

Agenda

Trafford Locality Board Meeting

Date: Tuesday 20th October 2026

Time: 1.00pm

Venue: Meeting Room 12 and via MS Teams

Item No.	Time	Duration	Subject	Paper/ Verbal	For Approval/ Discussion/ Information	By Whom
1a	1.00	10 mins	Apologies for Absence		Info	Chair
1b			Declarations of Interest		Info	Chair
1c			Minutes of the Meeting Held on 29 th September	Paper	Approval	Chair
1d			Action Log & Matters Arising	Paper	Discuss	Chair
1e			Forward Plan	Paper	Info	Chair
2	1.05	5 mins	Public Questions		Discuss	Chair
3	1.10	20 mins	NHS Reforms a) Place Partnership Agreement Position Paper	Paper	Discuss/ Info	COD / TM
4	1.30	15 mins	Live Well Neighbourhood Plan a) PCN Neighbourhood Plan Submissions	Paper	Discuss/ Info	JW
5	1.45	15 mins	Healthwatch Q2 Performance Report 26/27	Paper	Discuss/ Info	HF

6	2	0 mins	Locality Scorecard *for information	Paper	Info	
Part 2: s75						
7	2.00		S75 Deed of Variation 2026/27	To follow	Discuss/ Info	COD
8			Any Other Urgent Business			

Minutes

Trafford Locality Board

Date: Tuesday 29th September 2026

Time: 9.30 am

Venue: Meeting Room 12 and via MS Teams

Present	Apologies
Tom Ross (TR) Leader of Council and Co-Chair Sara Todd, Place Based Lead NHS GM Trafford & Chief Executive of Trafford Council Cllr George Devlin (GD) Trafford Councillor Heather Fairfield (HF) Healthwatch Trafford Charlotte Bailey, Chief People Officer NHS GM Darren Banks (DB) Group Director of Strategy, MFT Louise Grant (LG) GP Representative Manish Prasad (MP) Associate Medical Director, NHS GM Trafford Michelle Richards, (MR) GMMH on behalf of Elizabeth Calder Claire Robson, (CR) Public Health, Trafford Council on behalf of Helen Gollins Jane Slater, Councillor, Trafford Council In attendance: Thomas Maloney (TM) Programme Director Health and Care, NHS GM Trafford and Trafford Council Charlotte Walker (CW) Director Quality & Safeguarding, Adult Social Care, Trafford	Maggie Kufeldt (MK) Corporate Director of Adults & Wellbeing, Trafford Council Jane Wareing, GP Board and co-chair Bernadette Ashcroft (BA), VCFSE Representative, Trafford Community Collective Tom Rafferty, Acting Chief Strategy Officer, MFT Patricia Davies, LCO Chief Executive Elizabeth Calder, Director of Strategy, GMMH Helen Gollins (HG) Director of Public Health, Trafford Council

Item No.	Topic	Action
1a	APOLOGIES FOR ABSENCE Apologies for absence were received from Maggie Kufedlt, Jane Wareing, Bernadette Ashcroft, Tom Rafferty and Patricia Davies. Michelle Richards attended on behalf of Elizabeth Calder, and Claire Robson attended on behalf of Helen Gollins. Louise Grant attended virtually in her capacity as GP Board representative	
1b	DECLARATIONS OF INTEREST There were no declarations of interest.	
1c	MINUTES OF THE MEETING HELD ON THE 23RD JULY 2026 RESOLVED: the minutes of the meeting held on the 23 rd July 2026 were approved as an accurate record.	
1d	ACTION LOG & MATTERS ARISING COD provided an update regarding Earcare service proposals. It was confirmed that the work remained at an early stage and that no decisions had been made regarding service changes. Members were advised that engagement with general practice and wider stakeholders would take place as proposals developed. All remaining actions were reported as not yet due. RESOLVED: the action log and matters arising were noted.	
1e	FORWARD PLAN RESOLVED: the forward plan was noted.	
2	PUBLIC QUESTIONS There were no public questions received.	
3	TRAFFORD COUNCIL CQC LOCAL AUTHORITY ASSESSMENT CW presented a verbal update on Trafford Council's CQC assessment outcome.	

	The Board heard that the assessment highlighted significant strengths in partnership working, integrated care, staff engagement and the delivery of improvements. Positive recognition was given to sustained improvement activity across services. Areas identified for further development included transition arrangements into adulthood, support for carers, occupational therapy waiting times and strengthening oversight of data quality and governance arrangements. Members noted findings and acknowledged the progress already made. It was recognised that further work was required to strengthen support for carers and improve the quality and accessibility of performance information. JS noted her thanks for the staff and leadership who were working on improving the area and suggested the item could be considered at GP Board. CW to share the formal improvement plan with TLB and GP Board representatives. CW to engage with the GP Board to discuss improvement priorities and gather primary care feedback. RESOLVED: TLB noted the update.	ACTION
4	TRAFFORD OFSTED INSPECTION OF LOCAL AUTHORITY CHILDREN'S SERVICES ST presented a verbal update on the recently published Ofsted inspection report. Members were advised that whilst some areas, particularly support to care leavers, required improvement, strengths had been identified in services for children in care and within the workforce. The report identified concerns relating to delays in front-door services and the timeliness of safeguarding responses. These findings were accepted by the Council and were being addressed through an improvement programme. The Board was informed that a diagnostic review was underway and would inform a detailed improvement plan. An Improvement Board would be established with independent oversight. Workforce support, quality assurance processes, strategy discussions and governance	

	arrangements were all being strengthened as part of the response. Members discussed opportunities for greater health partner involvement, communication with frontline professionals and the need to ensure safeguarding concerns continued to be responded to appropriately during the improvement period. The Board formally recorded its thanks to Jill McGregor for her contribution and leadership and noted the appointment of an interim Director of Children's Services Risthardh Hare. The Children's Services Improvement Plan to be presented at a future Board meeting for fuller discussion and partner input. Ofsted inspection to be discussed at GP Board. ST to issue Communications to be issued to partners regarding the improvement journey, leadership changes and next steps. RESOLVED: TLB noted the update.	ACTION ACTION ACTION
5	NHS REFORM UPDATE - PLACE PARTNERSHIP DOCUMENT SUITE FEEDBACK OUTCOMES REPORT A report was presented outlining the Greater Manchester response to feedback received on the Place Partnership Framework documentation. Members discussed concerns regarding governance arrangements, roles and responsibilities, local flexibility and future review mechanisms. It was recognised that many of the issues raised were fundamental to the way organisations would work together in the future and that further clarity was required regarding decision-making processes and implementation timescales. The Board noted that further discussions would take place later in the meeting regarding timelines and governance arrangements. RESOLVED: TLB noted the report.	
6	TRAFFORD ANNUAL IMPACT REPORT TM presented the Trafford Annual Impact Report detailing progress against delivery plan priorities and cooperative commitments. The Board heard that 35 priorities had been completed, with only three reported as not progressing as planned. Significant achievements had	

	been made across prevention, primary care, mental health and wider partnership working. Members discussed the continuing challenge of health inequalities across Trafford and the importance of focusing on the wider determinants of health, including employment, housing and education. Discussion also took place regarding future outcome frameworks, population health measures and the interaction between the Locality Board and the Health and Wellbeing Board. Members welcomed the report and praised the progress achieved during the year. RESOLVED: TLB: 1. Noted the positive progress made in the delivery of the 2025/26 priorities and 25/28 Co operative Commitments; 2. Provided feedback regarding achievements, priorities and/or future priorities; and 3. Acknowledged and supported the next steps.	
7	TRAFFORD NEIGHBOURHOOD PLAN TM presented the final draft Trafford Live Well Neighbourhood Plan for approval ahead of the submission deadline. The Board heard that the plan had undergone significant refinement following extensive partner engagement. Discussion focused on neighbourhood working, place outcomes, workforce arrangements, multidisciplinary teams, communications and governance. Members emphasised the importance of producing accessible versions of the plan, supporting staff understanding of their roles and maintaining a long-term focus on improving outcomes. The Board welcomed the collaborative approach adopted in developing the plan and expressed support for its submission. Presentation slides and supporting material to be circulated to Board members. Easy-read and engagement versions of the plan to be developed to support wider staff and public understanding.	ACTION ACTION

	RESOLVED:TLB: 1. Acknowledged the co-production, support and contributions from all partners in developing the final version of the Trafford Live Well Neighbourhood Plan; and 2. Provided final comments and feedback on the submission for action before submitting to NHS GM by 30 September.	
8	HWBB/TLB Symposium A proposal was presented for a programme of joint workshops between the Trafford Locality Board and the Health and Wellbeing Board. Members agreed that the workshops would provide an opportunity to clarify responsibilities, reduce duplication and strengthen governance arrangements in light of the evolving Place Partnership Framework. A detailed proposal and draft agenda for the planned workshops in December 2026 and March 2027 to be developed and shared with members. RESOLVED: TLB: 1. Acknowledged the imminent change in place governance arrangements regarding the Place Partnership Framework; and 2. Supported the proposed purpose and outcomes of the proposed workshops in December 26 and March 27.	ACTION
9	REMOVAL OF CHESHIRE AND WIRRAL PARTNERSHIP (CWP) BUDGET FROM SECTION 75 AGREEMENT COD presented a report regarding the removal of the Cheshire and Wirral Partnership mental health budget from the Trafford Section 75 pooled budget arrangements. Members were advised that this was a technical governance amendment arising from wider NHS Greater Manchester governance changes. The amendment related solely to the treatment of the budget line within the agreement and would not result in any change to service provision or funding levels. RESOLVED: TLB: 1. Noted the changes to NHS GM governance arrangements that have	

	prompted a review of the Trafford Section 75 Agreement; 2. Noted that funding for Cheshire and Wirral Partnership mental health services no longer requires inclusion within the pooled budget in order to support service delivery; and 3. Agreed in principle that the Cheshire and Wirral Partnership budget should be removed from the Trafford Section 75 pooled budget and as such part of the deed of variation for 2026/27.	
10	ANY OTHER URGENT BUSINESS There was no other business.	

Trafford Locality Board - Action Log 26/27

Action No.	Date of Meeting	Agenda Item Ref.	Action	Update	Lead	Target Date	Status
183	17/02/2026	Draft Neighbourhood plan	TM to produce easy to read version to support resident engagement.		TM	15/12/2026	In Progress
206	23/07/2026	Neighbourhood Leadership Team Model	TM to draft role profile for JLG membership.	Document drafted and will be taken to October JLG.	TM	20/10/2026	closed
207	23/07/2026	Healthwatch	TM to have offline conversation with Healthwatch colleagues and others about how healthwatch data could be better used to inform planning.	TM is progressing conversation around data intelligence repository as part of live well neighbourhood plan. TM exploring with AL and HF persistent issues tracker, TM to provide verbal update.	TM	20/10/2026	closed
208	29/09/2026	Trafford Council CQC Local Authority Assessment	CW to share improvement plan with TLB and GP Board and attend GP Board to provide an update.	Requested from CW.	CW	20/10/2026	In Progress
209	29/09/2026	Childrens services improvement plan	Childrens services improvement plan to be brought to a future TLB meeting.	Added to forward plan.	ST	20/10/2026	closed
210	29/09/2026	Childrens services improvement plan	ST to send out communications noting leadership changes.		ST	20/10/2026	closed
211	29/09/2026	Childrens services improvement plan	Childrens services improvement to be discussed at GP board.	RH linked in with LG to ensure taken to GP Board.	ST	20/10/2026	closed
212	29/09/2026	Neighbourhood Plan	Final submission to be circulated to TLB.		TM	20/10/2026	closed
213	29/09/2026	HWBB/TLB Symposium	Detailed proposal and draft agenda for planned workshops in December and March to be shared with members.	Added to forward plan.	TM/HG	17/11/2026	closed

In
Progress
Overdue
Completed

Date & Time of Meeting	17th November	15th December
Part 1 – GM ICB Committee (Trafford)		
	Locality Update and Governance	Locality Update and Governance
	NHS Reform Update	NHS Reform Update
	Governance Review	
	Place Partnership Documentation	
	Finance, Performance and Sustainability	Finance, Performance and Sustainability
		Locality Scorecard
	Risk	Risk
	Risk Register	
	Quality	Quality
		Locality Scorecard
		Cqc update
	Primary Care	Primary Care
	Childrens	Childrens
		Childrens Improvement
	TCAPS	TCAPS
	TCAPs Highlight Report	TCAPs Highlight Report
	JLG	JLG
	TLB/HWBB Session planning	TLB/HWBB feedback
	IMC Transformation	Integrated Neighbourhood Team
	Partner Update	Partner Update
	Future of Healthwatch	Healthwatch Performance Report
Part 2 – Section 75 Committee		

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.

Name of Committee / Board		Trafford Locality Board		
Date of Meeting		20th October 2026		
Report Title		Place Health and Care Partnership document suite and confirmation statement		
Report Author & Job Title		Thomas Maloney, Programme Director Health and Care, Trafford Council & NHS GM (Trafford)		
Organisation Exec Lead		Cathy O'Driscoll, Interim Place Partnership Director, NHS GM (Trafford)		
OUTCOME REQUIRED <i>(please highlight)</i>	Approval	Assurance	Discussion x	Information x
EXECUTIVE SUMMARY				
To provide an update on the Place Health and Care Partnership document suite, confirm the broad direction of travel and set out the further work required before partner organisations are asked to approve the final suite and proceed to the NHS Greater Manchester confirmation statement process.				
RECOMMENDATIONS				
The Board are asked to: • Note the progress made in developing the Place Health and Care Partnership document suite following the programme of partner workshops and detailed review. • Endorse the broad direction, shared outcomes and proposed operating model described in the suite as the basis for completing the remaining work, without approving the documents at this stage. • Note that the documents are undergoing final revision with NHS Greater Manchester and will return to the Locality Board, expected approximately October 19th 2026, once that work is complete. • Support the intention that all partner organisations should be in a position to sign up to the final suite through their own governance arrangements, subject to satisfactory resolution of the outstanding legal, financial, governance, workforce and operational matters. • Note that no confirmation statement will be submitted to NHS Greater Manchester until the final document suite has returned to the Locality Board and each partner has completed its own internal assurance and approval route and provided evidence of approval • Receive a further paper in November presenting the final document suite, the proposed Trafford confirmation statement. • Note that any subsequent legal, financial, workforce, hosting or delegation arrangements will remain subject to separate due diligence and formal approval by the relevant organisations.				
CONSIDERATIONS – these must be completed before submission to the Board – Reports with incomplete coversheet information will not be accepted and shared with the board				

Risk implications <i>(Please provide a high-level description of any risks relating to this paper, including reference to appropriate organisational risk register)</i>	There are generic risks regarding timeframes slipping for signing of the Place Partnership Agreement if certain gateways are not adhered to, whether the responsibility of GM or Place. We will communicate any changes to the stated timeframe via our established Governance T&F Group.
Financial implications and comment/approval <i>(Please detail which organisation(s) will be impacted, and if not required, please briefly detail why)</i>	Name/Designation: N/A
	Comment / Approval: N/A
Comment by Trafford Clinical and Practitioner Senate (TCAPS) and/or Clinical Lead <i>(If not required, please briefly detail why)</i>	Date of TCAPS / Clinical Lead comment (Delete appropriately): N/A
	Name/Designation: (If appropriate) N/A
	Comment: N/A
What is the impact on inequalities? <i>(Please provide a high-level description of any known impacts)</i>	N/A
Equality Impact Assessment / Quality Impact Assessment Outcome <i>(If not appropriate at this stage please state if an EIA or QIA is necessary)</i>	N/A
People and Communities: Communications & Engagement <i>(Please detail relevant patient/public engagement completed and/or planned, and if not required please briefly detail why)</i>	N/A
Trafford's Carbon Footprint <i>(Please provide a high-level description of any known positive and/or negative impacts – consider the following topics: energy usage; staff or public transport; waste or materials used. Include steps that could be taken to reduce carbon within relevant plans)</i>	N/A
Links to Measurement / Outcomes <i>(Please detail if this is included within the report)</i>	N/A
Enabler implications	Legal implications: Implications will be considered via the organisational due diligence process alluded to in the paper.

	Workforce implications: Implications will be considered via the organisational due diligence process alluded to in the paper.
	Digital implications: Implications will be considered via the organisational due diligence process alluded to in the paper.
	Estates implications: Implications will be considered via the organisational due diligence process alluded to in the paper.
Sub-Board Sign-Off / Comments (i.e. Trafford Provider Collaborative Board, H&SC Delivery Steering Group)	This paper has not been to any previous partnership meeting, however content builds from previously tabled reports through the Locality Board and Governance Task and Finish group.
Organisation Exec Lead Sign off	Cathy O'Driscoll, Interim Place Partnership Director, NHS GM (Trafford)

1.0 Executive Summary

- 1.1 NHS Greater Manchester has developed a suite of documents intended to establish a consistent framework for the operation of Place Health and Care Partnerships across Greater Manchester. The suite comprises the Partnership Agreement, Outcomes Framework, Place Fund, Place Team Approach and Governance Framework, and is intended to provide a single operating model for partnership working at Place level.
- 1.2 Following a programme of partner workshops, engagement and detailed review, Trafford partners have broadly supported the direction of travel while identifying a number of issues requiring further development before formal approval can be sought. The document suite is currently undergoing final revision with NHS Greater Manchester and will be brought back to the Trafford Locality Board for consideration alongside a proposed Trafford confirmation statement and implementation plan.
- 1.3 The proposals are intended to strengthen partnership working across Trafford by supporting collaborative leadership, neighbourhood delivery, prevention, improved population health outcomes and more effective stewardship of collective resources. The arrangements seek to bring together NHS organisations, Trafford Council, primary care, the voluntary, community, faith and social enterprise sector and other partners around a shared set of outcomes whilst retaining the sovereignty, statutory responsibilities and decision-making authority of each individual organisation.

- 1.4 This paper does not seek approval of the final document suite, nor does it seek approval of any transfer of budgets, delegation of statutory functions, workforce arrangements, hosting arrangements, contractual commitments or amendments to existing Section 75 agreements. Any such arrangements will remain subject to separate due diligence, assurance and formal approval through the governance arrangements of the relevant organisations.
- 1.5 Whilst there is broad support for the proposed direction of travel, a number of important matters remain to be resolved before implementation can proceed. These include finalisation of the Outcomes Framework, clarification of Place Fund arrangements, agreement of the Place Team model, confirmation of hosting arrangements, completion of legal and financial due diligence, and confirmation of partner representation and signatory arrangements.
- 1.6 The paper therefore seeks endorsement of the broad direction of travel whilst recognising that further work is required to address outstanding governance, financial, legal, operational and workforce considerations. It also sets out the proposed process for assurance, approval and formal sign-off by partner organisations before any Trafford confirmation statement is submitted to NHS Greater Manchester.
- 1.7 Subject to satisfactory resolution of these matters, the proposed Place Health and Care Partnership arrangements provide an opportunity to strengthen partnership working across Trafford, improve collective accountability for outcomes and support delivery of Trafford's wider health, care and Live Well ambitions whilst maintaining local accountability and organisational sovereignty. The final document suite will be presented to the Locality Board in November 2026 together with evidence of partner assurance, approval routes and any remaining matters requiring local determination.
- 1.8 NHS Greater Manchester has developed a suite of documents intended to establish a consistent framework for the operation of Place Health and Care Partnerships across Greater Manchester. The suite comprises the Partnership Agreement, Outcomes Framework, Place Fund, Place Team Approach and Governance Framework, and is intended to provide a single operating model for partnership working at Place level.

2.0 Background and Purpose

- 2.1 The Greater Manchester proposals position Place Health and Care Partnerships as the principal forum through which NHS organisations, local authorities, primary care, the voluntary, community, faith and social enterprise sector and other partners work together to improve outcomes for their local

population. The framework connects strategic commissioning at Greater Manchester level with local insight, neighbourhood delivery and collective stewardship of resources.

- 2.2 The Partnership Agreement is the anchor document. It sets the shared purpose, behaviours, responsibilities and governance principles for partners, while making clear that the partnership is not a separate legal entity and does not displace the statutory accountabilities or decision-making authority of any sovereign organisation.
- 2.3 The purpose of this paper is to update the Trafford Locality Board on the developing suite, invite continued support for its broad direction and establish the safeguards and further work required before the final documents are presented for approval in November 2026.

3.0 The Document Suite

Document	Purpose	Draft Position Statement	Actions
Partnership Agreement	The overarching framework for shared intent, principles, roles, governance and ways of working.	Broad direction supported; final approval deferred pending local completion and assurance.	Stakeholders to confirm organisational governance and anticipated timeframes
Outcomes Framework	Defines the shared outcomes and the measures through which progress and accountability will be tracked.	Shared outcomes and structure noted; measures, baselines and ownership to be completed before approval.	Explore through planned TLB and HWBB Symposium a shared outcomes framework and connectivity of Live Well outcomes and associated metrics
Place Fund	Sets the direction for financial stewardship, visibility of resources and alignment with prevention and neighbourhood delivery.	Principles noted; detailed financial and governance work required before any commitment.	Consider governance arrangements in place to have sight of place fund
Place Team Approach	Describes the purpose, capabilities, membership and possible configuration of the multi-partner Place Team.	Direction supported; the Trafford operating model and partner contributions to be developed through implementation planning.	Schedule a T&F Group, considered previously at the Governance T&F Group to determine definition and make-up of the Place Team – linked to existing place hosting mobilisation meeting
Place Governance	Appraise mechanisms linking NHS GM, the Place Fund and Place Team, including	Options and principles noted; formal legal decisions reserved to the	Agree ToR for Trafford PHCP Board. Ongoing review / audit of Better Care Fund and

	Section 75 and contractual routes.	relevant partner organisations.	completion of SD75 Deed of Variation (October 26)
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4.0 Assessment of the proposals

Place Partnership Agreement

- 4.1 The Place Partnership Agreement (PPA) provides a sound basis for local partnership working. It commits partners to act on a “best for place” and “best for GM” basis, supports consensus as the default approach to decisions and retains reserved matters and statutory accountability within each organisation. It also links the Outcomes Framework, Place Fund and Place Team into one coherent arrangement.
- 4.2 Before final adoption, the Trafford version of the PPA will need the local nuances inserting (Naming conventions, vision, parties, commencement). The remaining Section 75 arrangements, schedules and terms of reference should also be integrated into the new PPA appropriately – with advice being sought on how to do this clearly and effectively. These matters will be considered through the final revision process and must be resolved, or clearly identified for subsequent local implementation, before formal approval is sought.
- 4.3 Confirmation of signatories to the PPA is required from existing members of the Locality Board plus representation from all primary care professions – not currently represented in the current membership of the Board. An agreed position on signatories to the PPA is to be agreed in-principal ahead of presenting the final suite of documents at the November Board meeting.

5.0 Outcomes Framework

- 5.1 The framework proposes four shared outcomes: narrowing inequalities in healthy life expectancy while improving outcomes overall; increasing care delivered in neighbourhood settings; improving staff wellbeing and retention; and making more effective use of collective resources through continuous improvement.
- 5.2 The proposed metric library covers access, cancer, children and young people, community services, elective care, end of life, experience, financial sustainability, long-term conditions, mental health, quality, inequalities, immunisation, urgent care and workforce. However, the current schedule remains developmental. It contains a significant number of “TBC” entries, incomplete baselines and targets, and some measures without confirmed leads. The final framework should be focused enough to drive decisions rather than become an exhaustive list of performance metrics. Due

consideration to the emergent Live Well outcomes and associated metrics and its inclusion in the Outcomes Framework should be clarified.

6.0 Place Fund

- 6.1 The Place Fund proposals support a clearer view of resources, collective stewardship and a planned shift towards prevention, early intervention and neighbourhood delivery. The current proposition describes 2026/27 as a shadow year in which NHS Greater Manchester continues to hold the fund centrally while places work with the wider financial picture and influence decisions within agreed rules.
- 6.2 The Board is asked to note the strategic direction, not to approve a transfer of budgets or liabilities through this paper. Any pooling, delegation, hosting, risk sharing or change to existing Section 75 arrangements must be supported by detailed financial, legal and governance advice and approved through the relevant partner processes.

7.0 Place Team Approach

- 7.1.1 The proposed Place Team is a virtual, multidisciplinary resource drawn from partners. Its role is to connect strategy to neighbourhood delivery and bring together leadership, analysis, improvement, programme management, finance, clinical and care expertise and community engagement. The model expressly allows local flexibility, ranging from integrated and hybrid teams to dispersed or fluid matrix arrangements.
- 7.1.2 This flexibility is appropriate for Trafford given our current arrangements. Support for the direction of travel should not predetermine a host or employment model. The next phase should define the functions Trafford needs, the capacity each partner will contribute, the accountabilities for hosted or ring-fenced roles and the practical relationship between the Place Team, the Board and delivery arrangements. The Governance Task and Finish Group agreed to a separate meeting of partners to work through the definition of Place Team, reporting back to our Board appropriately.

Governance

- 7.3 The governance appraisal considers internal ICB delegation, a Section 75 agreement, a formal contract and a memorandum of understanding. Its stated direction is that a Section 75 route is preferred where a local authority hosts the Place Fund, while a contractual route is preferred where an NHS trust hosts the Place Team. It also states that decisions about the Place Fund and Place Team should remain with the Place Partnership rather than sit solely with the host organisation.

- 7.4 The Locality Board is invited to note that core principle while recognising that the final instruments will depend on confirmed hosting decisions, due diligence and the respective powers and approvals of the parties. Consideration of this update should not be interpreted as advance approval of a new or varied Section 75 agreement, contract, staff transfer or delegation.
- 7.5 Nothing within the proposed arrangements transfers statutory functions, legal responsibilities, organisational sovereignty or decision-making authority from any partner organisation unless subject to separate formal approval through the relevant governance arrangements.

8.0 Future Trafford confirmation statement

- 8.1 The final paper will include a proposed Trafford confirmation statement for consideration. The current working form is retained below to show the intended safeguards, but it is not presented for approval at this meeting:
- 8.2 “The Trafford Locality Board confirms its agreement to the core direction, shared outcomes and operating principles set out in the Place Health and Care Partnership document suite. This confirmation is made on the basis that each partner retains its statutory functions, sovereignty and internal approval requirements; that outstanding Trafford-specific content and technical detail will be completed; and that any subsequent legal, financial, employment, hosting or delegation arrangements will be subject to the appropriate due diligence and formal decisions of the relevant organisations.”
- 8.3 Partner confirmation will need to be explicit and recorded. Where a representative cannot bind their organisation, the local process will need to obtain confirmation from the appropriate accountable body or authorised officer. Submission of the Trafford statement will only follow the Boards consideration of the final suite and completion of the agreed partner approval routes (November 26).

9.0 Formal approval and signature by partner organisations

- 9.1 The final Partnership Agreement will require formal commitment by the named parties. Attendance at the Locality Board, or support expressed by an individual representative, should not by itself be treated as authority to bind their organisation. Each party should therefore confirm the governance route through which it can approve and sign the final document, together with the officer or office-holder authorised to provide that signature.

- 9.2 This is particularly relevant for Manchester NHS Foundation Trust, Greater Manchester Mental Health Foundation Trust, primary care representatives of Trafford GP Board and nominated officers/representatives from the additional primary care professions. Their representatives are likely to need to take the final suite back through the relevant trust, board or constituent-body arrangements before a signature can be given on behalf of the organisation or sector.
- 9.3 The proposed process is:
1. Local process and assurance: The final suite is circulated (Week commencing 19th October 26) to all proposed parties, with a standard assurance template asking each organisation to confirm any remaining concerns, its approval route, the authorised signatory and the date by which approval can be secured.
 2. Locality Board consideration: The final suite, proposed Trafford confirmation statement, schedule of resolved and outstanding matters, and partner approval plan return to the Committee in November 2026. The Board considers whether the suite is ready to proceed into formal organisational approval and signature. Additional partner discussions are to take place at a meeting of the established Governance T&F Group on the 28th October 2026 ahead of the Locality Board meeting in November.
 3. Constituent-body approval: Each party follows its own governance process. Partner representatives should be given sufficient opportunity to consult and obtain the necessary mandate from their relevant trust, board, member practices or other constituent bodies. Other partners should follow their equivalent authorised route.
 4. Formal signature: Signatures are collected only after the relevant approvals have been obtained. A single controlled final version will be used, supported by a signature schedule recording the approving body, decision date, signatory and any conditions or reservations.
 5. Confirmation and implementation: The Trafford confirmation statement is submitted to NHS Greater Manchester only when the agreed threshold for partner approval has been met and the Board is satisfied that any remaining qualifications are explicit – it is expected this will be after the November meeting of the Board, however if further time is required to complete the

process the final confirmation will take place at the December meeting of the Board (15th). Material legal, financial, workforce, hosting or delegation arrangements should continue through separate due diligence and approval processes.

10. Key matters to complete before implementation

- 10.1 Complete the Trafford-specific Partnership Agreement, including parties, vision, term, schedules and terms of reference.
- 10.2 Confirm the concise set of oversight measures, baselines, ambitions, reporting frequency, data ownership and named leads.
- 10.3 Agree the local contribution and accountability model for the Place Team, including any hosted, assigned, seconded or ring-fenced capacity.
- 10.4 Confirm current Place Fund proposition, including scope, decision rights, controls, risk and gain share, treatment of overspends and underspends contained within the existing Section 75 agreement via confirmation of 26/27 Deed of Variation (Due October Locality Board).
- 10.5 Complete legal, financial, procurement, VAT, workforce, information governance and equality assurance for any formal implementation arrangements.
- 10.6 Produce an implementation plan with accountable leads, milestones, dependencies, risks and reporting arrangements.

11. Implications for Trafford Place

11.1 Governance Implications

- 11.2 The proposed Place Health and Care Partnership framework provides an opportunity to strengthen collaborative decision-making across Trafford whilst maintaining the sovereignty, statutory duties and formal accountabilities of partner organisations. The Partnership Agreement makes clear that the partnership is not a separate legal entity and does not replace existing governance arrangements. However, further work is required to clearly define the decisions that will be taken collectively through the Place Partnership, those that remain reserved to individual organisations and those retained by NHS Greater Manchester. The final document suite should also clearly set out dispute resolution and escalation arrangements where consensus cannot be reached.

11.3 Financial Implications

- 11.4 This paper does not seek approval for any transfer of budgets, delegation of financial responsibility or amendment to existing financial arrangements. The proposed Place Fund represents a strategic approach to collective stewardship of resources, with 2026/27 operating as a shadow year. Any future arrangements relating to pooled budgets, hosting, risk-sharing, gain-share mechanisms, management of overspends and underspends, or variations to existing Section 75 arrangements will require separate financial appraisal, due diligence and approval through the relevant governance processes of partner organisations. Trafford partners will require assurance that financial liabilities remain proportionate to delegated authority and decision-making responsibility.

11.5 Workforce and Place Team Implications

- 11.6 The proposed Place Team model aligns with Trafford's ambition to deliver integrated services through collaborative leadership and neighbourhood-based delivery. Further work is required to determine the functions, capacity, partner contributions and accountability arrangements needed to support the Trafford model. Any future decisions relating to hosting, recruitment, secondment, assignment or employment responsibilities will remain subject to detailed workforce, organisational development and legal consideration by the relevant partner organisations.

11.7 Hosting Arrangements

- 11.8 The final document suite does not currently identify a preferred host organisation for either the Place Team or any future Place Fund arrangements. Trafford partners will need to consider the implications of hosting arrangements, including employer responsibilities, governance oversight, contractual liabilities, financial administration and support services. No hosting arrangement should be assumed or agreed until the appropriate options appraisal, due diligence and formal organisational approvals have been completed.

11.9 Strategic and Service Delivery Implications

The proposed framework supports Trafford's existing commitment to integrated working, prevention, neighbourhood delivery and reducing health inequalities. The final Outcomes Framework should demonstrate clear alignment with Trafford priorities, including the Live Well agenda, wider determinants of health, community wellbeing and neighbourhood outcomes.

The framework should support delivery across the whole health and care system rather than focusing solely on NHS performance measures.

- 11.10 The proposed arrangements provide an opportunity to strengthen partnership working across Trafford, align resources more effectively around local priorities, support prevention and neighbourhood delivery, reduce duplication across organisations and improve collective accountability for population health outcomes. Successful implementation should support improved outcomes for residents whilst maintaining strong local ownership and accountability.

12. Risks and Areas Requiring Further Assurance

12.1 Key Risks and Mitigations

Risk	Potential Impact	Mitigation
Lack of clarity on decision-making and delegated authority	Uncertainty regarding accountability and delays in decision-making	Final document suite to include clear governance, delegation and escalation arrangements.
Financial governance and risk-sharing arrangements not fully defined	Potential exposure to unknown liabilities and reduced partner confidence	Detailed financial framework and any changes to Section 75 arrangements to be subject to separate due diligence and approval.
Place Team model and hosting arrangements remain unresolved	Unclear workforce, accountability and employer responsibilities	Completion of Place Team design work and formal options appraisal before implementation.
Outcomes Framework not sufficiently developed	Difficulty measuring delivery, impact and partner accountability	Agree a focused set of outcomes, baselines, targets and accountable leads prior to approval.
Insufficient partner representation and organisational sign-off	Delays to implementation and risk of incomplete system commitment	Confirm partner representation, approval routes and authorised signatories through a formal assurance process.
Misalignment between GM requirements and Trafford priorities	Reduced ability to deliver local outcomes and respond to local need	Ensure alignment with Trafford priorities, Live Well ambitions and wider locality plans through the final document suite.

- 12.2 Whilst these risks require further assurance and resolution, they are considered manageable through the proposed programme of due diligence, partner engagement and formal organisational approval processes. A further report will be presented to the Locality Board setting out progress against each area and any residual risks prior to implementation.

13. Next steps

1. Record the Boards comments on the direction of travel and any further matters to be addressed.
2. Complete the final document revisions with NHS Greater Manchester, drawing together the issues raised through the partner workshops and detailed review.
3. Circulate the revised suite to partner organisations for final assurance and preparation for their respective approval routes.
4. Confirm with each proposed party its formal approval route, authorised signatory and requirements for consultation with constituent bodies, and maintain a consolidated approval and signature schedule.
5. Return the final suite and proposed Trafford confirmation statement to the Board, expected in November 2026.
6. Following Board consideration, secure and document confirmation from each Trafford partner through its authorised route before any statement is submitted to NHS Greater Manchester. Return a further implementation and assurance report before any material legal, financial, workforce or hosting arrangement takes effect.

Name of Committee / Board	Trafford Locality Board			
Date of Meeting	20th October 2026			
Report Title	PCN Neighbourhood Action Plans			
Report Author & Job Title	Heather Lukeman			
Organisation Exec Lead	Thomas Maloney			
OUTCOME REQUIRED <i>(please highlight)</i>	Approval	Assurance	Discussion	Information X
EXECUTIVE SUMMARY				
Following review by the Trafford Primary Care MDT, all five Trafford PCN BeCCoR Neighbourhood Action Plans for 2026/27 were presented to and approved by the Trafford Senior Leadership Team (SLT). The review confirmed that all five plans meet the NHS Greater Manchester ICB criteria, demonstrating a focus on identified BeCCoR cohorts and unmet need, value for money, and collaborative working with neighbourhood partners. Three plans (Altrincham Healthcare Alliance, Trafford West and Trafford Central) were approved with no further clarification required. The remaining two plans (Trafford South and Trafford North) were approved subject to minor clarification regarding contingency costs, in line with the GM review template. These clarifications have since been received. All five plans include a commitment to supporting Neighbourhood Leadership Teams (NLTs) and MDTs. This supports the locality wide approach to establishing and embedding neighbourhood working. The approved plans support Trafford's wider neighbourhood working ambitions by directing investment towards identified cohorts with unmet need and strengthening collaboration between general practice and neighbourhood partners. Delivery and impact will be reviewed at the end of the 2026/27 period, drawing on PCN reporting against their proposed measures, evidence of activity and reach, and learning from partnership working. The PCNs have been notified of the approval outcomes and will be expected to support end-of-year evaluation. The locality will support in providing NHS Greater Manchester ICB with an evaluation of each plan, including delivery, outcomes and learning, to inform the assessment of impact and support consideration of future investment in neighbourhood prevention activity.				
RECOMMENDATIONS				
The Locality Board is asked to note the outcome of the SLT review and approval of the five Trafford PCN BeCCoR Neighbourhood Action Plans for 2026/27.				
CONSIDERATIONS – these must be completed before submission to the Board – Reports with incomplete coversheet information will not be accepted and shared with the board				

Risk implications <i>(Please provide a high-level description of any risks relating to this paper, including reference to appropriate organisational risk register)</i>	There is a risk that the intended benefits of the Neighbourhood Action Plans may not be fully realised if planned activity is not delivered as expected or if outcomes are not adequately evidenced. This will be mitigated through end-of-year evaluation, with PCNs expected to report on delivery, reach, outcomes and learning to inform the locality's evaluation. There is also a longer-term risk relating to the sustainability of NLT and MDT arrangements beyond the current funding period, as future investment has not been confirmed. The evaluation will help inform future commissioning and funding decisions.
Financial implications and comment/approval <i>(Please detail which organisation(s) will be impacted, and if not required, please briefly detail why)</i>	Name/Designation:
	Comment / Approval <i>(Delete appropriately)</i> :
Comment by Trafford Clinical and Practitioner Senate (TCAPS) and/or Clinical Lead <i>(If not required, please briefly detail why)</i>	Date of TCAPS / Clinical Lead comment <i>(Delete appropriately)</i> :
	Name/Designation: <i>(If appropriate)</i>
	Comment:
What is the impact on inequalities? <i>(Please provide a high-level description of any known impacts)</i>	The Neighbourhood Action Plans aim to address health inequalities by targeting identified BeCCoR cohorts with unmet health needs and supporting more proactive, coordinated care through general practice and neighbourhood partners. The plans seek to improve access, engagement and outcomes for people who may face barriers to accessing services. PCN evaluation at year end will help assess the extent to which the activity has reached target populations and contributed to reducing inequalities.
Equality Impact Assessment / Quality Impact Assessment Outcome <i>(If not appropriate at this stage please state if an EIA or QIA is necessary)</i>	
People and Communities: Communications & Engagement <i>(Please detail relevant patient/public engagement completed and/or planned, and if not required please briefly detail why)</i>	The Neighbourhood Action Plans have been discussed and developed at PCN and neighbourhood level, incorporating local priorities and partner input. The plans were subsequently reviewed through the Trafford Primary Care MDT and approved by SLT. The Locality Board provides the final locality level oversight of the approval process. Engagement with patients and the

	public will be supported through delivery of the plans, where appropriate, with learning and outcomes captured as part of the end of year evaluation.
Trafford's Carbon Footprint <i>(Please provide a high-level description of any known positive and/or negative impacts – consider the following topics: energy usage; staff or public transport; waste or materials used. Include steps that could be taken to reduce carbon within relevant plans)</i>	The plans are not expected to have a significant direct impact on Trafford's carbon footprint. Some travel may be required for staff to attend NLTs, MDTs and neighbourhood meetings, which could result in additional transport-related emissions. This could be mitigated by using virtual or hybrid meetings where appropriate, coordinating meetings to minimise unnecessary travel, and making use of existing local meeting venues. The plans may also support more coordinated care and reduce duplication across services, although any resulting environmental benefits have not been quantified.
Links to Measurement / Outcomes <i>(Please detail if this is included within the report)</i>	The five PCN Neighbourhood Action Plans include proposed measures and intended outcomes for their respective target cohorts. Progress and impact will be assessed through end of year evaluation, with PCNs expected to provide evidence of activity delivered, patient reach, outcomes against their stated measures and learning from neighbourhood partnership working.
Enabler implications	Legal implications:
	Workforce implications:
	Digital implications:
	Estates implications:
Sub-Board Sign-Off / Comments <i>(i.e. Trafford Provider Collaborative Board, H&SC Delivery Steering Group)</i>	
Organisation Exec Lead Sign off	

View results

Respondent

1

Anonymous

15:21

Time to complete

About this submission

Tell us who is submitting the plan and where it has been discussed and agreed.

1

If you have one, what is the name of your scheme (e.g. Brookvale Neighbourhood reaching the missed middle)

Cardiovascular Disease, Dementia prevention and Wellbeing

2

Who is submitting this plan? *

☒ PCN☐ Single practice☐ Group of practices not submitting as a PCN

3

Name of the submitting PCN or practice(s) *

Altrincham Healthcare Alliance

4

Names and roles of the practice or PCN leads for this work *

Dr Kate Jennings and Dr Marik Sangha – Clinical Directors
Frances Ward – Business Manager

5

Name of the neighbourhood *

South Trafford

6

Name of the neighbourhood forum or meeting where the plan was discussed and agreed *

Joint meeting between public health (Zoe Ball, Emily Paine), Integrated Neighbourhood Lead (Julia Worthington) and Altrincham Healthcare Alliance (Kate Jennings, Marik Sangha, Frances Ward)

7

Date the plan was most recently discussed and agreed (DD/MM/YYYY) *

27/08/2026

Core cohort and target group

The Curator BeCCoR dashboard will bring together the full BeCCoR cohort across Greater Manchester. Authorised users will be able to view and filter patient-level cohort status, indicators of unmet need and geographic information. This is intended to make it easier for practices and neighbourhood partners to identify and size target groups, agree priorities and track progress without having to create these measures themselves. Until the dashboard is available, use the best information currently available.

8

Which BeCCoR clinical cohort(s) are included in this plan? *

- ☒ CVNeed — hypertension
- ☐ CVNeed — atrial fibrillation
- ☐ CVNeed — diabetes
- ☐ CVNeed — secondary prevention of CVD/lipid optimisation
- ☐ CVNeed/ACR — chronic kidney disease or albuminuria need
- ☐ Primary prevention — high QRISK
- ☐ RespNeed — adult asthma
- ☐ RespNeed — asthma in children and young people
- ☐ RespNeed — COPD
- ☒ Other BeCCoR Cohort - Describe below

9

If you selected "Other BeCCoR cohort", describe it here. (Maximum 150 words)

The Altrincham area has an ageing population, with a growing number of people living with dementia. This population is more likely to experience multiple long-term health conditions and associated comorbidities, while also facing significant barriers to accessing healthcare and support. In addition, many individuals have unmet social and wider determinants of health needs, which can negatively impact their overall health, wellbeing and ability to remain independent. As a result, some individuals present to healthcare services at a point of crisis, when earlier identification of need, preventative intervention and appropriate community-based support may have helped to avoid deterioration, emergency department attendances or hospital admissions. The proposed cohort focuses on people living with cardiovascular disease and with dementia. By targeting this group through proactive health reviews, health promotion and strengthened links with social prescribing and community support, the programme aims to identify unmet needs earlier, improve health outcomes and reduce avoidable use of urgent care.

10

What are the main indicators of unmet need used to define the target group? *

The below indicators will all be available to view, filter and easily track on the BeCCoR dashboard once available. Picking from one of the below will allow you to easily filter your chosen cohorts to better understand how you may work together in the plan to meet their need.

Select all that apply. If you select 'Other', please type the indicator in the text box that appears.

- ☒ Missing or overdue key checks, readings or reviews
- ☒ Repeated non-attendance or no response
- ☐ Outstanding treatment optimisation or not treated to target
- ☒ Repeated urgent-care use or unplanned admissions
- ☒ Wider non-medical needs affecting health
- ☐ Whole clinical cohort; no further unmet-need prioritisation
- ☐ Other

11

Which population or inequality characteristics actively shape the plan? *

Select only characteristics that actively affect how the target group is defined or how the plan will be delivered.

Select all that apply. If you select 'Other', please type the characteristic in the text box that appears.

- ☐ Deprivation / IMD
- ☐ Ethnicity
- ☒ Age
- ☐ Sex or gender
- ☒ Frailty
- ☐ Mental health
- ☐ Disability, learning disability or autism
- ☐ Inclusion health (those experiencing homelessness, struggling with addiction, vulnerable migrants or refugees (inc asylum seekers), Gypsy, Roma & traveller communities, sex workers, in prison or recently released or under probation, victims of modern slavery)
- ☐ None; the whole clinical cohort is prioritised
- ☐ Other

12

Describe the defined target group in your own words (including demographics) Maximum 250 words *

Bring together the clinical cohort, unmet need and relevant inequality characteristics selected above. Describe the specific local group, including any geographic or eligibility criteria. You do not need to repeat every selection.

South Trafford is an affluent area, with life expectancy approximately 10 years longer than in more deprived areas of Manchester. However, increased longevity is associated with a growing number of people living with multiple long-term conditions and co-morbidities. GM Tableau data shows that 29.6% of CVD patients within Altrincham Healthcare Alliance PCN are aged over 80.

Dementia prevalence is also increasing. NHS Digital reported that 22,752 people in Greater Manchester were living with dementia at the end of March 2025, with this projected to increase by 9.3% by 2030. Trafford estimates that 3,595 people will be living with dementia by 2030, a 50% increase since 2010.

There is a strong relationship between cardiovascular health and dementia. Alzheimer's Research UK reported in 2023 that 40% of dementia cases are associated with potentially modifiable risk factors. Within our PCN, 38% of people living with dementia have hypertension, stroke or TIA, highlighting the overlap between CVD risk and dementia.

People living with dementia can be harder to engage with routine healthcare and often rely on carers to attend appointments. In 2025/26, 24% of our dementia cohort did not receive an annual review.

By targeting this population, we aim to provide a multidisciplinary approach to managing cardiovascular risk, promoting healthy lifestyles and reducing social isolation, while identifying wider social needs through social prescribing. Earlier intervention aims to reduce deterioration, avoidable A&E attendances and emergency admissions, while supporting independence and quality of life.

13

Approximately how many people are in the defined target group? *

Use the BeCCoR dashboard count where available. If the dashboard is not yet available, or the target group has been further refined locally, enter your best current estimate as a whole number.

411

Please enter a whole number

Need, barriers, intended improvement and measurement

Tell us what local information shows for the target group, what may be contributing to the current position, what you intend to improve and how progress will be assessed. An indicator of unmet need describes the current problem; a barrier is something contributing to it; a measure is what you will track over time.

14

Why has this target group been prioritised for neighbourhood action? (Maximum 500 words) *

Briefly summarise the local evidence of need or inequality and why neighbourhood working offers an opportunity to improve the current position. Specific barriers are asked about next.

Having met with Public Health, Dementia is a key neighbourhood target for Trafford. This is because it is already having a substantial impact on the borough. They shared data that it is the leading cause of death among Trafford residents aged 65 and over, accounting for 14.2% of all deaths in this age group and overtaking heart disease as the primary cause of mortality. The estimated annual cost of dementia care in Trafford is £122 million and is expected to rise significantly over the coming years.

Neighbourhood working provides a practical mechanism for us to bring together the work we do in primary care with community organisations and local authority services to support a more proactive approach to brain health and dementia. Through neighbourhood networks, we can ensure GP practice staff and their patients are aware of the current Dementia pathways following diagnosis, what support that is available and we can contribute to the formulation of future plans for Trafford.

A neighbourhood approach can also help tackle social isolation, strengthen support for unpaid carers, and develop more dementia-friendly communities, enabling people to remain independent and connected to their local area for longer. These are all recognised factors that can improve quality of life for people living with dementia and their families whilst helping to reduce future demand on health and care services. Working closely with Age UK, the Carer's Centre, Home Instead and other organisations ensures we have up to date information about services, can access these resources and the knowledge they have, as well as contributing to the creation of new services.

With an expected increase in diagnosis of 9.3% in Greater Manchester in the next four years, Dementia services are expected to struggle. Dementia patients are more likely to have co-morbidities such as cardiovascular disease and are at increased risk of falls and therefore unplanned admissions. In 2026 alone in Trafford there have been 11,948 emergency admissions from Dementia patients in crisis. GPs in our PCN report they are seeing an increased number of crisis referrals that might have been prevented. Through working alongside neighbourhood partners, we aim to tackle the barriers facing Dementia patients and their carers to ensure they have access to the healthcare they require, as well as ensuring their social needs are also met.

15

What are the main barriers likely to be contributing to the current situation in your neighbourhood? *

Select all that apply. Select "Not sure yet" if the barriers will be explored during delivery. If you select "Other", type the barrier in the text box that appears, this might include barriers that you experience as a practitioner or service provider.

- ☐ Language or communication needs
- ☒ Digital exclusion
- ☐ Transport, mobility or physical access
- ☒ Appointment timing, work or caring responsibilities
- ☒ Confidence, anxiety or lack of trust
- ☒ Understanding of the condition or health literacy
- ☐ Financial, housing, food or fuel insecurity
- ☒ Social isolation or limited support
- ☒ Fragmented services or referral pathways
- ☒ Current recall or appointment arrangements do not meet the group's needs
- ☐ Not sure yet
- ☐ Other

16

Which single measure will be used as the primary indicator of progress? *

Select the one measure that best shows whether the main improvement is being achieved. If you select "Other", type the primary measure in the text box that appears.

- ☒ Target group reached or engaged
- ☐ BeCCoR review or relevant key checks completed
- ☐ Reduction in missing or overdue information, checks or reviews
- ☐ Clinical action completed, treatment optimised or people treated to target
- ☐ A&E attendances
- ☐ Patient-reported Health Confidence Score
- ☐ Personal Wellbeing Score or Loneliness measure
- ☐ Live Well, social-prescribing or community support
- ☐ New diagnoses or annual review completion
- ☐ Relevant QOF indicators
- ☐ Staff confidence or neighbourhood working
- ☐ Improvement in demographic recording
- ☐ Other

17

What is the current baseline for the primary measure? *

Give the value, date and source. If it is not yet known, explain how and by when it will be established.

According to QoF data, at 31st March 2026, there were 363 people on the practice's Dementia registers. Across the practices, 276 of these patients had a Dementia annual review, representing 76%. This is the baseline. There are now 411 patients on our practice's Dementia QoF registers. This figure has increased by 48 people since 31st March, an increase of 12%. In requesting practices achieve 80% of Dementia reviews, this represents a target of 329 people, up 53 additional reviews based on 31st March achievement. With the aim to engage this harder to reach group, an increase in the number of reviews will be an indicator of engagement.

18

Are there any additional measures you will monitor? If so, list up to three. (Maximum 250 words)

These are other things not selected as your primary measure above that you would want to measure as the project progresses. These might help show wider benefit (secondary measures) or possible unintended effects (balancing measures). Do not repeat the primary measure and leave blank if none.

For each additional aim try to ensure it is Specific, Measurable, Achievable, Realistic and Timebound

Live Well, social-prescribing or community support

Social prescribers will be available after the clinical appointment to screen patients to see what unmet needs they have that might be impacting on their health, such as finance, social isolation and housing, as well as offering Health Promotion around smoking, alcohol, moving more and healthy eating. They will offer resources and link in with the VCSE sector to support these patients to slow the rate of Dementia and improve their overall health to reduce the chance of a health crisis or unplanned admission. To date, only 25% of our PCN patients with Dementia have been given Social Prescribing Support previously. We will aim to increase this to at least 45%, being aware we will have only 6 months to complete this project in.

19

What change do you aim to achieve in the primary measure by 31 March 2027? (Maximum 250 words) *

Using the baseline above, state the intended amount or direction of change for the defined target group. Where relevant, identify any part of the target group for whom improvement is particularly important.

Example: "Reduce the proportion of [target group] with a missed or overdue review from 25% to 15% by 31 March 2027, with a particular focus on people living in areas of higher deprivation."

We will only having six months to achieve this target and are aware of the increased diagnosis' by 12% and the increased time associated with these more in-depth appointments. We are aiming to increase the number of Dementia patients with a review across the PCN from 76% in March 2026 to 80% by March 2027. Particular focus will be made to target those who did not have a Dementia annual review in 25/26 QoF year.

Co-design, delivery and neighbourhood fit

Describe how the approach has been shaped with relevant neighbourhood partners and how those partners will contribute to delivery. Simply naming an organisation is not sufficient: explain its involvement, contribution and role.

20

How will your plan be delivered? (Maximum 500 words) *

Describe the activities or changes in approach, including any targeted outreach, changes to access or recall, clinical action, referral pathways or wider support.

Explain how these respond to the needs and barriers identified above.

The plan will adopt a three-pronged approach, combining comprehensive dementia reviews, a community-based Dementia Open Day and providing feedback and intelligence to community services to identify gaps in provision.

As part of the Dementia reviews, administrative staff will proactively telephone patients and their carers to arrange appointments at a mutually convenient time, supporting both to attend wherever possible. Telephone contact, rather than text messaging, will ensure clear communication and understanding of the appointment and help reduce barriers to engagement. Particular focus will be given to patients who did not receive an annual review in 2025/26.

Using an MDT approach, patients will receive a comprehensive GP review covering dementia and cardiovascular health, including identification and management of relevant risk factors. Where appropriate, a practice nurse will undertake blood tests, blood pressure monitoring and other relevant health checks. Practices will aim to coordinate appointments wherever possible to minimise the need for patients to attend multiple times.

Following the clinical review, patients and carers will meet with a Social Prescriber to identify wider social, emotional and practical needs, provide tailored information and advice, and connect them with relevant community and voluntary sector support. Using the 'what matters to me' approach, the social prescribers will develop a plan with the patients and their carers to ensure their needs are met. Patient experiences will be gathered and be used to provide intelligence to TLCO and Public Health about gaps in local services and working together as part of the Dementia Strategy group to help develop future local services.

The appointment will also support each patient's named carer by referring them for advice and support from the Carers Centre, who provide wellbeing checks, support with finances, counselling and befriending. This will help carers maintain their own health and wellbeing while continuing to provide effective support. Our Social Prescribers report that patients are often unaware of available community support, particularly as the Memory Clinic resource packs can feel overwhelming following diagnosis and therefore not always read. Though Age UK are commissioned to provide support following diagnosis, for multiple reasons, not all patients engage with this service or remember being contacted by them. The memory clinic has shared their resources, which the Social Prescribers will develop to become a concise one- to two-page resource providing accessible health promotion advice on smoking, alcohol, diet and physical activity, alongside information about local groups, support networks and services for patients and carers.

The social prescribing team will plan the Dementia Open Day in partnership with Home Instead, the Carers Centre and the Alzheimer's society. At present they are trying to secure a venue to hold the event in the next 4-5 months. It will provide a community-based opportunity for people living with dementia and their carers to access information, advice and support in an informal and accessible setting. The event will bring together local health, social care, community and VCSE organisations to promote healthy lifestyles, social engagement and early intervention. Health promotion information around stop smoking, alcohol and healthy eating will be available, and we will approach Trafford Leisure to see if they could provide a stall and lead an activity such as chair-based exercises.

21

Please provide the costing for each identified activity in question 20. *

Start each activity on a new line.

Consider breakdown using the format: Category | Costed item | Amount | Deliverer | Basis of costing | with each clustered activity on a new line/new paragraph.

Costings sheet submitted separately

22

If the costs listed above don't total your allocation, please identify this and explain clearly the rationale for this. Any contingency costs should be clearly identified and justified. (Maximum 250 words) *

N/A

23

Why does the proposed spend represent good value for money? Refer to the size and need of the target group, expected reach or benefit, unit or session costs, the costing basis and existing resources. (Maximum 500 words) *

The NHS England National Cost Collection Publication estimated that, in 2024/25, the average cost of a non-elective emergency admission for a person living with dementia was £7,425. By providing more comprehensive health reviews and proactively engaging with people living with dementia who may be harder to reach, alongside enhanced healthcare and social prescribing support, the programme aims to reduce avoidable emergency admissions and the associated costs of secondary care.

Supporting people living with dementia to maintain their independence for as long as possible and delaying or preventing the need for long-term residential care could also generate significant savings in social care costs. Early intervention and appropriate community-based support can help individuals remain well and independent within their own homes for longer.

Providing targeted support to unpaid carers is equally important. By improving carers' access to advice, support and health checks, and strengthening their resilience, the programme aims to reduce the risk of carer breakdown and the subsequent need for more intensive and costly care arrangements. Carers can often prioritise the needs of the person they support at the expense of their own physical and mental health. Providing earlier support and encouraging carers to recognise and address their own health and wellbeing needs may reduce the likelihood of them requiring healthcare interventions at a point of crisis.

The planned open day will provide an opportunity to equip people living with dementia and their carers with practical information on how lifestyle choices, physical activity and social engagement can support healthy ageing and potentially slow the progression of dementia. It will also provide a direct link to local community and voluntary sector services, enabling individuals and carers to access appropriate support at an earlier stage.

The anticipated outcome is that improved health promotion, earlier identification of unmet needs and stronger links with community support will contribute to reductions in avoidable healthcare and social care costs. This reflects the principle that prevention and early intervention are generally more effective and cost-efficient than responding to needs once they have escalated to crisis point.

The £1,153.28 allocated for room hire and Social Prescriber time represents a relatively modest investment in relation to the potential reach and impact of the event. A similar event held in November 2025 attracted approximately 500 attendees, demonstrating the potential for this approach to engage a significant number of people within the local community and provide access to information and support at scale.

The majority of the proposed costs relate to staff time required to deliver the clinics. The comprehensive nature of the reviews means that additional consultation time will be required, with potential locum cover needed to maintain routine services while staff undertake these appointments.

It is estimated that the combined cost of a 30-minute GP review, a 30-minute nurse review and the associated administrative time required to arrange and coordinate the appointment is £78.94 per patient. This represents a relatively small investment when compared with the estimated £7,425 cost of a non-elective emergency admission. The proposed approach therefore offers the potential for a strong return on investment through prevention, earlier intervention and improved management of people living with dementia and their carers within the community.

24

Which partners will or have been be involved in co-design and/or delivery? *

Please state the partners if you select other

- ☒ Practice team
- ☒ PCN / MDT
- ☒ Neighbourhood / INT team
- ☐ Local authority
- ☒ Social prescribing
- ☒ VCFSE / community groups
- ☐ Mental health services
- ☒ Secondary care / specialist services
- ☐ Other

25

How have practices, communities and neighbourhood partners helped shape this plan? State who was involved, how views were gathered and what changed or was confirmed as a result. (Maximum 500 words) *

Discussions were held with all five practices at our monthly PCN meetings. Data indicated that almost 30% of our CVNeed patients were aged over 80, highlighting the need to prioritise the health and wellbeing of our older population. Dementia patients were subsequently identified as a smaller, more targeted group who face additional barriers and inequalities within this age category.

The Social Prescribing team played a key role in discussions around the support needs and barriers experienced by people living with dementia and their carers. Based on their experience, they recommended providing patients with information and resources in a simpler, more accessible way, rather than overwhelming them with information covering the entire journey from diagnosis through to end-of-life care.

Their experience of supporting people living with dementia highlighted that many patients are unaware of the support available to them. Offering all patients with dementia a screening appointment would provide an opportunity to identify unmet needs and ensure appropriate support is offered at an early stage. They recommended that information should then be tailored to the individual's current stage of diagnosis, focusing on practical ways to live well for longer, including healthy lifestyle choices, social engagement and maintaining independence.

The team also highlighted the significant pressures experienced by unpaid carers, who can often neglect their own health and wellbeing as a result of their caring responsibilities. They recommended working in partnership with the local carers centre to ensure carers are appropriately supported and offered a health check to identify and address their own health needs.

Public Health have identified Dementia as a neighbourhood priority and provided intelligence and data in support of the plan. They recognised the importance of addressing the needs of people living with dementia alongside those of their carers. The lack of support available to carers following a dementia diagnosis has consistently been identified as a significant gap in dementia services. This can contribute to adverse health outcomes for carers themselves, as well as for the people they support. Public Health therefore encouraged the inclusion of carers within dementia annual reviews, providing an opportunity to ensure that carers are also appropriately supported, informed and connected to available resources and services. Public Health highlighted the Dementia Strategy Group, which we will now send representation to future meetings to contribute to the development of community services.

As part of the development of the South Neighbourhood Locality Plan, a number of VCSE sector organisations, including Trafford Carers Centre, Age UK and local faith groups, identified dementia as a key priority. They highlighted the need for improved dementia support and stronger neighbourhood-based partnership working across Trafford. As well as linking patients to these services, we will also provide feedback of gaps in provision, to try to expand the community support available. The views and experiences of organisations working directly with people living with dementia and their carers have therefore been instrumental in shaping this plan. Their insight has helped to ensure that the proposed approach reflects the needs identified at community level and supports a more coordinated, person-centred approach to dementia care and prevention.

26

Is the work expected to benefit people beyond the defined core target group? *

☒ Yes

☐ No

27

If yes, briefly describe the potential wider benefit. (Maximum 150 words)

Carers supporting individuals living with dementia will be offered additional support and connected with relevant community services, including the local Carers Centre, for advice, guidance and practical assistance. The Carers Centre will also offer carers a health check, providing an opportunity to identify and address their own health and wellbeing needs and to ensure that their caring responsibilities do not prevent them from prioritising their own health.

By ensuring that people living with dementia are well informed about their condition, aware of the support available to them and offered an appropriate health review, we aim to reduce the stress, uncertainty and challenges experienced by those supporting them. This holistic approach will help to strengthen support for both individuals living with dementia and their carers, with the overall aim of improving their health, wellbeing and quality of life.

Funding, value for money and confirmation

Set out the proposed use of the Neighbourhood Prevention Allocation. Costs should be clear, proportionate to the target group and intended benefit, and linked to new or additional delivery activity.

28

Amount allocated to practice delivery (£; enter 0 if none)

£34,697.46

29

Amount allocated to external, VCFSE or community partners (£; enter 0 if none)

30

Amount allocated to PCN or GP federation delivery (£; enter 0 if none)

31

Any other comments. Please use this space to indicate if you are going to submit supporting documentation via email (e.g. costing template). If sending additional documentation please send through to gmicb-tr.tccgpc@nhs.net.

32

I confirm that this plan has been discussed with the relevant practices and neighbourhood partners and has been checked against the four assessment criteria and that I am happy for information of this plan to be shared anonymously. *

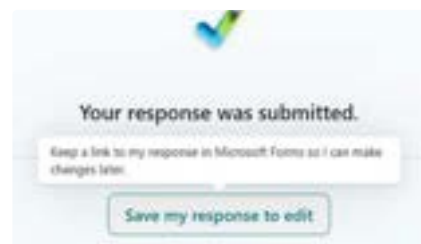
BeCCOR Pillar 3C
Four Assessment Criteria

- Represent good value for money;
- Focus on improving outcomes for the identified BeCCoR core cohort, while recognising any potential wider benefit;
- Have been co-designed and will be delivered with relevant neighbourhood partners;
- Support neighbourhood working and relevant local strategic priorities.

☐ Yes

33

IMPORTANT - PLEASE NOTE When you have submitted this form- please then click on '**save my response to edit**'. This will then give you an internet link that you need to save somewhere, which will then allow you to re-edit your response at any future date.



No answer provided.

View results

Respondent

3

Anonymous

35:29

Time to complete

About this submission

Tell us who is submitting the plan and where it has been discussed and agreed.

1

If you have one, what is the name of your scheme (e.g. Brookvale Neighbourhood reaching the missed middle)

North Trafford PCN - High Risk Diabetes

2

Who is submitting this plan? *

☒ PCN☐ Single practice☐ Group of practices not submitting as a PCN

3

Name of the submitting PCN or practice(s) *

North Trafford Primary Care Network

4

Names and roles of the practice or PCN leads for this work *

North Trafford Group Practice
Dr Joseph Chandy & Dr Zahid Ahmed – Clinical Lead
Mr Muhammad Ahmed – Admin Lead
Delamere Medical Practice
Dr Farrah Sheikh and Yasir Ali
Limelight Health and wellbeing
Clinical Leads, ACP Nurse Sharon Norbury and DR Joe Rylands (for MDT and other meetings), Rasha Abdalla –non clinical Lead
Lostock Medical Centre
Dr George is clinical lead and Sarah is Data handler

5

Name of the neighbourhood *

Trafford North

6

Name of the neighbourhood forum or meeting where the plan was discussed and agreed *

North Trafford PCN Meeting 17/09/2026

7

Date the plan was most recently discussed and agreed (DD/MM/YYYY) *

17/09/2026

Core cohort and target group

The Curator BeCCoR dashboard will bring together the full BeCCoR cohort across Greater Manchester. Authorised users will be able to view and filter patient-level cohort status, indicators of unmet need and geographic information. This is intended to make it easier for practices and neighbourhood partners to identify and size target groups, agree priorities and track progress without having to create these measures themselves. Until the dashboard is available, use the best information currently available.

8

Which BeCCoR clinical cohort(s) are included in this plan? *

- ☐ CVNeed — hypertension
- ☐ CVNeed — atrial fibrillation
- ☒ CVNeed — diabetes
- ☐ CVNeed — secondary prevention of CVD/lipid optimisation
- ☐ CVNeed/ACR — chronic kidney disease or albuminuria need
- ☐ Primary prevention — high QRISK
- ☐ RespNeed — adult asthma
- ☐ RespNeed — asthma in children and young people
- ☐ RespNeed — COPD
- ☐ Other BeCCoR Cohort - Describe below

9

If you selected "Other BeCCoR cohort", describe it here. (Maximum 150 words)

No answer provided.

10

What are the main indicators of unmet need used to define the target group? *

The below indicators will all be available to view, filter and easily track on the BeCCoR dashboard once available. Picking from one of the below will allow you to easily filter your chosen cohorts to better understand how you may work together in the plan to meet their need.

Select all that apply. If you select 'Other', please type the indicator in the text box that appears.

- ☒ Missing or overdue key checks, readings or reviews
- ☒ Repeated non-attendance or no response
- ☒ Outstanding treatment optimisation or not treated to target
- ☒ Repeated urgent-care use or unplanned admissions
- ☒ Wider non-medical needs affecting health
- ☐ Whole clinical cohort; no further unmet-need prioritisation
- ☐ Other

11

Which population or inequality characteristics actively shape the plan? *

Select only characteristics that actively affect how the target group is defined or how the plan will be delivered.

Select all that apply. If you select 'Other', please type the characteristic in the text box that appears.

- ☒ Deprivation / IMD
- ☒ Ethnicity
- ☒ Age
- ☐ Sex or gender
- ☒ Frailty
- ☒ Mental health
- ☒ Disability, learning disability or autism
- ☐ Inclusion health (those experiencing homelessness, struggling with addiction, vulnerable migrants or refugees (inc asylum seekers), Gypsy, Roma & traveller communities, sex workers, in prison or recently released or under probation, victims of modern slavery)
- ☐ None; the whole clinical cohort is prioritised
- ☐ Other

12

Describe the defined target group in your own words (including demographics) Maximum 250 words *

Bring together the clinical cohort, unmet need and relevant inequality characteristics selected above. Describe the specific local group, including any geographic or eligibility criteria. You do not need to repeat every selection.

The primary target group is adults registered with PCN member practice who are within the BeCCoR CVNeed diabetes cohort and have evidence of high or unmet need. Priority will be given to people with missing or overdue diabetes reviews/key checks, incomplete monitoring, repeated non-attendance or non-response, poor clinical control or outstanding treatment optimisation

The target group will be refined using the BeCCoR/Curator dashboard or practice searches. including relevant inequality characteristics such as deprivation, age, frailty, mental health need and other locally evidenced barriers. The intention is not to invite the entire diabetes register into an additional pathway, but to focus neighbourhood resource on patients where clinical risk and barriers to engagement overlap.

13

Approximately how many people are in the defined target group? *

Use the BeCCoR dashboard count where available. If the dashboard is not yet available, or the target group has been further refined locally, enter your best current estimate as a whole number.

Please enter a whole number

Need, barriers, intended improvement and measurement

Tell us what local information shows for the target group, what may be contributing to the current position, what you intend to improve and how progress will be assessed. An indicator of unmet need describes the current problem; a barrier is something contributing to it; a measure is what you will track over time.

14

Why has this target group been prioritised for neighbourhood action? (Maximum 500 words) *

Briefly summarise the local evidence of need or inequality and why neighbourhood working offers an opportunity to improve the current position. Specific barriers are asked about next.

Diabetes has been selected as the core BeCCoR priority because PCN can identify a defined group of patients in whom clinical risk, incomplete care and barriers to engagement overlap. Routine recall alone may not be sufficient for patients who repeatedly do not attend or respond, have overdue monitoring, remain above treatment targets, or experience wider circumstances that affect their ability to engage with care.

A neighbourhood approach provides an opportunity to combine proactive clinical review with practical support for the factors that influence health. The four practices can use a common identification approach while retaining practice-level knowledge of individual patients. MDT working can then connect clinical actions with Live Well, social prescribing, VCFSE/community support and, where relevant, mental health, housing, pharmacy, dietetic/weight-management and other neighbourhood services.

The plan therefore combines a measurable BeCCoR diabetes intervention with a wider prevention approach. It is designed to improve engagement with high-risk diabetes patients while strengthening sustainable referral pathways and neighbourhood relationships that can benefit a wider population

15

What are the main barriers likely to be contributing to the current situation in your neighbourhood? *

Select all that apply. Select "Not sure yet" if the barriers will be explored during delivery. If you select "Other", type the barrier in the text box that appears, this might include barriers that you experience as a practitioner or service provider.

- ☒ Language or communication needs
- ☒ Digital exclusion
- ☒ Transport, mobility or physical access
- ☒ Appointment timing, work or caring responsibilities
- ☒ Confidence, anxiety or lack of trust
- ☒ Understanding of the condition or health literacy
- ☒ Financial, housing, food or fuel insecurity
- ☒ Social isolation or limited support
- ☒ Fragmented services or referral pathways
- ☒ Current recall or appointment arrangements do not meet the group's needs
- ☐ Not sure yet
- ☐ Other

16

Which single measure will be used as the primary indicator of progress? *

Select the one measure that best shows whether the main improvement is being achieved. If you select "Other", type the primary measure in the text box that appears.

- ☐ Target group reached or engaged
- ☒ BeCCoR review or relevant key checks completed
- ☐ Reduction in missing or overdue information, checks or reviews
- ☐ Clinical action completed, treatment optimised or people treated to target
- ☐ A&E attendances
- ☐ Patient-reported Health Confidence Score
- ☐ Personal Wellbeing Score or Loneliness measure
- ☐ Live Well, social-prescribing or community support
- ☐ New diagnoses or annual review completion
- ☐ Relevant QOF indicators
- ☐ Staff confidence or neighbourhood working
- ☐ Improvement in demographic recording
- ☐ Other

17

What is the current baseline for the primary measure? *

Give the value, date and source. If it is not yet known, explain how and by when it will be established.

The PCN will quantify, by practice, the number of high-risk diabetes patients meeting the agreed unmet-need criteria and the number/proportion with outstanding BeCCoR review elements or relevant key checks. The baseline will also record non-attendance/non-response and treatment-optimisation need where available.

18

Are there any additional measures you will monitor? If so, list up to three. (Maximum 250 words)

These are other things not selected as your primary measure above that you would want to measure as the project progresses. These might help show wider benefit (secondary measures) or possible unintended effects (balancing measures). Do not repeat the primary measure and leave blank if none.

For each additional aim try to ensure it is Specific , Measurable, Achievable, Realistic and Timebound

- 1) Engagement: number and proportion of prioritised high-risk diabetes patients successfully contacted and engaging with an offered review/intervention, with particular attention to patients with previous non-attendance/non-response.
- 2) Clinical optimisation: number/proportion of engaged patients with identified clinical action completed, including completion of overdue monitoring and treatment optimisation where clinically indicated. HbA1c change can be reported as a supporting clinical outcome once baseline data and appropriate follow-up periods are known.
- 3) Wider support: number/proportion of patients with an identified non-clinical need who are offered or connected to Live Well, social prescribing, VCFSE/community or other appropriate neighbourhood support, recorded using appropriate clinical/SNOMED/social-prescribing codes.

19

What change do you aim to achieve in the primary measure by 31 March 2027? (Maximum 250 words) *

Using the baseline above, state the intended amount or direction of change for the defined target group. Where relevant, identify any part of the target group for whom improvement is particularly important.

Example: "Reduce the proportion of [target group] with a missed or overdue review from 25% to 15% by 31 March 2027, with a particular focus on people living in areas of higher deprivation."

We plan to target the whole group and reduce the proportion of the target group with the identified unmet indicators. By 31 March 2027 the PCN aims to demonstrate a measurable increase in

- The PCN practices intend to attempt to contact each patient under the cohort criteria to achieve maximum outcome
- completion of BeCCoR reviews/relevant key checks among the defined high-risk diabetes target group compared with the confirmed baseline.
- Delivery will place particular emphasis on patients who have previously not attended or responded to conventional recall and on those with outstanding treatment optimisation or wider barriers to engagement.
- The PCN will also demonstrate improved connection to neighbourhood support for patients with identified non-clinical needs.

Co-design, delivery and neighbourhood fit

Describe how the approach has been shaped with relevant neighbourhood partners and how those partners will contribute to delivery. Simply naming an organisation is not sufficient: explain its involvement, contribution and role.

20

How will your plan be delivered? (Maximum 500 words) *

Describe the activities or changes in approach, including any targeted outreach, changes to access or recall, clinical action, referral pathways or wider support.

Explain how these respond to the needs and barriers identified above.

- PCN practices will use a common identification and prioritisation process, supported by the BeCCoR/Curator dashboard and practice data, to identify high-risk diabetes patients with unmet need. Practices will focus on patients with overdue reviews/key checks, repeated non-attendance/non-response, poor control or outstanding treatment optimisation and relevant wider needs.
- Each practice will nominate 1–2 leads, including a clinical prescriber, and will operate a regular case-finding MDT. The MDT will review the prioritised list, agree the most appropriate engagement route, coordinate completion of required clinical review activity, identify treatment-optimisation actions and flag non-clinical barriers requiring neighbourhood support. The exact frequency will be agreed locally; the proposed model is a weekly practice-level operational meeting with monthly PCN oversight.
- Engagement will go beyond standard recall where needed. Approaches may include personalised telephone/SMS contact, flexible or opportunistic appointments, community-based activity and coordinated follow-up. Clinical activity will be linked to clear routes into Live Well, social prescribing, VCFSE/community services and other relevant partners. Non-clinical interventions will be coded appropriately on practice systems.
- A monthly PCN oversight meeting will review activity across all four practices, address pathway barriers, coordinate partners, monitor outcomes and share learning. The PCN/practices will engage with the neighbourhood forum at least quarterly, with additional working meetings as required.

21

Please provide the costing for each identified activity in question 20. *

Start each activity on a new line.

Consider breakdown using the format: Category | Costed item | Amount | Deliverer | Basis of costing | with each clustered activity on a new line/new paragraph.

<i am not able to copy paste the table>

Category Costed item Amount Deliverer Basis of costing Clinical MDT Protected clinical/MDT time for identification and review of high-risk Diabetes/CVNeed patients £22,368.00 North Trafford Group Practice, Delamere Medical Practice . Limelight Health and Wellbeing
Lostock Medical Centre

Category Costed item Amount Deliverer Basis of costing Clinical MDT

Protected GP/clinical time for weekly or fortnightly MDTs, review of complex cases, non-engagement and treatment optimisation

Clinical capacity Additional clinical sessions and capacity £27,939.24 North Trafford Group Practice, Delamere Medical Practice

Limelight Health and Wellbeing , Lostock Medical Centre, GP, ACP/Practice Nurse, HCA/phlebotomy and other clinical delivery capacity to undertake proactive reviews and interventions

Administration & project management Searches, patient identification, administration and operational support £8,484.00 North Trafford Group Practice, Delamere Medical Practice, Limelight Health and Wellbeing ,Lostock Medical Centre, BeCCoR searches, cohort identification, project coordination, workforce coordination and administrative support Care coordination Patient follow-up, care coordination and monitoring/evaluation £4,720.00 North Trafford Group Practice, Delamere Medical Practice, Limelight Health and Wellbeing, Lostock Medical Centre, Patient contact, recalls, follow-up of non-responders, MDT actions and monitoring of outcomes

Care navigation / management Management and care-navigation support £5,981.22 North Trafford Group Practice,Delamere Medical Practice

Limelight Health and Wellbeing, Lostock Medical Centre, Operational management, care navigation and support to patients requiring additional engagement

PCN/neighbourhood oversight Clinical and programme oversight £3,940.00 North Trafford PCN/North Trafford Group Practice, Delamere Medical Practice,

Limelight Health and Wellbeing, Lostock Medical Centre, Practice and PCN oversight, progress reviews, MDT evaluation and neighbourhood coordination,

Community engagement Community outreach, interpreter support, venues and healthy-lifestyle engagement £8,290.00 Practices / community partners Targeted outreach, language/interpreter support, community engagement, venues and healthy-lifestyle activity

Total £81,722.46

22

If the costs listed above don't total your allocation, please identify this and explain clearly the rationale for this. Any contingency costs should be clearly identified and justified. (Maximum 250 words) *

NA

23

Why does the proposed spend represent good value for money? Refer to the size and need of the target group, expected reach or benefit, unit or session costs, the costing basis and existing resources. (Maximum 500 words) *

The proposed model concentrates

- additional resource on a defined high-risk diabetes population rather than duplicating routine care for the whole diabetes register.

- Patients will be prioritised using existing BeCCoR/Curator and practice searches, allowing additional clinical and neighbourhood capacity to be directed towards people with incomplete care, treatment-optimisation needs, previous non-engagement and wider barriers.

- Protected practice time supports proactive case review and coordinated action, while PCN oversight enables four practices to share pathways, data, learning and neighbourhood relationships rather than developing four separate infrastructures.

- The model will use existing Live Well, social prescribing, VCFSE and neighbourhood services wherever possible;

- The approach also aims to reduce wasted or repeated contacts by matching patients to more appropriate engagement routes and addressing clinical and non-clinical needs together.

24

Which partners will or have been be involved in co-design and/or delivery? *

Please state the partners if you select other

- ☒ Practice team
- ☒ PCN / MDT
- ☒ Neighbourhood / INT team
- ☒ Local authority
- ☒ Social prescribing
- ☒ VCFSE / community groups
- ☒ Mental health services
- ☒ Secondary care / specialist services
- ☐ Other

25

How have practices, communities and neighbourhood partners helped shape this plan? State who was involved, how views were gathered and what changed or was confirmed as a result. (Maximum 500 words) *

The plan will be developed and agreed through the relevant neighbourhood forum, with representation from the four practices/PCN and relevant neighbourhood partners. Initial PCN discussion has identified high-risk diabetes as the core BeCCoR clinical priority as a linked wider prevention priority.

The neighbourhood co-design process will test the proposed target group, barriers and delivery routes against partner and community insight. Partners will be asked specifically to identify where existing pathways are difficult to navigate, which community assets can support engagement, how Live Well/social prescribing and VCFSE routes can be strengthened, and what additional activity would add value rather than duplicate current provision.

Practice teams will contribute patient-level operational insight in a non-identifiable form, including patterns of missed reviews/non-attendance and barriers encountered through recall and care navigation. The BeCCoR/Curator dashboard will provide demographic and unmet-need information as available.

26

Is the work expected to benefit people beyond the defined core target group? *

- ☒ Yes
- ☐ No

27

If yes, briefly describe the potential wider benefit. (Maximum 150 words)

The delivery model is expected to benefit people beyond the defined high-risk diabetes cohort. Stronger Live Well, social-prescribing, VCFSE and community referral pathways can be used for other long-term conditions and prevention needs. Learning from personalised outreach and alternative engagement approaches may also improve access for other patients who do not respond to conventional recall.

Funding, value for money and confirmation

Set out the proposed use of the Neighbourhood Prevention Allocation. Costs should be clear, proportionate to the target group and intended benefit, and linked to new or additional delivery activity.

28

Amount allocated to practice delivery (£; enter 0 if none)

29

Amount allocated to external, VCFSE or community partners (£; enter 0 if none)

30

Amount allocated to PCN or GP federation delivery (£; enter 0 if none)

31

Any other comments. Please use this space to indicate if you are going to submit supporting documentation via email (e.g. costing template). If sending additional documentation please send through to gmicb-tr.tccgpc@nhs.net.

No answer provided.

32

I confirm that this plan has been discussed with the relevant practices and neighbourhood partners and has been checked against the four assessment criteria and that I am happy for information of this plan to be shared anonymously. *

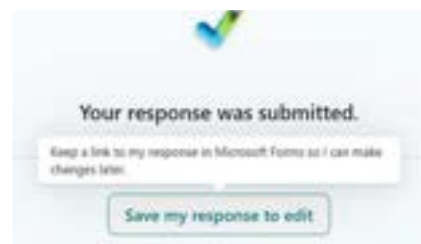
BeCCOR Pillar 3C
Four Assessment Criteria

- Represent good value for money;
- Focus on improving outcomes for the identified BeCCoR core cohort, while recognising any potential wider benefit;
- Have been co-designed and will be delivered with relevant neighbourhood partners;
- Support neighbourhood working and relevant local strategic priorities.

☒ Yes

33

IMPORTANT - PLEASE NOTE When you have submitted this form- please then click on '**save my response to edit**'. This will then give you an internet link that you need to save somewhere, which will then allow you to re-edit your response at any future date.



No answer provided.

View results

Respondent

5

Anonymous

29:22

Time to complete

About this submission

Tell us who is submitting the plan and where it has been discussed and agreed.

1

If you have one, what is the name of your scheme (e.g. Brookvale Neighbourhood reaching the missed middle)

Sale Central Health Optimisation and Neighbourhood Support Programme

2

Who is submitting this plan? *

☒ PCN☐ Single practice☐ Group of practices not submitting as a PCN

3

Name of the submitting PCN or practice(s) *

Sale Central PCN on behalf of all 5 member practies

4

Names and roles of the practice or PCN leads for this work *

Ronnie Viner, PCN Manager and Harish Thampy, PCN CD

5

Name of the neighbourhood *

Trafford Central

6

Name of the neighbourhood forum or meeting where the plan was discussed and agreed *

Sale PCN/Central Neighbourhood liaison meeting 10th September 2026

7

Date the plan was most recently discussed and agreed (DD/MM/YYYY) *

23/09/2026

Core cohort and target group

The Curator BeCCoR dashboard will bring together the full BeCCoR cohort across Greater Manchester. Authorised users will be able to view and filter patient-level cohort status, indicators of unmet need and geographic information. This is intended to make it easier for practices and neighbourhood partners to identify and size target groups, agree priorities and track progress without having to create these measures themselves. Until the dashboard is available, use the best information currently available.

8

Which BeCCoR clinical cohort(s) are included in this plan? *

- ☒ CVNeed — hypertension
- ☒ CVNeed — atrial fibrillation
- ☐ CVNeed — diabetes
- ☐ CVNeed — secondary prevention of CVD/lipid optimisation
- ☐ CVNeed/ACR — chronic kidney disease or albuminuria need
- ☐ Primary prevention — high QRISK
- ☒ RespNeed — adult asthma
- ☐ RespNeed — asthma in children and young people
- ☒ RespNeed — COPD
- ☒ Other BeCCoR Cohort - Describe below

9

If you selected "Other BeCCoR cohort", describe it here. (Maximum 150 words)

Heart failure patients, including those with missing or incompletely coded diagnoses. There is no dedicated heart failure service in Trafford, a health inequality for our neighbourhood compared to other localities. This group have substantial unmet need and are at high risk of clinical deterioration, urgent care use and avoidable hospital admission. The programme will provide proactive case-finding, register validation, specialist review and optimisation of evidence-based treatment. The cohort also includes frail residents of residential and nursing homes, who often have complex clinical and non-medical needs and may not receive equitable access to proactive and preventative services leaving them disproportionately at risk of admission due to this health inequality. The care-home work will extend beyond medicines optimisation to address frailty, falls risk, end-of-life care, physical activity, mobility and care following hospital discharge including opportunistic prevention by identifying undiagnosed cardiovascular and respiratory risk. It will strengthen multidisciplinary working with community rehabilitation, Live Well and our VCSE neighbourhood partners.

10

What are the main indicators of unmet need used to define the target group? *

The below indicators will all be available to view, filter and easily track on the BeCCoR dashboard once available. Picking from one of the below will allow you to easily filter your chosen cohorts to better understand how you may work together in the plan to meet their need.

Select all that apply. If you select 'Other', please type the indicator in the text box that appears.

- ☒ Missing or overdue key checks, readings or reviews
- ☒ Repeated non-attendance or no response
- ☒ Outstanding treatment optimisation or not treated to target
- ☒ Repeated urgent-care use or unplanned admissions
- ☒ Wider non-medical needs affecting health
- ☐ Whole clinical cohort; no further unmet-need prioritisation
- ☐ Other

11

Which population or inequality characteristics actively shape the plan? *

Select only characteristics that actively affect how the target group is defined or how the plan will be delivered.

Select all that apply. If you select 'Other', please type the characteristic in the text box that appears.

- ☐ Deprivation / IMD
- ☐ Ethnicity
- ☐ Age
- ☐ Sex or gender
- ☐ Frailty
- ☐ Mental health
- ☐ Disability, learning disability or autism
- ☐ Inclusion health (those experiencing homelessness, struggling with addiction, vulnerable migrants or refugees (inc asylum seekers), Gypsy, Roma & traveller communities, sex workers, in prison or recently released or under probation, victims of modern slavery)
- ☒ None; the whole clinical cohort is prioritised
- ☐ Other

12

Describe the defined target group in your own words (including demographics) Maximum 250 words *

Bring together the clinical cohort, unmet need and relevant inequality characteristics selected above. Describe the specific local group, including any geographic or eligibility criteria. You do not need to repeat every selection.

The target group comprises patients across Sale Central PCN's population of approximately 65,000 residents who have cardiovascular or respiratory disease and evidence of significant unmet clinical need. It includes people with high-risk asthma and COPD, alongside those with heart failure, who commonly also have co-existing hypertension, atrial fibrillation and other cardiovascular comorbidities. These patients may have missing or overdue reviews, suboptimal disease control, opportunities for treatment optimisation, repeated non-attendance or high levels of urgent care use.

The PCN serves a diverse population across both affluent and more deprived communities. Particular focus will be given to people who do not engage with routine primary care or experience barriers related to frailty, disability, mental health, social isolation, caring responsibilities, housing, finances, health literacy or access to appointments.

As described in Q9, this target group includes people with heart failure, particularly where diagnoses are missing or incompletely coded, and frail residents of residential and nursing homes. Both groups face substantial unmet need and risk of avoidable deterioration or admission. The programme will provide case-finding, register validation, specialist review, treatment optimisation, medicines safety, falls prevention, rehabilitation support and connection to Live Well and neighbourhood services, supporting people to remain well in their usual residence. In addition, using part of our funding to allow primary care input into the integrated neighbourhood teams who serve those in our population with the most complex health and psychosocial needs will address a significant health inequality and reduce use of crisis pathways and admissions amongst this small but significant population.

13

Approximately how many people are in the defined target group? *

Use the BeCCoR dashboard count where available. If the dashboard is not yet available, or the target group has been further refined locally, enter your best current estimate as a whole number.

4500

Please enter a whole number

Need, barriers, intended improvement and measurement

Tell us what local information shows for the target group, what may be contributing to the current position, what you intend to improve and how progress will be assessed. An indicator of unmet need describes the current problem; a barrier is something contributing to it; a measure is what you will track over time.

14

Why has this target group been prioritised for neighbourhood action? (Maximum 500 words) *

Briefly summarise the local evidence of need or inequality and why neighbourhood working offers an opportunity to improve the current position. Specific barriers are asked about next.

The selected cohorts have a high risk of preventable deterioration, urgent care use and hospital admission, alongside clear opportunities for earlier identification, evidence-based treatment optimisation and wider preventative support. The programme focuses on people with high-risk asthma and COPD, alongside those with heart failure, who commonly have co-existing hypertension, atrial fibrillation and other cardiovascular comorbidities. These patients may have poorly controlled disease, incomplete monitoring, missing or incompletely coded diagnoses, or outstanding opportunities for medicines optimisation. Heart failure is a particular priority because Trafford does not currently have a dedicated heart failure service in contrast to other localities. This creates a significant gap for a clinically complex population at high risk of deterioration and hospital admission. Proactive case-finding, register validation and specialist review provide an opportunity to identify unmet need earlier and optimise treatment before patients present in crisis. Frail residents of residential and nursing homes are also prioritised because they frequently have complex clinical and non-medical needs, polypharmacy, falls risk and increased vulnerability to avoidable deterioration and hospital transfer. This group may not receive equitable access to proactive, preventative and specialist services. The programme will therefore extend beyond medicines optimisation to address frailty, mobility, physical activity, rehabilitation, post-discharge care and end-of-life care planning through coordinated multidisciplinary and neighbourhood support. Repeated non-attendance or failure to respond to routine recall should not be interpreted as an absence of need. It may reflect unsuitable appointment arrangements, communication or mobility difficulties, limited health literacy, social isolation, caring responsibilities, or pressures relating to housing, finances, welfare and employment. Conventional recall and condition-specific appointments may therefore fail to reach those with the greatest unmet need. Neighbourhood action is required because clinical treatment alone cannot address the wider factors influencing health outcomes. Targeted clinical reviews will be linked to Live Well, social prescribing and trusted community services, including support for smoking cessation, physical activity, housing, financial and welfare concerns, loneliness and isolation. This supports an early, preventative approach in which partners share responsibility for outcomes rather than passing people between services. The plan aligns with four Central Trafford Live Well neighbourhood priorities: cardiovascular and respiratory health, frailty, training, and prevention of long-term conditions. It also builds on all five member practices becoming Active Practices and supports the Trafford Moving Strategy by embedding physical activity conversations, referral and signposting within holistic reviews, community activity and care-home pathways. In addition, this funding will be used to support GP attendance at the integrated neighbour teams which promotes a holistic multi-agency approach to managing and supporting our most vulnerable cohorts who experience the most significant health inequalities and have highest use of crisis pathways and acute admissions in our population. Targeted outreach, extended-access clinics and community health awareness days will provide alternative routes for people who do not engage with routine care. Every contact will be used to complete relevant clinical optimisation and prevention actions. The intended result is earlier intervention, improved disease control and self-management, more effective use of neighbourhood support, and reduced avoidable urgent care use and hospital admission.

15

What are the main barriers likely to be contributing to the current situation in your neighbourhood? *

Select all that apply. Select "Not sure yet" if the barriers will be explored during delivery. If you select "Other", type the barrier in the text box that appears, this might include barriers that you experience as a practitioner or service provider.

- ☒ Language or communication needs
- ☒ Digital exclusion
- ☒ Transport, mobility or physical access
- ☒ Appointment timing, work or caring responsibilities
- ☒ Confidence, anxiety or lack of trust
- ☒ Understanding of the condition or health literacy
- ☒ Financial, housing, food or fuel insecurity
- ☒ Social isolation or limited support
- ☒ Fragmented services or referral pathways
- ☒ Current recall or appointment arrangements do not meet the group's needs
- ☐ Not sure yet
- ☐ Other

16

Which single measure will be used as the primary indicator of progress? *

Select the one measure that best shows whether the main improvement is being achieved. If you select "Other", type the primary measure in the text box that appears.

- ☐ Target group reached or engaged
- ☒ BeCCoR review or relevant key checks completed
- ☐ Reduction in missing or overdue information, checks or reviews
- ☐ Clinical action completed, treatment optimised or people treated to target
- ☐ A&E attendances
- ☐ Patient-reported Health Confidence Score
- ☐ Personal Wellbeing Score or loneliness measure
- ☐ Live Well, social-prescribing or community support
- ☐ New diagnoses or annual review completion
- ☐ Relevant QOF indicators
- ☐ Staff confidence or neighbourhood working
- ☐ Improvement in demographic recording
- ☐ Other

17

What is the current baseline for the primary measure? *

Give the value, date and source. If it is not yet known, explain how and by when it will be established.

The baseline is not yet available as a single PCN-wide figure. It will be established at mobilisation through the BeCCoR dashboard, EMIS searches and register-validation work across all five practices. For each selected cohort, the PCN Manager will record the number of eligible patients, those with missing or overdue reviews or key checks, previous non-responders, and those requiring treatment optimisation. The baseline will be agreed before the first specialist clinic and used as the denominator for monthly monitoring. For care-home residents, baseline data will include the number receiving pharmacist-led medication reviews, identified medicines-safety issues, falls-related risks, post-discharge reviews, and recent urgent care or hospital use where these data are available. For community engagement, the baseline will include previous uptake of routine recall among targeted patients who have not responded or engaged. The PCN would also wish to establish baseline referral and signposting rates into Live Well, social prescribing and wider neighbourhood services including the integrated neighbourhood team. However, no consistent PCN-wide data are currently available on the number of referrals made, the services to which patients are directed, or whether patients subsequently engage with the support offered. A baseline will therefore be established during mobilisation by agreeing standard referral and recording processes across the five practices and reviewing current referral activity where this can be identified. Subsequent monitoring will record referrals and signposting arising from holistic reviews, care-home work and community events, together with uptake where partner data are available. These data will allow the programme to distinguish activity from genuine improvement, assess whether it is reaching patients with the greatest unmet need, and examine variation across practices, clinical cohorts and population groups.

18

Are there any additional measures you will monitor? If so, list up to three. (Maximum 250 words)

These are other things not selected as your primary measure above that you would want to measure as the project progresses. These might help show wider benefit (secondary measures) or possible unintended effects (balancing measures). Do not repeat the primary measure and leave blank if none.

For each additional aim try to ensure it is Specific, Measurable, Achievable, Realistic and Timebound

- 1. Engagement and equity: number and proportion of targeted patients contacted, booked and attending, including previous non-responders; route of engagement; attendance through extended access or community events; and reach by practice, age, deprivation and other available inequality characteristics.
- 2. Optimisation and neighbourhood connection: number and proportion receiving a documented clinical optimisation action; smoking cessation support; physical activity referral or signposting; alcohol intervention; vaccination, screening or NHS Health Check action; and referral or signposting to Live Well, social prescribing or another relevant neighbourhood partner, with uptake recorded where available. Discussion of patients within the integrated neighbourhood team will be documented with greater primary care integration through GP attendance at multidisciplinary team meetings.
- 3. Avoidable demand and system learning: urgent care use or unplanned admissions within identified high-risk cohorts where reliable data are available; medication-safety interventions, falls risks and post-discharge actions in care homes; and staff/partner confidence in neighbourhood pathways. Findings will be reviewed through a QI cycle and shared with neighbourhood partners.

19

What change do you aim to achieve in the primary measure by 31 March 2027? (Maximum 250 words) *

Using the baseline above, state the intended amount or direction of change for the defined target group. Where relevant, identify any part of the target group for whom improvement is particularly important.

Example: "Reduce the proportion of [target group] with a missed or overdue review from 25% to 15% by 31 March 2027, with a particular focus on people living in areas of higher deprivation."

By 31 March 2027, the programme will increase completion of BeCCoR reviews and relevant key checks among prioritised patients with high-risk asthma, COPD and heart failure, including those with co-existing hypertension, atrial fibrillation and other cardiovascular comorbidities. Particular emphasis will be placed on patients who are overdue for review, have previously not responded to routine recall, require treatment optimisation, or are identified through case-finding as missing from relevant disease registers and using assertive outreach for these patients. A numerical improvement target will be set once the PCN-wide baseline and eligible cohort denominator have been validated at mobilisation.

The Holistic Cardiovascular and Respiratory Care Review Service will deliver 24 specialist pharmacist-led clinics. Although patients will be identified through specific clinical cohorts, the service will not provide narrowly condition-specific reviews. Each consultation will combine evidence-based clinical assessment and treatment optimisation with review of smoking, physical activity, weight, alcohol use, vaccination, cancer screening, pulse and blood pressure, overdue NHS Health Checks and wider non-medical needs. Appropriate referral or signposting to Live Well and relevant neighbourhood services will be documented.

An increased proportion of clinics will be offered through extended access arrangements to improve equitable access for working-age patients, carers and others who find it difficult to attend during standard practice hours.

For care-home residents, the intended change is increased proactive medication review, medicines optimisation, medicines safety activity and identification of preventable deterioration, falls risk and unmet frailty needs. Residents will be connected to relevant neighbourhood services, including frailty, dementia, rehabilitation and Live Well support, while reducing medicines waste and improving prescribing quality where clinically appropriate. Across all high-risk groups, urgent care use, hospital admission and engagement with neighbourhood support services will be monitored as longer-term outcomes.

Co-design, delivery and neighbourhood fit

Describe how the approach has been shaped with relevant neighbourhood partners and how those partners will contribute to delivery. Simply naming an organisation is not sufficient: explain its involvement, contribution and role.

20

How will your plan be delivered? (Maximum 500 words) *

Describe the activities or changes in approach, including any targeted outreach, changes to access or recall, clinical action, referral pathways or wider support.

Explain how these respond to the needs and barriers identified above.

Delivery will be organised through five connected workstreams that combine targeted clinical intervention with neighbourhood support and prevention. First, practices will undertake case-finding, coding and register validation to identify patients with high-risk asthma, COPD and heart failure, including those whose diagnosis may be missing, incompletely coded or who sit outside routine recall systems. Particular focus will be given to patients who have not engaged with previous invitations, have overdue reviews or monitoring, or require treatment optimisation. Dedicated administrative support will use proactive, repeated and tailored outreach rather than relying on a single invitation. An increased proportion of appointments will be offered through extended access arrangements to improve equitable access for working-age patients, carers and others who may find attendance during routine practice hours difficult. Second, the Holistic Cardiovascular and Respiratory Care Review Service will deliver 24 specialist pharmacist-led clinics across the five practices. Although patients will be identified through specific disease cohorts, reviews will adopt a holistic approach rather than focusing solely on a single condition. Consultations will include clinical optimisation alongside smoking cessation, physical activity, weight management, alcohol screening, vaccination, cancer screening, pulse and blood pressure checks, NHS Health Checks and assessment of wider non-medical needs. Every contact will be used as an opportunity to connect patients to appropriate support through Live Well, social prescribing and relevant neighbourhood services, including Trafford Physical Activity Referral, pulmonary rehabilitation, peer support and smoking cessation services. Third, a dedicated senior clinical pharmacist will support residential and nursing homes over six months, contributing to the neighbourhood priority around frailty. The role will provide proactive medication review, medicines optimisation and medicines safety activity, including post-discharge review, identification of falls risks and prevention of avoidable deterioration. The pharmacist will support multidisciplinary decision-making, improve prescribing quality, reduce medicines waste where clinically appropriate, provide training to care-home staff and strengthen links with frailty services, community rehabilitation, dementia support, physical activity opportunities, carers' services, Live Well and neighbourhood partners. This work will help residents remain independent and well within their usual place of residence wherever possible. Fourth, two Community Health Awareness Days will bring together primary care, Live Well, neighbourhood, VCFSE, local authority and specialist partners within trusted community settings. Targeted promotion will focus on residents who may not routinely access preventative services. Activities will include blood pressure and pulse checks, cardiovascular and respiratory health promotion, smoking cessation, alcohol brief interventions, physical activity advice, screening and vaccination promotion, and booking overdue NHS Health Checks. Residents will also be connected directly to support for housing, welfare, finances, employment, loneliness and other wider determinants of health. Fifth, protected neighbourhood leadership and additional PCN Manager capacity will provide programme coordination, governance, data review and evaluation. Working closely with the Central Trafford neighbourhood lead, the programme will align with the wider Live Well neighbourhood priorities of cardiovascular and respiratory health, frailty, training and prevention of long-term conditions. Monthly quality improvement review will examine engagement, non-attendance, review completion, treatment optimisation, referrals into Live Well and neighbourhood services, and indicators of avoidable urgent care use. GP attendance at the integrated neighbourhood team will further augment cross syst

21

Please provide the costing for each identified activity in question 20. *

Start each activity on a new line.

Consider breakdown using the format: Category | Costed item | Amount | Deliverer | Basis of costing | with each clustered activity on a new line/new paragraph.

Neighbourhood leadership - GP leadership: one session per month - £3,000 - 6 sessions at £500

INT MDT - Weekly GP attendance - £13,000 - 26 sessions at £500

Care-home frailty - Senior clinical pharmacist, 0.4 WTE for six months - £27,648 - 0.4 of £69,120 annual basis

Holistic Cardiovascular and Respiratory Care Review Service - 48 specialist pharmacist clinics plus practice case-finding, coding and register validation - £17,000 - 48 clinics at £250 (£12,000) plus £1,000 per practice setup and coding work (£5,000)

Clinic administration - Booking, call-recall and onward referrals - £1,009.20 - 60 hours at £16.82

Health inequalities / neighbourhood PCN leadership - Dedicated Health Inequalities and Neighbourhood Lead - £4,500 - 12 sessions at £375

Programme management - Additional PCN Manager capacity for data, analytics, evaluation and coordination - £3,640 - 104 hours at £35

Patient and community engagement - Patient engagement programme including Patient Participation Group (PPG) involvement, neighbourhood engagement events, co-design workshops, feedback and evaluation activity - £10,000 - 2 events at £5,000

22

If the costs listed above don't total your allocation, please identify this and explain clearly the rationale for this. Any contingency costs should be clearly identified and justified. (Maximum 250 words) *

The proposed activities total £79,797.20 compared with the confirmed Prevention Allocation Fund of £78,596.69, a difference of £1,200.51. Sale Central PCN will meet any costs incurred above the allocated funding through existing PCN resources. No additional funding is being requested and expenditure from the Prevention Allocation Fund will not exceed the allocated amount.

23

Why does the proposed spend represent good value for money? Refer to the size and need of the target group, expected reach or benefit, unit or session costs, the costing basis and existing resources. (Maximum 500 words) *

The investment combines direct delivery for high-risk patients with the infrastructure required to identify people who are currently missed, strengthen engagement with those who do not routinely access services, coordinate neighbourhood support and measure impact across a PCN population of approximately 65,000 people. Funding is targeted at cohorts with high unmet need and a significant risk of preventable deterioration, urgent care use and hospital admission, whilst making maximum use of existing Live Well, social prescribing, community, VCFSE and public health services rather than duplicating provision.

The £17,000 Holistic Cardiovascular and Respiratory Care Review Service funds 24 specialist pharmacist-led clinics alongside case-finding, coding and register validation across all five practices. This is essential because clinical capacity alone has limited value if high-risk patients are not accurately identified or do not engage with routine recall. The programme therefore combines proactive outreach, targeted call-recall and flexible booking arrangements, including extended-access appointments, to improve equitable access for groups who may otherwise not attend. Holistic reviews maximise the value of each contact by addressing disease optimisation, prevention and wider determinants of health within a single appointment, whilst facilitating referral and signposting into Live Well and neighbourhood services where appropriate.

The £27,648 care-home pharmacist investment provides dedicated specialist clinical support for frail residents of residential and nursing homes, a population at high risk of polypharmacy, falls, deterioration and avoidable hospital admission. The role extends beyond medicines optimisation to include medicines safety, post-discharge review, staff education, multidisciplinary coordination and connection to frailty, rehabilitation, dementia and neighbourhood services. It also offers opportunities to reduce medicines waste and improve prescribing quality, generating both clinical and financial benefits.

Weekly GP MDT input provides protected senior clinical decision-making for patients with complex needs, supporting earlier intervention and coordinated management. The two Community Health Awareness Days create alternative routes into prevention and support for residents who may not respond to traditional invitation methods, while enabling multiple neighbourhood partners to engage residents in a single trusted setting.

Leadership and additional PCN Manager capacity represent proportionate enabling costs. They provide programme coordination, partner engagement, data quality, evaluation and quality improvement activity necessary to ensure that the separate initiatives operate as a coherent neighbourhood programme rather than isolated projects. The programme aligns with the Central Trafford neighbourhood priorities of cardiovascular and respiratory health, frailty, training and prevention of long-term conditions, supports the Trafford Moving Strategy, and builds on the PCN's Active Practices work.

A patient and community engagement programme will be established to ensure residents and Patient Participation Groups are actively involved in shaping neighbourhood priorities and service development. Engagement sessions will be used to gather feedback on existing services, understand barriers to access, identify opportunities for improvement and inform future neighbourhood working. Feedback will be used to refine delivery throughout the programme and evaluate whether activities are meeting the needs of local residents, particularly those who may not traditionally engage with primary care.

Importantly, the investment will leave a legacy beyond the funding period through improved disease registers, strengthened referral pathways, better integration with Live Well and neighbourhood services, enhanced staff capability and stronger partnerships across the neighbourhood. The PCN will meet any expenditure above the allocated

24

Which partners will or have been be involved in co-design and/or delivery? *

Please state the partners if you select other

- ☒ Practice team
- ☒ PCN / MDT
- ☒ Neighbourhood / INT team
- ☒ Local authority
- ☒ Social prescribing
- ☒ VCFSE / community groups
- ☒ Mental health services
- ☒ Secondary care / specialist services
- ☐ Other

25

How have practices, communities and neighbourhood partners helped shape this plan? State who was involved, how views were gathered and what changed or was confirmed as a result. (Maximum 500 words) *

The plan has been developed through liaison with the Central Trafford neighbourhood lead to ensure that the PCN's proposals contribute to, and do not sit separately from, the wider Live Well neighbourhood plan. This process confirmed alignment with four of the neighbourhood's thirteen priorities: cardiovascular and respiratory health; frailty; training; and prevention of long-term conditions. It also reinforced two principles for delivery: acting early by combining clinical and non-clinical support, and partners learning and adapting together with shared responsibility for outcomes.

Sale Central's five member practices have shaped the operational model through their knowledge of local cohorts, routine recall limitations and practice capacity. Their recent work to become Active Practices provides the basis for incorporating physical activity conversations and referral into long-term condition reviews, and for supporting implementation of the Trafford Moving Strategy. Practice delivery across the full PCN footprint also recognises the mixed socioeconomic profile of the population and the need to provide consistent access while tailoring outreach locally.

Neighbourhood discussions identified practical services and assets that the programme can connect to. Respiratory reviews can refer or signpost to Trafford Physical Activity Referral, pulmonary rehabilitation, local peer support, smoking cessation and trusted respiratory information. For frailty, the care-home pharmacist will develop joined-up working with community rehabilitation's care-home pathway and explore accessible physical activity for residents. Live Well and social prescribing will provide routes to support for housing, finances, welfare, employment, loneliness, isolation and other non-medical needs.

The community awareness model has been shaped to enable local authority, public health, VCFSE, Live Well and clinical partners to work in one setting rather than expecting residents to navigate separate services. Partners will contribute information, brief interventions, direct referral routes and training. Opportunities include Living Well with Dementia, falls prevention, bereavement support, cost-of-living advice and partner-led training in smoking, alcohol, diet, activity and Making Every Contact Count.

26

Is the work expected to benefit people beyond the defined core target group? *

☒ Yes

☐ No

27

If yes, briefly describe the potential wider benefit. (Maximum 150 words)

Yes. Opportunistic blood pressure and pulse checks, NHS Health Check booking, smoking cessation, alcohol intervention, screening and vaccination promotion may identify unmet need beyond the initial BeCCoR cohorts. Community Health Awareness Days will increase awareness of Live Well and trusted neighbourhood support among residents who are not routinely connected to services. Stronger referral pathways, better disease registers, staff training and shared QI learning will also benefit other long-term condition groups. The care-home model may improve medicines safety, frailty management and coordination for residents beyond those initially prioritised, while learning from outreach and extended access can inform future prevention work across Sale Central and the wider Central Trafford neighbourhood.

Funding, value for money and confirmation

Set out the proposed use of the Neighbourhood Prevention Allocation. Costs should be clear, proportionate to the target group and intended benefit, and linked to new or additional delivery activity.

28

Amount allocated to practice delivery (£; enter 0 if none)

£13,000 allocated to practices to provide protected primary care clinician time for attendance and input into Health & Care MDTs for identified complex/high-risk patients. £1,009.20 for administration (pre- and post-) for the Holistic Cardiovascular and Respiratory Care Review Service.

29

Amount allocated to external, VCFSE or community partners (£; enter 0 if none)

0

30

Amount allocated to PCN or GP federation delivery (£; enter 0 if none)

65788

31

Any other comments. Please use this space to indicate if you are going to submit supporting documentation via email (e.g. costing template). If sending additional documentation please send through to gmicb-tr.tccgpc@nhs.net.

The completed Prevention, Population Health and Neighbourhood Action Plan Costing Template will be submitted as supporting documentation.

32

I confirm that this plan has been discussed with the relevant practices and neighbourhood partners and has been checked against the four assessment criteria and that I am happy for information of this plan to be shared anonymously. *

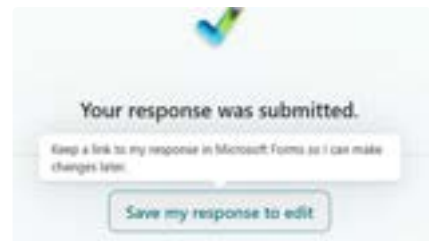
BeCCOR Pillar 3C
Four Assessment Criteria

- Represent good value for money;
- Focus on improving outcomes for the identified BeCCoR core cohort, while recognising any potential wider benefit;
- Have been co-designed and will be delivered with relevant neighbourhood partners;
- Support neighbourhood working and relevant local strategic priorities.

☐ Yes

33

IMPORTANT - PLEASE NOTE When you have submitted this form- please then click on **'save my response to edit'**. This will then give you an internet link that you need to save somewhere, which will then allow you to re-edit your response at any future date.



No answer provided.

View results

Respondent

4

Anonymous

26:50

Time to complete

About this submission

Tell us who is submitting the plan and where it has been discussed and agreed.

1

If you have one, what is the name of your scheme (e.g. Brookvale Neighbourhood reaching the missed middle)

Trafford West Connected Care & Prevention Programme

2

Who is submitting this plan? *

☒ PCN☐ Single practice☐ Group of practices not submitting as a PCN

3

Name of the submitting PCN or practice(s) *

Trafford West PCN

4

Names and roles of the practice or PCN leads for this work *

Dr Clare Reeves & Dr Jane Wareing (Clinical Directors) and Tori Friend (PCN Manager - Operational)

5

Name of the neighbourhood *

Trafford West

6

Name of the neighbourhood forum or meeting where the plan was discussed and agreed *

West Neighbourhood Network Meeting 07/08/2026

7

Date the plan was most recently discussed and agreed (DD/MM/YYYY) *

11/08/2026

Core cohort and target group

The Curator BeCCoR dashboard will bring together the full BeCCoR cohort across Greater Manchester. Authorised users will be able to view and filter patient-level cohort status, indicators of unmet need and geographic information. This is intended to make it easier for practices and neighbourhood partners to identify and size target groups, agree priorities and track progress without having to create these measures themselves. Until the dashboard is available, use the best information currently available.

8

Which BeCCoR clinical cohort(s) are included in this plan? *

- ☐ CVNeed — hypertension
- ☐ CVNeed — atrial fibrillation
- ☒ CVNeed — diabetes
- ☐ CVNeed — secondary prevention of CVD/lipid optimisation
- ☐ CVNeed/ACR — chronic kidney disease or albuminuria need
- ☒ Primary prevention — high QRISK
- ☐ RespNeed — adult asthma
- ☐ RespNeed — asthma in children and young people
- ☐ RespNeed — COPD
- ☒ Other BeCCoR Cohort - Describe below

9

If you selected "Other BeCCoR cohort", describe it here. (Maximum 150 words)

Complex patients at high risk of hospital admissions and people with previously undiagnosed hypertension and/or unidentified cardiovascular risk factors identified through proactive community case finding, who require further assessment, primary prevention and risk reduction.

10

What are the main indicators of unmet need used to define the target group? *

The below indicators will all be available to view, filter and easily track on the BeCCoR dashboard once available. Picking from one of the below will allow you to easily filter your chosen cohorts to better understand how you may work together in the plan to meet their need.

Select all that apply. If you select 'Other', please type the indicator in the text box that appears.

- ☒ Missing or overdue key checks, readings or reviews
- ☒ Repeated non-attendance or no response
- ☒ Outstanding treatment optimisation or not treated to target
- ☒ Repeated urgent-care use or unplanned admissions
- ☒ Wider non-medical needs affecting health
- ☐ Whole clinical cohort; no further unmet-need prioritisation
- ☐ Other

11

Which population or inequality characteristics actively shape the plan? *

Select only characteristics that actively affect how the target group is defined or how the plan will be delivered.

Select all that apply. If you select 'Other', please type the characteristic in the text box that appears.

- ☐ Deprivation / IMD
- ☐ Ethnicity
- ☐ Age
- ☐ Sex or gender
- ☐ Frailty
- ☐ Mental health
- ☐ Disability, learning disability or autism
- ☐ Inclusion health (those experiencing homelessness, struggling with addiction, vulnerable migrants or refugees (inc asylum seekers), Gypsy, Roma & traveller communities, sex workers, in prison or recently released or under probation, victims of modern slavery)
- ☒ None; the whole clinical cohort is prioritised
- ☐ Other

12

Describe the defined target group in your own words (including demographics) Maximum 250 words *

Bring together the clinical cohort, unmet need and relevant inequality characteristics selected above. Describe the specific local group, including any geographic or eligibility criteria. You do not need to repeat every selection.

The target group is Trafford West residents with identified or potentially unmet cardiovascular health needs, with a particular focus on people at increased risk of CVD who may not be fully engaged with routine preventative care. This includes:

The wider population at increased risk of CVD, including people with previously unidentified or undiagnosed cardiovascular risk factors who may benefit from proactive case finding, assessment and early intervention.

Patients with diabetes identified as having high cardiovascular need through CVNeed, particularly those with gaps in care, missed reviews or appointments, incomplete monitoring, or opportunities for improved treatment optimisation and risk-factor management.

Patients with multiple and complex health and/or wider needs who are at increased risk of deterioration, avoidable A&E attendance or unplanned hospital admission and would benefit from a coordinated multidisciplinary approach.

There will be a particular focus on identifying and engaging people experiencing unmet need or barriers to accessing conventional primary care pathways, using proactive and neighbourhood-based approaches to improve access to prevention, optimisation and wider health and wellbeing support.

13

Approximately how many people are in the defined target group? *

Use the BeCCoR dashboard count where available. If the dashboard is not yet available, or the target group has been further refined locally, enter your best current estimate as a whole number.

2424

Please enter a whole number

Need, barriers, intended improvement and measurement

Tell us what local information shows for the target group, what may be contributing to the current position, what you intend to improve and how progress will be assessed. An indicator of unmet need describes the current problem; a barrier is something contributing to it; a measure is what you will track over time.

14

Why has this target group been prioritised for neighbourhood action? (Maximum 500 words) *

Briefly summarise the local evidence of need or inequality and why neighbourhood working offers an opportunity to improve the current position. Specific barriers are asked about next.

People at increased cardiovascular risk experience significant health inequalities and often have unmet prevention needs, particularly where there are barriers to accessing routine primary care and lifestyle support.

The neighbourhood has identified an opportunity to improve early identification, coordinated management and prevention through a collaborative neighbourhood approach. The plan aims to develop an integrated prevention model that brings together general practice, neighbourhood partners and Live Well services to improve cardiovascular risk identification, support lifestyle and behavioural change, and address wider determinants of health. By delivering coordinated interventions closer to communities, the programme aims to improve engagement, reduce health inequalities and provide more proactive care for those at highest risk

15

What are the main barriers likely to be contributing to the current situation in your neighbourhood? *

Select all that apply. Select "Not sure yet" if the barriers will be explored during delivery. If you select "Other", type the barrier in the text box that appears, this might include barriers that you experience as a practitioner or service provider.

- ☒ Language or communication needs
- ☒ Digital exclusion
- ☒ Transport, mobility or physical access
- ☒ Appointment timing, work or caring responsibilities
- ☒ Confidence, anxiety or lack of trust
- ☒ Understanding of the condition or health literacy
- ☒ Financial, housing, food or fuel insecurity
- ☒ Social isolation or limited support
- ☒ Fragmented services or referral pathways
- ☒ Current recall or appointment arrangements do not meet the group's needs
- ☐ Not sure yet
- ☐ Other

16

Which single measure will be used as the primary indicator of progress? *

Select the one measure that best shows whether the main improvement is being achieved. If you select "Other", type the primary measure in the text box that appears.

- ☐ Target group reached or engaged
- ☐ BeCCoR review or relevant key checks completed
- ☐ Reduction in missing or overdue information, checks or reviews
- ☒ Clinical action completed, treatment optimised or people treated to target
- ☐ A&E attendances
- ☐ Patient-reported Health Confidence Score
- ☐ Personal Wellbeing Score or loneliness measure
- ☐ Live Well, social-prescribing or community support
- ☐ New diagnoses or annual review completion
- ☐ Relevant QOF indicators
- ☐ Staff confidence or neighbourhood working
- ☐ Improvement in demographic recording
- ☐ Other

17

What is the current baseline for the primary measure? *

Give the value, date and source. If it is not yet known, explain how and by when it will be established.

The baseline differs across the three elements of the programme and will be established using existing data alongside information generated through the initial stages of delivery. Wider CVD risk cohort: A definitive baseline is not yet known, as a key purpose of this element of the programme is to identify previously unrecognised cardiovascular risk within the community. We will begin to establish the baseline using data already generated through the SISU Health machine, including the report provided by BlueSci, alongside ongoing SISU activity. This will provide information on the number of people assessed, cardiovascular risk factors identified and the level of potential unmet or previously unidentified need. As the pathway develops, this data will provide the baseline against which subsequent reach and outcomes can be monitored. Diabetes/high CVNeed cohort: The identified diabetes population is 3,369 patients. Baseline activity will use CVNeed and practice data to identify patients who are overdue for reviews, have gaps in core care processes or monitoring, or require further clinical optimisation. This will establish the starting position for the targeted Community Appointment Day activity. Complex/high-risk cohort: The baseline will be established once patients appropriate for enhanced Health and Care MDT input have been identified. Baseline information will include current levels of A&E attendance and/or unplanned hospital use within the defined cohort, enabling comparison following MDT intervention. Baseline measures will be confirmed during the initial delivery period and used to monitor progress through to 31 March 2027.

18

Are there any additional measures you will monitor? If so, list up to three. (Maximum 250 words)

These are other things not selected as your primary measure above that you would want to measure as the project progresses. These might help show wider benefit (secondary measures) or possible unintended effects (balancing measures). Do not repeat the primary measure and leave blank if none.

For each additional aim try to ensure it is Specific , Measurable, Achievable, Realistic and Timebound

1. Increase in completion of annual reviews: Monitor the number and proportion of identified patients who were previously overdue or had gaps in care and subsequently complete their required annual review and/or outstanding monitoring during the project period.
2. Patient engagement with targeted interventions: Monitor uptake and attendance among patients invited to targeted neighbourhood interventions, including community appointment days, to assess whether alternative approaches improve engagement with patients who have previously not responded to or engaged with routine care.
3. Staff confidence in neighbourhood working: Assess staff confidence in working across organisational boundaries and using neighbourhood pathways through feedback from participating practice and neighbourhood teams, with the aim of demonstrating improved confidence and collaborative working by March 2027.

19

What change do you aim to achieve in the primary measure by 31 March 2027? (Maximum 250 words) *

Using the baseline above, state the intended amount or direction of change for the defined target group. Where relevant, identify any part of the target group for whom improvement is particularly important.

Example: "Reduce the proportion of [target group] with a missed or overdue review from 25% to 15% by 31 March 2027, with a particular focus on people living in areas of higher deprivation."

By 31 March 2027, we aim to achieve the following improvements:

1. CVD prevention and case finding: Ensure patients identified through community-based case finding as having hypertension, increased cardiovascular risk or associated long-term conditions are provided with an appropriate pathway for holistic lifestyle and social support, alongside appropriate clinical management and clear next steps for ongoing care.
2. Diabetes/high CVNeed cohort: Increase the proportion of patients with diabetes receiving their required core care processes by targeting an additional 5% of the identified diabetes cohort (approximately 168 patients from a cohort of 3,369). Activity will particularly focus on patients with unmet need, including those who are overdue reviews, have gaps in care or have been harder to engage through conventional recall, using targeted community appointment days and proactive outreach.
3. Complex/high-risk cohort: Achieve a 10% reduction in A&E attendances among the identified complex/high-risk patient cohort receiving enhanced multidisciplinary team (MDT) input, through proactive management, preventative care planning and coordinated neighbourhood support by 31 March 2027.

Co-design, delivery and neighbourhood fit

Describe how the approach has been shaped with relevant neighbourhood partners and how those partners will contribute to delivery. Simply naming an organisation is not sufficient: explain its involvement, contribution and role.

20

How will your plan be delivered? (Maximum 500 words) *

Describe the activities or changes in approach, including any targeted outreach, changes to access or recall, clinical action, referral pathways or wider support.

Explain how these respond to the needs and barriers identified above.

Delivery will include proactive case finding using CVNeed searches alongside the development of coordinated pathways across primary care and neighbourhood services. The aim is to identify cardiovascular risk earlier, provide clear routes for intervention and offer alternative ways of engaging patients who may not routinely access preventative care. SISU Health machines will be used within community settings to support cardiovascular risk identification. A key part of the project will be developing the pathway around the machines, ensuring that information generated through SISU leads to appropriate follow-up and intervention. Data extracted from SISU will help us understand the level of previously unidentified cardiovascular risk within the community, the characteristics of those engaging with the machines and the types of intervention subsequently required.

The pathway will be developed collaboratively between primary care, community pharmacy, Live Well/social prescribing and other neighbourhood partners. Where results indicate a potential clinical need, clear routes into primary care or community pharmacy will support further assessment, monitoring and appropriate medical management. Where lifestyle or wider determinants of health are identified, patients will be connected with Live Well, social prescribing and relevant community support. This will provide a more holistic response to cardiovascular risk rather than focusing solely on clinical indicators. Learning from the SISU pathway will then be used to develop similar approaches across other areas of Trafford West. This could include making greater use of existing blood pressure machines within community pharmacies and developing simple QR-code based routes through which patients can access information, submit or act on readings, and be directed towards appropriate clinical, lifestyle or social support. This will allow us to test how community-based cardiovascular case finding can be expanded using existing neighbourhood assets.

Three Community Appointment Days will also be delivered, providing targeted multidisciplinary interventions for higher-risk cohorts. Building on the diabetes Community Appointment Day model, these will focus particularly on patients with unmet need, outstanding care processes, opportunities for optimisation or previous non-engagement with routine recall. Primary care input into Health and Care MDTs will be strengthened for patients with multiple and complex needs who are at increased risk of deterioration or unplanned hospital use. This will support earlier intervention, preventative care planning and advance care planning.

The learning and data from these different approaches will be reviewed through the neighbourhood partnership to understand what works, improve pathways and identify opportunities to embed successful approaches across Trafford West beyond the initial project period.

21

Please provide the costing for each identified activity in question 20. *

Start each activity on a new line.

Consider breakdown using the format: Category | Costed item | Amount | Deliverer | Basis of costing | with each clustered activity on a new line/new paragraph.

Community Appointment Days | 3 targeted Community Appointment Days | £22,500 (£7,500 per CAD) | PCN | Clinical and support workforce, venue, equipment and administration to deliver multidisciplinary community-based reviews for identified high-risk cohorts, including patients with diabetes and high CVNeed.

Holistic Pathways in the Community | Development and delivery of community-based prevention pathways | £10,000 | PCN / Practices / Neighbourhood Partners | Workforce capacity, pathway development and implementation to support CVD case finding, SISU Health activity, onward clinical management, lifestyle interventions, Live Well and wider social support.

Neighbourhood Leadership | Neighbourhood Leadership Team | £4,800 | PCN / INT | Protected clinical and programme time to develop and coordinate the neighbourhood prevention strategy, strengthen partnership working and oversee delivery of agreed priorities.

Health & Care MDTs | Primary Care participation in Health & Care MDTs | £20,800 | PCN / Practices | Protected primary care clinician time to support proactive multidisciplinary management of complex/high-risk patients, including prevention and advance care planning, with the aim of reducing deterioration, avoidable A&E attendance and unplanned admissions.

Project Management & Evaluation | Programme coordination, monitoring and evaluation | £5,000 | PCN | Project management capacity to coordinate delivery across workstreams and partners, monitor identified cohorts and outcomes, support data collection and evaluation, and complete programme reporting.

Total Neighbourhood Prevention Allocation requested: £63,100.

22

If the costs listed above don't total your allocation, please identify this and explain clearly the rationale for this. Any contingency costs should be clearly identified and justified. (Maximum 250 words) *

The indicative costs identified above total £63,100, compared with the available Neighbourhood Prevention Allocation of £60,474.98, creating a difference of £2,625.02.

The costs provided represent the anticipated maximum cost of delivering the proposed programme, including three Community Appointment Days at an estimated £7,500 per event. Actual expenditure will be managed within the confirmed allocation of £60,474.98, with costs reviewed and adjusted across the programme as delivery arrangements and final workforce requirements are confirmed.

No expenditure above the allocated £60,474.98 will be committed. Any efficiencies achieved through use of existing PCN, practice or neighbourhood resources will be used to support delivery of the agreed activities within the overall allocation.

23

Why does the proposed spend represent good value for money? Refer to the size and need of the target group, expected reach or benefit, unit or session costs, the costing basis and existing resources. (Maximum 500 words) *

The proposed investment represents good value for money by combining targeted direct patient interventions with the development of sustainable neighbourhood approaches to prevention, making use of existing primary care, community and neighbourhood resources wherever possible.

Three Community Appointment Days will be delivered at an indicative cost of £7,500 per event (£22,500 total), providing targeted multidisciplinary access for higher-risk patients, including people with diabetes and high CVNeed who have outstanding care processes, require optimisation or have been difficult to engage through conventional recall. Based on the identified diabetes cohort of 3,369 patients, the programme aims to reach an additional 5% (approximately 168 patients). The CAD model enables multiple reviews, investigations and interventions during a single attendance, making efficient use of clinical and support workforce and reducing the need for multiple separate appointments.

The £10,000 community pathway allocation will support development and implementation of a community cardiovascular case-finding pathway, initially centred around SISU Health in Partington. The intended reach is a 20% increase in unique individuals using SISU by the end of Quarter 3, compared with baseline activity. Funding will also support development of clear onward pathways between community settings, primary care, community pharmacy and Live Well/social prescribing. Learning will inform development of similar approaches elsewhere across Trafford West using existing community assets, including pharmacy-based blood pressure machines and QR-code enabled pathways.

The £20,800 allocation for primary care participation in Health and Care MDTs will provide protected clinical capacity to proactively support an expected cohort of 20 patients with multiple and complex needs who are at increased risk of deterioration and unplanned care. Coordinated multidisciplinary intervention, prevention and care planning will aim to achieve a 10% reduction in A&E attendances across the defined cohort, measured against an equivalent pre-intervention baseline period.

Investment in neighbourhood leadership (£4,800) and project management/evaluation (£5,000) provides proportionate capacity to coordinate delivery, monitor outcomes and develop pathways that can be sustained beyond the funding period.

Overall, funding is focused on additional capacity and targeted intervention where existing approaches are not sufficiently identifying or engaging unmet need, while developing sustainable neighbourhood models with potential benefit beyond the initial cohorts.

24

Which partners will or have been be involved in co-design and/or delivery? *

Please state the partners if you select other

- ☒ Practice team
- ☒ PCN / MDT
- ☒ Neighbourhood / INT team
- ☒ Local authority
- ☒ Social prescribing
- ☒ VCFSE / community groups
- ☒ Mental health services
- ☒ Secondary care / specialist services
- ☐ Other

25

How have practices, communities and neighbourhood partners helped shape this plan? State who was involved, how views were gathered and what changed or was confirmed as a result. (Maximum 500 words) *

The plan has been developed collaboratively through the Trafford West Neighbourhood Forum, which brings together representatives from general practice, primary care, community services and a wide range of neighbourhood and community partners.

A dedicated workshop session was held through the Neighbourhood Forum to discuss local population needs, areas of unmet need and the priorities that partners felt should form the focus of the neighbourhood plan. This provided an opportunity for partners to share their experience of working with local communities, identify barriers to accessing existing services and consider where a more coordinated neighbourhood approach could add value.

The discussion confirmed the importance of focusing on prevention and proactive identification of cardiovascular risk, while recognising that clinical intervention alone will not address the wider factors affecting people's health. This helped shape the whole-system approach within the plan, including stronger links with Live Well and community support, holistic pathways for lifestyle and social needs, and opportunities to provide preventative interventions in community settings.

The workshop also supported the development of the proposed neighbourhood MDT and leadership approach, recognising the value of bringing primary care and wider partners together to support people with complex needs and coordinate future prevention activity.

Practice representatives have also contributed to the development of the proposed pathways and delivery model, ensuring that the approach complements existing primary care provision while providing additional ways to identify and engage people whose needs may not be met through conventional recall and appointment models.

26

Is the work expected to benefit people beyond the defined core target group? *

☒ Yes

☐ No

27

If yes, briefly describe the potential wider benefit. (Maximum 150 words)

The work is expected to have wider benefits beyond the defined target cohorts. Community-based case finding, including use of SISU Health machines, may identify people with previously unrecognised hypertension or increased cardiovascular risk and provide routes into appropriate clinical management, lifestyle support and Live Well services.

The Community Appointment Day model will also provide learning on alternative ways of engaging people who may not access or respond to traditional primary care pathways, which can be applied to other long-term conditions and population groups.

The development of stronger neighbourhood pathways, Neighbourhood Leadership and closer working between primary care, Health and Care MDTs and community partners will create a more coordinated approach to prevention that can support the wider Trafford West population and provide a foundation for future neighbourhood prevention activity.

Funding, value for money and confirmation

Set out the proposed use of the Neighbourhood Prevention Allocation. Costs should be clear, proportionate to the target group and intended benefit, and linked to new or additional delivery activity.

28

Amount allocated to practice delivery (£; enter 0 if none)

£20,800 allocated to practices to provide protected primary care clinician time for attendance and input into Health & Care MDTs for identified complex/high-risk patients.

29

Amount allocated to external, VCFSE or community partners (£; enter 0 if none)

30

Amount allocated to PCN or GP federation delivery (£; enter 0 if none)

31

Any other comments. Please use this space to indicate if you are going to submit supporting documentation via email (e.g. costing template). If sending additional documentation please send through to gmicb-tr.tccgpc@nhs.net.

The programme aligns with Trafford locality priorities around prevention and early intervention, reducing health inequalities and developing integrated neighbourhood models of care. It supports the shift towards proactive, community-based prevention and the development of Live Well by making better use of neighbourhood assets and strengthening links between primary care, community pharmacy, social prescribing and wider partners.

The community case-finding element particularly supports this approach by creating opportunities for residents, including those who may not routinely engage with traditional healthcare pathways, to identify and act on cardiovascular risk within their own community. The programme aims to increase individual involvement in managing health and establish sustainable approaches to prevention that can be replicated across Trafford West.

32

I confirm that this plan has been discussed with the relevant practices and neighbourhood partners and has been checked against the four assessment criteria and that I am happy for information of this plan to be shared anonymously. *

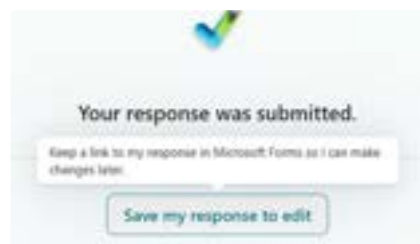
BeCCOR Pillar 3C
Four Assessment Criteria

- Represent good value for money;
- Focus on improving outcomes for the identified BeCCoR core cohort, while recognising any potential wider benefit;
- Have been co-designed and will be delivered with relevant neighbourhood partners;
- Support neighbourhood working and relevant local strategic priorities.

☒ Yes

33

IMPORTANT - PLEASE NOTE When you have submitted this form- please then click on '**save my response to edit**'. This will then give you an internet link that you need to save somewhere, which will then allow you to re-edit your response at any future date.



No answer provided.

View results

Respondent

6

Anonymous

55:27

Time to complete

About this submission

Tell us who is submitting the plan and where it has been discussed and agreed.

1

If you have one, what is the name of your scheme (e.g. Brookvale Neighbourhood reaching the missed middle)

No answer provided.

2

Who is submitting this plan? *



PCN



Single practice



Group of practices not submitting as a PCN

3

Name of the submitting PCN or practice(s) *

South Trafford PCN

4

Names and roles of the practice or PCN leads for this work *

Dr Taylor-Bernard GP and Clinical Director for the PCN

5

Name of the neighbourhood *

Trafford South

6

Name of the neighbourhood forum or meeting where the plan was discussed and agreed *

Discussed during GP board meeting, Trafford PCN delivery meeting and PCN meeting

7

Date the plan was most recently discussed and agreed (DD/MM/YYYY) *

08/10/2026

Core cohort and target group

The Curator BeCCoR dashboard will bring together the full BeCCoR cohort across Greater Manchester. Authorised users will be able to view and filter patient-level cohort status, indicators of unmet need and geographic information. This is intended to make it easier for practices and neighbourhood partners to identify and size target groups, agree priorities and track progress without having to create these measures themselves. Until the dashboard is available, use the best information currently available.

8

Which BeCCoR clinical cohort(s) are included in this plan? *

- ☐ CVNeed — hypertension
- ☐ CVNeed — atrial fibrillation
- ☐ CVNeed — diabetes
- ☐ CVNeed — secondary prevention of CVD/lipid optimisation
- ☐ CVNeed/ACR — chronic kidney disease or albuminuria need
- ☒ Primary prevention — high QRISK
- ☐ RespNeed — adult asthma
- ☐ RespNeed — asthma in children and young people
- ☐ RespNeed — COPD
- ☐ Other BeCCoR Cohort - Describe below

9

If you selected "Other BeCCoR cohort", describe it here. (Maximum 150 words)

No answer provided.

10

What are the main indicators of unmet need used to define the target group? *

The below indicators will all be available to view, filter and easily track on the BeCCoR dashboard once available. Picking from one of the below will allow you to easily filter your chosen cohorts to better understand how you may work together in the plan to meet their need.

Select all that apply. If you select 'Other', please type the indicator in the text box that appears.

- ☒ Missing or overdue key checks, readings or reviews
- ☐ Repeated non-attendance or no response
- ☐ Outstanding treatment optimisation or not treated to target
- ☐ Repeated urgent-care use or unplanned admissions
- ☐ Wider non-medical needs affecting health
- ☒ Whole clinical cohort; no further unmet-need prioritisation
- ☐ Other

11

Which population or inequality characteristics actively shape the plan? *

Select only characteristics that actively affect how the target group is defined or how the plan will be delivered.

Select all that apply. If you select 'Other', please type the characteristic in the text box that appears.

- ☐ Deprivation / IMD
- ☐ Ethnicity
- ☐ Age
- ☐ Sex or gender
- ☐ Frailty
- ☐ Mental health
- ☐ Disability, learning disability or autism
- ☐ Inclusion health (those experiencing homelessness, struggling with addiction, vulnerable migrants or refugees (inc asylum seekers), Gypsy, Roma & traveller communities, sex workers, in prison or recently released or under probation, victims of modern slavery)
- ☒ None; the whole clinical cohort is prioritised
- ☐ Other

12

Describe the defined target group in your own words (including demographics) Maximum 250 words *

Bring together the clinical cohort, unmet need and relevant inequality characteristics selected above. Describe the specific local group, including any geographic or eligibility criteria. You do not need to repeat every selection.

We have chosen this target group after looking at the data. Most patients in this group don't attend the surgeries regularly. This can be due to isolation, difficulty attending the surgery, communication barriers or lack of understanding about basic health checks. This is a great opportunity to reach out to them

13

Approximately how many people are in the defined target group? *

Use the BeCCoR dashboard count where available. If the dashboard is not yet available, or the target group has been further refined locally, enter your best current estimate as a whole number.

Please enter a whole number

Need, barriers, intended improvement and measurement

Tell us what local information shows for the target group, what may be contributing to the current position, what you intend to improve and how progress will be assessed. An indicator of unmet need describes the current problem; a barrier is something contributing to it; a measure is what you will track over time.

14

Why has this target group been prioritised for neighbourhood action? (Maximum 500 words) *

Briefly summarise the local evidence of need or inequality and why neighbourhood working offers an opportunity to improve the current position. Specific barriers are asked about next.

The challenge is to address health and social care inequalities and to subsequently empower individuals, families and communities to improve their health and wellbeing. Our aim is to better deliver culturally informed health services and overcome cultural barriers around health education and screening that have been embedded into communities for generations. Low uptake rates show that we are not getting the message across to certain patient cohorts. We want to work with the communities to find solutions.

We hope that by building better relationships with our local communities we can empower people to make informed decisions about their health specifically around screening, and the early detection of Cancer and Cardiovascular Diseases .

We are also limited by a fairly small budget, so we want to focus on being proactive and trying to prevent health issues in the future.

15

What are the main barriers likely to be contributing to the current situation in your neighbourhood? *

Select all that apply. Select "Not sure yet" if the barriers will be explored during delivery. If you select "Other", type the barrier in the text box that appears, this might include barriers that you experience as a practitioner or service provider.

- ☒ Language or communication needs
- ☐ Digital exclusion
- ☒ Transport, mobility or physical access
- ☒ Appointment timing, work or caring responsibilities
- ☐ Confidence, anxiety or lack of trust
- ☒ Understanding of the condition or health literacy
- ☐ Financial, housing, food or fuel insecurity
- ☐ Social isolation or limited support
- ☐ Fragmented services or referral pathways
- ☐ Current recall or appointment arrangements do not meet the group's needs
- ☐ Not sure yet
- ☐ Other

16

Which single measure will be used as the primary indicator of progress? *

Select the one measure that best shows whether the main improvement is being achieved. If you select "Other", type the primary measure in the text box that appears.

- ☒ Target group reached or engaged
- ☐ BeCCoR review or relevant key checks completed
- ☐ Reduction in missing or overdue information, checks or reviews
- ☐ Clinical action completed, treatment optimised or people treated to target
- ☐ A&E attendances
- ☐ Patient-reported Health Confidence Score
- ☐ Personal Wellbeing Score or loneliness measure
- ☐ Live Well, social-prescribing or community support
- ☐ New diagnoses or annual review completion
- ☐ Relevant QOF indicators
- ☐ Staff confidence or neighbourhood working
- ☐ Improvement in demographic recording
- ☐ Other

17

What is the current baseline for the primary measure? *

Give the value, date and source. If it is not yet known, explain how and by when it will be established.

1247

18

Are there any additional measures you will monitor? If so, list up to three. (Maximum 250 words)

These are other things not selected as your primary measure above that you would want to measure as the project progresses. These might help show wider benefit (secondary measures) or possible unintended effects (balancing measures). Do not repeat the primary measure and leave blank if none.

For each additional aim try to ensure it is Specific , Measurable, Achievable, Realistic and Timebound

Reduction in missing Qrisk by arranging up to date blood tests and physical health checks.
Clinical actions completed based on results and findings.

19

What change do you aim to achieve in the primary measure by 31 March 2027? (Maximum 250 words) *

Using the baseline above, state the intended amount or direction of change for the defined target group. Where relevant, identify any part of the target group for whom improvement is particularly important.

Example: "Reduce the proportion of [target group] with a missed or overdue review from 25% to 15% by 31 March 2027, with a particular focus on people living in areas of higher deprivation."

We are aiming to reach out to every patients in the cohort. we would like to complete at least 50% of the Qrisk reviews but we are hoping to reach 80%. We will particularly focus on patients that very rarely attend practices and from ethnic minorities.

Co-design, delivery and neighbourhood fit

Describe how the approach has been shaped with relevant neighbourhood partners and how those partners will contribute to delivery. Simply naming an organisation is not sufficient: explain its involvement, contribution and role.

20

How will your plan be delivered? (Maximum 500 words) *

Describe the activities or changes in approach, including any targeted outreach, changes to access or recall, clinical action, referral pathways or wider support.

Explain how these respond to the needs and barriers identified above.

Our plan is in two parts.
First, we have agreed to take part in the suggested Trafford Neighbourhood plan suggested by Trafford Locality as we want to engage with the wider community and local services. As agreed we will attend 2 monthly in person neighbourhood meetings and also WEEKLY MDTs when our patients are being discussed. We will also include the Neighbourhood plan on our PCN agenda every 2 months and invite relevant representatives from the other sectors. This will use half of our budget.
Secondly, we will work at PCN and practice levels to deliver specific CVD clinics. Those clinics will be specifically for the target groups. Patients will be able to get their bloods done and have a discussion with a practice nurse/GP/pharmacist following the results. This will use the second part of our budget.
We will also engaged with the local communities.
We have met with BHA to gain an insight into their work and to gain contacts within the local mosque as a first step to building relationships. We are keen to break down taboos around health checks and screening and to work with the communities to find ways to address these. We hope, over time, to also work with varied communities including other ethnic minority groups, carers, men, deprived communities and LGBTQ+ communities.
We are looking at better ways to give the community information on the importance of Cardiovascular health checks and the national screening programmes: bowel, breast and cervical cancer

21

Please provide the costing for each identified activity in question 20. *

Start each activity on a new line.

Consider breakdown using the format: Category | Costed item | Amount | Deliverer | Basis of costing | with each clustered activity on a new line/new paragraph.

Locum cover for CD attending 2 monthly half day meetings and CD's expenses/remuneration: 2400£
Weekly MDTs attendance and preparation: 12500£
CVD clinics (phlebotomist and Nurse): 240£ each, total of 10900£

22

If the costs listed above don't total your allocation, please identify this and explain clearly the rationale for this. Any contingency costs should be clearly identified and justified. (Maximum 250 words) *

N/A

23

Why does the proposed spend represent good value for money? Refer to the size and need of the target group, expected reach or benefit, unit or session costs, the costing basis and existing resources. (Maximum 500 words) *

We have a very small budget compare to other larger PCNs but we want to engage in the Neighbourhood work so needed to allocate some of our budget to meetings and MDTs.
We feel those CVD clinics and voluntary engagement with the different local community groups will provide a great opportunity to improve health and prevent long term conditions such as cardiovascular diseases, CKD and much more.
Getting engagement from local community groups will help people take control of their own health. Our hope is that we can break down myths and misconceptions that people may have and by doing that they will book the health check or attend the screening appointment.

24

Which partners will or have been be involved in co-design and/or delivery? *

Please state the partners if you select other

- ☒ Practice team
- ☒ PCN / MDT
- ☒ Neighbourhood / INT team
- ☐ Local authority
- ☐ Social prescribing
- ☒ VCFSE / community groups
- ☐ Mental health services
- ☐ Secondary care / specialist services
- ☐ Other

25

How have practices, communities and neighbourhood partners helped shape this plan? State who was involved, how views were gathered and what changed or was confirmed as a result. (Maximum 500 words) *

Trafford locality suggested the Neighbourhood plan and it was discussed during the GP board meeting. We then discussed it during our PVN meeting and agreed to take part. This was again discussed at the Trafford PCN delivery group on the 08/10/2026 and we were advised to revise our plan and commit to 6 months instead of 12. Therefore, we have agreed to attend weekly MDTs rather than 2 weekly.
We also discussed how we could set up our own PCN plan and targeted this specific cohort. Each practice discussed it internally and we felt those CVD clinics were the most efficient ways to obtain results.

26

Is the work expected to benefit people beyond the defined core target group? *

- ☒ Yes
- ☐ No

27

If yes, briefly describe the potential wider benefit. (Maximum 150 words)

As discussed, we are opening this will be the start of a better engagement from certain minority and groups.

Funding, value for money and confirmation

Set out the proposed use of the Neighbourhood Prevention Allocation. Costs should be clear, proportionate to the target group and intended benefit, and linked to new or additional delivery activity.

28

Amount allocated to practice delivery (£; enter 0 if none)

23397£ to cover CVD clinics delivery and MDTs attendances

29

Amount allocated to external, VCFSE or community partners (£; enter 0 if none)

0

30

Amount allocated to PCN or GP federation delivery (£; enter 0 if none)

2400£ for CD attendances and cover to in person meetings.

31

Any other comments. Please use this space to indicate if you are going to submit supporting documentation via email (e.g. costing template). If sending additional documentation please send through to gmicb-tr.tccgpc@nhs.net.

No answer provided.

32

I confirm that this plan has been discussed with the relevant practices and neighbourhood partners and has been checked against the four assessment criteria and that I am happy for information of this plan to be shared anonymously. *

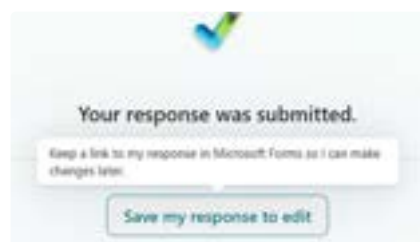
BeCCOR Pillar 3C
Four Assessment Criteria

- Represent good value for money;
- Focus on improving outcomes for the identified BeCCoR core cohort, while recognising any potential wider benefit;
- Have been co-designed and will be delivered with relevant neighbourhood partners;
- Support neighbourhood working and relevant local strategic priorities.

☒ Yes

33

IMPORTANT - PLEASE NOTE When you have submitted this form- please then click on **'save my response to edit'**. This will then give you an internet link that you need to save somewhere, which will then allow you to re-edit your response at any future date.



No answer provided.

Name of Committee / Board		Trafford Locality Board		
Date of Meeting		20th October 2026		
Report Title		Performance Report July –August –September 2026		
Report Author & Job Title		Mara Moon, Communications and Information Officer		
Organisation Exec Lead		Andrew Latham		
OUTCOME REQUIRED <i>(please highlight)</i>	Approval	Assurance	Discussion	Information
EXECUTIVE SUMMARY				
A summary of Healthwatch Trafford’s performance and impact during the period July to September 2026. This includes research, engagement activities, local concerns, and strategic updates.				
RECOMMENDATIONS				
1. To note the report.				
CONSIDERATIONS – these must be completed before submission to the Board – Reports with incomplete coversheet information will not be accepted and shared with the board				
Risk implications <i>(Please provide a high-level description of any risks relating to this paper, including reference to appropriate organisational risk register)</i>		None		
Financial implications and comment/approval <i>(Please detail which organisation(s) will be impacted, and if not required, please briefly detail why)</i>		Name/Designation: N/A		
		Comment / Approval <i>(Delete appropriately)</i> N/A		
Comment by Trafford Clinical and Practitioner Senate (TCAPS) and/or Clinical Lead <i>(If not required, please briefly detail why)</i>		Date of TCAPS / Clinical Lead comment <i>(Delete appropriately)</i> : N/A		
		Name/Designation: <i>(If appropriate)</i> N/A		
		Comment: N/A		
What is the impact on inequalities? <i>(Please provide a high-level description of any known impacts)</i>		N/A, update only		

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

Performance Report

July – August – September 2026



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Highlights during reporting period July to September '26

Research

- **Living Well in Sale and Partington**

Our Living Well in Sale and Partington report was published in July. To provide evidence for Trafford Council's Live Well pilot scheme in Sale and Partington, we surveyed 765 residents. A further 11 residents took part in three focus groups held in Partington and Sale. The research explored what helps residents maintain their wellbeing, what barriers they face, and what improvements they would like to see within their local communities. The project was informed by the Five Ways to Wellbeing framework: Connect, Be Active, Take Notice, Keep Learning and Give.

Physical activity and connecting with others were the two wellbeing factors that residents considered most important. The most commonly reported barriers to wellbeing activities were time pressures related to work, caring and family responsibilities, followed by cost and a lack of awareness of available activities and support. Respondents with a disability or long-term health condition were less confident finding information about local services and support, and were more likely to experience physical and mental health barriers to participation.

- **Ageing Well in Trafford**

Our Ageing Well in Trafford report was published in September, with experiences from 50 residents aged over 50. Trafford Council commissioned Healthwatch Trafford to explore the experiences of Trafford residents aged 50 and over when accessing health, wellbeing, and community support services. Our aim was to understand the barriers people face and highlight good practice, while hearing more about what people need in the future.

Through a series of semi-structured, discussions, residents identified barriers at almost every point in the patient journey. Some valued digital services but others told us how important it was to be able to access care over the phone and face-to-face. People frequently had to coordinate their own care, chase referrals, and repeating information several times over to different professionals. Other common themes included difficulty getting appointments, long waiting times, poor communication between organisations and complex referral pathways.

People highlighted transport, mobility, their housing situation, confidence, and awareness as factors affecting their ability to access support. They also talked about the 'invisibility gap', where those experiencing significant difficulties but did not meet the criteria for specialist support fell through the cracks.

Engagement

- **Phlebotomy**

Planning began for a targeted engagement project to gather patient experiences of blood-testing services across Trafford. The work was designed to compare current patient experiences with the findings of Healthwatch Trafford's earlier phlebotomy work and determine how satisfied patients are with the current appointment-based service.

The phlebotomy survey was promoted in clinics, community centres and Primary Care Networks. Face-to-face engagement was undertaken at approximately five phlebotomy clinics across Trafford, enabling patients to share their experiences of accessing blood-testing services. By 24 September, approximately **154 responses** had been received through a combination of face-to-face engagement and the online survey.

Further visits were being coordinated for Altrincham Hospital, Trafford General Hospital, Limelight and Woodsend. Discussions also took place with staff from Manchester University NHS Foundation Trust to support access to the hospital clinics and plan engagement around clinic activity and patient attendance.

The project involved continued coordination with colleagues, volunteers, clinic managers and NHS contacts to agree suitable dates, support patient engagement and ensure that the work reached people using different phlebotomy locations across Trafford.

- **Enter & View**

Healthwatch Trafford successfully completed an Enter & View visit at Partington Central Surgery in September. The visit provided an opportunity to learn more about the practice, speak with patients and staff, gather feedback and assess accessibility.

Building on this work, early planning began for a further Enter & View visit to Partington Family Practice. As the two practices operate from the same building, the proposed second visit presents an opportunity to understand and compare patient experiences across both practices while identifying shared themes and examples of good practice.

- **Partnership and Internal Networking**

We attended a Live Well workshop, with the aim of strengthening our understanding of local activity and support future engagement with organisations and community groups across Trafford's different neighbourhoods.

- **Engagement with Muslim and Interfaith Communities**

Work began to strengthen Healthwatch Trafford's relationships with Muslim communities, mosques, Islamic centres and interfaith organisations across Trafford. The work is intended to

create longer-term relationships, improve representation from communities that are not always heard and provide routes for concerns about health and social care services to be raised with commissioners and decision-makers.

Volunteers

Volunteer Recruitment and Development

Three new volunteers were recruited during the reporting period:

- One research volunteer to support evidence gathering, analysis and report development.
- Two authorised representatives to support Enter & View activity and gather patient experiences.

The new volunteers have increased the organisation's capacity to support engagement projects, Enter & View visits and community outreach. Volunteers continued to play an important role in speaking with residents, distributing surveys and supporting the collection of feedback.

- **Youthwatch Review**

Work was undertaken to review and restructure Youthwatch because participation had become limited. Existing young volunteers were approached to establish whether they wished to continue and what types of activities they would be interested in supporting. The intention was to invite interested members to an informal discussion and use their feedback to shape the future structure and activities of the programme.

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:

GPs

GPs were praised several times for their swift treatment:

"As soon as I had slightly raised bp I was put on medication. I'm presuming to treat it before it caused problems."

"Autistic young adult really struggling with anxiety and eating disorder. Contacted GP who instigated telephone appointment same day and dietician referral"

Dentistry

People in Trafford are continuing to have difficulty finding a dentist, in some cases having been without one for a number of years. In one case, although the patient had accessed a dentist, the care was poor:

"Dentist: clueless about anorexia and purging. Made to feel ashamed + guilty. Poor repair of teeth by a poor dentist. Ongoing major dental issues + hardly ever an appointment available."

"I am having difficulty finding a Dentist who is accepting new NHS patients, I have been trying on and off for over 3 years, just recently I have contacted several that are listed on the NHS website as taking on but they have not responded and the few that have are not, the information from How to find a Dentist was wrong. I am frustrated and disappointed"

One caller informed us that they could not access NHS care and had sought private dental treatment, though were finding the cost difficult. Another person emailed asking for help finding NHS dentist as had been unable to for almost four years.

Hospitals

Hospital staff were commended, and several people were positive about the speed and efficiency with which they were seen. However, several patient safety issues were raised:

"Thoroughness of testing ... was commendable. Communication from the Dr to the patient 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. What needs changing? 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 ... A nurse was certain my husband had been given intravenous antibiotics. He hadn't because the vein had been missed and it was too late to administer again in the original department. But the box ...had been ticked and that was that. An 85 year old protesting otherwise was not to be heard."

"Fast tracked to ... Altrincham General, suspected skin cancer. Withington Community Hospital outpatient Plastics department cut it out two weeks later. Excellent service."

"I didn't wait long the receptionists were friendly and I was quickly triaged. Nothing to improve on. The Doctor and nurse I saw were lovely and the Doctor extremely friendly, helpful and reassuring."

"Ward staff had no idea about anorexia or re-feeding syndrome. Kept telling me I had to eat + only big heavy meals offered ... didn't eat anything for 3 full days + constantly hypoglycaemic ... self discharged in the end for my own safety + to minimise risk. No one anywhere talks openly about anorexia or eating disorders ... Made to feel like I'm to blame."

"Urgent referral to gynae which the gp was told should be 4-6 weeks. Current wait time for an initial 'urgent' consult was 16 weeks and is now 27 weeks. Having previously had [cancer] that presented as a benign cyst this is causing me significant stress. The next available appointment to raise this with the gp is ... 14 days."

One resident, whose spouse was admitted to hospital, shared some patient safety concerns with us, including: wash facilities flooding; pain medicine not being given at correct times; patients not being fed, and staff not being aware that food was not being provided; food being cold and described as poor quality; body fluids on bedding from previous permeating patient clothes; dirty sinks, basins, and soap dispensers; and no answer when requesting help via call button.

Urgent care and 111

One patient had a generally good experience in hospital, with the staff described as 'caring' and 'humane'. However, another was left waiting for care in a corridor, and another felt that they were given confusing and conflicting guidance:

"Efficient - triage system worked well, blood tests and doctor assessment followed in an orderly and transparent manner, doctor had excellent access to relevant health data 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. ... I would have appreciated the freedom Doctors once had to tell you their view on risks e.g. in our case would it be OK to continue with holiday plans? Litigious society now prevents this I feel."

"Brilliant advice. Stopped my son (17) potentially dying ... I rang 111 for advice as he was thoroughly miserable. They booked him into Trafford General to see a gp, he was fast tracked in, then on to the ED. He was diagnosed with glandular fever, tonsillitis and his organs were starting to fail. ... He recovered quickly and fully. I would never have thought he was in a life threatening situation so wouldn't have taken him to ED."

"take to hospital via ambulance , waited 19 hours for a bed in a corridor"

"Unfortunately my own personal experience of NHS 111 has been very poor with either totally wrong advice given (even pharmacies told me it was wrong advice) or needing to get 3 people involved for an appointment at the local walk in ... Still have problems with my foot now"

Care in the community and social care

There was mixed feedback around community and social care; people had both positive and negative experiences with the district nursing team, and one patient was left in need of urgent help after they were discharged from hospital:

"Awful experience with my father's palliative and end of life care. Not turning up to check on him when promised"

"Brilliant, couldn't fault the service. Post operation wound care."

"Following a failed discharge from Salford Royal Hospital, where no intermediate care plan or home environment check was carried out, my partner was sent out without a safe way to live at home. Their permanent Trafford home of 20 years has only an upstairs toilet and bathroom. Because of their severe heart disease and instability, climbing stairs is a direct threat to their life. They are temporarily resting at my single-level ... as an emergency stop-gap so they can remain on strict bed and chair rest. They have been referred to the Trafford One-Stop clinic, but a 45-minute taxi journey each way to Trafford is medically impossible and physically dangerous for them right now. We emailed the Trafford Local Care Organisation SPoA team to request a virtual/telephone assessment and an urgent Occupational Therapy Home Assessment for their permanent property, but we have had no response from hospital PALS teams since Tuesday."

Strategic updates

The 'Ageing Well in Trafford' report was published following presentation at the Age Well Board. The over-55s identified barriers at almost every point in the patient journey. People reported having to coordinate their own care, chase referrals and repeat information several times. There was poor communication between organisations and complex referral pathways. Those experiencing significant difficulties who did not meet criteria for specialist support reported falling through the cracks.

We also produced a summary of long-standing issues that have yet to be addressed. Such examples span many years, but they continue to be raised by patients most recently in Enter and View reports. Clearly, some concerns of patients may not be possible to address because of 'technical' issues, but better communication amongst staff and patients could perhaps offer some mitigation.

The Enter and View of both Partington GP practices is underway and should provide a good overview of service and patient need and opinion in that area.

We have been visiting most of the phlebotomy clinics across Trafford as part of a Healthwatch 100 survey (and as follow up to similar work we did in 2019) and we are getting a sizeable number of responses from patients.

Discussion around the future of Healthwatch continues unabated both nationally and locally. Lord Hunt is leading the debate in the House of Lords. In Greater Manchester a letter was sent to Wes Streeting and a second to Yvette Cooper on behalf of the Integrated Care Partnership supporting the need for independent scrutiny.

In Greater Manchester a small group representing the 10 Healthwatch has been set up to flesh out models for an independent public and patient voice should the government set out alternative or enhanced proposals which differ from existing Healthwatch models.

However, time is short. Some Healthwatch cannot recruit to vacant posts, staff are looking for alternative employment. There are different types of contract and grant agreements in place with differing notice requirements and little time for consultation. Although any transitional arrangements may well take us well into 2027, some Healthwatch may end up simply providing their statutory duties or even folding. Stockport MBC is a good example, who have contracted Healthwatch Bury to provide this. If any other Healthwatch can no longer carry on, it is possible that another Healthwatch may step in over the coming months.

In Trafford we remain committed to fulfilling our role for as long as we are able and to looking at providing an independent voice for the people of Trafford, whether it be under the

Healthwatch brand or a new organisation. We have been scrupulous in keeping the Trafford Partnership up to date with events as they occur and will continue to do so.



Heather Fairfield
Chair of Directors

Name of Committee / Board		Trafford Locality Board		
Date of Meeting		20th October 2026		
Report Title		Trafford Locality Scorecard – October 2026		
Report Author & Job Title		Phil Jefferson, NHS GM, Intelligence Analyst (Trafford)		
Organisation Exec Lead		Thomas Maloney Programme Director Health and Care, NHS GM (Trafford) / Trafford Council		
OUTCOME REQUIRED	Approval	Assurance X	Discussion X	Information X
EXECUTIVE SUMMARY				
The purpose of this paper is to present the current version of the Trafford Locality Scorecard and provide an update on progress. To help identify priority areas, a set of focus metrics have been identified for discussion at Locality Board and, where available, narrative from Service Leads is included. To note there are no wholesale changes from the previous months report and work highlighted in the previous report has been retained in this month's report to highlight the continued relevance of work being carried out by partners. The Trafford Locality Scorecard was originally produced to align with Trafford's 7 Delivery Ambitions for 25/26. It includes metrics covering both NHS and Local Authority priority work areas. It is in addition to the existing GMICB Scorecards and dashboards available from the GM Intelligence Hub.				
RECOMMENDATIONS				
The Board is asked to: a) Note the progress update related to the Trafford Locality Scorecard (October 2026) and accompanying narrative.				
CONSIDERATIONS – these must be completed before submission to the Board – Reports with incomplete coversheet information will not be accepted and shared with the board				
Risk implications <i>(Please provide a high-level description of any risks relating to this paper, including reference to appropriate organisational risk register)</i>		There is a general risk that if we don't mobilise adequate performance arrangements in the locality, we will be unable to have the correct levels of assurance specifically at our Locality Board of the localities delegated responsibilities.		
Financial implications and comment/approval <i>(Please detail which organisation(s) will be impacted, and if not required, please briefly detail why)</i>		Name/Designation: Thomas Maloney, Programme Director Health and Care, NHS GM (Trafford) / Trafford Council Comment / Approval: Finance can be linked directly and indirectly to performance and therefore its imperative finance and performance together inform our efforts on sustainability in its broadest sense.		
Date of TCAPS / Clinical Lead comment: 11-Nov-25				

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

Trafford Locality Monthly Locality Scorecard Update October 2026

Locality Scorecard



Greater Manchester
Integrated Care

Priority	Code	Metric	Latest	Nat/Loc	Target	Aim	Prev	Curr	Perf	TA	GM	Focus
CYP & Maternity	CYP001	First EHC Plans issued	Jul-2026	Loc	60.0%	Higher	72.9%	82.4%	⬆	G		N
	CYP003	Family Help Assessments completed	Jul-2026	Loc	60.0%	Higher	66.1%	54.5%	⬇	R		N
	CYP004	Age 0-5 hospital dental extractions due to tooth decay - 12M Rate per 100,000	TBC									N
Prev. & Protection	PP001	Proportion of physically active adults	Mar-2024	Nat	67.6%	Higher	68.3%	65.7%	⬇	R	3	N
	PP002	National Screening Programme - Bowel Age 50-59 (Every 30 months, being phased in)	Sep-2026	Nat	70.0%	Higher	53.4%	54.6%	⬆	R	3	N
	PP003	National Screening Programme - Bowel Age 60-74 (Every 30 months)	Sep-2026	Nat	70.0%	Higher	79.0%	79.4%	⬆	G	2	N
	PP004	National Screening Programme - Breast Age 50-70 (Every 36 months)	Sep-2026	Nat	70.0%	Higher	72.9%	72.1%	⬇	G	1	N
	PP005	National Screening Programme - Cervical - Standard Age 25-49 (Every 42 months)	Sep-2026	Nat	80.0%	Higher	72.9%	72.8%	⬇	R	2	Y
	PP006	National Screening Programme - Cervical - Extended Age 50-64 (Every 66 months)	Sep-2026	Nat	80.0%	Higher	78.5%	78.3%	⬇	R	2	N
	PP007	Childhood Immunisations Age 2 MMR First Dose	Sep-2026	Nat	95.0%	Higher	88.3%	87.1%	⬇	R	3	N
	PP008	Childhood Immunisations Age 5 MMR Second Dose	Sep-2026	Nat	95.0%	Higher	93.2%	93.2%	⬆	R	2	N
	PP009	NHS Health Checks Age 40-74 (Received a health check in last 5 years)	Sep-2026	Loc	36.0%	Higher	50.3%	51.1%	⬆	G	5	N
Community Care	ASCOF_2A	% New care users who received short-term support (did not need follow-up support)	Jun-2026	Loc	60.0%	Higher	62.2%	56.0%	⬇	R		N
	ASCOF_2C	Rate of permanent admissions to residential and nursing placements (65+)	Jun-2026	Loc	484.0	Lower	80.0	122.3	⬇	G		N
	ASCOF_3D	% People using social care in receipt of direct payments	Jun-2026	Loc	61.0%	Higher	19.0%	18.8%	⬇	R		N
Mental Health	MH001	MH Inappropriate OAPS (Bed Days)	Aug-2026	Nat	0	Lower	170	195	⬇	R	1	Y
	MH002	MH Patients No Criteria to Reside	Sep-2026	Nat	0	Lower	15	17	⬇	R	9	Y
	MH003	MH Long Length of Stay (% with LOS 60+ Days)	Aug-2026	Nat	0.0%	Lower	30.0%	30.0%	➡	R	7	Y
	MH004	Dementia Diagnosis Rate	Jun-2026	Nat	66.7%	Higher	0.0%	71.1%	⬆	G	7	N
Planned Care & Long Term Conditions	LTC001	% of patients with >20% 10-year CVD risk score treated with statins	Mar-2026	Nat	60.0%	Higher	67.4%	67.7%	⬆	G	5	N
	LTC002	% of diabetic patients received all 8 diabetes care processes	Mar-2026	Nat	100.0%	Higher	45.0%	61.1%	⬆	R		N
	LTC003	CKD QOF Registers (Currently Annual Only)	Mar-2026	Loc	4.41%	Higher	5.39%	5.78%	⬆	G		N
Primary Care	PC001	GP appointments - percentage of regular appointments within 14 days	Aug-2026	Loc	81.6%	Higher	82.2%	82.0%	⬇	G	5	N
	PC003	Antimicrobial resistance (% broad-spectrum antibiotic prescribing)	Jun-2025	Nat	10.0%	Lower	8.5%	8.6%	⬇	G	9	N
Urgent Care	UC001	A&E 4-hour Performance	Sep-2026	Nat	78.0%	Higher	71.7%	71.6%	⬇	R	2	Y
	UC002	A&E Attendance Rate per 1,000	Sep-2026	Loc	38.7	Lower	38.4	40.7	⬇	R	1	N
	UC004	2 Hour Urgent Community Response (First Care Contacts)	Aug-2026	Nat	70.0%	Higher	98.4%	98.1%	⬇	G	2	N
	UC006	Hospital admissions for alcohol-specific conditions (12M Rate per 100,000)	TBC									N

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

Refreshed: 13 October 2026

Achieving or Above Target Metrics

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

Priority	Code	Metric	Latest	Nat/Loc	Target	Aim	Prev	Curr	Perf	TA	GM	Focus
Prev. & Protection	PP009	NHS Health Checks Age 40-74 (Received a health check in last 5 years)	Sep-2026	Loc	36.0%	Higher	50.3%	51.1%	⬆️	G	5	N
Community Care	ASCOF_3D	% People using social care in receipt of direct payments	Jun-2026	Loc	0.6	Higher	0.2	0.2	⬇️	G		N
Mental Health	MH004	Dementia Diagnosis Rate	Jun-2026	Nat	66.7%	Higher	0.0%	71.1%	⬆️	G	7	N
Planned Care & LTC	LTC001	% of patients with >=20% 10-year CVD risk score treated with statins	Mar-2026	Nat	60.0%	Higher	67.4%	67.7%	⬆️	G	5	N
Planned Care & LTC	LTC003	CKD QOF Registers (Currently Annual Only)	Mar-2026	Loc	4.41%	Higher	5.39%	5.78%	⬆️	G		N
Primary Care	PC001	GP appointments - percentage of regular appointments within 14 days	Aug-2026	Loc	81.6%	Higher	82.2%	82.0%	⬇️	G	5	N
Primary Care	PC003	Antimicrobial resistance (% broad-spectrum antibiotic prescribing)	Jun-2025	Nat	10.0%	Lower	8.5%	8.6%	⬇️	G	9	N
Urgent Care	UC004	2 Hour Urgent Community Response (First Care Contacts)	Aug-2026	Nat	70.0	Higher	1.0	1.0	⬇️	G	2	N

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

Refreshed: 13 October 2026

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

Focus Metrics and Narrative

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

Priority	Code	Metric	Latest	Nat/Loc	Target	Aim	Prev	Curr	Perf	TA	GM	Focus
Prev. & Protection	PP005	National Screening Programme - Cervical - Standard Age 25-49 (Every 42 months)	Sep-2026	Nat	80.0%	Higher	72.9%	72.8%	↓	R	2	Y
Mental Health	MH001	MH Inappropriate OAPS (Bed Days)	Aug-2026	Nat	0	Lower	170	195	↓	R	1	Y
Mental Health	MH002	MH Patients No Criteria to Reside	Sep-2026	Nat	0	Lower	15	17	↓	R	9	Y
Mental Health	MH003	MH Long Length of Stay (% with LOS 60+ Days)	Aug-2026	Nat	0.0%	Lower	30.0%	30.0%	→	R	7	Y
Urgent Care	UC001	A&E 4-hour Performance	Sep-2026	Nat	78.0%	Higher	71.7%	71.6%	↓	R	2	Y

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

Refreshed: 13 October 2026

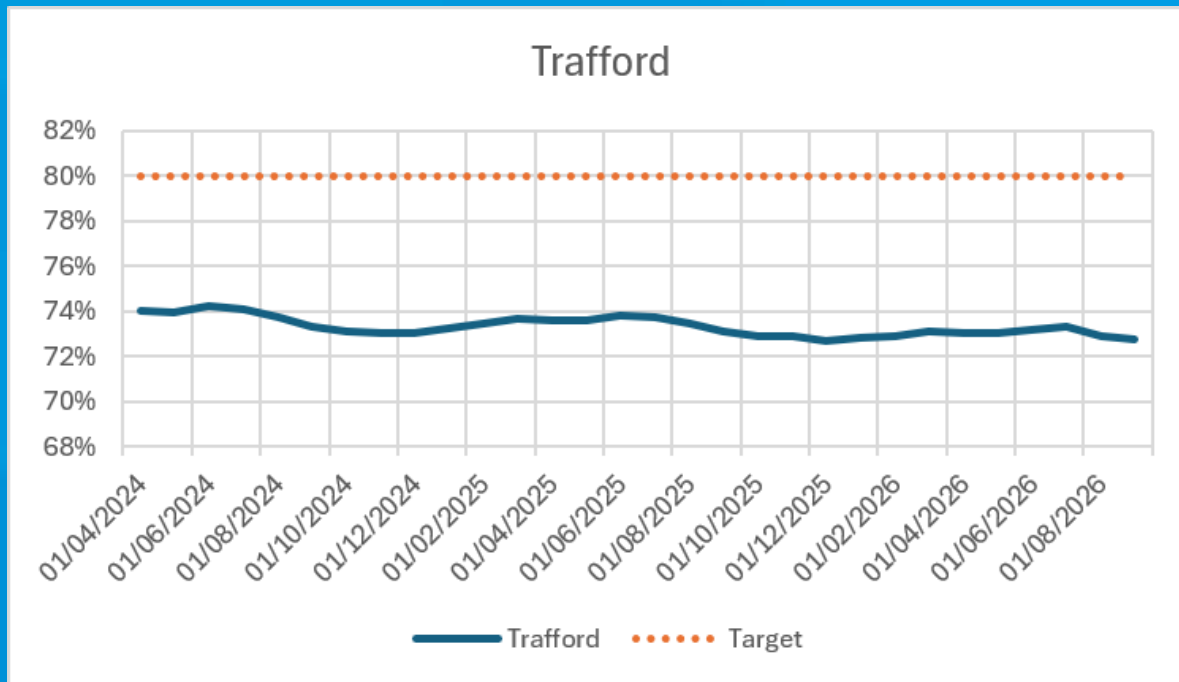
- Based on the identification of focus metrics we will coordinate a response from lead officers across the partnership and include narrative and mitigation that's in place, in the monthly report for FPS and/or TLB.
- On the following slides there is a more detailed position on each of the focus metrics, including rationale for identification, current performance and includes narrative where available from lead officers.

Priority – Prevention & Protection

National Screening Programme - Cervical - Standard (Age 25-49) (Every 42 months)

Focus Rationale

In September 2026 coverage showed a small decrease to 72.8% and has decreased from 73.1% over the same period in the previous year. This is below the target of 80%. The actual numbers behind the latest coverage are 22,019 women screened out of an eligible population of 30,257. To achieve the 80% target would require an additional 5,212 screenings.



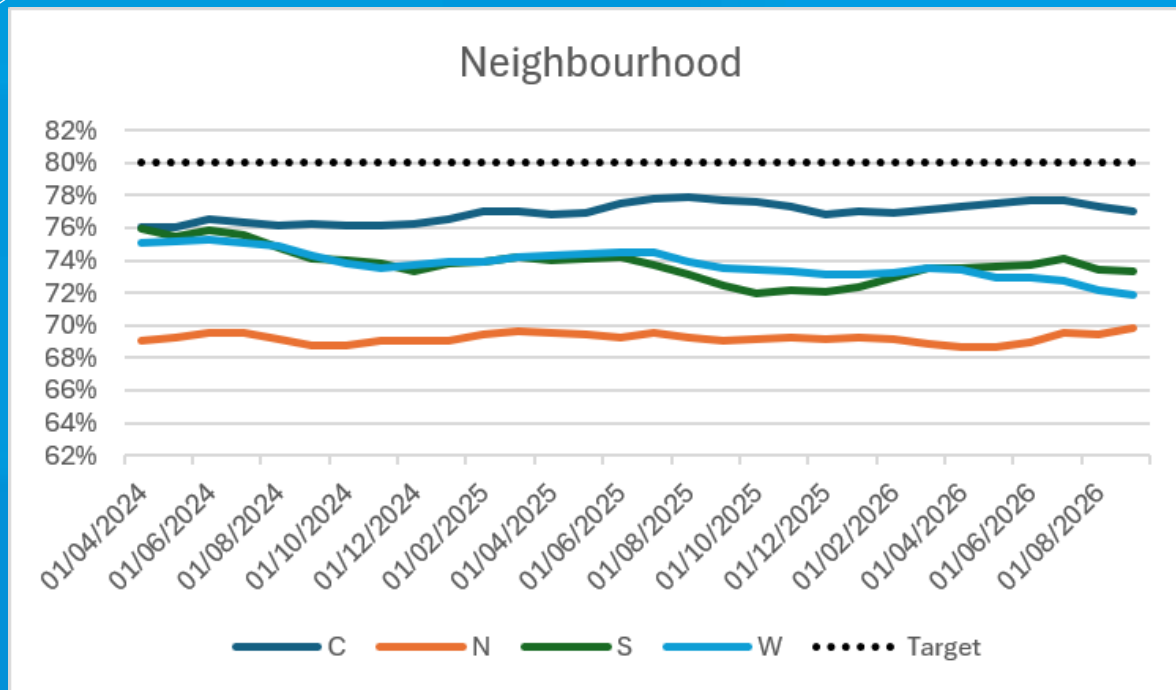
- Has shown a gradual decrease from 74.7% in June 2025 to 72.8% in September 2026
- Trafford's statistical neighbour in GM is Stockport Locality whose latest coverage is 74.3%
- Neighbourhood data is shown on the next slide

Priority – Prevention & Protection

National Screening Programme - Cervical - Standard (Age 25-49) (Every 42 months)

Focus Rationale

In September 2026 coverage showed a small decrease to 72.8% and has decreased from 73.1% over the same period in the previous year. This is below the target of 80%. The actual numbers behind the latest coverage are 22,019 women screened out of an eligible population of 30,257. To achieve the 80% target would require an additional 5,212 screenings.



- After a dip around January, coverage in North neighbourhood has improved and is now slightly above where it was in the same period last year.
- Trafford's statistical neighbour in GM is Stockport Locality whose latest coverage is 74.3%
- Additional narrative provided by Public Health colleagues is included on the next page.

Cervical screening was the focus item at the 14th October Trafford Locality Cancer Steering Group. The group is attended by PCN cancer leads, Cancer Screening Improvement Leads (NHSE); Trafford neighbourhood network lead; Public Health, ICB Trafford GM Cancer alliance reps and VBME. Barriers and enablers were discussed, including:

- Online booking, text reminders and extended access for nurse appointments at weekends and in evenings
- Education sessions for admin team – sharing between practices (West PCN sharing their approach to this)
- Answer Cancer Training on having difficult conversations and resources on NHS Future website promoted
- Outreach to Hong Kong Chinese community undertaken by Altrincham Health Alliance
- Escalation of issues re cytology to NHSE team
- Neighbourhood lead to connect with Family Hub leads to explore further opportunities through PPGs and Family Hubs to raise awareness and promote uptake

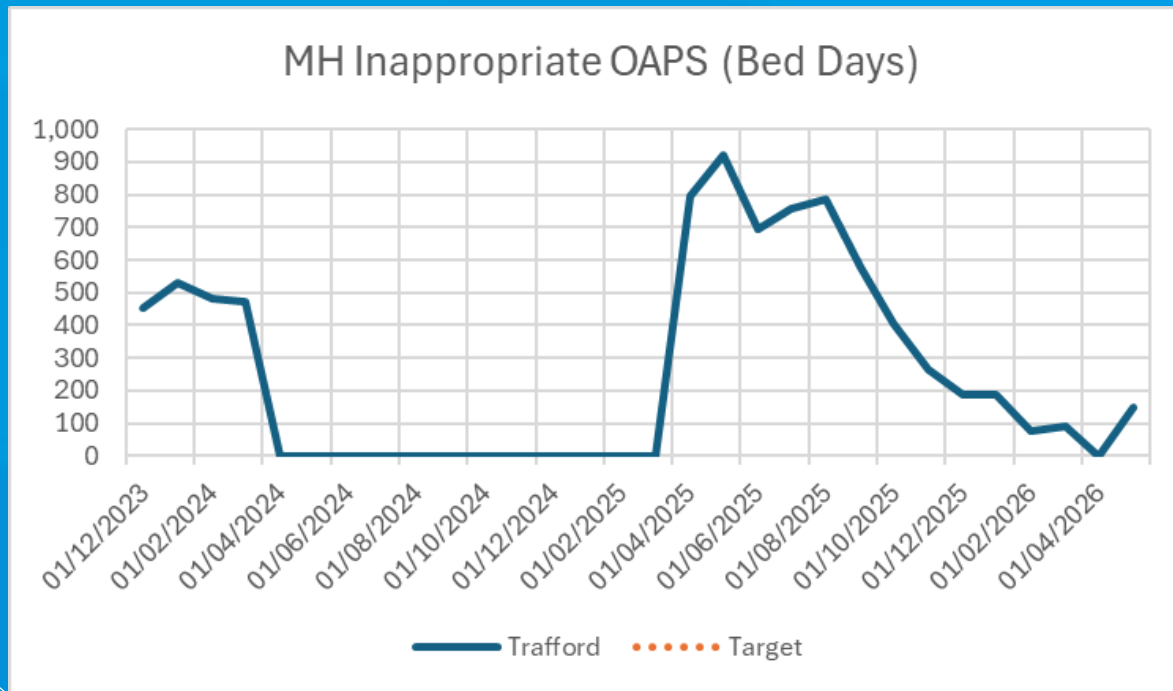
Screening performance was also discussed with West, North, Central and Altrincham Healthcare Alliance PCNs during October/November as part of Public Health/PCN meetings.

Priority - Mental Health

MH Inappropriate Out of Area Placements (Bed Days)

Focus Rationale

In August 2022, the number of bed days related to OAPS was zero. From this point the number increased to a peak of 920 (May 2025). Between May 2025 and August 2026 the number decreased from 920 to 195 (A decrease of 79%). To achieve 0 OAPs would require a decrease of 195 bed days.



The Mental Health Metrics on this and the following slides are linked to a Performance Improvement Plan for Trafford Locality which focuses on patients who are Clinically Ready for Discharge (CRFD) but whose discharge is delayed.

CRFD Locality 2025-26 Targets

- GM overall target is 25% reduction
- Trafford target is 33% reduction
- Includes Adult Acute only (clarified by GM 31/07/25 – this is a change to last year).

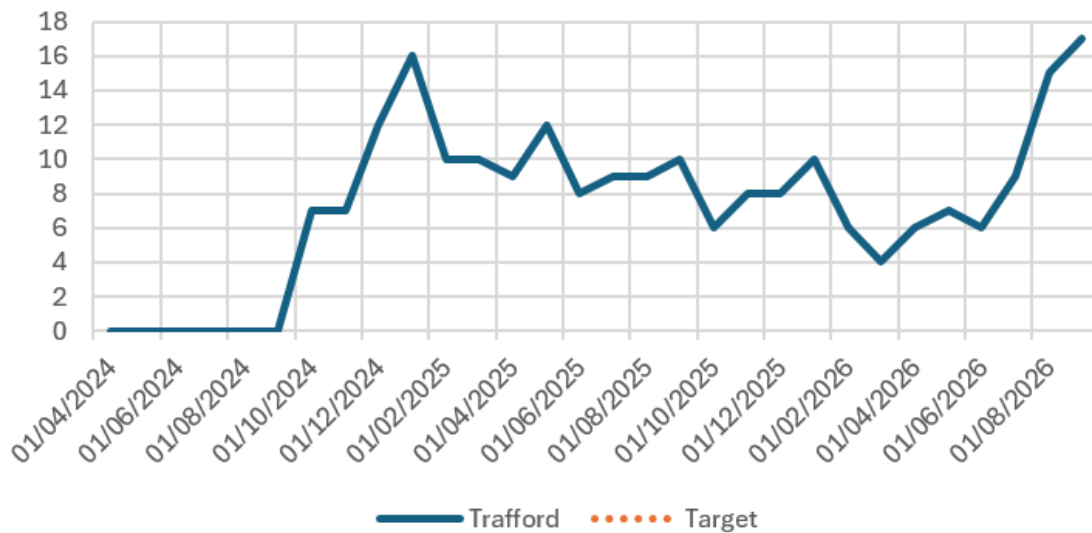
Priority - Mental Health

MH Patients No Criteria to Reside

Focus Rationale

The number of patients with NCTR in September was 17, this is higher than the previous peak of 16 in January 2025. To achieve 0 patients with NCTR would require a decrease of 17 patients

MH Patients No Criteria to Reside



CRFD Locality 2025-26 Targets (continued)

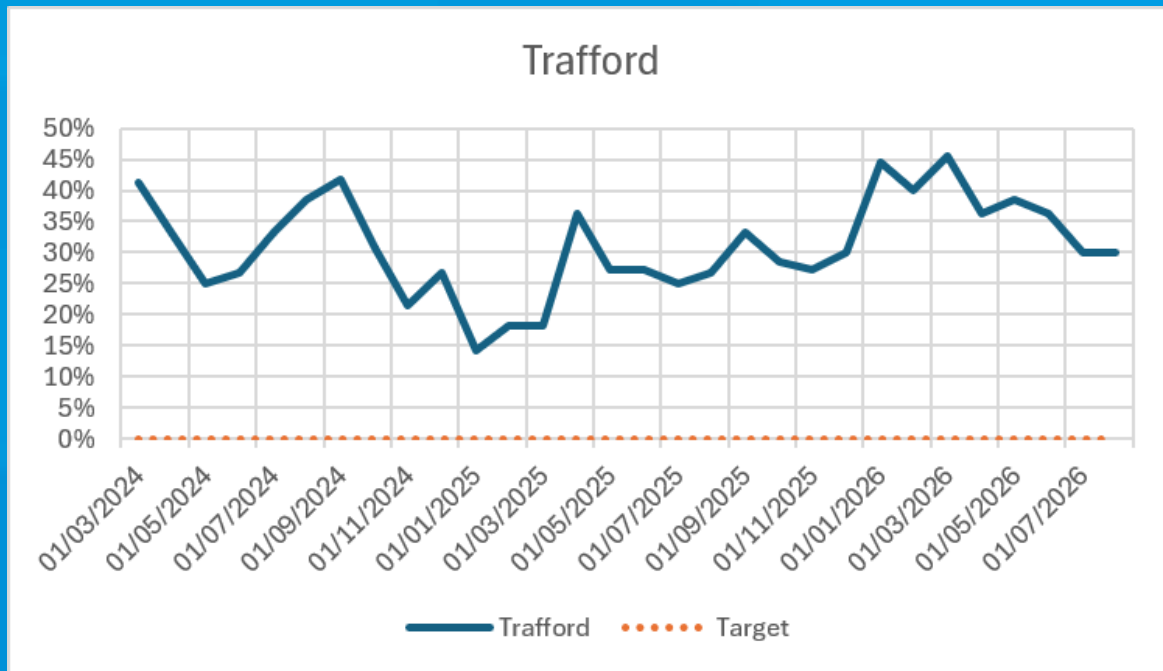
- Older Adult CRFD are not included in this target (but should still be tracked locally).
- Rehab CRFD are not included in this target (but should still be tracked locally)
- Trafford's 33% reduction equates to no more than 2080 bed days lost to CRFD between April 25-March 26.
- This requires an average of no more than 5.7 people who are classed as CRFD in adult acute beds per day.

Priority - Mental Health

MH Long Length of Stay (% with LOS 60+ Days)

Focus Rationale

In September 2024, the percentage of LLOS over 60 days was 41%. This has decreased to 30% in August 2026. The actual numbers behind the latest rate are 15 (LLOS 60+ days) out of a total of 50 LLoS. To achieve 0 patients with LLOS 60 days would require a decrease of 15 patients.



Overall progress

- The number of bed days lost to CRFD has been trending downwards in recent months, from a peak of 45% in March to 30% in the most recent data.

Narrative (Continued)

Overall progress

Other 3 have plans in place for discharge ASAP.

We hold weekly MADE meetings where all CRFD are discussed, and plans agreed.

Plans

Ensure Trafford MADE meeting agenda focusses on the oversight of people who are CRFD, including:

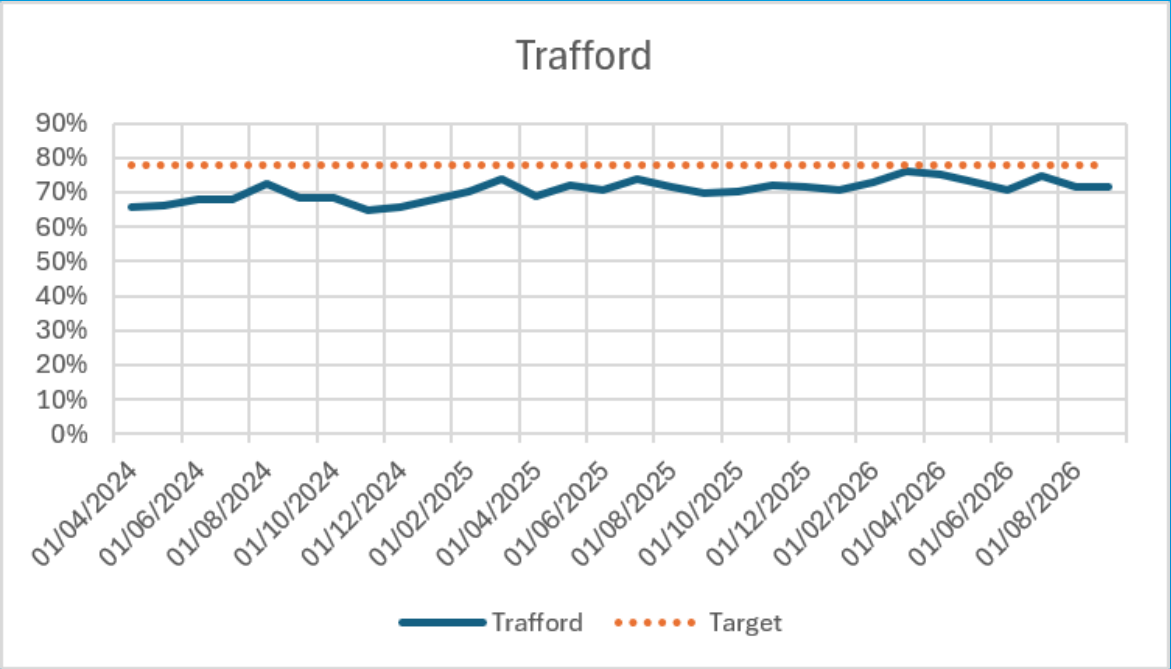
- Complex cases
- People with a Learning Disability and/or Autism
- Joint funded cases, and
- Length of stay and readmission rates
- OAPS

Consolidate block purchase of rehabilitation beds from Wigan and Salford localities to bring Trafford patients closer to home, achieve better value and maximise available capacity.

Priority – Urgent Care A&E 4-hour Performance

Focus Rationale

In July 2026, the 4-Hour performance rate was 74.9%. This declined to 71.6% in September 2026. The actual numbers behind the latest rate are 5,743 patients seen within 4 hours out of a total of 8,023 attendances. To achieve the target of 78% would require an additional 515 patients to be seen within 4 hours (based on September figures)



There are several initiatives either currently in place or planned to help improve A&E 4-Hour performance. The following summary is provided by the Trafford Urgent Care lead:

- Care closer to home initiatives (routes from discharge back to Single Point of Access)
- System Visibility & Active Leadership Programme progress, risks and milestones
- Urgent Emergency Care Horizon Point 2 Development (Newton Europe)
- Key System Intervention Points Building a community model & intervening at the right point

(Narrative is continued on following slides)

Narrative (Continued)

- New capability offering Activity that can be removed from the hospital that can happen in the community – evidence the impact through case reviews on capabilities that would have prevented an escalation in need
- Pull model Creating visibility of a patient's journey so community services can 'pull' patients who are considered 'complex discharges
- Refreshing of Manchester and Trafford Operational Delivery Group TOR to allow collaborative problem solving for transition points in the system (e.g. discharges/SpOA single point of access)
- Ensuring escalation and resolution if 'Inappropriate transfer of work to GP' as per joint chief medical officers joint working group 4 principles nationally mandated, 'complete care
- Complete care (fit notes and discharge letters): Trusts should ensure that on discharge or after an outpatient appointment, patients receive everything they need. Therefore, where patients need them, fit notes should be issued for the appropriate length of time to avoid unnecessary return appointments to General Practice. Good quality handover is pivotal to ongoing care
- Daily PTLs (Patient Tracking) meetings

Narrative (Continued)

- Establishment of the new Trafford High Intensity User Scheme as part of the Primary Care Quality Contract
- Daily MADE in place with GMMH and partners, to support internal and external next steps actions
- For those patients where there are specific barriers, a meeting is set up to discuss the barriers and potential options and these will involve the patient's MDT, local commissioners, and senior system leaders
- GMMH patient flow service (PFS) ensures that a standardised approach is delivered across all GMMH services with practitioners available 24/7 to support system flow to all GMMH beds
- Senior Gate Keeping Initiative- to support and promote least restrictive community crisis options and to prevent delays in people requiring specialist mental health inpatient care when accessing A&E. The role has been evidenced to reduce the conversion rate for admissions, therefore supporting people to remain in the community with the appropriate care. When admission is required the implementation of the purposeful admission framework will support effective and efficient inpatient admissions.