	39.1%	32.5%
2022-23	36.4%	34.6%	35.5%	30.7%	30.8%	29.3%	19.0%	18.1%	18.7%	31.7%	26.8%	26.8%
2023-24	27.5%	25.0%	26.0%	24.5%	25.9%	24.0%	20.5%	17.4%	22.3%	21.0%	14.7%	14.5%
2024-25	16.5%	15.1%	16.4%	16.6%	20.2%	15.8%	11.6%	11.3%	12.6%	14.3%	10.1%	8.8%
2025-26	12.8%	9.7%	10.6%	10.9%	12.8%	9.9%	7.5%	8.2%	11.9%	12.5%	7.6%	8.7%
2026-27	11.8%											

Selected measure at April 2026 has continuously increased for 2 period(s) of time

Latest Value GM Benchmarking
National Rank against other localities



Narrative

- The proportion of patients waiting over 6 weeks increased to 11.8% in April 2026 (from 8.7% in March), indicating a deterioration in diagnostic performance and movement away from the 1% national standard.
- Despite this increase, Bury remains in the upper quartile nationally (19th of 106), reflecting relatively strong performance compared to peers.
- Within GM, Bury (11.8%) sits mid-to-higher compared to localities, performing better than higher-wait areas (e.g. Bolton, Rochdale, Salford) but above the lowest-wait systems (e.g. Tameside, Trafford).
- The longer-term trend shows a significant improvement since 2021/22, with sustained reductions from >30% to 8–13% during 2025/26, although recent months indicate some reversal of progress.

RTT incomplete: 65+ week waits

"The number of 65+ week incomplete RTT pathways based on data provided by NHS and independent sector organisations and reviewed by NHS commissioners via SDCS. The definitions that apply for RTT waiting times, as well as guidance on recording and reporting RTT data, can be found on the NHS England and NHS Improvement Consultant-led referral to treatment waiting times rules and guidance webpage."

Source: Consultant-led RTT Waiting Times data collection (National Statistics). (Monthly)



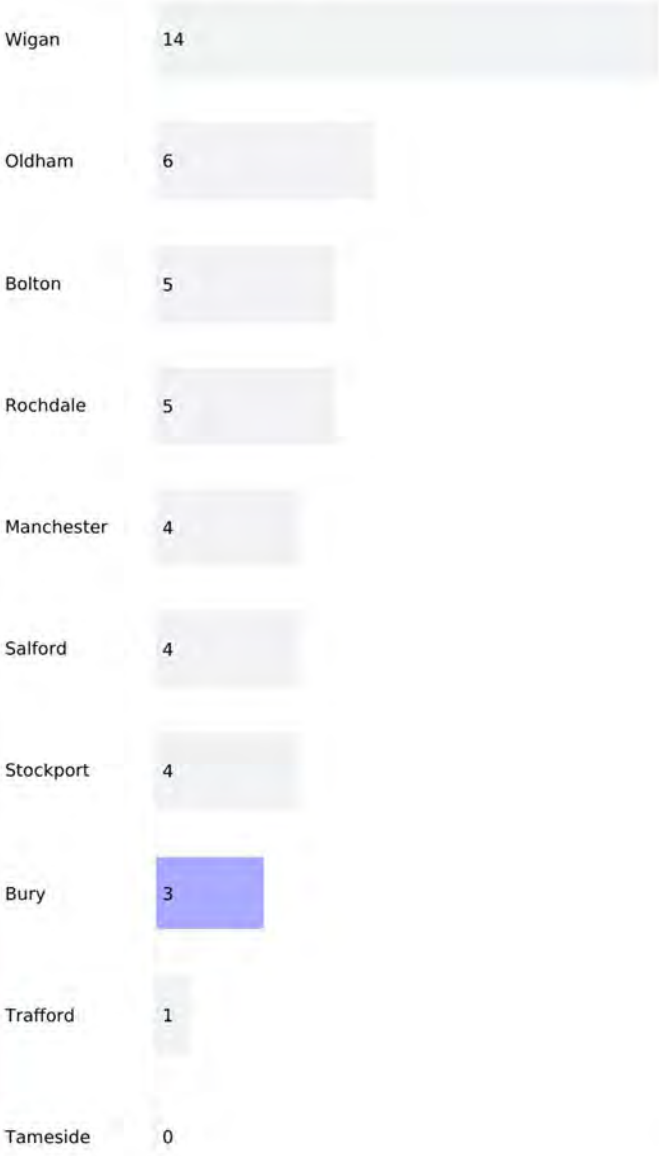
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	888	980	1,009	871	749	678	662	618	617	630	590	505
2022-23	526	530	626	739	882	1,165	1,007	1,070	1,142	1,099	773	513
2023-24	688	674	685	663	877	752	646	549	602	560	371	191
2024-25	166	190	218	184	162	38	32	34	22	21	11	5
2025-26	4	7	4	5	5	4	4	4	1	2	1	1
2026-27	3											

Selected measure at April 2026 has continuously increased for 1 period(s) of time

Latest Value GM Benchmarking
National Rank against other localities



Narrative

- In April 2026, three Bury-registered patient was reported as waiting 65 weeks or more, higher than the position recorded in March 2026. These waits are associated with Gynaecology services
- Sustained improvement from historic highs, with near elimination since 2024/25.
- 4th nationally (upper quartile) and among top performers in GM.
- Bury ranks as the 8th lowest locality across Greater Manchester for the number of 65+ week waits.

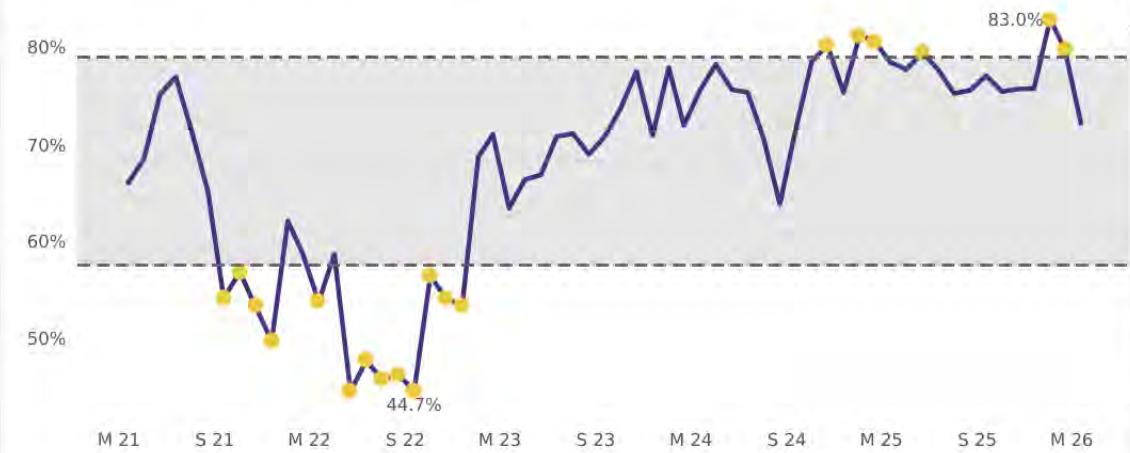
28 Day Wait from Referral to Faster Diagnosis (Monthly): All Patients

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

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



Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	66.2%	68.6%	75.2%	77.0%	71.4%	65.2%	54.3%	57.0%	53.4%	49.9%	62.2%	58.9%
2022-23	53.9%	58.8%	44.7%	47.8%	46.0%	46.4%	44.7%	56.6%	54.3%	53.5%	68.8%	71.1%
2023-24	63.5%	66.5%	67.0%	70.9%	71.2%	69.1%	70.9%	73.8%	77.6%	71.0%	78.0%	72.1%
2024-25	75.7%	78.3%	75.7%	75.5%	70.7%	64.0%	71.6%	78.6%	80.3%	75.4%	81.3%	80.7%
2025-26	78.6%	77.8%	79.5%	77.8%	75.3%	75.7%	77.2%	75.5%	75.8%	75.9%	83.0%	79.9%
2026-27	72.3%											

Selected measure at April 2026 has continuously decreased for 2 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities

Bolton	81.0%
Stockport	79.4%
Tameside	78.8%
Wigan	78.7%
Trafford	77.9%
Manchester	75.9%
Oldham	75.7%
Rochdale	74.3%
Salford	73.3%
Bury	72.3%
NHS Greater Manchester Integrated Care Board	77.0%

Narrative

- 28-day Faster Diagnosis performance declined to 72.3% in April 2026, down from 79.9% in March (-7.6pp)
- Performance is now below the 80% national standard and below the GM average (77.0%)
- Ranked 77th of 106 nationally (mid-quartile)
- Follows a period of improvement, with recent deterioration requiring focus to regain compliance

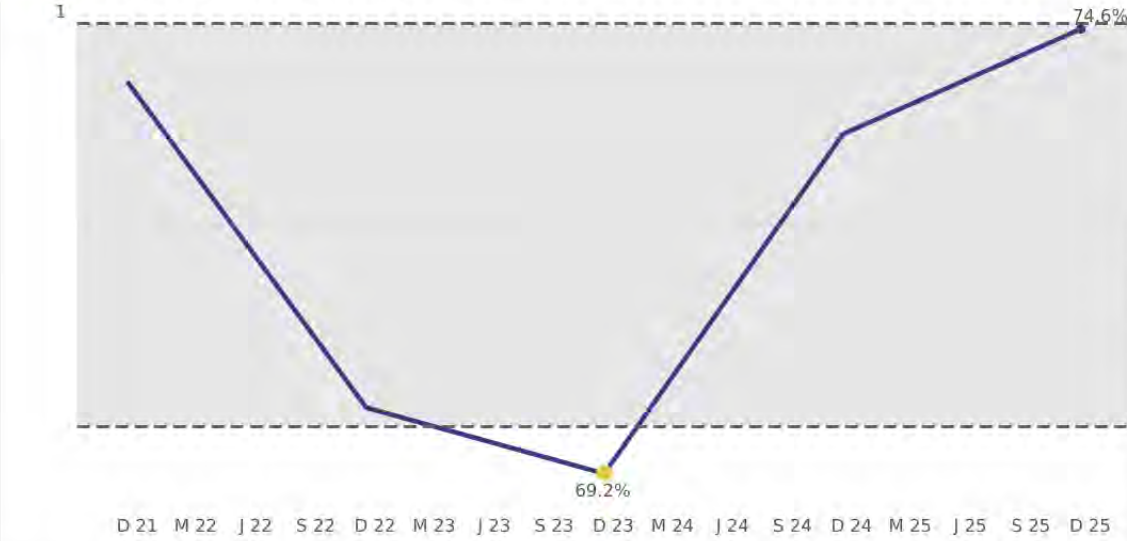
Breast screening coverage, females aged 53-70, screened in last 36 months

3-year screening coverage %: The number of females registered to the practice screened adequately in previous 36 months divided by the number of eligible females on last day of the review period

Source: Fingertips, Public Health Data, Public Health Outcomes Framework (Annual)

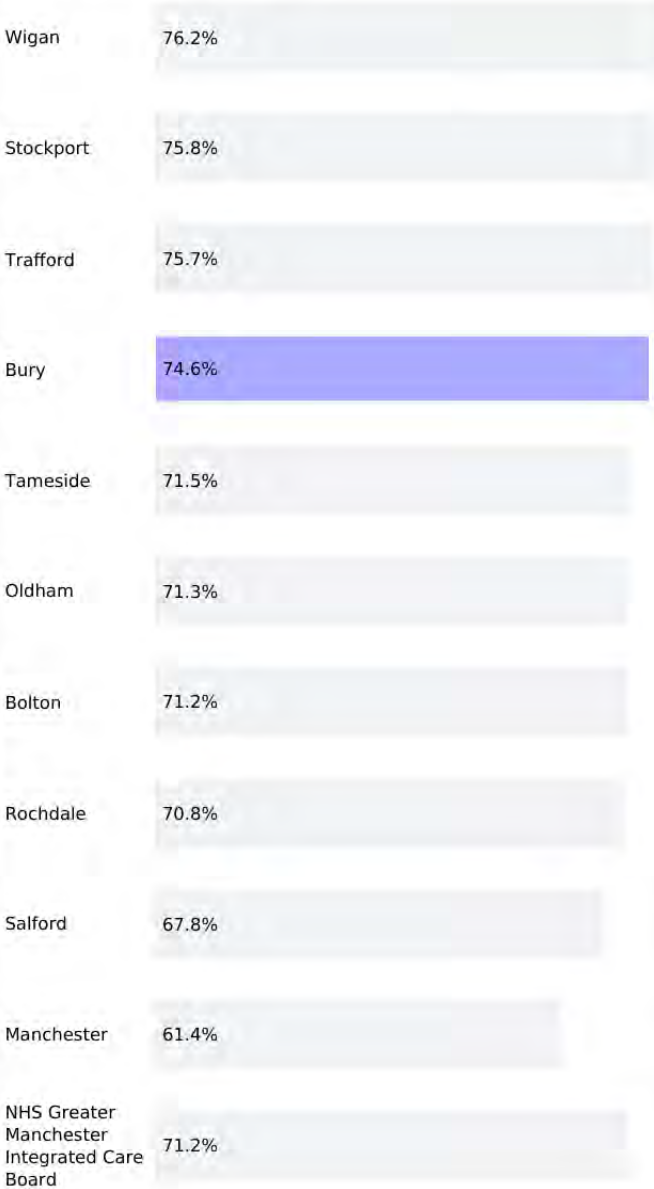


Outliers more than 1 standard deviation from the mean



2021-22	Dec	73.9%
2022-23		70.0%
2023-24		69.2%
2024-25		73.3%
2025-26		74.6%

Latest Value GM Benchmarking
National Rank against other localities



Narrative

- The GM Cancer Screening Dashboard indicates that, in April 2026 Bury Registered patients reached 66.1%, which is above the benchmark of 60%.
- Performance is comparable to Bolton (65.0%), Salford (66.1%) and Stockport (65.0%)
- Below higher-performing areas including Trafford (74.7%), Heywood/Middleton/Rochdale (68.0%) and Oldham (66.8%)
- Above Manchester (55.9%) and Tameside (61.5%), indicating relatively stronger uptake than lowest performers
- Overall, Bury demonstrates moderate performance with scope for improvement to reach top quartile levels.

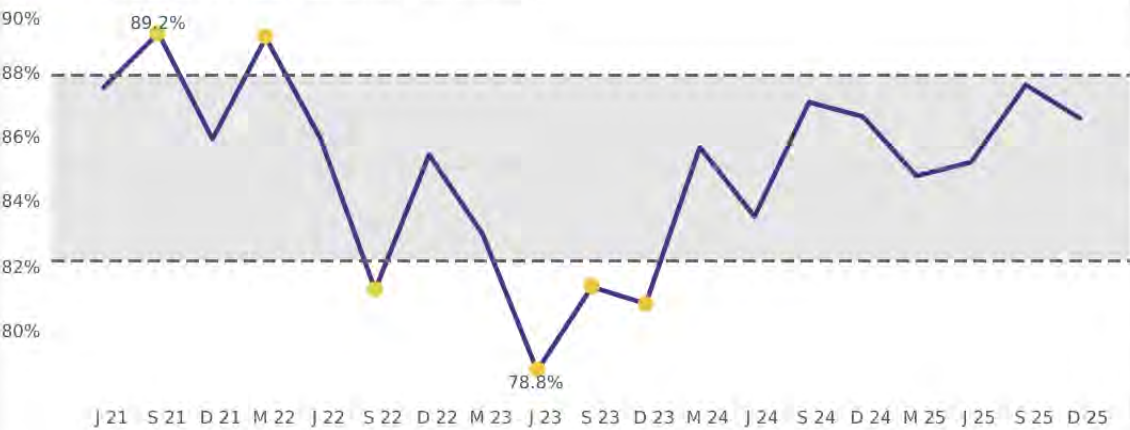
COVER immunisation: MMR2 Uptake at 5 years old

Population vaccination coverage – MMR for two doses (5 years old)

Source: Cover of vaccination evaluated rapidly (COVER) programme (Quarterly)



Outliers more than 1 standard deviation from the mean



	Jun	Sep	Dec	Mar
2021-22	87.6%	89.2%	86.0%	89.1%
2022-23	86.0%	81.3%	85.5%	83.0%
2023-24	78.8%	81.4%	80.9%	85.7%
2024-25	83.6%	87.1%	86.7%	84.8%
2025-26	85.3%	87.6%	86.6%	

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

Latest Value GM Benchmarking

National Rank against other localities

Stockport	89.8%
Wigan	87.9%
Rochdale	87.8%
Trafford	87.5%
Bolton	86.7%
Bury	86.6%
Oldham	83.1%
Tameside	81.6%
Salford	80.8%
Manchester	76.3%

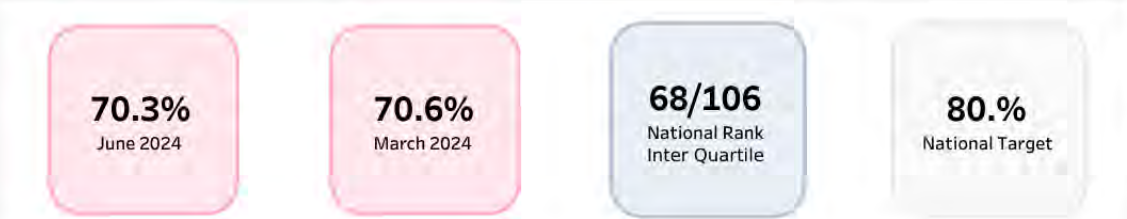
Narrative

- As of Dec 2025, the MMR2 uptake rate at age five years in Bury stands at 86.6%, representing a slight decrease from 87.6% in Sept 2025.
- Among the GM localities, Bury ranks sixth.
- However, both Bury, and all other GM localities remain below the national target of 95%.

Females, 25-64, attending cervical screening within target period (3.5 or 5.5 year coverage, %)

The overall cervical screening coverage: the number of women screened adequately in the previous 42 months (if aged 24-49) or 66 months (if aged 50-64) divided by the number of eligible women on last day of review period.

Source: Cervical Screening Programme - Coverage Statistics [Management Information] (Quarterly)



Outliers more than 1 standard deviation from the mean

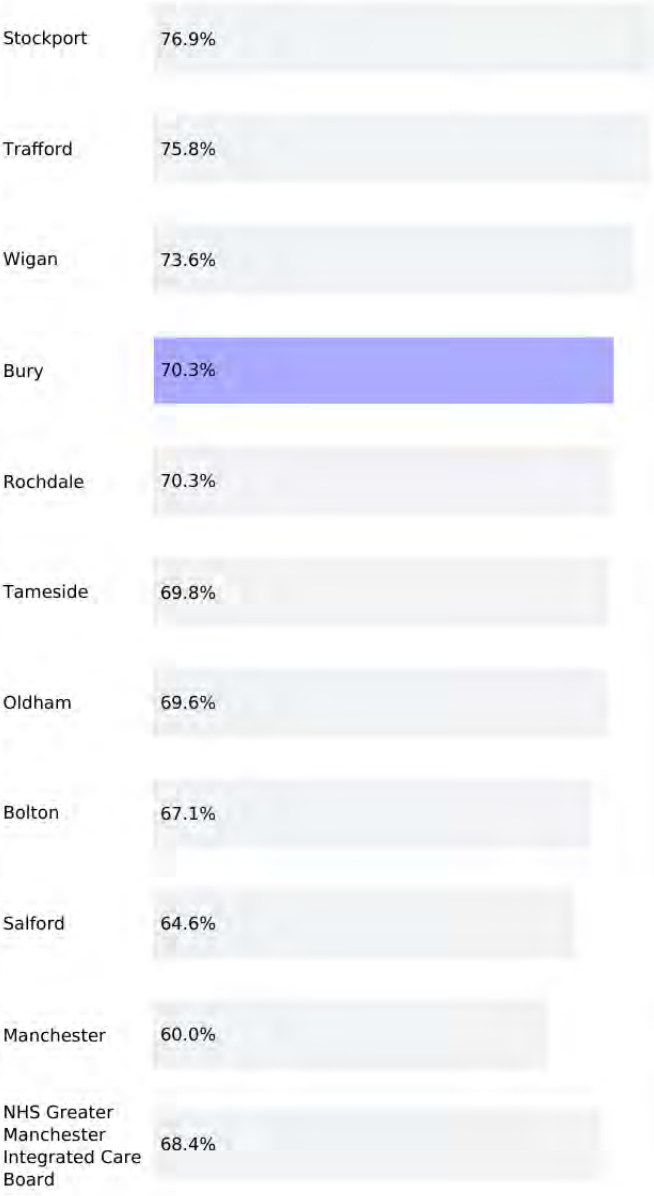


	Jun	Sep	Dec	Mar
2021-22	72.7%	71.9%	71.5%	71.7%
2022-23	71.1%	69.9%	69.2%	69.9%
2023-24	70.0%	69.8%	70.4%	70.6%
2024-25	70.3%			

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

Latest Value GM Benchmarking

National Rank against other localities



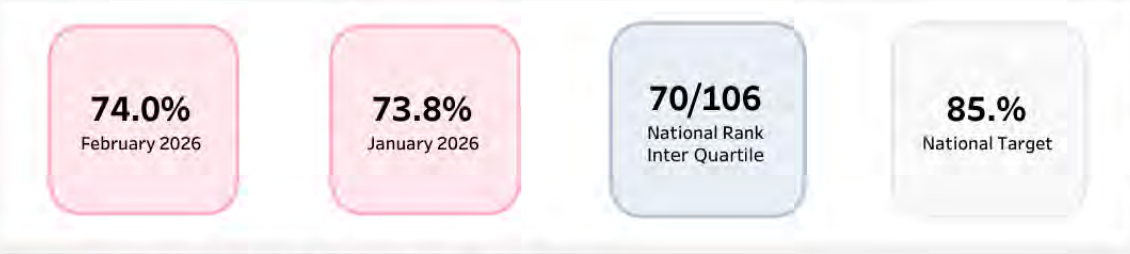
Narrative

- The GM Cancer Screening Dashboard indicates that, in April 2026 Cervical screening coverage in Bury is 69.5% (extended 50–64) and 66.5% (standard 25–49), indicating mid-range performance across GM.
- Performance is comparable to HMR and Oldham, and broadly in line with Bolton.
- Below top-performing localities including Stockport (72.9% / 74.5%) and Trafford (72.1% / 72.3%)
- Above lower-performing areas such as Manchester (64.6% / 54.7%) and Salford (64.6% / 61.3%)
- Overall, Bury demonstrates moderate uptake with opportunity to improve towards top quartile levels.

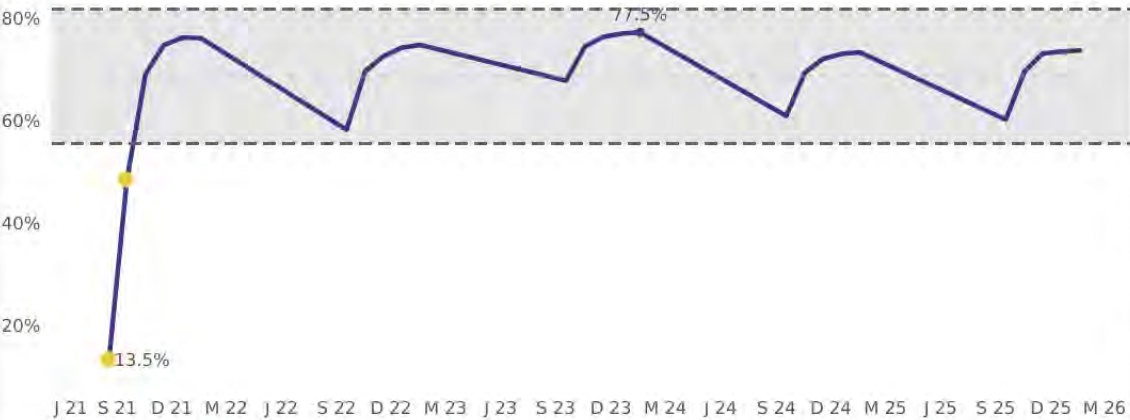
Seasonal Flu Vaccine Uptake: 65 years and over

The uptake of seasonal influenza vaccination among those aged 65 and over

Source: Seasonal influenza vaccine uptake in GP patients: monthly data, 2022 to 2023 (Monthly)



Outliers more than 1 standard deviation from the mean



	Sep	Oct	Nov	Dec	Jan	Feb
2021-22	13.5%	48.8%	69.4%	75.0%	76.5%	76.4%
2022-23		58.5%	69.9%	72.8%	74.6%	75.1%
2023-24		68.1%	74.7%	76.6%	77.3%	77.5%
2024-25		61.2%	69.7%	72.3%	73.3%	73.6%
2025-26		60.5%	69.9%	73.4%	73.8%	74.0%

Selected measure at February 2026 has continuously increased for 4 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities

Stockport	79.5%
Trafford	75.7%
Bury	74.0%
Wigan	73.9%
Rochdale	72.2%
Oldham	72.1%
Bolton	71.4%
Tameside	69.8%
Salford	69.0%
Manchester	62.8%
NHS Greater Manchester Integrated Care Board	72.0%

Narrative

- Uptake of the seasonal influenza vaccine among those aged 65 years and over in Bury increased to 74.0% in February 2026, representing a slight improvement from 73.8% in January 2026.
- This also reflects a year-on-year increase compared with February 2025, when uptake was reported at 73.6%.

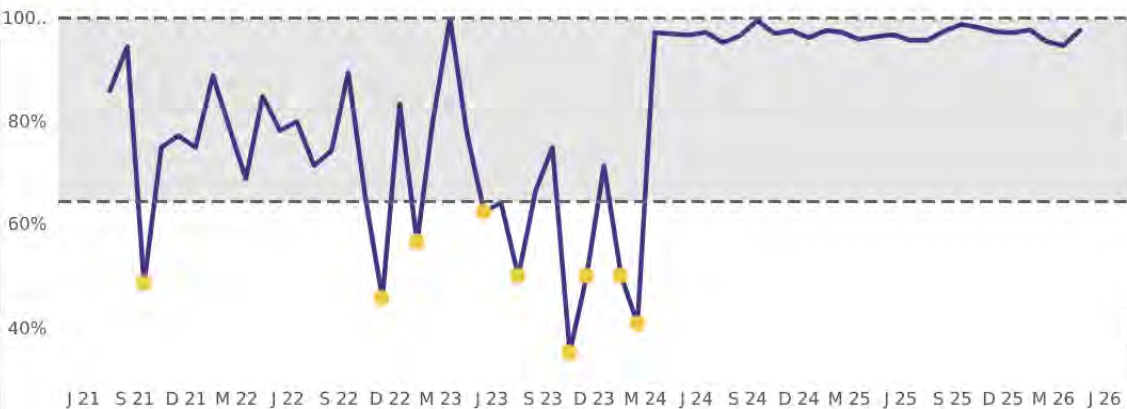
% 2-hour Urgent Community Response (UCR) first care contacts

Percentage of 2-hour UCR referrals subject to the 2-hour response standard (as specified in the UCR technical guidance), with an RTT end date in reporting month, that achieved the 2-hour response standards

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



Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22					86.0%	94.5%	48.5%	75.0%	77.3%	75.0%	88.9%	79.4%
2022-23	68.9%	84.9%	78.3%	80.0%	71.4%	74.4%	89.5%	65.0%	45.8%	83.3%	56.5%	80.0%
2023-24	100.0%	77.8%	62.5%	64.3%	50.0%	66.7%	75.0%	35.3%	50.0%	71.4%	50.0%	40.9%
2024-25	97.3%	97.0%	96.8%	97.3%	95.3%	96.7%	99.6%	97.1%	97.6%	96.3%	97.7%	97.3%
2025-26	96.0%	96.5%	96.9%	95.8%	95.8%	97.6%	98.8%	98.2%	97.4%	97.2%	97.8%	95.5%
2026-27	94.8%	97.7%										

Selected measure at May 2026 has continuously increased for 1 period(s) of time

Latest Value GM Benchmarking

Tameside	100.0%
Oldham	98.1%
Trafford	97.8%
Bury	97.7%
Stockport	95.5%
Manchester	95.3%
Salford	83.7%
Rochdale	82.2%
Wigan	80.9%
Bolton	71.0%
NHS Greater Manchester Integrated Care Board	89.7%

Narrative

- Bury UCR 2-hour response performance is 97.7% (May 2026), above the 70% national target and improved from 94.8% in April
- Performance is among the strongest in GM, ranking just below Tameside (100%), Oldham (98.1%) and Trafford (97.8%)
- Outperforms GM average (89.7%) and is higher than most localities including Stockport (95.5%) and Manchester (95.3%)
- Significantly above lower-performing areas such as Salford (83.7%), Rochdale (82.2%) and Bolton (71.0%)
- Overall, Bury demonstrates consistently high performance and sustained compliance with the 2-hour standard

Oversight Metrics Glossary

Domain	Code	Measure	Description	Data Source	Frequency	Latest	Updated	RAG rated against	Desired Direction
Cancer	N/A	Cancers Diagnosed at an Early Stage (12-month rolling): All Tumours Staged within RCRD	12-month rolling count of cancers diagnosed at stages 1 and 2 divided by 12-month rolling count of cancers diagnosed at stages 1, 2, 3, and 4	Rapid Cancer Registration Data (RCRD) at Tumour Level	Monthly	Dec 25	2nd Thursday	National Target	Increase
	S086a	Inappropriate adult acute mental health Out of Area Placement (OAP) bed days	Inappropriate Out of Area Placements	Out of Area Placements in Mental Health Services Official Statistics	Monthly	Apr 26	2nd Thursday	National Target	Decrease
	S081a	Talking Therapies: Access Rate	Number of people accessing first treatment	Improving Access to Psychological Therapies Data Set	Monthly	Apr 26	2nd Thursday	No Target	Increase
	EAS01	Dementia: Diagnosis Rate (Aged 65+)	Dementia: Diagnosis Rate (Aged 65+)	Primary Care Dementia Data	Monthly	Mar 26	2nd Thursday	National Target	Increase
	S030a	% of patients aged 14+ with a completed LD health check	% of patients aged 14+ with a completed LD health check	Learning Disabilities Health Check Scheme	Monthly	Apr 26	2nd Thursday	National Target	Increase
	S110a	Overall Access to Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses	Number of people who receive two or more contacts from NHS or NHS commissioned community mental health services (in transformed and non-transformed PCNs) for adults and older adults with...	Published MHSDS	Monthly	Apr 26	2nd Thursday	National Median	Increase
	S125a	Long length of stay for adults (60+ days)	Number of people for a given CCG discharged from an adult acute inpatient bed with a hospital spell over 60 days (calculated from the point of admission to the point of discharge)	Published MHSDS	Monthly	Apr 26	2nd Thursday	National Target	Decrease
	EH09	Access to Children and Young Peoples Mental Health Services	Number of CYP aged 0-17 supported through NHS funded mental health services receiving at least one contact.	Published MHSDS	Monthly	Apr 26	2nd Thursday	National Median	Increase
	S131a	Women Accessing Specialist Community Perinatal Mental Health Services	Number of women accessing specialist community PMH and MMHS services in the reporting period	Published MHSDS	Quarterly	Apr 26	2nd Thursday	No Target	Increase
	N/A	Number of MH patients with no criteria to reside (NCTR)	Number of MH patients with no criteria to reside	GM Admissions - Local	Monthly	May 26	1st	No Target	Decrease
	N/A	Percentage of MH patients with no criteria to reside (NCTR)	Percentage of MH patients with no criteria to reside	GM Admissions - Local	Monthly	May 26	1st	No Target	Decrease
	N/A	Proportion of routine eating disorder referrals cases entering treatment within four weeks, aged 0-18	Proportion of referrals with eating disorders categorized as routine cases entering treatment within four weeks in RP, aged 0-18	Published MHSDS	Monthly	Apr 26	2nd Thursday	National Target	Increase
Primary Care	S053b	% of hypertension patients who are treated to target as per NICE guidance		NHS Quality Outcome Framework	Annual	Mar 25	2nd Thursday	National Target	Increase
	S129a	GP appointments - percentage of regular appointments within 14 days	Percentage of appointments where the time between booking and appointment was 'Same day', '1 day', '2 to 7 days' or '8 to 14 days'	Appointments in General Practice	Monthly	Apr 26	Last Thursday	National Median	Increase
	S053c	% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins	% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins	CVD Prevent	Quarterly	Dec 25	2nd Thursday	National Median	Increase
Quality	S037A	% of patients describing the overall experience of their GP practice as good	The weighted percentage of people who report through the GP Patient Survey their overall experience of their GP practice as 'very good' or 'fairly good'	GP Patient Survey	Annual	Mar 23	2nd Thursday	National Median	Increase
	S042a	E. coli blood stream infections	12-month rolling counts of E. coli	National Statistics: E. coli bacteraemia: monthly data by local...	Monthly	Apr 26	1st Wednesday	No Target	Decrease
	S044b	Antimicrobial resistance: proportion of broad-spectrum antibiotic prescribing in primary care	The proportion of broad-spectrum antibiotic prescribing in primary care	EPACT Prescribing Data	Monthly	Jun 25	2nd Thursday	National Target	Decrease
	S044a	Antimicrobial resistance: total prescribing of antibiotics in primary care	The proportion of antibiotic prescribing in primary care	EPACT Prescribing Data	Monthly	Jun 25	2nd Thursday	National Target	Decrease

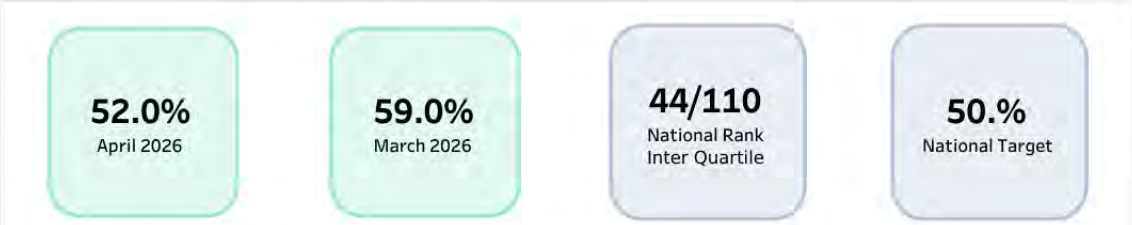
Sight Metrics Glossary

Domain	Code	Measure	Description	Data Source	Frequency	Latest	RAG rated against	Target/National
Elective Care	EB20	RTT incomplete: 65+ week waits		Consultant-led RTT Waiting Times data collection (National Statistics).	Monthly	Apr 26	National Target	0,
	EB26x	Diagnostic 6ww: All	% of Patients waiting over 6 weeks for a diagnostic test or procedure	Monthly Diagnostics Waiting Times and Activity Return - DM01	Monthly	Apr 26	National Target	1.%
	EB28	Diagnostic 6ww: All	% of Patients waiting over 6 weeks for a diagnostic test or procedure	Monthly Diagnostics Waiting Times and Activity Return - DM01	Monthly	Apr 26	National Target	1.%
	EB28x	Diagnostic 6ww: All	% of Patients waiting over 6 weeks for a diagnostic test or procedure	Monthly Diagnostics Waiting Times and Activity Return - DM01	Monthly	Apr 26	National Target	1.%
Cancer	S012a	28 Day Wait from Referral to Faster Diagnosis (Monthly): All Patients	Count of patients told cancer diagnosis outcome within 28 days divided by total count of patients told cancer diagnosis outcome following their urgent referral for suspected cancer, referral for breast symptoms, or urgent screening referral	National Cancer Waiting Times Monitoring Data Set (CWT)	Monthly	Apr 26	National Target	80.%
Materni..	S022a	Number of stillbirths per 1,000 total births	Count of cancers diagnosed at stages 1 and 2 divided by count of cancers diagnosed at stages 1, 2, 3, and 4	MBRRACE-UK - Perinatal Mortality Surveillance Report	Annual	Dec 24	National Median	3
	S104a	Number of neonatal deaths per 1,000 total live births	Number of neonatal deaths per 1,000 total live births	MBRRACE-UK - Perinatal Mortality Surveillance Report	Annual	Dec 24	National Median	1
Screenin g and Im munisati ons	S047A	Seasonal Flu Vaccine Uptake: 65 years and over	number of people over 65 who received the seasonal influenza vaccination divided by the number of eligible people who are aged 65 and over	Seasonal influenza vaccine uptake in GP patients: monthly data, 2022 to 2023	Monthly	Feb 26	National Target	85.%
	S046a	COVER immunisation: MMR2 Uptake at 5 years old	% children whose fifth birthday falls within the time period who have received two doses of MMR vaccination	Cover of vaccination evaluated rapidly (COVER) programme	Quarterly	Dec 25	National Target	95.%
	S050a	Females, 25-64, attending cervical screening within target period (3.5 or 5.5 year coverage, %)	% of females, age 25-64 yrs, attending cervical screening within target period (3.5 yrs if aged 24-49 or 5.5 yrs if aged 50-64)	Cervical Screening Programme – Coverage Statistics [Management Information]	Quarterly	Jun 24	National Target	80.%
	S049a	Breast screening coverage, females aged 53-70, screened in last 36 months	% women eligible for screening who have had a test with a recorded result at least once in the previous 36 months	Fingertips, Public Health Data, Public Health Outcomes Framework	Annual	Dec 25	No Target	
Commu..	N/A	% 2-hour Urgent Community Response (UCR) first care contacts	Percentage of 2-hour Urgent Community Response referrals subject to the 2-hour standard where care was provided within two hours	Community Services Data Set (CSDS)	Monthly	May 26	National Target	

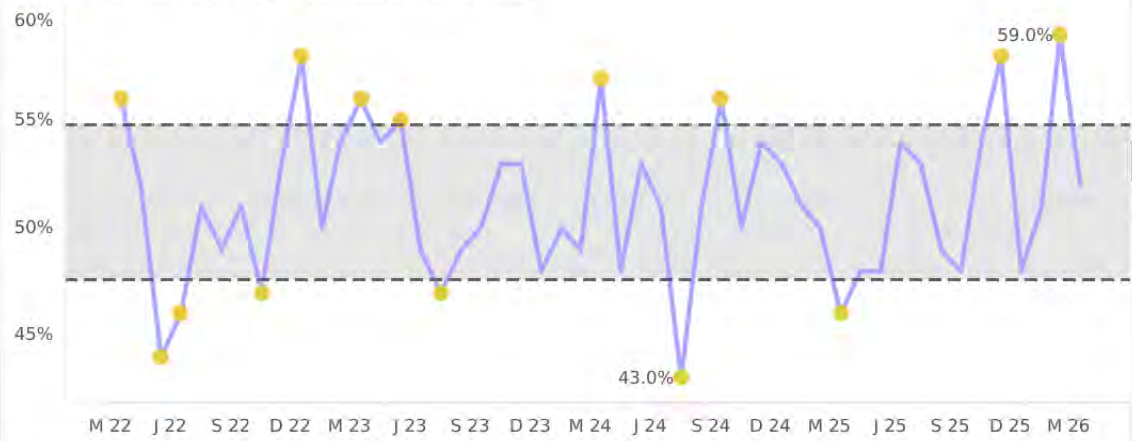
Talking Therapies: Recovery Rate

The proportion of people who complete treatment who are moving to recovery

Source: Improving Access to Psychological Therapies Data Set (Monthly)



Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	56.0%	52.0%	44.0%	46.0%	51.0%	49.0%	51.0%	47.0%	53.0%	58.0%	50.0%	54.0%
2023-24	56.0%	54.0%	55.0%	49.0%	47.0%	49.0%	50.0%	53.0%	53.0%	48.0%	50.0%	49.0%
2024-25	57.0%	48.0%	53.0%	51.0%	43.0%	51.0%	56.0%	50.0%	54.0%	53.0%	51.0%	50.0%
2025-26	46.0%	48.0%	48.0%	54.0%	53.0%	49.0%	48.0%	54.0%	58.0%	48.0%	51.0%	59.0%
2026-27	52.0%											

Selected measure at April 2026 has continuously decreased for 1 period(s) of time

Latest Value GM Benchmarking
National Rank against other localities

5	Trafford	61.0%
35	Tameside	53.0%
44	Bury	52.0%
53	Wigan	51.0%
65	Bolton	50.0%
	Stockport	50.0%
93	Rochdale	46.0%
101	Oldham	42.0%
	Manchester	42.0%
107	Salford	39.0%

Narrative

- Bury Talking Therapies recovery rate is 52.0% (April 2026), down from 59.0% in March (-7.0pp), but remains above the 50% national target.
- Longer-term performance shows fluctuation between ~45%–60%, with no sustained upward trend.
- Recovery rates have consistently varied month-to-month, indicating instability in outcomes.
- The latest decline follows a period of relatively stronger performance earlier in 2025/26.
- Compared to peers, Bury sits mid-range within GM, performing better than several localities but below the strongest performers.

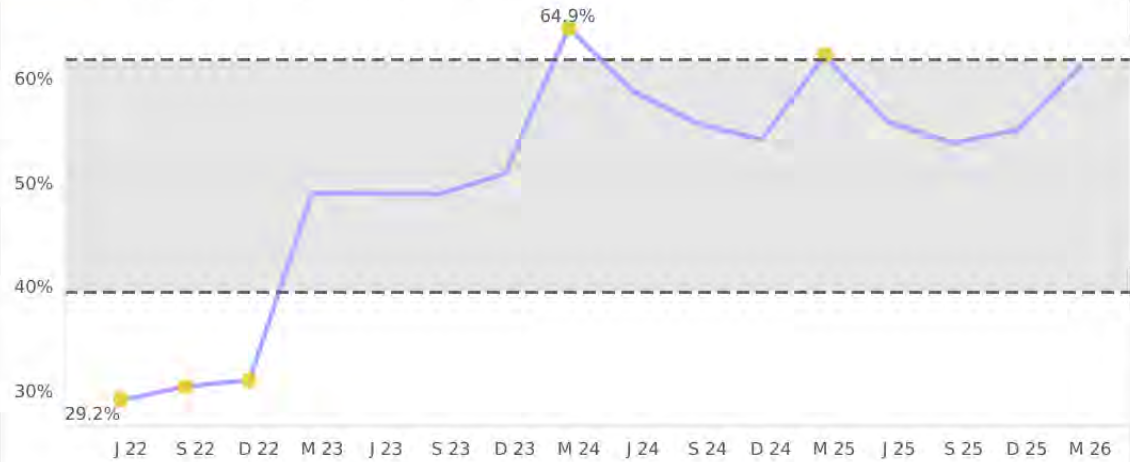
% of people with SMI to receive all six physical health checks in the preceding 12 months. - Mental Health Patients

People with severe mental illness receiving a full annual physical health check and follow up interventions

Source: Physical Health Checks for people with Severe Mental Illness (Quarterly)



Outliers more than 1 standard deviation from the mean



	Jun	Sep	Dec	Mar
2022-23	29.2%	30.5%	31.1%	49.1%
2023-24	49.0%	49.0%	50.9%	64.9%
2024-25	58.8%	55.8%	54.2%	62.2%
2025-26	55.9%	53.9%	55.2%	61.3%

Selected measure at March 2026 has continuously increased for 2 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities

5	Tameside	76.1%
6	Trafford	75.0%
10	Stockport	74.3%
11	Salford	74.0%
12	Wigan	73.8%
33	Oldham	68.3%
34	Rochdale	68.0%
38	Bolton	67.3%
42	Manchester	66.7%
69	Bury	61.3%
6	NHS Greater Manchester Integrated Care Board	69.9%

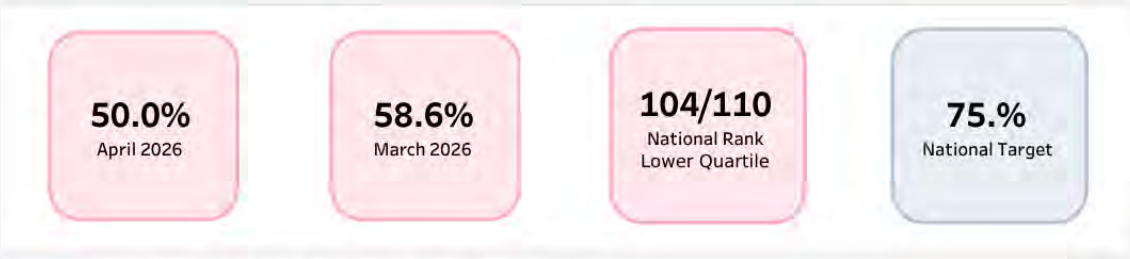
Narrative

- Published data indicates that, as of March 2026, 61.8% of individuals registered in Bury with a serious mental illness (SMI) had completed all six recommended physical health checks within the preceding 12 months. This equates to 1,273 out of 2,060 eligible patients.
- In comparison, the Greater Manchester (GM) average for the same period was 68.7%, indicating that Bury is currently performing below the GM average.

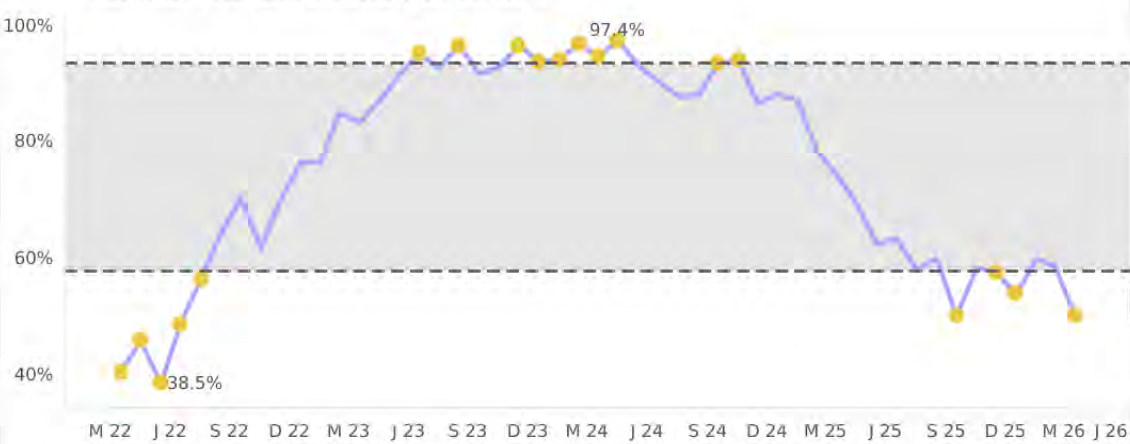
Talking Therapies: 6 Week Waits

The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period.

Source: Improving Access to Psychological Therapies Data Set (Monthly)



Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	40.5%	45.8%	38.5%	48.7%	56.4%	64.3%	70.3%	61.9%	70.0%	76.5%	76.7%	85.0%
2023-24	83.3%	87.0%	91.5%	95.1%	92.7%	96.7%	91.7%	92.9%	96.7%	93.8%	94.1%	96.9%
2024-25	94.7%	97.4%	93.2%	90.5%	87.8%	88.0%	93.5%	93.9%	86.7%	88.2%	86.8%	78.6%
2025-26	74.4%	69.4%	62.5%	63.4%	58.1%	60.0%	50.0%	58.3%	57.6%	53.8%	60.0%	58.6%
2026-27	50.0%											

Selected measure at April 2026 has continuously decreased for 2 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities

49	Oldham	92.1%
66	Tameside	87.2%
79	Bolton	81.5%
83	Wigan	80.0%
88	Trafford	76.1%
89	Manchester	75.2%
93	Salford	74.2%
95	Stockport	71.1%
104	Bury	50.0%
109	Rochdale	34.6%
33	NHS Greater Manchester Integrated Care Board	74.5%

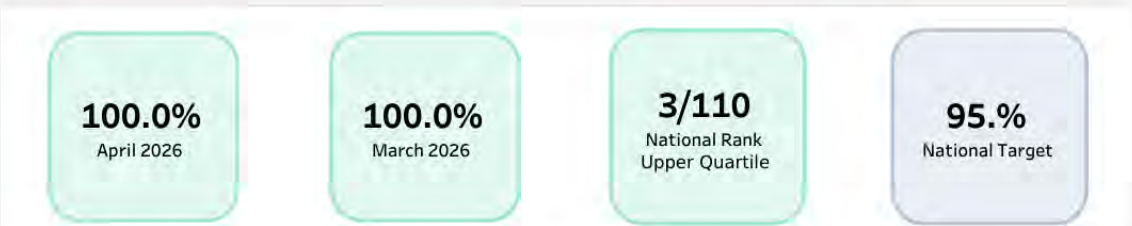
Narrative

- Talking Therapies 6-week waits in Bury have declined further to 50.0% (April 2026), down from 58.6% in March (-8.6pp)
- Performance remains well below the 75% national target and continues to sit in the lower quartile (104th/110)
- Trend shows sustained deterioration since mid-2024, following previous high performance (>90%)
- Over the past 12 months, performance has stabilised at a lower level (~50–60%), with limited recovery
- Bury continues to perform significantly below the GM average (74.5%), with a persistent gap to peers.

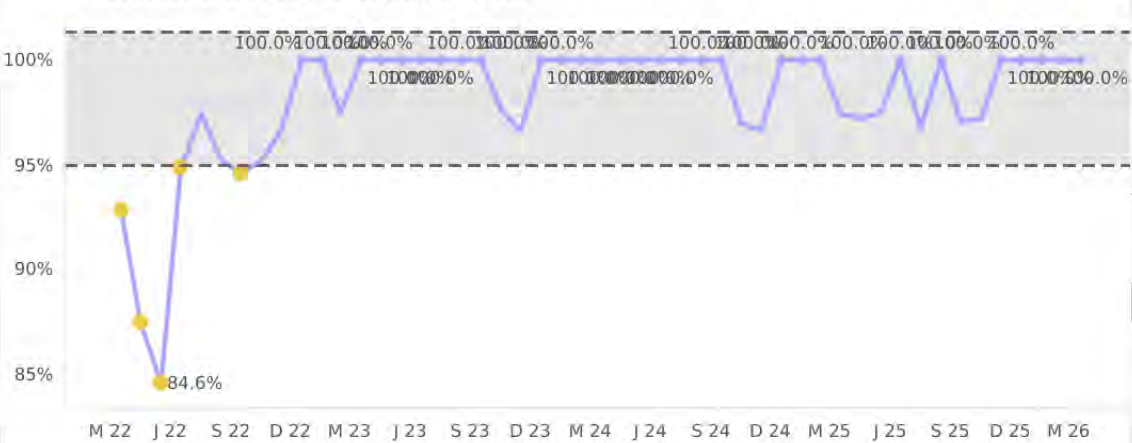
Talking Therapies: 18 Week Waits

The proportion of people that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period.

Source: Improving Access to Psychological Therapies Data Set (Monthly)



Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	92.9%	87.5%	84.6%	94.9%	97.4%	95.2%	94.6%	95.2%	96.7%	100.0%	100.0%	97.5%
2023-24	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.6%	96.7%	100.0%	100.0%	100.0%
2024-25	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.0%	96.7%	100.0%	100.0%	100.0%
2025-26	97.4%	97.2%	97.5%	100.0%	96.8%	100.0%	97.1%	97.2%	100.0%	100.0%	100.0%	100.0%
2026-27	100.0%											

Selected measure at April 2026 has continuously for 4 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities

3	Bury	100.0%
	Oldham	100.0%
	Salford	100.0%
	Trafford	100.0%
	Wigan	100.0%
90	Bolton	98.1%
92	Tameside	97.9%
93	Stockport	97.8%
98	Manchester	96.3%
99	Rochdale	96.2%
29	NHS Greater Manchester Integrated Care Board	98.4%

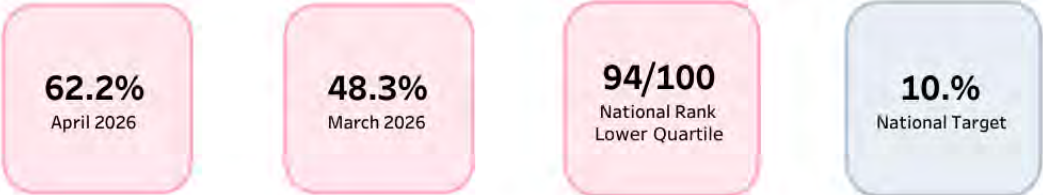
Narrative

- Talking Therapies 18-week waits in Bury remain 100% in April 2026, sustaining full compliance with the 95% national target.
- Performance has been consistently at or near 100% since 2023, demonstrating sustained high delivery and stability.
- Bury is ranked 3rd nationally (upper quartile), reflecting strong comparative performance.
- Over recent months, performance has remained stable with minimal variation, indicating robust pathway management.
- Bury continues to perform above the GM average (98.4%), with only marginal variation across localities at this high level.

Talking Therapies: Second Treatment Waits

The proportion of people that waited more than 90 days from their first treatment appointment to their second treatment appointment.

Source: Improving Access to Psychological Therapies Data Set (Monthly)



Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	28.6%	45.3%	34.9%	19.1%	17.0%	18.6%	30.6%	15.8%	21.9%	17.9%	23.8%	23.1%
2023-24	31.0%	15.7%	17.9%	20.9%	16.1%	13.5%	8.1%	21.3%	15.8%	28.9%	29.7%	30.6%
2024-25	29.4%	31.9%	20.0%	24.3%	25.0%	39.4%	42.4%	55.6%	35.9%	44.0%	39.0%	28.2%
2025-26	23.3%	18.6%	24.4%	22.0%	27.6%	37.9%	43.3%	45.5%	47.8%	51.9%	51.7%	48.3%
2026-27	62.2%											

Selected measure at April 2026 has continuously increased for 1 period(s) of time

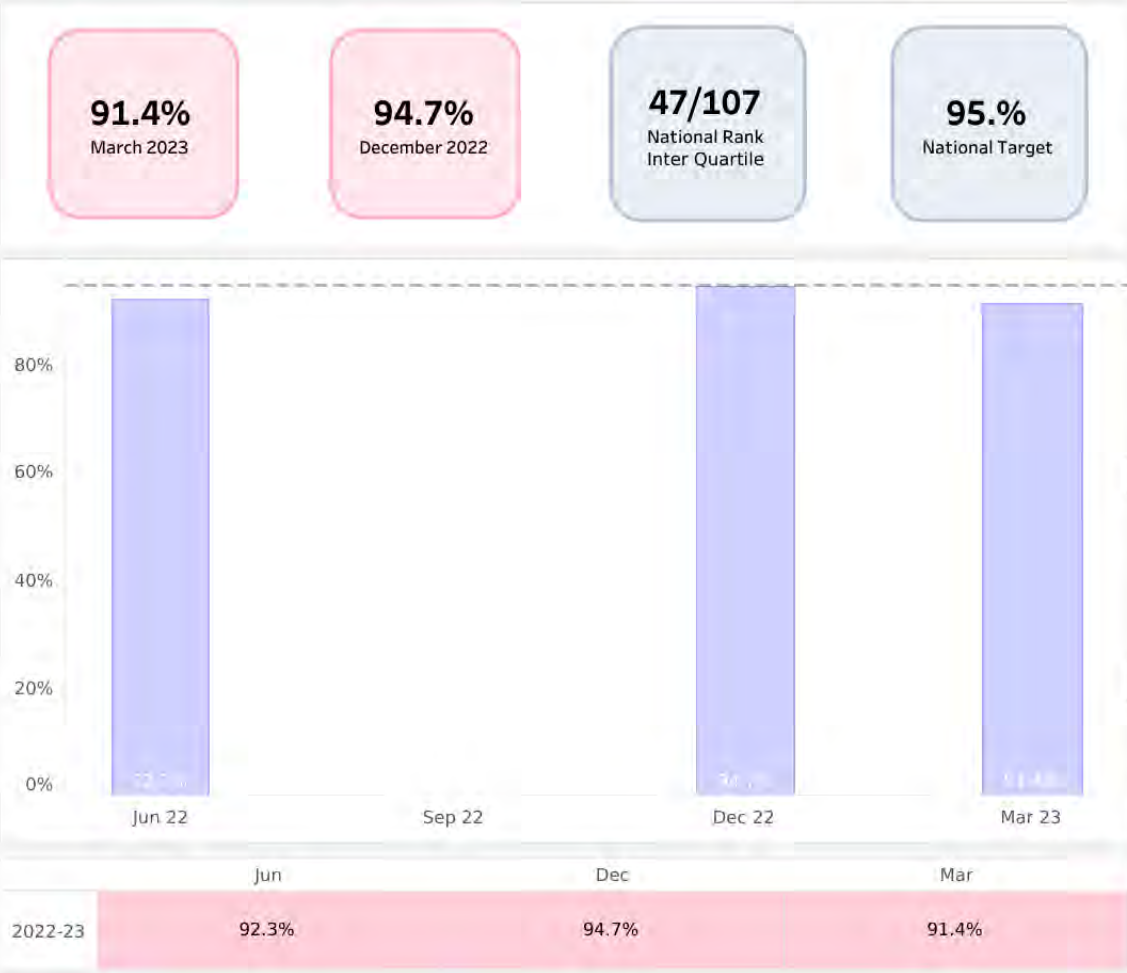
Latest Value GM Benchmarking
National Rank against other localities

42	Oldham	23.5%
69	Manchester	36.0%
72	Wigan	37.5%
75	Trafford	39.1%
76	Salford	39.4%
78	Tameside	41.9%
87	Bolton	50.0%
89	Stockport	51.9%
94	Bury	62.2%
95	Rochdale	63.6%
32	NHS Greater Manchester Integrated Care Board	42.6%

- Narrative
- Talking Therapies second treatment waits in Bury have increased to 62.2% (April 2026), up significantly from 48.3% in March (+13.9pp)
 - Performance remains substantially above the 10% national target (higher is worse) and continues to be in the lower quartile (94th/100)
 - Trend shows clear deterioration over the past 18 months, rising from around 15–25% during 2023/24 to consistently 40–60% in 2025/26
 - Recent data indicates a sharp upward trend, with waits worsening in the last 3–4 months following a period of already poor performance
 - Bury remains above the GM average (42.6%), with a significant and widening gap to peers, indicating sustained systemic pressure in second treatment access.

CYP Eating Disorders: Routine - % within 4 weeks
C&YP Routine Eating Disorders: 4 Week Waits (Rolling 12 mths)

Source: Children and Young People with an Eating Disorder: Waiting Times. (Quarterly)



Selected measure at March 2023 has continuously decreased for 1 period(s) of time

Latest Value GM Benchmarking
National Rank against other localities

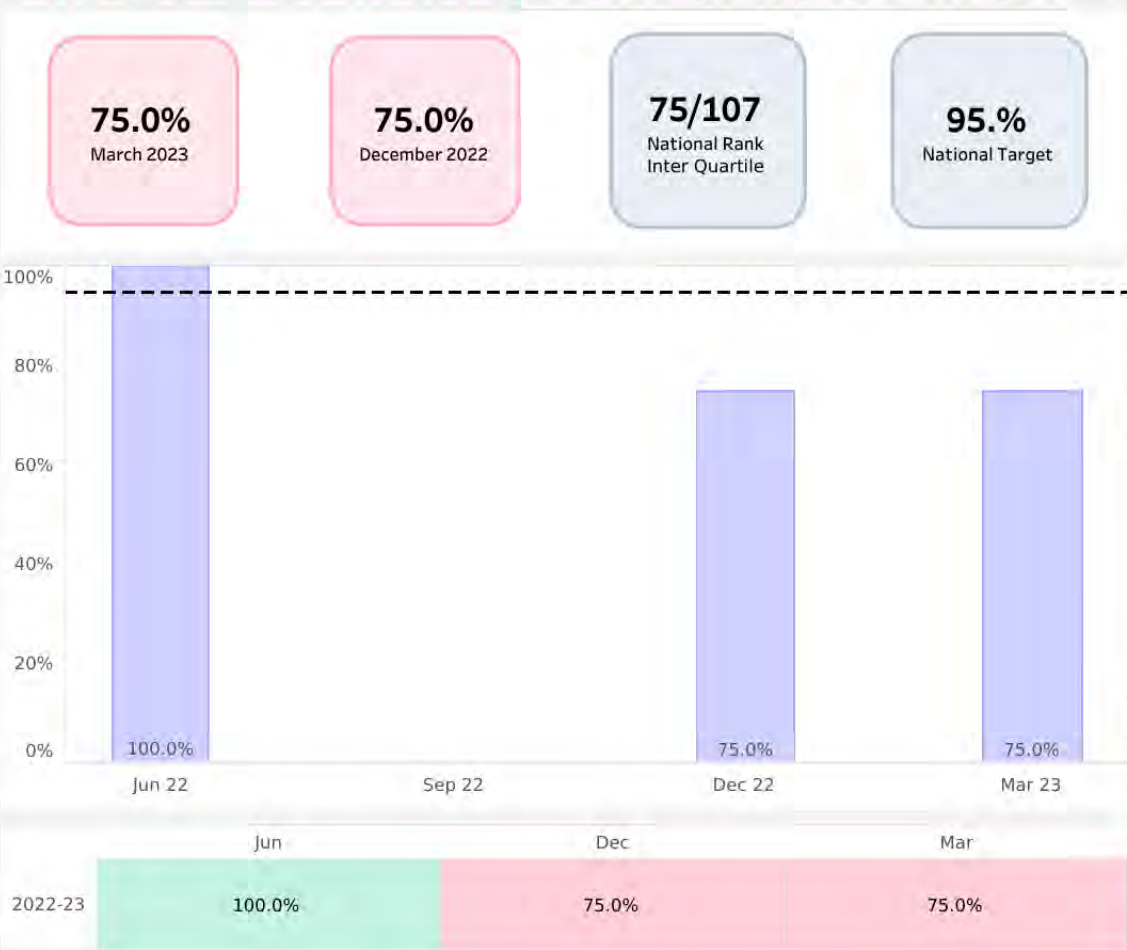
18	Salford	100.0%
28	Trafford	98.5%
30	Manchester	97.7%
34	Rochdale	96.3%
39	Stockport	94.5%
45	Oldham	92.0%
47	Bury	91.4%
51	Bolton	89.5%
52	Wigan	89.4%
56	Tameside	84.6%
11	NHS Greater Manchester Integrated Care Board	94.7%

Narrative

- Data taken from the Greater Manchester Eating Disorder Dashboard, shows 5% of patients with routine eating disorders in the Children and Young People (CYP) category were seen within four weeks during March 2026. Specifically, 4 out of 7 patients received care within the four-week target timeframe.
- GM reported figures shows 71% In March 26 with 84 out of 118 patients receiving care within four weeks.

CYP Eating Disorders: Urgent - % within 1 week
C&YP Urgent Eating Disorders: 1 Week Waits (Rolling 12 mths)

Source: Children and Young People with an Eating Disorder: Waiting Times. (Quarterly)



Selected measure at March 2023 has continuously for 1 period(s) of time

Latest Value GM Benchmarking
National Rank against other localities

18	Rochdale	100.0%
	Salford	100.0%
	Trafford	100.0%
56	Manchester	90.0%
64	Bolton	83.3%
75	Bury	75.0%
	Stockport	75.0%
84	Oldham	66.7%
	Tameside	66.7%
88	Wigan	63.6%
20	NHS Greater Manchester Integrated Care Board	83.5%

Narrative

- In March 2026, no Bury-registered children and young people with an urgent eating disorder were seen, and therefore no patients were treated within the one-week target timeframe.
- Across Greater Manchester, performance in March 2026 was reported at 85%, with 11 out of 13 patients receiving care within one week.

Access to Individual Placement and Support Services - Mental Health Patients

Access to Individual Placement and Support Services

Source: Published MHSDS (Monthly)

290

April 2026

275

March 2026

57/106

National Rank
Inter Quartile

325.0

National Median

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023-24	25	25	30	30	30	30	30	30	30	35	40	40
2024-25	55	55	65	70	75	75	80	85	85	90	90	95
2025-26	90	90	150	165	175	180	210	230	250	250	265	275
2026-27	290											

Selected measure at April 2026 has continuously increased for 3 period(s) of time

Latest Value GM Benchmarking

Rate Per 1000 | Count (National Rank)

Salford	2.06	650 (22)
Tameside	1.58	355 (49)
Rochdale	1.49	370 (47)
Stockport	1.44	470 (35)
Bury	1.37	290 (57)
Trafford	1.35	335 (52)
Wigan	1.25	435 (39)
Oldham	1.19	320 (54)
Bolton	1.18	390 (45)
Manchester	1.16	845 (16)

Narrative

Bury – Access to IPS (Employment Support)

- Activity has increased to 290 in April 2026 (up from 275 in March), continuing a strong upward trajectory.
- Numbers have more than tripled over the past 12 months (from 90 in early 2025), with accelerated growth since mid-2025.
- Bury remains mid-range nationally (57th of 106), indicating average relative performance despite rapid growth.
- Benchmarking shows Bury’s rate (1.37 per 1,000) is broadly comparable to peers but below higher-performing areas (e.g. Salford, Tameside).
- Overall, Bury demonstrates sustained expansion in access, with further opportunity to improve relative position within GM.

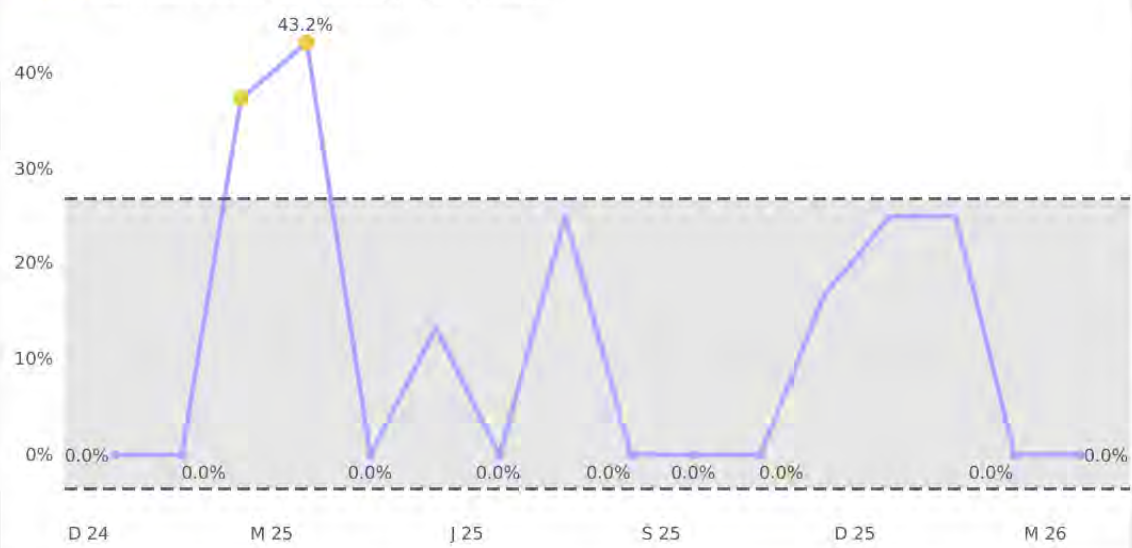
Percentage of CYP receiving Autism assessment within 18 weeks of referral

Percentage of CYP receiving Autism assessment within 18 weeks of referral

Source: Local Autism_ADHD Submission (Monthly)



Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023-24												
2024-25												
2025-26	43.2%	0.0%	13.3%	0.0%	25.0%	0.0%	0.0%	0.0%	0.0%	16.7%	25.0%	25.0%
2026-27	0.0%											

Selected measure at April 2026 has continuously for 1 period(s) of time

Latest Value GM Benchmarking

Salford	27.3%
Oldham	9.1%
Trafford	9.1%
Tameside	5.9%
Manchester	5.4%
Wigan	4.3%
Bolton	0.0%
Bury	0.0%
Rochdale	0.0%
Stockport	0.0%
NHS Greater Manchester Integrated Care Board	9.0%

Narrative

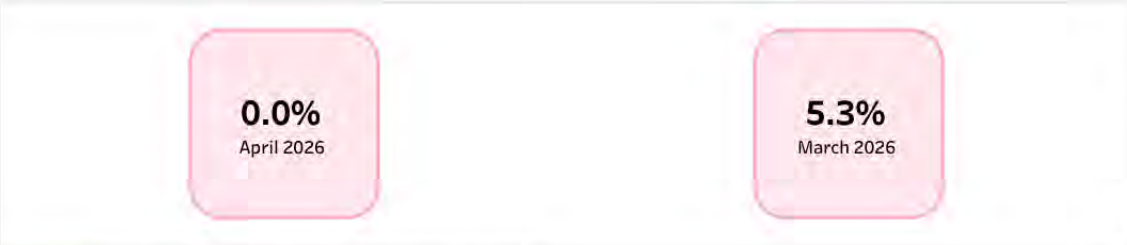
Bury – CYP Autism Assessment within 18 Weeks

- Performance remains at 0.0% in April 2026, unchanged from March, indicating no patients seen within the 18-week standard for a second consecutive month.
- Performance continues to be highly volatile, with multiple months at 0% over the past year and intermittent short-lived improvements.
- Trend shows no sustained recovery, with performance fluctuating between 0% and 25%, indicating inconsistent pathway delivery.
- Bury remains well below the GM average (9.0%) and sits among the lowest-performing localities across GM.
- Data should be interpreted with caution due to known methodology differences between national and local reporting, with further work underway to address this.

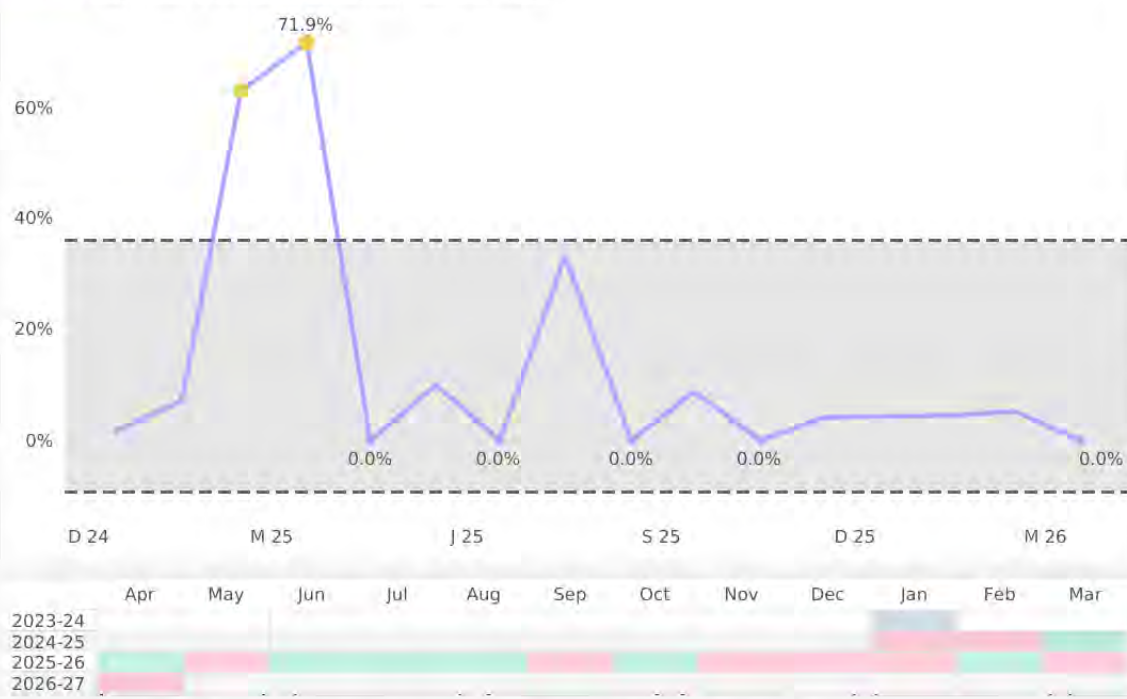
Percentage of CYP receiving ADHD assessment within 18 weeks of referral

Percentage of CYP receiving ADHD assessment within 18 weeks of referral

Source: Local Autism_ADHD Submission (Monthly)



Outliers more than 1 standard deviation from the mean



Selected measure at April 2026 has continuously decreased for 1 period(s) of time

Latest Value GM Benchmarking

Oldham	100.0%
Bolton	50.0%
Trafford	30.0%
Manchester	18.8%
Salford	15.0%
Wigan	4.5%
Bury	0.0%
Rochdale	0.0%
Stockport	0.0%
Tameside	0.0%
NHS Greater Manchester Integrated Care Board	19.2%

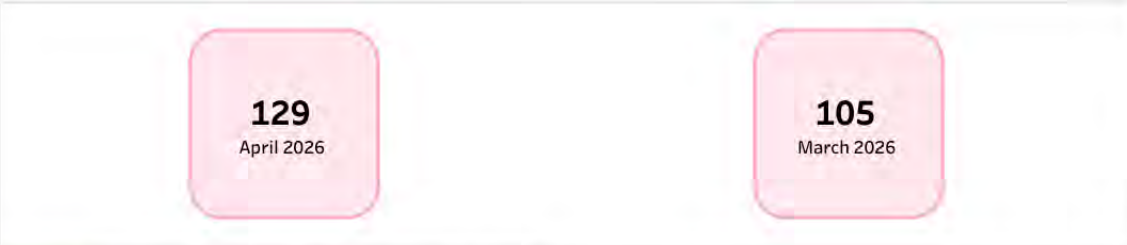
Narrative

- Bury – CYP ADHD Assessment within 18 Weeks.
- Performance has declined to 0.0% in April 2026, down from 5.3% in March, indicating no patients seen within the 18-week standard.
 - Delivery remains consistently very low and highly variable, with multiple months at or near 0% over the past year.
 - Trend shows no sustained improvement, with only sporadic short-term increases followed by deterioration.
 - Bury remains well below the GM average (19.2%) and continues to sit among the lowest-performing localities.
 - Overall performance indicates significant and ongoing capacity challenges within the assessment pathway.

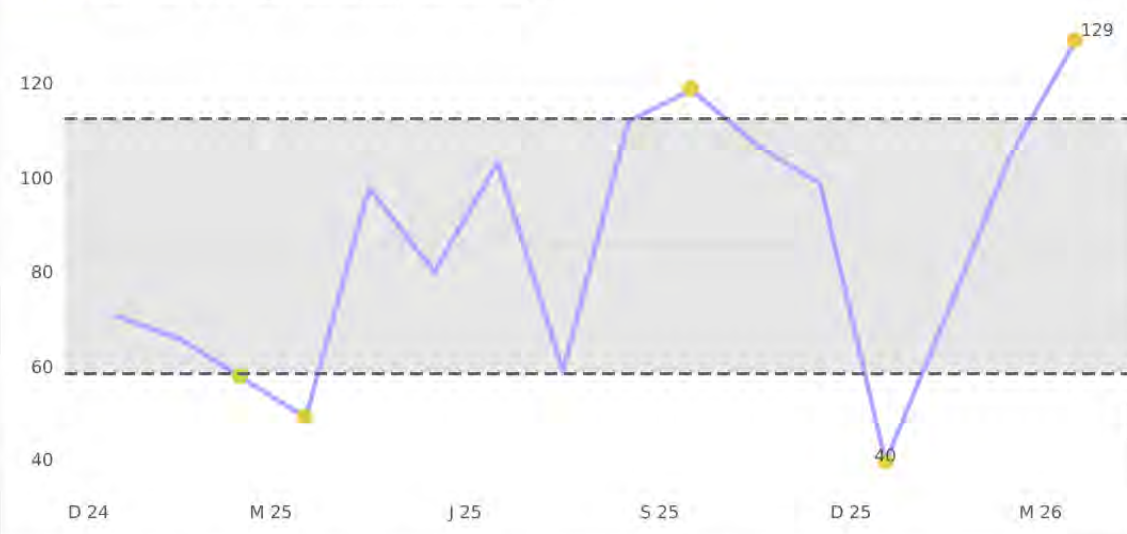
Autism average wait in weeks from referral to first assessment - Mental Health Patients

Autism average wait in weeks from referral to first assessment

Source: Local Autism_ADHD Submission (Monthly)



Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023-24												
2024-25										71	66	58
2025-26	49	98	80	103	59	112	119	107	99	40	73	105
2026-27	129											

Selected measure at April 2026 has continuously increased for 3 period(s) of time

Latest Value GM Benchmarking

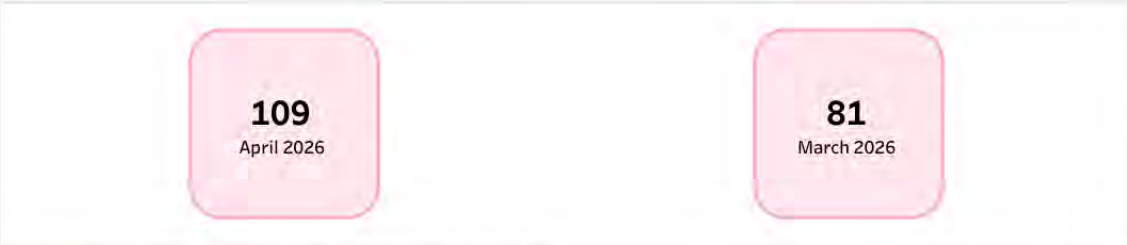
Bolton	59
Rochdale	77
Stockport	88
Oldham	92
Wigan	114
Salford	115
Manchester	116
Bury	129
Trafford	137
Tameside	151

- Narrative
- Bury – Autism Average Wait (Weeks from Referral to First Assessment)
- Average wait has increased to 129 weeks (April 2026), up from 105 weeks in March.
 - Trend shows overall deterioration with recent sharp increases, indicating growing backlog.
 - Bury remains mid-to-lower range across GM, with several areas reporting shorter waits.
 - Overall performance reflects increasing delays and sustained pathway pressure.
 - Note: Figures may differ locally due to methodology differences, a review paper is in development.

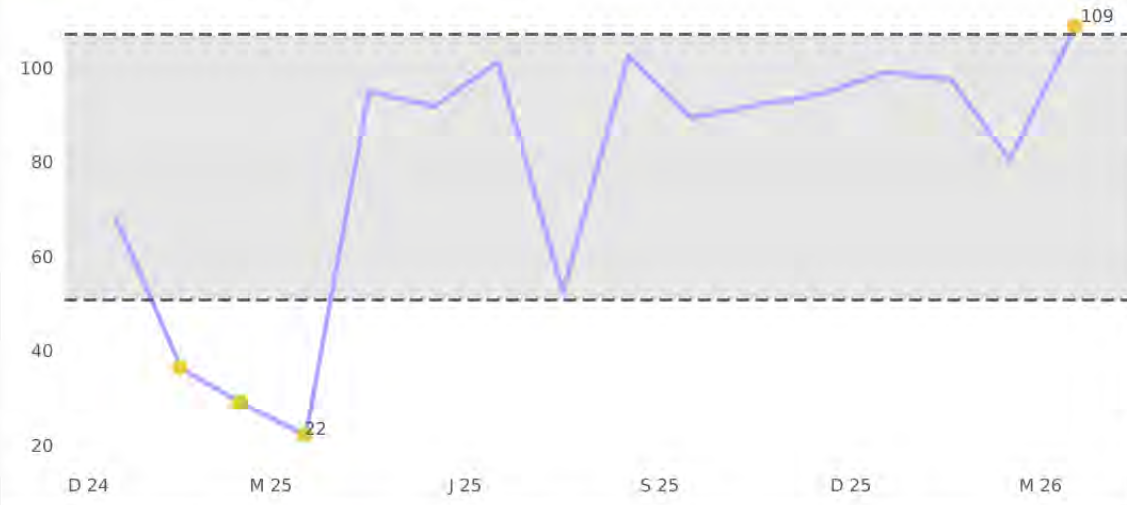
ADHD average wait in weeks from referral to first assessment - Mental Health Patients

ADHD average wait in weeks from referral to first assessment

Source: Local Autism_ADHD Submission (Monthly)



Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023-24												
2024-25										68	37	29
2025-26	22	95	92	102	53	103	90	92	95	99	98	81
2026-27	109											

Selected measure at April 2026 has continuously increased for 1 period(s) of time

Latest Value GM Benchmarking

Oldham	1
Manchester	58
Stockport	53
Wigan	71
Bolton	74
Trafford	62
Salford	115
Rochdale	115
Bury	109
Tameside	152

Narrative

- Bury – ADHD Average Wait (Referral to First Assessment)
- Average wait has increased to 109 weeks (April 2026), up from 81 weeks in March, reversing recent improvement.
- Waits remain consistently high, with most of the past year in the 80–100+ week range.
- Bury sits towards the higher end across GM, with longer waits than most localities and only outperforming the highest-wait areas.
- Overall trend indicates sustained pressure with recent deterioration in waiting times.
- Note: Figures may differ locally due to methodology differences; a review paper is in development

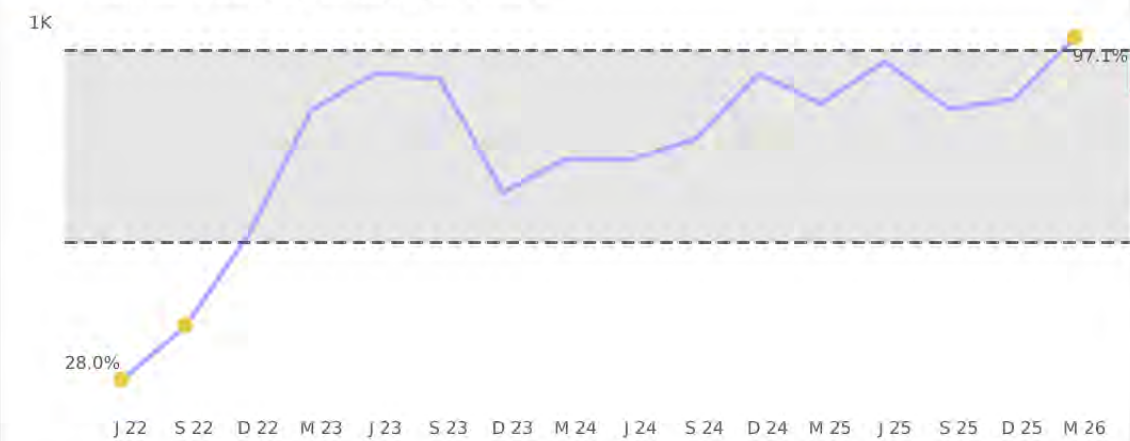
% of CHC referrals completed within 28 days

Percentage of referrals completed (including discounted referrals) within 28 Days

Source: Continuing Healthcare and NHS-funded Nursing Care quarterly published figures (Quarterly)



Outliers more than 1 standard deviation from the mean



	Jun	Sep	Dec	Mar
2022-23	28.0%	38.9%	57.5%	82.5%
2023-24	90.0%	88.9%	66.0%	72.7%
2024-25	72.5%	76.6%	89.7%	83.9%
2025-26	92.3%	82.8%	84.6%	97.1%

Selected measure at March 2026 has continuously increased for 2 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities

5	Bury	97.1%
8	Stockport	95.7%
9	Salford	94.9%
11	Bolton	94.8%
29	Tameside	90.5%
40	Trafford	86.5%
43	Rochdale	86.2%
52	Oldham	83.3%
62	Manchester	81.7%
73	Wigan	76.1%

Narrative

- Bury – CHC Referrals Completed Within 28 Days Performance improved to 97.1% in March 2026 (up from 84.6% in December), reflecting a strong upward trend.
- Bury is delivering consistently high performance, now approaching full compliance.
- Ranked 5th nationally (upper quartile), indicating very strong delivery.
- Benchmarking Bury (97.1%) is the top-performing locality in Greater Manchester.
- It performs above all GM peers, with most areas in the mid-80% to mid-90% range.

Number of prescriptions dispensed per 1000 patients

Number of prescriptions dispensed per 1000 patients

Source: Patient Level Prescribing Data (Monthly)

909.5

July 2025

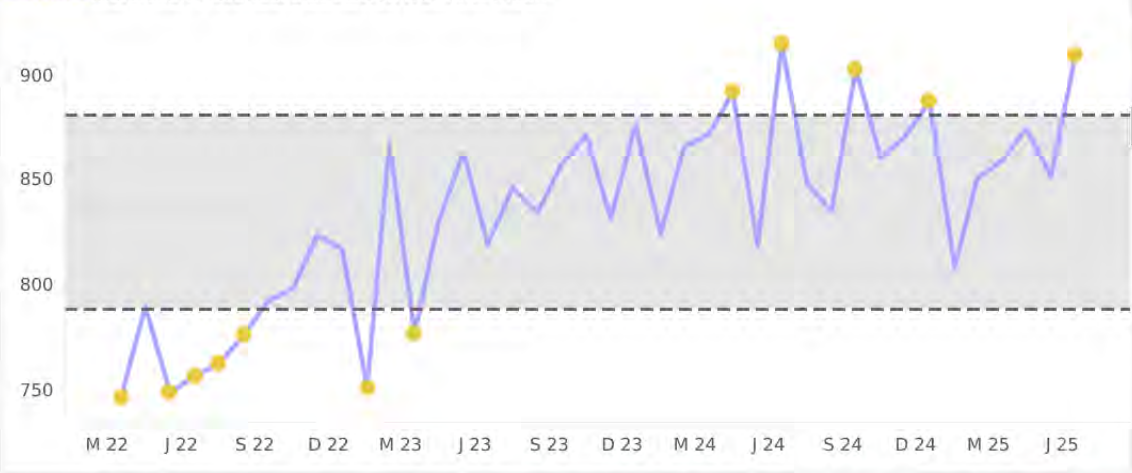
852.2

May 2025

110/117

National Rank
Lower Quartile

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	746.7	789.8	749.2	756.5	762.9	776.6	792.5	798.6	823.8	817.4	751.3	868.2
2023-24	777.0	830.8	863.4	819.6	846.6	834.6	857.7	871.4	831.8	876.7	824.7	865.8
2024-25	871.9	891.9	818.8	915.0	848.7	835.9	903.0	860.7	870.8	887.7	808.9	850.8
2025-26	859.6	874.4	852.2	909.5								

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

Latest Value GM Benchmarking

National Rank against other localities

107	Manchester	825
108	Bolton	856
109	Salford	902
110	Bury	909
111	Rochdale	924
112	Wigan	984
113	Oldham	986
114	Trafford	995
115	Stockport	1,042
116	Tameside	1,099
39	NHS Greater Manchester Integrated Care Board	932

Narrative

- In July 2025, the number of prescriptions issued per 1,000 patients was 909.5, representing an increase from June 2025, when the rate was 852.2.
- However, this reflects an increase compared to July 2024, when the figure stood at 915.0.
- Bury currently ranks fourth among the Greater Manchester localities and remains below the Greater Manchester average of 932.

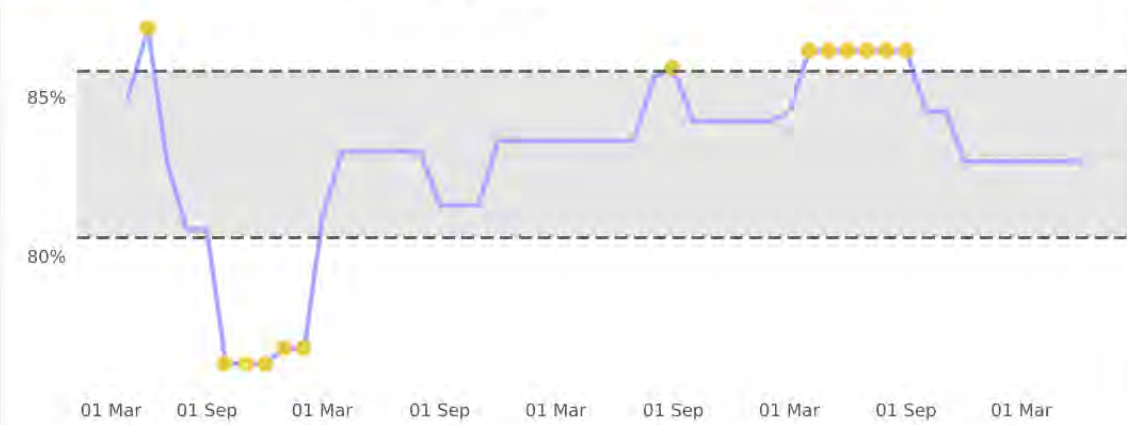
Percentage of Care Homes rated Good or Outstanding

The % of Care Homes rated Good or Outstanding at the end of the period

Source: CQC (Monthly)



Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23												
2023-24												
2024-25												
2025-26												
2026-27												

Latest Value GM Benchmarking
Rank against other localities

1	Wigan	92.6%
2	Trafford	87.5%
3	Oldham	85.7%
4	Bolton	85.5%
5	Bury	83.0%
6	Salford	82.5%
7	Manchester	80.8%
8	Stockport	73.8%
9	Tameside	73.5%
10	Rochdale	64.2%

Narrative

- Bury – Care Homes Rated Good or Outstanding Performance remains stable at 83.0% (April–May 2026) with no recent change.
- Trend shows sustained stability, following earlier variation.
- Bury ranks 5th across GM, indicating mid-to-upper quartile performance.
- Performance is above Manchester (80.8%) and Stockport (73.8%), but below higher-performing areas (e.g. Wigan 92.6%, Trafford 87.5%).
- Overall, Bury demonstrates consistent performance with scope to close the gap to top quartile areas.



BURY
INTEGRATED CARE
PARTNERSHIP

Locality Performance Report June 2026

Part of Greater Manchester
Integrated Care Partnership



Presentation by:

Bury - Oversight Metrics

Show Definitions

Domain	Code	Measure	Frequency	Date	Latest	Previous	Change	Target/Median	Numerator	Denominator	Quartile
Mental Health & Learning Disabilities	N/A	Adult inpatients with autism only	Monthly	Apr 26	2	2	➡	2	N/A	N/A	N/A
	N/A	Adult inpatients with LD and LDA	Monthly	Apr 26	4	4	➡	3	N/A	N/A	N/A
	S030a	% of patients aged 14+ with a completed LD health check	Monthly	Apr 26	3.9%	88.53%	🔻	75.%	47	1,195	Inter
	EH09	Access to Children and Young Peoples Mental Health Services	Monthly	Apr 26	3,665	3,690	🔻	5,885 566000.00%	N/A	N/A	Lower
	EAS01	Dementia: Diagnosis Rate (Aged 65+)	Monthly	Mar 26	76.3%	76.50%	🔻	66.7%	1,891	2,477	Upper
	S086a	Inappropriate adult acute mental health Out of Area Placement (OAP) bed days (rolling 3 month total)	Monthly	Apr 26	3,605	3,455	🔻	0 36250.00%	N/A	N/A	Lower
	N/A	Number of MH patients with no criteria to reside - number of beds occupied by mental health patients who are ready to be discharged	Monthly	May 26	8	14	➡	N/A	N/A	N/A	Inter
	N/A	Percentage of MH patients with no criteria to reside (NCTR)	Monthly	May 26	9.4%	15.73%	➡	N/A	8	85	Inter
	S110a	Overall Access to Community MH Services for Adults and Older Adults with Severe Mental Illnesses	Monthly	Apr 26	3,100	2,375	➡	5,445 442500.00%	N/A	N/A	Inter
	S081a	Talking Therapies: Access Rate	Monthly	Apr 26	290	300	🔻	N/A	N/A	N/A	Lower
	S131a	Women Accessing Specialist Community Perinatal Mental Health Services	Quarterly	Apr 26	195	195	↔	N/A	N/A	N/A	Lower
	S125a	Long length of stay for adults (60+ days)	Monthly	Apr 26	25.0%	23.08%	🔻	0.% 25.00%	15	60	Inter
	N/A	Proportion of routine eating disorder referrals cases entering treatment within four weeks, aged 0-18	Monthly	Apr 26	126.0%	126.00%	➡	N/A 8600.00%	126	N/A	Lower
Cancer	N/A	Cancers Diagnosed at an Early Stage (12-month rolling): All Tumours Staged within RCRD	Monthly	Dec 25	59.9%	59.97%	🔻	N/A 60.83%	470	785	Inter
Primary Care	S053b	% of hypertension patients who are treated to target as per NICE guidance	Annual	Mar 25	70.6%	69.59%	➡	77.% 69.69%	22,781	32,267	Inter
	S053c	% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins	Quarterly	Dec 25	65.0%	64.54%	➡	64.07% 63.95%	7,115	10,945	Inter
	S129a	GP appointments - percentage of regular appointments within 14 days	Monthly	Apr 26	80.2%	79.57%	➡	80.49% 82.14%	62,467	77,908	Inter
Quality	S042a	E. coli blood stream infections	Monthly	Apr 26	121	128	➡	N/A	N/A	N/A	Upper
	S044a	Antimicrobial resistance: total prescribing of antibiotics in primary care	Monthly	Jun 25	68.9%	69.78%	🔻	87.1% 81.01%	N/A	N/A	Upper
	S044b	Antimicrobial resistance: proportion of broad-spectrum antibiotic prescribing in primary care	Monthly	Jun 25	5.6%	5.57%	🔻	10.% 7.73%	5,314	95,172	Upper
	S037A	% of patients describing the overall experience of their GP practice as good	Annual	Mar 23	71.4%		↔	73.90% 72.96%	N/A	N/A	N/A

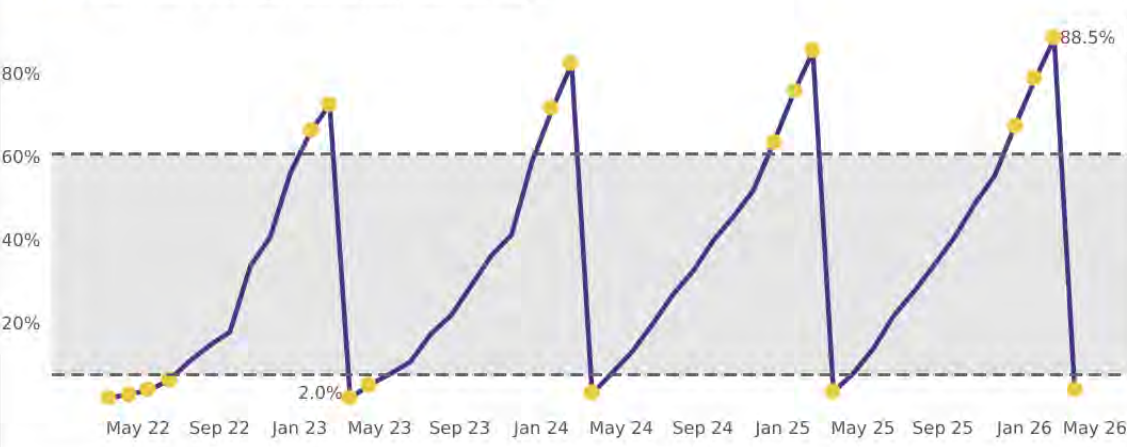
% of patients aged 14+ with a completed LD health check

The % of people on the QOF Learning Disability Register who received an annual health check between the start of the financial year and the end of the reporting period

Source: Learning Disabilities Health Check Scheme (Monthly)



Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	2.0%	3.1%	3.9%	6.5%	10.9%	14.8%	18.0%	33.8%	40.8%	56.4%	66.4%	72.7%
2023-24	2.0%	5.4%	7.9%	10.8%	17.5%	22.0%	29.1%	36.5%	41.3%	58.9%	71.7%	82.5%
2024-25	3.2%	8.1%	13.3%	19.8%	26.9%	32.7%	39.9%	45.8%	52.1%	63.7%	75.9%	85.5%
2025-26	3.6%	8.0%	14.1%	21.9%	27.7%	34.2%	40.7%	48.9%	55.6%	67.7%	79.1%	88.5%
2026-27	3.9%											

Selected measure at April 2026 has continuously decreased for 1 period(s) of time

Latest Value GM Benchmarking
National Rank against other localities

11	Stockport	5.4%
13	Trafford	5.0%
20	Wigan	4.7%
39	Bury	3.9%
44	Rochdale	3.9%
47	Bolton	3.8%
51	Manchester	3.6%
54	Oldham	3.5%
81	Tameside	2.8%
90	Salford	2.6%
14	NHS Greater Manchester Integrated Care Board	3.9%

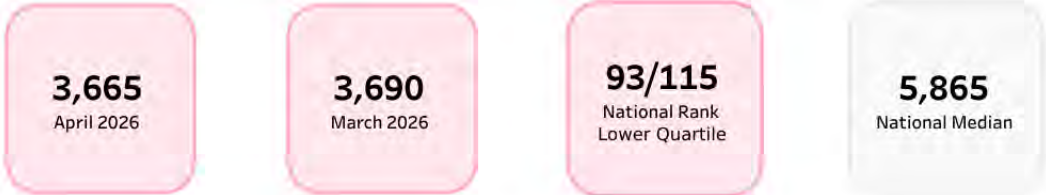
Narrative

- The performance metrics for LD health checks have been reset for the 2026/2027 reporting period, accounting for the significant decline observed in the latest data.
- In April 2026, 3.9% of patients aged 14 and above completed an LD health check, showing an improvement compared to 3.6% in April 2025.
- Bury's performance matches the GM average (3.9%), ranking 4th across localities.

Access to Children and Young Peoples Mental Health Services

Access to Children and Young Peoples Mental Health Services

Source: Published MHSDS (Monthly)



Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23				2,545	2,570	2,565	2,600	2,740	2,790	2,930	2,990	3,075
2023-24	3,100	3,170	3,195	3,230	3,245	3,305	3,345	3,425	3,475	3,545	3,590	3,610
2024-25	3,640	3,680	3,675	3,635	3,570	3,565	3,575	3,560	3,520	3,495	3,500	3,500
2025-26	3,500	3,475	3,470	3,500	3,470	3,515	3,530	3,595	3,600	3,595	3,625	3,690
2026-27	3,665											

Selected measure at April 2026 has continuously decreased for 1 period(s) of time

Latest Value GM Benchmarking

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

Manchester	111.4	16,210 (21)
Tameside	103.3	4,930 (74)
Trafford	94.6	5,045 (70)
Bury	82.1	3,665 (93)
Rochdale	77.4	4,530 (81)
Salford	76.9	5,055 (69)
Stockport	69.1	4,595 (78)
Oldham	67.3	4,240 (84)
Wigan	63.6	4,465 (82)
Bolton	55.3	4,235 (85)

The rate is calculated using the 0-17 registered population figure for each locality | Bury: 45,310

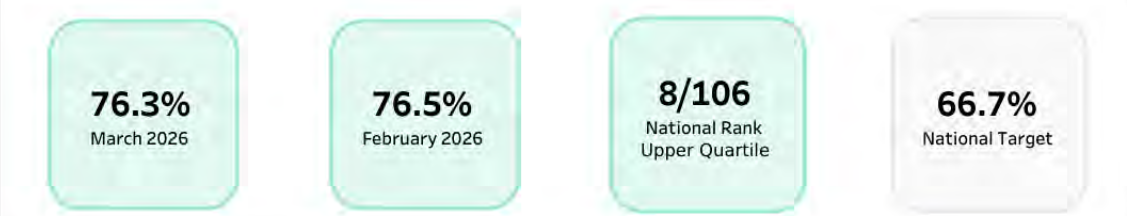
Narrative

- In April 2026, a total of 3,665 attendances for Children and Young People’s Mental Health Services were recorded among patients registered in Bury.
- This represents a decrease compared with the 3,690 attendances reported in March 2026 and is also higher than the 3,500 attendances recorded in April 2025.
- Bury currently reports an access rate of 82.3 per 1,000 population, ranking fourth highest among the Greater Manchester localities.

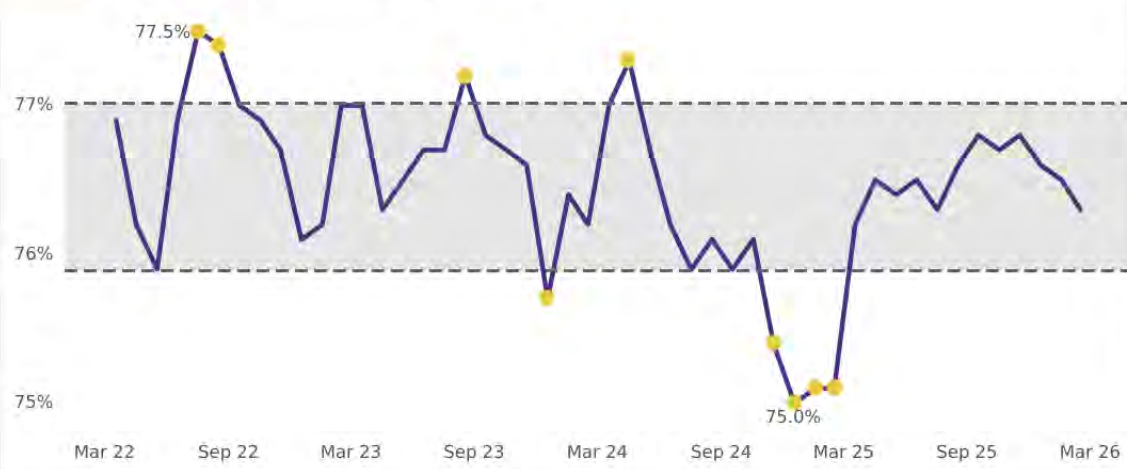
Dementia: Diagnosis Rate (Aged 65+)

Diagnosis rate for people aged 65 and over, with a diagnosis of dementia recorded in primary care, expressed as a percentage of the estimated prevalence based on GP registered populations.

Source: Primary Care Dementia Data (Monthly)



Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	76.9%	76.2%	75.9%	76.9%	77.5%	77.4%	77.0%	76.9%	76.7%	76.1%	76.2%	77.0%
2023-24	77.0%	76.3%	76.5%	76.7%	76.7%	77.2%	76.8%	76.7%	76.6%	75.7%	76.4%	76.2%
2024-25	77.0%	77.3%	76.7%	76.2%	75.9%	76.1%	75.9%	76.1%	75.4%	75.0%	75.1%	75.1%
2025-26	76.2%	76.5%	76.4%	76.5%	76.3%	76.6%	76.8%	76.7%	76.8%	76.6%	76.5%	76.3%

Selected measure at March 2026 has continuously decreased for 3 period(s) of time

Latest Value GM Benchmarking
National Rank against other localities

7	Manchester	76.4%
8	Bury	76.3%
9	Rochdale	76.2%
11	Oldham	75.8%
12	Salford	75.3%
16	Stockport	74.7%
26	Tameside	72.3%
27	Wigan	72.0%
36	Trafford	70.7%
38	Bolton	70.2%
3	NHS Greater Manchester Integrated Care Board	73.9%

Narrative

- As of March 2026, 76.3% of patients aged 65 and over in Bury have received a dementia diagnosis.
- Bury’s diagnosis rate is higher than the Greater Manchester (GM) average, which stands at 73.9%, and ranks 2nd highest among the GM localities.
- Both Bury and GM exceed the national target for dementia diagnosis, which is set at 66.7%.
- Please note reporting for this metric has changed to quarterly. Next publication is July 2026.

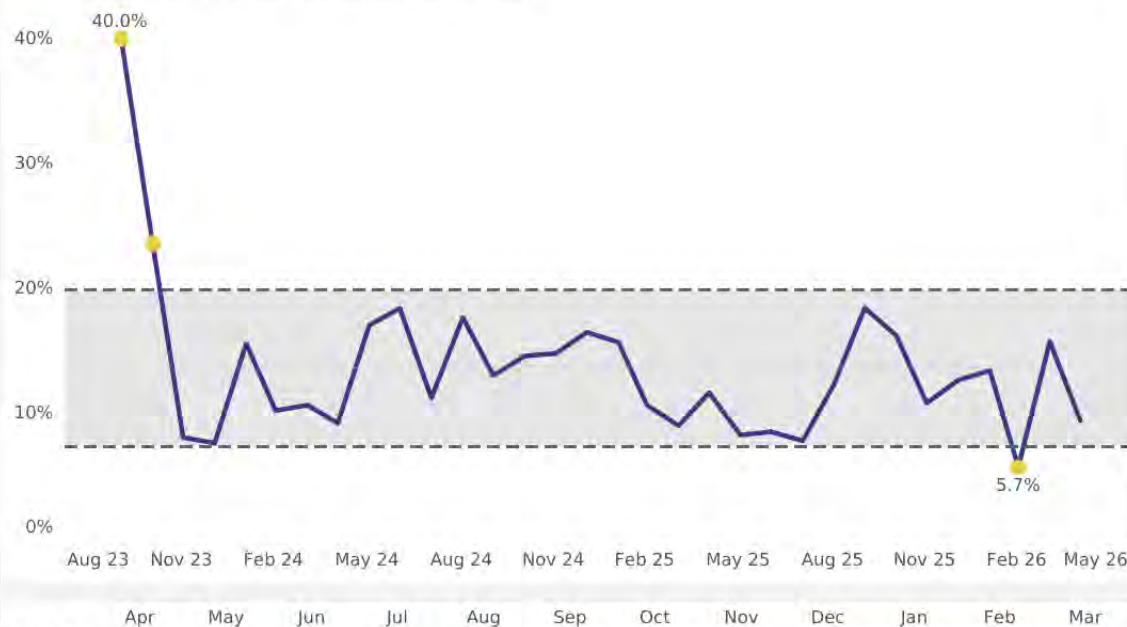
Percentage of MH patients with no criteria to reside (NCTR)

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

Source: GM Admissions - Local (Monthly)



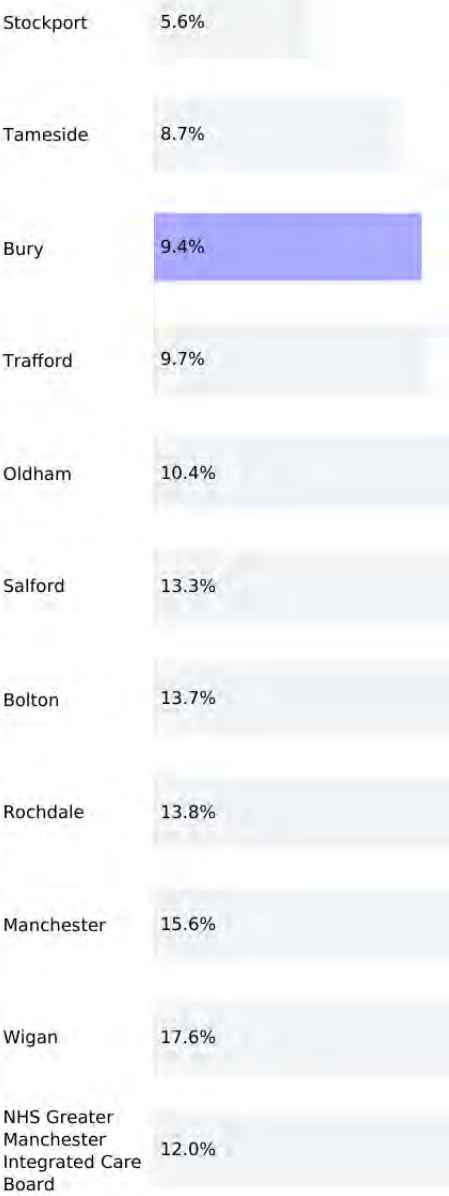
Outliers more than 1 standard deviation from the mean



2023-24	
2024-25	
2025-26	
2026-27	

Selected measure at May 2026 has continuously decreased for 1 period(s) of time

Latest Value GM Benchmarking



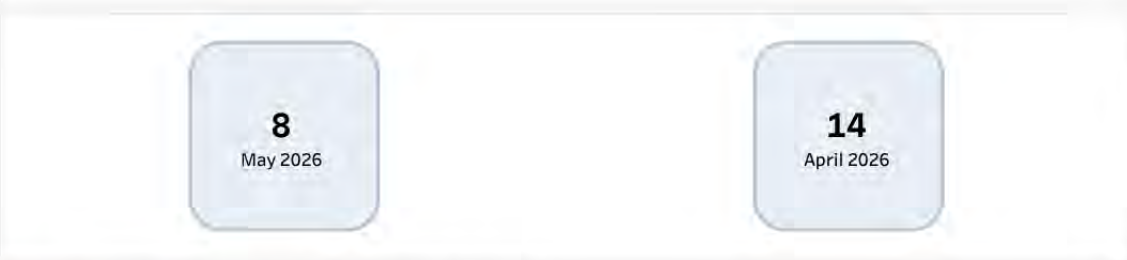
Narrative

- As of May 2026, 9.4% of mental health patients in Bury are reported as having no criteria to reside (NCTR), representing a decrease from 15.7% in April 2026.
- Bury's performance is above the Greater Manchester (GM) average of 12.0%, with Bury ranking as the third lowest locality across GM.
- Despite this improvement, continued focus is required to sustain progress and maintain performance below the GM average, particularly given historical volatility.

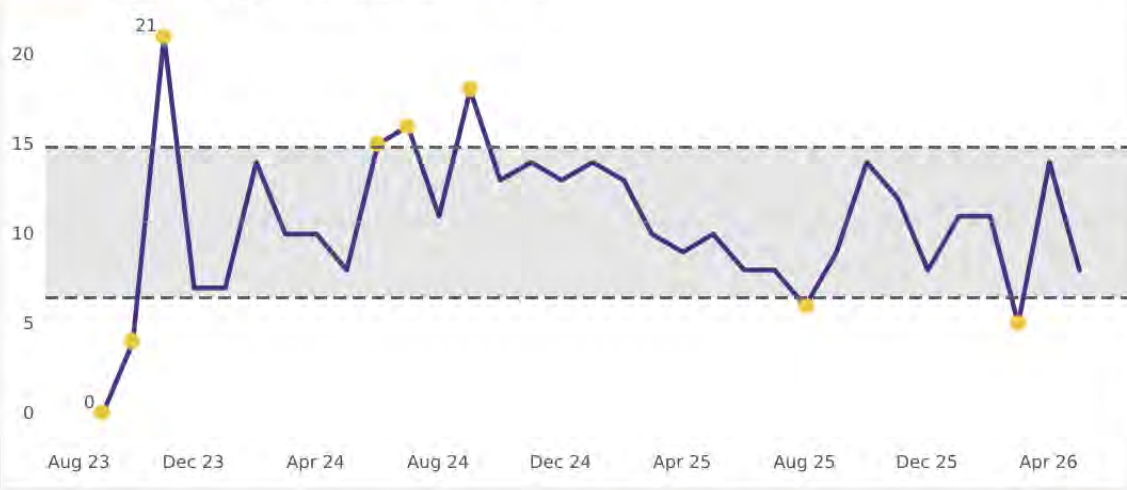
Number of MH patients with no criteria to reside (NCTR)

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

Source: GM Admissions - Local (Monthly)



Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023-24						0	4	21	7	7	14	10
2024-25	10	8	15	16	11	18	13	14	13	14	13	10
2025-26	9	10	8	8	6	9	14	12	8	11	11	5
2026-27	14	8										

Selected measure at May 2026 has continuously decreased for 1 period(s) of time

Latest Value GM Benchmarking
Rate per 1000 | Count

Tameside	0.026	6
Trafford	0.028	7
Bury	0.038	8
Stockport	0.024	8
Rochdale	0.036	9
Oldham	0.045	12
Wigan	0.034	12
Bolton	0.039	13
Salford	0.043	14
Manchester	0.051	38
NHS Greater Manchester Integrated Care Board	0.039	127

The rate is calculated using the registered population figure for each locality | Bury: 211,388

Narrative

- This metric is monitored daily to ensure timely oversight and responsiveness.
- In May 2026, the number of mental health patients in Bury recorded as having no criteria to reside (NCTR) decreased to 8, down from 14 in April (-6 patients month-on-month).
- This equates to a rate of 0.038 per 1,000 population, which is slightly below the Greater Manchester (GM) average of 0.039.
- Bury’s rate is therefore broadly in line with the GM average and comparable with several better-performing localities, indicating relatively strong system performance.

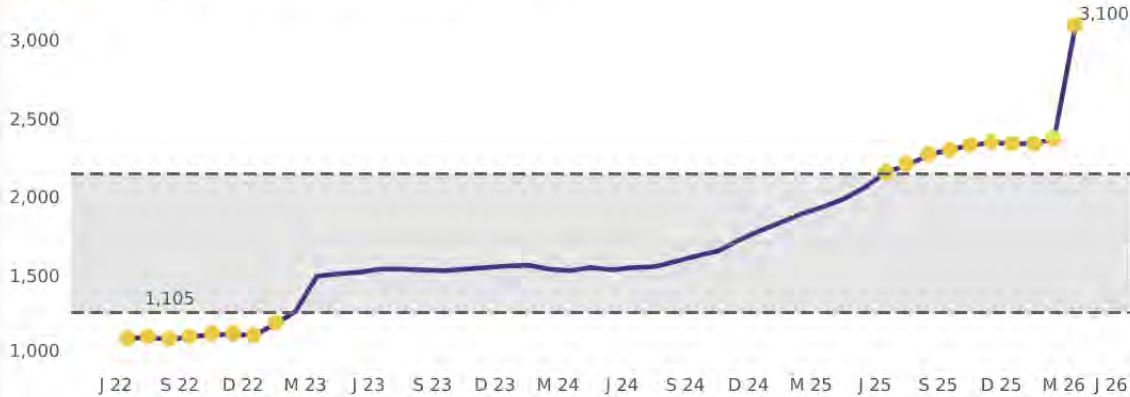
Overall Access to Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses

Number of people who receive two or more contacts from NHS or NHS commissioned community mental health services (in transformed and non-transformed PCNs) for adults and older adults with severe mental illnesses, in a rolling 12 month period

Source: Published MHSDS (Monthly)



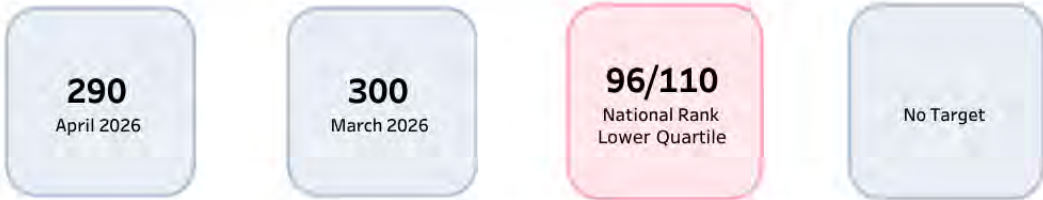
Outliers more than 1 standard deviation from the mean



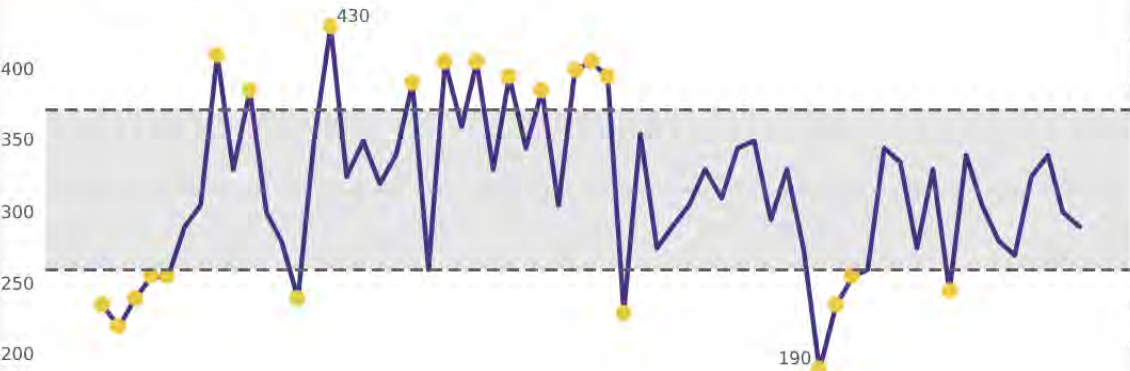
Talking Therapies: Access Rate

This indicator tracks our ambition to expand Improving Access to Psychological Therapies (IAPT) services, also known as NHS Talking Therapies. The primary purpose of this indicator is to measure improvements in access to psychological therapy (via IAPT) for people with depression and/or anxiety disorders.

Source: Improving Access to Psychological Therapies Data Set (Monthly)



Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	235	220	240	255	255	290	305	410	330	385	300	280
2022-23	240	350	430	325	350	320	340	390	260	405	360	405
2023-24	330	395	345	385	305	400	405	395	230	355	275	290
2024-25	305	330	310	345	350	295	330	275	190	235	255	260
2025-26	345	335	275	330	245	340	305	280	270	325	340	300
2026-27	290											

Selected measure at April 2026 has continuously decreased for 2 period(s) of time

Latest Value GM Benchmarking
Rate per 1000 | Count (National rank)

1	Salford	2.5	825 (39)
2	Manchester	2.3	1,715 (19)
3	Trafford	2.0	490 (66)
4	Tameside	1.8	410 (81)
5	Bolton	1.6	550 (60)
6	Oldham	1.6	435 (76)
7	Wigan	1.4	505 (63)
8	Stockport	1.4	465 (72)
9	Bury	1.4	290 (96)
10	Rochdale	1.3	335 (89)

The rate is calculated using the registered population figure for each locality | Bury: 211,388

Narrative

- In April 2026, 290 people in Bury accessed Talking Therapies services, a slight decrease from 300 in March.
- Bury’s rate of 1.4 per 1,000 population is below the Greater Manchester leaders and ranks 9th across GM, indicating comparatively lower access.
- Nationally, Bury is ranked 96th out of 110 systems (lower quartile), highlighting a continued gap to national benchmarks and the need to improve access to psychological therapies.

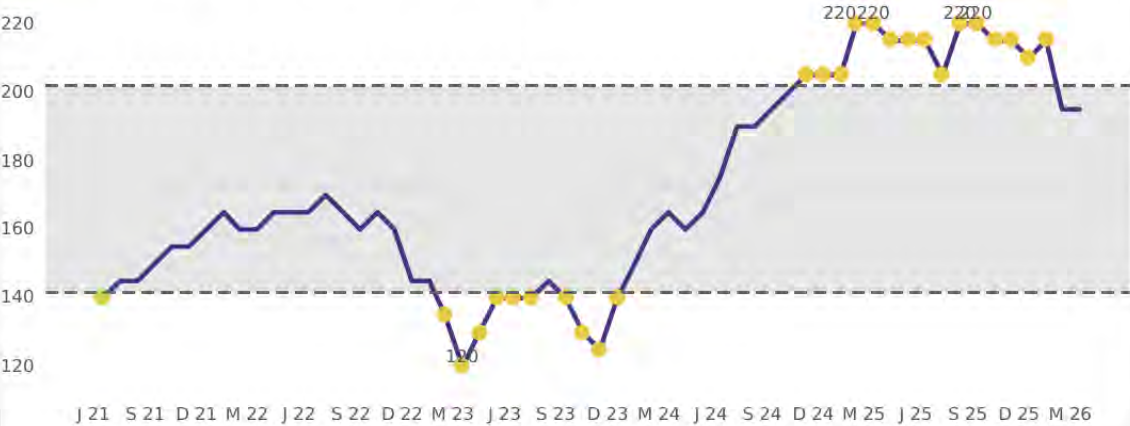
Women Accessing Specialist Community Perinatal Mental Health Services

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

Source: Published MHSDS (Quarterly)



Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22				140	145	145	150	155	155	160	165	160
2022-23	160	165	165	165	170	165	160	165	160	145	145	135
2023-24	120	130	140	140	140	145	140	130	125	140	150	160
2024-25	165	160	165	175	190	190	195	200	205	205	205	220
2025-26	220	215	215	215	205	220	220	215	215	210	215	195
2026-27	195											

Selected measure at April 2026 has continuously for 1 period(s) of time

Latest Value GM Benchmarking
Rate per 1000 | Count (National Rank)

1	Stockport	5.3	335 (59)
2	Bury	4.8	195 (91)
3	Tameside	4.7	215 (84)
4	Rochdale	4.4	225 (79)
5	Trafford	3.9	185 (94)
6	Wigan	3.7	250 (76)
7	Oldham	3.7	200 (90)
8	Bolton	3.1	205 (86)
9	Salford	2.8	220 (81)
10	Manchester	2.6	520 (42)

The rate is calculated using the 15-44 female population figure for each locality | Bury 40,940

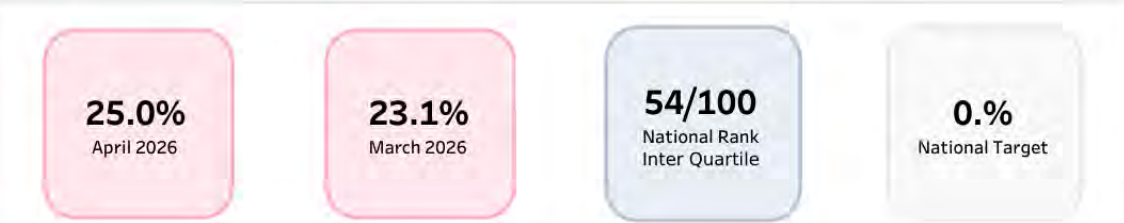
Narrative

- In April 2026, 195 women in Bury accessed specialist community perinatal mental health services, unchanged from March 2026.
- Bury’s rate of 4.8 per 1,000 population is the second highest in Greater Manchester, indicating strong relative performance within the system.
- However, Bury is ranked 91st out of 107 systems nationally (lower quartile), highlighting a continued gap to national benchmarks despite good performance locally.

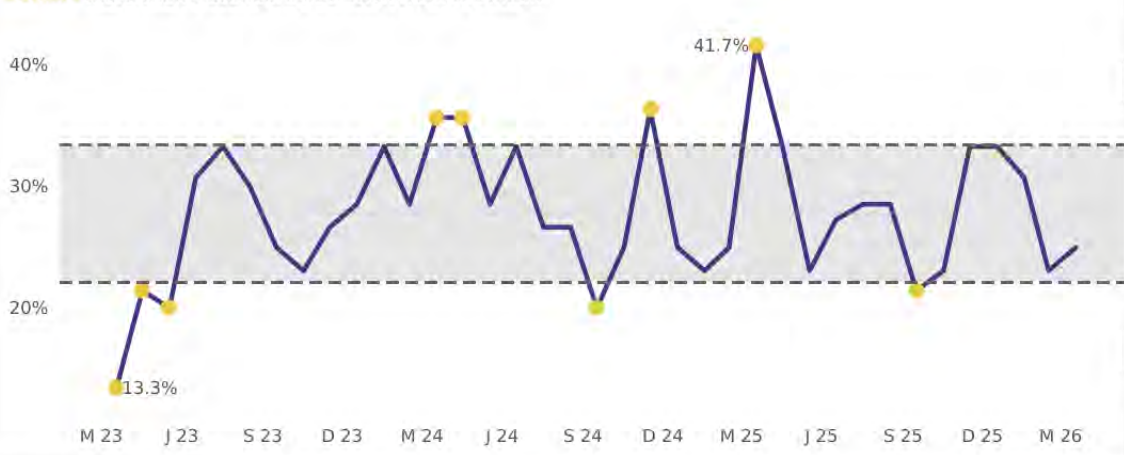
Long length of stay for adults (60+ days) - Mental Health Patients

Proportion of all discharges from adult acute and older adult acute beds, with a length of stay of over 60 days

Source: Published MHSDS (Monthly)



Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023-24	13.3%	21.4%	20.0%	30.8%	33.3%	30.0%	25.0%	23.1%	26.7%	28.6%	33.3%	28.6%
2024-25	35.7%	35.7%	28.6%	33.3%	26.7%	26.7%	20.0%	25.0%	36.4%	25.0%	23.1%	25.0%
2025-26	41.7%	33.3%	23.1%	27.3%	28.6%	28.6%	21.4%	23.1%	33.3%	33.3%	30.8%	23.1%
2026-27	25.0%											

Selected measure at April 2026 has continuously increased for 1 period(s) of time

Latest Value GM Benchmarking
National Rank against other localities

6	Salford	13.3%
26	Rochdale	18.8%
27	Oldham	19.0%
54	Bury	25.0%
62	Wigan	26.7%
65	Tameside	27.3%
71	Stockport	28.6%
95	Bolton	36.4%
98	Trafford	41.7%
99	Manchester	42.4%
28	NHS Greater Manchester Integrated Care Board	28.8%

Narrative

- In April 2026, 25.0% of adult mental health discharges in Bury had a length of stay exceeding 60 days, an increase from 23.1% in March.
- Bury’s performance is below the Greater Manchester average of 28.8% and broadly in line with the national interquartile range (ranked 54th of 100), indicating average comparative performance.
- Despite this, the recent increase highlights continued pressure on discharge flow and the need to reduce long lengths of stay and associated bed occupancy.

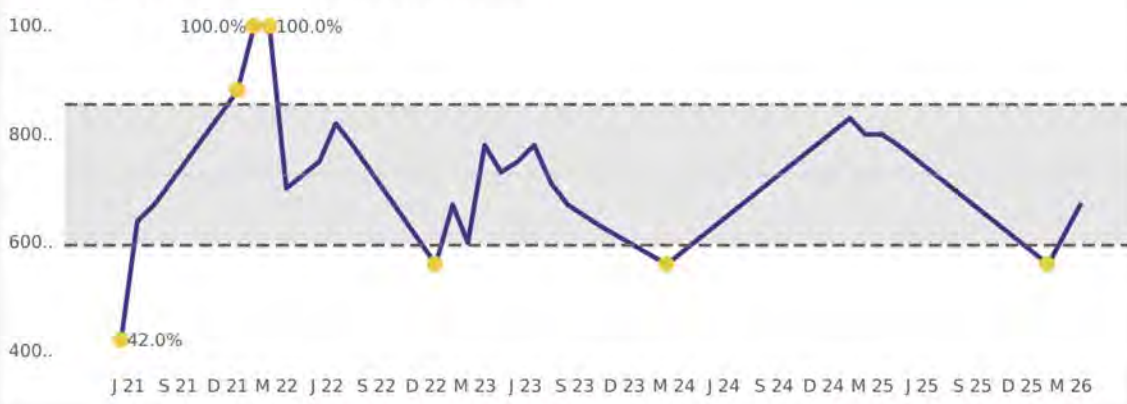
Proportion of routine eating disorder referrals cases entering treatment within four weeks, aged 0-18 - Mental Health Patients

Proportion of all discharges from adult acute and older adult acute beds, with a length of stay of over 60 days

Source: Published MHSDS (Monthly)



Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Nov	Jan	Feb	Mar
2021-22			42.0%	64.0%	67.0%			88.0%	100.0%	100.0%
2022-23	70.0%		75.0%	82.0%	78.0%			56.0%	67.0%	60.0%
2023-24	78.0%	73.0%	75.0%	78.0%	71.0%	67.0%	63.0%			56.0%
2024-25									83.0%	80.0%
2025-26	80.0%	78.0%							56.0%	
2026-27	67.0%									

Selected measure at April 2026 has continuously increased for 1 period(s) of time

Latest Value GM Benchmarking
National Rank against other localities

46	Salford	88.0%
	Wigan	88.0%
56	Stockport	85.0%
	Trafford	85.0%
79	Manchester	73.0%
86	Bury	67.0%
	Tameside	67.0%
102	Bolton	50.0%
	Rochdale	50.0%
107	Oldham	33.0%
27	NHS Greater Manchester Integrated Care Board	73.0%

Narrative

- Performance is stable at 67.0% (February–April 2026) but remains below the GM average (73.0%).
- Trend shows ongoing variability, with recent improvement following a period of decline.
- Delivery remains inconsistent, with performance fluctuating across months.
- Bury ranks 86th nationally (lower quartile), indicating continued poor relative performance.
- Most GM localities continue to outperform Bury, with several achieving ≥85%

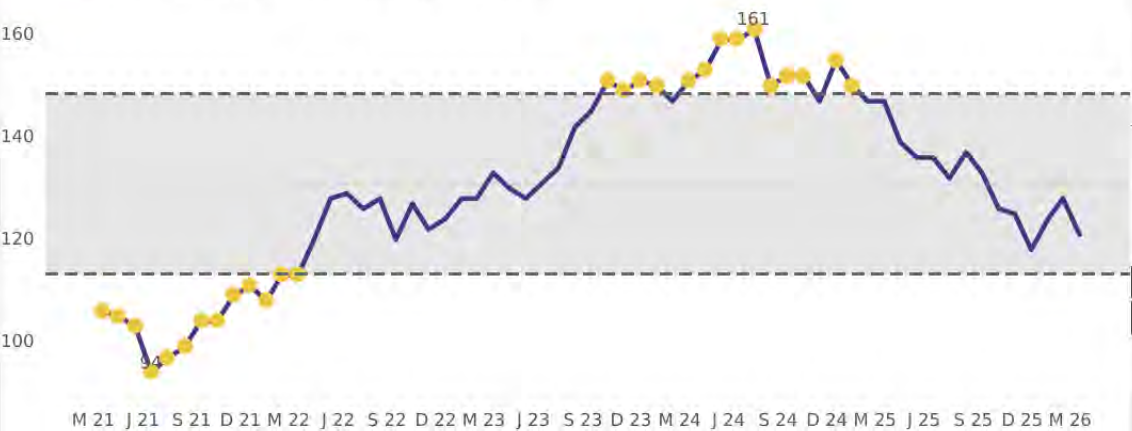
E. coli blood stream infections

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

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



Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	106	105	103	94	97	99	104	104	109	111	108	113
2022-23	113	120	128	129	126	128	120	127	122	124	128	128
2023-24	133	130	128		134	142	145	151	149	151	150	147
2024-25	151	153	159	159	161	150	152	152	147	155	150	147
2025-26	147	139	136	136	132	137	133	126	125	118	124	128
2026-27	121											

Selected measure at April 2026 has continuously decreased for 1 period(s) of time

Latest Value GM Benchmarking
Rate per 1000 | Count (National Rank)

Salford	0.50	163.0 (23)
Wigan	0.55	194.0 (29)
Bury	0.57	121.0 (10)
Bolton	0.58	195.0 (30)
Manchester	0.59	439.0 (68)
Rochdale	0.60	151.0 (20)
Oldham	0.65	174.0 (24)
Stockport	0.78	258.0 (48)
Trafford	0.83	206.0 (32)
Tameside	0.95	218.0 (38)

The rate is calculated using the registered population figure for each locality | Bury: 211,388

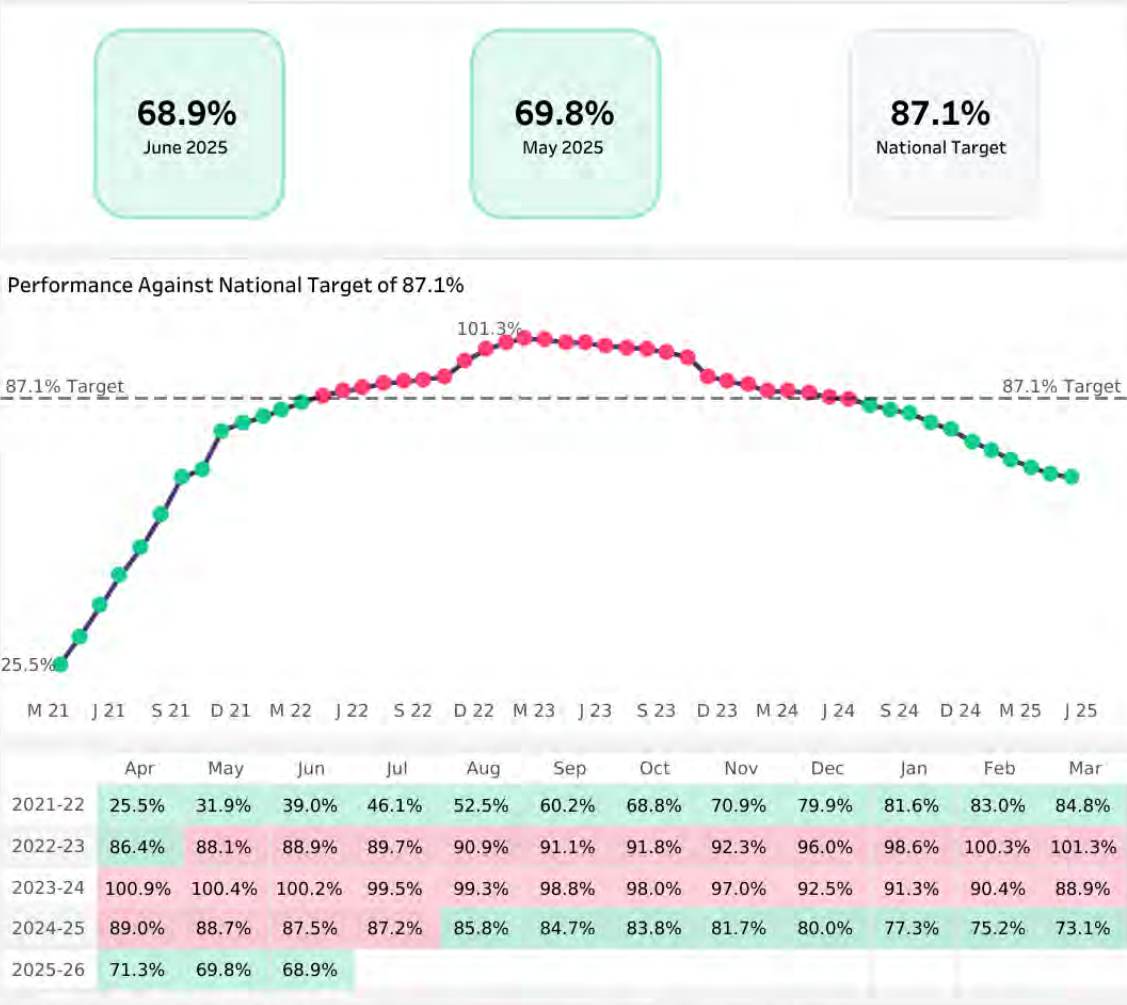
Narrative

- Over the 12-month period ending April 2026, a total of 121 cases of E. coli bloodstream infections were recorded among patients registered in Bury.
- This represents a slight decrease compared with March 2026, when 128 cases were reported, and is notably lower than the 147 cases recorded in April 2025.
- Bury currently reports an infection rate of 0.57 per 1,000 population, ranking as the 3rd lowest rate among the Greater Manchester (GM) localities.

Antimicrobial resistance: total prescribing of antibiotics in primary care

The number of antibiotic (antibacterial) items prescribed in primary care, divided by the item-based Specific Therapeutic group Age-Sex related Prescribing Unit STAR-PU

Source: EPACT Prescribing Data (Monthly)



Selected measure at June 2025 has continuously decreased for 14 period(s) of time

Latest Value GM Benchmarking

Bury	68.9%
Rochdale	74.6%
Salford	77.5%
Bolton	79.4%
Tameside	80.2%
Manchester	80.4%
Trafford	82.3%
Oldham	85.4%
Wigan	87.6%
Stockport	91.4%

Narrative

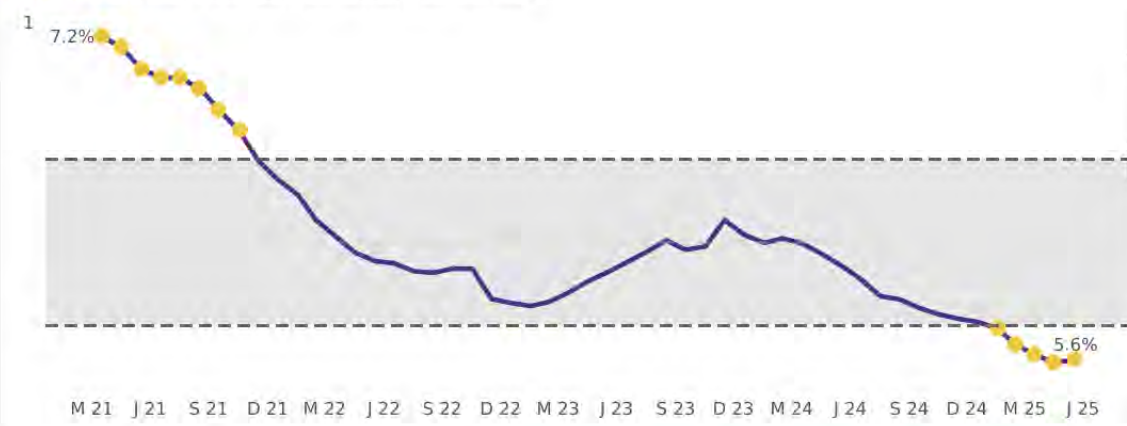
- In June 2025, 68.9% of total antibiotic prescribing in primary care for the Bury population met the relevant criteria, where a lower percentage indicates improved prescribing practice.
- This represents a substantial improvement compared with June 2024, when the corresponding figure was 87.5%.
- Bury currently reports the lowest percentage among the Greater Manchester localities and has successfully met the national target of remaining below 87.1%.

Antimicrobial resistance: proportion of broad-spectrum antibiotic prescribing in primary care
The number of broad-spectrum antibiotic (antibacterials) items from co-amoxiclav, cephalosporin class and fluoroquinolone class drugs as a percentage of the total number of antibacterial items prescribed in primary care.

Source: EPACT Prescribing Data (Monthly)



Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	7.2%	7.1%	7.0%	7.0%	7.0%	6.9%	6.8%	6.7%	6.6%	6.5%	6.4%	6.3%
2022-23	6.2%	6.1%	6.1%	6.1%	6.0%	6.0%	6.0%	6.0%	5.9%	5.9%	5.9%	5.9%
2023-24	5.9%	6.0%	6.0%	6.1%	6.1%	6.2%	6.1%	6.2%	6.3%	6.2%	6.2%	6.2%
2024-25	6.2%	6.1%	6.1%	6.0%	5.9%	5.9%	5.8%	5.8%	5.8%	5.8%	5.7%	5.7%
2025-26	5.6%	5.6%	5.6%									

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

Latest Value GM Benchmarking
National Rank against other localities

14	Oldham	5.5%
15	Bury	5.6%
19	Bolton	5.9%
20	Tameside	5.9%
22	Rochdale	6.0%
43	Manchester	7.4%
51	Stockport	7.6%
74	Salford	8.4%
79	Trafford	8.6%
100	Wigan	9.6%

Narrative

- Bury’s rate of broad-spectrum antibiotic prescribing in June 2025 is 5.6%, the same as the previous month.
- The chart shows that the selected measure has decreased continuously over the past 15 reporting periods, highlighting sustained improvement.
- Bury currently reports the 2nd lowest percentage of broad-spectrum prescribing among the Greater Manchester (GM) localities.
- This performance is within the national target threshold of less than 10%.

Bury - Sight Metrics

Domain	Code	Measure	Frequency	Date	Latest	Previous	Change	Target/Median	Numerator	Denominator	
Urgent Care	N/A	A&E 4 hour performance	Monthly	May 26	73.8%	74.9%	⬇️	78.0%	6,999	9,478	N/A
	N/A	A&E Attendances	Monthly	May 26	9,478.0	7,161.0	⬆️	N/A	9,478	N/A	N/A
	N/A	No Reason/Criteria To Reside patients (NCTR) as % of occupied beds	Monthly	May 26	17.7%	15.6%	⬆️	N/A	1,813	10,237	N/A
	EM11	Total number of specific acute non-elective spells	Monthly	May 26	1,960.0	2,045.0	⬇️	N/A	1,960	N/A	Upper
Elective Care	EB26x	Diagnostic 6ww: All	Monthly	Apr 26	11.8%	8.7%	⬆️	1.0%	627	5,326	Upper
	EB28	Diagnostic 6ww: All	Monthly	Apr 26	11.8%	8.7%	⬆️	1.0%	627	5,326	Upper
	EB28x	Diagnostic 6ww: All	Monthly	Apr 26	11.8%	8.7%	⬆️	1.0%	627	5,326	Upper
	EB20	RTT incomplete: 65+ week waits	Monthly	Apr 26	3.000	1.0	⬆️	0.	3	N/A	Upper
Cancer	S012a	28 Day Wait from Referral to Faster Diagnosis (Monthly): All Patients	Monthly	Apr 26	72.3%	79.9%	⬇️	80.0%	670	927	Inter
Maternity	S104a	Number of neonatal deaths per 1,000 total live births	Annual	Dec 24	1.9	1.5	⬆️	1.5	4	2,077	Lower
	S022a	Number of stillbirths per 1,000 total births	Annual	Dec 24	5.3	5.4	⬇️	2.5	11	2,077	Lower
Screening and Immunisations	S049a	Breast screening coverage, females aged 53-70, screened in last 36 months	Annual	Dec 25	74.6%	73.3%	⬆️	N/A	16,689	22,380	Inter
	S046a	COVER immunisation: MMR2 Uptake at 5 years old	Quarterly	Dec 25	86.6%	87.6%	⬇️	95.0%	511	590	Inter
	S050a	Females, 25-64, attending cervical screening within target period (3.5 or 5.5 year coverage, %)	Quarterly	Jun 24	70.3%	70.6%	⬇️	80.0%	37,935	53,940	Inter
	S047A	Seasonal Flu Vaccine Uptake: 65 years and over	Monthly	Feb 26	74.0%	73.8%	⬆️	85.0%	28,892	39,039	Inter

Bury - Sight Metrics

The below metrics are currently missing from the report due to lack of locality level reporting or the measure is currently being built.

Theme	Indicator	
Cancer	Total patients waiting over 62 days to begin cancer treatment vs target	Build in progress
LD and Autism	Inpatients with a learning disability and/or autism per million head of population	Build in progress
Primary Care and Community Services	Proportion of Urgent Community Response referrals reached within two hours	Currently available in the scorecard at trust level but not locality
	Proportion of virtual ward beds occupied	Currently unavailable at locality level due to inaccurate reporting
	Units of Dental Activity delivered as a proportion of all Units of Dental Activity contracted	Build in progress
Screening and immunisation	Bowel screening, aged 60-74, screened in the last 30 months	DQ issues
Urgent and Emergency Care	Reduce adult general and acute bed occupancy below 92%	Currently available in the scorecard at trust level but not locality

A&E 4 hour performance

Number of attendances at A&E departments, and of these, the number of attendances where the patient spent less than 4 hours from time of arrival to time of admission, or discharge, or transfer.

Source: Emergency Care Dataset (ECDS) (Monthly)



Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	78.2%	75.9%	72.1%	67.5%	68.1%	66.0%	65.0%	64.8%	63.0%	63.8%	63.8%	63.0%
2022-23	64.6%	64.6%	65.7%	63.0%	64.6%	61.7%	60.5%	60.1%	55.7%	64.3%	65.3%	65.1%
2023-24	68.2%	71.1%	73.0%	71.1%	68.8%	65.2%	64.8%	61.1%	57.8%	58.7%	59.7%	63.4%
2024-25	67.9%	66.9%	68.1%	67.5%	68.6%	66.4%	68.7%	63.9%	61.3%	64.7%	69.2%	72.2%
2025-26	72.5%	69.3%	69.7%	75.0%	73.4%	71.8%	68.8%	68.7%	67.9%	68.0%	66.7%	75.5%
2026-27	74.9%	74.4%	71.3%									

Selected measure at June 2026 has continuously decreased for 3 period(s) of time

Latest Value GM Benchmarking

Rochdale	74.2%
Wigan	72.6%
Manchester	72.3%
Bury	71.3%
Trafford	70.7%
Stockport	68.9%
Salford	68.6%
Bolton	66.8%
Tameside	65.3%
Oldham	63.9%
NHS Greater Manchester Integrated Care Board	69.8%

Narrative

- This metric is monitored daily to support timely performance oversight.
- In June 2026, Bury achieved a 4-hour emergency care performance rate of 71.3%, decreasing from 74.4% in May 2026.
- This represents a year-on-year improvement compared with 69.7% in June 2025.
- Bury’s performance exceeds the Greater Manchester average of 69.8%, ranking 4th highest among GM localities.

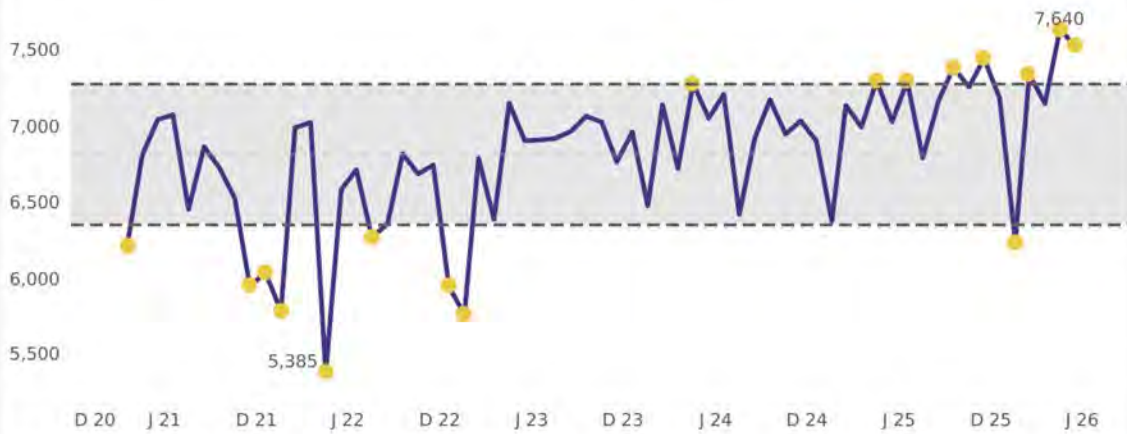
A&E Attendances

Number of attendances at A&E departments

Source: Emergency Care Dataset (ECDS) (Monthly)



Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	6,220	6,816	7,049	7,079	6,459	6,869	6,734	6,532	5,954	6,042	5,791	6,995
2022-23	7,029	5,385	6,589	6,718	6,275	6,363	6,823	6,691	6,750	5,953	5,766	6,793
2023-24	6,394	7,156	6,909	6,914	6,925	6,971	7,070	7,032	6,770	6,966	6,481	7,145
2024-25	6,727	7,285	7,058	7,214	6,426	6,930	7,178	6,952	7,040	6,910	6,382	7,141
2025-26	6,999	7,303	7,034	7,299	6,797	7,168	7,390	7,263	7,450	7,188	6,244	7,345
2026-27	7,154	7,640	7,529									

Selected measure at June 2026 has continuously decreased for 1 period(s) of time

Latest Value GM Benchmarking

Attendances Rate per 1000 population & Count

Salford	31.7	10,257
Trafford	31.7	7,850
Bolton	31.8	10,650
Stockport	33.3	11,003
Bury	35.6	7,529
Manchester	37.4	27,987
Wigan	38.1	13,421
Oldham	39.2	10,488
Rochdale	40.0	10,123
Tameside	45.4	10,385

The rate is calculated using the registered population figure for each locality | Bury: 211,388

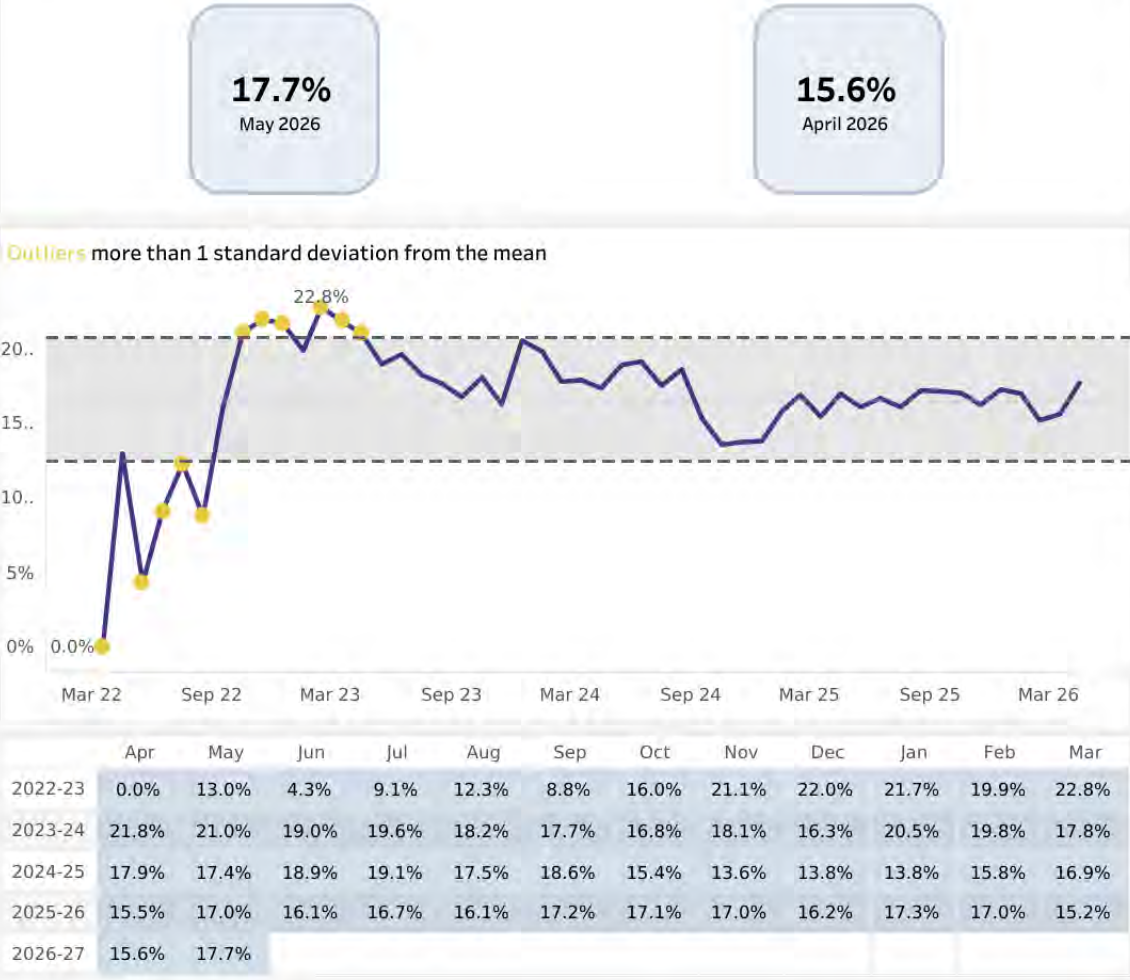
Narrative

- In June 2026, Bury recorded 7,529 A&E attendances, a decrease from 7,640 attendances in May 2026.
- Attendances in June 2025 were lower than current levels, with 7,034 attendances recorded.
- Bury’s attendance rate is 35.6 per 1,000 population, ranking 5th lowest across Greater Manchester localities.

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

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

Source: GM Admissions - Local (Monthly)



Selected measure at May 2026 has continuously increased for 2 period(s) of time

Latest Value GM Benchmarking

Stockport	9.2%
Oldham	9.5%
Tameside	11.3%
Rochdale	14.5%
Manchester	15.2%
Trafford	15.5%
Bolton	15.5%
Bury	17.7%
Wigan	18.5%
Salford	19.5%
NHS Greater Manchester Integrated Care Board	14.5%

Narrative

- This metric is monitored daily to support ongoing performance oversight.
- NCTR has increased to 17.7% in May 2026 (from 15.6%), indicating a deterioration in discharge performance.
- Bury is performing above the GM average (14.5%) and is among the higher-rate localities.
- Performance has remained consistently elevated throughout 2025/26 (16–18%), reflecting sustained system pressure on flow and discharge pathways.

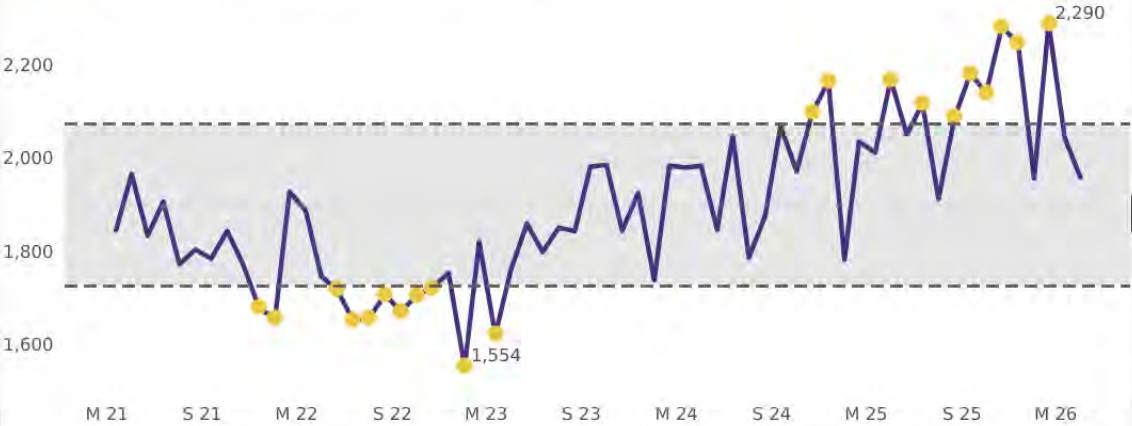
Total number of specific acute non-elective spells

Number of specific acute non-elective spells in the period (auto-calculated sum of E.M.11a and E.M.11b)

Source: National Flows APC (Monthly)



Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	1,847	1,967	1,835	1,908	1,774	1,805	1,786	1,845	1,775	1,681	1,657	1,929
2022-23	1,889	1,748	1,718	1,654	1,658	1,709	1,672	1,707	1,724	1,755	1,554	1,822
2023-24	1,622	1,762	1,861	1,800	1,852	1,845	1,983	1,987	1,846	1,926	1,740	1,985
2024-25	1,981	1,985	1,848	2,049	1,788	1,876	2,070	1,973	2,099	2,166	1,784	2,037
2025-26	2,013	2,170	2,052	2,118	1,914	2,089	2,182	2,142	2,283	2,247	1,958	2,290
2026-27	2,045	1,960										

Selected measure at May 2026 has continuously decreased for 2 period(s) of time

Latest Value GM Benchmarking
Count & Rate Per 1000 Population

Manchester	5.7	4,236
Trafford	6.2	1,539
Oldham	8.9	2,387
Tameside	8.8	2,009
Bolton	9.1	3,047
Bury	9.3	1,960
Salford	9.9	3,210
Wigan	10.4	3,663
Rochdale	10.4	2,627
Stockport	10.5	3,454

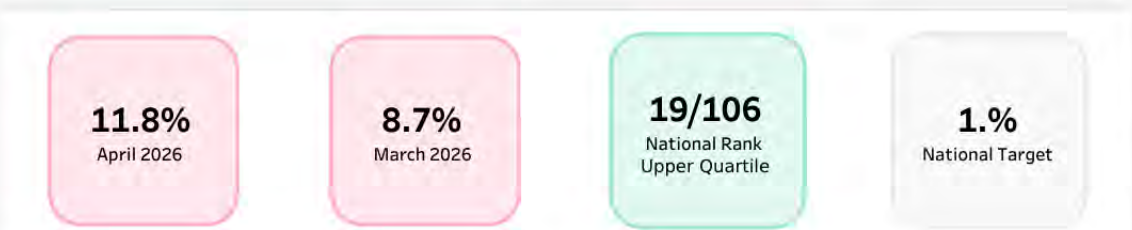
The rate is calculated using the registered population figure for each locality | Bury: 211,388

Narrative

- Non-elective activity reduced to 1,960 in May 2026 (from 2,045 in April), indicating a short-term easing.
- However, demand remains elevated compared to prior years, reflecting ongoing system pressure.
- Bury sits mid-ranking within GM (9.3 per 1,000 population), performing better than higher-rate localities (e.g. Salford, Wigan, Stockport) but above the lowest-rate areas (e.g. Manchester, Trafford).

Diagnostic 6ww: All
% of Patients waiting over 6 weeks for a diagnostic test or procedure

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



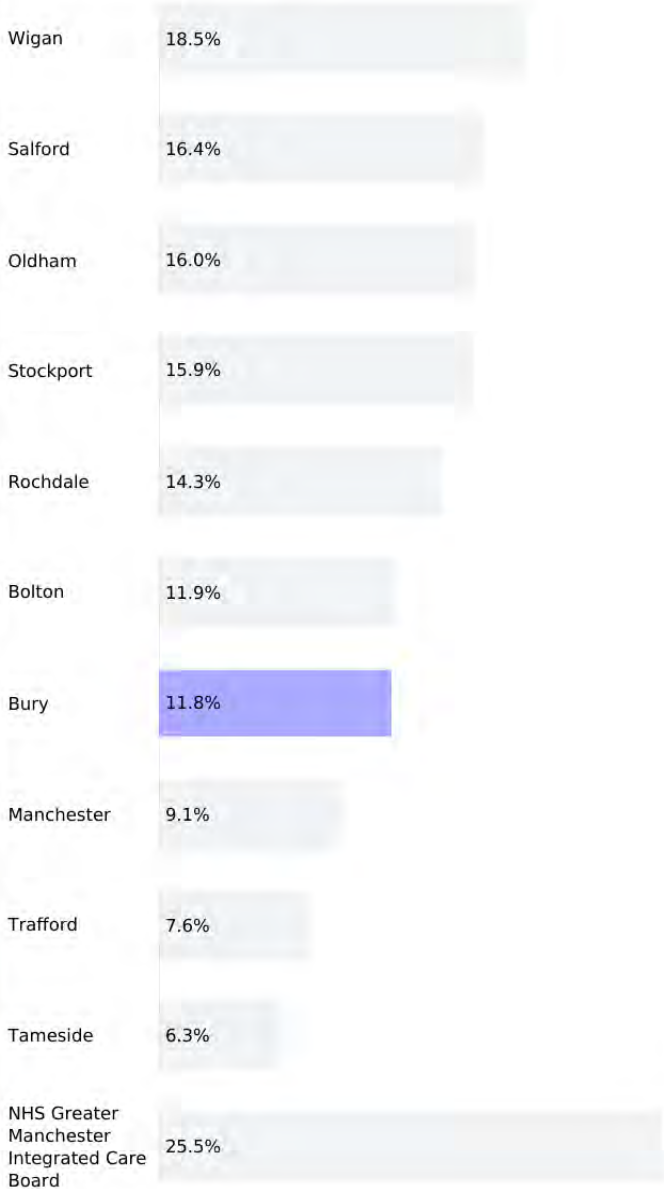
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	36.7%	34.4%	36.7%	40.1%	40.7%	40.6%	45.7%	42.8%	42.9%	46.0%	39.1%	32.5%
2022-23	36.4%	34.6%	35.5%	30.7%	30.8%	29.3%	19.0%	18.1%	18.7%	31.7%	26.8%	26.8%
2023-24	27.5%	25.0%	26.0%	24.5%	25.9%	24.0%	20.5%	17.4%	22.3%	21.0%	14.7%	14.5%
2024-25	16.5%	15.1%	16.4%	16.6%	20.2%	15.8%	11.6%	11.3%	12.6%	14.3%	10.1%	8.8%
2025-26	12.8%	9.7%	10.6%	10.9%	12.8%	9.9%	7.5%	8.2%	11.9%	12.5%	7.6%	8.7%
2026-27	11.8%											

Selected measure at April 2026 has continuously increased for 2 period(s) of time

Latest Value GM Benchmarking
National Rank against other localities



Narrative

- The proportion of patients waiting over 6 weeks increased to 11.8% in April 2026 (from 8.7% in March), indicating a deterioration in diagnostic performance and movement away from the 1% national standard.
- Despite this increase, Bury remains in the upper quartile nationally (19th of 106), reflecting relatively strong performance compared to peers.
- Within GM, Bury (11.8%) sits mid-to-higher compared to localities, performing better than higher-wait areas (e.g. Bolton, Rochdale, Salford) but above the lowest-wait systems (e.g. Tameside, Trafford).
- The longer-term trend shows a significant improvement since 2021/22, with sustained reductions from >30% to 8–13% during 2025/26, although recent months indicate some reversal of progress.

RTT incomplete: 65+ week waits

"The number of 65+ week incomplete RTT pathways based on data provided by NHS and independent sector organisations and reviewed by NHS commissioners via SDCS. The definitions that apply for RTT waiting times, as well as guidance on recording and reporting RTT data, can be found on the NHS England and NHS Improvement Consultant-led referral to treatment waiting times rules and guidance webpage."

Source: Consultant-led RTT Waiting Times data collection (National Statistics). (Monthly)



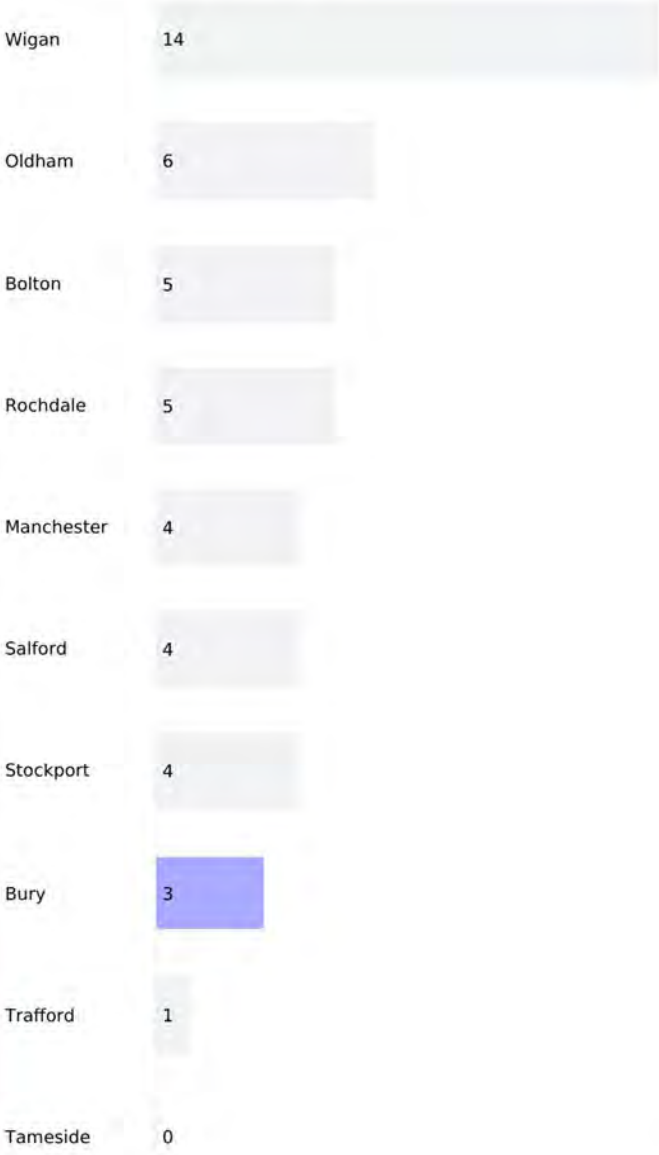
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	888	980	1,009	871	749	678	662	618	617	630	590	505
2022-23	526	530	626	739	882	1,165	1,007	1,070	1,142	1,099	773	513
2023-24	688	674	685	663	877	752	646	549	602	560	371	191
2024-25	166	190	218	184	162	38	32	34	22	21	11	5
2025-26	4	7	4	5	5	4	4	4	1	2	1	1
2026-27	3											

Selected measure at April 2026 has continuously increased for 1 period(s) of time

Latest Value GM Benchmarking
National Rank against other localities



Narrative

- In April 2026, three Bury-registered patient was reported as waiting 65 weeks or more, higher than the position recorded in March 2026. These waits are associated with Gynaecology services
- Sustained improvement from historic highs, with near elimination since 2024/25.
- 4th nationally (upper quartile) and among top performers in GM.
- Bury ranks as the 8th lowest locality across Greater Manchester for the number of 65+ week waits.

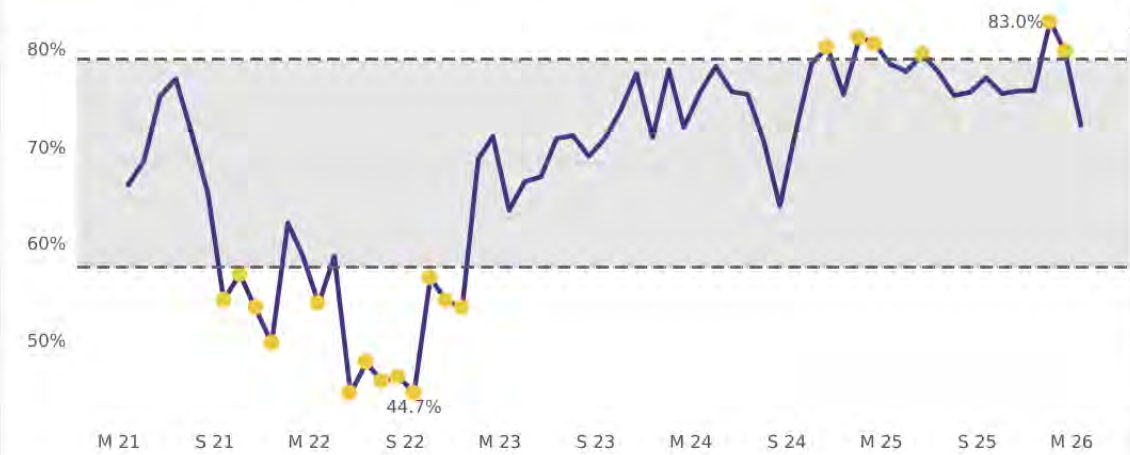
28 Day Wait from Referral to Faster Diagnosis (Monthly): All Patients

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

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



Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	66.2%	68.6%	75.2%	77.0%	71.4%	65.2%	54.3%	57.0%	53.4%	49.9%	62.2%	58.9%
2022-23	53.9%	58.8%	44.7%	47.8%	46.0%	46.4%	44.7%	56.6%	54.3%	53.5%	68.8%	71.1%
2023-24	63.5%	66.5%	67.0%	70.9%	71.2%	69.1%	70.9%	73.8%	77.6%	71.0%	78.0%	72.1%
2024-25	75.7%	78.3%	75.7%	75.5%	70.7%	64.0%	71.6%	78.6%	80.3%	75.4%	81.3%	80.7%
2025-26	78.6%	77.8%	79.5%	77.8%	75.3%	75.7%	77.2%	75.5%	75.8%	75.9%	83.0%	79.9%
2026-27	72.3%											

Selected measure at April 2026 has continuously decreased for 2 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities

Bolton	81.0%
Stockport	79.4%
Tameside	78.8%
Wigan	78.7%
Trafford	77.9%
Manchester	75.9%
Oldham	75.7%
Rochdale	74.3%
Salford	73.3%
Bury	72.3%
NHS Greater Manchester Integrated Care Board	77.0%

Narrative

- 28-day Faster Diagnosis performance declined to 72.3% in April 2026, down from 79.9% in March (-7.6pp)
- Performance is now below the 80% national standard and below the GM average (77.0%)
- Ranked 77th of 106 nationally (mid-quartile)
- Follows a period of improvement, with recent deterioration requiring focus to regain compliance

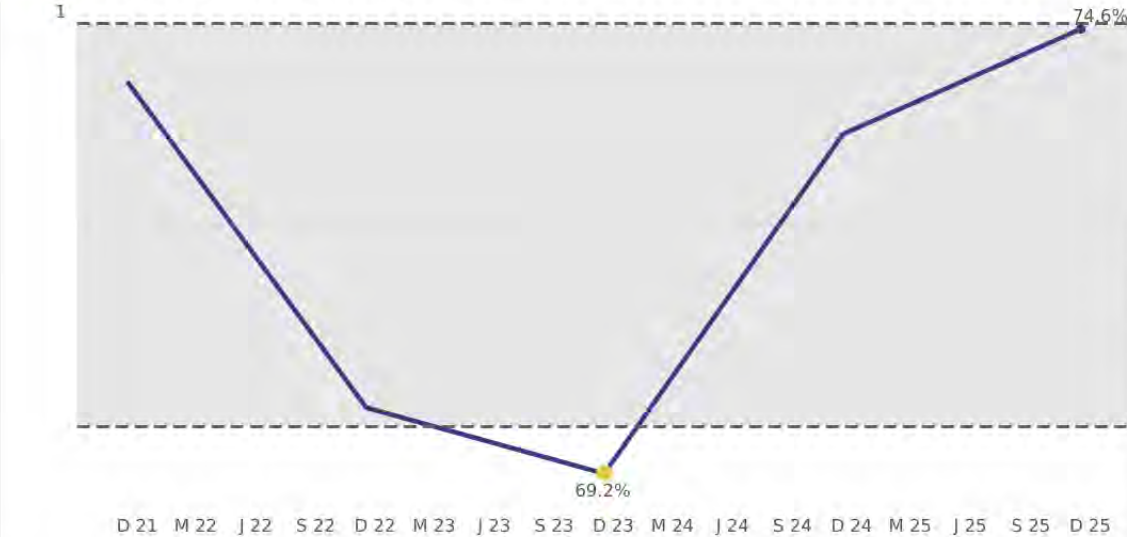
Breast screening coverage, females aged 53-70, screened in last 36 months

3-year screening coverage %: The number of females registered to the practice screened adequately in previous 36 months divided by the number of eligible females on last day of the review period

Source: Fingertips, Public Health Data, Public Health Outcomes Framework (Annual)

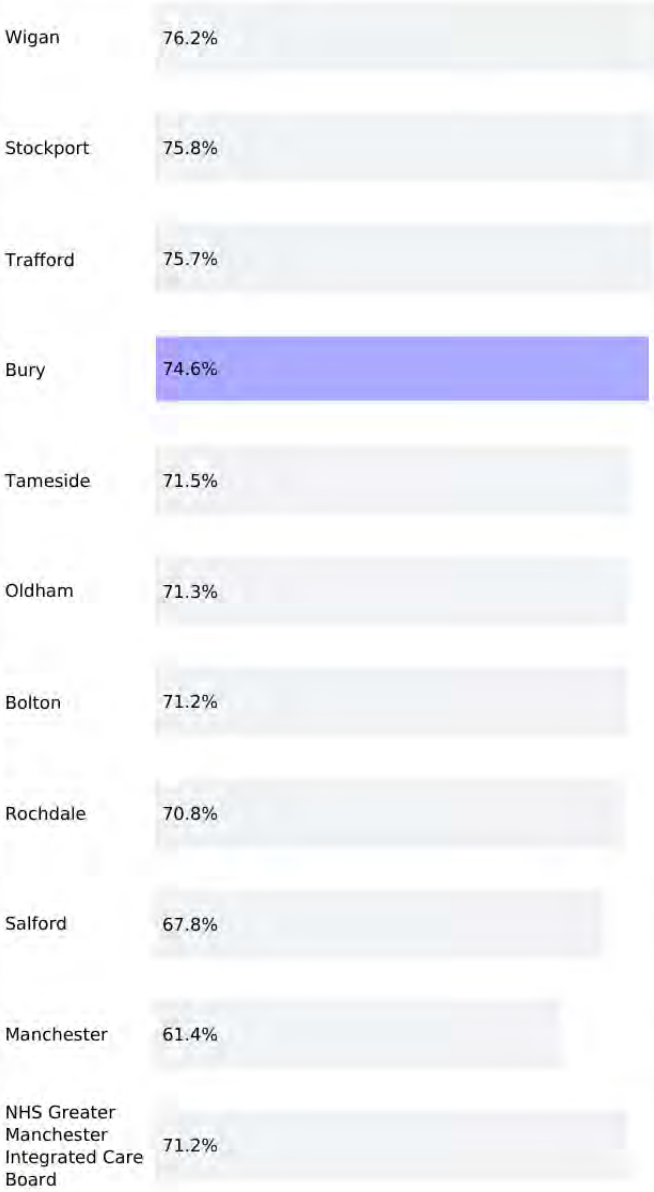


Outliers more than 1 standard deviation from the mean



2021-22	Dec	73.9%
2022-23		70.0%
2023-24		69.2%
2024-25		73.3%
2025-26		74.6%

Latest Value GM Benchmarking
National Rank against other localities



Narrative

- The GM Cancer Screening Dashboard indicates that, in April 2026 Bury Registered patients reached 66.1%, which is above the benchmark of 60%.
- Performance is comparable to Bolton (65.0%), Salford (66.1%) and Stockport (65.0%)
- Below higher-performing areas including Trafford (74.7%), Heywood/Middleton/Rochdale (68.0%) and Oldham (66.8%)
- Above Manchester (55.9%) and Tameside (61.5%), indicating relatively stronger uptake than lowest performers
- Overall, Bury demonstrates moderate performance with scope for improvement to reach top quartile levels.

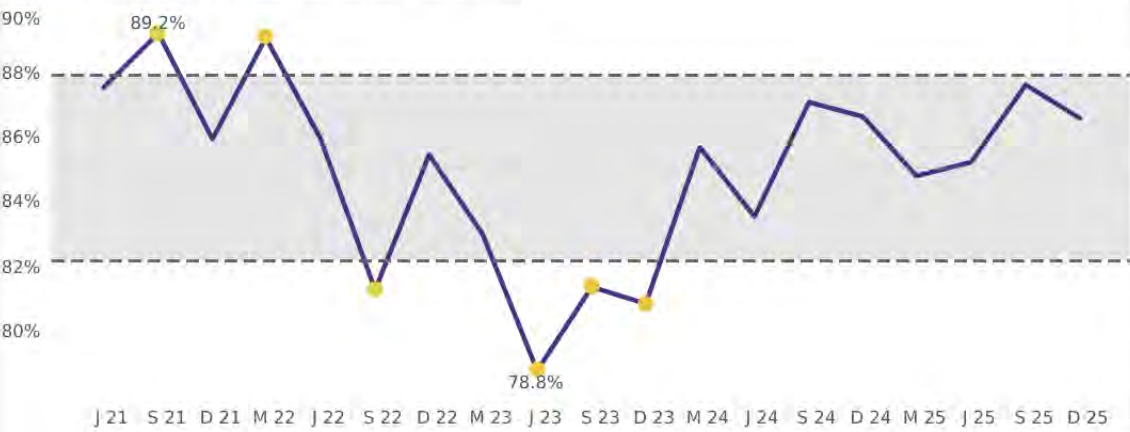
COVER immunisation: MMR2 Uptake at 5 years old

Population vaccination coverage – MMR for two doses (5 years old)

Source: Cover of vaccination evaluated rapidly (COVER) programme (Quarterly)



Outliers more than 1 standard deviation from the mean



	Jun	Sep	Dec	Mar
2021-22	87.6%	89.2%	86.0%	89.1%
2022-23	86.0%	81.3%	85.5%	83.0%
2023-24	78.8%	81.4%	80.9%	85.7%
2024-25	83.6%	87.1%	86.7%	84.8%
2025-26	85.3%	87.6%	86.6%	

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

Latest Value GM Benchmarking

National Rank against other localities

Stockport	89.8%
Wigan	87.9%
Rochdale	87.8%
Trafford	87.5%
Bolton	86.7%
Bury	86.6%
Oldham	83.1%
Tameside	81.6%
Salford	80.8%
Manchester	76.3%

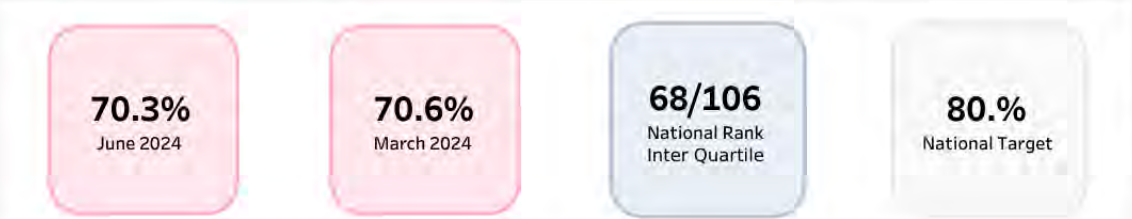
Narrative

- As of Dec 2025, the MMR2 uptake rate at age five years in Bury stands at 86.6%, representing a slight decrease from 87.6% in Sept 2025.
- Among the GM localities, Bury ranks sixth.
- However, both Bury, and all other GM localities remain below the national target of 95%.

Females, 25-64, attending cervical screening within target period (3.5 or 5.5 year coverage, %)

The overall cervical screening coverage: the number of women screened adequately in the previous 42 months (if aged 24-49) or 66 months (if aged 50-64) divided by the number of eligible women on last day of review period.

Source: Cervical Screening Programme - Coverage Statistics [Management Information] (Quarterly)



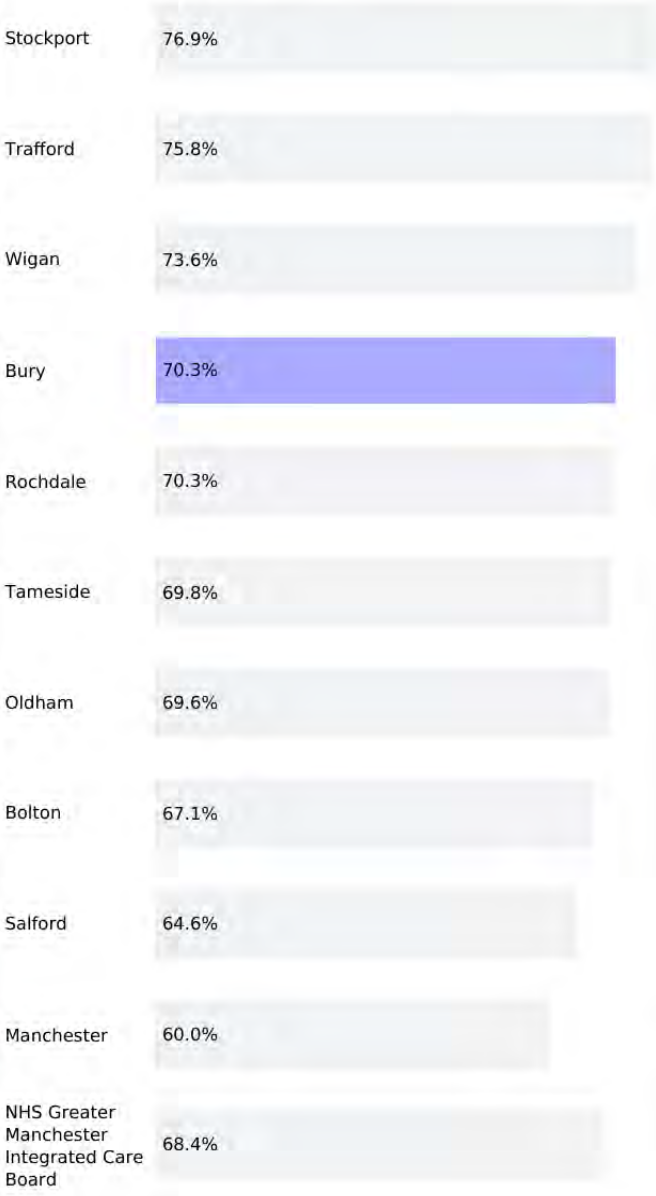
Outliers more than 1 standard deviation from the mean



	Jun	Sep	Dec	Mar
2021-22	72.7%	71.9%	71.5%	71.7%
2022-23	71.1%	69.9%	69.2%	69.9%
2023-24	70.0%	69.8%	70.4%	70.6%
2024-25	70.3%			

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

Latest Value GM Benchmarking
National Rank against other localities



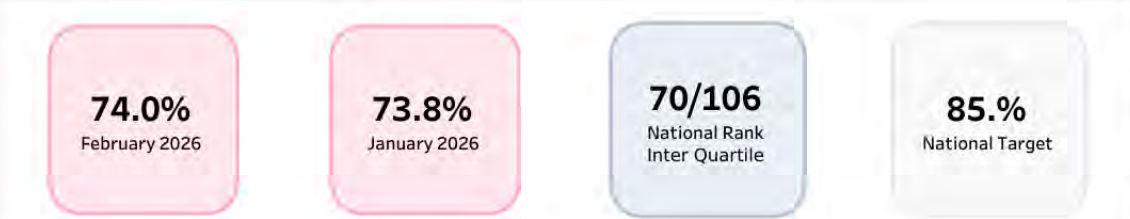
Narrative

- The GM Cancer Screening Dashboard indicates that, in April 2026 Cervical screening coverage in Bury is 69.5% (extended 50–64) and 66.5% (standard 25–49), indicating mid-range performance across GM.
- Performance is comparable to HMR and Oldham, and broadly in line with Bolton.
- Below top-performing localities including Stockport (72.9% / 74.5%) and Trafford (72.1% / 72.3%)
- Above lower-performing areas such as Manchester (64.6% / 54.7%) and Salford (64.6% / 61.3%)
- Overall, Bury demonstrates moderate uptake with opportunity to improve towards top quartile levels.

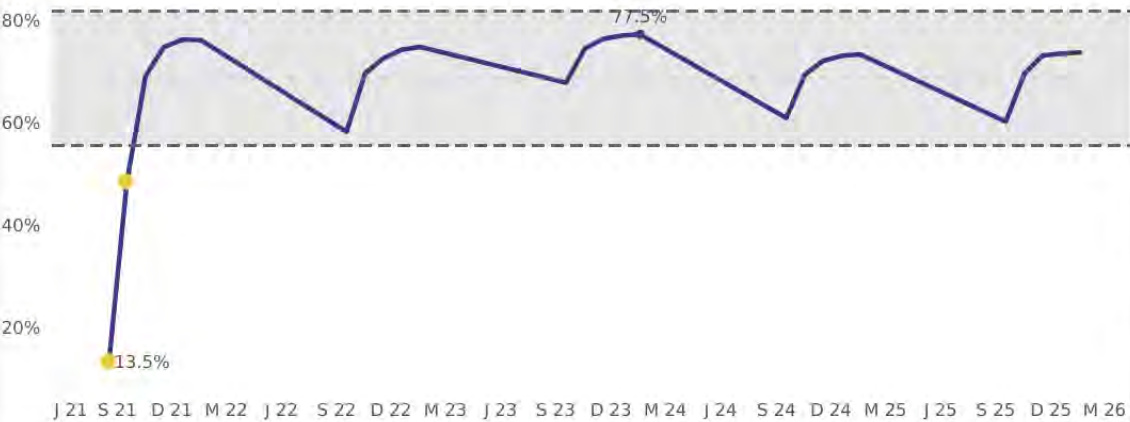
Seasonal Flu Vaccine Uptake: 65 years and over

The uptake of seasonal influenza vaccination among those aged 65 and over

Source: Seasonal influenza vaccine uptake in GP patients: monthly data, 2022 to 2023 (Monthly)



Outliers more than 1 standard deviation from the mean



	Sep	Oct	Nov	Dec	Jan	Feb
2021-22	13.5%	48.8%	69.4%	75.0%	76.5%	76.4%
2022-23		58.5%	69.9%	72.8%	74.6%	75.1%
2023-24		68.1%	74.7%	76.6%	77.3%	77.5%
2024-25		61.2%	69.7%	72.3%	73.3%	73.6%
2025-26		60.5%	69.9%	73.4%	73.8%	74.0%

Selected measure at February 2026 has continuously increased for 4 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities

Stockport	79.5%
Trafford	75.7%
Bury	74.0%
Wigan	73.9%
Rochdale	72.2%
Oldham	72.1%
Bolton	71.4%
Tameside	69.8%
Salford	69.0%
Manchester	62.8%
NHS Greater Manchester Integrated Care Board	72.0%

Narrative

- Uptake of the seasonal influenza vaccine among those aged 65 years and over in Bury increased to 74.0% in February 2026, representing a slight improvement from 73.8% in January 2026.
- This also reflects a year-on-year increase compared with February 2025, when uptake was reported at 73.6%.

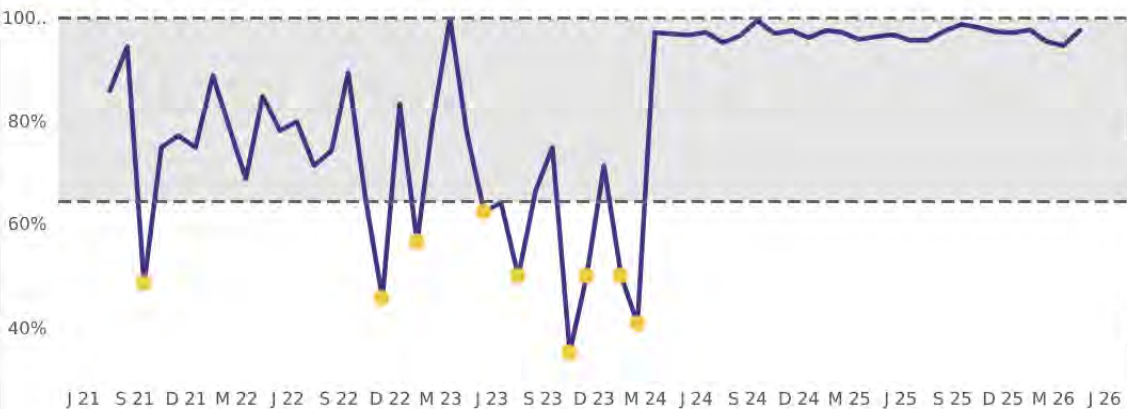
% 2-hour Urgent Community Response (UCR) first care contacts

Percentage of 2-hour UCR referrals subject to the 2-hour response standard (as specified in the UCR technical guidance), with an RTT end date in reporting month, that achieved the 2-hour response standards

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



Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22					86.0%	94.5%	48.5%	75.0%	77.3%	75.0%	88.9%	79.4%
2022-23	68.9%	84.9%	78.3%	80.0%	71.4%	74.4%	89.5%	65.0%	45.8%	83.3%	56.5%	80.0%
2023-24	100.0%	77.8%	62.5%	64.3%	50.0%	66.7%	75.0%	35.3%	50.0%	71.4%	50.0%	40.9%
2024-25	97.3%	97.0%	96.8%	97.3%	95.3%	96.7%	99.6%	97.1%	97.6%	96.3%	97.7%	97.3%
2025-26	96.0%	96.5%	96.9%	95.8%	95.8%	97.6%	98.8%	98.2%	97.4%	97.2%	97.8%	95.5%
2026-27	94.8%	97.7%										

Selected measure at May 2026 has continuously increased for 1 period(s) of time

Latest Value GM Benchmarking

Tameside	100.0%
Oldham	98.1%
Trafford	97.8%
Bury	97.7%
Stockport	95.5%
Manchester	95.3%
Salford	83.7%
Rochdale	82.2%
Wigan	80.9%
Bolton	71.0%
NHS Greater Manchester Integrated Care Board	89.7%

Narrative

- Bury UCR 2-hour response performance is 97.7% (May 2026), above the 70% national target and improved from 94.8% in April
- Performance is among the strongest in GM, ranking just below Tameside (100%), Oldham (98.1%) and Trafford (97.8%)
- Outperforms GM average (89.7%) and is higher than most localities including Stockport (95.5%) and Manchester (95.3%)
- Significantly above lower-performing areas such as Salford (83.7%), Rochdale (82.2%) and Bolton (71.0%)
- Overall, Bury demonstrates consistently high performance and sustained compliance with the 2-hour standard

Oversight Metrics Glossary

Domain	Code	Measure	Description	Data Source	Frequency	Latest	Updated	RAG rated against	Desired Direction
Cancer	N/A	Cancers Diagnosed at an Early Stage (12-month rolling): All Tumours Staged within RCRD	12-month rolling count of cancers diagnosed at stages 1 and 2 divided by 12-month rolling count of cancers diagnosed at stages 1, 2, 3, and 4	Rapid Cancer Registration Data (RCRD) at Tumour Level	Monthly	Dec 25	2nd Thursday	National Target	Increase
	S086a	Inappropriate adult acute mental health Out of Area Placement (OAP) bed days	Inappropriate Out of Area Placements	Out of Area Placements in Mental Health Services Official Statistics	Monthly	Apr 26	2nd Thursday	National Target	Decrease
	S081a	Talking Therapies: Access Rate	Number of people accessing first treatment	Improving Access to Psychological Therapies Data Set	Monthly	Apr 26	2nd Thursday	No Target	Increase
	EAS01	Dementia: Diagnosis Rate (Aged 65+)	Dementia: Diagnosis Rate (Aged 65+)	Primary Care Dementia Data	Monthly	Mar 26	2nd Thursday	National Target	Increase
	S030a	% of patients aged 14+ with a completed LD health check	% of patients aged 14+ with a completed LD health check	Learning Disabilities Health Check Scheme	Monthly	Apr 26	2nd Thursday	National Target	Increase
	S110a	Overall Access to Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses	Number of people who receive two or more contacts from NHS or NHS commissioned community mental health services (in transformed and non-transformed PCNs) for adults and older adults with...	Published MHSDS	Monthly	Apr 26	2nd Thursday	National Median	Increase
	S125a	Long length of stay for adults (60+ days)	Number of people for a given CCG discharged from an adult acute inpatient bed with a hospital spell over 60 days (calculated from the point of admission to the point of discharge)	Published MHSDS	Monthly	Apr 26	2nd Thursday	National Target	Decrease
	EH09	Access to Children and Young Peoples Mental Health Services	Number of CYP aged 0-17 supported through NHS funded mental health services receiving at least one contact.	Published MHSDS	Monthly	Apr 26	2nd Thursday	National Median	Increase
	S131a	Women Accessing Specialist Community Perinatal Mental Health Services	Number of women accessing specialist community PMH and MMHS services in the reporting period	Published MHSDS	Quarterly	Apr 26	2nd Thursday	No Target	Increase
	N/A	Number of MH patients with no criteria to reside (NCTR)	Number of MH patients with no criteria to reside	GM Admissions - Local	Monthly	May 26	1st	No Target	Decrease
	N/A	Percentage of MH patients with no criteria to reside (NCTR)	Percentage of MH patients with no criteria to reside	GM Admissions - Local	Monthly	May 26	1st	No Target	Decrease
	N/A	Proportion of routine eating disorder referrals cases entering treatment within four weeks, aged 0-18	Proportion of referrals with eating disorders categorized as routine cases entering treatment within four weeks in RP, aged 0-18	Published MHSDS	Monthly	Apr 26	2nd Thursday	National Target	Increase
Primary Care	S053b	% of hypertension patients who are treated to target as per NICE guidance		NHS Quality Outcome Framework	Annual	Mar 25	2nd Thursday	National Target	Increase
	S129a	GP appointments - percentage of regular appointments within 14 days	Percentage of appointments where the time between booking and appointment was 'Same day', '1 day', '2 to 7 days' or '8 to 14 days'	Appointments in General Practice	Monthly	Apr 26	Last Thursday	National Median	Increase
	S053c	% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins	% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins	CVD Prevent	Quarterly	Dec 25	2nd Thursday	National Median	Increase
Quality	S037A	% of patients describing the overall experience of their GP practice as good	The weighted percentage of people who report through the GP Patient Survey their overall experience of their GP practice as 'very good' or 'fairly good'	GP Patient Survey	Annual	Mar 23	2nd Thursday	National Median	Increase
	S042a	E. coli blood stream infections	12-month rolling counts of E. coli	National Statistics: E. coli bacteraemia: monthly data by loc...	Monthly	Apr 26	1st Wednesday	No Target	Decrease
	S044b	Antimicrobial resistance: proportion of broad-spectrum antibiotic prescribing in primary care	The proportion of broad-spectrum antibiotic prescribing in primary care	EPACT Prescribing Data	Monthly	Jun 25	2nd Thursday	National Target	Decrease
	S044a	Antimicrobial resistance: total prescribing of antibiotics in primary care	The proportion of antibiotic prescribing in primary care	EPACT Prescribing Data	Monthly	Jun 25	2nd Thursday	National Target	Decrease

Sight Metrics Glossary

Domain	Code	Measure	Description	Data Source	Frequency	Latest	RAG rated against	Target/National
Elective Care	EB20	RTT incomplete: 65+ week waits		Consultant-led RTT Waiting Times data collection (National Statistics).	Monthly	Apr 26	National Target	0,
	EB26x	Diagnostic 6ww: All	% of Patients waiting over 6 weeks for a diagnostic test or procedure	Monthly Diagnostics Waiting Times and Activity Return - DM01	Monthly	Apr 26	National Target	1.%
	EB28	Diagnostic 6ww: All	% of Patients waiting over 6 weeks for a diagnostic test or procedure	Monthly Diagnostics Waiting Times and Activity Return - DM01	Monthly	Apr 26	National Target	1.%
	EB28x	Diagnostic 6ww: All	% of Patients waiting over 6 weeks for a diagnostic test or procedure	Monthly Diagnostics Waiting Times and Activity Return - DM01	Monthly	Apr 26	National Target	1.%
Cancer	S012a	28 Day Wait from Referral to Faster Diagnosis (Monthly): All Patients	Count of patients told cancer diagnosis outcome within 28 days divided by total count of patients told cancer diagnosis outcome following their urgent referral for suspected cancer, referral for breast symptoms, or urgent screening referral	National Cancer Waiting Times Monitoring Data Set (CWT)	Monthly	Apr 26	National Target	80.%
Materni..	S022a	Number of stillbirths per 1,000 total births	Count of cancers diagnosed at stages 1 and 2 divided by count of cancers diagnosed at stages 1, 2, 3, and 4	MBRRACE-UK - Perinatal Mortality Surveillance Report	Annual	Dec 24	National Median	3
	S104a	Number of neonatal deaths per 1,000 total live births	Number of neonatal deaths per 1,000 total live births	MBRRACE-UK - Perinatal Mortality Surveillance Report	Annual	Dec 24	National Median	1
Screenin g and Im munisati ons	S047A	Seasonal Flu Vaccine Uptake: 65 years and over	number of people over 65 who received the seasonal influenza vaccination divided by the number of eligible people who are aged 65 and over	Seasonal influenza vaccine uptake in GP patients: monthly data, 2022 to 2023	Monthly	Feb 26	National Target	85.%
	S046a	COVER immunisation: MMR2 Uptake at 5 years old	% children whose fifth birthday falls within the time period who have received two doses of MMR vaccination	Cover of vaccination evaluated rapidly (COVER) programme	Quarterly	Dec 25	National Target	95.%
	S050a	Females, 25-64, attending cervical screening within target period (3.5 or 5.5 year coverage, %)	% of females, age 25-64 yrs, attending cervical screening within target period (3.5 yrs if aged 24-49 or 5.5 yrs if aged 50-64)	Cervical Screening Programme – Coverage Statistics [Management Information]	Quarterly	Jun 24	National Target	80.%
	S049a	Breast screening coverage, females aged 53-70, screened in last 36 months	% women eligible for screening who have had a test with a recorded result at least once in the previous 36 months	Fingertips, Public Health Data, Public Health Outcomes Framework	Annual	Dec 25	No Target	
Commu..	N/A	% 2-hour Urgent Community Response (UCR) first care contacts	Percentage of 2-hour Urgent Community Response referrals subject to the 2-hour standard where care was provided within two hours	Community Services Data Set (CSDS)	Monthly	May 26	National Target	

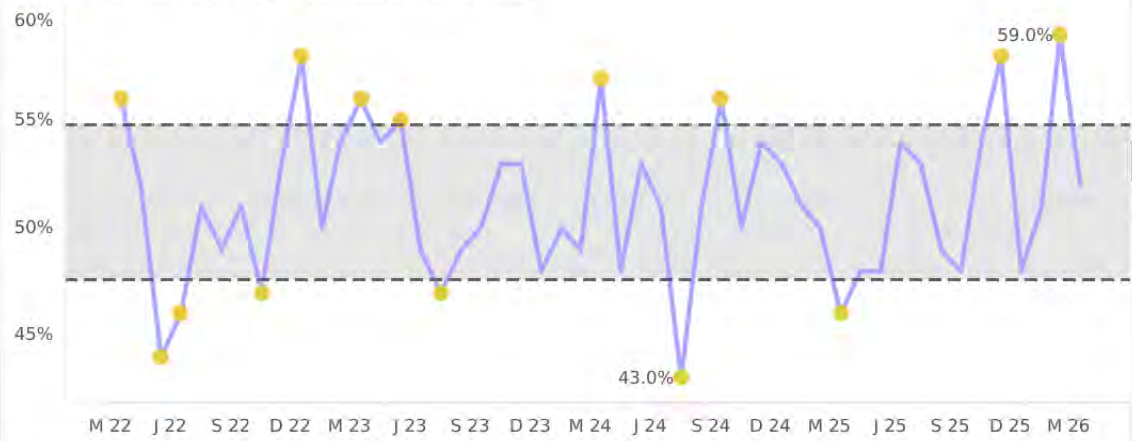
Talking Therapies: Recovery Rate

The proportion of people who complete treatment who are moving to recovery

Source: Improving Access to Psychological Therapies Data Set (Monthly)



Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	56.0%	52.0%	44.0%	46.0%	51.0%	49.0%	51.0%	47.0%	53.0%	58.0%	50.0%	54.0%
2023-24	56.0%	54.0%	55.0%	49.0%	47.0%	49.0%	50.0%	53.0%	53.0%	48.0%	50.0%	49.0%
2024-25	57.0%	48.0%	53.0%	51.0%	43.0%	51.0%	56.0%	50.0%	54.0%	53.0%	51.0%	50.0%
2025-26	46.0%	48.0%	48.0%	54.0%	53.0%	49.0%	48.0%	54.0%	58.0%	48.0%	51.0%	59.0%
2026-27	52.0%											

Selected measure at April 2026 has continuously decreased for 1 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities

5	Trafford	61.0%
35	Tameside	53.0%
44	Bury	52.0%
53	Wigan	51.0%
65	Bolton	50.0%
	Stockport	50.0%
93	Rochdale	46.0%
101	Oldham	42.0%
	Manchester	42.0%
107	Salford	39.0%

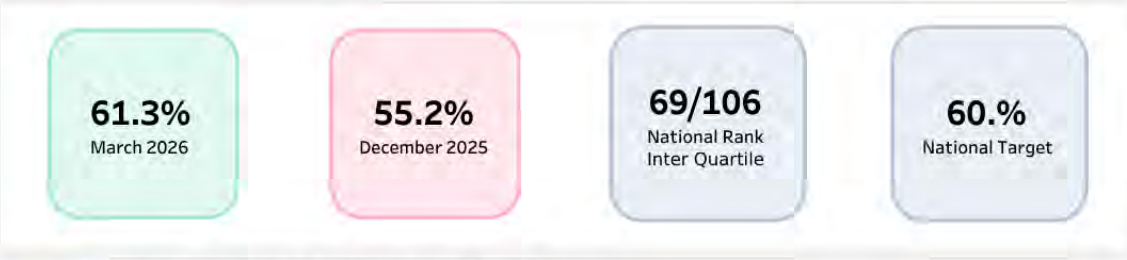
Narrative

- Bury Talking Therapies recovery rate is 52.0% (April 2026), down from 59.0% in March (-7.0pp), but remains above the 50% national target.
- Longer-term performance shows fluctuation between ~45%–60%, with no sustained upward trend.
- Recovery rates have consistently varied month-to-month, indicating instability in outcomes.
- The latest decline follows a period of relatively stronger performance earlier in 2025/26.
- Compared to peers, Bury sits mid-range within GM, performing better than several localities but below the strongest performers.

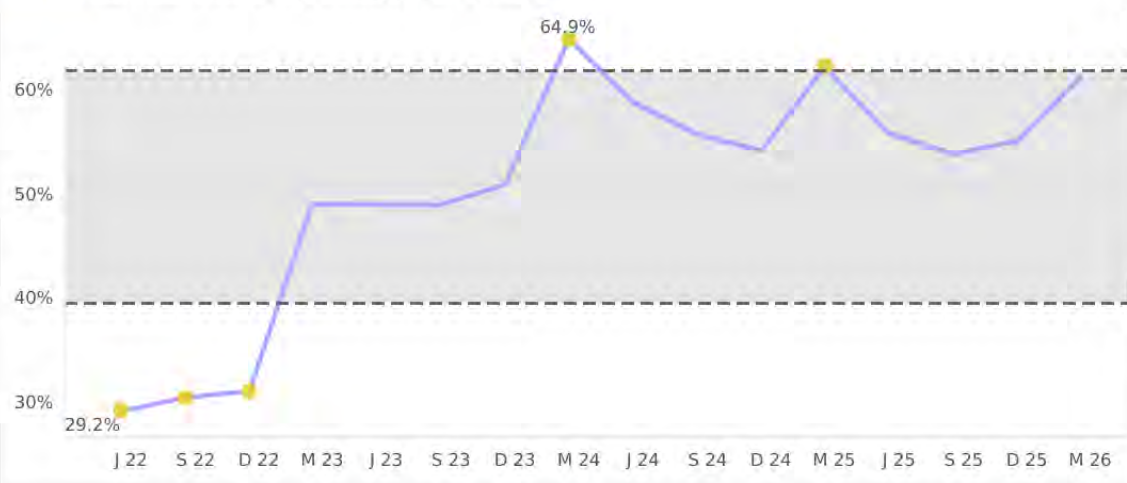
% of people with SMI to receive all six physical health checks in the preceding 12 months. - Mental Health Patients

People with severe mental illness receiving a full annual physical health check and follow up interventions

Source: Physical Health Checks for people with Severe Mental Illness (Quarterly)



Outliers more than 1 standard deviation from the mean



	Jun	Sep	Dec	Mar
2022-23	29.2%	30.5%	31.1%	49.1%
2023-24	49.0%	49.0%	50.9%	64.9%
2024-25	58.8%	55.8%	54.2%	62.2%
2025-26	55.9%	53.9%	55.2%	61.3%

Selected measure at March 2026 has continuously increased for 2 period(s) of time

Latest Value GM Benchmarking
National Rank against other localities

5	Tameside	76.1%
6	Trafford	75.0%
10	Stockport	74.3%
11	Salford	74.0%
12	Wigan	73.8%
33	Oldham	68.3%
34	Rochdale	68.0%
38	Bolton	67.3%
42	Manchester	66.7%
69	Bury	61.3%
6	NHS Greater Manchester Integrated Care Board	69.9%

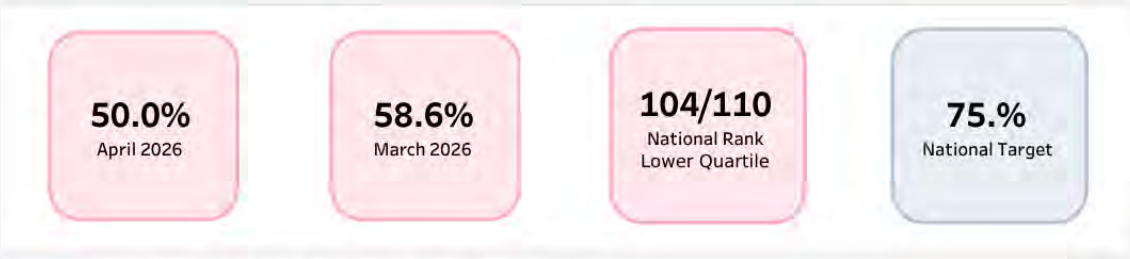
Narrative

- Published data indicates that, as of March 2026, 61.8% of individuals registered in Bury with a serious mental illness (SMI) had completed all six recommended physical health checks within the preceding 12 months. This equates to 1,273 out of 2,060 eligible patients.
- In comparison, the Greater Manchester (GM) average for the same period was 68.7%, indicating that Bury is currently performing below the GM average.

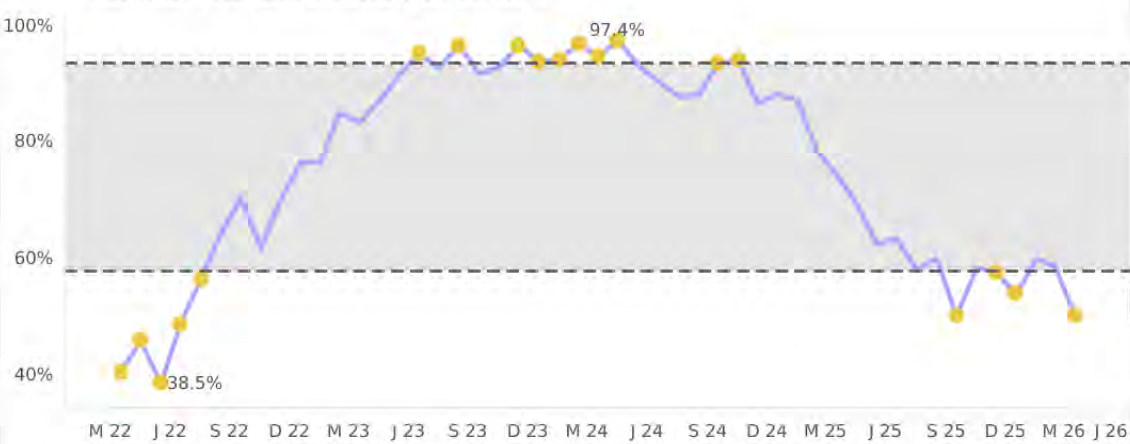
Talking Therapies: 6 Week Waits

The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period.

Source: Improving Access to Psychological Therapies Data Set (Monthly)



Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	40.5%	45.8%	38.5%	48.7%	56.4%	64.3%	70.3%	61.9%	70.0%	76.5%	76.7%	85.0%
2023-24	83.3%	87.0%	91.5%	95.1%	92.7%	96.7%	91.7%	92.9%	96.7%	93.8%	94.1%	96.9%
2024-25	94.7%	97.4%	93.2%	90.5%	87.8%	88.0%	93.5%	93.9%	86.7%	88.2%	86.8%	78.6%
2025-26	74.4%	69.4%	62.5%	63.4%	58.1%	60.0%	50.0%	58.3%	57.6%	53.8%	60.0%	58.6%
2026-27	50.0%											

Selected measure at April 2026 has continuously decreased for 2 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities

49	Oldham	92.1%
66	Tameside	87.2%
79	Bolton	81.5%
83	Wigan	80.0%
88	Trafford	76.1%
89	Manchester	75.2%
93	Salford	74.2%
95	Stockport	71.1%
104	Bury	50.0%
109	Rochdale	34.6%
33	NHS Greater Manchester Integrated Care Board	74.5%

Narrative

- Talking Therapies 6-week waits in Bury have declined further to 50.0% (April 2026), down from 58.6% in March (-8.6pp)
- Performance remains well below the 75% national target and continues to sit in the lower quartile (104th/110)
- Trend shows sustained deterioration since mid-2024, following previous high performance (>90%)
- Over the past 12 months, performance has stabilised at a lower level (~50–60%), with limited recovery
- Bury continues to perform significantly below the GM average (74.5%), with a persistent gap to peers.

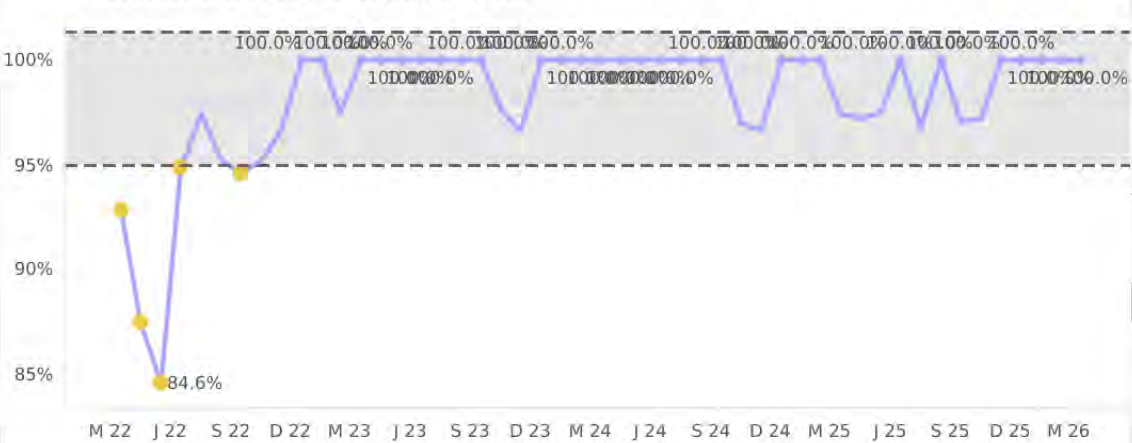
Talking Therapies: 18 Week Waits

The proportion of people that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period.

Source: Improving Access to Psychological Therapies Data Set (Monthly)



Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	92.9%	87.5%	84.6%	94.9%	97.4%	95.2%	94.6%	95.2%	96.7%	100.0%	100.0%	97.5%
2023-24	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.6%	96.7%	100.0%	100.0%	100.0%
2024-25	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.0%	96.7%	100.0%	100.0%	100.0%
2025-26	97.4%	97.2%	97.5%	100.0%	96.8%	100.0%	97.1%	97.2%	100.0%	100.0%	100.0%	100.0%
2026-27	100.0%											

Selected measure at April 2026 has continuously for 4 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities

3	Bury	100.0%
	Oldham	100.0%
	Salford	100.0%
	Trafford	100.0%
	Wigan	100.0%
90	Bolton	98.1%
92	Tameside	97.9%
93	Stockport	97.8%
98	Manchester	96.3%
99	Rochdale	96.2%
29	NHS Greater Manchester Integrated Care Board	98.4%

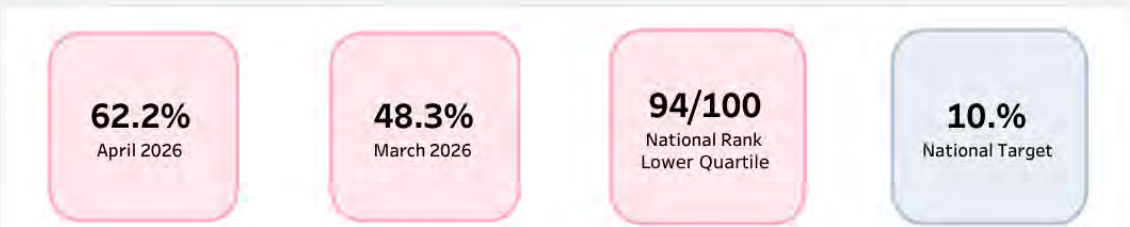
Narrative

- Talking Therapies 18-week waits in Bury remain 100% in April 2026, sustaining full compliance with the 95% national target.
- Performance has been consistently at or near 100% since 2023, demonstrating sustained high delivery and stability.
- Bury is ranked 3rd nationally (upper quartile), reflecting strong comparative performance.
- Over recent months, performance has remained stable with minimal variation, indicating robust pathway management.
- Bury continues to perform above the GM average (98.4%), with only marginal variation across localities at this high level.

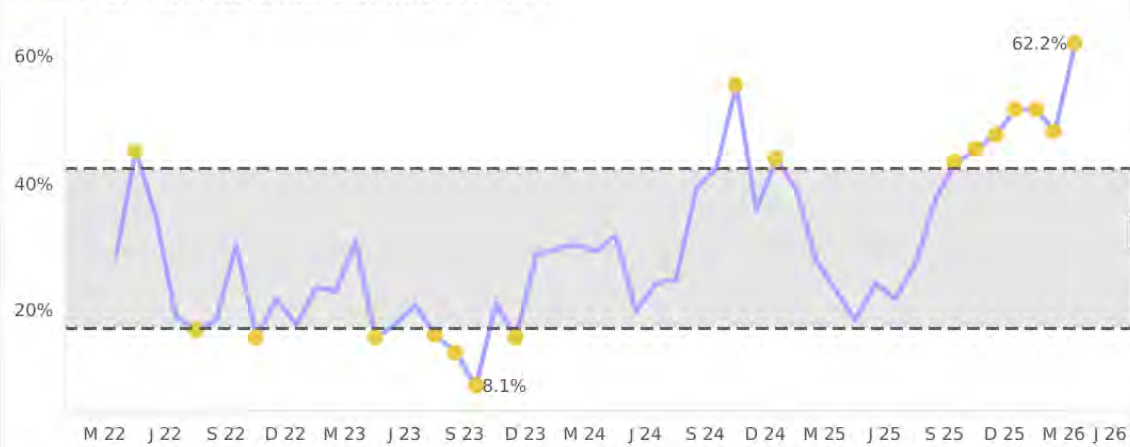
Talking Therapies: Second Treatment Waits

The proportion of people that waited more than 90 days from their first treatment appointment to their second treatment appointment.

Source: Improving Access to Psychological Therapies Data Set (Monthly)



Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	28.6%	45.3%	34.9%	19.1%	17.0%	18.6%	30.6%	15.8%	21.9%	17.9%	23.8%	23.1%
2023-24	31.0%	15.7%	17.9%	20.9%	16.1%	13.5%	8.1%	21.3%	15.8%	28.9%	29.7%	30.6%
2024-25	29.4%	31.9%	20.0%	24.3%	25.0%	39.4%	42.4%	55.6%	35.9%	44.0%	39.0%	28.2%
2025-26	23.3%	18.6%	24.4%	22.0%	27.6%	37.9%	43.3%	45.5%	47.8%	51.9%	51.7%	48.3%
2026-27	62.2%											

Selected measure at April 2026 has continuously increased for 1 period(s) of time

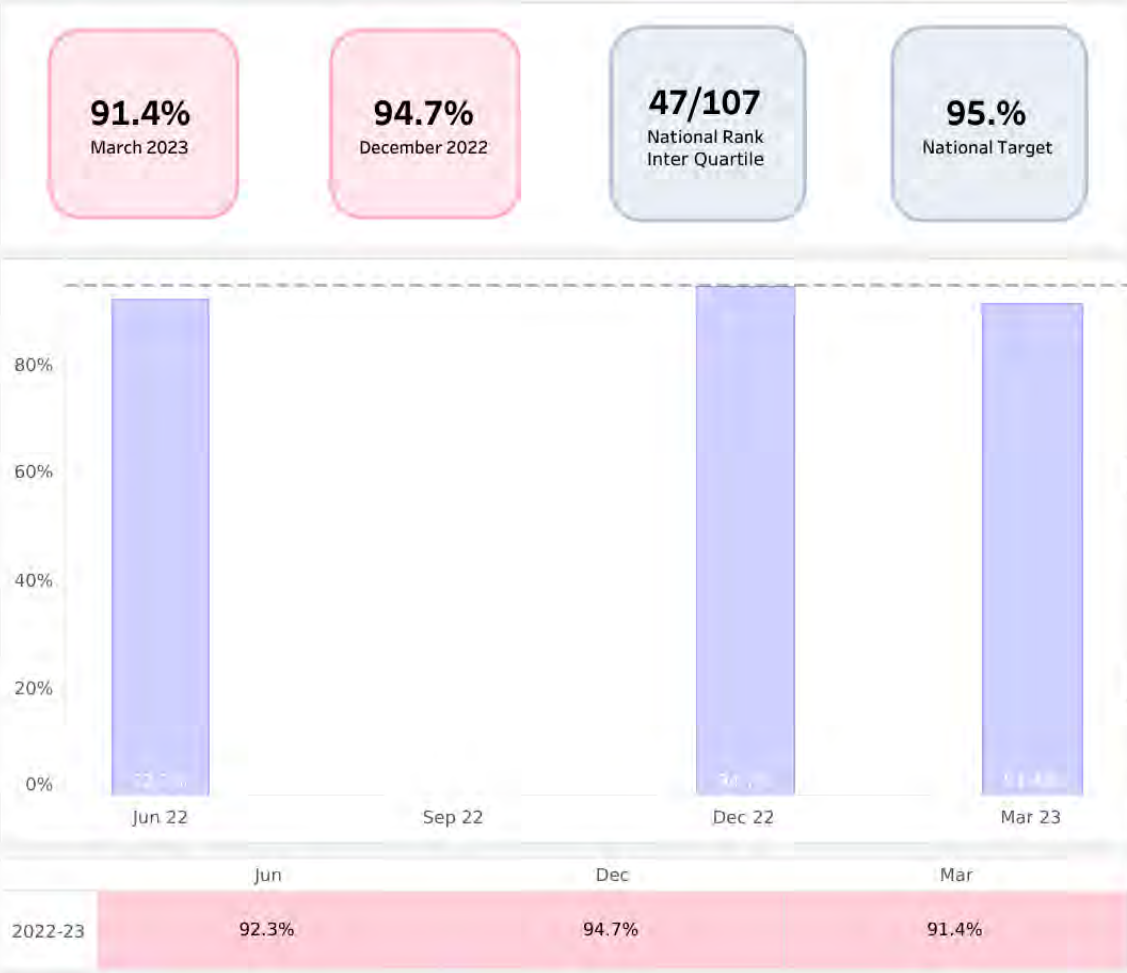
Latest Value GM Benchmarking
National Rank against other localities

42	Oldham	23.5%
69	Manchester	36.0%
72	Wigan	37.5%
75	Trafford	39.1%
76	Salford	39.4%
78	Tameside	41.9%
87	Bolton	50.0%
89	Stockport	51.9%
94	Bury	62.2%
95	Rochdale	63.6%
32	NHS Greater Manchester Integrated Care Board	42.6%

- Narrative
- Talking Therapies second treatment waits in Bury have increased to 62.2% (April 2026), up significantly from 48.3% in March (+13.9pp)
 - Performance remains substantially above the 10% national target (higher is worse) and continues to be in the lower quartile (94th/100)
 - Trend shows clear deterioration over the past 18 months, rising from around 15–25% during 2023/24 to consistently 40–60% in 2025/26
 - Recent data indicates a sharp upward trend, with waits worsening in the last 3–4 months following a period of already poor performance
 - Bury remains above the GM average (42.6%), with a significant and widening gap to peers, indicating sustained systemic pressure in second treatment access.

CYP Eating Disorders: Routine - % within 4 weeks
C&YP Routine Eating Disorders: 4 Week Waits (Rolling 12 mths)

Source: Children and Young People with an Eating Disorder: Waiting Times. (Quarterly)



Selected measure at March 2023 has continuously decreased for 1 period(s) of time

Latest Value GM Benchmarking
National Rank against other localities

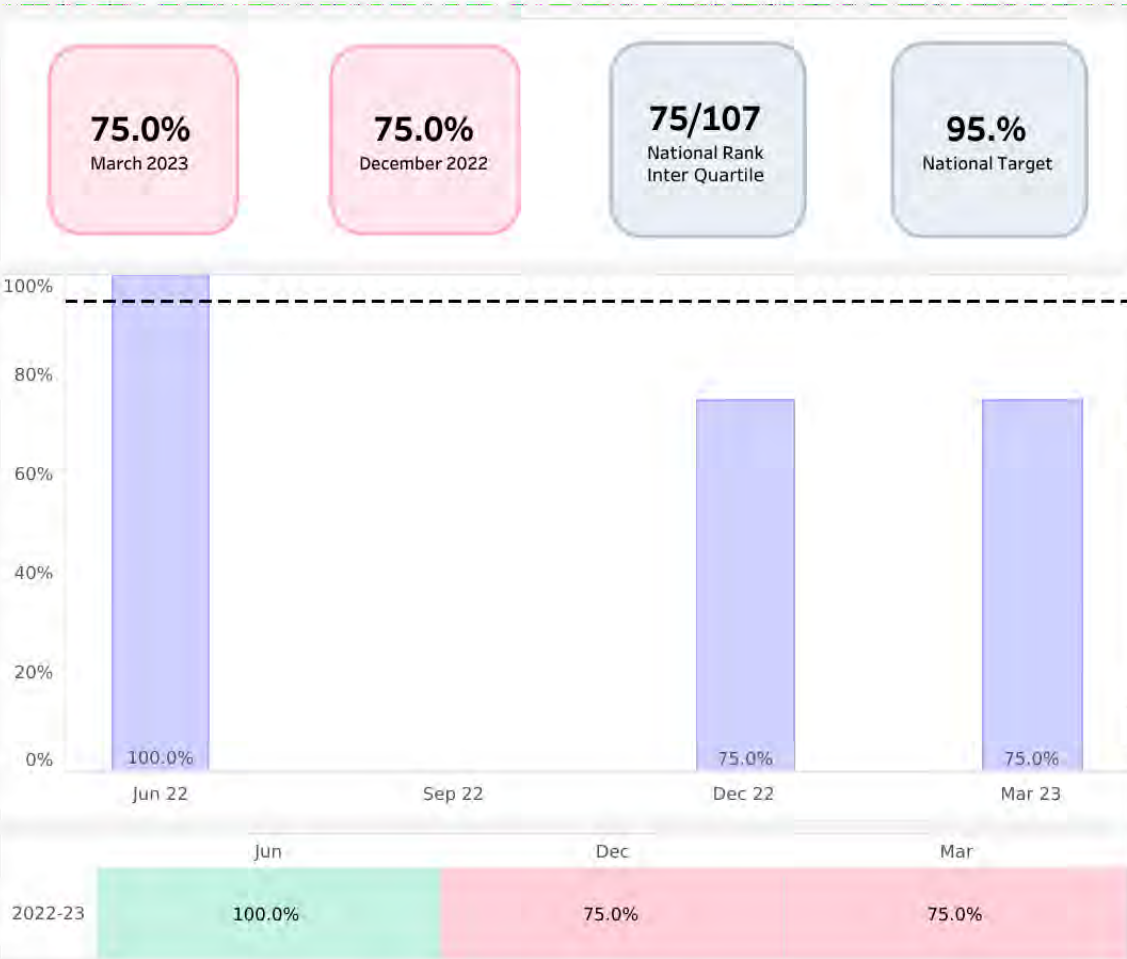
18	Salford	100.0%
28	Trafford	98.5%
30	Manchester	97.7%
34	Rochdale	96.3%
39	Stockport	94.5%
45	Oldham	92.0%
47	Bury	91.4%
51	Bolton	89.5%
52	Wigan	89.4%
56	Tameside	84.6%
11	NHS Greater Manchester Integrated Care Board	94.7%

Narrative

- Data taken from the Greater Manchester Eating Disorder Dashboard, shows 5% of patients with routine eating disorders in the Children and Young People (CYP) category were seen within four weeks during March 2026. Specifically, 4 out of 7 patients received care within the four-week target timeframe.
- GM reported figures shows 71% In March 26 with 84 out of 118 patients receiving care within four weeks.

CYP Eating Disorders: Urgent - % within 1 week
C&YP Urgent Eating Disorders: 1 Week Waits (Rolling 12 mths)

Source: Children and Young People with an Eating Disorder: Waiting Times. (Quarterly)



Selected measure at March 2023 has continuously for 1 period(s) of time

Latest Value GM Benchmarking
National Rank against other localities

18	Rochdale	100.0%
	Salford	100.0%
	Trafford	100.0%
56	Manchester	90.0%
64	Bolton	83.3%
75	Bury	75.0%
	Stockport	75.0%
84	Oldham	66.7%
	Tameside	66.7%
88	Wigan	63.6%
20	NHS Greater Manchester Integrated Care Board	83.5%

Narrative

- In March 2026, no Bury-registered children and young people with an urgent eating disorder were seen, and therefore no patients were treated within the one-week target timeframe.
- Across Greater Manchester, performance in March 2026 was reported at 85%, with 11 out of 13 patients receiving care within one week.

Access to Individual Placement and Support Services - Mental Health Patients

Access to Individual Placement and Support Services

Source: Published MHSDS (Monthly)

290

April 2026

275

March 2026

57/106

National Rank
Inter Quartile

325.0

National Median

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023-24	25	25	30	30	30	30	30	30	30	35	40	40
2024-25	55	55	65	70	75	75	80	85	85	90	90	95
2025-26	90	90	150	165	175	180	210	230	250	250	265	275
2026-27	290											

Selected measure at April 2026 has continuously increased for 3 period(s) of time

Latest Value GM Benchmarking

Rate Per 1000 | Count (National Rank)

Salford	2.06	650 (22)
Tameside	1.58	355 (49)
Rochdale	1.49	370 (47)
Stockport	1.44	470 (35)
Bury	1.37	290 (57)
Trafford	1.35	335 (52)
Wigan	1.25	435 (39)
Oldham	1.19	320 (54)
Bolton	1.18	390 (45)
Manchester	1.16	845 (16)

Narrative

Bury – Access to IPS (Employment Support)

- Activity has increased to 290 in April 2026 (up from 275 in March), continuing a strong upward trajectory.
- Numbers have more than tripled over the past 12 months (from 90 in early 2025), with accelerated growth since mid-2025.
- Bury remains mid-range nationally (57th of 106), indicating average relative performance despite rapid growth.
- Benchmarking shows Bury’s rate (1.37 per 1,000) is broadly comparable to peers but below higher-performing areas (e.g. Salford, Tameside).
- Overall, Bury demonstrates sustained expansion in access, with further opportunity to improve relative position within GM.

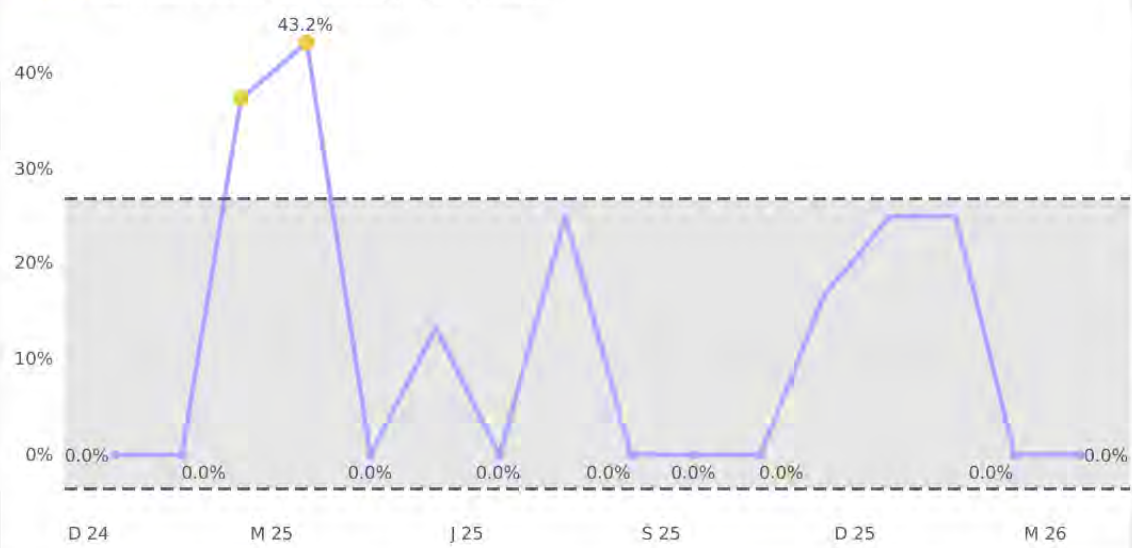
Percentage of CYP receiving Autism assessment within 18 weeks of referral

Percentage of CYP receiving Autism assessment within 18 weeks of referral

Source: Local Autism_ADHD Submission (Monthly)



Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023-24												
2024-25												
2025-26	43.2%	0.0%	13.3%	0.0%	25.0%	0.0%	0.0%	0.0%	16.7%	25.0%	25.0%	0.0%
2026-27	0.0%											

Selected measure at April 2026 has continuously for 1 period(s) of time

Latest Value GM Benchmarking

Salford	27.3%
Oldham	9.1%
Trafford	9.1%
Tameside	5.9%
Manchester	5.4%
Wigan	4.3%
Bolton	0.0%
Bury	0.0%
Rochdale	0.0%
Stockport	0.0%
NHS Greater Manchester Integrated Care Board	9.0%

Narrative

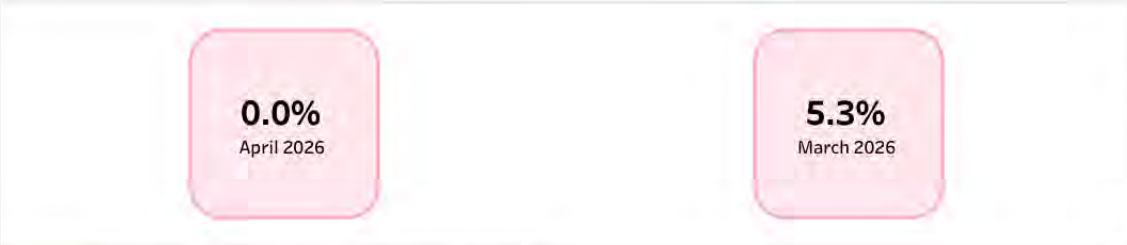
Bury – CYP Autism Assessment within 18 Weeks

- Performance remains at 0.0% in April 2026, unchanged from March, indicating no patients seen within the 18-week standard for a second consecutive month.
- Performance continues to be highly volatile, with multiple months at 0% over the past year and intermittent short-lived improvements.
- Trend shows no sustained recovery, with performance fluctuating between 0% and 25%, indicating inconsistent pathway delivery.
- Bury remains well below the GM average (9.0%) and sits among the lowest-performing localities across GM.
- Data should be interpreted with caution due to known methodology differences between national and local reporting, with further work underway to address this.

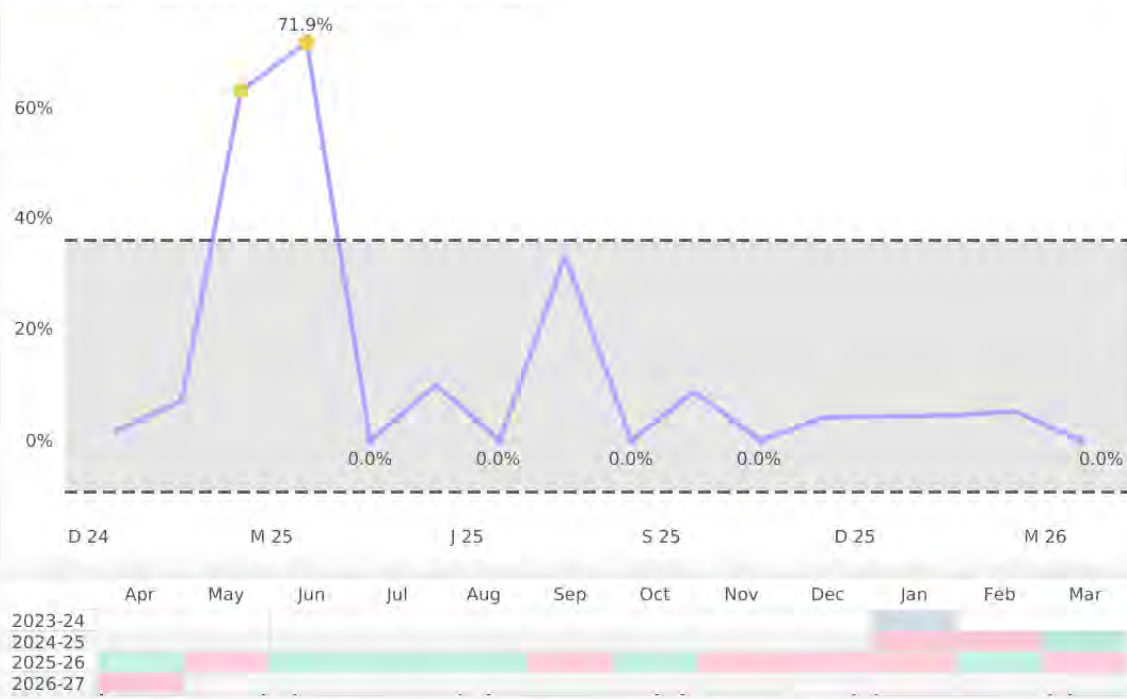
Percentage of CYP receiving ADHD assessment within 18 weeks of referral

Percentage of CYP receiving ADHD assessment within 18 weeks of referral

Source: Local Autism_ADHD Submission (Monthly)



Outliers more than 1 standard deviation from the mean



Selected measure at April 2026 has continuously decreased for 1 period(s) of time

Latest Value GM Benchmarking

Oldham	100.0%
Bolton	50.0%
Trafford	30.0%
Manchester	18.8%
Salford	15.0%
Wigan	4.5%
Bury	0.0%
Rochdale	0.0%
Stockport	0.0%
Tameside	0.0%
NHS Greater Manchester Integrated Care Board	19.2%

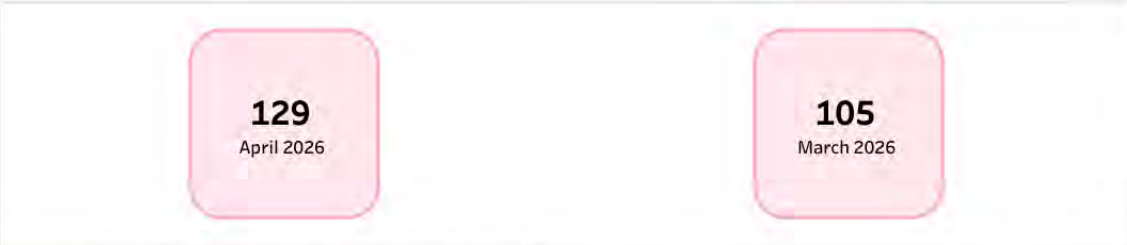
Narrative

- Bury – CYP ADHD Assessment within 18 Weeks.
- Performance has declined to 0.0% in April 2026, down from 5.3% in March, indicating no patients seen within the 18-week standard.
 - Delivery remains consistently very low and highly variable, with multiple months at or near 0% over the past year.
 - Trend shows no sustained improvement, with only sporadic short-term increases followed by deterioration.
 - Bury remains well below the GM average (19.2%) and continues to sit among the lowest-performing localities.
 - Overall performance indicates significant and ongoing capacity challenges within the assessment pathway.

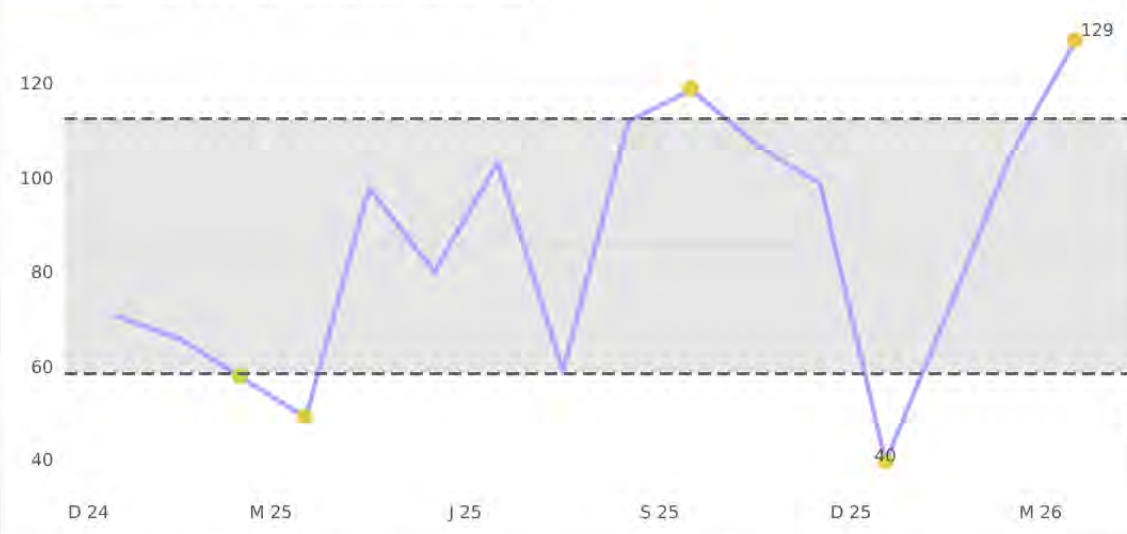
Autism average wait in weeks from referral to first assessment - Mental Health Patients

Autism average wait in weeks from referral to first assessment

Source: Local Autism_ADHD Submission (Monthly)



Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023-24												
2024-25										71	66	58
2025-26	49	98	80	103	59	112	119	107	99	40	73	105
2026-27	129											

Selected measure at April 2026 has continuously increased for 3 period(s) of time

Latest Value GM Benchmarking

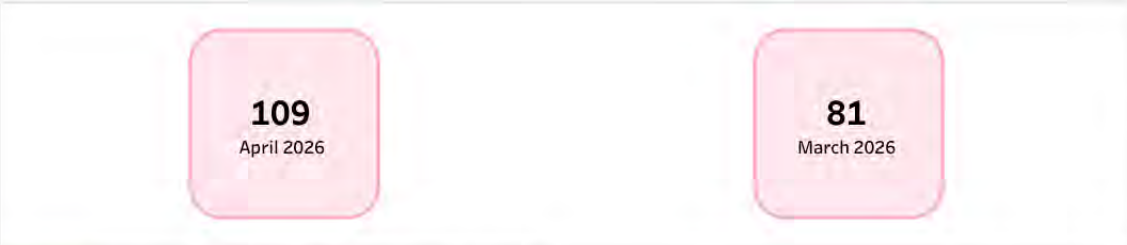
Bolton	59
Rochdale	77
Stockport	88
Oldham	92
Wigan	114
Salford	115
Manchester	116
Bury	129
Trafford	137
Tameside	151

- Narrative
- Bury – Autism Average Wait (Weeks from Referral to First Assessment)
- Average wait has increased to 129 weeks (April 2026), up from 105 weeks in March.
 - Trend shows overall deterioration with recent sharp increases, indicating growing backlog.
 - Bury remains mid-to-lower range across GM, with several areas reporting shorter waits.
 - Overall performance reflects increasing delays and sustained pathway pressure.
 - Note: Figures may differ locally due to methodology differences, a review paper is in development.

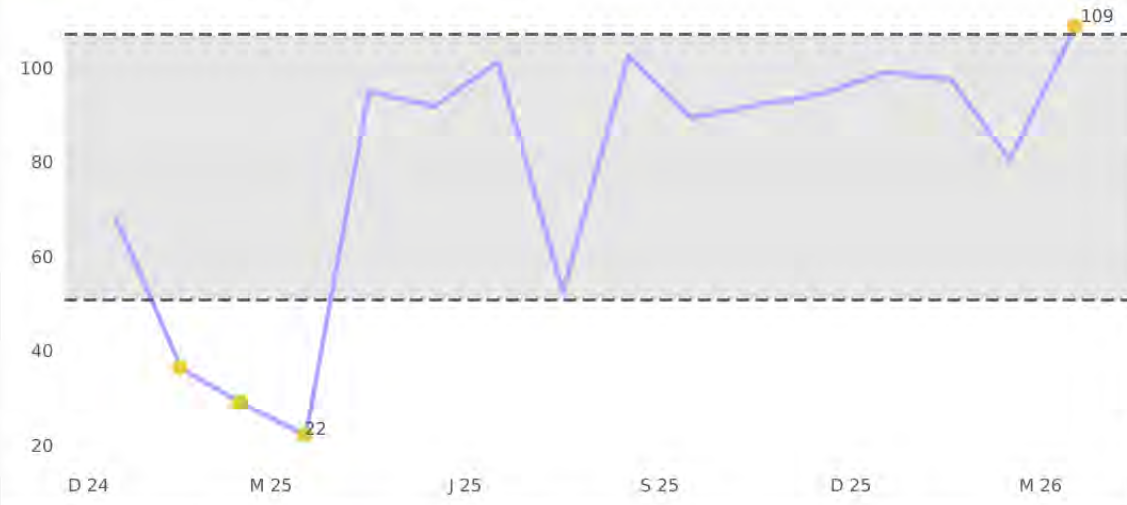
ADHD average wait in weeks from referral to first assessment - Mental Health Patients

ADHD average wait in weeks from referral to first assessment

Source: Local Autism_ADHD Submission (Monthly)



Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023-24												
2024-25										68	37	29
2025-26	22	95	92	102	53	103	90	92	95	99	98	81
2026-27	109											

Selected measure at April 2026 has continuously increased for 1 period(s) of time

Latest Value GM Benchmarking

Oldham	1
Manchester	58
Stockport	53
Wigan	71
Bolton	74
Trafford	62
Salford	115
Rochdale	115
Bury	109
Tameside	152

Narrative

- Bury – ADHD Average Wait (Referral to First Assessment)
- Average wait has increased to 109 weeks (April 2026), up from 81 weeks in March, reversing recent improvement.
- Waits remain consistently high, with most of the past year in the 80–100+ week range.
- Bury sits towards the higher end across GM, with longer waits than most localities and only outperforming the highest-wait areas.
- Overall trend indicates sustained pressure with recent deterioration in waiting times.
- Note: Figures may differ locally due to methodology differences; a review paper is in development

% of CHC referrals completed within 28 days

Percentage of referrals completed (including discounted referrals) within 28 Days

Source: Continuing Healthcare and NHS-funded Nursing Care quarterly published figures (Quarterly)



Outliers more than 1 standard deviation from the mean



	Jun	Sep	Dec	Mar
2022-23	28.0%	38.9%	57.5%	82.5%
2023-24	90.0%	88.9%	66.0%	72.7%
2024-25	72.5%	76.6%	89.7%	83.9%
2025-26	92.3%	82.8%	84.6%	97.1%

Selected measure at March 2026 has continuously increased for 2 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities

5	Bury	97.1%
8	Stockport	95.7%
9	Salford	94.9%
11	Bolton	94.8%
29	Tameside	90.5%
40	Trafford	86.5%
43	Rochdale	86.2%
52	Oldham	83.3%
62	Manchester	81.7%
73	Wigan	76.1%

Narrative

- Bury – CHC Referrals Completed Within 28 Days
Performance improved to 97.1% in March 2026 (up from 84.6% in December), reflecting a strong upward trend.
- Bury is delivering consistently high performance, now approaching full compliance.
- Ranked 5th nationally (upper quartile), indicating very strong delivery.
- Benchmarking Bury (97.1%) is the top-performing locality in Greater Manchester.
- It performs above all GM peers, with most areas in the mid-80% to mid-90% range.

Number of prescriptions dispensed per 1000 patients

Number of prescriptions dispensed per 1000 patients

Source: Patient Level Prescribing Data (Monthly)

909.5

July 2025

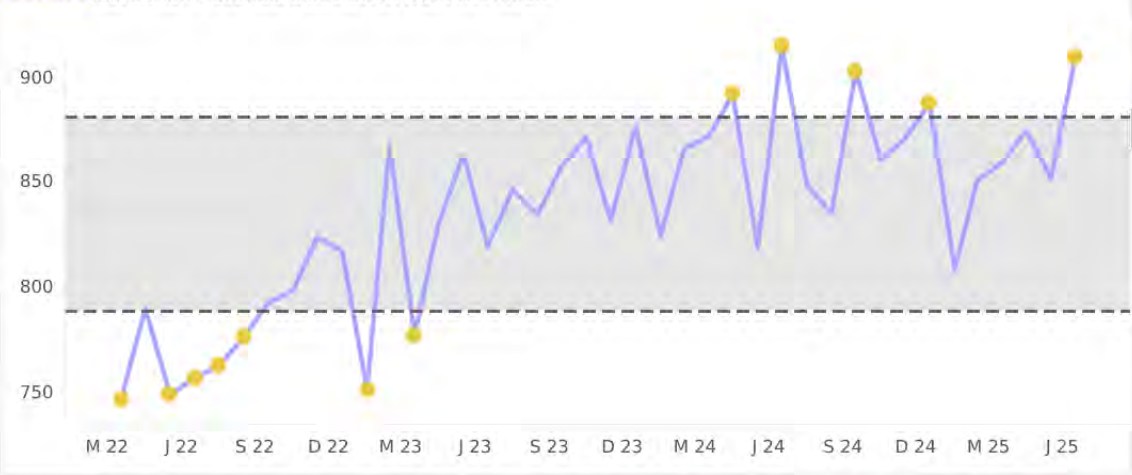
852.2

May 2025

110/117

National Rank
Lower Quartile

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	746.7	789.8	749.2	756.5	762.9	776.6	792.5	798.6	823.8	817.4	751.3	868.2
2023-24	777.0	830.8	863.4	819.6	846.6	834.6	857.7	871.4	831.8	876.7	824.7	865.8
2024-25	871.9	891.9	818.8	915.0	848.7	835.9	903.0	860.7	870.8	887.7	808.9	850.8
2025-26	859.6	874.4	852.2	909.5								

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

Latest Value GM Benchmarking

National Rank against other localities

107 Manchester

825

108 Bolton

856

109 Salford

902

110 Bury

909

111 Rochdale

924

112 Wigan

984

113 Oldham

986

114 Trafford

995

115 Stockport

1,042

116 Tameside

1,099

39

NHS Greater
Manchester
Integrated Care
Board

932

Narrative

- In July 2025, the number of prescriptions issued per 1,000 patients was 909.5, representing an increase from June 2025, when the rate was 852.2.
- However, this reflects an increase compared to July 2024, when the figure stood at 915.0.
- Bury currently ranks fourth among the Greater Manchester localities and remains below the Greater Manchester average of 932.

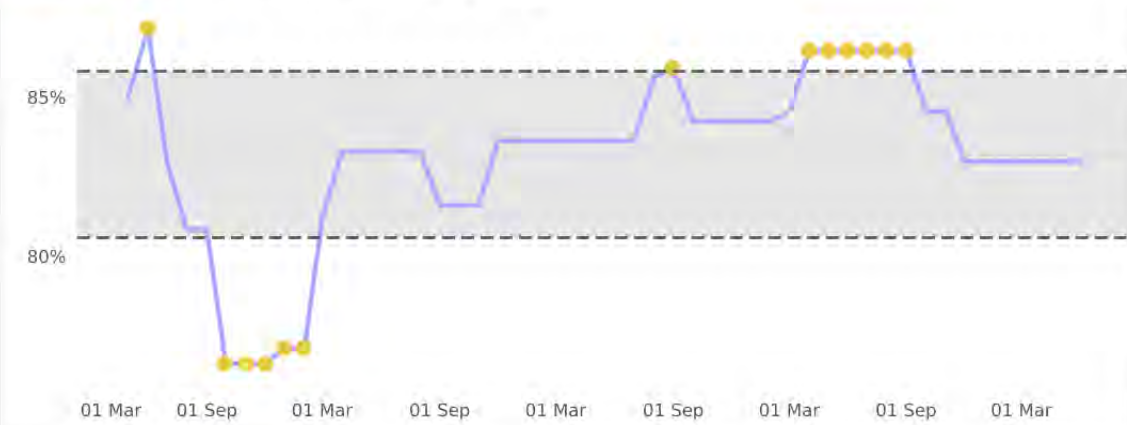
Percentage of Care Homes rated Good or Outstanding

The % of Care Homes rated Good or Outstanding at the end of the period

Source: CQC (Monthly)



Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23												
2023-24												
2024-25												
2025-26												
2026-27												

Latest Value GM Benchmarking
Rank against other localities

1	Wigan	92.6%
2	Trafford	87.5%
3	Oldham	85.7%
4	Bolton	85.5%
5	Bury	83.0%
6	Salford	82.5%
7	Manchester	80.8%
8	Stockport	73.8%
9	Tameside	73.5%
10	Rochdale	64.2%

Narrative

- Bury – Care Homes Rated Good or Outstanding Performance remains stable at 83.0% (April–May 2026) with no recent change.
- Trend shows sustained stability, following earlier variation.
- Bury ranks 5th across GM, indicating mid-to-upper quartile performance.
- Performance is above Manchester (80.8%) and Stockport (73.8%), but below higher-performing areas (e.g. Wigan 92.6%, Trafford 87.5%).
- Overall, Bury demonstrates consistent performance with scope to close the gap to top quartile areas.

Meeting: Locality Board			
Meeting Date	06 July 2026	Action	Receive
Item No.	16	Confidential	No
Title	SEND Improvement and Assurance Board Minutes – 11 th June 2026		
Presented By	Will Blandamer, Deputy Place Based Lead		
Author			
Clinical Lead	N/A		

Executive Summary
The minutes from the SEND Improvement and Assurance Board held on the 11 th June 2026 are attached for information.
Recommendations
It is recommended that the Locality Board note the minutes.

OUTCOME REQUIRED (Please Indicate)	Approval ☐	Assurance ☐	Discussion ☐	Information ☒
APPROVAL ONLY; (please indicate) whether this is required from the pooled (S75) budget or non-pooled budget	Pooled Budget ☐	Non-Pooled Budget ☐		

Links to Locality Plan priorities	
Scale our work on Population Health Management - Improve population health and reduce health inequality of those in the most disadvantaged areas	☒
Drive prevention, reducing prevalence and proactive care – supporting Demand Reduction through primary intervention, secondary preventions and tertiary prevention	☒
Transforming Community Care in Neighbourhoods - fully realising the benefit of neighbourhood team working with a focus on the assets of residents and communities and providing proactive care	☒
Optimise Care in institutional settings and prioritising the key characteristics of reform.	☒

Implications						
Are the risks already included on the Locality Risk Register?	Yes	☐	No	☒	N/A	☐
Are there any risks of 15 and above that need to be considered for escalation via an NHS GM Statutory Committee or Board in line with the Risk Escalation process ?	Yes	☐	No	☒	N/A	☐
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☒	N/A	☐
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☒	N/A	☐
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☒	N/A	☐
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☒	N/A	☐
Are there any financial Implications?	Yes	☐	No	☒	N/A	☐
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☒	N/A	☐
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☒	No	☐	N/A	☐

Governance and Reporting		
Meeting	Date	Outcome
N/A		

Minutes

SEND Improvement & Assurance Board Meeting 11th June 2026

	ATTENDANCE	ROLE	ORGANISATION
	James Franklin Smith	CEO/Vice-Chair	Oak Learning Partnership
	Lynne Ridsdale	Chief Executive	Bury Council
	Kate Waterhouse	Executive Director of Strategy & Transformation & Vice-Chair	Bury Council
	Jeanette Richards	Executive Director for Children, Young People & Education	Bury Council
	Cllr Mary Walsh	Shadow Cabinet Member for Children & Young People	Bury Council
	Cllr Lucy Smith	Lead Member for Children & Young People	Bury Council
	Ben Dunne	Director of Early Years, Education and Skills	Bury Council
	Wendy Young	Head of Service, SEND & Inclusion	Bury Council
	Jo McMaster	Designated Children's Officer for SEND (Bury)	NHS GM (Bury)
	Robert Arrowsmith	Head of Strategy, Assurance and Reform	Bury Council
	Beth Speak	Children's Transformation & Improvement Manager	Bury Council
	Scout Stirling	SEND Youth Ambassador	Bury Council
	Jane Bernhardt	Chair	BURY2GETHER
	Martin McAndrew	Director	BURY2GETHER
	~~Dr Cathy Fines~~	Medical Director	NHS GM

	Ian Trafford	Project Manager	NHS GM
	Chris Bell	Joint Interim CEO	Vision Trust
	Kathryn Mort	Headteacher	East Ward Primary School, Bury
	Sarah Walton (deputized by Maryam Ali-Ansari)	Assistant Principal Personal Development Vocational & Foundation	Bury College
	Rachel O'Neil	Headteacher/ SENDCO	Hoyle Nursery School
	Kirsty Jankowski (deputized by Gurinder Rayat)	Designated Social Care Officer	Bury Council
	Additional		
	Kevin Burns	DfE SEND Adviser	DfE
	Gareth Llewellyn	Senior SEND Delivery Case Lead	DfE
	Andy Bradburn	Service Manager – Skills, Children's Services	Bury Council
	Nick Bell	Secondary Inclusion Lead	Bury Council
	Louisa Yau	Improvement Delivery Officer	Bury Council
	Apologies		
	Deborah Glassbrook	Independent Chair	Optimising Potential Limited
	Will Blandamer	Executive Director, Health and Adult Care; Deputy Place Lead	Bury Council; NHS GM (Bury)
	Linda Evans	Director of Children's Social Care & Early Help	Bury Council
	Collette Radcliffe	Early Years Service Manager	Bury Council
	Beth Osbaldeston	SEND Inclusion Ambassador	Bury Council
	Catherine Jackson	Associate Director of Nursing, Quality & Safeguarding (Bury)	NHS GM (Bury)
	Janet Wray	NHSE Adviser	NHSE
	Cllr Tamoor Tariq	Lead Member for Health	Bury Council
	Jon Hobday	Director of Public Health	Bury Council
	Sebastian Heywood	Minutes taker	Bury Council
	Helen Corbishley	Head of Performance and Delivery	Bury Council
	Catherine Dent	Headteacher	Elmsbank School and College, Bury

1	Welcome and Introduction
	The Vice-Chair welcomed the Board.
2	Local Area SEND Reform Plan
	Overview

Ben Dunne introduced the latest versions of the SEND reform plan, the data template and the maturity assessment and recapped the development approach, including weekly task and finish reference group meetings, SIAB on 12 May, engagement and consultation sessions with Change Makers, Bury2Gether and SIAB members, and ongoing online consultation with schools. He stated that he was keen to capture schools' views across all phases and settings, particularly on working relationships across health, education and social care and on the team around the school model and that school feedback would continue to be incorporated into the plan up to submission.

Maturity Assessment

He confirmed that following SIAB feedback, the maturity assessment had been amended to change co-production from "developing" to "emerging" to reflect views that this had been over-optimistic. He confirmed that the rest of the assessment largely remained unchanged and that the reform plan aligned well with the self-evaluation and maturity assessment.

Data

He thanked colleagues across finance and data, particularly Robert Arrowsmith, for work on the data template and projections. He invited Robert to explain the modelling and a timeline graphic.

Robert Arrowsmith explained the visual which was designed to clearly show the timing of the national reforms and their impact, noting that the plan and guidance focused on 2026 to 2030, however key reforms would take effect much later. He described the current phase as one of development and preparation for the new system, with major inputs over the next three to four years including the Experts at Hand model, steps to improve inclusion in mainstream schools and capital investment. The new ISP assessments would not begin until September 2029 and transfers from EHCPs to ISPs would not start until September 2030. He also highlighted the national guarantee that any child in a special school in 2029 could remain there for the rest of their school career. He said this meant change would be extremely gradual and that the existing system, which continued to generate high EHCP numbers and cost pressures, was likely to remain largely unchanged during the life of the plan.

He noted that the Department for Education had indicated that the number of children and young people needing specialist provision and EHCPs would return to current levels by 2035, with continued growth before then. The period from 2029/30 to 2035 should be seen as one of implementation before a steadier state could emerge. This was important to note as it explained the apparent disconnect between the ambition of the plan and the continued growth in EHCPs shown in the modelling.

Robert outlined the local modelling and noted that a regional tool had projected more than 4,500 EHCPs by 2029, but Bury had discounted that as too high because it relied on an older baseline and trajectory. Instead, local modelling by finance and performance colleagues used more recent trends, including numbers of new EHCPs and cessations, and reflected tighter management of the process and a stronger local system since 2024. Bury was projecting around 3,600 EHCPs by the end of 2027 and just over 4,000 by the end of 2029, which still assumed some improvement, with new EHCPs falling from around 35 per month

recently to 30 per month in the current year and 25 per month in future years. However even with those assumptions, the model still showed growth.

The model therefore projected increasing costs and a cumulative deficit reaching around £43 million by the end of 2027/28 before allowing for the high needs support grant. He explained that the grant might remove around £19 million of the current £21 million deficit, leaving around £2 million, but that deficits would then rebuild in 2026/27 and 2027/28 to around £25 million. He said the question of what would happen to these rebuilt deficits when central government assumed responsibility had not really been fully answered yet, and that the Local Government Association had raised this with the DfE.

The Vice-Chair noted that the graphic was incredibly useful and likely to ease anxiety about the speed of reform by making the timeline visually clear. He asked how the ongoing projected deficit affected the previous strategy to meet Project Safety Valve milestones. Jeanette Richards responded that Bury had received formal notification that Project Safety Valve had ceased, so the authority was now operating outside that agreement. Commitments around sufficiency in Bury would continue, but the rebuilding deficit and lack of clarity about the route back to central government responsibility were worrying.

Robert Arrowsmith clarified that the modelling already assumed continuing strengthening within the local system and some shadow adoption of the norms of the future system by schools before the reforms formally began.

The Vice-Chair stated that parents' perceptions and the extent to which schools met need more effectively would also influence demand for EHCPs. Robert Arrowsmith agreed and confirmed the modelling assumed a degree of confidence in both the national and local trajectory and that the local system would continue to strengthen.

Cllr Lucy Smith noted that communication about timing was critical, as concern about timescales had come through in engagement activity. She also asked how schools were receiving the reform messages, warning that schools should not interpret the timeline as meaning they did not need to act until 2030. This would be a repeat of previous delays in not implementing the 2014 changes appropriately. The Vice-Chair agreed there was a balance to strike between easing anxiety and ensuring schools still responded at pace and that engagement with heads, Trust leaders and the local authority would be important, and that inclusive practice was also being reinforced through Ofsted.

Ben Dunne advised that the Communities of Practice and Experts at Hand model would build on the improvement journey.

Martin McAndrew reported that national discussions had acknowledged the expected spike in demand, but there had been no clear suggestion of how it would be mitigated. He advised the long implementation period had partly come from parent voice, both to protect children already in the system and to give the new arrangements time to work. He felt parents believed demand might reduce more quickly than expected if people understood there was no immediate urgency, which would give time to improve mainstream support. He noted that if support did not improve before 2029/30, there could be a secondary spike as families sought EHCPs before the deadline.

Robert Arrowsmith confirmed the plan reflected pressure on EHCP numbers and cost as well as aspirations for improved inclusion and attainment for children with identified SEND over the life of the plan. He noted that there was scope for substantial strengthening before the formal transfer points in the national reforms.

Reforms Plan

Ben Dunne summarised revisions to the latest draft of the plan since the previous SIAB discussion in May. He confirmed the document now reflected engagement feedback including from DfE Adviser and Senior Case Lead. The co-production elements had been strengthened acknowledging that because of tight (nationally set) timescales, co-production had not initially been where we needed it to be but productive sessions with Change Makers had helped address this. He confirmed that the Experts at Hand model was now clearer, the three-year roadmap had been strengthened, the data template and financial modelling had been added, and measures and KPIs had been reviewed.

He outlined the proposed governance arrangements set out in the plan, confirming that the SEND Partnership Board, chaired by James Franklin-Smith, would oversee three sub-groups: a *data assurance sub-group* to support quarterly submissions to the DfE and monitor delivery against year one commitments; an *Experts at Hand sub-group* with strong representation from across sectors and phases to develop the model with schools and other stakeholders; and a *SEND sufficiency sub-group* to oversee future numbers and the large capital programme through to 2030. He confirmed that the SEND Partnership Board would then report directly into the Education & Inclusion Board as well as feeding into local governance arrangements including Council Scrutiny and the Bury Locality Board.

He noted that the Experts at Hand model remained central. He referred to ongoing consultation with schools and said the local area wanted feedback on how the model should operate and what support schools would need. He described a triage matrix setting out the universal, targeted, targeted plus and specialist support available across education, health and social care, and said the aim was to create a strong universal offer so that the specialist tier remained as small as possible.

The Vice-Chair asked how the sub-groups would be populated. Ben Dunne responded that this would need to form a significant part of the next SEND Partnership Board agenda to ensure we get the right people around the table, and that strong involvement from school representatives would be essential.

Jo McMaster raised that while there was no specific reference to the neurodevelopmental hub, which formed part of the health graduated approach and was therefore an important gap from a health perspective. Jeanette Richards agreed this should be added.

DfE Adviser Kevin Burns stated that he had attended several meetings, reviewed multiple drafts and provided detailed feedback, mainly on clarity and language to ensure the plan explicitly met the relevant criteria. He emphasized that he was not part of the official tiers and could not guarantee the outcome of later stages of DfE sign-off, however it was his view that subject to some further

	amendments responding to advice provided outside of the meeting, the plan met the required criteria that should pass through the approval process. The Vice-Chair noted that the plan had been developed through a national process that all local authorities were navigating. and that the team had responded to feedback and tried to secure as much collaboration and co-production as possible. Jeanette Richards thanked everyone who had worked on the plan under significant time pressure and said the partnership should be proud of it. Lynne Ridsdale confirmed that she was happy for her approval to be taken from the meeting and was pleased that the plan felt like a logical step in the local area's ongoing improvement journey, aligning neatly with the reforms. She was happy to put her name to the plan and expected Colin's approval on behalf of the ICB to be straightforward. The Vice-Chair concluded that, with no further objections, SIAB had agreed the plan and the meeting's main agenda item was complete.
3	UPCOMING MEETING DATES
	Upcoming meeting dates: - 14th July 10.00 – 13.00 Bury College - agenda to be agreed - September 10.00 – 13.00 Town Hall (Date to be agreed with Chairperson) - November 10.00 – 13.00 Town Hall (Date to be agreed with Chairperson) - January 10.00 – 13.00 Towan Hall (Date to be agreed with Chairperson)