# Agenda

## Trafford Locality Board Meeting

Date: Thursday, 23 July 2026

Time: 9.00am

Venue: Meeting Room 12 and via MS Teams

| Item No. | Time | Duration | Subject | Paper/ Verbal | For Approval/ Discussion/ Information | By Whom |
|---|---|---|---|---|---|---|
| 1a | 9:00 | 5 mins | Apologies for Absence | | Info | Chair |
| 1b | | | Declarations of Interest | | Info | Chair |
| 1c | | | Minutes of the Meeting Held on 16th June 2026 | Paper | Approval | Chair |
| 1d | | | Action Log & Matters Arising | Paper | Discuss | Chair |
| 1e | | | Forward Plan | | Info | Chair |
| 2 | 9:05 | 5 mins | **Public Questions** | | Discuss | Chair |
| 3 | 9:10 | 30 mins | **NHS Reform Update** | | Discuss/Info | COD/TM |
| 3a | | | Place Partnership Documents<br>a) Place Health and Care Partnership Summary Slides<br>b) Place Partnership Agreement<br>c) Outcomes Framework<br>d) Place Fund<br>e) Place Team<br>f) Place Governance | Paper | | TM |

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| 3b | | | Place mobilisation update and next steps on Place workforce employment arrangements formal letter | Paper | | ST/COD |
| 4 | 9:40 | 30 mins | **TPCB Report - Integrated Neighbourhood Team Model** | Paper | Discuss/Info | MK/TM |
| 4a | | | Health & Care MDT | | | |
| 4b | | | Neighbourhood Leadership Teams | | | |
| 5 | 10.10 | 30 mins | **Public Health** | | Discuss/Info | HG |
| 5a | | | Director of Public Health Annual report 2025/26 | Paper | | |
| 5b | | | Update to Operational Local Health Economy Outbreak Plan | Paper | | |
| 6 | 10.40 | 15 mins | **Healthwatch Performance Report** | Paper | Discuss/Info | HF |
| 7 | | | **Any Other Urgent Business** | | | |

# Minutes

## Trafford Locality Board

Date: Tuesday, 16 June 2026

Time: 1.00 pm

Venue: Meeting Room 12 and via MS Teams

| Present | Apologies |
|---|---|
| Tom Ross (TR) Leader of Council and Co-Chair<br>Jane Wareing (JW) GP Board Representative and Co-Chair<br>Kate Shethwood (KS) on behalf of Director of Public Health, Trafford Council<br>Heather Fairfield (HF) Healthwatch Trafford<br>Elizabeth Calder (EC), Director of Strategy, GMMH<br>Bernadette Ashcroft (BA), VCFSE Representative, Trafford Community Collective<br>Tom Rafferty, Acting Chief Strategy Officer, MFT<br>Darren Banks (DB) Group Director of Strategy, MFT<br>Maggie Kufeldt (MK) Corporate Director of Adults & Wellbeing, Trafford Council<br>Manish Prasad (MP) Associate Medical Director, NHS GM Trafford<br><br>In attendance:<br>Adam Hebden (AH) Director of Strategy, MFT<br>Thomas Maloney (TM) Programme Director Health and Care, NHS GM Trafford and Trafford Council<br>Patricia Davies (PD) LCO Chief Executive<br>Cllr Jane Slater (JS) Trafford Councillor | Charlotte Bailey (CB) Chief People Officer NHS GM<br>Sara Todd, Place Based Lead NHS GM Trafford & Chief Executive of Trafford Council<br>Cllr George Devlin (GD) Trafford Councillor<br>Helen Golllins (HG) Director of Public Health, Trafford Council<br>Tom Rafferty, Acting Chief Strategy Officer, MFT |

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| Pippa Dewhirst, Governance Team Leader, NHS GM<br>Helena Hamlet, Observer | |

| Item No. | Topic | Action |
|---|---|---|
| 1 | **APOLOGIES FOR ABSENCE**<br><br>Apologies for absence were received from Sara Todd, Tom Rafferty, Charlotte Bailey, George Devlin and Helen Gollins. | |
| 2 | **DECLARATIONS OF INTEREST**<br><br>There were no declarations of interest. | |
| 3 | **MINUTES OF THE MEETING HELD ON THE 19TH MAY 2026**<br><br>RESOLVED: the minutes of the meeting held on the 19th May 2026 were approved as an accurate record. | |
| 4 | **ACTION LOG & MATTERS ARISING**<br><br>The action log was reviewed.<br><br>DB gave an update with regards to action No 195 that he had taken to try and get the tram announcement changed to notify passengers that the next stop would be the hospital. DB advised that it was possible but would be expensive and may require sponsorship to cover the cost.<br><br>RESOLVED: the action log and matters arising were noted. | |
| 5 | **FORWARD PLAN**<br><br>RESOLVED: the forward plan was noted. | |
| 6 | **PUBLIC QUESTIONS**<br><br>There were no public questions received. | |
| 7 | **REFORM UPDATE**<br><br>COD shared the locality staffing structure following the restructure for information and provided an overview of the roles and any vacancies. COD agreed to circulate the staffing structure. JW asked if the neighbourhood roles would be aligned to specific neighbourhoods. COD confirmed neighbourhoods would be assigned leads and this detail would be shared when available. | ACTION<br><br>ACTION |

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| | RESOLVED: TLB noted the reform update. | |
| **8** | **LIVE WELL NEIGHBOURHOOD PLAN PROGRESS REPORT**<br><br>The report summarised the development of the Trafford Live Well Neighbourhood Plan so far, and updated the Board on activity and achievements since the submission of the first draft in February 2026. TM provided an overview of the presentation which covered:<br><br>• Background and context;<br>• Responding to neighbourhood health framework;<br>• 2026/27 requirements;<br>• Longer term reform 2027-29;<br>• Review of plan priorities;<br>• Key achievements; and<br>• Next steps.<br><br>TM highlighted the priorities had been refined and the transformational and brilliant everyday priorities were listed in the presentation. TM asked the Board if they supported or thought additional priorities should be included.<br><br>DB queried if with regards to priorities there was a cpag link to ensure that element was covered aswell as elective. TM confirmed there was and advised MP was producing a report covering the role of cpag that would be considered at Trafford Provider Collaborative Board and the Governance Task and Finish Group before being considered at TLB. COD gave further assurance that elective was covered in the priorities.<br><br>HF noted that the three everyday priorities with ticks contributed to transformational priorities and challenged TM to articulate that a visual way for the final plan, TM agreed this could be developed.<br><br>KS suggested that SEND reforms should be covered in the transformational priorities.<br><br>JS gave thanks for the helpful update.<br><br>RESOLVED: TLB:<br><br>a) Acknowledged the update, including the Neighbourhood Plan developments and achievements.<br><br>b) Acknowledged and support the next steps | ACTION |

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| **10** | **THE LOCAL AREA SEND REFORM PLAN**<br><br>This item was considered first on the agenda.<br><br>The Board were asked to consider the:<br><br>• SEND reform plan;<br>• SEND reform plan data template;<br>• Maturity matrix; and<br>• Trafford SEND dashboard.<br><br>The suite of documents would form the proposed submission to the DFE which was due on the 19th June 2026. The documents had been coproduced across the partnership with input from a wide cross section of people both internal and external. They had been submitted to DFE advisers and the feedback enacted to strengthen the case for Trafford and how we would implement the changes to improve outcomes for children and young people. The Strategic SEND Partnership Board which also included representatives from schools and the Parent Carer Forum as well as health and council employees endorsed these papers and the submission on the 11th June 2026. The papers would also go to ICB leaders for sign off which was being coordinated through GM colleagues.<br><br>JM provided an overview of the plan for the benefit of the Board who had previously considered the outline principles and asked for the Board's approval to submit the documents.<br><br>TR noted the tight timescales were due to government deadlines but confirmed his support and noted his thanks for the officers who had produced the plan. JM suggested progress against the plan was brought back to TLB, noted need to ensure was shared endeavour and noted the importance of ensuring correct membership at SEND Board.<br><br>RESOLVED: The Board is asked to review the SEND documents attached and approve their submission to DFE ahead of the 19th June 2026 deadline. | |
| **11** | **TPCB FUTURE GOVERNANCE ARRANGEMENTS**<br><br>As part of the local governance review Trafford Provider Collaborative Board (TPCB) considered a proposal to stand down TPCB and replace with a Joint Leadership Group (JLG) bringing together partners to work collectively across NHS, Local Authority, VCFSE and Community partners. The purpose of the group would be to create a forum to provide place wide oversight of Trafford's Health and care brilliant everyday and transformation priorities, translate strategy into delivery and collectively agree resourcing to deliver agreed priorities. The change in governance arrangements supported the emergent place partnership governance and was a direct response to the expectations | |

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| | for each place to have a 'Delivery Board'. TPCB had supported the change in governance arrangements and was currently reviewing the draft terms of reference and membership to ensure it was comprehensive and suited the needs of the group. Trafford Locality Board were asked to review the proposal, offer any feedback and support the first meeting of the group to be held in July 2026.<br><br>MK summarised the report for the Board.<br><br>TM noted further work was planned to confirm arrangements for the 'engine room' including the membership.<br><br>JW suggested pharmacy colleagues were included in the membership. MP agreed it was important to have representation from wider primary care colleagues and advised he had engaged with them as part of the wider clinical leadership paper.<br><br>RESOLVED: TLB supported the JLG proposal, pending finalising the ToR (Including feedback from partners on membership and alignment with the Place Health and Care Partnership documentation). | |
| **12** | **NHS GM TRAFFORD FINANCE REPORT**<br><br>TLB were presented with the financial position for the ICS overall and the locality delegated budgets by NHS GM for March 2026. As at Month 12 the ICS reported a surplus of £24.1m, an improvement compared to M11. The main reason for the improved position was due to the majority of the GM NHS Providers meeting the eligibility criteria and therefore receiving additional Deficit Support Funding of £21.3m The localities final position for 2025/26 reported an overspend of £1.39m which was in line with expectations at M11. This improvement in the YTD position was a result of changes to the funding for 2 IMHAD packages, with the LA taking on funding of 50% of one case, and the second case being funded within a block payment. The discharge fund had also been audited and reallocated unutilised funds to offset overspends within CHC. The locality had delivered the full CIP target of £2.9m. An increased financial control framework remained in place with the system required to demonstrate and provide assurance there was a credible plan to deliver the forecast to secure the remainder of the deficit support funding.<br><br>TM advised the finance report had been provided for information to close off the finance report for 2025/26 and going forward the Board would be provided with a finance jigsaw report on a bi-monthly basis. TM advised whilst he could not answer any financial queries he would act as conduit to circulate any queries to Sara Naylor who was acting as Trafford's finance lead.<br><br>RESOLVED: TLB: | |

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| | • Noted the outturn position of a £24.1m surplus following the receipt of additional deficit support funding by GM NHS Providers of £21.3m.<br>• Noted that NHS GM delivered an outturn position of a deficit of £7.5m in line with plan, with GM Providers delivering a surplus of £24.1m<br>• Noted a locality year end variance of £1.39m overspend for commissioned services and a forecast variance of £1.39m.<br>• Noted the workstreams in place targeting the cost pressure and the increased grip and control measures for the locality<br>• Noted the delivery of CIP of £635.6m, a shortfall of £20.4m against the system target of £656.0m, with NHS GM delivering the CIP savings target of £175.0m in full.<br>• Noted the locality have delivered the CIP target of £2.9m in full.<br>• Noted the continuation of the increased financial control framework including local recovery plans. | |
| **13** | **TRAFFORD SECTION 75 AGREEMENT: 25/26 END OF YEAR REPORT**<br><br>The formal Section 75 Agreement between Trafford Council and NHS Greater Manchester (Trafford locality) contains the Better Care Fund and Learning Disabilities Pool. This was supported by Trafford Joint Section 75 Committee, which meet monthly to drive strategic direction, monitor delivery and address areas of escalation. The report was provided to give Trafford Locality Board an overview of performance against these programmes in 2025/26, to highlight system successes and challenges and how the learning from the year have been built into 2026/27 strategic plans.<br><br>AC provided as overview as per the report.<br><br>COD thanked AC for the summary and advised the intention was to provide quarterly updates in the future to provide clarity on how money was invested.<br><br>HF noted GP results were good as were healthchecks but highlighted concern about occupational therapy delays especially when they were up to six months and queried if we measure if these people ended up in care as a result. MK advised MFT and the Local Authority had a joint responsibility to provide occupational therapy and over the past year occupational therapy performance had been reviewed. MK advised there would not be direct evidence that a wait results in care admission but was pleased the OT wait list had reduced and the assessment process had improved.<br><br>HF also queried if there was any measure for the amount of corridor care in the hospitals. PD advised this was not monitored although | |

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| | Trafford has lowest ambulance handover wait and movement through accident and emergency in the region and corridor wait is monitored and there is no particular issue. HF queried what it would be on an average day and PD advised today there were none.<br><br>RESOLVED: The Locality Board noted:<br><br>• 2025/26 performance of:<br><br>o Better Care Fund National Metrics<br>o Learning Disabilities Pooled Budget<br><br>• the performance and progress of key schemes within the Better Care Fund Programme and note next steps in their development. | |
| **15** | **ANY OTHER URGENT BUSINESS**<br><br>There was no other business. | |

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# Urgent and Emergency Care (UEC) Capacity Fund – 2026/27

## Executive Summary

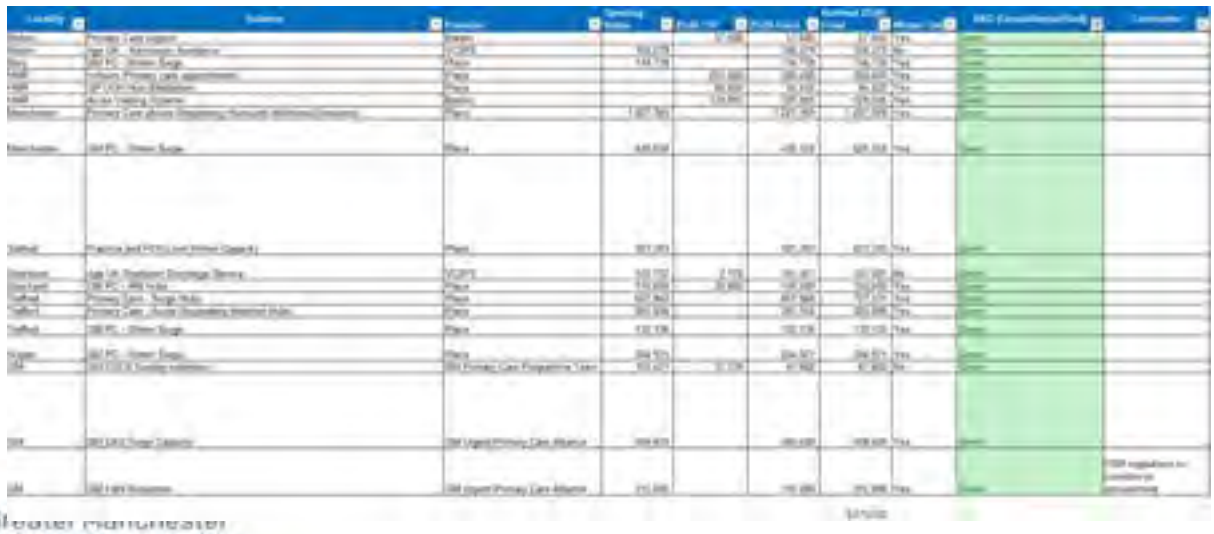
The UEC Capacity Fund is intended to provide additional capacity and resilience across urgent and emergency care pathways, with a particular focus on supporting delivery of the 4-hour standard of care, patient flow, admission avoidance, and system resilience during periods of pressure. The 2026/27 review has therefore assessed whether schemes funded through the current portfolio continue to demonstrate additional, measurable impact on these priorities, and whether continued investment represents good value for money.

The Fund also carries a £5m CIP requirement in 2026/27. This creates a necessary but challenging balance: the system must release savings and improve the effectiveness of investment, while avoiding decisions that destabilise winter resilience, primary care access, discharge capacity, admission avoidance or delivery of the 4-hour standard. The current decision should therefore be framed as a transitional financial and commissioning control, not a full strategic reset. It applies to the £8.4m Place and GM-wide portfolio currently in scope, while the remaining £43m within Acute and Mental Health provider arrangements will require a later whole-Fund review to inform 2027/28 contractual decisions.

## 1. Trafford position

For Trafford, the outcome is particularly positive as the locality has secured continued investment through its approved, Green-rated schemes, providing confidence that key winter resilience and urgent care capacity initiatives can proceed into 2026/27. The decision recognises the importance of maintaining schemes that demonstrate operational benefit and alignment with urgent and emergency care priorities.

There is a commitment to supporting local delivery of winter resilience measures while balancing the wider financial challenges facing the Greater Manchester system. Trafford's approved schemes will support the locality's ability to manage winter demand, reduce pressure on urgent and emergency care services and maintain patient flow across the system. The continuation of Green-rated schemes means that these investments are protected and can be implemented as planned throughout the winter period.



The evaluation has produced a clear, system-wide assessment of all UEC Capacity Fund schemes within scope of this exercise, supported by a set of analytical tables that model the financial baseline, scheme performance profile, and range of CIP opportunities arising from the review.

**Total All Evaluated Schemes by RAG Rating**

| Locality | Amber | Green | Red | Grand Total |
|---|---|---|---|---|
| Bolton | 603,700 | 165,879 | | 769,579 |
| Bury | | 114,739 | 50,059 | 164,798 |
| GM | | 952,170 | 672,349 | 1,624,519 |
| HMR | 294,551 | 423,827 | 40,253 | 758,631 |
| Manchester | | 1,653,927 | 42,138 | 1,696,065 |
| Oldham | 270,403 | | | 270,403 |
| Salford | | 921,393 | | 921,393 |
| Stockport | | 251,001 | | 251,001 |
| Tameside | 436,238 | | 40,000 | 476,238 |
| Trafford | | 1,183,175 | | 1,183,175 |
| Wigan | | 204,921 | 36,811 | 241,733 |
| **Grand Total** | **1,604,892** | **5,871,032** | **881,611** | **8,357,534** |

The next phase of work will be undertaken jointly between localities and the FES PMO, focusing on validating the impact of Amber-rated schemes, monitoring delivery and ensuring benefits realisation across the approved portfolio. Further updates will be provided as this work progresses.

**Trafford Locality Board - Action Log 26/27**

| Action No. | Date of Meeting | Agenda Item Ref. | Action | Update | Lead | Target Date | Status |
|---|---|---|---|---|---|---|---|
| 182 | 2/17/2026 | Draft Neighbourhood plan | TLB feedback to be incorporated into final submission in May including vision statement etc. | Submission not due until September. | TM | 9/1/2026 | In Progress |
| 183 | 2/17/2026 | Draft Neighbourhood plan | TM to produce easy to read version to support resident engagement. | | TM | 10/1/2026 | In Progress |
| 191 | 3/17/2026 | Earcare | Detailed options paper to be brought to TLB incorporating TLB feedback. | | AC | 8/18/2026 | In Progress |
| 201 | 6/16/2026 | Reforms | PD to share the locality staffing structure. | | PD | 7/23/2026 | Completed |
| 202 | 6/16/2026 | Reforms | COD to share which neighbourhood leads had been assigned to. | | COD | 8/18/2026 | In Progress |
| 203 | 6/16/2026 | Live well neighbourhood plan | TM to develop the priority slide to articulate that three of the every day priorities contributed to transformational priorities. | | TM | 8/18/2026 | In Progress |

In Progress
Overdue
Completed

| Date & Time of Meeting | 18 Aug 1pm | 15 Sept 1pm | 20th October |
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| | | | |
| Part 1 – GM ICB Committee (Trafford) | | | |
| | Locality Update and Governance | Locality Update and Governance | Locality Update and Governance |
| | NHS Reform Update | NHS Reform Update | NHS Reform Update |
| | Governance Review | Governance Task and Finish Group | Governance Task and Finish Group |
| | | | |
| | | | |
| | Finance, Performance and Sustainability | Finance, Performance and Sustainability | Finance, Performance and Sustainability |
| | Locality Scorecard | Finance Jigsaw Report | |
| | | | |
| | | | |
| | | | |
| | Risk | Risk | Risk |
| | Risk Register | | |
| | | | |
| | Quality | Quality | Quality |
| | | | |
| | | | |
| | Primary Care | Primary Care | Primary Care |
| | | Primary Care Highlight Report | |
| | | | |
| | Childrens | Childrens | Childrens |
| | Childrens Update | | |
| | | | |
| | | | |
| | TCAPS | TCAPS | TCAPS |
| | | TCAPs Highlight Report | TCAPs Highlight Report |
| | | | |
| | | | |
| | JLG | JLG | JLG |
| | Annual Impact Report | Estates | TLB/HWBB Session |
| | | | |
| | | | |
| | Partner Update | Partner Update | Partner Update |
| | | | Healthwatch Performance Report |
| | | | |
| **Part 2 – Section 75 Committee** | | | |
| | s75 Deed of Variation | | |
| | S75 Quarterly Report | | |

# Public Question Time – Trafford Locality Board

**This item is time limited to 5 minutes.**

Public Questions

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

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

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

Name:

Contact Details:

Question:

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

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|---|---|---|---|---|
| **Name of Committee / Board** | Trafford Locality Board | | | |
| **Date of Meeting** | 23rd July 2026 | | | |
| **Report Title** | Place Health and Care Partnership Document Suite and Place mobilisation update and next steps on Place workforce employment arrangements | | | |
| **Report Author & Job Title** | Pippa Dewhirst, Governance Manager, NHS GM | | | |
| **Organisation Exec Lead** | Thomas Maloney, Programme Director Health and Care, Trafford Council / NHS GM (Trafford) | | | |
| **OUTCOME REQUIRED** *(please highlight)* | Approval | Assurance X | Discussion X | Information X |

**EXECUTIVE SUMMARY**

The Place Partnership document suite are provided for review, feedback will be formally sent through to GM for collation via a designated portal. All 10 localities are reviewing through their local governance and once feedback is processed and built into the documents centrally finalised versions will be taken through GM governance and shared with localities once approved.

The Place mobilisation update and next steps on Place workforce employment arrangements formal letter is provided for information.

**RECOMMENDATION**

Trafford Locality Board is asked to consider the place partnership documents and suggest any feedback to be sent to the central team for consideration.

**CONSIDERATIONS – these must be completed before submission to the Board – Reports with incomplete coversheet information will not be accepted and shared with the board**

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| **Risk implications** ***(Please provide a high-level description of any risks relating to this paper, including reference to appropriate organisational risk register)*** | Effective governance arrangements will support future risk management. |
| **Financial implications and comment/approval** ***(Please detail which organisation(s) will be impacted, and if not required, please briefly detail why)*** | Name/Designation: Julie Flanagan, Associate Director of Finance |
| | Comment : |
| **Comment by Trafford Clinical and Practitioner Senate (TCAPS) and/or Clinical Lead** ***(If not required, please briefly detail why)*** | Date of TCAPS / Clinical Lead comment: N/A |
| | Name/Designation: Manish Prasad, Associate Medical Director |
| | Comment: CCPL governance review ongoing. |
| **What is the impact on inequalities?** (P***lease provide a*** | N/A |

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| ***high-level description of any known impacts)*** | |
| **Equality Impact Assessment / Quality Impact Assessment Outcome** ***(If not appropriate at this stage please state if an EIA or QIA is necessary)*** | N/A |
| **People and Communities: Communications & Engagement** ***(Please detail relevant patient/public engagement completed and/or planned, and if not required please briefly detail why)*** | Task and Finish Group will incorporate lived experience in governance review. |
| **Trafford's Carbon Footprint** ***(Please provide a high-level description of any known positive and/or negative impacts – consider the following topics: energy usage; staff or public transport; waste or materials used. Include steps that could be taken to reduce carbon within relevant plans)*** | N/A |
| **Links to Measurement / Outcomes** ***(Please detail if this is included within the report)*** | Place partnership agreement contains draft outcomes framework which the task and finish group will continue to help shape. |
| **Enabler implications** | **Legal implications:** N/A |
| | **Workforce implications:** N/A |
| | **Digital implications:** N/A |
| | **Estates implications:** N/A |
| **Sub-Board Sign-Off / Comments** **(i.e. Trafford Provider Collaborative Board, H&SC Delivery Steering Group)** | Documents to be taken to TLB for feedback. |
| **Organisation Exec Lead Sign off** | Thomas Maloney, Programme Director Health and Care |

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# Place Health and Care Partnerships Summary Slides

Part of Greater Manchester Integrated Care Partnership

# About This Document and Contents



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**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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# Executive Summary and Introduction

Part of Greater Manchester
Integrated Care Partnership

# Foreword

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

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

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

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

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

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

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

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

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

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

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

**Professor Colin Scales**
**Acting Chief Executive**
**NHS Greater Manchester**

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# 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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**System Convenor – to enable delivery of the ICP strategy**

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

## Strategic Commissioner

### Needs Assessment & Outcomes Setting

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

### Strategy and Planning

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

### Contracting & Evaluating Impact of System

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

Clear Accountability and Trust

## Ten Integrated Place Partnerships

### Local Insight-led Planning

Develop priorities and plans to address:

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

### Integrated Delivery at Place

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

### Aligning Partnership Incentives & Resource

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

**Enablers:** portfolio/s to encompass all of these functions

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

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

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

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

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

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

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# Introducing the PHCP Document Suite

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



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## Partnership Agreement

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

### Place Fund

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

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

### Outcomes Framework

Articulates what the PHCPs are uniquely accountable for delivering.

Describes interdependencies with other partners and strategies.

### Place Team

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

Sets out how multi-partner teams work together to deliver

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

### Place Governance

Sets out governance options for NHS GM's relationship with Place Partnerships

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

# Logic Model - Place Delivery



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## Inputs

**Governance inputs:**
- Partnership Agreement
- Place Fund
- Place Team
- Place Governance

**Investments into:**
- Place Teams
- Place Grants
- Neighbourhood services through contracts

## Key Activities

Integrated Neighbourhood Team Activity

Demand Management Initiatives

Activity in Live Well Centres and Spaces

Primary Care activity

Community Services Activity and Access

## Metrics and Outcomes

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

**Delivery Measures:** Uniform across the 10 localities

Place Specific

*Supported by measures to show cost avoidance and demand reduction*

## Contributing to GM Strategy

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

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

## Leading to Change in Place and System

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

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# Partnership Agreement

Part of Greater Manchester
Integrated Care Partnership

# Partnership Agreement



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

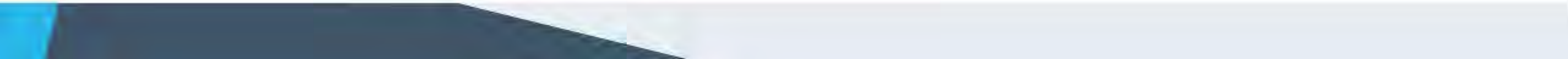
Sets the **shared intent and principles** for Place Partnership working

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

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

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

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



# Partnership Agreement: Structure by section

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

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

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

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

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

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

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

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

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

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

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

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

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# Place Outcomes Framework

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# Place Outcomes Framework



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

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

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

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

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

# Place Outcomes Framework – Linking delivery measures to outcomes



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## Outcome 1
**Keeping people healthy and preventing ill health**

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

## Outcome 3
**Supporting staff wellbeing and retention**

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

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

**Uniform across all 10 PHCPs**

**Delivery measures**

**PHCP Specific**

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

# Outcomes Framework composition

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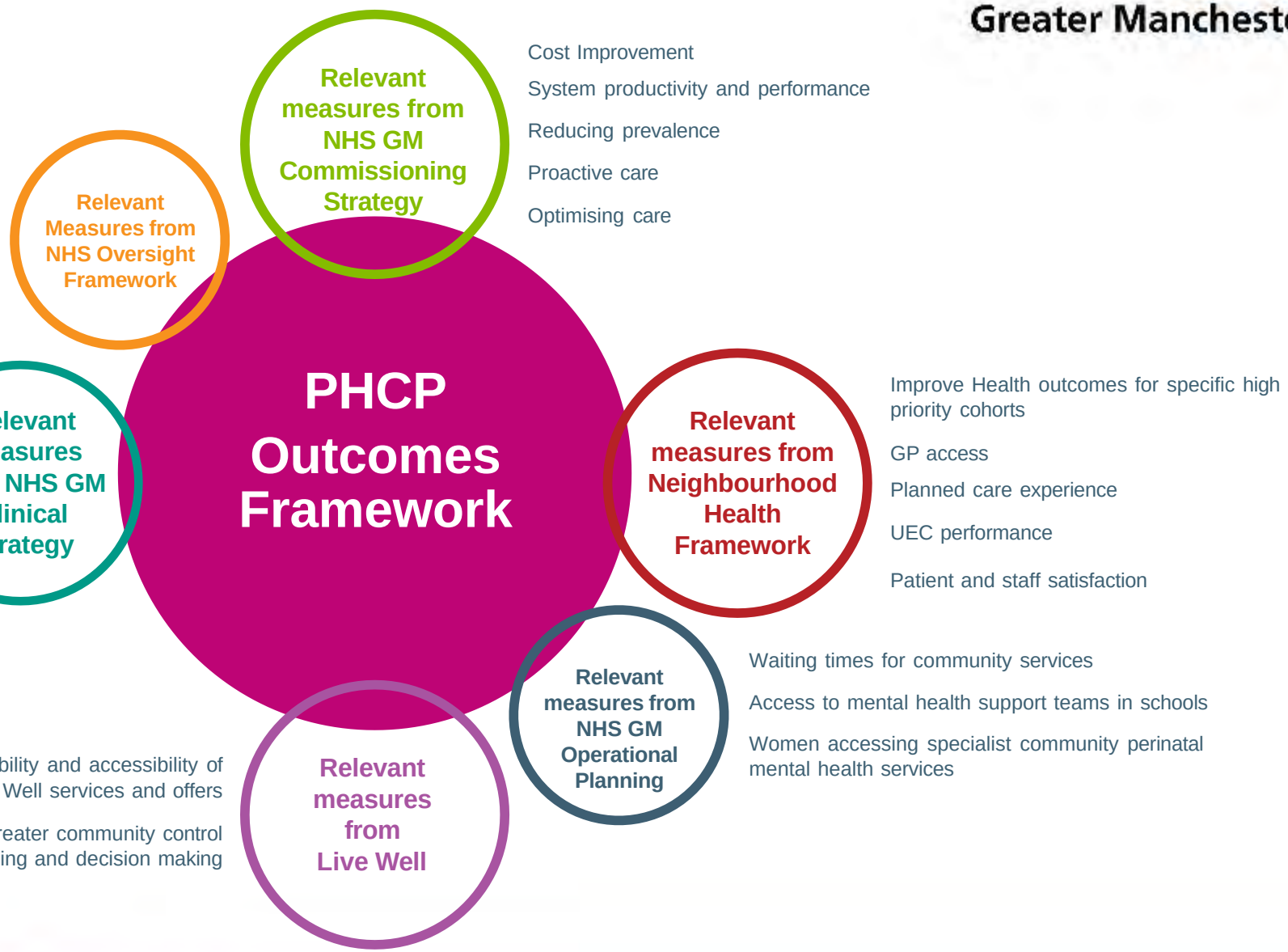

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# Place Fund

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# Place Fund



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

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

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

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

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

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

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

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

# What is included in the Place Fund?



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## Core Place Fund
- Initial scope

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

**Includes:**

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

## Wider Place Fund scope
- Aligned Place Level Expenditure

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

**Includes:**

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

## Future alignment into the Place Fund

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

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

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

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

# Place Fund: How this works in 2026/27



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## 2026/27: Shadow Year for the Place Financial Framework

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

The ICB will continue to hold Place Fund budgets centrally

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

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

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

## Commitment to Development in Year

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

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

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

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

The place fund will launch in April 2027.

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# Place Team

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

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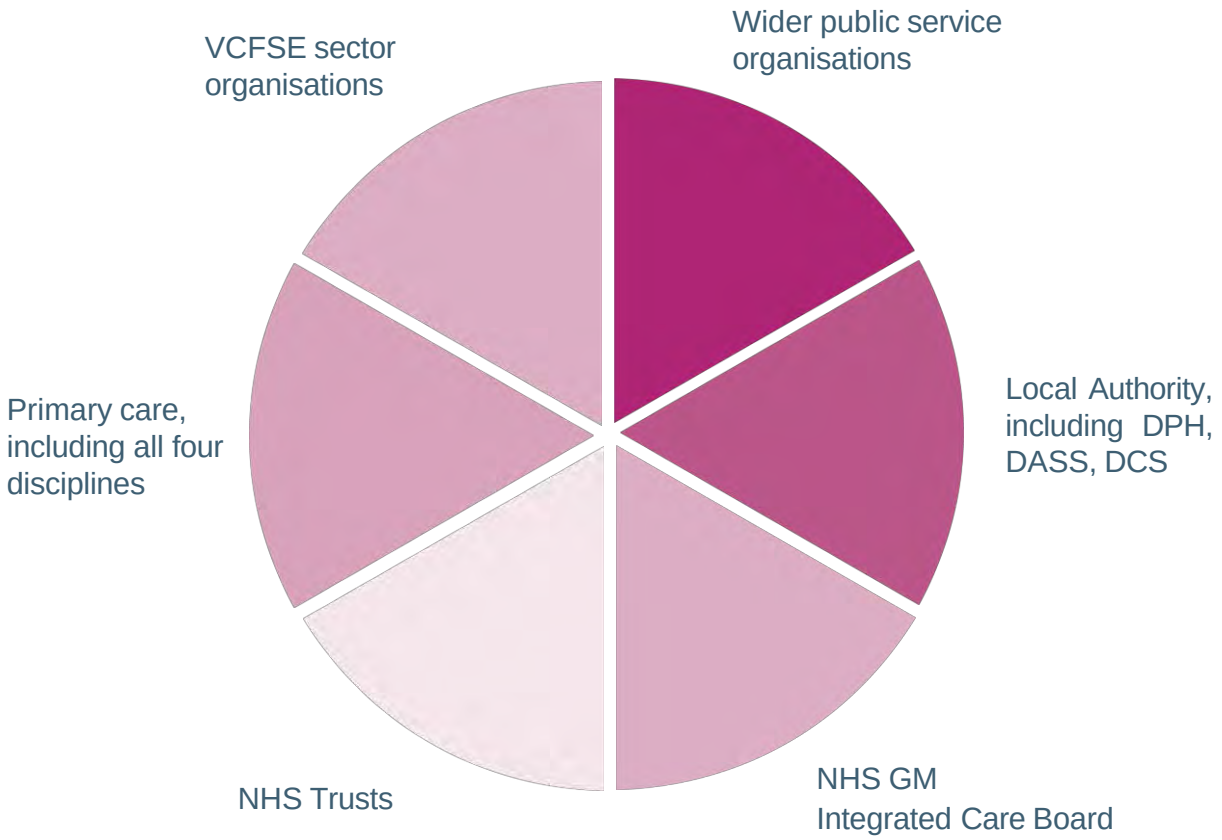


## Creating success through:

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

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

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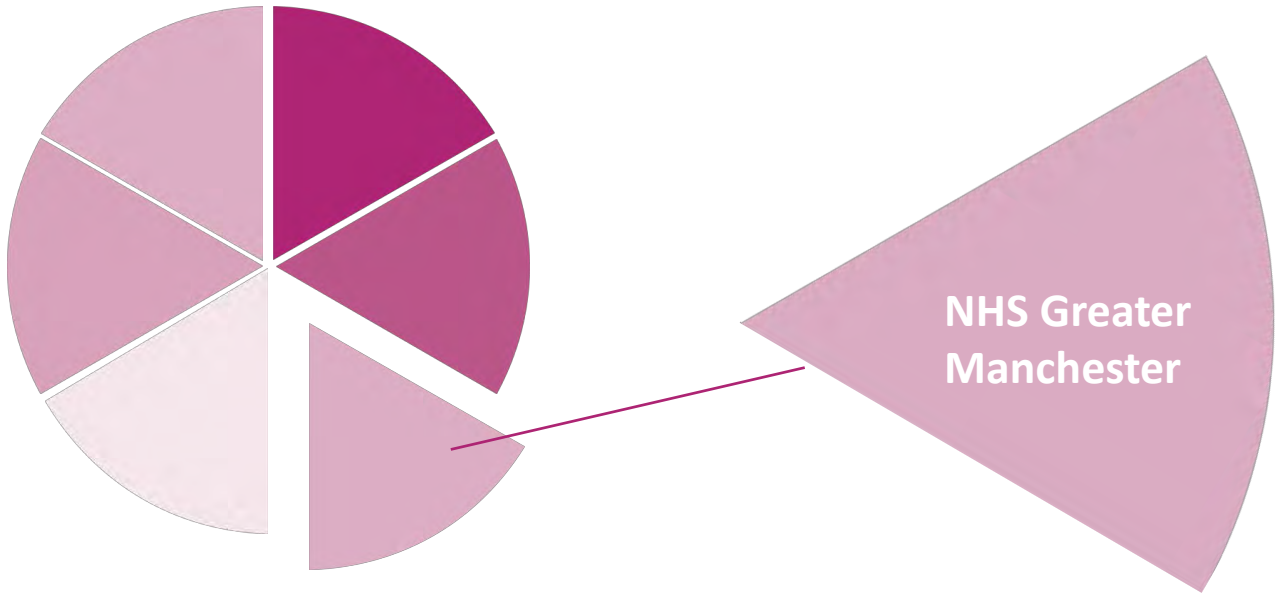
**NHS GM contributes alongside all partners**

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

**Components of the NHS GM Model Place Team**




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

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

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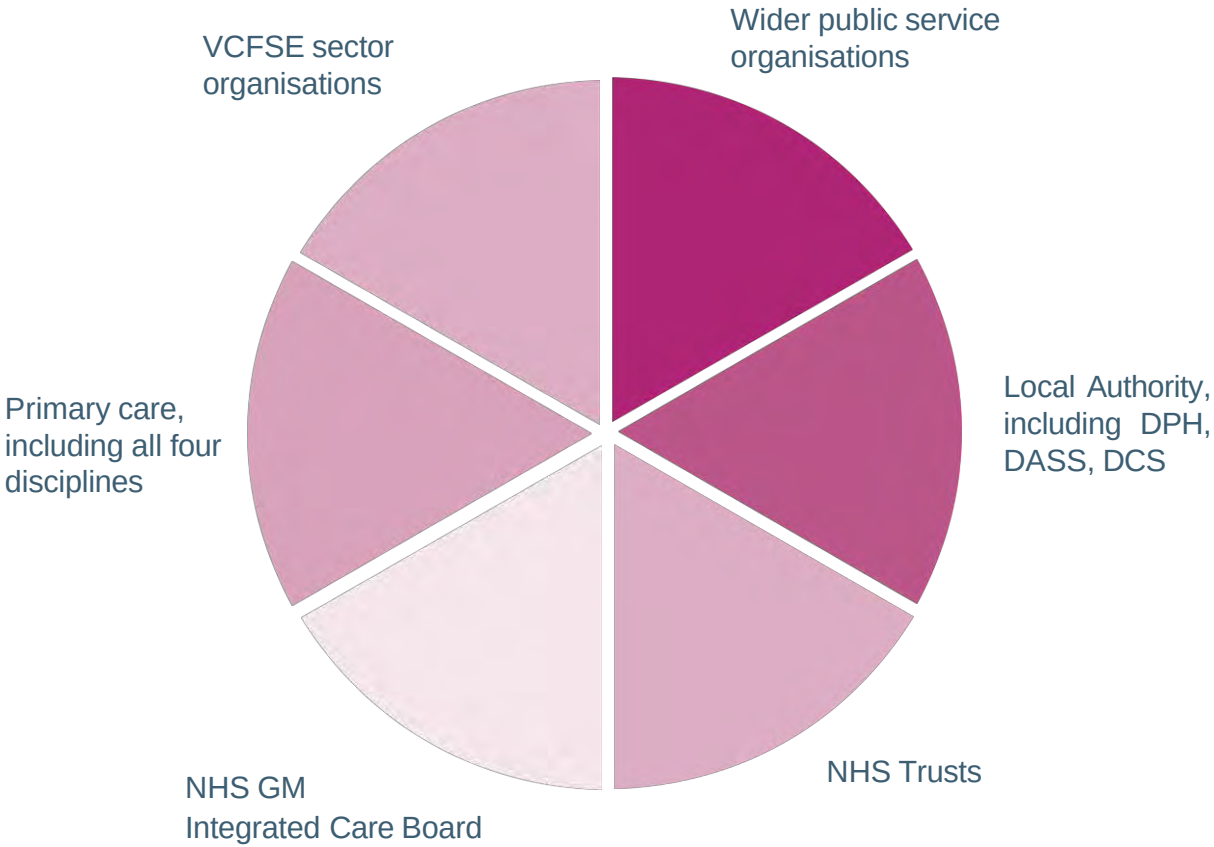
| Model | Scenario Summary |
|---|---|
| Fully Integrated | A single, fully integrated Place Team hosted and line-managed by one organisation, with staff from all partners collectively accountable to the Place Lead and Place Partnership, enabling clear ownership, strong leadership and rapid, joined-up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



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# Governance

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# Place Governance



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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<br>Preferred host: Local Government | Section 75 (added to existing BCF S75s) |
| Place Team | Funded by NHS GM<br>Preferred host: NHS Trust | Contract (added to existing NHS contract) |
| | Alternative host – Local Government | Section 75 (added to existing BCF S75s) |

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

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# Appendix

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# Engagement & Sign Off Plan

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21 -22 May
Reiteration and Amends

1 May
Chief Officer and DPL Check in

6 May
Chief Officer Update

12 May
DPL Session

20 May
Chief Officers – sign off

11 June
Executives Committee – sign off

# 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 | | ✓ |

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



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## Outcome 1

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

## Outcome 2

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

## Outcome 3

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

## Outcome 4

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

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

**Uniform across all 10 PHCPs**

**Delivery measures**

**PHCP Specific**

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

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

Part of Greater Manchester Integrated Care Partnership

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# Narrative Overview: Place Partnership Agreement

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

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

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# Definitions and Glossary

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

## "Accountability"

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

## "Agreement"

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

## "Best for Place"

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

## "Best for GM"

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

## "Commissioning Organisation"

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

## "Delivery Board"

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

## "GM Operating Model"

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

### "Greater Manchester (GM) Strategy"

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

### "Integrated Neighbourhood Team (INT)"

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

### "Local Care Organisation (LCO) / Provider Collaborative"

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

### "Neighbourhood"

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

### "Place Outcomes Framework"

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

### "Partner" or "Partners"

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

### "Partnership Board"

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

### "Place"

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

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**“Place Funding Framework”**

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

**“Place Neighbourhood Plan(s)”**

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

**“Place Health and Care Partnership”**

The Partners working together in accordance with this Agreement.

**“Population Health Management”**

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

**“Reserved Matters”**

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

**“Responsibility”**

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

**“VCFSE”**

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

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# Change Log

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

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| | | |
|---|---|---|
| **027** | Section 10.1 removed some duplication in purpose within the section to support clarity | Completed |
| **028** | Section 75 considerations need to be made either as part of the Agreement, Terms of Reference or as a connected document | Ongoing |
| **029** | Updated following Chief Officer Feedback – Jonathan to make some further additions following consultation with Mills&Reeve and place colleagues (Trafford). | Completed |
| **030** | Section 7.5 added to strengthen the connection and approach to decision making with regards Place Fund, and follow the principles set out in section 8 | Completed |
| **031** | Updates to bring consistency across Accountability, Responsibility and Stewardship | Completed |
| **032** | Rewording to section 1.1 based on feedback to strengthen the context and purpose of this work | Completed |
| **033** | Section 1.3 and 1.4 swapped around to support the flow of the document | Completed |
| **034** | Expansion of aligned, complimentary and supporting documents within section 1.4 | Completed |
| **035** | Further additions/changes are flagged in the feedback tracker on the SharePoint | Completed |
| **036** | Inclusion of sections 5.5 and 6.5 to support opportunities around place team approaches | Completed |
| **037** | Section 1.5 adjustment made to working “Governance Framework” to Terms of Reference | Completed |
| **038** | Inclusion of Section 6.2 to outline the role of the Place Lead | Completed |
| **039** | Section 8.3 added to demonstrate the close connection and relationship to Health and Wellbeing Boards | Completed |
| **040** | Section 10.3 removed to recognise the elements included in previous sections covering the breadth of connection into Clinical | Completed |
| **041** | Section 9.2 updated the ordering to recognise the importance of the commitment to stakeholders and communities | Completed |
| **042** | Consideration to moving “variable” elements of the agreement into a schedule for a cleaner approach to individual place changes | Ongoing |

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# 1. Purpose, Parties and Status of the Agreement

## 1.1 Context and Purpose

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

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

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

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

## 1.2 Parties

This Agreement is made between the following Partners:

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

## 1.3 Principles of Partnership

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

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

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## 1.4 Status of the Agreement

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

## 1.5 Inclusion of New Parties

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

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

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

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# 2. Commencement and Term

## 2.1 Context

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

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

Partners recognise that maintaining the relevance, integrity and effectiveness of this Agreement is a shared responsibility. The commitments in this section ensure that the Agreement remains a living framework, actively stewarded, regularly 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 undergo a formal annual review, ensuring it remains aligned with the Place Outcomes Framework, the GM Operating Model, Greater Manchester Strategy (GMS) and the needs of residents and communities.
- Partners will consider renewal, extension or variation no later than six months before the end of the Term, allowing sufficient time for internal governance processes across all Partners, as sovereign organisations.
- The Agreement may be updated at any time to reflect:
  - changes in legislation or statutory responsibilities;
  - developments in GMS, governance or delegated functions;
  - material changes in the scope, ambition or operating model of the Place Health and Care Partnership.
- Any updates or variations will be agreed collectively through the Partnership Board and approved through each Partner's internal governance arrangements as necessary.

## 2.2 Early Termination

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

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# 3. Shared Vision, Purpose and Strategic Context

## 3.1 Why this matters

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

## 3.2 Greater Manchester Strategic Context

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

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

It also supports the wider Greater Manchester Combined Authority vision:

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

## 3.3 Place Vision

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

## 3.4 Purpose of the Agreement

This Agreement exists to:

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

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# 4. Strategic Priorities and Place Outcomes Framework

## 4.1 Context

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

## 4.2 Strategic Priorities

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

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

## 4.3 Place Outcomes Framework

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

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

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

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

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

## 4.4 How the Place Outcomes Framework will be used

The Place Outcomes Framework will:

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

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

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

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

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

## 4.5 Place Outcomes Framework Principles

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

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

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- providing one version of the truth via a balanced scorecard

### 4.5 Place Outcomes Framework Structure

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

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

**Delivery Measures: Uniform across the 10 Locations**

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

**Delivery Measures: Place Specific**

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

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# 5. System Characteristics, Leadership and Culture

## 5.1 Context

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

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

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

## 5.2 Leadership Characteristics

Partners commit to leadership behaviours that:

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

## 5.3 Cultural Characteristics

Partners will foster a culture that:

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

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

## 5.4 The Place Team

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

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

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

## 5.5 Hosted and Ringfenced Roles

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

These roles may:

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

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

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

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

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

## 5.6 Application

These characteristics will be reflected in:

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

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# 6. Roles, Responsibilities and Collective Capability

## 6.1 Context

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

## 6.2 Place Lead

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

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

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

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

## 6.3 Shared Responsibilities of All Partners

All Partners will:

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

## 6.4 Collective Resource and Capability Commitments

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

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

## 6.5 Operationalising Shared Capability

To make this real, Partners will:

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

## 6.6 Hosted, Assigned and Ringfenced Workforce Arrangements

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

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

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

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

In all cases:

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

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

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

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

## 6.7 Commitment to Continuous Development

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

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

## 6.8 Responsibilities Matrix

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

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

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

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

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# 7. Place Funding

## 7.1 Context

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

## 7.2 The Place Funding Framework

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

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

## 7.3 Principles of Place Funding

The Place Funding Framework is underpinned by the following principles:

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

## 7.4 Application

The Place Funding Framework will be used to:

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

## 7.5 Decision making

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

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

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

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

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# 8. Governance and Decision-Making

## 8.1 Context

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

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

## 8.2 Governance Structure

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

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

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

## 8.3 Health and Wellbeing Board

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

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

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

## 8.4 Decision-Making

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

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

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

## 8.5 Accountability

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

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

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

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# 9. Transparency, Information and Learning

## 9.1 Context

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

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

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

## 9.2 Commitments

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

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

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

## 9.3 Safeguards and Responsibilities

Partners acknowledge that:

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

## 9.4 Commitment to System Learning

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

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

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# 10. Clinical Strategy

## 10.1 Clinical Governance

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

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

Partners agree to work together to:

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

Clinical governance at Place will focus on:

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

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

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

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

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

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

## 10.2 Quality Oversight & Assurance

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

Place quality arrangements will be fully aligned with:

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

The PHCP will support quality by:

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

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

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

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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.

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# 11. Problem Resolution and Escalation

## 11.1 Context

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

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

## 11.2 Principles

When managing disagreements, Partners will:

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

## 11.3 Place Approach

If a disagreement arises between Partners:

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

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

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

a. Independent Facilitator

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

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

b. Mediation

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

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

c. Exit, termination or non-resolution

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

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

- that the issue need not be resolved.

## 11.4 Commissioning Level Disputes

Where a Commissioning Organisation is both:

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

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

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

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

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

## 11.5 Commitment to Learning

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

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# 12. Review, Variation and Evolution

## 12.1 Context

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

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

## 12.2 Commitments

Partners agree that:

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

- incorporate new schedules (e.g., funding, outcomes, operating models) as they are agreed;
- adapt to changes in the scope or ambition of the PHCP.

### 12.3 Transparency and communication

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

## 14. Signatures

*(Signature blocks adapted for each Place.)*

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*Schedule 1 - Place Outcomes Framework*

*Schedule 2 - Place Fund*

*Schedule 3 - Place Team Approach*

**Outcomes Framework: Narrative Introduction**

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

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

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

| Metric Ref | Metric Description | Rationale | Metric Type |
|---|---|---|---|
| | **Reduce inequality** | | |
| Live Well/EX1 | % 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 | 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 | 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 | 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 | 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 | 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 | % 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 | 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 - consis across place |
| EH15 | 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 - consis across place |
| Chil1 | Reduction in dental extractions in children due to dental cavities | Improve health outcomes with specific focus on children and young people as a high-priority cohort | Annual Oversight |
| Chil2 | Reduction in high/very high unmet need for children with asthma (beccor) | Improve health outcomes with specific focus on children and young people as a high-priority cohort | Annual Oversight |
| Chil3 | 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 | 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 | 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 | (a) No. of children re-referred into children’s social care within 12 months<br>(b) No. of children stepped up from Early Help to Social Care* | A successful LW approach will strengthen and enrich existing approaches to early and targeted family help, providing early intervention for families experiencing challenges, helping children thrive within their own homes and reducing the need for intensive social care interventions. Measures reflect success in stemming the flow of | Delivery Metric - consis across place |
| | **Cancer** | | |
| OF0009 | 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 - consis |
| Can1 | Cancer Screening rates | Improve health outcomes for people with cancer through early diagnosis and treatment | Delivery Metric - consis |
| | **Long Term Conditions** | | |
| LiveWell/AD2 | % patients with long-term conditions repeatedly not taking up offers of support who are then identified and helped (“Missingness” positively addressed) | Improve health outcomes for people long term conditions - Initial phases focused of cardio-vascular disease, diabetes and respiratory conditions. Scope for wider expansion to a range of other long-term conditions, e.g. | Delivery Metric - consis across place |
| OF0054 | 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 - consis across place |
| OF0053 | Percentage of hypertension patients treated to target | Improve health outcomes for people with hypertension through improved diagnosis and treatment | Delivery Metric - consis across place |
| LD/SMI1 | 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 - consis across place |
| SMI1 | 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 - consis across place |
| | **Imms** | | |
| Imms2 | Childhood vaccinations | Improve health outcomes with specific focus on children and young people as a high-priority cohort | Delivery Metric - consis |
| Imms3 | Winter illness vaccination rates | Improve health outcomes by prioritising individuals who benefit from vaccination as a key cohort | Delivery Metric - consis |

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

| Metric Ref | Metric Description | Rationale | Metric Type |
|---|---|---|---|
| | **Access to General Practice** | | |
| Live Well/ EX4 | % 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 | 90% of clinically urgent patients on the same day by March 2027 | Improve access to general practice so people can see their GP in a timely, high-quality way | Delivery Metric - consistent across place |
| | **CHC** | | |
| OF00XX | Percentage of continuing healthcare referrals completed in 28 days | Better co-ordination of care for high-priority cohorts | Delivery Metric - consistent across place |
| | **Children and Young People** | | |
| Nat6 | 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 | Reduction of community waits for children, as part of delivering Medium Term Planning Framework success measures | Improve quality and access to care for children and young people by enhancing paediatric expertise across the pathway, including primary care | Delivery Metric - consistent across place |
| | **Community** | | |
| Nat18/OF0025 | For those adult patients not discharged on their DRD, the average (mean) number of days from the DRD to discharge | Ensure there is better co-ordination of discharge process and capacity planning across health and care services, enabling patients to be discharged efficiently and effectively. Contribute to an improvement in the average length of discharge | Delivery Metric - consistent across place |
| Nat17 | The proportion of adult patients discharged from acute hospitals on their discharge ready date (DRD) | Ensure there is better co-ordination of discharge process and capacity planning across health and care services, enabling patients to be discharged efficiently and effectively. Contribute to an improvement in the average length of discharge | Delivery Metric - consistent across place |
| E.D.25 | Increased utilisation of Pharmacy First, Hypertension Case Finding, Contraception services | Better access in community and reduce reliance on others services | Delivery Metric - consistent across place |
| OP1 | 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 | A&G: deliver a 10% increase in requests for Advice & Guidance over 25/26 baseline in 2026/27 | Improve experiences of planned care and support delivery of the referral to treatment (RTT) standard | Delivery Metric - consistent across place |
| EL2 | 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 | Deliver more follow-up outpatient care in neighbourhoods | Delivery Metric - consistent across place |
| EL5 | Referral rates: reduce referrals by 5% across 10 specialties in 2026/27 vs 2025/26 baseline, in line with BeCCoR EQIS scheme | Improve experiences of planned care and support delivery of the referral to treatment (RTT) standard | Delivery Metric - consistent across place |
| Nat12 | 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 | Better identify people coming to the end of life and improve access to services so people can die in a place of their choosing by increasing the number of people identified as approaching end of life by 10% | Better identify people coming to the end of life and improve access to services so people can die in a place of their choosing | Delivery Metric - consistent across place |
| Nat3 | 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 | Reduction in medicines related harm through neighbourhood approaches | Improve safety of care | Delivery Metric - consistent across place |
| | **Long Term Conditions** | | |
| Nat4 | 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 | Reduction in those with high/very high unmet need (CVD, Diabetes, Asthma, COPD) through neighbourhood approaches (beccor) | Improve health outcomes for people with long term conditions | Delivery Metric - consistent across place |
| OF0052 / Nat5 | 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 | Reducing the number of admissions to inpatient settings and reducing length of stay for people with learning disability and/or autism | Improved provision and co-ordination of care people with mental illness. Ensure there is better co-ordination of discharge process and capacity planning across health and care services, enabling patients to be discharged efficiently and | Delivery Metric - consistent across place |
| OF0034 | Percentage change in the number of inpatients who are autistic or have a learning disability | Improving lives of those with LD and/or autism | Delivery Metric - consistent across place |
| EK.5.a and b | 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 | Average LOS (physical and mental health) to be improved | Improved provision and co-ordination of care people with mental illness. Ensure there is better co-ordination of discharge process and capacity planning across health and care services, enabling patients to be discharged efficiently and | Delivery Metric - consistent across place |
| MH2 Also Live | Reducing the number of people presenting to A&E in mental health crisis (all age) | Improved provision and co-ordination of care people with mental illness. Ensure there is better co-ordination of discharge process and capacity planning across health and care services, enabling patients to be discharged efficiently and | Delivery Metric - consistent across place |
| MH1 | Reduction in CRFD for adults, older adults and rehab patients in MH inpatient settings | Improved provision and co-ordination of care people with mental illness. Ensure there is better co-ordination of discharge process and capacity planning across health and care services, enabling patients to be discharged efficiently and | Delivery Metric - consistent across place |
| | **UEC** | | |
| Nat16 | 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 | Reduce non-elective admissions and bed days of one day or over by 10% for people with mild to severe frailty, in a care home or housebound by March 2029 | Help people with mid to severe frailty, in a care home or housebound, to stay healthier, manage escalating conditions and maintain greater independence for longer. | Delivery Metric - consistent across place |
| Nat13 | Keep growth flat and work towards an overall reduction in non-elective admissions for high priority cohorts | Better co-ordination of reactive care for high-priority cohorts (those with mid to severe frailty, in a care home or housebound and end of life), increasing use of urgent care provision in the community. For example, by making use of a | Delivery Metric - consistent across place |
| Nat15 | Contribute to an overall reduction in type 1 ED attendances for high priority cohorts | Better co-ordination of reactive care for high-priority cohorts (those with mid to severe frailty, in a care home or housebound and end of life), increasing use of urgent care provision in the community. For example, by making use of a | Delivery Metric - consistent across place |
| | **Live Well infrastructure** | | |
| Live Well/WOW1 | % of neighbourhoods in each locality with a Live Well access point (Centres and Spaces)<br>% LW centres offering:<br>I. Employment support pathway<br>II. Housing support and advice<br>**III. Mental health & wellbeing support**<br>**IV. Primary care**<br>V. Debt advice & income support* | The ambition through LW is for residents to be able to access support in their local area, with "priority offers" available through their local access points. The metric reflects the five proposed priority offers at the time of writing | GMS Implementation monitoring |

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

| Metric Ref | Metric Description | Rationale | Metric Type |
|---|---|---|---|
| | **Workforce** | | |
| Live Well/WO | % 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 | Staff sickness rate | Improve staff satisfaction | Delivery Metric - consistent across place |
| OF0061 | Staff survey – raising concerns sub-score | Improve staff satisfaction | Delivery Metric - consistent across place |
| OF0084 | Staff survey engagement theme score | Improve staff satisfaction | Annual Oversight |
| Ref TBC | Staff survey - We are compassionate and inclusive headline metric score | Improve staff satisfaction, wellbeing and retention | Annual Oversight |
| Ref TBC | WRES indicator 5 - %staff experiencing harrassment, bullying or abuse from patients/relatives/public | GM agreement via the ICP to combat racism and support staff and communities. | Annual Oversight |
| Ref TBC | WRES indicator 6 - %staff experiencing harrassment, bullying or abuse from colleagues, managers | GM agreement via the ICP to combat racism and support staff and communities. | Annual Oversight |
| Ref TBC | WRES 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 | 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 | Metric Description | Rationale | Metric Type |
|---|---|---|---|
| | **Experience** | | |
| Nat20B | 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 | Improve patient satisfaction with NHS services | Annual Oversight |
| Nat10 | 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 | Improve shared decision making | Improve satisfaction with NHS services | Annual Oversight |
| OV13 | Mental Health services experience scores to be improved | Improve patient satisfaction with NHS services | Annual Oversight |
| | **Financial stability and productivity** | | |
| 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 | 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 | 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 | Place delivers non-financial savings through demand management initiatives - specific metrics TBC | To deliver financial stability | Delivery Metric - consistent across place |
| NEW | 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 | Shift to greater community control of funding and participation in decision-making around how public money is spent<br>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 | GMS Delivery Monitoring |
| | **Quality** | | |
| IMPR1 | Increase in QI capabilities (as evidenced by QI skills question on staff survey) | Embed quality improvement methodology | Annual Oversight |

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# Place Fund

Part of Greater Manchester Integrated Care Partnership

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## Place Fund: Narrative Overview

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

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

## Background and Strategic Context

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

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

## The Financial Opportunity

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

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

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

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

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

**The Place Fund**

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

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

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

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

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

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

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

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

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

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

**Draft Finances**

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

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

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

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

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

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

**Shadow Year**

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

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

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

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

**Future Planning**

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

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

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

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 in order to fully enable this approach.

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

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

NHS
Greater Manchester

# Place Team Framework
# DRAFT V1

Part of Greater Manchester
Integrated Care Partnership

NHS Greater Manchester

## Place Team: Narrative Overview

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

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

## Background and strategic context

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

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

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

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

## The purpose of a Place Team

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

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

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

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

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

**Core place capabilities**

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

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

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

**Skills and expertise across the partnership**

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

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

**Membership of the Place Team**

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

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

Strong links are also required with:

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

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

**How Place Teams operate**

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

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

**Place Health and Care Partnership leadership**

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

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

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

**NHS Greater Manchester's contribution as a partner at place**

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

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

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

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

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

**Approaches to Place Team configuration**

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

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

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

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

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## Implementation and next steps

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

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

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# DRAFT – FOR COMMENT

## Governance Options Appraisal: NHS GM to Place Partnership

Part of Greater Manchester Integrated Care Partnership

NHS Greater Manchester

## Place Governance Options Appraisal: Narrative Overview

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

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

### 1. Introduction

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

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

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

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

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

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

1.6 The options considered within this paper are:

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

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

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

## 2. Governance Options

### Option 1. Internal delegation within NHS GM

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

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

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

**Benefits**

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

**Risks**

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

GM.

**Option 2. Section 75 Agreement (NHS Act 2006)**

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

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

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

**Benefits**

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

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

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

**Risks**

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

**<u>Option 3. Formal Contract (Legally Binding Service Contract)</u>**

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

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

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

**Benefits**

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

precisely defined.

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

**Risks**

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

**Option 4: Memorandum of Understanding (MOU)**

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

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

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

**Benefits:**

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

**Risks:**

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

NHS Greater Manchester

## 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.

NHS Greater Manchester

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<br>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<br>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<br><br>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<br><br>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.

NHS Greater Manchester

# 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)<br><br>Deliverability/effectiveness – 3 (already in place, or will be established anyway but only as single organisation)<br><br>Cost – 5 (within existing resources, as exists already)<br><br>Total - 10 | Strategic alignment – 2 (partners are able to be members of governance but does not reflect spirit of partnership)<br><br>Deliverability/effectiveness – 2 (doesn't achieve staff transfer)<br><br>Cost – 5 (within existing resources, as exists already)<br><br>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<br><br>Strategic alignment – 5 (in line with place partnership approach of operating model)<br><br>Deliverability/effectiveness – 5 (already in place, or will be established anyway)<br><br>Cost – 5 (for LA within existing resources, as exists already for BCF)<br><br>Total – 0 for NHS Trusts as not possible<br><br>**Total – 15 for LAs** | Note – not possible for NHS Trust therefore score of 0<br><br>Strategic alignment – 5 (in line with place partnership approach of operating model)<br><br>Deliverability/effectiveness – 3 (TUPE requirements more complex to non NHS employer)<br><br>Cost – 5 (for LA within existing resources, as exists already for BCF)<br><br>Total – 0 for NHS Trusts as not possible<br><br>**Total – 13 for LAs** |
| **Contract mechanism** – through the NHS standard contract | Strategic alignment – 4 (able to reflect place partnership approach of operating model)<br><br>Deliverability/effectiveness – 5 (already in place) | Strategic alignment – 4 (able to reflect place partnership approach of operating model)<br><br>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)<br><br>**Total – 14 for NHS Trusts**<br><br>Total – 12 for LAs | Cost – 5 for NHS Trusts (within existing resources, as exists already), 2 for LA (due to potential VAT issues)<br><br>**Total – 14 for NHS Trusts**<br><br>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)<br><br>Deliverability/effectiveness – 1 (easy to implement but not clear or firm enough for delivery)<br><br>Cost – 5 (not costly)<br><br>Total - 8 | Strategic alignment – 2 (partners are able to be members of group but informal nature doesn't put sufficient weight behind arrangement)<br><br>Deliverability/effectiveness – 1 (easy to implement but not clear or firm enough for delivery and doesn't achieve staff transfer)<br><br>Cost – 5 (not costly)<br><br>Total - 8 |

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6th July 2026

Dear Colin,

**Subject: Place mobilisation update and next steps on Place workforce employment arrangements**

Thank you for your letter of 26 May 2026, and your request that we confirm our position on Place workforce employment arrangements. This has been considered collectively through our Place Partnership arrangements, and our response is set out below:

1. **Whether Trafford's preferred direction of travel remains transfer to the Local Care Organisation hosted via Manchester University NHS Foundation Trust.**

Our preferred direction of travel remains that the place team transfer to the employment of Manchester University NHS Foundation Trust aligned to the Local Care Organisation, supporting the wider Place Health and Care Partnership.

This position is recognised as the preferred option by GMMH. From a Mental Health perspective the proposed arrangements assume that Mental Health commissioning continues to be undertaken at a GM level, in line with the agreed GM strategy and fully aligned to Mental Health provision.

2. **Confirmation that there remains organisational willingness in principle to act as the receiving employer on behalf of the partnership.**

There remains organisational willingness, pending due diligence and the further information requested below.

3. **Any key considerations, dependencies or updated local context we should be aware of.**

We have recently appointed to a 6-month (flexible) Place Director role filling the vacancy which materialised following the previous postholder departure from Trafford. As we work towards the place transfer we will ensure that the proposed arrangements for this role ensure the capacity within the place team is optimised in supporting the Place Partnership. Whilst the proposed employment arrangements for the Place Team do not preclude options that are currently under consideration for the role, we note that we will work together to finalise these arrangements in due course.

We would ask that the proposed structure for the Place team is shared, including details of which posts would transfer with a postholder versus those that would transfer as vacancies.

We would ask for confirmation of the Place Team hosting arrangements including but not exclusively the proposed budget to be transferred to support the team and the mechanism through which the funding would be transferred, along with details of future funding arrangements to ensure that such funding would be sustainable (e.g. inflationary uplift) and whether ringfenced arrangements for this funding will be applied.

We request confirmation of the funding source for Place teams across GM and whether it is included in the overall running costs of the ICB or taken from commissioning budgets.

We welcome the commitment to strengthen place leadership, neighbourhood delivery, prevention and integrated working across Greater Manchester but would request clarity via the developing Place Health and Care Partnership Framework to receive finer detail regarding accountability, reporting arrangements and capacity of the Place Team in relation to central NHS GM functions.

We would request details of the reporting and lines of accountability for the Place function into the ICB under the new structures

Acknowledging that work is currently underway via the Place Health and Care Partnership Framework within NHS GM to more clearly define the roles and responsibilities of the Central ICB and Place Teams, clarity is requested on the formal connections that would exist post transfer between the Place team and functions that are being managed centrally by the ICB. These include critical enabler functions such as business intelligence/data analytics and finance, and additional functions such as Strategic Commissioning, Safeguarding, SEND, Individualised Packages of Care, including Continuing Health Care. We remain concerned that Place teams will not receive the support required to deliver their functions without the appropriate working and governance arrangements being established. It is therefore important to understand how the Place team will work together with those functions, as well as the expectations on those functions to work with Place Teams and the wider Place Partnership including statutory officers in the Local Authority (Director Children's Services / Director Adult Services / Director Public Health).

We recognise the significant opportunities that we have to transform the way that we deliver services, integrating care and supporting people to live longer, healthier lives. It is important that we get the new Place arrangements right and we are committed to working together to ensure the new operating model is a success.

Yours sincerely,

Mark Cubbon
Chief Executive, Manchester University NHS Foundation Trust

Sara Todd
Chief Executive, Trafford Council & Place Based Lead

Chris Oliver
Chief Executive, Greater Manchester Mental Health NHS Foundation Trust

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cc: Patricia Davies, Chief Executive, Trafford Local Care Organisation

| | | | | |
|---|---|---|---|---|
| **Name of Committee / Board** | Trafford Locality Board | | | |
| **Date of Meeting** | Thursday 23rd July 2026 | | | |
| **Report Title** | Trafford Integrated Neighbourhood Team Model Update | | | |
| **Report Author & Job Title** | Thomas Maloney, Programme Director Health and Care, Trafford Council / NHS GM | | | |
| **Organisation Exec Lead** | Thomas Maloney, Programme Director Health and Care, Trafford Council / NHS GM | | | |
| **OUTCOME REQUIRED** | Approval | **Assurance** X | **Discussion** X | **Information** X |

## EXECUTIVE SUMMARY

This presentation seeks to present progress regarding two core components of our overarching Trafford Integrated Neighbourhood Team Model:

1. Trafford Health & Care Multi-Disciplinary Teams x4 (MDT)
2. Neighbourhood Leadership Teams x4 (NLT)

The presentation is a high-level summary of more detailed papers which have been coproduced with partners and regularly taken through the established INT Working Group and the Trafford Provider Collaborative Board and the newly established Trafford Joint Leadership Group (Effective July 26).

The update contains key information as to how we are working towards delivery of a consistent, place-based approach to integrated working, bringing together health, social care and community partners to improve health outcomes, reduce avoidable hospital admissions and care placements, and promote independence. It describes how a defined MDT workforce, revised eligibility criteria, referral and delivery arrangements will support residents with complex and overlapping needs. It also describes progress made on establishing a vision, purpose, deliverables and practical details of the proposed NLTs, including dedicated leadership roles, project and coordination support.

## RECOMMENDATIONS

Trafford Locality Board is asked to:

- Note the proposed Trafford Health & Care MDT and Neighbourhood Leadership Team models
- Support continued engagement with partner organisations to confirm workforce capacity and resource contributions via senior organisational decision making forums.

## CONSIDERATIONS – these must be completed before submission to the Board – Reports with incomplete coversheet information will not be accepted and shared with the board

| | |
|---|---|
| **Risk implications** ***(Please provide a high-level description of any risks relating to this paper, including reference to*** | Failure to secure sufficient workforce capacity, partner commitment and resources may impact successful implementation of both models. There is also a risk that inconsistent participation across organisations could limit |

| | |
|---|---|
| ***appropriate organisational risk register)*** | the effectiveness of integrated working and achievement of intended outcomes. Risks relating to governance, information sharing and ongoing sustainability will need to be managed through implementation arrangements and existing organisational governance processes. |
| **Financial implications and comment/approval** ***(Please detail which organisation(s) will be impacted, and if not required, please briefly detail why)*** | Name/Designation: Thomas Maloney, Programme Director Health and Care, Trafford Council / NHS GM |
| | Comment:<br>The model is intended to be delivered through a collaborative contribution of existing resources and workforce capacity from partner organisations. Discussions are ongoing with Trafford Council, NHS GM Place Team and VCFSE partners regarding workforce and funding commitments necessary to support implementation. Any additional financial implications will be identified through the Executive-to-Executive sign-off process. |
| **Comment by Trafford Clinical and Practitioner Senate (TCAPS) and/or Clinical Lead** ***(If not required, please briefly detail why)*** | Date of Clinical Lead comment: N/A |
| | Name/Designation: Thomas Maloney, Programme Director Health and Care, Trafford Council / NHS GM |
| | Comment:<br>The proposed model aligns with neighbourhood-based integrated care principles and supports proactive management of residents with long-term conditions, complex needs and risk of avoidable hospital admissions. Clinical representation is embedded within the MDT model through General Practice, Case Management Nursing, Physiotherapy, Occupational Therapy and Mental Health Practitioners. |
| **What is the impact on inequalities? (P*lease provide a high-level description of any known impacts)*** | The proposed MDT model is expected to reduce health inequalities through earlier identification of need, improved access to coordinated support and enhanced community-based care. The model specifically aims to support vulnerable residents and will monitor access, activity and outcomes through a health inequalities and Fairer Trafford lens across neighbourhoods and population groups. |
| **Equality Impact Assessment / Quality Impact Assessment Outcome** ***(If not appropriate at this stage please state if an EIA or QIA is necessary)*** | NA |
| **People and Communities: Communications & Engagement** ***(Please detail relevant patient/public engagement completed and/or planned, and if not required please briefly detail why)*** | The models have been informed through extensive engagement with system partners, including learning from the Central Neighbourhood pilot, MDT mapping exercises, partner workshops, neighbourhood intelligence, research evidence and collaborative design activity across Trafford organisations. Ongoing |

| | |
|---|---|
| | engagement will continue through partner governance processes and implementation planning. |
| **Trafford's Carbon Footprint** ***(Please provide a high-level description of any known positive and/or negative impacts – consider the following topics: energy usage; staff or public transport; waste or materials used. Include steps that could be taken to reduce carbon within relevant plans)*** | The MDT model may contribute positively to Trafford's carbon footprint by supporting more care closer to home, reducing unnecessary hospital activity and enabling residents to access support within their local neighbourhood. The use of hybrid meetings where appropriate may also reduce staff travel. Future co-location arrangements should consider sustainable use of existing estate and facilities. |
| **Links to Measurement / Outcomes** ***(Please detail if this is included within the report)*** | The report includes a proposed outcomes and measurement framework for H&C MDT model, and the NLTs will be responsible for monitoring performance against their agreed Neighbourhood Action Plan. These measures will align with the developing Place Partnership Outcomes Framework. |
| **Enabler implications** | **Legal implications:** Appropriate information-sharing, consent and governance arrangements will be required to support multi-agency working and MDT decision-making across organisational boundaries. |
| | **Workforce implications:** Both models require dedicated participation from Care Navigators, Administrators, Social Workers, Occupational Therapists, GPs, Physiotherapists, Social Prescribers, Case Management Nurses and Mental Health Practitioners, alongside wider partner representation where required. Workforce capacity and organisational commitment remain key implementation requirements. |
| | **Digital implications:** The model will require effective information sharing, coordinated case management processes and facilities to support hybrid MDT meetings. Existing systems should be utilised where possible. |
| | **Estates implications:** The are no identified estates implication as a hybrid model has been favoured for the H&C MDT Model and the Neighbourhood Leadership teams will sue existing neighbourhood based venues. |
| **Sub-Board Sign-Off / Comments** **(i.e. Trafford Provider Collaborative Board, H&SC Delivery Steering Group)** | The INT Working Group and Trafford Provider Collaborative Board have been co-authors of the detailed papers behind each of the proposals, with the detail summarised for the purposes of the presentation. |
| **Organisation Exec Lead Sign off** | Thomas Maloney, Programme Director Health and Care, Trafford Council / NHS GM |

# Trafford Integrated Neighbourhood Model Update

Health and Care MDT Model
Neighbourhood Leadership Teams

July 2026


Trafford
Integrated Care Partnership

Part of Greater Manchester Integrated Care Partnership

**Trafford Neighbourhood Plan:**

# Integrated Neighbourhood Teams Model (Draft)

Trafford
Integrated Care Partnership

## Multi-Disciplinary Teams, Services and Offers

- Trafford Team Together
- Central INT (Pilot)
- WorkWell
- GP High Intensity User MDT
- Changing Futures

In Trafford we have several established Multi-Disciplinary Teams (MDT) and services that fit within and strengthen the Trafford Live Well Neighbourhood Team approach. These MDT's and integrated services embody our shared values and work collaboratively in neighbourhoods, delivering integrated offers to our diverse communities. Each MDT or service will focus on a particular cohort or thematic area such as families, young people, complex adults, community safety, health inequalities, or community resilience

## Neighbourhood Leadership Teams


The Neighbourhood Leadership Team (NLT) exists to bring together key partner organisations, public services, voluntary and community sector partners, residents, housing providers, health, police, and others into a single leadership forum that jointly owns the vision, priorities, and holds accountability for the delivery of a Neighbourhood Action Plan

Neighbourhood Action Plans


## Live Well Integrated Neighbourhood Team

Trafford's Live Well Neighbourhood Teams are locally rooted, multi agency partnerships that bring together health services, social care, primary care, mental health, housing, employment support, and the VCFSE sector across a neighbourhood network to work across the life-course around the needs of residents.

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# Trafford Neighbourhood Leadership Teams

**Trafford Neighbourhood Leadership Teams:**

## Vision and Purpose

Trafford Integrated Care Partnership

## Neighbourhood Leadership Team Vision

*"To bring together partner organisations into a single, decision-making leadership forum at a neighbourhood level to deliver the best outcomes for residents through a data and intelligence informed Live Well Neighbourhood Action Plan"*

## Neighbourhood Leadership Team Principles

By working together our Neighbourhood Leadership Teams will support:

- Trafford residents to be part of **stronger communities**
- Trafford residents to live **healthy and independent lives** where possible
- Our most **vulnerable residents** to live better lives

**Trafford Neighbourhood Leadership Teams:**

# Purpose and Deliverables

Trafford Integrated Care Partnership

## Neighbourhood Leadership Team Purpose

- Provide strategic leadership and coordination at neighbourhood level.
- Strengthen partnership working and integration across agencies
- Drive operational delivery of neighbourhood plans that focus on reducing inequalities and improving equity, aligned with BeCCoR, Live Well and Fairer Trafford principles
- Embed public participation and lived experience
- Monitor progress, impact, and performance against shared metrics

## Deliverables

- A Bespoke Neighbourhood Action Plan
- Joint Performance Framework
- Coordinated Partnership Delivery Model
- Community Engagement and Co Production Plan
- Integrated Problem-Solving Initiatives
- Annual Neighbourhood Impact Assessment
- Resource Coordination and Optimisation

**Trafford Neighbourhood Leadership Teams:**

# The Team

Trafford Integrated Care Partnership

## The Team

Whilst each neighbourhood has the same core vision and aims, the different cohorts and organisations within them mean that make-up of each NLT may differs in response.

For example, where there may be a strong homelessness presence from VCFSE organisations one neighbourhood, this organisation will be included in membership for that specific neighbourhoods but not all four.

This ensures NLTs can address Neighbourhood specific issues in a more holistic way. We have agreed a core and extended membership

## Meeting Arrangements

- Meeting Frequency: **Bi-Monthly,** remaining flexible
- Administration: Utilising available funding to create necessary capacity
- Project Support and Coordination: A partnership commitment
- Chairing: Neighbourhood Leads

**Trafford Neighbourhood Leadership Teams:**

# Next Steps

Trafford Integrated Care Partnership

- Agree **resourcing and recruitment** for basic **administration**
- Agree **project management support and coordi**nation for the mobilsation phase pending a future review of requirements
- Develop an outline '**Organisation/Team Develop**ment' support offer in partnership with the NLTs
- Agree **go-live dates** for each NLT

Trafford
Integrated Care Partnership

# Trafford Health and Care MDT Model

**Trafford Health and Care MDTs:**

# Vision and Principles

Trafford
Integrated Care Partnership

## Trafford Health & Care MDT Vision

*"A connected neighbourhood where people experience seamless, person-centred support close to home, enabled by integrated multi-disciplinary teams working together to improve health, wellbeing and independence through prevention and community-based care"*

## Trafford Health & Care MDT Principles

By working together our Trafford Health and Care MDT will support:

- Trafford residents to be part of **stronger communities**
- Trafford residents to live **healthy and independent lives** where possible
- Our most vulnerable residents to **live better lives**

**Trafford Health and Care MDTs:**
**Purpose**

Trafford
Integrated Care Partnership

# Health & Care MDTs: Purpose

- The purpose of the H&C MDT model is to deliver a consistent, place-based approach to integrated working across all four neighbourhoods, **improving outcomes for people with complex and overlapping needs.**

- Building on the learning from the Central pilot, the H&C MDT pilot we will **strengthen early identification, enable proactive, coordinated "team around the person"** support, and enhance collaboration across health, social care, and wider partners.

- Through this, it will embed a sustainable, neighbourhood-based model that ensures those **residents who require an MDT approach will experience seamless, person-centred support close to home,** improving population health outcomes, and shift the system towards a more preventative model of care and support.

**Trafford Health and Care MDTs:**

# The Team

Trafford Integrated Care Partnership

## Health & Care MDT
## The Team

**The core team would consist of:**

- Care Navigator
- Administration
- Social Worker
- Occupational Therapist
- General Practice
- Physiotherapist
- Social Prescriber / Link Worker
- Case Management Nurse (or equivalent)
- Mental Health Practitioner

- Attendance and liaison where necessary from wider partners, will support more complex cases requiring cross agency involvement.
- The team will also be able to refer to specialist MDTs in the system where appropriate such as onward referral routes that are being curated as part of work under the stewardship of the Changing Futures Steering Group and a broader Making Every Adult Matter (MEAM) framework.
- Named representatives for each core role and key partner organisations will be identified within each neighbourhood to strengthen accountability and continuity.
- The core MDT membership should include representatives with sufficient seniority, authority and delegated decision-making responsibility to enable timely decisions, coordinated action and rapid resolution of barriers.

**Trafford Health and Care MDTs:**

# Eligibility Criteria

Trafford Integrated Care Partnership

## Health & Care MDT
## Eligibility Criteria

- Must be registered with a Trafford GP and at risk of an unplanned hospital admission or being admitted to a care or residential home, where this could be avoided through proactive health and/or social care support. Or have one or multiple of the following long-term conditions:

✓ **CVD**

✓ **Diabetes**

✓ **COPD**

✓ **Dementia**

- Fundamentally there needs to a clear requirement for an MDT approach to enable better outcomes for the resident.
- The H&C MDT's are not a team working on singular issues that can be resolved in one organisation, one department or by one clinician/practitioner, therefore careful consideration is required as to appropriate referrals.
- This must be supported by local triage arrangements to ensure flexibility and avoid unintended exclusion of residents with complex needs.

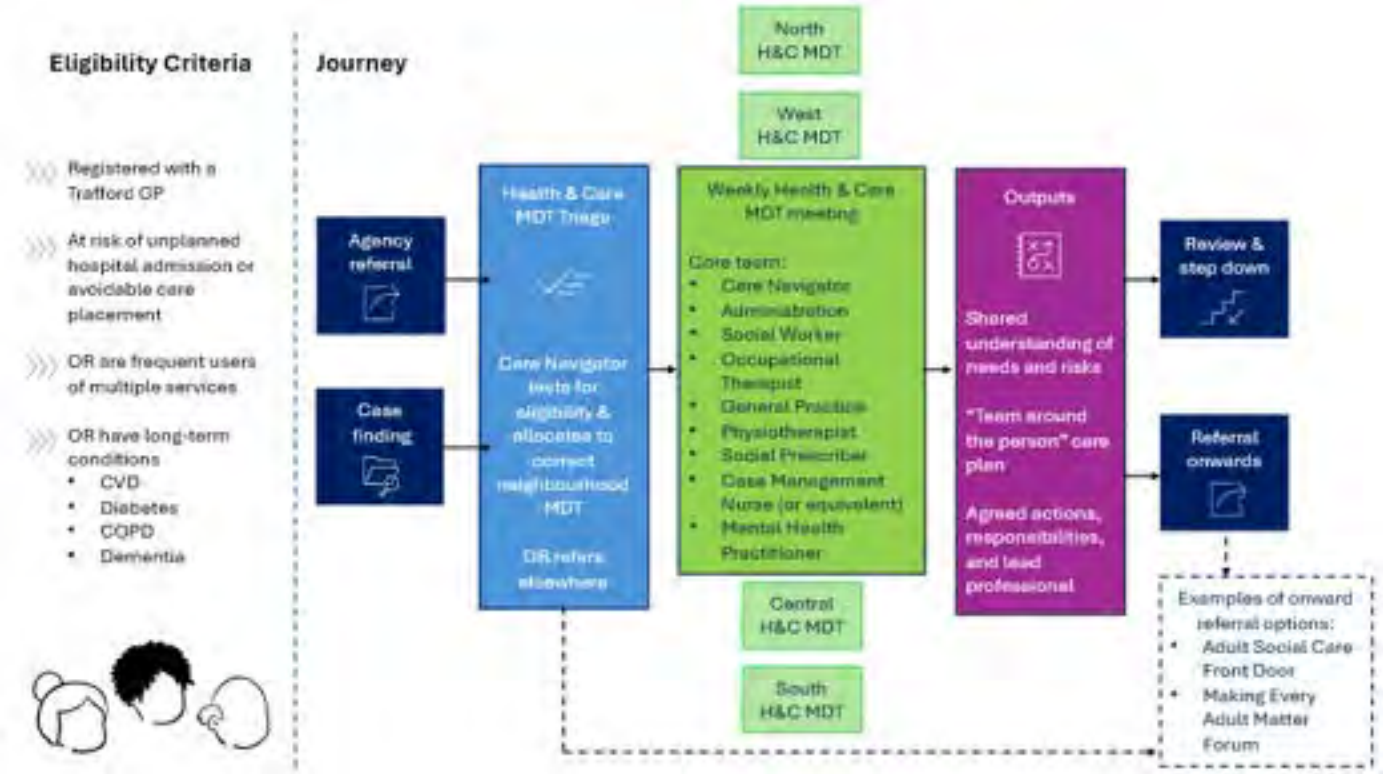
**Trafford Health and Care MDTs:**

# Eligibility Criteria

Trafford
Integrated Care Partnership

- Cases can be proactively identified internally by H&C MDT members from the constituent partners. People can, with their consent, be referred by a range of agencies
- Meetings will be hybrid based on efficiency and effectiveness
- Further work to be carried out on measuring impact
- Actively discussing resourcing of the required roles (Care Navigation and Business Support)

## Health & Care MDT Delivery Model



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# Recommendations

**Trafford Integrated Neighbourhood Team:**

# Recommendations

Trafford Integrated Care Partnership

The Board are asked to:

- Note the proposed Trafford Health & Care MDT and Neighbourhood Leadership Team models.
- Support continued engagement amongst partner organisations to confirm workforce capacity and resource contributions via senior organisational decision-making forums.

| | | | | |
|---|---|---|---|---|
| **Name of Committee / Board** | **Trafford Locality Board** | | | |
| **Date of Meeting** | **23/07/2026** | | | |
| **Report Title** | **Director of Public Health Annual report 2025/26** | | | |
| **Report Author & Job Title** | **Claudia Cohen, Public Health Registrar, Helen Gollins Director of Public Health** | | | |
| **Organisation Exec Lead** | **Cllr Slater** | | | |
| **OUTCOME REQUIRED** *(please highlight)* | Approval | Assurance | Discussion | Information X |

## EXECUTIVE SUMMARY

The Director of Public Health has a duty to write an annual report about the health of their population and it is the local authority's duty to publish it[i], in order to inform the public and decision makers about key health issues that require attention. The content and structure may be decided locally. This year, we focussed on older adults, looking at how we can help our population thrive in later life. We used the book Joyspan, written by a leading doctor of older adults, to structure the report. "Joyspan" refers to the time spent experiencing joy and fulfilment in life, and can be achieved through 4 concepts: Grow, Connect, Adapt, Give. For each concept we: reviewed the evidence for its effectiveness in helping people age well; identified what is already in place in Trafford to help achieve it; and considered what could be done to improve residents' ability to enact the concept. We also used "Guest Editors", four older adults from different areas and backgrounds from across the borough. They were given the body of the report and asked to provide their personal reflections, in order to get the residents' perspectives of thriving in later life.

## RECOMMENDATIONS

1. As a system commitment to widening participation, prioritise engagement with older male residents living in less affluent parts of the Borough to better understand how we can support them to take up and complete referrals to programmes such as PARS and talking therapies, as well as opportunities in the VCFSE sector such as the Mile Shy club. Use this insight to inform local commissioning decisions.
2. The Public Health Directorate, with support from the Trafford Community Collective, to allocate small grants funding for VCFSE organisations to bid to run projects with older adults that focus on the 5 ways to wellbeing (connect, be active, learn, give, take notice). Particular focus to be given to those who are most isolated, such as LGBTQ groups and carers.
3. Support coordinated communications and engagement activity to raise awareness of opportunities across Trafford for older people to participate in activities that support mental and physical wellbeing. This should include accessible paper-based information (for example What's on Where guides) alongside digital promotion. Neighbourhood networks will play a facilitating role, helping to connect formal communications with local knowledge, trusted relationships and feedback from older residents.
4. System partners to make better use in commissioning decisions of evidence for the efficacy of using creative arts for health gain – explore feasibility of expanding activities that help older adults move more and impact positively on mental health such as 'dementia discos'.
5. Consider ways in which transport can be provided to enable more older people to participate in social activities by building on the learning from Ageing in Place in Old Trafford regarding active travel and barriers for older residents. Age UK Salford and Trafford will be continuing this work via Live Well in Later Life (formerly Ageing in Place).
6. Neighbourhood networks and community hubs to continue to build on work to prioritise interventions that address loneliness.

7. As a system explore the potential for measures of belonging and social connectedness to be included in Trafford neighbourhood scorecard and our Neighbourhood Performance Arrangements, to ensure qualitative aspects are also captured. Consider including social capital and connectiveness within service specifications.
8. As a system take a joint, proactive strategic approach to co-ordinating and promoting awareness of support available to Trafford residents specifically during life changes. Priority focus to be given to bereavement support, living well with dementia, managing long term conditions and caring.
9. Encourage self-care opportunities amongst older adults:
    - Public Health Directorate and neighbourhood leads to proactively encourage older adults to attend health checks
    - Public Health Directorate to work with Trafford Carers Centre to deliver a mental wellbeing project.
10. As a system collectively challenge ageism and stereotypes and advocate for inclusive language that celebrates older age, including in reports and grants applications. Involve the Council's communication teams to ensure change throughout the organisation 11. Trafford Community Safety Partnership to explore potential routes for securing longer term funding of the Safer Ageing Domestic Abuse Advisor (SADAA)
11. The Public Health Directorate, with support from the Trafford Community Collective, to allocate small grants funding for VCFSE organisations to bid to run projects with older adults that focus on the 5 ways to wellbeing, with particular focus to be given to those who are most isolated, such as LGBTQ groups and carers.
12. Trafford Council and Trafford Community Collective to pilot a signposting service for older adults towards volunteering opportunities, helping them to connect with others and their community. Trafford Community Collective to review the current Volunteering Strategy.
13. Public Health Directorate and the neighbourhood network leads, supported by the VCFSE Engagement Officers, to advertise the Ageing in Place (Live Well in Later Life as of January 2026) and South Network's Older Adults Group to encourage older adults to further take up civic engagement opportunities.

| **CONSIDERATIONS – these must be completed before submission to the Board – Reports with incomplete coversheet information will not be accepted and shared with the board** | |
|---|---|
| **Risk implications** ***(Please provide a high-level description of any risks relating to this paper, including reference to appropriate organisational risk register)*** | N/A |
| **Financial implications and comment/approval** ***(Please detail which organisation(s) will be impacted, and if not required, please briefly detail why)*** | Name/Designation: Not required, report for information only |
| | Comment / Approval *(Delete appropriately): NA* |
| **Comment by Trafford Clinical and Practitioner Senate (TCAPS) and/or** | Date Clinical Lead comment (Delete appropriately): |
| | Name/Designation: Manish Patel, Place Medical Director |

| | |
|---|---|
| **Clinical Lead** ***(If not required, please briefly detail why)*** | Comment: |
| **What is the impact on inequalities?** **(P*lease provide a high-level description of any known impacts)*** | Inequalities are explored in the report, such as in HLE and in uptake of services and support for certain groups of older adults. As a result, recommendations include prioritising engagement with older men and those in less affluent areas to understand how we can support them to uptake referrals, and allocating grants to fund VCFSE organisations to run wellbeing projects for those more isolated like carers and LGBTQ groups. |
| **Equality Impact Assessment / Quality Impact Assessment Outcome** ***(If not appropriate at this stage please state if an EIA or QIA is necessary)*** | N/A not necessary |
| **People and Communities: Communications & Engagement** ***(Please detail relevant patient/public engagement completed and/or planned, and if not required please briefly detail why)*** | Guest editors were consulted. These were 5 residents across Trafford, two of whom were care home residents. A full comms plan has been drafted, and a short version of the report will be printed to be distributed around Trafford. |
| **Trafford's Carbon Footprint** ***(Please provide a high-level description of any known positive and/or negative impacts – consider the following topics: energy usage; staff or public transport; waste or materials used. Include steps that could be taken to reduce carbon within relevant plans)*** | We are publishing the full report online only rather than in print, given its length.<br>We are publishing the short report in print (200 copies), balancing the need to reduce waste with ensuring older residents are not digitally excluded.<br>No other impacts. |
| **Links to Measurement / Outcomes** ***(Please detail if this is included within the report)*** | No specific links to measurements, but report to be shared and used to inform work going forward with ageing well. |
| **Enabler implications** | **Legal implications: NA** |
| | **Workforce implications: NA** |
| | **Digital implications: Report to be added to Council Website** |
| | **Estates implications: NA** |
| **Sub-Board Sign-Off / Comments** **(i.e. Trafford Provider Collaborative Board, H&SC Delivery Steering Group)** | Has been presented at Trafford Health and Wellbeing Board |
| **Organisation Exec Lead Sign off** | Cllr Slater |

Trafford
Integrated Care Partnership

[i] Directors of public health in local government: roles, responsibilities and context - GOV.UK

TRAFFORD COUNCIL

# Trafford Council Public Health Annual Report 2025–26: Thriving in Later Life

## A Short Summary

# Introduction

**People are living longer, and the proportion of older people is increasing. Staying healthy is not just about living longer or genetics – it's also about the amount of time we feel happy and fulfilled. This has been called "joyspan" and experts suggest this can be achieved by growing, connecting with others, adapting to change, and giving to others.**

Trafford is already recognised as an age-friendly place. We want to maintain an environment that helps residents do all these things, so they can feel positive and fulfilled for longer, whilst recognising the challenges that may come with ageing. This report explains how.

## Grow

**"*Grow*"** means lifelong learning, staying active, having purpose, and being open to new experiences. Keeping active helps keep our minds sharp, reduces anxiety and boosts self-confidence. It's never too late to start to feel the benefit. In Trafford there are many opportunities to become more physically active including physical activity referral programmes, strength and balance classes, and a range of offers provided by voluntary organisations with some subsidised by the Council, such as the Mile Shy Running Club.

Opportunities for keeping our minds sharp as we age include a men's activity hub run by Age UK Salford and Trafford and the University of the Third Age (U3A) which offers a wide range of classes, from Bridge to Table Tennis, in Hale, Davyhulme and Sale. Creative activities like music or movement help people to feel better in their bodies and minds.

In 2025/26, Trafford Council offered small grants for community organisations to run wellbeing projects for older adults who are more isolated. Our guest editors[1] told us that sensory issues can limit participation, and so activities need to be inclusive. One of our recommendations is to help people know about the range of activities that they can access in their neighbourhood and to communicate this using hard copy information like What's on Where guides as well as using online methods of communication.

1. We asked four Trafford residents to read our report and give their reflections on their reflections on thriving in later life

# Connect

"***Connect***" means building and maintaining relationships that give a sense of belonging. This helps reduce loneliness, which puts us at more risk of physical and mental health conditions. Older adults are at risk of loneliness as they may face things like bereavement, caring responsibilities and isolation. In North Trafford the Ageing in Place group, made up of community residents, aim to create a supportive neighbourhood for older adults and to address factors that lead to unfair differences in health outcomes. They have worked on a mural for Trafford Bar tram stop and held the Ayres Road Festival. A directory of chatty cafes in South Trafford helps connect people, and a Community Transport Project in the Central neighbourhood helps get people to appointments. Volunteers in Trafford libraries are providing hands-on guidance for older people to connect through technology so that they can pursue hobbies or keep in touch with family. Age UK Salford and Trafford's social prescribing service for older adults has also helped to provide opportunities for social connection.

Guest editors reminded us that care home residents can still feel lonely. They highlighted music as a powerful way to lift mood and connect. Trafford Council are commissioning "Dementia Discos", where older residents can enjoy music and connection. We are exploring how to improve transport for older adults, and we support neighbourhood networks and groups that help connect older residents.

# Adapt

***"Adapt"*** is about staying resilient when encountering life's challenges. Life changes in later life may include retirement, becoming a carer, navigating health challenges, bereavement, or changes in living arrangements. Building resilience means being more able to manage difficulties when they come.

Carers can get support from Trafford Carers Centre, which offer free health checks, financial advice and respite. Trafford Council has run two "Living Well with Demetia" days in Trafford, which helped connect over 800 residents with organisations providing support. There is support for those with health problems, like Happier Healthier Me run by the Voice of BME, who provide health checks and cooking classes. Our guest editors valued peer-support groups such as the Autism Support Group.

Trafford Council also commission stop smoking services and health checks to older adults through Age UK Salford and Trafford. Trafford Adult Social Care help those with mental and physical health problems, disabilities, carers, and older people by referring them to Community Link Officers, who can help people access services they may have faced barriers to. The Trafford Collective also played a key role in helping older adults to access pension credit and winter fuel payments they were entitled to. A bereavement services event organised by the council in 2025 is set to be repeated, providing an opportunity to help residents and families talk about death and raise awareness of the support, advice and care that is available for helping to deal with end of life.

Trafford Council will continue to work closely with the community in raising awareness of services for bereavement, caring, dementia and health problems, and will keep promoting health checks. We will work with our Health and Social Care and voluntary sector partners to challenge ageism and use inclusive language that celebrates older age.

## Give

***"Give"*** is about helping the needs of others and giving to wider society - for example through activities such as volunteering, community service, or participation in social and political activities. This can increase independence, physical activity, and quality of life. Volunteering with other generations has a positive effect on children's views of older adults, helping to challenge ageism in society. Older adults are the most likely group to volunteer and bring valuable skills and experience. In Trafford older adults already volunteer with School Streets, helping children get to school safely, in faith settings, and in charities like Age UK Salford and Trafford.

Older adults participating in the Ageing in Place group have improved the place they live by lobbying for benches along Ayres Road to help people with mobility issues.

Our guest editors also highlighted that "Give" can be achieved by simple acts of kindness, like reading the news to a friend, which can make a big difference to their day.

There are many volunteering opportunities in Trafford, but they can be hard to find. Trafford Council are therefore funding a signposting service to help older adults find volunteering roles and connect with their community. Guest editors also suggested a local printed newspaper to share volunteer opportunities, advice and local stories.

# Conclusions

**This report explains why helping older people in Trafford to grow, connect, adapt and give can support them to live healthier, happier lives. Many activities already exist across the borough, and local information about our older population helps us understand where more support is needed.**

Recommendations for Trafford Council and our partners focus on working together across health, the council and community groups to involve those facing isolation, fund local wellbeing projects, improve access to activities, support people through life changes, challenge ageism, and create more chances for older adults to volunteer, have their say and participate in their community.

More examples of Opportunities to Grow, Connect, Adapt and Give in Trafford are included at the end of this booklet.

## Other Examples of Opportunities to **Grow, Connect, Adapt, and Give in Trafford**

| Activity | Information | Contact details |
|---|---|---|
| **Falls Prevention Classes**<br><br>**Healthy Hips and Hearts Classes** | These are falls prevention classes, that work on strength and balance. Referral required<br><br>Healthy Hips and Hearts Classes also offered, no referral needed | Age UK Trafford and Salford<br><br>Contact Tom Snape<br>phone: 0161 672 9642<br><br>email: tom.snape@ageuksalfordandtrafford.org.uk |
| **Healthy Hips and Heart Hearts** | Exercise sessions to help with general everyday life. Seated and standing options are available. Please call for availability. | Voice of BME<br>Contact<br>**0161 848 7018** |
| **Heathy Hips and Hearts, Hearts**<br><br>**Strength and Cardio sessions** | | The Hub, Altrincham<br>Contact the Hub office on<br>**0161 941 2018** or info@ourhub.org |
| **Walking Football, Urmston** | A walking football group run by Age UK Salford and Trafford for women | Age UK Salford and Trafford<br>Contact Alison McKenna, **07918577383** or email alison.mckenna@ageuksalfordandtrafford.org.uk |
| **Head Start** | a free and inclusive physical activity programme designed to promote mental health | Sale Sharks Foundation,<br>Email **eamon.hasoon@salesharks.com** |

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| **Empower You** | Dance and exercise classes for those with learning impairments, autism and their carers and family | Call or text **07529 224 226** (call or text) or rachael.mallard@beyondempower.co.uk |
| **Physical Activity Referral Service, Trafford Leisure** | Offers tailored 12-week activity programmes suitable for your needs and abilities | Ask your GP for a referral, email activeliving@traffordleisure.co.uk |
| **University of the Third Age (U3A)** | Offer range of classes like Origami, Egyptology, Languages, Art, IT | See Websites for contact:<br>Sale https://sale.u3asite.uk/welcome-3/<br>Davyhulme https://davyhulme.u3asite.uk/<br>Hale https://hale.u3asite.uk/ |
| **Home Library Service** | Delivers books to those who cannot get out to libraries | Contact Age UK Trafford and Salford to join the service:<br>Email: Admin@ageuksalfordandtrafford.org.uk<br>Telephone: **0161 746 7000** |
| **Music Sessions- String of Hearts** | Limelight, fortnightly on Tuesdays 2 - 3.30 pm.<br>The Claremont Centre, Sale, fortnightly on Fridays 1 - 2.30 pm.<br>Brooklands Church of the Nazarene, Fortnightly on Fridays 2 - 3.30 pm.<br>Broomwood Community Centre, Monthly on Thursdays 2 - 3.30 pm. | Contact String of Hearts to sign up:<br>Email: info@stringofhearts.co.uk<br>Phone: **07354 745 567** |
| **Running and Walking Groups** | Walking groups in Eccles, Old Trafford, Partington, Sale, Stretford, Swinton, The Trafford Centre and Wythenshawe. | Complete the registration form for https://www.mileshyclub.com/referralformwalking Mile Shy Club |
| **Women's Walking Cricket**<br>**Weekly Walking Group** | In Seymour Park, Tuesdays 12:30-13:30 | Lancashire Cricket Foundation contact Kay kfloyd@lancashirecricket.co.uk or **07917 750924** |
| **Knit and Natter Group** | Crafting and knitting groups to socialise | The Hub, Altrincham<br>Contact the Hub office on **0161 941 2018** or email Vicky on volunteer@ourhub.org |
| **Live Well in Later Life Group** | Community action group of older adults focussed on improving the environment and wellbeing of older adults in North Trafford | Carrie Williams<br>carrie@traffordcollective.org.uk |
| **Social Prescribing Service- a way of linking you to sources of support within your community.** | Social Prescribing can link you to local groups and activities, help you make positive lifestyle changes, learn new things and make friends | Age UK Salford and Trafford (Only for those registered with partner GP surgeries) call **0161 672 9640** or email social.prescribing@ageuktrafford.org.uk |
| **Chatty Cafes** | Cafes running sessions for socialising in Stretford and Sale | https://thechattycafescheme.co.uk |
| **Go Digital- help with IT skills** | Urmston Library – Wednesdays, 1pm to 3pm<br>Stretford Library – Tuesdays, 12:30pm to 2:30pm<br>Sale Library – Thursdays, 11am to 1pm<br>Coppice Library – Fridays, 12pm to 2pm | Drop in between the times shown |

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|---|---|---|
| **Digital Champions** | Bespoke Digital support for people over 50. Covering a a wide range of topics including NHS digital App | Please contact **0161 746 7000** for more information and to book an appointment |
| **Cyril Flint befrienders in Care Homes** | Volunteers visit care homes to chat with residents | Cyril Flint<br>**0161 942 9465**<br>E-mail **ruth@cyrilflint.org** |
| **Dementia support group, Sale** | They offer personalised help and advice face to face | Alzheimer's UK<br>Contact **0161 962 4769**<br>**manchester@alzheimers.org.uk** |
| **Memory Loss Advice Service** | 2 dementia advisors and 1 mild cognitive impairment advisor, advice about managing different situations and enable you and your family or carers to live as full a life as possible - to maintain skills, family roles, and social activities. | Age UK Salford and Trafford<br>Email: **dementiaadvisor@ageuksalfordandtrafford.org.uk**<br>Telephone: **0161 746 3944** |
| **Passion for Life – Dementia Day Care** | Specialist Dementia Day Support available each weekday 9:30am - 3:30pm across Trafford in Hale, Sale and Urmston in self-contained settings that are accessible, vibrant and specifically designed to support people in later life. Highly responsive and personalised care is delivered by a professional trained and experienced workforce who are experts in dementia care and support. | Please contact Jo Gorton on **0161 672 9644** |
| **Carer's events** | Weekly chatty cafes, craft groups, peer support groups, book clubs, etc. | Trafford Carers Centre<br>Carers helpline **0161 848 2400** |
| **Intergen Trafford** | Older adults volunteering in schools of a variety of ageing. | Intergen Trafford<br>**enquiries@intergen-trafford.org.uk**<br>**0161 460 7925** |
| **Age UK Salford and Trafford-Volunteering** | Volunteering opportunities in Age UK Salford and Trafford's services, such as with the Men's Group | Age UK Trafford and Salford<br>please contact Eleanor (Trafford area)<br>**0161 746 9754** |
| **Age UK Salford and Trafford-Social activities** | Variety of weekly or monthly activities including hub socials, men's room and afternoon tea to encourage social interaction in a warm friendly space | Age UK Trafford and Salford<br>Telephone: **0161 746 7000** |
| **Age UK Salford and Trafford-Mental Health & Wellbeing service** | Supporting people to improve their mental health by advice on self help, goal setting and promoting informed choice | Age UK Trafford and Salford<br>Email: **mentalhealth@ageuksalfordandtrafford.org.uk**<br>Telephone: **0161 746 7000** |
| **Age UK Salford and Trafford-Information and Advice** | Provision of an Information and Advice services for 50+ residents and their carers<br>General Advice / Signposting, Benefit Checks, Form Filling (by appointment) Making a Will (discounted wills service available by appointment). Help to find a Range of Care Solutions, Identifying your Housing Options , Traders List (reputable traders). Information on Local Groups and Activities | Advice line open Monday – Wednesday 9.30am – 1pm<br>**0161 746 3940** (at other times will be directed to Age UK Salford and Trafford advice line) |

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|---|---|---|
| **Pulmonary rehabilitation classes** | Exercise and education programme for those with breathing conditions | Trafford Local Care Organisation. **0161 549 6750** |
| **Parkinson's Support** | Support for those with Parkinson's, including physio, speech and language, psychology, diet advice | TLCO Neuro Rehab team **0161 912 4141** |
| **Healthier and Happier Me** | This is a programme for people with health problems that includes cooking classes, health checks, advice and physical activity | Voice of BME<br>Contact **0161 848 7018** |
| **Stop Smoking and Health Checks** | Stop smoking advice and support. Health checks offer basic lifestyle checks and guidance | Age UK Trafford and Salford<br>Email: lucychidlow@ageuksalfordandtrafford.org.uk<br>Telephone: **0161 746 7000** |
| **Adult Social Care Social Prescribing service- for people with mental and physical health conditions, disabilities, carers or older people** | Social prescribers can refer you to community organisations and classes that may help with your wellbeing | Anyone can refer into the service<br>Contact number:<br>**0161 291 3659** or Tel: **0300 303 9650** |
| **Working Well** | Tailored support to help older adults access meaningful roles | Email workwell@stretfordpublichall.org.uk |
| **Volunteer Hubs** | **Sale:** Our Sale West, Susan Astbury, **07341 206441**, Susan.Astbury@oursalewest.org.uk<br>**North- Old Trafford:** St John's Centre, Claire Trivino, **07842 528964**, claire@stjohnscentre.org<br>**North- Stretford:** Stretford Public Hall, Kaf Bays, **07518 902991**, katherine@stretfordpublichall.org.uk<br>**South:** Altrincham Baptist Church, Vicky Williams, **0161 941 2018,** victoriawilliams@ourhub.org<br>**West- Partington:** Hope Centre, Hayley Barker, **0161 660 0299**, volunteer@thehideawaypartington.com<br>**West- Urmston:** Age UK Salford & Trafford, Eleanor Smith (interim), **07399 654747**, Eleanor.Smith@ageuktrafford.org.uk | |
| **ChurchLife** | Volunteer with support groups for families and children held at churches throughout Trafford | Suzanne Kelly<br>suzannek@lifechurch.uk.net |

**Access the Trafford Directory - Adults and Older People by scanning the QR Code opposite:**

TRAFFORD COUNCIL






# Trafford Council Public Health Annual Report 2025–26: Thriving in Later Life

This year's annual report considers how **Grow, Connect, Adapt, and Give** can improve resilience and contribute to thriving in everyday circumstances during later life.

# Table of Contents

# Foreword

## Councillor Jane Slater, Executive Member for Healthy and Independent Lives

**Ageing is often perceived in very negative terms, yet many people enjoy a happy, healthy later life and continue to make a significant contribution to their friends, families and wider society. The role of older people in volunteering, sharing their time and knowledge, or in providing care to others, is invaluable in improving the quality of life for us all.**

However, there are real challenges in this life stage, and many face barriers to achieving happiness and health. The negative effect of inequality also accumulates throughout life and therefore has a large effect on older people. In Trafford, we continue to see a gap between our poorer and richer areas in life expectancy and healthy life expectancy.

Our ambition is to enable every resident to thrive as they age by creating communities where people feel valued, supported, and able to experience joy and fulfilment for longer. Trafford is already an age-friendly borough, and we are committed to building on this foundation. This means investing in health and prevention, strengthening local networks, and recognising the significant role older people play in our society. By working together, we can help our residents truly thrive in later life.

**Councillor Jane Slater**
Executive Member for Healthy and Independent Lives

# Welcome

## Helen Gollins, Director of Public Health

**One experience that unites us all is that we are growing older every day. Staying healthy as we age is not just about living longer, but about enjoying that time and feeling happy and fulfilled, a concept named "Joyspan" by a leading older adults doctor.**

This report considers how we can foster Joyspan in Trafford for our older residents. It brings together evidence on what supports thriving in later life, highlights the strengths we already have in the community and identifies areas where further action is needed. Our guest editors, Sheila, Carrie, Colin, David and Mark, a group of older adults from across Trafford, ensure this report reflects the lived experience of our residents. Their insights and reflections have helped us understand what thriving in later life truly means.

We also wanted to use this report to celebrate the contributions older residents make to our borough economically, socially and culturally, whilst also acknowledging the real challenges many older people face. Ensuring that everyone has the opportunity to thrive requires us to address these challenges collectively.

At the end of this report, I will set out my recommendations for how Trafford Council and our partners in the health, social care, and community sectors can work together to make Trafford an even better place to thrive in later life. These recommendations aim to strengthen the conditions that allow people to live well, making Trafford an even better place to grow older with good health, fulfilment, and joy.

I hope you enjoy reading this report, and I would like to give special thanks to all the guest editors and my team for all their hard work and passion in producing this report, especially Claudia Cohen, Claire Robson, Zoe Ball, Paul Burton, and Kate Hardman.

**Helen Gollins**
Director of Public Health
for Trafford Council

# Chapter 1: **Introduction and Setting the Scene**

## Introduction

**A triumph of public health and modern medicine is that people are living longer and the number of people in older age groups is increasing[1].** As highlighted in the Chief Medical Officer's Annual Report 2023, ageing well in older years isn't just about increasing lifespan – or length of life, but it's also about maintaining independence, minimising time spent in ill health and maximising overall quality of life[2]. Only 25% of lifespan is due to genetic factors[3], meaning 75% could be explained by lifestyle and environment. The concept of *"joyspan" has* been identified by geriatrician Dr Kerry Burnight[4] as the time spent experiencing joy and fulfilment in life (see Glossary). She identifies four things we can do to enable joyspan: *Grow, Connect, Adapt* and *Give*. These are very similar to the five ways to good mental wellbeing (Figure 1) [5,6].


***Figure 1: 5 Ways to Wellbeing***

This year's annual report considers how *Grow, Connect, Adapt,* and *Give* can improve resilience and contribute to thriving in everyday circumstances during later life.

## Demographic Snapshot of Older Adults in Trafford

**Older adults (aged 65 and over) currently make up 17.6% of Trafford's population – that's 41, 297 people[7].** This is expected to rise to 48,100 by 2030 and 53,400 by 2040, with the greatest growth in those aged 80-84[8] . The current distribution of older adults varies across the borough, from 7.8% in Gorse Hill and Cornbrook to almost 1 in 4 in Bowdon and Hale Barns and Timperley South (see Appendix 1).

In 2019, an estimated 13% of older adults in Trafford experienced income deprivation, similar to the England rate. At all ages, people in poverty are more likely to be in poorer health than those not[9]. In addition, there may be a greater proportion of older adults in areas of Trafford described as "asset-rich, cash-poor", due to owning houses which have increased in value despite having limited available cash. Factors such as caring responsibilities, local ties to family and communities, and lack of suitable smaller homes may impact older residents' ability to downsize. Older adults described as "asset-rich, cash-poor" report that the economic downturn has impacted their financial, social, mental and physical wellbeing[10].

The older population is less ethnically diverse compared to all ages however this is expected to change with time (see Appendix 1).Older people are increasingly likely to identify as lesbian, bisexual, gay or another minoritised sexuality[11].

Life expectancy at 65 (how much longer adults at 65 are expected to live on average) for Trafford males is 18.7 years and for females 21.4 years (2021-23 data), similar to the England averages. However, there is an inequality in life expectancy between the most and least deprived areas of Trafford of 6.2 years for males and 4.3 years for females, meaning those who live in more deprived areas are expected to die sooner than those who live in less deprived areas. Healthy life expectancy[12] at 65 (the number of years lived in good health) for Trafford males is 10.8 years and for females 11.8 years (2021-23 data), both statistically similar to the England average.

Trafford is officially accredited by the World Health Organisation (WHO) as an age-friendly borough[12], and our Age Well Board aligns its strategic objectives with the WHO's age-friendly domains, working to improve ways in which residents can continue to age well. The age-friendly domains are shown in Appendix 2. Figure 2 summarises how Trafford is performing compared to the national average across a range of ageing well outcomes (Appendix 3 provides details on how these outcomes have been calculated and for what time period). While at a glance the headline indicators present an overall positive trend, they can hide significant inequalities between different population groups and different neighbourhoods within Trafford.

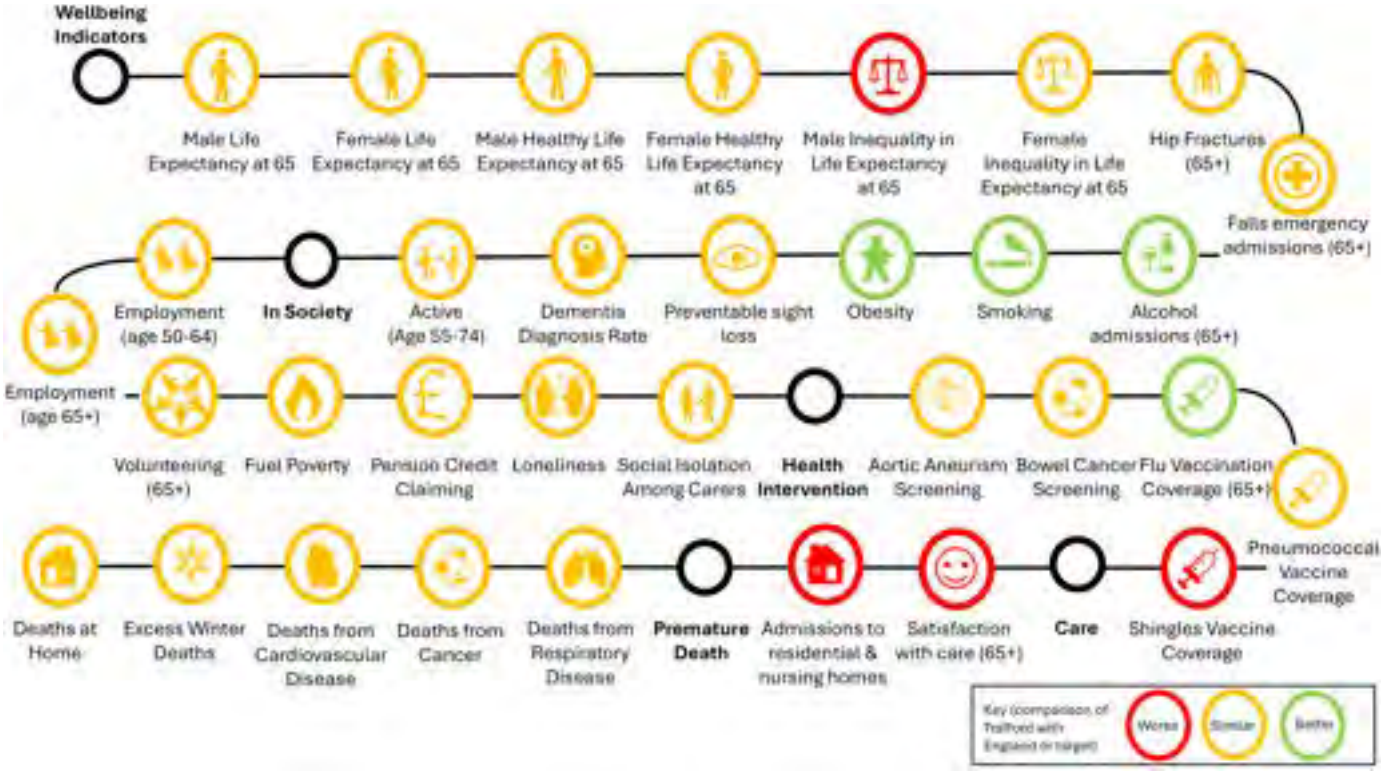



*Figure 2: Ageing Well Outcomes for Trafford*

1. Health Life Expectancy is a measure that estimates how long a person can expect to live with good or very good health (Had a good innings? The importance of healthy life expectancy | Local Government Association)

# Chapter 2: **Guest Editors' Bios**

**To ensure this report reflects and involves our older residents, we sought out volunteers to read the report and give their reflections. Five individuals from a variety of backgrounds generously gave their time.**

## Sheila Young, 95

Sheila has lived her entire life in the Sale area of Trafford, raising a family and adapting to many changes, including the loss of her husband along with sight and hearing loss. Known for a friendly, approachable manner and a love of being around others, Sheila also has a passion for singing and music. Her deep roots in the community include 17 years as a midday assistant at a local school—where having fun with the children was a daily joy—and additional work at Sale Library.

## Carrie Williams

Carrie is the Ageing in Place Coordinator for the Ageing in Place Project (now the "Live Well in Later Life" group). Having lived in Old Trafford for 23 years, she brings both personal insight and professional experience, helping to ensure that the voices and views of older residents are well represented.

## Colin Driver, 90

Colin has lived in the Davyhulme area of Trafford for most of his adult life, raising his family there while spending his career as a telephone engineer. Cognitive changes have since made independent living more difficult, and he now resides in a care home. Deeply rooted in his community, Colin spent 45 years as a licensed reader at St Mary's Church in Davyhulme, regularly preaching and delivering school assemblies, and also served as a magistrate for 19 years.

2. Note this project has been renamed as the Live Well in Later Life group as of January 2026

## David Balmer, a resident since 1988


David recently retired after a 35year career as an analytical chemist in north Manchester and now serves as a resident representative with the Old Trafford Ageing in Place group. Drawing on his working class background, long-standing community ties, and the personal impact of recovering from a serious illness that led to two months in intensive care in 2019 (involving a level four hospital incident), he is committed to addressing the growing socioeconomic isolation and mental health challenges faced by older, working-class residents**.**

## Mark Simpson

Mark was diagnosed with autism just over a decade ago in his early 50s. He is engaged in a wide variety of autism-related activities as a trainer, expert by experience, peer mentor, discussion group chair, peer support worker, interviewer and co-chair of the Trafford Autism Partnership. He balances these activities with a part-time role as a tax consultant. Mark has been married for 30 years, with two adult children and has lived in Hale Barns most of his adult life.

# Chapter 3: **Grow- Lifelong Learning, Purpose and Personal Development**

**"Grow"** is about lifelong learning, having a sense of purpose, keeping active and having a mindset that is open and interested in learning new things.

## Why is this important for health and wellbeing in older age?

**Lifelong learning is a determinant of healthy ageing[13] and can include developing new skills such as taking up a new creative hobby or becoming more physically active.**

Learning new things also helps us stay connected[14], engage with others and be able to cope better with life's ups and downs[15]. There is evidence that music can have a positive impact on people's mental health.

Staying active with regular moderate exercise, like walking, cycling, and strength training, can help lift your mood, improve memory, and keep your mind sharp [16]. Those who exercise report lower levels of anxiety and greater scores in life satisfaction, happiness, sense of worthwhile and resilience, as well as feeling more able to achieve their goals. A physically active lifestyle is also associated with better health in later life and living longer [17,18]. It's never too late to start being physically active - taking up physical activity later in life can still improve physical health and cognition [15,19,20] and reduce the risk of falls and associated injuries by improving balance and stamina[21].

The national guidelines for adults aged 65 and over are that they should aim to:

- be physically active every day, even if it's just light activity
- do activities that improve strength, balance and flexibility at least 2 days a week
- do at least 150 minutes of moderate intensity activity a week or 75 minutes of vigorous intensity activity if you are already physically active
- reduce time spent sitting or lying down and break up long periods of not moving with some activity

# What does this look like for Trafford residents?

**In Trafford, according to a survey of residents aged over 65, around half reported being active at least 150 minutes a week, and around 35% were considered inactive (note only a small sample of 288 Trafford residents were surveyed)[22].**

The proportion of older adults meeting balance and strength exercise guidelines nationally is less than 1 in 5.

In England, older women and older people in more deprived areas had greater rates of admission to hospital for falls than those in the least deprived areas[23]. In Trafford, the rates of admission to hospital for falls has been above the England average, but this is generally decreasing.

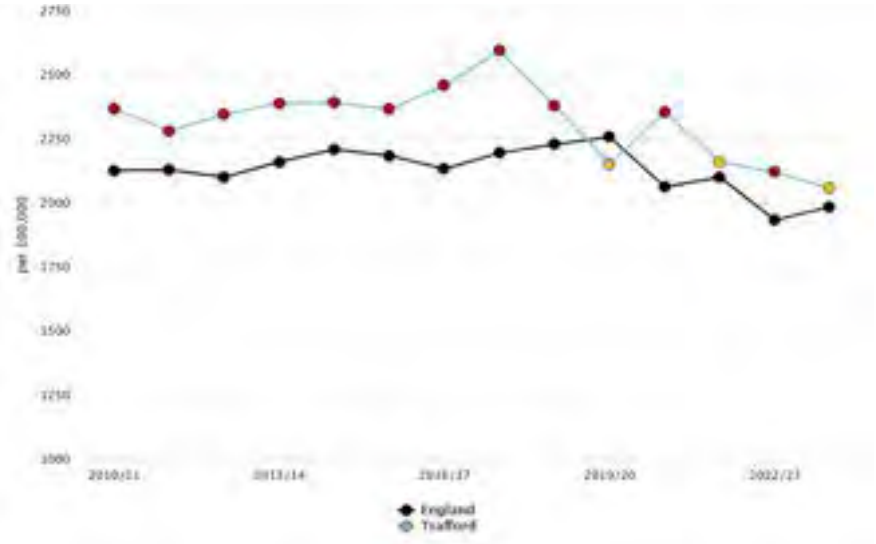



*Figure 3: Emergency Hospital Admissions for Falls over Time in England and Trafford, 2010/11-2022/23, Fingertips. [24]*

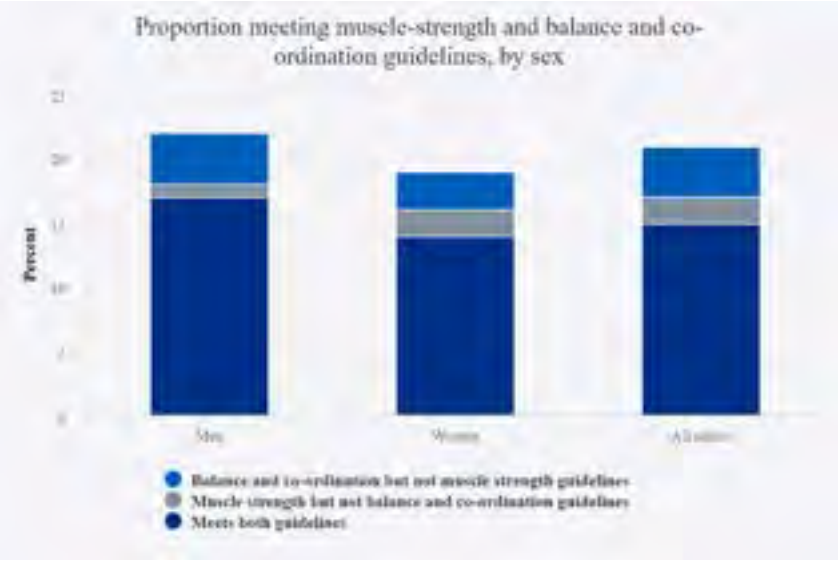



*Figure 4: Proportion of Older Adults Meeting Muscle-Strength and Balance and Co-Ordination Guidelines 2021, NHS Digital, Health Survey for England*

# Trafford-based examples of opportunities supporting older adults to 'grow'

## Lifelong learning

In Hale, Davyhulme and Sale the **University of the Third Age (U3A)** offers a wide range of in person and online learning opportunities for older adults across a variety of subjects such as Origami, Languages, Bridge, Egyptology, Table Tennis, Art, and IT [26]. In Hale alone, U3A has over 1000 members and 70 activity groups.

**String of Hearts** run music therapy sessions for older adults as well as those who are housebound.

**Age UK** run a home Library service and a men's activity hub which includes activities like dominoes and table tennis[27].

Trafford's neighbourhood networks play a significant role in helping residents connect into these kinds of opportunities and helping overcome barriers to engagement such as accessibility.

## Moving more and Physical Activity Referral Services

**Trafford Leisure supports over 10,000 visits from older people each year.**

There is a Moving More referral programme and a Physical Activity Referral Service (PARS). PARS allows your GP to refer you to an instructor at one of the Trafford leisure centres who design 12-week activity plans tailored to your abilities and needs[28] . In Trafford, uptake among residents aged 65 and over is around 45%, similar to other age groups. However, approximately a third of those aged 65 and over either do not take up the referral or do not complete the activity. This has similarly been seen in referrals for older adults to talking therapies (IAPT Improving Access to Psychological Therapies), where Trafford older adults were less likely to complete the course than those under 65 [29].

### Case Study: Trafford Leisure and PARS

"I joined the programme to have a purpose again as 12 months ago, I lost my daughter to cancer. I lost hope, my purpose and confidence. On the days I exercise I feel much happier, and it is helping my depression. I have just recently completed the programme, and I am now a member of move Urmston."

"I was isolated in house many years, alone. Coming to leisure centre was big step for me. I meet new friends — before I have no friends. I look forward for class every week. I miss human connection very much. Now I feel my mental health getting better"

There are plenty of opportunities in the community to stay fit and sharp organised by the Voluntary, Faith, Community and Social Enterprise (VCFSE) sector. For example, the Mile Shy Club, funded by the Live Well grant, is a running club that welcomes people of all ages and abilities and also runs walking groups[30]. They currently have almost 70 runners aged 60 and over, some of which are in their 70s. Whilst uptake in North, Central and South Trafford is good, there is less uptake in the West neighbourhood, and overall less uptake in men compared to women. Lancashire Cricket Foundation run a weekly walking group, supported by Trafford Public Health and GM moving, and run a Women's Walking Cricket group funded by Sport England[31]. Further opportunities can be found in Appendix 4.

Dancing is an important form of movement that is beneficial for health and wellbeing. In the West neighbourhood, the organisation Toy House organised a "Tea Dance" event which included information on falls prevention. There is interest in setting up Dementia discos – using music to inspire memories, conversation and friendships in and between people living with dementia.

## Strength and balance

**Trafford Council commissions strength and balance classes via Age UK across the borough.** GPs refer into the service, and classes are led by a suitably qualified instructor[32]. Age UK report receiving 190 referrals to the classes since April 2025 alone[33]. Trafford Leisure also provides falls prevention classes and offers a variety of walking sports.

Trafford Council commissioned Voice of BME to run "Healthy Hips and Hearts" to provide falls prevention classes for residents in ethnically minoritised groups through the public health's health inequality grant. Classes regularly have over 20 participants of South Asian and African Caribbean background, primarily women. They also do brain training activities after each class.

We recognise that there are both real and perceived barriers for some older adults being able to access activities that help them 'grow'. Barriers might include for example access to reliable transport, the ability to access and navigate digital information to find out about opportunities in the first place and having the personal confidence to connect in with established groups. This will be discussed further in chapter 3.

### Case Study: Trafford Strength and Balance Classes

Mrs J is 84 and lives on her own. She has poor balance and recently diagnosed macular degeneration. She was referred to the postural stability class by her GP.

Mrs J had been experiencing several falls in her home in the last 18 months. No serious injuries occurred in this time however the frequency had become a cause for concern for her, her family and her GP. The recent diagnoses of macular degeneration was causing further difficulties with her balance and confidence and creating a fear of falling. Consequently, she began to reduce her daily activities and avoided certain situations that would recreate that fear.

At Mrs J's initial assessment, we agreed to focus on specific balance exercises that would improve her movement around the house and give her more confidence to leave the house. At her first session she was pleasantly surprised at how much she could do and slowly began to have a little more self-belief in her ability. The key was to translate this belief away from the safety of the weekly session. This improvement in balance, confidence and overall mobility has enabled her to be active in her daily life and once again bring a certain quality to it, saying:

"I've found these sessions invaluable and never thought I'd be able to do the things in the session like walking backwards. This has made a big difference to how I feel."

Mrs J will soon begin a follow-on class around the corner from where she lives to maintain the progress she has built in these first eight sessions. To date she has had no further falls and has seen improvements in all her post programme measurements.

# Recommendations

- **As a system commitment to widening participation, prioritise engagement with older male residents living in less affluent parts of the Borough to better understand how we can support them to take up and complete referrals to programmes such as PARS and talking therapies, as well as opportunities in the VCFSE sector such as the Mile Shy club. Use this insight to inform local commissioning decisions.**
- **The Public Health Directorate, with support from the Trafford Community Collective, to allocate small grants funding for VCFSE organisations to bid to run projects with older adults that focus on the 5 ways to wellbeing (connect, be active, learn, give, take notice). Particular focus to be given to those who are most isolated, such as LGBTQ groups and carers.**
- **Support coordinated communications and engagement activity to raise awareness of opportunities across Trafford for older people to participate in activities that support mental and physical wellbeing. This should include accessible paper-based information (for example What's on Where guides) alongside digital promotion. Neighbourhood networks will play a facilitating role, helping to connect formal communications with local knowledge, trusted relationships and feedback from older residents.**
- **System partners to make better use in commissioning decisions of evidence for the efficacy of using creative arts for health gain – explore feasibility of expanding activities that help older adults move more and impact positively on mental health such as 'dementia discos'.**

# Chapter 4 **Connect - Relationships, Belonging & Community**

**"Connect"** is about developing and maintaining relationships that enable a sense of belonging and community.

## Why is this important for health and wellbeing in older age?

**Research has shown that the social participation and community support domains of the age-friendly cities framework (Appendix 2) are associated with life satisfaction in older adults[34].** The theme for the 2025 International Day of Older Persons (IDOP) was therefore "Building Belonging: Celebrating the power of our social connections"[35].

Not feeling part of your neighbourhood is a risk factor for loneliness in older age[36]. Loneliness is a risk factor for poorer mental and physical health, including conditions like diabetes, dementia, depression and frailty [37,38,39] and vice versa poor health is a risk factor for loneliness. Other risk factors for loneliness in older adults are losing a spouse, not feeling able to do the things you want due to family or financial circumstances, and living alone [40]. According to Age UK, around 1.4 million older people experience loneliness nationally.

Maintaining healthy sexual relationships is an important aspect of 'connect' and it correlates with greater enjoyment of life for older adults[41]. However, research shows people aged 50 and over are assumed to be non-sexual in relation to their sex and intimacy needs, and there is often a lack of visibility in sexual health promotional materials and less permission to speak up about sexual health issues[42]. A national survey found less than 20% of older people concerned about their sex life sought help[43]. Some research has shown that older adults experiencing sexual difficulties are at increased risk of depression[44].

## What does this look like for Trafford residents?

**In 2023/24, the percentage of Trafford adult social care users aged 65 and over that had as much social contact as they would like was 37.6%, lower than England (43.1%).**

**The proportion of carers who had as much social contact as they would like was 25.2%, lower than England (30%)[45].**

In the 2023/24 Community Life Survey, among Trafford adults aged 50+ years, 24% felt a very strong feeling of belonging to their immediate neighbourhood (compared to 23% England). 47% felt a fairly strong feeling of belonging, higher than England (44%). 70% 'definitely agreed' that if they needed help there would be people there for them, slightly lower than England (72%)[46].

Some individuals may lack a wider network which makes coping with adverse life events, such as bereavement, much more difficult, with an increased likelihood of depression, and may then adopt other health-harming behaviours, such as increased alcohol consumption. Those who connect with wider networks may be able to mitigate some of these adverse effects, as their connection with others enables them to foster greater resilience and evolve better coping strategies.

The proportion of those aged 65 and over living alone is increasing[47]. In 2021, the Census showed that there were 12,764 one-person households of adults aged 65 or over in Trafford[48]. With increases in life expectancy and high levels of ageing without children in the 'baby boomer' generation, there may be many older adults in the future without children to care for them. This could mean more older adults needing formal care in the future[49]. Strengthening and connecting community relationships is therefore important for older people to age well.

Although the frequency of sexual activity tends to decline with age, older adults are still sexually active. In a study in England, 86% of men and 60% women age 60-69 reported being sexually active, as did 59% men and 34% women age 70-79 and 31% of men and 14% of women aged 80 years or older[50]. In Trafford STI rates are increasing in people aged 45 and over. Bisexual older adults experience higher rates of STI and HIV.

# Trafford-based examples of opportunities supporting older adults to 'connect'

In North Trafford, **the Ageing in Place Pathfinder steering group**, made up of community representatives and residents, meets every 6 weeks, with a goal of creating supportive neighbourhoods and reducing health inequalities for people over 50. This year they have held Ayres Road Festival for older residents, identified resident volunteers to be '**Pension Credit Champions**' to encourage others to access their credit, and created a series of murals with OT Creative Space for the Trafford Bar tram stop[51]. They have also completed walking and wheeling audits with Trafford Council and Transport for Greater Manchester, which has resulted in the installation of three additional benches. The work of the group will continue to spread and grow over the next three years in the form of Live Well in Later Life.

*Figure 5: Residents taking part in Community Reporting with Yellow Jigsaw as part of the Ageing in Place Pathfinder.*

The south neighbourhood older people's network has produced a **directory of 'Chatty Cafes'** to help older people socially connect.

A successful pilot **Community Transport Project** has been established in our Central neighbourhood taking older residents to health appointments, clinics, rehab sessions and other health related activity.

To celebrate **International Day of Older People (IDOP),** Age UK Salford and Trafford and Trafford Carers Centre (TCC) ran events which brought together residents and agencies with the aim of raising awareness of support available as well as listening to resident voice. For **Age Without Limits (AwL) Day**, Trafford Council and TCC held a bhangra-themed session in Old Trafford, challenging ageist stereotypes and encouraging older adults to keep active and connect with others.

*Figure 6: Bhangracise class at the Age Without Limits Day*

Home Instead has created a **What's on Where** (or **WOW**) **Guide** which is regularly updated throughout the year to help older people to know what is available that they can get involved with. See appendix 4 for further examples.

Trafford Council is enabling older residents to use technology for connection, independence, and access to essential services. Our **Go Digital** programme that runs in libraries across the borough is supported by **Digital Champion volunteers** helping to provide hands-on guidance in a friendly environment. To remove financial barriers to access, devices such as smartphones, tablets, and laptops are being provided to those on low income. Age UK also runs a **Digital Champions** programme, teaching skills for things like online shopping, safe internet use, and adapting to modern life[52].


*Figure 7: Residents at the Age Without Limits Day*

## Case Study: Trafford Council's Go Digital

*A former soldier in their 80s from Sale had little experience with technology before joining the classes. In just ten weeks, they learned how to surf the internet, shop on Amazon, and email family living on the other side of the world.*

Trafford Age UK run a **social prescribing service for older adults** struggling with their mental wellbeing, which helps identify opportunities for social connection in the community. Individuals, relatives or healthcare professionals can refer to the service. Trafford Age UK reported that this service has seen over 200 people in the last three years, with 85% of service users reporting reduction in anxiety levels and increase in wellbeing as per ONS measurements pre and post intervention. Since starting, over two thirds of referrals were female. 45% were referred from West neighbourhood profiles, 26% from South, 20% from Central and 9% from North. 41% were 50-64 years old, 22% 65-74, 29% 75-84 and 8% 85 and over.

## Case Study: Age UK Older Adults Mental Wellbeing Social Prescribing

This 65-year-old gentlemen was referred to Age UK Trafford's Mental Health & Wellbeing Service.

He lived alone within a sheltered housing scheme. He had a grown-up children, but the relationships were quite strained and contact was intermittent. The client stated he had been depressed at times over many years but had no diagnosis. He also complained of feeling very anxious at times and low in mood with little to no motivation. He reported having many physical issues including severe COPD, aspergillosis, asthma and was under a specialist at the hospital.

The service ensured he had access to relevant services and helplines. They discussed sleep hygiene, arranged a medication review, gave clothing and footwear and a hot water bottle to prevent him staying in bed all day. He was signposted to the What's On Where guide and he began to increase his social connections, both with new people and with his family, attending singing, photography and fishing to wellbeing groups. His ONS score improved from 19 to 27.

Trafford Public Health has worked with the University of Sheffield to begin implementing the **Sexual Rights Charter and Three Ps guidance.** This includes providing Age UK with guidance for conversations around sexual health during their health checks. We are also planning focus groups of older people to understand their needs around sexual health and wellbeing.

# Recommendations

- **Consider ways in which transport can be provided to enable more older people to participate in social activities by building on the learning from Ageing in Place in Old Trafford regarding active travel and barriers for older residents. Age UK Salford and Trafford will be continuing this work via the Live Well in Later Life (formerly Ageing in Place).**
- **Neighbourhood networks and community hubs to continue to build on work to prioritise interventions that address loneliness.**
- **As a system explore the potential for measures of belonging and social connectedness to be included in Trafford neighbourhood scorecard and our Neighbourhood Performance Arrangements, to ensure qualitative aspects are also captured. Consider including social capital and connectiveness within service specifications.**

# Chapter 5: **Adapt - Developing Resilience and Maintaining Flexibility Through Changes**

**"Adapt"** is about remaining resilient when encountering life's challenges.

## Why is this important for health and wellbeing in older age?

There are many life changes that impact on older age including, for example, retirement, becoming a carer, health challenges, bereavement, or changes in living arrangements[53,54].

Building resilience provides individuals with greater capacity to manage difficulties when they arise [55]. However, some people may be reluctant to seek help from outside agencies, fearing it could make them appear vulnerable. This can lead to unhelpful coping strategies, such as increased alcohol use. Key characteristics of resilience include adaptive coping styles - optimism, positive emotions, community involvement, social support, independence in daily living, and physical activity.

A positive view of ageing strengthens resilience, while negative perceptions such as ageism can undermine it[57]. With almost two-thirds of older adults reporting being treated or spoken to negatively since turning 50[58], challenging stereotypes and addressing ageism in society is essential to support wellbeing and resilience.

## What does this look like for Trafford residents?

**In Trafford in 2023, almost 1 in 10 of the population experienced fuel poverty, and of those aged 60 and over, 13% experienced income deprivation, similar to England rates.**

Census data from 2021 showed 278,946 people aged 65 and over lived in care homes. Although the majority are white, care home populations are becoming more ethnically diverse since the last census. The North West and North East had higher proportions of those aged 65 and over living in care homes than other regions[59]. In Trafford in 2023/24, 780 people per 100,000 were admitted to care or residential homes, higher than the England rate (566 per 100,000).

Data from Trafford Carers Centre (Feb 2025) shows **2,690 older adults (65+) are carers**, making up over a third of all carers locally. Many face health challenges themselves: 58% of all Trafford carers have a health need. Social isolation remains a concern, with only 25% of carers in Trafford report having as much social contact as they would like.

The proportion of people requiring palliative care or support is increasing both in Trafford and nationally, as shown in Figure 8[60].

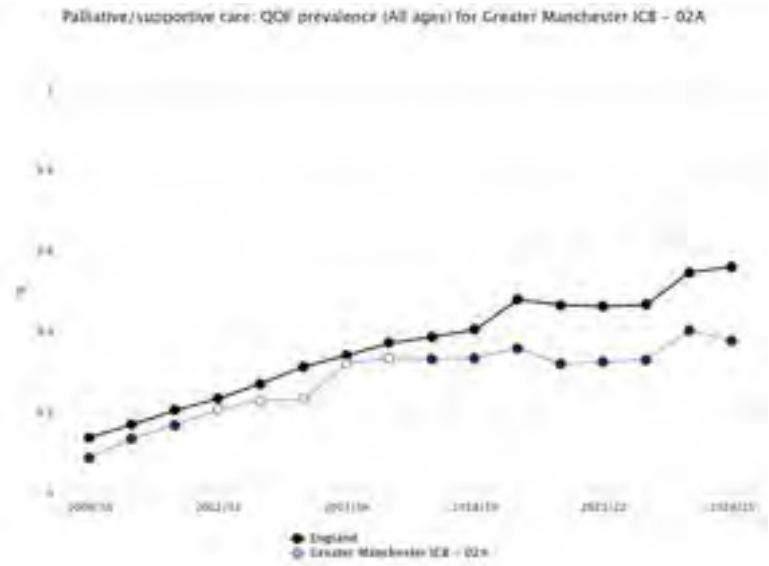



*Figure 8: The proportion of people requiring palliative support or care in Trafford compared to England over time, Fingertips*

Trafford has a greater proportion of deaths occurring in hospital and smaller proportion occurring at home or in hospice care than England, although Trafford is following the national trends, as shown in the three graphs below[61].

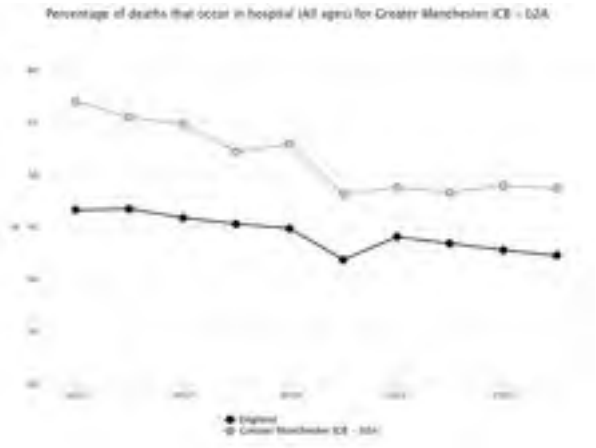
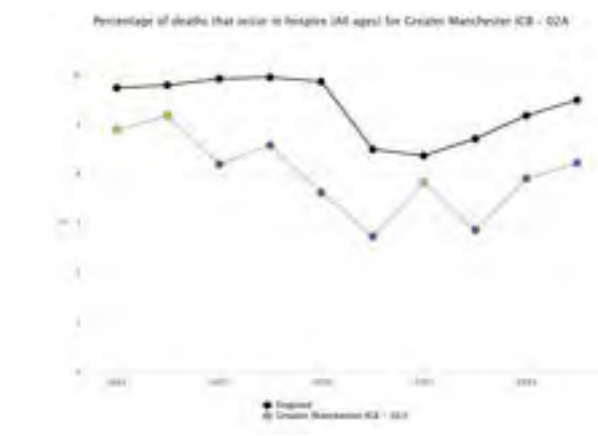


*Figure 9: Percentage of deaths occurring in hospital over time in Trafford compared to England, Fingertips*



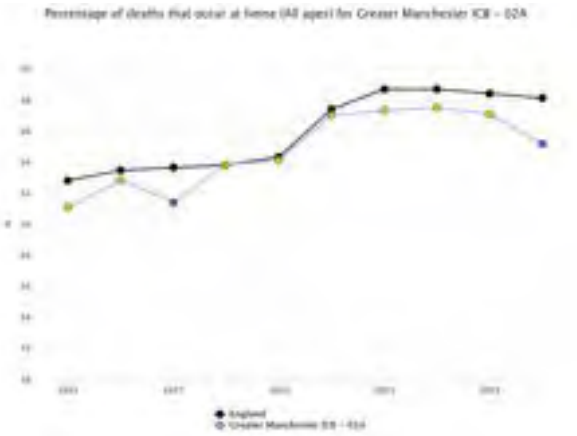


*Figure 10 (Left): Percentage of deaths occurring in Hospice over time in Trafford compared to England, Fingertips*

*Figure11 (Right): Percentage of deaths occurring at home over time in Trafford compared to England, Fingertips*

# Trafford-based examples of opportunities supporting older adults to 'adapt'

## Support for Those with Long-Term Conditions

The incidence of long-term conditions such as diabetes, respiratory illness, and cardiovascular disease increases with age, making access to tailored support essential for maintaining independence and wellbeing. Trafford offers a wide range of services to help residents manage these conditions and improve quality of life:

- **Pulmonary Rehabilitation:** Trafford Local Care Organisation (TCLO) classes in Partington and Old Trafford for people with respiratory conditions. Using focus groups, interpreters and assistance from Voice of BME, the team were able to double the percentage of non-white participants completing pulmonary rehabilitation in 2023.
- **Parkinson's Support:** Specialist exercise groups delivered by Sale Sharks and TLCO's Neuro Rehabilitation Team.
- **Happier Healthier Me:** Voice of BME programme providing wellbeing support for diabetes, COPD, and high blood pressure through health checks, cooking classes, rehabilitation, and resilience sessions.
- **Stop Smoking & Health Checks:** Age UK Salford & Trafford deliver targeted checks and cessation support in high-need areas; since April, 40 residents referred for smoking support and 50 for health checks.

These initiatives aim to reduce health risks, promote self-management, and ensure equitable access to support for older residents across Trafford. An example is shown in the case study below.

### Case Study: Age UK Health Checks and Smoking Cessation

Age UK Trafford & Salford staff visited a sheltered housing scheme in North Trafford to provide health checks and stop smoking advice. One resident, in their mid-sixties, initially felt anxious about attending and disclosed difficulties with reading and writing. With support from the Age UK representative, they completed the health check, which showed slightly raised blood pressure and an underweight BMI.

During the conversation, the resident shared recent bereavements, financial struggles, and anxiety, alongside being a heavy smoker. The staff member discussed available support, including financial assistance (Personal Independence Payment, Household Support Fund), GP follow-up, and mental health services.

With consent, a plan was agreed with the Scheme Manager to help the resident complete benefit forms and explore health and wellbeing support when ready. The resident said 'Thank you for listening and not judging' and said to the scheme manager 'I had a really good talk to the lady and can see a way forward'.

# Living well with Dementia

As residents live longer, dementia rates are increasing, making it a priority to ensure people can live well with the condition. Trafford's South and Central Neighbourhood Lead hosted two successful **"Living Well with Dementia"** events, collectively attended by over 800 residents.

***Figure 12: Living Well with Dementia event, Altrincham 2025***

These events brought together residents and representatives from more than 20 health, care, VCFSE, and business organisations involved in supporting people with dementia. Organisations valued the opportunity to better understand the challenges residents face, promote their services, and build partnerships to strengthen the support available.

Residents were encouraged to engage with **Trafford's Dementia Strategy Group**, ensuring lived experience shapes the borough's approach. Feedback highlighted the need for more peer-support groups and practical information on home adaptations—preferably in paper format, recognising that not everyone has or wants online access. Further examples of dementia support can be found in Appendix 4.

# Support for Carers

Under the **Care Act 2014**, unpaid carers are entitled to a free statutory assessment. Trafford Carers Centre deliver these assessments, addressing urgent needs and planning longer-term support such as respite, equipment, health checks, financial advice, and benefits. Carers are signposted to counselling, social groups, digital support, and specialist services. Welfare advisors from Trafford Carers Centre and ACCG assist with forms to ensure carers receive the financial support to which they are entitled.

## Case Study: Trafford Carers Centre

A local carer attended a routine health check at the Carers Centre, initially saying they felt "fine" and only wanted to discuss a minor issue. Like many carers, they had been prioritising the needs of the person they care for over their own health.

During the assessment, they revealed a previous diagnosis of Type 2 diabetes, which they were managing through diet alone. Blood tests showed very high glucose levels, raised blood pressure, and symptoms such as changes in vision. The nurse provided advice, arranged a follow-up test, and shared resources from Diabetes UK to explain the risks of uncontrolled diabetes.

After discussing the benefits of treatment, the carer agreed to start medication, improve their diet, and increase physical activity. Within weeks, their blood glucose levels returned to a healthy range, and they felt empowered to monitor their progress.

This case shows how health checks at the Carers Centre can give carers the time and space to focus on their own health, identify hidden risks, and make positive changes for long-term wellbeing.

# Trafford Adult Social Care

Adult Social Care help those with mental and physical health problems, disabilities, carers, and older people. People can be referred by friends and family, health and care professionals or refer themselves. Referral reasons including housing issues, finance issues, health and fitness reasons, social isolation and domestic abuse. The new triage referral system has had over 2000 referrals between July and November 2025, with cases triaged in under 3 days on average. Initial assessments are completed by social workers, and if needed they are referred to community link officers (CLOs). CLOs work with the community to promote wellbeing and independence under the Care Act 2014. They assist individuals with overcoming barriers to services and community activities; support people with deep-rooted complex mental health conditions to participate in groups; and connect individuals with their interests, boosting confidence, reducing anxiety and restoring purpose to their lives. CLOs work closely with many of the Trafford council and VCFSE sector programmes.

# Domestic Abuse Support

SafeLives research shows older victims experience abuse for twice as long before seeking help and are underrepresented in services. Nearly half have a disability, and 18% of domestic homicide victims are aged 65+.

In 2023, Trafford commissioned a **Safer Ageing Domestic Abuse Advisor (SADAA)** through Trafford Domestic Abuse Services (TDAS) to provide tailored support for victims aged 55+. The role offers risk assessment, outreach, practical and emotional support, and works with local agencies to reduce barriers. All service users reported improved safety and risk management. Victims described the support as life-changing, helping them understand coercive control and regain strength.

# Working in Older Age

Remaining in or returning to work later in life can bring significant benefits, including improved financial security, enhanced wellbeing, and opportunities to stay socially connected. In August 2024, Trafford Council strengthened its commitment to these principles by signing the Age-Friendly Employment Pledge.

Through collaboration with **Working Well**, tailored support has been offered to help older residents access meaningful employment opportunities. Trafford has also delivered **bespoke job clubs** across the borough, providing practical advice and confidence-building sessions for those seeking work.

# Pension Credit and the Cost of Living

The rising cost of living has placed significant pressure on older residents, making it more important than ever that people claim the benefits and entitlements they are eligible for. To address this, neighbourhood network leads worked closely with **Trafford Collective**, the Council, and frontline partners to deliver a borough-wide **Pension Credit campaign** aimed at increasing uptake among those most at risk.

Analysis highlighted a clear social gradient, with the majority of non-claimants living in more deprived areas. Using the **Council's Welfare Rights resources**, targeted letters and follow-up calls were made to ensure residents understood their entitlement—particularly ahead of winter, when changes to **Winter Fuel Payment eligibility** left many former claimants vulnerable.

These coordinated efforts helped raise awareness, improve benefit uptake, and reduce financial insecurity for older residents during a challenging period.

# Living Well at End-of-Life

Dying and death are part of life, and supporting people who are dying, caring for someone dying, or bereaved is vital for population wellbeing. The concept of "dying well" focuses on ensuring individuals receive the right care and feel safe in their final moments, while promoting a compassionate community approach—where people are informed about death, loss, and care, and services adapt to local needs.

Evidence shows that communities engaged in planning and decision-making are better connected and supportive, improving health and wellbeing. A community-focused approach to end-of-life care and bereavement support requires collaboration across health and social care, local authorities, and the voluntary, community, faith, and social enterprise sectors.

Trafford hosted two key events to promote openness around death, dying, and grief.

- **Bereavement Services Event (Oct 2025):** Over 200 attendees engaged with health, care, and legal partners to improve understanding of the bereavement journey.
- **Dead Good Festival (May 2024):** Part of Dying Matters Awareness Week, this creative event encouraged dialogue on death and connected residents to local support.

# Recommendations

- **As a system take a joint, proactive strategic approach to co-ordinating and promoting awareness of support available to Trafford residents specifically during life changes. Priority focus to be given to bereavement support, living well with dementia, managing long term conditions and caring.**
- **Encourage self-care opportunities amongst older adults:**
  - **Public Health Directorate and neighbourhood leads to proactively encourage older adults to attend health checks**
  - **Public Health Directorate to work with Trafford Carers Centre to deliver a mental wellbeing project**
- **As a system collectively challenge ageism and stereotypes and advocate for inclusive language that celebrates older age, including in reports and grants applications. Involve the Council's communication teams to ensure change throughout the organisation.**
- **Trafford Community Safety Partnership to explore potential routes for securing longer term funding of the Safer Ageing Domestic Abuse Advisor (SADAA).**

# Chapter 6: **Give – Contribution, kindness and helping others**

**"Give"** is about finding ways to contribute to the needs of others and wider society – for example through activities such as volunteering, community service, or participation in social and political activities.[62]

## Why is this important for health and wellbeing in older age?

Research has shown volunteering in later life can improve wellbeing by improving sense of purpose and decreasing loneliness, and it is associated with increased independence and higher physical activity levels[63]. Particularly, intergenerational activities, such as volunteering in schools or choirs, can improve older adults' sense of empowerment[64], reduce low mood and improve quality of life[65,66], and engagement in them is associated with increased social and physical activity[67]. Intergenerational programs have also shown positive impacts on children's perceptions of older adults[68], further challenging ageist stereotypes, and are recommended by the WHO Global Report on Ageism as a strategy to reduce ageism in societies[69].

Older adults are the most likely group to volunteer, and have been the only age group to see an increase in levels of civic engagement in recent years[70]. However, the Centre for Ageing Better found that 632,000 fewer older adults volunteer now compared to before the pandemic. Reasons given were health problems and not having enough time due to changes in living and working circumstances. They advocate for local authorities becoming age-friendly places to ensure older adults age well and can contribute their vital role to society longer [72]. Trafford has been an age-friendly local authority since 2019.

## What does this look like for Trafford residents?

Of older adults (50+) in Trafford surveyed in the community life survey 23/24, 41% engaged in civic participation, activism or consultation activities in the last 12 months. 22% engaged in formal volunteering at least once a month and 26% engaged in informal volunteering at least once a month, similar to England rates[72].

# Trafford-based examples of opportunities supporting older adults to 'give'


*Figure 13: Volunteer Hubs in Trafford*

There are many older adults already volunteering in Trafford, and residents can find advice and guidance for volunteering opportunities at Trafford's six **volunteer hubs**, shown in Figure 13[3]. Across the six hubs there are over 430 volunteers. A 2024 survey of a sample of volunteers in the South hub found that 58% were aged 65 or over.

Intergen Trafford is a charity where older adults volunteer in schools. There are currently 72 volunteers across 26 schools in Trafford. Furthermore, 15-20 older adults already volunteer with the Council's **School Streets** initiative, helping children and families get to school safely. Older people therefore clearly have an important role in communities as carers, connectors, volunteers and leaders, which should be celebrated[73].

## Case Study: School Streets Volunteers

Denise and Neville, aged 59, are regular volunteers at Victoria Park Infants School Street. They said: "We find the School Street experience to be rewarding. The day is productive and we enjoy saying hi to the kids and families as they arrive at school. It's a great way to give back to the community and it's beneficial for overall wellbeing."

3. Note Partington Volunteer Hub is currently undergoing change, including appointing a new Volunteer Coordinator

Faith groups provide an opportunity to volunteer and carry out social justice. In Trafford, volunteers with ChurchLife work to address food poverty, support wellbeing, and provide activities for children and families. An example is LifeTots, where older adults facilitate weekly toddler and parent/carer groups, serving more than 60 pre-nursery children and their families. Volunteers reported gaining spiritual growth, social connection, and a renewed sense of purpose through contributing to the community.

## Case Study: LifeChurch Volunteer

"Volunteering in my church is such a great experience, and now that I am fully retired I also volunteer with ramblers wellbeing walks for health. It gives me an opportunity to talk and be more connected with the wider community and this also gives me a sense of purpose"

*Figure 14: ChurchLife Volunteers*

Many older adults also sit on **Ageing in Place** and the **South Neighbourhood's Older Adults Network**, completing work to enhance their communities across the borough. For example, the Ageing in Place group has undertaken community audits to improve the walkability of the local area in Old Trafford for all residents by advocating for increased street benches which should be in place in the next few months. Research showed nationally older adults living in more deprived areas felt less positive about where they lived . The Ageing in Place Pathfinder work to improve walkability of Old Trafford by residents is an example of older adults' vital contribution to the community, making it a better place to live by undertaking local improvement work, such as community litter picking. Also, in conjunction with Ageing in Place, to celebrate older adults for the IDOP Seymour Primary school held a grandparent's special day. The South Neighbourhood also worked with the volunteer coordinator to hold a showcase of volunteering opportunities in January.

*Figure 15: Members of the Ageing in Place Pathfinder group undertaking the walk and wheel-ability audit*

Many of Age UK's services are also assisted by older adult volunteers. An example is shown below. Other opportunities for volunteering are shown in Appendix 4.

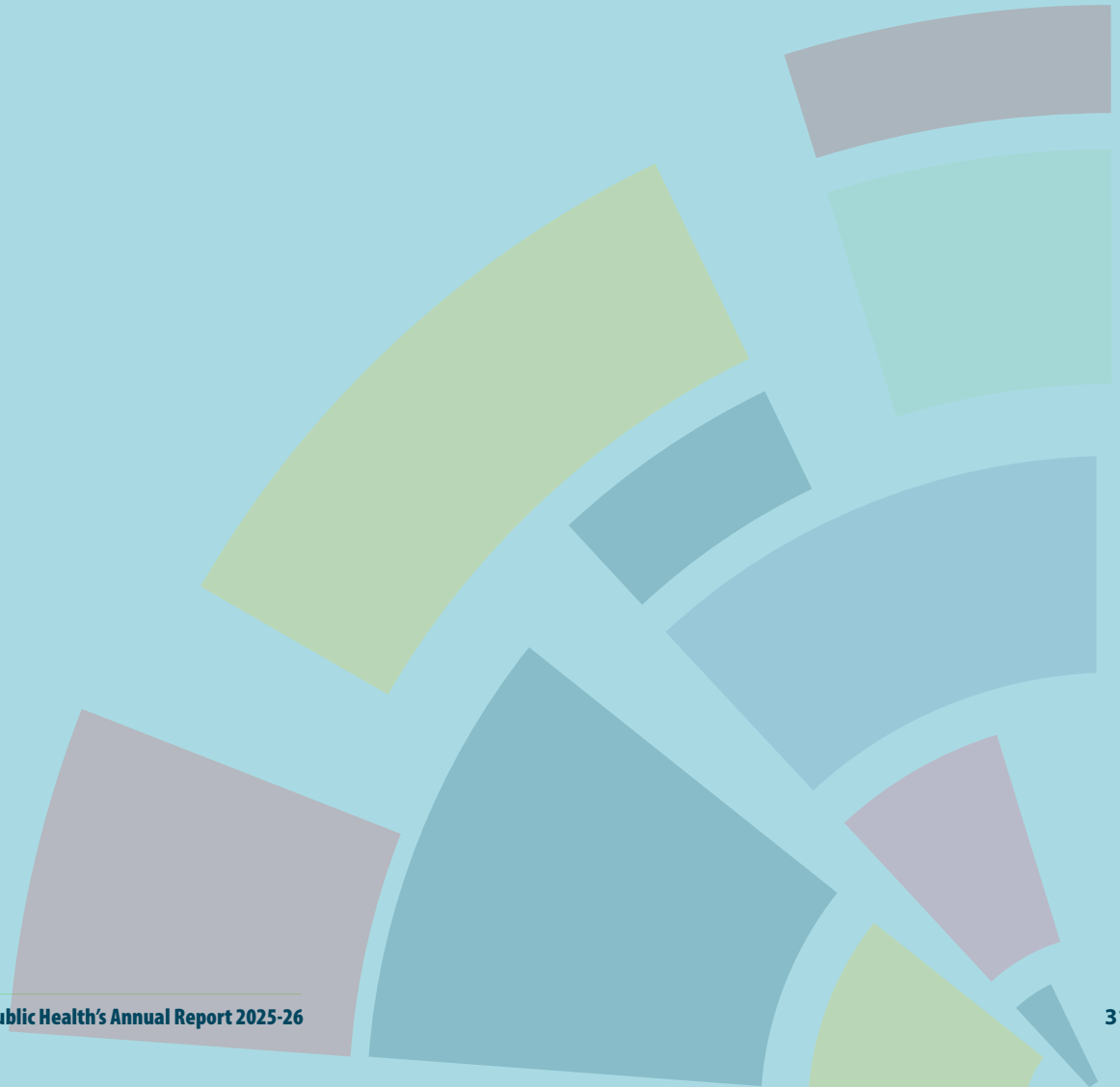
## Case Study: Age UK Men's Group Volunteer

After retiring from full time employment July 2021, I unfortunately found myself attending the GP suffering from anxiety which after a length of time led to counselling sessions and they were a great help during this time my doctor messaged someone that he knew at Age UK and I was contacted to complete an application form for volunteering [...] I jumped at the chance and as this was the end of 2022, it was basically to start at the beginning of 2023, which fitted in nicely with the end of my counselling sessions.

This was great. It turns out it was just what I needed. 3 or so hours on most Mondays getting together with a group of men talking, laughing, having a cup of tea or coffee with biscuits, joking, playing cards, pool, darts and indoor bowls. It just felt like I was helping men who needed something to look forward to and were enjoying the sessions."

# Recommendations

- **Trafford Council and Trafford Community Collective to pilot a signposting service for older adults towards volunteering opportunities, helping them to connect with others and their community. Trafford Community Collective to review the current Volunteering Strategy.**
- **Public Health Directorate and the neighbourhood network leads, supported by the VCFSE Engagement Officers, to advertise the Ageing in Place (Live Well in Later Life as of January 2026) and South Network's Older Adults Group to encourage older adults to further take up civic engagement opportunities.**



# Chapter 7: **Guest Editors' Reflections**

## Introduction

**The guest editors reflect on the significant demographic and social changes affecting older people in Trafford.** Rising rent costs and ongoing gentrification are making it increasingly difficult for longstanding residents to remain in the communities they call home. Older renters are often spending over half their disposable income on housing, leaving them financially vulnerable and at risk of displacement. The cost of care adds further pressure, with even relatively affluent residents finding their resources quickly depleted.

Alongside these economic challenges, wider financial support has become harder to access. The reduction of highstreet banks and the declining visibility of inperson bank managers limits opportunities for older residents to receive trusted, face-to-face advice, something many rely on when navigating major financial decisions.

Housing dynamics also create barriers. Many older residents are "asset rich but cash poor," owning homes that have soared in value without experiencing a comparable rise in income. Downsizing, often suggested as a solution, is rarely straightforward. Adult children living at home, caring responsibilities, deep social roots, a lack of suitable accessible homes, and the stress of moving in later life all limit options. Moving house in later life may require trusted individuals to help manage and support with the process, which not everyone has. Meanwhile, local development continues to prioritise highvalue properties, restricting affordable choices.

As a result, many older people remain in homes that have become increasingly difficult to manage, risking deterioration in both their housing conditions and wellbeing. These patterns reduce movement within the housing market, adding pressure across generations. Together, these reflections highlight the key issues facing older residents -financial insecurity, reduced access to support, housing constraints, and demographic change - and the importance of ensuring they are not left behind as Trafford continues to evolve.

## Grow

The guest editors emphasise the importance of giving older people space and time to share their stories, noting that being genuinely listened to supports confidence, identity and wellbeing. Sensory impairments such as sight and hearing loss can make communication harder and limit participation, meaning that activities must be inclusive by design.

They highlight the value of intergenerational interaction, as many older people enjoy having younger people around and benefit from the energy and perspectives this brings. At the same time, simply being surrounded by others does not guarantee meaningful connection. Residents can still feel isolated, miss fun, and want connection with people who share their interests.

Many older adults (55+) may be autistic without having received a formal diagnosis, particularly those who grew up before autism was widely recognised in childhood. Women are especially likely to have been overlooked due to masking and historic gender bias in diagnostic practices. Creating opportunities for older people to share experiences with others who understand their circumstances is therefore vital.

The guest editor reflects on the delicate balance between safety and independence for older people. A strong focus on safety, particularly the fear of falling, can unintentionally limit autonomy, reduce motivation, and contribute to physical deconditioning.

Finally, they stress the wisdom and experience older people bring, highlighting the mutual benefits of mentoring and opportunities where their knowledge can support others. They also point to a growing challenge: many older residents simply do not know what activities, services, or support exist locally, especially those who do not use the internet at a time when information is increasingly digital only. This lack of accessible, offline information can significantly hinder participation and connection.

## Connect

The guest editors highlight the vital role of meaningful connection in later life. They note that many older people value relationships with peers of the same sex, yet care homes often have predominantly female residents and staff. This raises opportunities for inreach from men's groups to help broaden social connection. Church also provides a strong sense of community for many older residents, offering familiarity, shared values and regular opportunities for connection.

Care home residents enjoy getting out into the community, but limited staffing restricts how often this can happen. Visits from external groups into care settings are therefore very welcome, providing stimulation, variety and a sense of connection to the wider world. Such visits can also be mutually beneficial, particularly for younger residents who gain confidence, perspective and intergenerational understanding. The editors also reflected on changing family dynamics as care needs increase and independence may reduce, noting that greater reliance on family members can become a source of concern for many older residents.

Music is identified as a powerful tool for connection, moodlifting and shared experience. It supports reminiscence and belonging - whether through familiar songs or shared cultural expressions like football chants.

They also reflect on the experiences of many autistic adults, who often face loneliness partly because their social pathways and relationship patterns differ from the general population. Peer connections - especially with others who share similar experiences - can provide understanding, confidence and mutual support. These relationships can reduce isolation and encourage wider engagement in the community.

## Adapt

The guest editors highlight the significant impact that sight and hearing loss can have on older people, often leading to depression, anxiety and distress. They emphasise the importance of peer support groups and access to therapeutic support, ensuring residents can talk openly with others who understand their experiences rather than suffering in silence.

They also note how small practical challenges - such as glasses steaming up or becoming wet in the rain - can reduce enjoyment of outdoor walks and limit daily life. While technology can help people stay engaged and connected, many residents need hands-on support to set up and use digital tools effectively.

Reflections on neurodiversity highlighted that many autistic people find change and uncertainty challenging and may experience increased anxiety as routines shift with age. Groupbased support can build resilience and provide practical strategies for managing anxiety. Although fewer autistic adults experience traditional retirement due to lower employment rates, transitions can still be difficult; gradual moves into less stressful roles can help. Ageing carers also expressed concern about the future independence of autistic adult children, emphasising the value of transition programmes that build practical skills and confidence.

The editors also stress that improved local transport is essential for helping older residents stay active and connected. Shorter and more accessible walks to bus stops, seating at stops, and more frequent local routes would make everyday travel more manageable. Increased Ring and Ride provision is also needed to ensure older people with mobility limitations, can continue to get out and about, maintain independence, and sustain social connections.

# Give

The guest editors suggested that a local printed newspaper designed specifically for Trafford residents who don't use the internet, could play a valuable role in helping people stay connected with community life. Such a publication could also create opportunities for older residents to contribute-through sharing stories, memories, advice or local knowledge - supporting both a sense of purpose and stronger community tie.

Editors also highlighted the importance of small, informal acts of kindness - such as reading the news to a friend - showing how simple gestures can strengthen relationships and make a big difference to someone's day.

Reflections on neurodiversity emphasised the importance of fair and inclusive opportunities for autistic adults. Transition programmes can create roles where older autistic people act as mentors, sharing experience and insight. However, it was highlighted that volunteering expectations can sometimes undervalue autistic people's contributions. A key principle emerged: residents with lived experience should be paid for their work, with the *option* to donate back if they choose. This approach promotes fairness, recognises expertise and supports meaningful participation.

# Chapter 8: **Summary Recommendations**

**This report highlights why supporting our older residents of Trafford to "grow, connect, adapt and give" helps them to life longer, healthier and more fulfilling lives.**

It has demonstrated that there are a breadth of activities already taking place across our neighbourhoods supported by a wide range of system partners that are enabling older people to grow, connect, adapt and give.

The report has also highlighted important demographic information which together with our Older People's Needs Assessment (to be published Spring 2026) will provide valuable insights to help inform what action we need to take and where across our Borough to ensure all our older adults have equal opportunities to be supported to grow, connect, adapt and give.

Each of the chapter recommendations are set out below. Many of these require jointly owned action by Trafford system partners working together – spanning Health and Social Care, the Council and Voluntary, Community, Faith and Social Enterprise sectors.

Trafford's Age Well Board will wish to review how these recommendations sit alongside the Board's objectives and how these might best support Trafford's residents to thrive in later life.

Overall chapter recommendations are summarised below:

## Grow

1. As a system commitment to widening participation, prioritise engagement with older male residents living in less affluent parts of the Borough to better understand how we can support them to take up and complete referrals to programmes such as PARS and talking therapies, as well as opportunities in the VCFSE sector such as the Mile Shy club. Use this insight to inform local commissioning decisions.
2. The Public Health Directorate, with support from the Trafford Community Collective, to allocate small grants funding for VCFSE organisations to bid to run projects with older adults that focus on the 5 ways to wellbeing (connect, be active, learn, give, take notice). Particular focus to be given to those who are most isolated, such as LGBTQ groups and carers.
3. Support coordinated communications and engagement activity to raise awareness of opportunities across Trafford for older people to participate in activities that support mental and physical wellbeing. This should include accessible paper-based information (for example What's on Where guides) alongside digital promotion. Neighbourhood networks will play a facilitating role, helping to connect formal communications with local knowledge, trusted relationships and feedback from older residents.
4. System partners to make better use in commissioning decisions of evidence for the efficacy of using creative arts for health gain – explore feasibility of expanding activities that help older adults move more and impact positively on mental health such as 'dementia discos'.

## Connect

5. Consider ways in which transport can be provided to enable more older people to participate in social activities by building on the learning from Ageing in Place in Old Trafford regarding active travel and barriers for older residents. Age UK Salford and Trafford will be continuing this work via Live Well in Later Life (formerly Ageing in Place).
6. Neighbourhood networks and community hubs to continue to build on work to prioritise interventions that address loneliness.
7. As a system explore the potential for measures of belonging and social connectedness to be included in Trafford neighbourhood scorecard and our Neighbourhood Performance Arrangements, to ensure qualitative aspects are also captured. Consider including social capital and connectiveness within service specifications.

## Adapt

8. As a system take a joint, proactive strategic approach to co-ordinating and promoting awareness of support available to Trafford residents specifically during life changes. Priority focus to be given to bereavement support, living well with dementia, managing long term conditions and caring.
9. Encourage self-care opportunities amongst older adults:
    - Public Health Directorate and neighbourhood leads to proactively encourage older adults to attend health checks
    - Public Health Directorate to work with Trafford Carers Centre to deliver a mental wellbeing project
10. As a system collectively challenge ageism and stereotypes and advocate for inclusive language that celebrates older age, including in reports and grants applications. Involve the Council's communication teams to ensure change throughout the organisation
11. Trafford Community Safety Partnership to explore potential routes for securing longer term funding of the **Safer Ageing Domestic Abuse Advisor** (SADAA)

## Give

12. Trafford Council and Trafford Community Collective to pilot a signposting service for older adults towards volunteering opportunities, helping them to connect with others and their community. Trafford Community Collective to review the current Volunteering Strategy.
13. Public Health Directorate and the neighbourhood network leads, supported by the VCFSE Engagement Officers, to advertise the Ageing in Place (Live Well in Later Life as of January 2026) and South Network's Older Adults Group to encourage older adults to further take up civic engagement opportunities.

# Appendix 1: **Map of Trafford Wards and Demographics of Trafford Older Adults**


*Figure 16: Trafford's wards and neighbourhood*

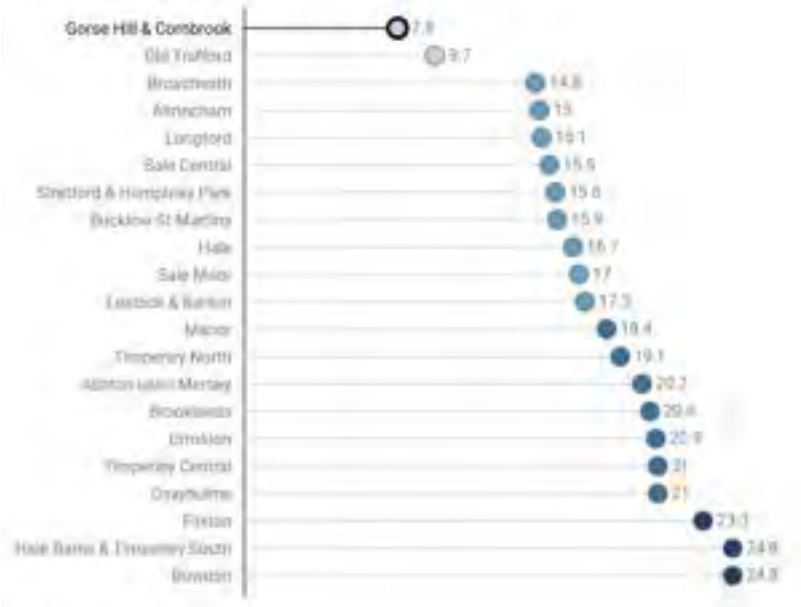



*Figure 17: Proportion of the resident population aged 65+ years; Trafford wards (ONS, mid-2022 estimate)*

| Group | Number of people (% of Total) |
|---|---|
| Asian, Asian British or Asian Welsh (including Bangladeshi, Chinese, Indian, Pakistani, Other Asian) | 1,350 (3.3%) |
| Black, Black British or Black Welsh (Including Caribbean, African, Other Black) | 620 (1.5%) |
| White: English Welsh, Scottish, Northern Irish, British | 35,900 (86.9%) |
| White: Other | 2,300 (5.6%) |
| Other | 255 (0.6%) |
| Total | 40,425 (100.0%) |

***Table 1: Ethnicity of Trafford Residents aged 65 and over. N.B. Numbers may differ from total population estimates due to rounding and small number suppression.***

# Appendix 2: **Ageing Well within Trafford Council**

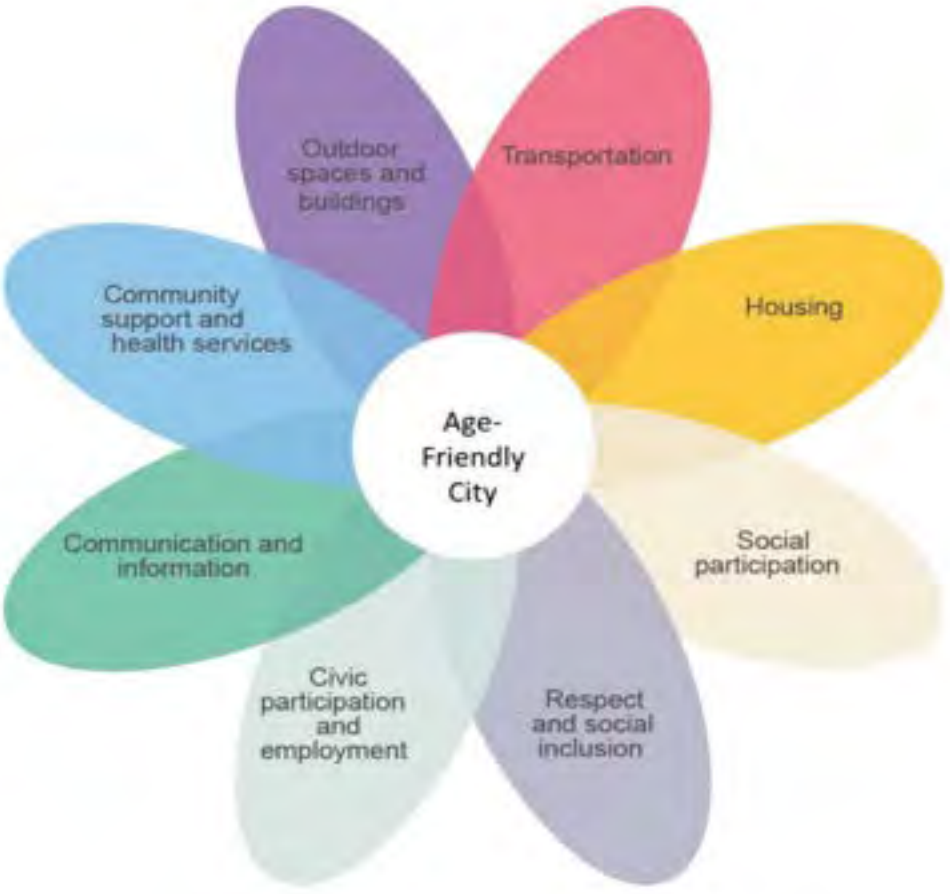



***Figure 18: Age-Friendly City, WHO***

Greater Manchester is recognised as an Age-Friendly region, a commitment led by the Greater Manchester Combined Authority (GMCA) in collaboration with local authorities, health and care partners, and the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector. Trafford itself is an Age-Friendly local authority. This regional approach is underpinned by the World Health Organization's Age-Friendly Cities and Communities Framework (Figure 1), which provides a shared structure for action across the life course.

The Board plays a key role in fostering collaboration across sectors to address the wider determinants of healthy ageing. It reports directly into the Trafford Health and Wellbeing Board, ensuring that its work supports and contributes to the borough's overarching health and wellbeing priorities. The Age Well Board's priorities are embedded within the Public Health Business Plan, which places a strong emphasis on ageing well and tackling the broader social, economic, and environmental factors that influence health outcomes.

# Appendix 3: **Calculation of Age Well Measures**

| | Indicator | Period | Trafford | England | Unit | Significance | Source |
|---|---|---|---|---|---|---|---|
| Wellbeing and Culture | Life expectancy at 65 (Male) | 2021-23 | 18.7 | | 18.7 Years | Similar to England | Public Health Outcomes Framework |
| | Life expectancy at 65 (Female) | 2021-23 | 21.4 | | 21.1 Years | Similar to England | Public Health Outcomes Framework |
| | Healthy life expectancy at 65 (Male) | 2021-23 | 10.8 | | 10.7 Years | Similar to England | Public Health Outcomes Framework |
| | Healthy life expectancy at 65 (Female) | 2021-23 | 11.8 | | 11.2 Years | Similar to England | Public Health Outcomes Framework |
| | Inequality in life expectancy at 65 (Male) | 2021-23 | 6.2 | | 6.6 Years | 3rd worst quintile | Public Health Outcomes Framework |
| | Inequality in life expectancy at 65 (Female) | 2021-23 | 4.2 | | 5 Years | Middle quintile | Public Health Outcomes Framework |
| | Hip fractures (65+) | 2023/24 | 487 | | 647.05 per 100,000 | Similar to England | Public Health Outcomes Framework |
| | Emergency admission rate to beds (age 65+) | 2023/24 | 5,056 | | 1,584.05 per 100,000 | Similar to England | Public Health Outcomes Framework |
| | Alcohol admissions rate (65+) (Narrow) | 2023/24 | 667 | | 664.09 per 100,000 | Better than England | Public Health Outcomes Framework |
| | Smoking (18+) | 2023-24 | 7.9 | | 15.3 Percentage | Better than England | Public Health Outcomes Framework |
| | Obesity (18+) | 2023/24 | 16.9 | | 28.5 Percentage | Better than England | Public Health Outcomes Framework |
| | Preventable eight loss (AHT) | 2023/24 | 42.3 | | 104.1 Rate per 100,000 | Similar to England | Public Health Outcomes Framework |
| | Dementia Diagnosis rate | 2026 | 66.7 | | 64.4 Percentage | Similar to target (66.7%) | Public Health Outcomes Framework |
| | Active (age 55-74) | 2023/24 | 57.3 | | 63.3 Percentage | Similar to England | Sport England - Active Lives |
| | Employment (age 50-64) | 2024 | 70.3 | | 68.5 Percentage | Similar to England | NOMIS Claimant Count |
| | Employment (age 65+) | 2021 | 15.2 | | 10.7 Percentage | Similar to England | NOMIS Claimant Count |
| | Volunteering (65+) in last 12 months | 2022/23 | 23.1 | | 19 Percentage | Similar to England | Sport England - Active Lives |
| Inequality | Fuel Poverty | 2022 | 9.8 | | 13.3 Percentage | Middle quintile | Public Health Outcomes Framework |
| | Pension Credit Claiming | Feb-25 | 10.1 | | 11 Percentage | Similar to England | Department for Work & Pensions |
| | Loneliness (65+) (Sometimes, often or always) | 2022/23 | 14 | | 12.4 Percentage | Similar to England | Sport England - Active Lives |
| | Social Isolation among Carers | 2023/24 | 35 | | 26 Percentage | Similar to England | Public Health Outcomes Framework |
| Health Protection | Aortic Aneurism Screening | 2023/24 | 81 | | 81.3 Percentage | Similar to England | Public Health Outcomes Framework |
| | Bowel Cancer Screening | 2024 | 72 | | 71.8 Percentage | Similar to England | Public Health Outcomes Framework |
| | Flu Vaccination Coverage (65+) | 2024/25 | 76.8 | | 71.7 Percentage | Higher than Target (75%) | Public Health Outcomes Framework |
| | Pneumococcal Vaccine Coverage | 2024/25 | 73.9 | | 73.6 Percentage | Similar to target (65% - 75%) | Public Health Outcomes Framework |
| | Shingles Vaccine Coverage | 2023/24 | 43.3 | | 48.3 Percentage | Lower than target (60%) | Public Health Outcomes Framework |
| Care | Satisfaction with Care (65+) | 2023/24 | 60 | | 62 Percentage | Lower than England | Adult Social Care Outcomes Framework |
| | Admissions to residential & nursing homes | 2023/24 | 779.6 | | 566 Rate per 100,000 | Higher than England | Adult Social Care Outcomes Framework |
| Premature Death | Deaths from Respiratory Diseases (<75) | 2022-24 | 39.7 | | 33.4 DSR per 100,000 | Similar to England | Public Health Outcomes Framework |
| | Deaths from Cancer (<75) | 2022-24 | 110 | | 100.2 DSR per 100,000 | Similar to England | Public Health Outcomes Framework |
| | Deaths from Cardiovascular Disease (<75) | 2022-24 | 76.7 | | 76.5 DSR per 100,000 | Similar to England | Public Health Outcomes Framework |
| | Excess Winter Deaths | 2021/22 | 7.6 | | 8.1 Ratio - %s | Similar to England | Public Health Outcomes Framework |
| | Deaths at home | 2024 | 27.1 | | 28.4 Percentage | Similar to England | Public Health Outcomes Framework |

# Appendix 4: **What's On**

## Grow

- Age UK run "Healthy Hips and Hearts" in South Trafford and a Walking Football group in Urmston [76].
- Voice of BME also run Health Hips and Hearts classes. The Hub in Altrincham also provide "Healthy Hips and Hearts" and "Strength and Cardio" classes [77].
- The Sale Sharks Foundation also offer Head Start, a free and inclusive physical activity programme designed to promote good mental health through safe, structured exercise [78].
- Empower You also offer dance and exercise classes for people with learning impairments and autism and their carers and family[79].

## Women's Walking Cricket

Alison: "I have attended 5/6 womens walking cricket sessions and I have met some really lovely new people. I started walking cricket as I have been a cricket fan since I was about 5 and I have loved it all my life and never had the chance to play then I saw this and its just amazing that over 60 I can suddenly start playing cricket of a sort. It's a really fun way to exercise, I had a really bad injury couple of years ago which meant I had to give up a lot of the sports I was doing and this way I can take part in a social sport that's fine for my bad ankle and gets me moving."

- Re-Engage hold activities for over 75's around Trafford (often tea dances).
- Dance Discovery deliver dance and movement session for over 50's at Sale Waterside Centre.
- Movement classes are held weekly at Limelight, Old Trafford.
- Andy's Man Club Old Trafford provide weekly support sessions for men over 18yrs old.
- 'Mindful Resort'- Men's Group run by Blue Sci at Night, provides a monthly group to improve health and wellbeing in Old Trafford.

## Connect

- The Hub in Altrincham also run a knit and natter group.
- Cyril Flint befrienders attend care homes in Trafford.

## Adapt

- Alzheimer's UK also run a dementia support service in Sale.
- Age UK Salford and Trafford run a memory loss advice service with advisors that support people and their families or carers before, during and after a dementia diagnosis, and supports on average over 200 people per quarter.
- Some care homes, such as Care UK's Halecroft Grange in Hale Barns, run a dementia café.
- Trafford Carers Centre are also running a Carer's Rights Day in November.
- Breath Champs group supports residents Lung Health.

## Give

- There are also older adults volunteering within Age UK to help run their services, such as the Men's Group.
- Intergenerational opportunities exist with Intergen Trafford, where older adults can volunteer in schools. There are currently 72 volunteers across 26 schools in Trafford.
- St John's Old Trafford have a large amount of volunteers, including Bread and Butter project (discounted food scheme) and Litter picking.

# Glossary

- **Joyspan -** the time spent experiencing joy and fulfilment in life [4]
- **Life Expectancy -** the average period that a person may expect to live.[1]
- **Healthy Life Expectancy -** how long a person can expect to live with good or very good health [80]
- **Health Inequalities -** unfair, and avoidable differences in health outcomes, like life expectancy or rate of disease [81]
- **Deprivation -** lacking the resources, conditions, and opportunities (beyond just income) needed in society. This leads to poorer health, higher illness, and lower life expectancy. It is measured through factors like housing, education, environment, and income to understand health inequalities [82]
- **Dementia -** a word used to describe a group of symptoms that occur when brain cells stop working properly in areas that control how we think, communicate and remember things [83]
- **Loneliness -** a feeling, related to whether the social contact we have is meaningful to us and meets our emotional needs [84]
- **Social Isolation -** being alone, whether or not that's what we want. Someone can be isolated but not feel lonely – and someone can feel lonely even when they're surrounded by people [85]

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81. NHS England » What are healthcare inequalities?
82. Introduction - ScotPHO
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84. Loneliness research and impact | Age UK

TRAFFORD
COUNCIL

# Thank you for reading

| | | | | |
|---|---|---|---|---|
| **Name of Committee / Board** | **Trafford Locality Board** | | | |
| **Date of Meeting** | **23/7/2026** | | | |
| **Report Title** | **Update to Operational Local Health Economy Outbreak Plan** | | | |
| **Report Author & Job Title** | **Helen Gollins, Director of Public Health & Emily Paine, Commissioning Support Officer** | | | |
| **Organisation Exec Lead** | **Cllr Slater, Executive Member for Healthy and Independent Lives, Trafford Council** | | | |
| **OUTCOME REQUIRED** *(please highlight)* | Approval | Assurance | Discussion | Information |

## EXECUTIVE SUMMARY


The Operational Local Health Economy Outbreak Plan sets out the roles, responsibilities and operational arrangements for partner organisations responding to an infectious disease outbreak in Trafford. Its purpose is to ensure a coordinated, timely and effective multi-agency response. It is intended to act as a companion to the GM Multi-agency Outbreak Plan.

The Plan has recently undergone a comprehensive review and update, undertaken jointly by Public Health and Emergency Planning colleagues. The review process was supported through the Health Protection Board, with all members provided with the opportunity to review the document and propose amendments.

Key updates to the Plan include:

- Updated organisational contact details and escalation routes.
- Revised treatment pathways, reflecting the commissioning of Mastercall Healthcare to provide services for Trafford residents exposed to communicable infectious diseases. This includes timely access to treatment, prophylactic therapies, vaccinations, clinical support and antiviral medications where required.
- Clarification of funding arrangements and responsibilities during outbreak responses.
- Inclusion of a new section on Person-Centred Approaches to Outbreak Response, strengthening consideration of individual needs and reducing barriers to accessing support and treatment.

The revised Plan provides greater clarity on operational processes and partner responsibilities, ensuring Trafford remains well prepared to respond effectively to infectious disease outbreaks.


## RECOMMENDATIONS

The Trafford Locality Board are asked to:

1. Review and acknowledge the updated Outbreak Plan.
2. Support progression of the Outbreak Plan to the Health and Wellbeing Board for final approval.
3. Support sharing of the Outbreak Plan with Greater Manchester.

**CONSIDERATIONS – these must be completed before submission to the Board – Reports with incomplete coversheet information will not be accepted and shared with the board**

| | |
|---|---|
| **Risk implications** (***Please provide a high-level description of any risks relating to this paper, including reference to appropriate organisational risk register)*** | Approval of the Local Outbreak Plan minimises risk to Trafford by outlining steps for all organisations involved to take in the event of an incident or outbreak. |
| **Financial implications and comment/approval** ***(Please detail which organisation(s) will be impacted, and if not required, please briefly detail why)*** | Name/Designation: |
| | Comment / Approval *(Delete appropriately): There are no financial implications for this outbreak plan.* |
| **Comment by Trafford Clinical and Practitioner Senate (TCAPS) and/or Clinical Lead** ***(If not required, please briefly detail why)*** | Date of TCAPS / Clinical Lead comment (Delete appropriately): |
| | Name/Designation: (If appropriate) |
| | Comment: |
| **What is the impact on inequalities?** (***Please provide a high-level description of any known impacts)*** | Certain groups experience greater exposure, vulnerability and poorer outcomes from infectious diseases, environmental hazards, and barriers to prevention. The steps in this outbreak plan are proportionate, person-centred, inclusive, and focused on reducing inequalities. |
| **Equality Impact Assessment / Quality Impact Assessment Outcome** ***(If not appropriate at this stage please state if an EIA or QIA is necessary)*** | n/a |
| **People and Communities: Communications & Engagement** ***(Please detail relevant patient/public engagement completed and/or planned, and if not required please briefly detail why)*** | The outbreak plan includes requirements for communication with the public in the event of different types of outbreaks. |
| **Trafford's Carbon Footprint** ***(Please provide a high-level description of any known positive and/or negative impacts – consider the following topics: energy usage; staff or public transport; waste or materials used. Include steps that could be taken to reduce carbon within relevant plans)*** | n/a |
| **Links to Measurement / Outcomes** ***(Please detail if this is included within the report)*** | **n/a** |
| **Enabler implications** | **Legal implications: n/a** |
| | **Workforce implications: n/a** |
| | **Digital implications: n/a** |

| | |
|---|---|
| | **Estates implications: n/a** |
| **Sub-Board Sign-Off / Comments**<br>**(i.e. Trafford Provider Collaborative Board, H&SC Delivery Steering Group)** | |
| **Organisation Exec Lead Sign off** | |

# Operational Local Health Economy Outbreak Plan

Trafford
July 2026

**Document Control**

| | |
|---|---|
| **Document title:** | Operational Local Health Economy Outbreak Plan: Trafford |
| **Document status:** | |
| **Document version:** | Version 19 |
| **Document date:** | July 2026 |
| **Document author(s):** *(Name, Title)* | Template: Karl Astbury, AGMA Civil Contingencies and Resilience Unit Business Partner<br>Adapted for Trafford System by Public Health Directorate in partnership with Trafford's Health Protection and Resilience Board. |
| **Document owner(s):** *(Name/organisation)* | Template: GM Local Health Resilience Partnership / Greater Manchester Resilience Forum<br>Borough Plan: Helen Gollins, Trafford Director of Public Health / Cathy O'Driscoll, Associate Director of Delivery & Transformation (Trafford), NHS GM ICB Trafford |

**Change History**

| Version | Date | Status | Notes |
|---|---|---|---|
| 0.01 | 15-09-21 | Initial draft | Following 1st Planning Group meeting |
| 11.00 | 08-02-23 | Addition | Added Glossary of Terms and Annex 7 & 8 |
| 11.00 | 12-02-23 | Amendment | Update to Part 3 to include other communicable diseases and tables added |
| 11.00 | 28-02-23 | Amendment | Removed CCG & PHE references |
| 12:00 | 28-04-23 | Amendment | Updated following SME comments |
| 13.00 | 15-05-23 | Amendment | Update of DPH |
| 14.00 | 22-05-23 | Amendment | Updated following further SME comments |
| 15:00 | 16-06-23 | Sent | Document sent for approval |
| 16.00 | 01-03-24 | Amendment | Change to UKHSA SPOC |
| 17.00 | 12-03-24 | Amendment | Changes to sections 2 & 3 |
| 18.00 | 16-09-24 | Amendment | Addition of outbreaks in asylum seeker hotel setting |
| 19.00 | 01-07-26 | Amendment | Reformatting and updating throughout |

**Approval**

| Approving group/body: FOR BOROUGH PLAN | Approval date |
|---|---|
| Trafford DPH | 1/7/2026 |
| Corporate Leadership Team | 08/07/2026 |
| Health Protection and Resilience Board | 17/7/2026 |
| Adults Directorate Management Team-Senior Leadership Team | 10/8/2026 |
| Health and Wellbeing Board | 11/9/2026 |
| Trafford Executive Briefing | 5/10/2026 |
| UKHSA North West | |

This plan was agreed by Trafford's Health Protection and Resilience Board on 17th July 2026 and signed off by Trafford's Health and Wellbeing Board on 11th September 2026. The plan will be updated as required and will be formally reviewed annually, next date for review, April 2027.

**Signed**

Helen Gollins, Director of Public Health, Trafford Council

**Signed**

Cathy O'Driscoll, Associate Director for Delivery & Transformation (Trafford), NHS GM ICB Trafford

## Glossary of Terms

| | |
|---|---|
| ARI | Acute Respiratory Infection |
| ASC | Adult Social Care |
| AVs | Antivirals |
| BBV | Blood Born Virus |
| CCDC | Consultant in Communicable Disease Control |
| CHP | Consultant in Health Protection |
| DPH | Director of Public Health |
| EHO | Environmental Health Officers |
| FIO | Forward Incident Officer |
| FT | Foundation Trust |
| GM ICS | Greater Manchester Integrated Care System |
| GTD | Go To Doc (Healthcare) |
| HCAIs | Health Care Associated Infections |
| HP | Health Protection |
| HPT | Health Protection Team (at UKHSA) |
| ILI | Influenza like illness |
| IPC | Infection prevention and control |
| ICP | Integrated Care Partnership |
| LA | Local Authority |
| LCT | Local Co-ordination Group |
| LOCT | Local Outbreak Control Team |
| LRF | Local Resilience Forum |
| NOK | Next of Kin |
| OCT | Outbreak Control Team |
| OHID | Office of Health Improvement and Disparities |
| PEP | Post exposure prophylaxis |
| PGD | Patient Group Direction |
| CIPCT | Community Infection Prevention Control Team |
| UKHSA | UK Health Security Agency (formerly PHE) |

Contents

## PART 1: Introduction, Governance, and Objectives

### 1.1 Introduction

Protecting and improving the health of our local population sits at the centre of public service delivery. A strong and proactive approach to Health Protection (HP), and particularly to the prevention and management of infectious disease outbreaks, is fundamental to this responsibility.

This Operational Local Health Economy Outbreak Plan (LOP) sets out how partners- including Public Health, NHS organisations, LA services, UK Health Security Agency (UKHSA), education settings, social care providers, and voluntary sector partners- work collaboratively to detect, assess, and respond to outbreaks in a timely and coordinated way. It provides a clear framework for action, ensuring that our response is both effective and consistent with national guidance. This plan should be implemented alongside the Greater Manchester Outbreak Plan.

We are committed to placing health equity and the reduction of health inequalities at the heart of every stage of our outbreak response. This means ensuring that our actions, our communication methods, and our engagement approaches are tailored to the needs of our diverse communities and settings. By doing so, we aim not only to control outbreaks but also to protect those who may be disproportionately affected due to social, economic, or structural barriers.

### 1.2 Governance

This plan operates within national legislation and public health guidance, including the Health and Social Care Act 2012[i] and NHS England infection prevention and control standards[ii]. It is a dynamic document, revised regularly to reflect current evidence, learning from incident reviews, and changes in local systems.

This plan is a key component of Trafford's Health Protection and Resilience Strategy.

The Director of Public Health (DPH) holds overall responsibility for the LOP. They ensure the plan is implemented, updated, and aligned with statutory public health duties[iii]. The DPH provides assurance of Health Protection plans and reports annually to the Health and Wellbeing Board.

A systematic approach to measurement, audit and improvement of services will be taken through multi-agency reviews including regular exercises to assess and improve the quality of services provided to protect health.

### 1.3 Aim of the Plan

The LOP describes the multi-agency operational arrangements for responding to health protection incidents or outbreaks of human infectious diseases that may harm people who, live in Trafford or are registered with a Trafford general practice.

### 1.4 Objectives of the Plan

This plan sets out:

- The roles and responsibilities of partners at a local operational level
- The key tasks/activities involved in responding to outbreaks
- Some of the specific requirements needed dependant on incident or outbreaks

### 1.5 Scope/Context of the Plan

This LOP is concerned with outbreaks and incidents:

- of human infectious diseases which could impact Trafford and neighbouring boroughs.
- requiring an Outbreak Control Team (OCT): see part 2 and 3
- not requiring an OCT: see part 4

### 1.6 Guidance and Documentation

The local health protection system will implement the appropriate guidance when required:

- National Guidance:
    - United Kingdom Health Security Agency (UKHSA) Communicable disease outbreak management guidance[iv].
    - UKHSA Acute Respiratory Infection in Care Homes guidance[v].
- GM Guidance:
    - GM Outbreak Plan (including Legionnaires Disease and High Consequence Infectious Disease (HCID) annexes)- Current versions of the GM Plan are held on the Government's Resilience Direct website[vi].
    - GM Annual Acute Respiratory Infections outbreak pack saved on Health Protection Board SharePoint.
- Local Documentation, saved on Health Protection Board SharePoint: Trafford Health Protection and Resilience Board Strategy. Local guidance, standard operating procedures, reporting logs direct local action.

### 1.7 Person-Centred Approach to Outbreak Response

An incident of infectious disease can affect individuals, families, and settings in many ways. In Trafford, our approach is guided by the Fairer Trafford principles, ensuring that actions are proportionate, person-centred, inclusive, and focused on reducing inequalities. We aim to protect public health while also recognising the wider social, emotional, and financial impacts on our residents and communities.

#### 1.7.1 Emotional and Psychological effects

The local health protection system partners acknowledge that the measures required to manage an outbreak can affect people differently. We aim to ensure people feel respected and supported throughout the response, with communication throughout the response that is clear, concise, and easy to understand to raise awareness and keep others informed. Our response should consider:

- Self-isolation may cause feelings of loneliness and anxiety.
- Social stigma may be felt by some.

We recognise that the experience of our residents during the 2020 pandemic and the associated trauma affected people in different ways, we will consider this during the management of an outbreak.

### 1.7.2 Daily life disruption

Outbreak control measures may disrupt residents' daily routines. Ensuring people can stay connected and supported is key to maintaining resilience within our communities. Potential impacts include:

- Potential impact of missing education for children who cannot attend school.
- May be unable to attend social activities, or usual physical activity.

### 1.7.3 Financial impact

We recognise that outbreaks can place additional pressures on households. Our approach aims to minimise these pressures and signpost individuals to available support, helping to reduce financial inequality. This may include:

- Need to remain off work and may not receive sick pay.
- Parents of a child who cannot attend school may need to remain at home, unable to work.

### 1.7.4 Impact on the setting

Organisations and settings may also experience challenges, such as:

- Operational challenges
- Financial implications
- Reputational risk
- Staff morale and well-being

The OCT must ensure incident control measures are proportionate, person-centred and equity-focused, protecting the health, social and emotional wellbeing of individuals involved. Our goal is to protect public health while supporting a fairer, more resilient Trafford for everyone.

## PART 2: Outbreak Management

### 2.1 Incident/Outbreak Detection and Notification

This Outbreak Plan must be followed in the event of an incident or outbreak.

### 2.1.1 Incident

| |
|---|
| An incident will involve a high consequence infectious disease (HCID) or a suspected, anticipated or actual evidence involving microbial contamination of food or water. |

A single case of, or a single exposure to a suspected or confirmed high consequence infectious disease. In the UK, a high consequence infectious disease (HCID) is defined

according to the following criteria[vii]:

- Acute infectious disease
- Typically has a high case-fatality rate
- May not have effective prophylaxis or treatment
- Often difficult to recognise and detect rapidly
- Ability to spread in the community and within healthcare settings
- Requires an enhanced individual, population and system response to ensure it is managed effectively, efficiently and safely

### 2.1.2 Outbreak

An outbreak is defined as :

- An incident in which at least 2 or more people affected by the same infectious disease are linked by time, place, or common exposure
- A greater than expected rate of infection compared with the usual background rate for the place and time where the outbreak has occurred

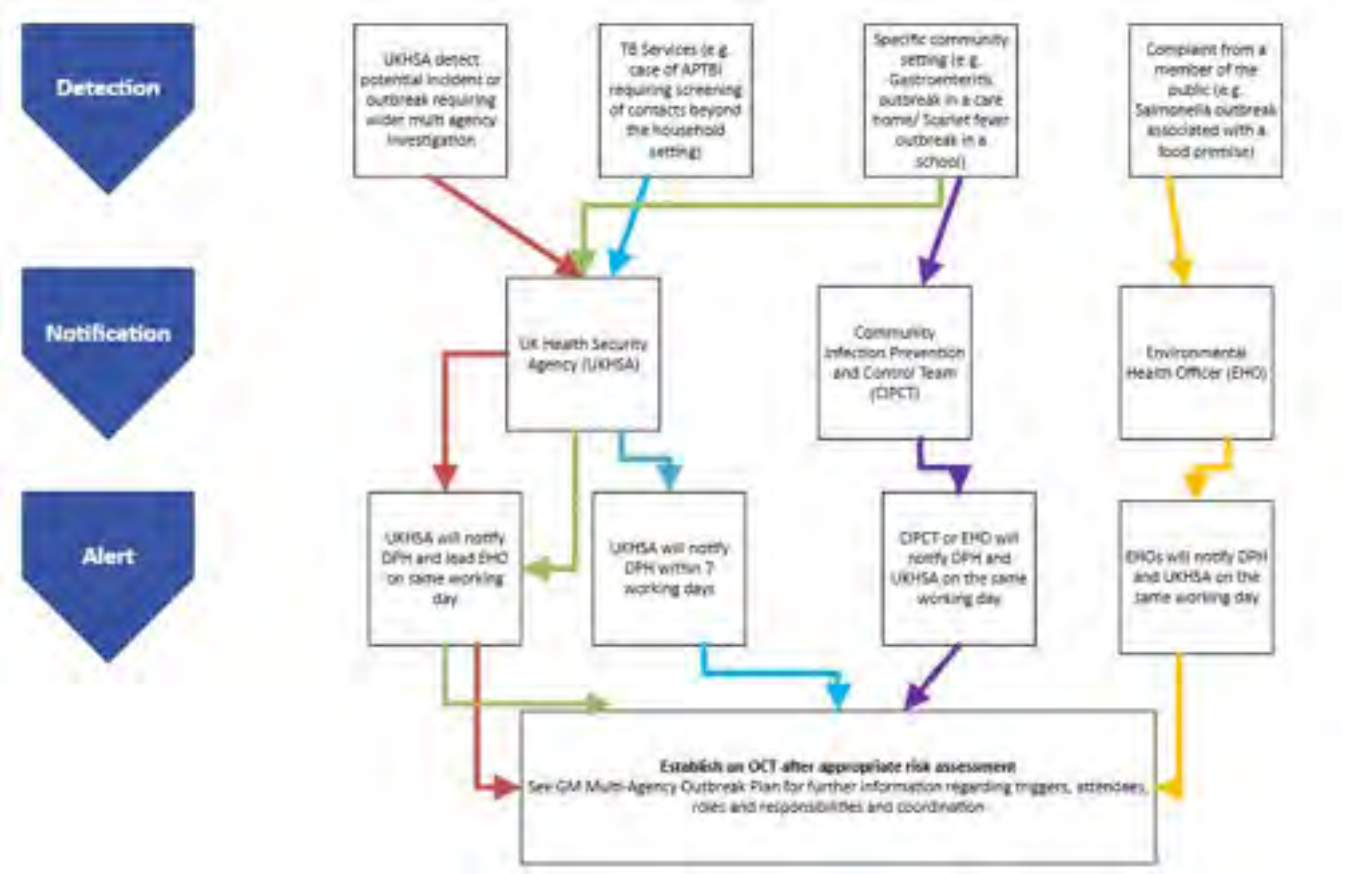
### 2.1.3 Detection and Notification

The Public Health Directorate or CIPCT may be made aware of an incident or outbreak from UKHSA, Regulatory Services or from settings. The CIPCT may be contacted by a variety of settings to report cases of infection/outbreak, including: UKHSA, nursing/care home staff, schools/nurseries, CIPCT from an NHS Trust, Microbiology/virology or Environmental Health Officers (EHO).

Notifiable diseases are certain infections that may present a risk to human health, and which must be reported to UKHSA[viii]. There are diseases which are not notifiable which will still require actions. Examples include:

- Health Care Associated Infections (HCAI)
- Hand, foot and mouth

Outbreaks of disease are usually detected and alerted in the following ways:




*Dependant on the outbreak and the infection confidential communications should be shared by UKHSA or the DPH via email stating the location and nature of the outbreak, and the number of people affected. This is used to notify the following:

- DPH
- UKHSA
- CIPCT
- ASC
- NW Ambulance Service
- Environmental Health
- Consultant Microbiologists
- GM NHS ICB
- Mastercall

### 2.2 Outbreak Control Team (OCT)

UKHSA will liaise directly with relevant partners to recommend and coordinate investigations and control measures. If needed, UKHSA will make the decision to convene an OCT.

Dependant on the infection and setting, locally confined smaller outbreaks will be recognised and declared by CIPCT with the response being led locally, such as Acute Respiratory Infection in a care home. See A*nnex 1* for contact information of partner organisations.

The OCT will function as a formal meeting of all partners to coordinate the control, investigation and management of an incident or outbreak. As such all discussions should be appropriately recorded. The number of OCTs required per incident/outbreak may vary.

The DPH will lead the local response to an outbreak within Trafford. This may be delegated to the Consultant in Public Health or other appropriate member of the CIPCT.

The OCT will cover:

- Situational analysis.
- Epidemiological investigation: establishing links between cases/sources based on questioning of cases/NOK and information on settings.
- Microbiological investigations: where a sample is taken and sent for analysis to a laboratory. See *Annex 2* for a list of stock locations and arrangements, including laboratory testing kits and medication. There are 2 types of investigations:
    - Clinical sampling: from human tissue (blood, respiratory secretions, salivary, faeces etc)
    - Environmental sampling: e.g., water, work surfaces etc.
- Implementing control measures usually include:
    - Identifying and controlling on-going sources. e.g. A cooling tower suspected of aerosolising Legionella, or a food premise with unsafe food preparation practice
    - Preventing/limiting onwards spread
    - Reducing likelihood of severe illness in specific vulnerable groups: usually by prompt post-exposure prophylaxis (PEP)
- Communication to settings, residents and elected members.

A template agenda for an OCT is in *Annex 3*.

All members of the OCT are responsible for effective information sharing across their respective organisations and for ensuring appropriate escalation. The OCT membership should include (context dependant):

- Public Health (Trafford LA)
- UKHSA
- GM NHS ICB Trafford Clinical Lead
- GM NHS ICB Trafford Commissioner
- Setting representation, Business/School/Care Home
- Education (Schools Only)
- Early Years Team (Early Years Settings Only)
- Commissioning (Care Homes Only)
- Commissioning (OP, LD and MH Care Homes Only and Extra Care)
- Head of Service- Early Intervention and Discharge
- Trafford Community Infection Prevention and Control Team
- Environmental Health
- Health and Safety Unit (Schools Only)
- Communications (NHS GM and /or Trafford Council)
- Administrative support.

An OCT should be minuted with a robust action log to be reviewed at the beginning of each

meeting.

### 2.2.1 Compliance measures

Where compliance with recommendations around control measures is an issue, enforcement powers may be used. For the purposes of outbreaks and health protection incidents, the bulk of enforcement powers lie with LA. Further information can be found here:

- https://www.cieh.org/what-is-environmental-health/resources/
- https://www.gov.uk/government/publications/communicable-disease-outbreak-management-guidance/toolkit-2-summary-of-health-protection-legislation
- https://www.legislation.gov.uk/ukpga/2004/36/part/2

## 2.3 Investigations

**Investigation Roles and Responsibilities**:
The below table outlines the multi-agency approach required in different potential types of investigations. A case definition should be agreed and reviewed throughout the investigation. The investigation provides data to enable to OCT to track the spread of cases to understand the communities affected by the incident/outbreak and the factors leading to transmission.

| | Response activity | | Potential responder(s) | | Considerations, comments or potential issues |
|---|---|---|---|---|---|
| | | | In hours (9-5) | Out of hours | |
| **Investigation**<br><br>(NB. Any setting where staff affected have access to Occupational Health, the investigation will be delivered through them) | Questionnaires / Interviews | | *UKHSA* | *UKHSA* | If notifiable (except sexual health clinics) |
| | | | *Hospital IPC team* | *Hospital IPC team* | For Acute Trust incidents |
| | | | *EHO* | *UKHSA* | Will investigate if foodborne outbreak / Legionella. |
| | Sampling | Respiratory samples (e.g., swabbing) | • *NHS Provider*<br>• *CIPCT* | • *NHS Provider (MFT and TLCO district nursing team).*<br>• *Care home-employed registered nurses.*<br>• *Mastercall* | Clinical respiratory sampling will be undertaken by a nurse if nursing bedded facility, or by appropriately experienced care staff in a residential care home. CIPCT will arrange swab delivery (up to 5 sample kits) through UKHSA incident log (ILOG) number to collate results relating to an outbreak. These are delivered by courier to the home. Courier will wait and take samples directly to UKHSA lab for processing. Results vie 'e-lab' to CIPCT or reported via UKHSA on-call HP Team for GM Out of Hours (OOH), weekend, Bank Holidays.<br><br>Out of hours GP on call service is provided by Mastercall, with the support of the out of Hours service lead and the out of hours clinicians could swab up to 5 contacts during weekends or Bank Holiday period. |

| | Response activity | | Potential responder(s) | | Considerations, comments or potential issues |
|---|---|---|---|---|---|
| | | | In hours (9-5) | Out of hours | |
| | | Faecal (GI outbreak) | *Environmental Health Officers* | *UKHSA* | EHOs will deliver faecal sample kits if required in settings where food, sanitary, or waterborne infection suspected and return to lab for monitoring of results. |
| | | Faecal (GI outbreak in a care home) | *Care home staff* | *Care home staff* | The decision to test for GI outbreak will be discussed with UKHSA and CIPCT and only indicated if there is a high attack rate or food borne origin suspected. CIPCT contact microbiology lab/UKHSA to obtain Incident Log (ILOG) number to be written on each specimen form. Care home will take to local GP for lab collection, or home will arrange drop off at hospital lab. Outbreak packs containing pots and forms with clear instructions are now located at four Trafford care homes (South, Central and West locations) for settings in to access quickly if required/instructed:<br>• **Urmston Manor:** 61-63 Church Rd, Urmston, Manchester M41 9EJ<br>Tel: 0161 747 6510<br>• **Amberley Care Home:** 28 Delaunays Rd, Sale M33 6RX<br>Tel: 0161 825 8222<br>• **Wyncourt Nursing Home:** 162 Park Rd, Timperley, Altrincham WA15 6QH<br>Tel: 0161 962 1290<br>• **Woodend Care Home – Bupa:** Bradgate Rd, Altrincham WA14 4QU<br>Tel: 0161 929 5127 |

| | Response activity | | Potential responder(s) | | Considerations, comments or potential issues |
|---|---|---|---|---|---|
| | | | In hours (9-5) | Out of hours | |
| | | Oral fluid (e.g., Hepatitis (Hep) A outbreak, measles outbreak) | • *Nursing bedded home – Nurse*<br>• *Residential bedded – CIPCT would be able to assist if requested*<br>• *In school or other community setting, community nurses contacted to request assistance on advice from UKHSA* | *N/A* | Arranged by UKHSA via outbreak control team, can be self-administered or under the direction of CIPCT or community nursing teams. |
| | | Urine test | • *GPs*<br>• *Hospital*<br>• *Care home* | • *OOH GP*<br>• *Hospital* | Rarely required in outbreak settings, however potentially requested in pneumococcal outbreak for urinary antigen detection on advice of UKHSA OCT or microbiologist. |
| | | Environmental (e.g., food / water) | • *Environmental Health Officers*<br>• *HSE*<br>• *Relevant Contractor* | *EHOs* | If Legionella also consider third party / legal duty holders e.g., water companies.<br>The contractor “Bureau Veritas” holds the contract for high-risk environmental sampling GM Wide. |

| | Response activity | | Potential responder(s) | | Considerations, comments or potential issues |
|---|---|---|---|---|---|
| | | | In hours (9-5) | Out of hours | |
| | | Blood tests (e.g. testing for hepatitis A immunity) | *NHS providers* | *NHS providers* | This the responsibility of the GP. |
| | | TB test (*Mantoux)* | *TB nurses* | *NA* | TB Nurses team: 0161 276 4387 |
| | | Scabies (skin scrape or clinical assessment) | *Primary care* | *Not needed* | If 1 or more residents in a care home become symptomatic with scabies rash/itching, CIPCT will offer support and guidance around management and treatment which requires careful co-ordination. Skin scrapings are not obtained by the infection control team. GP or dermatologist (where possible/required) may be called upon for clinical diagnosis. |
| | | Mass blood tests (e.g. IGRA testing) for TB | *TB nurses* | *TB nurses* | Unlikely to be required, but discussed at IMT/OCT following active TB contact if UKHSA/TB team recommendation. |
| | | Mass X-Ray (incl. mobile x-ray) | *UKHSA with support from local health economy* | *Not needed* | Unlikely to be required but can use Find and Treat if required. Would be agreed at OCT. |
| | | Transport to lab | *Local lab transport system* | *NA* | For respiratory samples – suspected Flu or other respiratory viral infection, courier will deliver to care home and return to lab. Other settings may need to return via GP or in some cases arrange own transport/hand delivery to MRI laboratory services for processing. |
| | | | *Postal* | *NA* | GI samples may go through the post via UKHSA/EHOs. |

| | Response activity | | Potential responder(s) | | Considerations, comments or potential issues |
|---|---|---|---|---|---|
| | | | In hours (9-5) | Out of hours | |
| | | | *Local lab transport system* | *Hand deliver* | Viral swabs, e.g. for suspected outbreak of Influenza, must be delivered to Virology laboratory at MRI. For suspected respiratory outbreak in a care home, transport of oral swabs will be the responsibility of the care home. Postal systems have proved unsuccessful leading to delayed diagnosis. |

### 2.4 Control Measures

**Control: Roles and Responsibilities**
The OCT will agree on control measures to prevent or limit onward spread of the incident or outbreak.

| | Response activity | Potential responder(s) | | Considerations, comments or potential issues |
|---|---|---|---|---|
| | | In hours (9-5) | Out of hours | |
| **Control** | Advice on infection, prevention & control measures | *CIPCT / EHOs / UKHSA* | *UKHSA* | All of the agencies listed, advise on precautions and measures taken to control infection, e.g., advice around personal protective equipment, environmental cleaning, hand hygiene, isolation measures, care home closure, emergency transfers/admissions, sampling, treatment, etc. Telephone advice would be supplemented with email information and links to national guidance |

| | Response activity | | Potential responder(s) | | Considerations, comments or potential issues |
|---|---|---|---|---|---|
| | | | In hours (9-5) | Out of hours | |
| | Exclusion advice, also transfer and movement of affected individuals. | | *CIPCT / EHOs / UKHSA* | *UKHSA* | Working to UKHSA and GM-led guidance and documentation for care homes and adult social care (ASC) settings. Online HP guidelines around exclusion or affected individuals in schools/childcare and community/workplace settings. Support and advice to education/childcare partners form CIPCT, and workplaces in the main from EHOs. |
| | Treatment and Prophylaxis<br><br>(Including immunoglobulin, vaccines, antivirals, antibiotics and anti-toxins) | Access | | | Where Rx/PEP available (not available for all pathogens / outbreaks). |
| | | Prescription | *GP* | *Mastercall (Out of hours GP provider)* | Mastercall 0161 476 9667 or 0161 477 9190. Public Health laboratory at MRI will support immunoglobulin provision.<br>Since December 2025, Mastercall are commissioned to provide prophylaxis in hours, if there is an outbreak in a care home. |
| | | Dispensary | *Commissioned Community Pharmacies* | *Commissioned Community Pharmacies* | AVs stock held by:<br>• **Malcolm's Pharmacy:** 28 Flixton Road, Urmston, 0161 747 2277<br>• **Timperley Pharmacy:** 250 Stockport Road, Timperley, 0161 948 5066<br>• **Mastercall** AV stock for outbreak management: International House, Pepper Road, Hazel Grove Stockport SK7 5BW, 0161 476 9667 or 0161 477 9190. |
| | | Transport | *Usual pharmacy delivery* | *Care Home Collection* | May require local response if the standard pharmacy delivery routes are not sufficient. |

| | Response activity | | Potential responder(s) | | Considerations, comments or potential issues |
|---|---|---|---|---|---|
| | | | In hours (9-5) | Out of hours | |
| | | Payment | *ICP, LA or HSC provider* | *ICP, LA or HSC provider* | For influenza antiviral provision, this is dependent on whether antivirals are prescribed during flu season or out of season (as defined by Chief Medical Officer Central Alerting System).<br>For scabies incidents, H&SC provider i.e. Care Home, are responsible for ensuring funded and timely treatment/prophylaxis. |
| | | Communication with cases / parents (e.g., consent forms) | • *Consent - Professional administering the treatment.*<br>• *General information – CICN/UKHSA*<br>• *UKHSA/Trafford Council would support* | *Out of hours provider/care giver* | The care giver would be responsible for communicating with their patient.<br>Provider management would be responsible for communicating to their own staff.<br>Trafford Council for communicating to its own staff, and DPH would take the lead on communicating with elected members and public.<br>UKHSA generally lead for press. |

| | Response activity | | Potential responder(s) | | Considerations, comments or potential issues |
|---|---|---|---|---|---|
| | | | In hours (9-5) | Out of hours | |
| | | Mass vaccination | • *NHSE*<br>• *UKHSA*<br>• *Local Public Health*<br>• *TICPT*<br>• *MFT and TLCO (both CIPCT and community nurses)*<br>• *IntraHealth* | N/A | NHSE would determine immunisation policy and pay for the vaccines.<br>For delivery:<br>Child and Young Person-related settings– ICB commission IntraHealth<br>Care homes- GPs treat confirmed cases, where 2 or more Mastercall provides prophylaxis prescribing as per locally agreed contract. |
| | | Mass chemoprophylaxis | *Mastercall (Out of Hours GP provider) via Pathfinder commissioned arrangement* | *Mastercall* | **In hours/extended hours:** AVs stocked as per medicines optimisation service specification which also includes Vancomycin for timely access for Clostridioides difficile infection:<br>• **Malcolm's Pharmacy:** 28 Flixton Road, Urmston, 0161 747 2277<br>• **Timperley Pharmacy:** 250 Stockport Road, Timperley, 0161 948 5066<br>• **Mastercall** AV stock for outbreak management: International House, Pepper Road, Hazel Grove Stockport SK7 5BW, 0161 476 9667, 0161 476 0400, 0161 474 2441 or 07824 351894. |
| | | BCG immunisation | *TB nurses* | *N/A* | TB Nurses team generic number: 0161 276 4387. Arrangements for children are currently under review with other boroughs in GM. |

| | Response activity | Potential responder(s) | | Considerations, comments or potential issues |
|---|---|---|---|---|
| | | In hours (9-5) | Out of hours | |
| | Enforcement of control measures | *Local Authority with UKHSA support* | *Local Authority with UKHSA support* | In practice this has not happened, Environmental Health would only be likely to be involved if a Food Hygiene issue. |

### 2.5 Communications

**Communications: Roles and Responsibilities**
A multi-agency response will be required to share information about the incident or outbreak with the public and other partners/agencies. Information will be clear, concise, and easy to understand to raise awareness and keep others informed.

| | Response activity | | Potential responder(s) | | Considerations, comments or potential issues |
|---|---|---|---|---|---|
| | | | In hours (9-5) | Out of hours | |
| **Communications** | To public | Setting specific advice letters (e.g. businesses, care homes, supported accommodation settings, day services) | • *OCT*<br>• *LA*<br>• *EHO*<br>• *UKHSA* | *UKHSA* | DPH would likely write to schools and care homes, EHO would likely write to businesses. |
| | | Update NHS 111 | • *NHS GM Trafford*<br>• *UKHSA* | *UKHSA* | |
| | | Helpline | *Trafford Council* | *Trafford Council* | Service and contact algorithm provided by UKHSA / LA. |
| | | Websites / social media | *Trafford Council* | *Trafford Council* | Trafford Council and NHS GM Trafford social media and website could be used. |

| | Response activity | | Potential responder(s) | | Considerations, comments or potential issues |
|---|---|---|---|---|---|
| | | | In hours (9-5) | Out of hours | |
| | | Door to door | *Trafford Council* | *Trafford Council* | Only needed in a community tension type scenario. |
| | To health partners | Briefings / sitrep's from OCT | *OCT and the stakeholders listed* | *OCT if severity requires OOH response.* | Include list of key local health economy partners (e.g. Mastercall, Hospital IPC Team, OOHs GPs, NHS 111, NWAS, Adults / Children's services, Social Care providers, other LAs, VCFSE Organisations) |
| | | Other relevant groups | *Responsibility of each agency* | *Responsibility of each agency* | |
| | To the media | | *Coordinated by UKHSA via OCT* | *UKHSA via OCT* | Include all partner agencies in discussion of key comms messages. |
| | To Elected Members / Committees e.g. Health and Wellbeing Boards | | *DPH in LA* | *DPH in LA if serious* | |
| | Internal briefs | | *Responsibility of each agency* | *If severity requires OOH response.* | All agencies involved, NHS, Trafford Council. |

## 2.6 Funding Arrangements

During an outbreak or incident control measures will need to be implemented that have financial implications. The guiding principles for this are:

- Protection of human health takes priority over funding challenges/financial discussions
- Where a local arrangement is in place re delivery of a certain aspect of the response (e.g. delivering an immunisation session in a school setting, partners must actively:
    - involve key decision makers form the relevant agency to formally approve the agreement (i.e. do not assume that the organisation will do it)
    - consider whether activity should be absorbed in existing contracts or whether additional funding is required and where commissioning responsibility lies, national guidance should be consulted to inform this.

Key commissioners in Trafford health economy include:

- **GM NHS ICB Trafford** commission acute services, mental health services, primary care services (GPs, some pharmacy schemes) community services incl. nursing (MFT and TLCO)
- **Trafford Council, Public Health** commission health services, including *school health and CIPCT, NHS MFT.*
- **Trafford Council, Adult social care commissioning** contracts with care providers, (Care home, home care Extra Care and Supported Living Services), Children's Social Care, ASC, and Learning Disability.
- **Trafford Council, Environmental Health** commissions Bureau Veritas as part of a GM contract.

See *Annex 4* for outbreak response pathway and agreed funding arrangements.

## PART 3: Local Operational Arrangements for Specific Types of Outbreaks Requiring an Outbreak Control Team

### 3. Introduction

The Director of Public Health has statutory responsibility for health protection. The Trafford Health Protection and Resilience Strategy 2026-2030, currently in development, will identify the local approach and priorities for health protection. National guidance and evidence are used to inform local practice, including:

- Arrangements for an outbreak of Influenza like illness in a care home[ix]
- Arrangements for investigating complex Tuberculosis (TB) incidents[x]
- Arrangements for investigating and controlling a BBV outbreak/incident[xi]
- Arrangements for meningococcal disease in a nursery/school/college[xii]
- Arrangements Hepatitis A in a school or childcare setting[xiii]
- Arrangements for outbreaks in seldom heard population
- Investigating outbreaks in asylum seeker hotel setting[xiv]
- Managing specific infectious diseases: A to Z[xv]
- Communicable disease outbreak management guidance[xvi]

Other communal settings, such children's residential homes, and supported accommodation for 16-18 year olds, and adults with learning disabilities and mental health needs are viewed as the case/contact home. The IPC team and others will sympathetically manage this outbreak as we would for people living in their own homes.

### 3.1 Arrangements for an Outbreak of Acute Respiratory Infection (ARI) in a Care Home

| | Response Activity | | Responders | | Considerations |
|---|---|---|---|---|---|
| | | | In hours | Out of hours | |
| **Investigations** | Detection / Alerting | • Two or more residents or staff suffering from ARI<br>• CICPT or UKHSA GM HPT if OOH alerted by care home<br>• Details will be obtained regarding affected staff / residents<br>• Outbreak email sent to relevant partners*<br>• CICPT and Care setting will communicate daily during period of the outbreak to monitor and advise | • CICPT<br>• GP<br>• MFT virology<br>• Mastercall | • UKHSA<br>• Mastercall | Refer to UKHSA ARI guidance |
| | Sampling | • If LFD COVID-19 kits available at the care home, swabs may be obtained to clarify if COVID outbreak in first instance.<br>• UKHSA courier delivered swabs on ILOG (Incident Log Number) to be obtained from up to 5 symptomatic people (most recent onset) if LFD not positive or kits unavailable.<br>• Swabs couriered to and from virology laboratory at MFT UKHSA labs for respiratory PCR | | | |
| **Control** | Advice IPC | • Transmission-based and standard IPC precaution advice – including respiratory protection (face mask/eye protection)<br>• Home closed to admissions and non-urgent transfers and appointments<br>• Affected residents isolated and staff | • CIPCT<br>• GP<br>• MFT virology<br>• Mastercall | • UKHSA<br>• Mastercall | • Setting may need to facilitate isolation of residents e.g. with dementia |

| | Response Activity | | Responders | | Considerations |
|---|---|---|---|---|---|
| | | | In hours | Out of hours | |
| | | excluded as per current guidance<br>• Notification to visitors re outbreak and consideration for reduced/paused visiting arrangements<br>• Deep clean before reopening | | | and cohorting of staff. |
| | Treatment / Prophylaxis | • OCT may need to be arranged to discuss management if difficult to contain outbreak and any operational issues identified by CIPCT<br>• Antiviral treatment/prophylaxis prescribed and administered dependant on lab results and CIPCT liaison with UKHSA HPT | | | |
| **Comms** | To care home | • Advice letters/newsletters/emails/outbreak info pack | • CICPT<br>• UKHSA comms | • No out of hours comms needed | |
| | To health partners | • Outbreak email*<br>• OCT minutes circulated | | | |
| | To media | • Coordinated by UKHSA if decided at OCT | | | |

### 3.2 Arrangements for Investigating Complex TB Incidents

| | Response Activity | | Responders | | Considerations |
|---|---|---|---|---|---|
| | | | In hours | Out of hours | |
| **Investigations** | Detection/Alerting | • Notifiable disease<br>• UKHSA / TB Nurse or CICPT alerted about greater than usual cases/linked cases<br>• Alert TB services<br>• Identify contacts of infected individuals | • UKHSA<br>• TB services<br>• CIPCT<br>• Microbiology laboratory | • UKHSA | |
| | Sampling | • Screen contacts / people in affected area<br>• Large scale screening if needed e.g. IGRA<br>• | | | |
| **Control** | Advice IPC | • Isolation<br>• Transmission-based (e.g., FFP3) and standard IPC precaution advice<br>• Provide advice/reassurance to worried individuals | • UKHSA<br>• TB services<br>• CIPCT | • UKHSA (if necessary) | • Prescribing<br>• Sourcing<br>• Individuals not complying with treatment due to complex social needs (e.g. homeless) |
| | Treatment / Prophylaxis | • Mass vaccinations – BCG<br>• TB antimicrobial therapy – via PGD or individual prescriptions<br>• Consider latent infections | | | |
| **Comms** | To public | • Advice letters<br>• Update NHS 111, helpline, social media | • UKHSA comms | • There is no out of hours | |

| | Response Activity | | Responders | | Considerations |
|---|---|---|---|---|---|
| | | | In hours | Out of hours | |
| | To health partners | • UKHSA communication to relevant partners<br>• OCT minutes circulated | | comms support. Silver Control will decide when comms need to be involved | |
| | To media | • Coordinate by UKHSA if decided at OCT | | | |

**3.3 Arrangements for Investigating and Controlling Blood-Borne Viruses (BBV)**

| | Response Activity | | Responders | | Considerations |
|---|---|---|---|---|---|
| | | | In hours | Out of hours | |
| **Investigations** | Detection/Alerting | • UKHSA/CIPCT notified when unusual numbers or cluster of cases | • UKHSA<br>• CMFT Virology laboratory<br>• GPs | • UKHSA (Alert only) | |
| | Sampling | • Blood samples for virology<br>• Screening of contacts<br>• Screen for multiple BBVs | | | |
| **Control** | Advice IPC | • Explain routes of transmission<br>• Transmission-based and standard IPC precaution advice | • UKHSA / Environ-mental Health<br>• CIPCT<br>• General Practice<br>• Hospital | • UKHSA | • Prescribing<br>• Sourcing |
| | Treatment/Prophylaxis | • PEP treatment for close contacts<br>• Vaccinations for close contacts and other contacts (dependant on virus) | | | |

| | Response Activity | | Responders | | Considerations |
|---|---|---|---|---|---|
| | | | In hours | Out of hours | |
| | | | Cons | | |
| **Comms** | To public | • Advice letters<br>• Update NHS 111, helpline, social media | • UKHSA<br>• CIPCT | | |
| | To health partners | • UKHSA communication to relevant partners<br>• OCT minutes circulated | | | |
| | To media | • Coordinate by UKHSA if decided at OCT | | | |

### 3.4 Investigating Meningococcal Disease in a Nursery, School or College

| | Response Activity | | Responders | | Considerations |
|---|---|---|---|---|---|
| | | | In hours | Out of hours | |
| **Investigations** | Detection/Alerting | • Meningococcal case notified to UKHSA<br>• Identify close contacts | • UKHSA<br>• CIPCT<br>• School nurses<br>• Children's Services<br>• Microbiology | • UKHSA | |
| | Sampling | • No screening needed, but highlight symptoms and importance of urgent medical attention<br>• Hospitalisation of anyone displaying symptoms | | | |

| | Response Activity | | Responders | | Considerations |
|---|---|---|---|---|---|
| | | | In hours | Out of hours | |
| **Control** | Advice IPC | • Highlight symptoms and importance of urgent medical attention | • UKHSA<br>• CIPCT<br>• School nurses<br>• Intrahealth<br>• GPs | • UKHSA | • Prescribing<br>• Sourcing |
| | Treatment/Prophylaxis | • Prophylactic antibiotics for close contacts<br>• Check vaccination status of rest of school/college – offer vaccination for unimmunised | | | |
| **Comms** | To public | • Advice letters<br>• Update NHS 111, helpline, social media | • UKHSA<br>• CIPCT | | |
| | To health partners | • UKHSA communication to relevant partners<br>• OCT minutes circulated | | | |
| | To media | • Coordinate by UKHSA if decided at OCT | | | |

### 3.5 Investigating Hepatitis A in a School or Childcare Setting

| | Response Activity | | Responders | | Considerations |
|---|---|---|---|---|---|
| | | | In hours | Out of hours | |
| **Investigations** | Detection/Alerting | • Notifiable disease<br>• UKHSA/CIPCT notified of case(s)<br>• Identify close contacts | • UKHSA<br>• CIPCT<br>• School nurses | • UKHSA | |

| | Response Activity | | Responders | | Considerations |
|---|---|---|---|---|---|
| | | | In hours | Out of hours | |
| | | • Identify source | • GPs | | |
| | Sampling | • Blood samples from all contacts for Hep A testing – students/staff/household | | | |
| **Control** | Advice IPC | • Increased hand hygiene and advice around environmental and enhanced cleaning.<br>• Extra measures for close contacts. | • UKHSA<br>• CIPCT<br>• IntraHealth<br>• School nurses<br>• GPs<br>• NHS GM Trafford meds optimisation team<br>• Environmental Health (food hygiene advice). | | • Availability of sufficient vaccine<br>• Ensure vaccinations are given in a timely manner |
| | Treatment/Prophylaxis | • No treatment available<br>• Immunoglobulin therapy for close identified/household contacts<br>• Vaccinate contacts | | | |
| **Comms** | To public | • Advice letters to schools/households | • UKHSA Comms | | |
| | To health partners | • UKHSA communication to relevant partners<br>• OCT minutes circulated | | | |

| | Response Activity | | Responders | | Considerations |
|---|---|---|---|---|---|
| | | | In hours | Out of hours | |
| | To media | • Coordinate by UKHSA if decided at OCT | | | |

### 3.6 Investigating Outbreaks in a Seldom Heard Population (e.g, Measles at a Traveller's Site)

| | Response Activity | | Responders | | Considerations |
|---|---|---|---|---|---|
| | | | In hours | Out of hours | |
| **Investigations** | Detection/Alerting | • Notifiable disease<br>• UKHSA/CIPCT notified of case(s)<br>• Identify close contacts<br>• Identify source | • UKHSA<br>• CIPCT<br>• PH Consultant | • Mastercall | |
| | Sampling | • UKHSA to provide kits if required | | | |
| **Control** | Advice IPC | • CIPCT<br>• Health Visitor<br>• Community Engagement Officer | • UKHSA<br>• CIPCT<br>• PH Consultant<br>• Environmental Health (food hygiene advice) | | • Health visiting/school nursing may be engaged depending on the context |
| | Treatment/Prophylaxis | • Advice from UKHSA<br>• Mass vaccination onsite | | | |

| | Response Activity | | Responders | | Considerations |
|---|---|---|---|---|---|
| | | | In hours | Out of hours | |
| **Comms** | To public | • Advice letters if relevant for contact population | | | |
| | To health partners | • UKHSA advice obtained<br>• Messages to GPs re increasing vaccine uptake / bringing forward routine vaccinations | | | |
| | To media | • Coordinate by UKHSA if decided at OCT | | | |

### 3.7 Investigating Outbreaks in Asylum Seeker Hotel Setting

| | Response Activity | | Responders | | Considerations |
|---|---|---|---|---|---|
| | | | In hours | Out of hours | |
| **Investigations** | Detection/Alerting | • Notifiable disease<br>• UKHSA/CIPCT notified of case(s)<br>• Identify close contacts<br>• Identify source | • Go To Doc (GTD) Healthcare primary care - GP and PN service<br>• CIPCT<br>• PH Consultant | • Contact in hours provider or specific arrangement made by SERCO | • Commissioned health service on-site availability (Monday to Friday) to monitor incidents/outbreaks of infection |
| | Sampling | • EH or UKHSA to provide kits if required – dependent on suspected organism | | | |

| | Response Activity | | Responders | | Considerations |
|---|---|---|---|---|---|
| | | | In hours | Out of hours | |
| **Control** | Advice IPC | • GTD on-site commissioned GP/primary care services<br>• CIPCT<br>• Health Visitor<br>• Community Engagement Officer | • GTD<br>• UKHSA<br>• CIPCT<br>• PH Consultant<br>• Environmental Health (food hygiene advice). | | • Health visiting / school nursing may be engaged depending on the context |
| | Treatment/Prophylaxis | • Advice from UKHSA<br>• Mass vaccination onsite | | | |
| **Comms** | To public | • Advice letters if relevant for contact population | | | |
| | To health partners | • UKHSA advice obtained<br>• Messages to GPs re increasing vaccine uptake / bringing forward routine vaccinations | | | |
| | To media | • Coordinate by UKHSA if decided at OCT | | | |

## PART 4: Local Operational Arrangements for Specific Types of Outbreaks Not Requiring an OCT

### Specific types of outbreaks in Care homes

Residents living in care homes are more vulnerable to infections and viruses compared to other populations because of existing health conditions, age and because of spread living in shared accommodation. Trafford's IPCT prioritises incidents and outbreaks in care homes.

- Suspected viral Gastroenteritis, managed by CIPCT
- Acute Respiratory Infections, managed by CIPCT including flu in flu season. A flu outbreak out of flu season will require an OCT.
- Management of PVL +ve MR/SSA incidents outside of the acute sector. CIPCT assist Primary Care if community incident or outbreak where required, to include advice and guidance around management and advice to patient or setting if required. OCT may be required if numerous cases identified in residential setting.
- iGAS (invasive A strep) – would be managed in collaboration with UKHSA

## PART 5: Declaring an Incident Over and Debrief

### 5.1 Local Authority-Led Incidents

Locally contained incidents will be declared over by the CIPCT based on risk assessments and national guidance. Throughout the incident the CIPCT will keep stakeholders informed through the weekly outbreak summary email.

### 5.2 UKHSA- Led Incidents

These incidents will be declared over at the Outbreak Control Team meeting. UKHSA may also write a formal report following a significant incident.

### 5.3 Debrief and Learning

The CIPCT and DPH will undertake a formal debrief exercise with all involved settings following any serious incident or series of repeated incidents. The debrief will review what occurred, assess the response actions taken, identify effective practice, and highlight opportunities for improvement. A written report will be provided to the setting upon completion of the debrief.

The Health Protection and Resilience Board will receive the report to support system-wide learning regarding incident response, communication processes, and measures to reduce the likelihood of future incidents.

## Appendices

## Annex 1: Key Contacts

In the event of an outbreak, the following contact details may be of assistance:

| *Organisation/title/department* | *Name/comment* |
|---|---|
| **GM Health Protection Team- UKHSA NW** | GM HPU |
| *Phone(s)* | *Email* |
| 0344 225 0562, opt 2 | gmanchpu@UKHSA.gov.uk |
| This SPOC is for in and out of hours | |

| *Organisation/title/department* | *Name/comment* |
|---|---|
| **UKHSA Public Health Laboratory Manchester** | Consultant Virologist and on-call Consultant Virologist |
| *Phone(s)* | *Email* |
| 0161 276 8853/4277 or via MRI switchboard out of hours (0161 276 1234) and ask for the on-call Consultant Virologist | |

| *Organisation/title/department* | *Name/comment* |
|---|---|
| **Public Health Trafford Council** | Helen Gollins, Director of Public Health |
| *Phone(s)* | *Email* |
| 07817 951555 | helen.gollins@trafford.gov.uk |

| *Organisation/title/department* | *Name/comment* |
|---|---|
| **Environmental Health Dept** | Suzanne Whittaker, Head of Regulatory Services<br>Nicola Duckworth, Regulatory Services Manager<br>Graeme Dixon, Team Leader Environmental Health |
| *Phone(s)* | *Email* |
| 07760 167319 (Suzanne)<br>07760 167473 (Nicola)<br>07734 598111 (Graeme) | suzanne.whittaker@trafford.gov.uk<br>nicola.duckworth@trafford.gov.uk<br>graeme.dixon@trafford.gov.uk<br>environmental.health@trafford.gov.uk -copy this email address into all communications |

| *Organisation/title/department* | *Name/comment* |
|---|---|
| **Trafford Community Infection Prevention and Control Team, MFT** | Anna Anobile, Matron for Infection Control, Trafford Public Health |
| *Phone(s)* | *Email* |
| 0161 912 5176 messages can be left. | anna.anobile@mft.nhs.uk<br>traffordcommunityipcteam@mft.nhs.uk |

| *Organisation/title/department* | *Name/comment* |
|---|---|
| **NHS GM Trafford** | Cathy O'Driscoll<br>Associate Director for Delivery & Transformation<br>NHS Greater Manchester Integrated Care |
| *Phone(s)* | *Email* |
| 07970 314169 | cathy.odriscoll@nhs.net |
| Out of hours SPOC for NHS GM Trafford is via NWAS ROCC on 0345 113 0099, Option 1 for GM UEC Hub. Ask for the locality NHS GM Trafford Director On Call. | |

| *Organisation/title/department* | *Name/comment* |
|---|---|
| **Mastercall Healthcare** | Out of hours and pathfinder primary care provider services |
| *Phone(s)* | *Email* |
| 0161 476 0400 option 2<br>0161 476 9667 | Michael Rooney – Medical Director:<br>michael.rooney1@nhs.net |

| *Organisation/title/department* | *Name/comment* |
|---|---|
| **IntraHealth** | School immunisations GM commissioned provider |
| *Phone(s)* | *Email* |
| | traffordimms@intrahealth.co.uk |

| *Organisation/title/department* | *Name/comment* |
|---|---|
| **TB Unit**<br>**Manchester Royal Infirmary** | Ryan Noonan, Lead TB Nurse |
| *Phone(s)* | *Email* |
| 0161 291 4035<br>0161 276 4387 or 07805 765912 | ryan.noonan@mft.nhs.uk |

| *Organisation/title/department* | *Name/comment* |
|---|---|
| **Go To Doc (GTD) Healthcare** | |
| *Phone(s)* | *Email* |
| 07778 365488 | GTD IPC specialist nurse<br>sarah.connolly15@nhs.net |
| 07934 710619 | GTD Senior operations manager<br>mandy.curran@nhs.net |
| 07834 168199 | GTD Head of specialist services<br>TBC |
| | GTD Ops Manager<br>bethany.mitchell3@nhs.net |
| 07714 091912 | GTD IPC lead<br>jane.doyle4@nhs.net |
| 079467 067955 | GTD Clinical Service Manager<br>kathryn.smith10@nhs.net |

**Annex 2:** Stocks of Laboratory Testing Kits, Medication, and Other Equipment

| Type of Stock | Where Located | Quantity | Arrangements for Access |
|---|---|---|---|
| Viral swabs and viral transport media (VTM) | UKHSA lab stock not kept by LA or TLCO<br><br>GP practices should each hold small stock | Up to 5 swabs and VTM bottles should be available at each GP practice. | Supplied by UKHSA and delivered to care home by courier following CIPCT ILOG request in event of flu outbreak.<br><br>For diagnosis of other suspected viral infection, individual GP practices should have been instructed to order small stock – up to 5 kits, from virology lab and keep as stock.<br><br>Swab kits may be requested from MRI Laboratory (0161 276 8854 Option 1) or via GP ICE lab ordering system |
| AVs | Malcolm's Pharmacy, 28 Flixton Road, Urmston, M41 5AA<br>0161 747 2277.<br><br>Timperley Pharmacy, 250 Stockport Road, Timperley, 0161 682 5066.<br><br>Mastercall: International House, Pepper Road, Hazel Grove Stockport SK7 5BW, 0161 476 9667 or 0161 477 9190. | | Malcolm's pharmacy opening hours: Monday to Friday 08:00 – 21:00; Saturday 09:00 – 17:00; Sunday - closed<br><br>Timperley Pharmacy opening hours:<br>Monday to Friday 08:00 – 21:00; Saturday 09:00 – 21:00; Sunday 09:00 – 18:00<br><br>Mastercall: In hours 08:00 am to 18:30 Mon to Friday<br>Out of Hours – 18:30 to 08:00 Monday to Friday<br>24 hours a day Saturday to Sunday<br><br>Instructions for how to access are detailed on the On-Call pack for OOH |
| Stool specimen kits | Basement of Trafford Town Hall, the Environmental Health "bunker" | Approximately 20 kits | Via Environmental Health, Admin Team public.protection_admin@trafford.gov.uk and environmental.health@trafford.gov.uk |

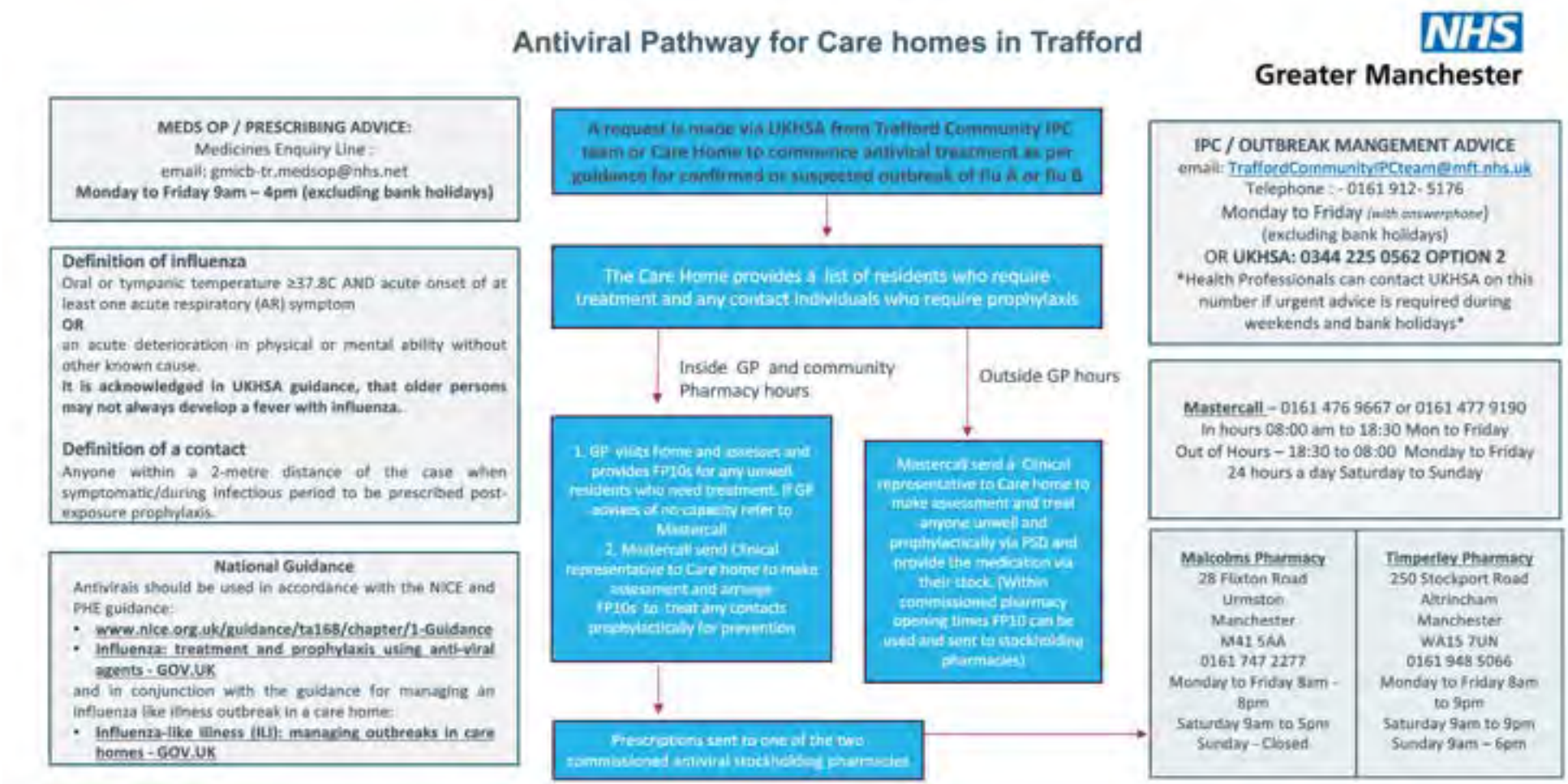
| Type of Stock | Where Located | Quantity | Arrangements for Access |
|---|---|---|---|
| Stool specimen kits for care home outbreaks | Can be obtained from 4 Trafford Care Homes:<br>• Amberley Care Home- 28 Delaunays Road, Sale. M33 6RX. 0161 825 8222<br>• Woodend Care Home, Bradgate Road, Altrincham. WA14 4QU. 0161 929 5127<br>• Wyncourt Nursing Home 162 Park Road, Timperley. WA15 6QH, 0161 962 1290<br>• Urmston Manor, Church Road, Urmston. M41 9EJ, 0161 747 6510 | Each pack has 5 testing pots and forms | Contact home manager directly to arrange collection |
| Food sampling pots and bags | Trafford Town Hall – Environmental health Team stock | Approximately 20 kits | Via Environmental Health, Admin Team public.protection_admin@trafford.gov.uk and environmental.health@trafford.gov.uk |

**Annex 3:** OCT Agenda Template

| **Outbreak Control Team Agenda** | |
|---|---|
| **Date** | |
| **Time** | |
| **Location** | |
| **1. Introduction** | (Reminder of confidentiality and need for accurate records) |
| **2. Appropriate membership** | • Public Health (Trafford LA)<br>• Business/School/Care Home<br>• Education (Schools Only)<br>• Early Years Team (Early Years Settings Only)<br>• Commissioning (OP, LD and MH Care Homes Only and Extra Care)<br>• Strategic Lead Urgent Care (Admission and Discharge Planning<br>• Trafford Community Infection Prevention and Control Team<br>• Environmental Health (Early Years/Businesses Only)<br>• Health and Safety Unit (Schools Only) |
| **3. Declarations of Conflicts of Interest** | |
| **4. Duty of Candour** | |
| **5. Items not on the Agenda** | |
| **6. Background** | a. Cases & Contacts |
| **7. Risk Management/Control Measures** | |
| **8. Further Investigation** | |
| **9. Communications** | |
| **10. Any Other Business** | |
| **11. Recommendation List with timescale and allocated responsibility** | |
| **12. Date and time of next meeting** | |

**Annex 4:** Outbreak Response Pathway

In the event of a funding regarding prophylactic antibiotics, antivirals, immunoglobulins or vaccinations in exceptional circumstance or seldom seen infectious or communicable disease, contact James Gray/ICB through Helen Gollins, Director of Public Health.



**Annex 5:** Potential Outbreak Settings or Sources

These are examples of community settings sometimes associated with outbreaks

- Care homes: nursing, residential, intermediate, extra care, supported living
- Schools / Colleges
- Nurseries / Child minders / Play centres
- Children's residential homes and supported accommodation
- University / student accommodation – none in Trafford
- Food outlets
- Petting farms
- Swimming pools / water activity parks
- Dental practices
- Community health care settings (GP practices, Integrated Care centres etc.)
- Prisons / Detention Centres - none in Trafford
- Workplaces
- Ports / airports - none in Trafford
- Hotels
- Leisure Centres
- Travellers Sites
- Private camp sites / holiday parks
- Community Hospitals
- Hostels
- Tattoo Parlours
- Resettlement or bridging hotels

## References


[i] Health and Social Care Act 2012, c. 7. Available at: https://www.legislation.gov.uk/ukpga/2012/7/contents/enacted

[ii] NHS England (2022) *National infection prevention and control guidance*. Available at: https://www.england.nhs.uk/publication/national-infection-prevention-and-control/

[iii] The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013. Available at: https://www.legislation.gov.uk/uksi/2013/351/contents

[iv] UK Health Security Agency (2025) *Communicable disease outbreak management guidance.* Available at: https://www.gov.uk/government/publications/communicable-disease-outbreak-management-guidance

[v] UK Health Security Agency (2024). *Management of acute respiratory infection outbreaks in care homes guidance. Available at: https://www.gov.uk/government/publications/acute-respiratory-disease-managing-outbreaks-in-care-homes/management-of-acute-respiratory-infection-outbreaks-in-care-homes-guidance*

[vi] Cabinet Office (2026). *Resilience Hub.* Available at: https://www.resilience.gov.uk/

[vii] UK Health Security Agency (2026). *High consequence infectious diseases (HCID).* Available at: https://www.gov.uk/guidance/high-consequence-infectious-diseases-hcid

[viii] UK Health Security Agency (2024) *Notifiable diseases and how to report them*. Available at: https://www.gov.uk/guidance/notifiable-diseases-and-how-to-report-them

[ix] UK Health Security Agency (2024). *Management of acute respiratory infection outbreaks in care homes guidance.* Available at: *https://www.gov.uk/government/publications/acute-respiratory-disease-managing-outbreaks-in-care-homes/management-of-acute-respiratory-infection-outbreaks-in-care-homes-guidance*

[x] UK Health Security Agency (2026). *Tuberculosis (TB): diagnosis, screening, management and data.* Available at: https://www.gov.uk/government/collections/tuberculosis-and-other-mycobacterial-diseases-diagnosis-screening-management-and-data

[xi] UK Health Security Agency (2020). *BBV-related infection control breaches: management toolkit.* Available at: https://www.gov.uk/government/publications/bbv-related-infection-control-breaches-management-toolkit

[xii] UK Health Security Agency (2025). *Meningococcal disease: guidance on public health management.* Available at: https://www.gov.uk/government/publications/meningococcal-disease-guidance-on-public-health-management

[xiii] UK Health Security Agency (2026). *Hepatitis A infection: prevention and control guidance*. Available at: https://www.gov.uk/government/publications/hepatitis-a-infection-prevention-and-control-guidance

[xiv] UK Health Security Agency (2024). *Outbreak management in short term asylum seeker accommodation.* Available at: https://www.gov.uk/government/publications/outbreak-management-in-short-term-asylum-seeker-accommodation

[xv] UK Health Security Agency (2026). *A to Z of infectious diseases in children and young people's settings.* Available at: https://www.gov.uk/government/publications/health-protection-in-schools-and-other-childcare-facilities/a-to-z-of-infectious-diseases-in-children-and-young-peoples-settings

[xvi] UK Health Security Agency (2025). *Communicable disease outbreak management guidance: principles to support local health protection systems.* Available at: https://www.gov.uk/government/publications/communicable-disease-outbreak-management-guidance/communicable-disease-outbreak-management-guidance-principles-to-support-local-health-protection-systems

| | | | | |
|---|---|---|---|---|
| **Name of Committee / Board** | **Trafford Locality Board** | | | |
| **Date of Meeting** | **23rd July 2026** | | | |
| **Report Title** | **Healthwatch Trafford Performance Report April – May – June 2026** | | | |
| **Report Author & Job Title** | **Andrew Latham, Chief Officer** | | | |
| **Organisation Exec Lead** | **Andrew Latham** | | | |
| **OUTCOME REQUIRED** *(please highlight)* | Approval | Assurance | Discussion | Information |

**EXECUTIVE SUMMARY**

**A summary of Healthwatch Trafford's performance and impact during the period April 2026 to June 2026. This includes research, engagement activities, local concerns, and strategic updates.**

**RECOMMENDATIONS**

1. To note the update.

**CONSIDERATIONS – these must be completed before submission to the Board – Reports with incomplete coversheet information will not be accepted and shared with the board**

| | |
|---|---|
| **Risk implications** ***(Please provide a high-level description of any risks relating to this paper, including reference to appropriate organisational risk register)*** | None |
| **Financial implications and comment/approval** ***(Please detail which organisation(s) will be impacted, and if not required, please briefly detail why)*** | Name/Designation: **N/A**<br>Comment / Approval *(Delete appropriately)* **N/A** |
| **Comment by Trafford Clinical and Practitioner Senate (TCAPS) and/or Clinical Lead** ***(If not required, please briefly detail why)*** | Date of TCAPS / Clinical Lead comment (Delete appropriately): **N/A**<br>Name/Designation: (If appropriate) **N/A**<br>Comment: **N/A** |
| **What is the impact on inequalities?** ***(Please provide a high-level description of any known impacts)*** | **N/A, update only** |

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

healthwatch Trafford

# Performance Report

April – May – June 2026

# Contents

# Highlights during reporting period April to June '26

## Research

- **Enter & View**

We published our Enter & View report following our visit to Boundary House, highlighting our findings and recommendations to support service improvement.

We heard from Delamere Medical Practice following our Enter & View visit in October last year. The practice provided updates on the actions taken in response to our recommendations, demonstrating continued commitment to improving patient experience.

- **Live Well**

Our Live Well project, in collaboration with Trafford Council, has been completed. The final report is being circulated, and Healthwatch is assisting the Council in presenting the findings of the report to relevant groups and meetings.

- **Ageing Well for Over 50s**

The first draft of our Ageing Well for Over 50s report has been sent to Trafford Council. This project was commissioned by Trafford Council and resulted in us engaging face to face with 50 Trafford residents aged over 50. They came from a mix of age groups, genders and ethnicities, and also represented many people who were disabled or who had a long-term health condition. Initial feedback from Trafford Council on the draft report has been positive, and the final version of the report will be published in July. Much of the engagement work (including 2 focus groups and arranging visits to community centres) occurred in June.

- **Oral Health in Under 5s Project**

The Oral Health in Under 5s project will involve surveying both parents and professionals, and these surveys are due to launch in July. Draft questionnaires were shared with Trafford public health in June, and they have provided comments which have been used to modify the surveys. A meeting arranged in June with the Chair of the Local Dental Committee will be held in July; this will be important for survey dissemination.

- **Reablement Project**

Discussions regarding our reablement project are still ongoing, but progress has been made on finding new contacts (with the help of Helen Ibbott) and also on developing the survey. Feedback from a contact has been used to make modifications to our survey, which is designed for people who have experienced reablement services in Trafford.

- **Safeguarding Adults Project**

We are running a project on the public's knowledge of safeguarding issues in Trafford (such as cuckooing). This is for the Trafford Safeguarding Adults Board, and we are collaborating with Healthwatch Oldham, who are running a similar project, by using the same survey. Healthwatch Trafford has held discussions in June which resulted in us starting initial work to plan two focus groups. These will be held in July, and the transcripts of these groups will be provided to relevant stakeholders by the end of July.

- **Healthwatch 100: Phlebotomy**

A Healthwatch 100 survey is being prepared on Phlebotomy. We are currently designing the survey. It will be used to explore the state of phlebotomy services in Trafford, and will also be compared with previous work that Healthwatch did on this topic in 2018. This will allow us to see if the change from walk-in to pre-booking has been received positively by Trafford residents.

## Engagement & Volunteering

- **Five Ways to Wellbeing**

We facilitated a focus group at the Life Centre in Sale to support the *Five Ways to Wellbeing* project. The session was attended by participants, who shared valuable insights and experiences to help inform the project and its future development.

- **Refugee Week Community Engagement**

As part of Refugee Week, we attended the community celebration at St Mary Magdalene Church in Sale. We promoted awareness of the How to Access Your GP information cards, encouraging people to understand that primary healthcare services are available regardless of immigration status. The event provided an opportunity to engage with diverse communities and raise awareness of access to healthcare.

- **Over 50s Focus Group**

We delivered a series of focus groups to gather the experiences of people aged 50 and over in accessing health and social care services, with a particular focus on identifying barriers to access. The sessions were well attended and highly engaging, taking place at:

    - Re-engage Tea Dance at Stretford Public Hall, where we spoke with attendees aged 70 and over.
    - VCAT Office in Stretford.
    - The Salvation Army building in Sale.

- **Volunteers**

Volunteers continued to support our engagement activities throughout the quarter, assisting with community events, facilitating conversations with residents, and helping us gather feedback from local people. Their contribution enabled us to reach a wider range of communities and strengthen our engagement with older adults and underrepresented groups across Trafford.

## Communications

- **Information and signposting activities**

As well as our engagement work, we also continue to perform our information provision function through the production of leaflets, guides, 'How To' guides, our quarterly and annual performance reports and highlights bulletin. We also manage a public inbox and respond to requests for information and signposting, and through same collect feedback on local health and social care services. This work is ongoing throughout the year.

# From the Trafford community

## Issues Raised

Patients often contact us to report their experiences of accessing health and social care services. In addition, we gather similar experiences through our survey work. Where possible we exercise our statutory duty to signpost people to the service or individual that is best placed to deal with their enquiry or concern. The below comments and summary illustrate the issues that have been reported to us in the quarter:

### GP Services

As in our previous report, people continued to report issues with access, being both refused appointments and also having their requests for advance booking denied, though one GP was praised for their manner:

*"Lovely manner and good knowledge"*

*"I was refused an appointment by the receptionist. This was for a 2yo child. It was only when I stated the statutory right for children under 5 to be seen by primary care within 24 hours. I was then offered telehealth, then had a face to face."*

*"I received a text from surgery asking me to make a GP appointment. I had then to phone up to make a GP appointment. This is absurd. There is no means of booking online."*

*"Asked for routine appointment three days ago through the online booking system. No response, or even acknowledgement as yet."*

A patient moved to Trafford and found that their new GP was not willing to enter into a shared care agreement for their ADHD medication where previous GP had been. The patient was very concerned about withdrawal of access to medication and the impact on their mental health as they had suffered greatly before.

## Hospitals

Feedback concerning hospital care was generally positive this quarter, with communication between staff and patients being praised, as well as the swift and efficient treatment received in urgent care. However, poor communication between staff, elderly patients not being listened to, and a lack of beds were raised as causes for concern:

*"Wythenshawe hospital. Thoroughness of testing to identify the problem in an 85 year old was commendable. Communication from the Dr to the patent excellent explaining each stage and results. Staff in the wards were simply angelic particularly as they were dealing with an unruly aggressive patient, very sick people and rapid turnover of bed occupants.*

*"Not enough beds - caused a difficult few hours of uncertainty and communications failure between the original team and the ward. The box ticking approach to communication between staff is frightening when it goes wrong which it will do. A nurse was certain my husband had been given intravenous antibiotics. He hadn't … The bits of paper simply didn't flow."*

*"Brilliant advice. Stopped my son (17) potentially dying … He recovered quickly and fully. I would never had thought he was in a life threatening situation so wouldn't have taken him to ED."*

*"Efficient - triage system worked well, blood tests and doctor assessment followed in an orderly and transparent manner, doctor had excellent access to relevant health date enough to diagnose, treat condition and, important how patient should manage condition and how to decide when or if to refer back to medics. Caring - very humane staff … as patient's wife I would have appreciated the freedom Doctors once had to tell you their view on risks"*

One patient's request for further investigation into their sleep condition was dismissed, so they contacted the hospital with a request for further tests and their concerns over possibly inaccurate record-keeping. The hospital responded, validating the patient's feelings and saying further tests have indeed been ordered.

## Social care

We heard a number of complaints around social care in Trafford, covering a number of issues:

*"Nothing has gone right since I started with them 33 months ago. They are always late or too early and my medicine is given with only 2 hours between [doses]"*

*"I called adult social services twice with concerns about my elderly dad who was living alone with dementia. Someone visited, said we weren't entitled to any care visits, gave some advice, took no notes and did no follow up as promised (a referral to the OT service). Second time they spent so long allocating a social worker to his case that he was in hospital and then a care home when I got a call back. Too slow and deeply disappointing."*

We referred one resident for advocacy after they told us of a complaint regarding Trafford Adult Social Care payments, having not received a response following a request for help from their support workers.

## Strategic updates

The consultation on the future of independent public and patient voice was extended to the 13 July with a final GM Healthwatch workshop scheduled for the 17 July to agree future configuration to be presented to the Integrated Partnership Board at the end of July.

At the June meeting of the ICP Strategy Group held on the 24 June, our interim report was well received. There was a clear and strong recognition of the vital role of local Healthwatch across Greater Manchester. Healthwatch was seen as a critical friend to the system providing necessary challenge and independence.

Key messages were to 'build and not reinvent', not duplicate existing community networks, whilst stressing the importance of funding and trusting a new model which is based on what is already working.

The strategy group noted that a hybrid model looked to be the preferred option with strong local delivery with a light touch GM oversight without micromanaging local delivery.

GM Healthwatch met with GMMH for the usual quarterly meeting where we were provided with an update on Section 75 transfers. There have been some issues particularly at Bolton, but lessons had been learned and it was expected that future transfers would proceed smoothly through better communication between both staff and service users.

The work plan is proceeding at pace with several surveys and reports in preparation. There have also been a number of face-to-face focus groups held which have been well attended.

We submitted our annual report to Companies House at the end of June which is a statutory requirement.

We were pleased to be invited to a VCFSE workshop on the 13 August to determine a way forward for Trafford leadership.

**Heather Fairfield**
**Chair of Directors**