Salford
Integrated Care Partnership

Agenda

Salford Integrated Care Partnership Committee

Date: 25 June 2026

Time: 9.00 am to 12.00 pm

Venue: Salford Suite, Civic Centre & Microsoft Teams

Chair: Dr Tom Regan

Item No.	Time	Duration	Subject	Paper/ Verbal	For Approval / Discussion / Information	By Whom
1.	9.00	10 mins	**Business As Usual:** a) Apologies and Declarations of Interest b) Minutes of Previous Meeting c) Action Log and Matters Arising	Verbal Paper Paper	Discussion Decision Discussion	Chair Chair All
2.	9.10	60 mins	**General Items** Adult Mental Health Update	Paper	Assurance / Information	Director of Adult Commissioning
3.	10.10	5 mins	**System Updates** a) System Partner Updates b) Place Lead Report	Verbal Paper	Information Information	All Place Lead
4.	10.15	5 mins	Any Other Business	Verbal	Discussion	All
	10.20	10 mins	**Break**			
5.	10.30	90 mins	Informal Session to discuss Future Place Partnership Arrangements	Paper	Decision	Delivery Director for Health and Care Integration
6.	12.00		Date and Time of Next Meeting: **To be confirmed**			

Salford
Integrated Care Partnership

Minutes

Salford Integrated Care Partnership Committee

Date: 26 February 2026

Time: 9.00 am to 12.00 pm

Venue: Microsoft Teams / Salford Suite

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Present

- Paul Dennett, City Mayor (PD) (*Chair*)
- Alison Page, Chief Executive, Salford Community & Voluntary Services (AP)
- Ben Whalley, Chief Executive Officer, Gaddum (BWh)
- Claire Vaughan, Associate Director of Clinical Leadership & System Integration (Salford), NHS Greater Manchester (CV)
- Diane Morrison, Director of Finance, Northern Care Alliance (DM)
- Elaina Quesada, Interim Director of Adult Social Care Operations, Salford City Council (EQ)
- Elaine Vermeulen, Associate Director of Finance (Salford), NHS Greater Manchester (EV)
- Elliott Patrick, Wider Primary Care Services Representative (EPa) *part attendance*
- Gillian McLauchlan, Interim Director of Public Health, Salford City Council (GMc)
- Hannah Dobrowolska, Delivery Director for Health and Care Integration (Salford), NHS Greater Manchester (HD)
- Harry Golby, Associate Director of Delivery and Transformation (Salford), NHS Greater Manchester (HG)
- Jim Cammell, Lead Member for Children's and Young People's Services (JC)
- Joanna Fawcus, Chief Officer / Director of Operations, Northern Care Alliance NHS Foundation Trust (JF)
- John Merry, Lead Member for Adult Social Care and Health (Deputy City Mayor responsibilities for LGA & Key Cities) (JM) part attendance
- Melissa Caslake, Executive Director of Childrens Services, Salford City Council (MC)
- Michelle Richards, Associate Director of Performance & Strategic Development, GMMH *on behalf of Liz Calder*
- Rachel Rosewell, Chief Finance Officer (S151), Salford City Council (RR)
- Sam Cook, Chief Officer, Healthwatch Salford (SC)
- Samuel Russell, Strategic Head of Finance for People (Children's and Adults) (SR)
- Sapna Tandon, Primary Medical Services Representative (ST)
- Stephen Young, Chief Executive and Place Lead, Salford City Council (SY)
- Tom Regan, Associate Medical Director, NHS Greater Manchester (TR)
- Tracy Kelly, Statutory Deputy City Mayor and Lead Member for Housing and Anti-Poverty (TK)
- Victoria Halliwell, Dean / Professor of Industry Collaboration in Health Care Education, School of Health and Society, University of Salford (VH)
- Elaine Redwood, Admin Support, NHS Greater Manchester (Minutes) (ER)
- Di Critchley, Engagement Officer, Salford City Council (for patient story) (DC)
- Chris Upton, North East Sector Lead. Head of IT & Assurance - NHS Heywood, Middleton, Rochdale & Salford. NHS Greater Manchester Integrated Care (item 5a) (CU)
- Mark Hicks. IT Operations Manager (Heywood, Middleton & Rochdale), NHS GM (item 5a) (MH)
- Joanne Farrell, Head of the City Mayor's Office (observing) (JFa)

Observing

Julie Dickinson, Strategic Healthcare Partner, Health & Medical Strategic Healthcare Team ***(member of public observing)***

Apologies

- Becky Wilkinson, Executive Director for Adult Social Care & Health Partnerships, Salford City Council (BW)
- Colin Scales, Deputy Chief Executive, NHS Greater Manchester (CS)
- Councillor Jack Youd, Deputy City Mayor & Lead Member for Finance, Support Services & Regeneration, Salford City Council
- Mishal Saeed, Executive Support Member for Social Care and Mental Health (MS)

Item No.	Topic	Action
1.	**Welcome, Introductions and Apologies** PD welcomed everyone to the meeting and the above apologies were noted.	
2.	**Patient Story** Deferred.	
3.	**Declarations of Interest** PD reminded board members of their obligation to declare any interest they may have on any issues arising at the meeting which might conflict with the business of the Locality. None were declared.	
4.	**Minutes of Previous Meeting, Action Log and Matters Arising** The minutes from the meeting held on 29 January 2026 were approved. Updates had been provided against the outstanding actions on the log. There were no matters arising.	
5.	**Annual Reports** a) **Information Management & Technology (Digital) Annual Report** CU mentioned the report provides an update on digital IT and delivery across Salford and Primary Care for 2025/26. During which, the focus was largely on maintaining operational stability whilst aligning programmes to the model ICB Blueprint, modern general practice and the NHS GM Reforms. The reforms have meant that various changes have been necessary and Salford is now managed through the North East Sector team (Bury, Rochdale, Oldham and Salford model) for which CU is the lead. The NHS Reform implementation has required significant realignment of the digital portfolios meaning some programmes have been ended, paused or slowed to protect statutory functions and to support GM-wide financial recovery. In 2026/27 the number of NHS GM funded solutions will be streamlined and practices need to submit an Expression of Interest in terms of which system they want to use in the future. In terms of system-wide information sharing, work is continuing around system integration and they are working on getting the children's feed into the GMCR by the end of March. EPaCCS engagement has been relaunched as part of a GM and sector-wide approach. There is no incentivisation around this, but it delivers benefits to patients in terms of improved outcomes, and to practises and partners in terms of resource savings. Health Innovation Manchester are working on a benefits realisation report around this, which will be published in the coming months. 2026/27 priorities include post-Reform delivery of the NHS Blueprint, continuing to support modern general practices through targeted digital support programmes including workflow optimisation, improved GPaCCs accuracy, practice telephony optimisation around cloud-based telephony platforms, website audits, and ongoing LIMS deployment with the NCA for Pathology. They will also continue to support safe AI and RPA adoption and continue to provide support for the online consultation framework, the procurement and the transition process and the move across to patient access to records. TK asked if this was always programmed in for this to happen and whether the additional costs being borne by others have been considered. PD believes this is being driven by the 10-Year Plan and mentioned he had seen that c£10bn is to be invested in NHS technology up to 2029 and yet these challenges are being raised here. He queried what are GM receiving from this national government commitment. CU explained it is complex and not yet known. They have specific allocations per head of population for specific disciplines, but don't have a holistic overview. AP mentioned digital exclusion is an issue with the shift from analogue to digital and suggested that the VCSE can help with this. However, there is no money going into the	

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sector for it. She queried what is the system approach to this, as we need to understand where the money is going, especially in relation to getting the various systems talking to each other and digital connectivity. TR also mentioned an issue around Primary and Secondary Care clinicians having different functionality within the GMCR relating to Prescribing and this is causing issues. It is his understanding that Kenny Li is doing some work around Shared Care Medicines but would like an update on where this is up to.

CU isn't aware of the work being done around Shared Care Medicines but agreed there is a disconnect between Primary and Secondary Care IT solutions. ST reiterated TR's point around Shared Care. She also mentioned workflow optimisation and that the current system doesn't work effectively. She asked what work is being done on this. CU mentioned, in terms of workflow optimisation, this is around reducing tasks or automating them. They are also looking at using automation/AI for some of the workflows in order to reduce the number of outstanding tasks and save time. There are some new market entrants/pilots of single system platforms that will help with this. However, the systems need to integrate and further work is needed on this. There is a piece of work being undertaken in the Digital Facilitation space to help practices improve some workflows.

ST mentioned that the responsibility of clinical safety officers has been passed onto GP practices and there are associated costs with Robotic Process Automation/AI. She asked how the team will ensure that the clinical safety officers at smaller practice level and larger practice level have equal competence, to ensure safety for the patients when passing these clinical safety officer roles to the practices. PD stressed there is an urgent need for significant engagement on this, so that we are not storing up problems in the future. MH mentioned the point around clinical safety officers is difficult, as it is a legal requirement for the deployment of any new medical devices, software or AI devices and is around how the practices will deploy them, therefore it is a GP responsibility. Some training is planned in July/August to support practices and the ICT team will also undertake the training in order to support practices.

In relation to integration of the way the system works, the GMCR brings together Primary Care and Acute practitioners. Adult Social Care is also connected and they are looking at adding Childrens into this. Community Pharmacies are increasingly being connected and Care Homes are also being brought in. There is a constant state of evolution around this in relation to collaborative working across GM. Integrating the VCSE is also in the pipeline. However, it will take time as it needs to go through a robust IG framework. A benefits report in relation to the GMCR is currently being worked on and this will be available to share. The reason for doing this is the national drive by NHS England around the NHS app. However, we have to accept that there are some accessibility issues around this and how socio-economic data affects digital access and also how that links in with outcomes. It is complex due to the amount of interconnected parts.

PD queried how we are engaging as a system as a part of this work and how is it being brought alive with the people using the systems in Salford. It feels as though the human interface isn't there. More engagement is needed and we need to get into the data that sits in the system to understand what is happening. He suggested that Health Innovation Manchester could be invited to this committee to present the GMCR benefits report.

HD highlighted that this annual report should be a whole partnership update, not just NHS focused. We need to have a whole partnership digital update, as we do for Estates. Benchmarking of the NHS app uptake would be interesting to see, as we have an opportunity across the partnership to increase uptake. She asked partners to commit to undertake more work on this by creating a delivery board (similar to the

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	Strategic Estates Group). This was not an agreed area of focus to date but feels like a must do as it cross-cuts all 3 agreed areas of focus. PD stressed that a quick response is needed around Safeguarding i.e. PARIS, Local Authority and Health systems talking to each other. ASC Directors are not assured from a Safeguarding point of view. MH mentioned that all systems have access to the GMCR which shows a holistic view of the patient's care. However, it doesn't write back to the systems supporting it. If 2-way integration is needed in the system, then the GMCR is not what this is for. Instead it is a tool to support clinical decisions to be made. However, if there are any specific needs regarding hand-over between teams, then these can be passed to the ICT team to look at. MH mentioned there is an aspiration to add alerts to the GMCR. EQ stressed the need to be mindful around what is the purpose of information sharing and what are the benefits to Salford patients. We also need to consider how the information works. A practical discussion is needed on how we can improve the system for frontline practitioners. A discussion is needed with MH and Information Governance on how to improve the system and this this can be taken to the GMCR Group for roll out across GM. GMc asked if there was any benchmarking data available in relation to the NHS app uptake, as 66% means we are not reaching nearly half of the population when using it as a means of communication. Need to engage with Stephen Fry on this. ***The committee noted the contents of the report and supported the broad aims of delivering digital themes to primary care services in the Salford locality.***	
6.	**General Items** **a) Update on Urgent and Emergency Care / Winter Planning** It was noted that this was an annual update. Any comments can be provided to HG. ***The committee noted the contents of the report.*** b) **Adult Social Care (ASC) Overspend** RR mentioned that the Northern Care Alliance (NCA) had written to Salford City Council (SCC) and the ICB to highlight an overspend on the Health and ASC contract of initially c£10m and to request support. An open book approach was agreed to understand the overspend. Most of the reasons behind the overspend were already known i.e. packages of care and a lot of work has been done, with the ask now being £8.2m (to be funded through the risk share arrangement). The report provides details of how the contract is split between SCC and the ICB and where the overspend lies i.e. cost of care, individual packages, not all savings targets being met etc. SCC are taking a request for an increase to the contract for £6m to Cabinet and then full Council for the council's element of the risk share. PD queried if the reasons behind the increase in care packages and cost of care have been looked at in detail. We need to understand the reasons behind the increases and clarity around the process of agreeing the packages that are being entered into is needed, as the council have a responsibility to manage the market. The volume of care packages is also an issue. TK declared an interest as the Lead Member for Housing. JF mentioned that all packages go through due diligence and there is an Assurance Framework which all decisions go through. Fee increases have also contributed to the overspend. PD asked if we have been benchmarked across comparable Local Authorities. DM highlighted that standard fees are set through the locality and in terms	

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of benchmarking, Salford is at the lower end for the standard fee we pay for residential care. Each request for a package is reviewed by a professional social worker, and a decision is then made. There is a robust scheme of delegation which has been set up recently for packages of care recommendations. Team managers can approve up to £700 – £1000 per week. Heads of service can authorise up to £3000 a week and anything above this goes to the DASS for sign off. They are as compliant as they can be in terms of professional scrutiny and oversight. Unfortunately, out of area placement costs are out of their control.

EQ highlighted that there is more that can be done on this. Better joined up working is needed both operationally and commissioning-wise in terms of market shaping. The Improvement Plan includes key actions on being more robust collectively on this. More needs to be done around prevention. A redesign programme and long-term plan is needed to create a framework with providers in order to negotiate the best price possible. A round table discussion on Supported Accommodation is needed as soon as possible in terms of bringing provision back into the city. Consideration on how we move forward on this is needed, as we need a strategic approach.

BWh highlighted that there are some complex individuals within the area and the VCSE would welcome getting into the details of this in terms of planning care. We need to connect people back to their communities. He would be happy to be involved in this work. PD stressed the need to keep people active in communities and out of residential care etc and placing people out of borough doesn't deliver on this commitment. There is a need to get into the data on these care packages and align with TK around the Supported Accommodation round table.

EQ highlighted that the main issue is not out of area placements, as the numbers are low. The issue is how we are managing the volume of patients for homecare/residential and we need a different approach. Market shaping is also an issue and we need to take action. TK agreed it is not about out of borough placements, but the need to improve what we have in the city. Preventative measures are not there and we need to get better in what we do. A strategic approach is needed and we need to get into the data.

TR mentioned some people in Salford are already in care packages which can't be changed, but we need to discuss preventing people getting to the point of needing packages of care. At the last meeting, we agreed a priority around Frailty and how we work with the community around not getting to the point of going into hospital and needing care packages early on. He has since attended a meeting at the Bevan Unit regarding moving to a 'step up' space for care. We need to consider how the prevention work is leading on improving care for people and making savings at the same time. We also need to manage the social care market in the city whilst also delaying people needing care. We need to support people around waiting well and look at what we are doing to help people not to need care.

TR doesn't feel that cost shunting is the issue here. We have a system that holds onto people in the system longer than we should. We need to think about getting people out of hospital sooner and about preventing them going in hospital in the first place. PD suggested it would be useful to get into data re re-admissions for those with care packages and also understand how long they live after being given a care package. Assurance around what is happening is needed.

AP highlighted this is an interesting conversation around where the investment is going, but we are not thinking about how people live in communities and how we invest more in this. We have previously talked about transport, the befriending service and the role community centres can have, but the cost of loneliness is underestimated. There is no continuity of investment. We need to consider what is already in the city and whether it

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	is right/in the right place. TK mentioned that we have talked about prevention and Live Well, but we need more support for the socially isolated and carers, and we need to improve the support on offer. TK would welcome working with someone on this. PD mentioned, in terms of the continuity issue, he followed up on Live Well with Andrew Lightfoot at the GMCA and he said they have committed to 3 years' funding of Live Well from 2025/26 and how the money is distributed is a matter for Salford. GMc queried if this is just the GMCA allocation or the totality of money for Live Well. This needs double checking. ***The committee:*** • ***noted the finance position of the Adults Social Care contract based on the month 9 (end of December) forecast from the NCA.*** • ***noted the finance risk to both commissioning partners through the risk-share arrangement within the Integrated Fund.*** • ***noted the content of the report and supporting appendix for information and assurance.*** c) **Voluntary, Community and Social Enterprise Strategic Update** Deferred. d) **Place Partnership Development** HD asked if the committee are happy to move to sister board arrangements between ICPC and the Health & Wellbeing Board. PD believes this is positive news. It is proposed that there will be 4 meetings per year of each board, with August being cancelled and the remaining 3 meetings being for informal sessions. PD agreed that anything we can do to streamline bureaucracy is welcomed, but we need to ensure that people aren't disenfranchised as a result. AP queried where the 2 Pride in Place Partnerships would report to (HWBB or Skills & Work). PD agreed this is a good point and there is a need to make sure they are properly integrated. GMc mentioned the proposal is to align the 2 boards (HWBB and ICPC) with the same chairs and then look at the other boards/groups that sit underneath. This is about trying to ensure the right items are being discussed in the right forums. There is an opportunity here to create something bigger than sum of all parts. GMc mentioned it is proposed that one of the informal sessions each year would be used as a Citizens Assembly. ***The committee:*** • ***noted the contents of this report.*** • ***agreed to the proposals outlined in section 3.4 of this paper and specifically around the creation of a 'sister committee' approach.*** • ***provided comments in relation to the proposals outlined around future Place Funding and Place Team arrangements.***	
7.	**System Updates** a) **System Partner Updates** • EQ mentioned ASC and the work around Programme Unify. This starts with Aspire coming back into SCC on 1st April. Onboarding is taking place and discussions around TUPE are being held. SCC are also working to transition NCA and GMMH colleagues in 2 stages and are at the point of agreeing a project plan. NCA staff based in GMMH are phase 1 and the target date for this is 1st June. The 2nd stage is staff within the NCA and they are aiming for the beginning of October for this. As part of this, discussions are taking place around the statutory responsibilities of the organisations. PD asked if the Prevention Demonstrator, Live Well and 10-Year Plan have been considered around this. EQ confirmed they have and further work is being done on the model with key organisations leading on areas most suited. Discussions have also taken place around what happens following the transfer of the 1000 staff this includes the transformation of the delivery model in order to	

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operate differently going forwards.

AP mentioned that Aspire is a separate charity organisation and there are some sensitivities around the decommissioning of a well-respected organisation and then TUPE'ing staff across. EQ mentioned that honest and open conversations had been had around this and they are hopeful that all the good work which Aspire has done will be retained and built upon. EQ believes they will be in a better place in terms of relationships going forward, especially in relation to Prevent, Reduce, Delay. PD highlighted it was great to hear of the developments made, as this was a commitment he made in his manifesto and the people of Salford voted for it. He highlighted that this doesn't mean that SCC won't commission more 3rd sector services going forward in relation to ASC.

- SC provided an update on Healthwatch. They have been working with commissioners in Salford and a workshop was held in February around the future of the independent patient voice in Salford. She highlighted that Healthwatch Salford will be in place until the end of March 2027 and committee members are welcome to feed into the ongoing engagement via Di Critchley. She mentioned the projects which Healthwatch have been working on and these included the Salford Adolescent Minds update, Vaping in Salford and their next area of focus is on Salford Veterans' experiences of ASC.

  PD stressed it is great that there is some certainty until the end of March next year, but queried how the system is working to provide further certainty. He suggested that HD picks up how we take this forward after next year. HD queried who this should sit with, EQ confirmed it would be her in terms of the partnership ASC want to create with the VCSE. However, we need to recognise the amount of work needed to get into a better place on this. We need to knit this into the co-production work with carers and work closely going forward. PD queried if there is an interface with GM on this. EQ confirmed there is a GM DASS function, so this is being considered in terms of working strategically on this. PD requested that ASC is discussed more at this committee. GMc is working with AP on this.

- MR provided an update around GMMH and mentioned that they were required to submit a 5-year Integrated Care delivery plan and she would be happy to share a copy with the committee and talk to it at a future meeting. MR met with CV and the team around their plans in terms of the Neighbourhood Plan. They have also been dealing with a critical incident where a property was flooded, which has meant a pressure on beds and the re-siting of patients.

  PD mentioned that there hasn't been any engagement with the committee on the 5-Year Plan before it was submitted. MR explained it had been submitted at a national level and that meetings with Locality Leads had taken place. However, it hadn't been brought to this committee due to the short turn around, but it will be an iterative plan. PD stressed this needs to be engaged upon as soon as possible. It feels as though GMMH are remote on this meeting and is concerned the work previously done on the Living Well model in Salford around Mental Health may potentially be undone. This will have a significant impact on the VCSE sector. **Action: GMMH to present the 5-Year Plan at the next meeting.** PD also noted the different Mental Health strategies and the need for coherence between them. MR is working with Pennine on theirs to try to align them. — **MR**

b) **Place Lead Report**
SY presented the paper and highlighted the organisational change around the GM system in terms of the impact on workforce in Salford whilst reducing running costs. JM mentioned this was discussed at the recent Health Cabinet meeting and concern was raised around the effectiveness of what is being suggested in terms of the cutback

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of staff. It was raised that this appears to be being done in order to retain staff in the centre, but we also need locality staff and we need to keep a close eye on this. SY explained that conversations are taking place in relation to this and he is aware of these issues/concerns.

PD asked where the ICB are up to in terms of Voluntary Redundancy (VR) and organisational form and whether locality staff will move to the Local Authority, stay within the ICB or move to another organisation. SY explained this was discussed at an Exec meeting last night, but they are not yet in a position to agree a decision.

HD explained that the VR1 process is complete. In terms of VR2 the panel have met and most have been agreed, but there are some pockets of staff which can't be agreed due to Business Continuity. It is expected that the majority of VR2 applicants will leave the organisation by the end of March. Final structures are due to be published on 11th March. By the end of March, we will know what the next phase is for each individual remaining staff member.

PD queried if this was just relating to the ICB Reform or whether it also included the changes at the NCA. HD confirmed this just related to the ICB. PD mentioned his reason for asking these questions is in order to seek assurance that the ICB is trying to hold onto the most skilled/competent staff to take us forward. He would be interested to see a split of who is retained/not retained as he doesn't feel that he has been assured around who is being retained. We need to safeguard ourselves in this process.

JF explained that the NCA ran a MARS scheme in the summer. This involved staff submitting applications, which were then reviewed by each Care Organisation. An Exec Overview Panel then reviewed the applications and raised any questions with the relevant organisations. There was then a panel which made the final decisions and staff were then contacted to check if they still wanted to proceed. The whole purpose was to not lose clinical staff who were still needed.

AP highlighted that Salford is a relational place and she requested that details are provided regarding which staff will be leaving, so they can wish them well. She also mentioned that the VCSE had made an offer to GM to discuss a possible option for parachuting some staff into the VCSE with a view to retain skills and expertise in the system.

TK mentioned the financial envelope and asked what this now looks like. It was noted that this shouldn't be just looked at through the finance lens, as challenges might be different across the localities. TK stressed the reason we are in this position is because of the finances. SR highlighted there are wider implications of the process i.e. is decision making consistent.

RR mentioned a paper is going to the GM Treasurers Group tomorrow from the ICB. There are ongoing discussions about a Locality Grant. Her concern is that Local Authorities might be asked to administer the Grants but won't have much control over the decision making around them. It is proposed that individual placement budgets are centralised and this doesn't seem to make sense. MC supports RR's point as she doesn't understand the logic around Individual Placement commissioning being retained at a GM-level. PD stressed the need for an action from this, as we need to be meaningfully engaged. SY explained there is now a sequence of meetings to discuss issues arising from this. HD stressed the need to focus on things which are in our control, as we have a lot of influence in this room around Saford decisions.

In terms of the HR processes, HD mentioned that the ICB have been following HR/legal processes and Unions have been involved. ICBs overall are having to make

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	50% cuts, with GM needing to make 39% reductions. PD stressed that the assurance he wants is around retaining skills and competency. HD stressed that some information has not been shared yet relating to the totality of the changing shape of the organisation. PD asked if there had been any implications for the ICB Board as part of this process. HD is not aware of any changes to the Board, but there have been 2 reductions within the Exec Team. SY mentioned that Place Leads are pushing for assurances, and regular meetings are now in place. JM queried if there was a template being applied from Whitehall regarding how many staff are needed in each area. Some assurances have been received from Andy Burnham that he is engaged with the Secretary of State around this, but more assurance is needed. A plan needs bringing forward which is acceptable and has democratic structure to it. HD stressed that it is really important to give credit to the ICB and Board in terms of their approach to localities. There isn't a template and therefore ICBs are taking different approaches. Unlike others, GM is putting a lot of effort and focus on Place. BWh mentioned the main concerns the VCSE have are around the diverse populations they support. There have been positive conversations between the VCSE and ICB regarding investment in the sector. However, they need to know the destination of portfolios when complete, as there may be short and medium-term barriers to services. PD mentioned the positive news that SCC passed the budget to ensure all VCSE contracts will be uplifted for the Cost of Living. In terms of commissioning intentions, he feels this is undermining what has been in place in Salford for years by adopting a one size fits all approach. AP highlighted that there are some good signs regarding proportionality and balance and decision making, but there is a lack of consistency. She would also like to be involved. GMc stressed the need to understand how localities are involved in all GM systems and the decisions around the spend. ***The committee:*** • ***noted the contents of the report.*** • ***agreed to disseminate and cascade the necessary key messages and information as appropriate.***	
8.	**Any Other Business** None.	
9.	**Date and Time of Next Meeting:** The meeting closed at 12.06 pm. The date of the next meeting is to be confirmed.	

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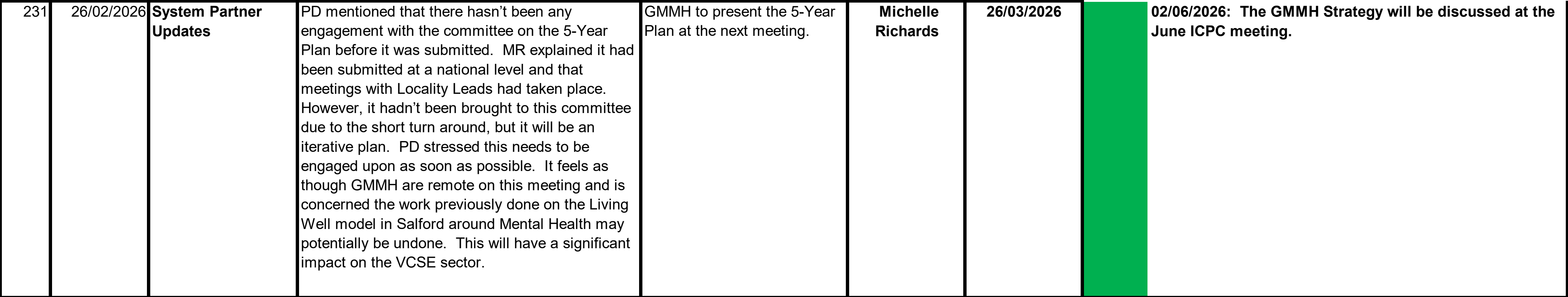
Actions Log: Salford Integrated Care Partnership Committee (previously Locality Board)

No	Date	Section	Details of the issue	Details of action agreed	Action Lead	Timescale / Deadline	Status	Update
172	27/03/2025	**Place Lead Report**	GMc mentioned that the expansion of the blood borne viruses testing is good, but she highlighted that there are different funding streams for each and we need to recognise this and the different patient pathways.	GMc to contact Jane Pilkington around this.	**Gillian McLauchlan**	**26/02/2026**		17/4/25 - Jane Pilkington now left NHSE so GM will pick up conversations with Alison Pye at GM 24/4/25 - In respect of blood borne viruses Salford Royal Emergency Department tested for Hepatitis C but not Hepatitis B because of pathways and capacity. A solution for this was being discussed with the Greater Manchester team. The action was ongoing. 22/05/25: GMc mentioned that Salford were the last to roll out HIV testing. We can now test for HIV, Hepatitis B and Hepatitis C, however there is an issue at SRFT in relation to managing the demand. We need to push this with the ICB. 23/10/25: Ongoing. 18/01/26 – Opt out testing in ED is a ICB commissioned service and responsibility. Locality team to action with respective team in the GM team. Note this is a risk as likely to be affected by reforms
179	22/05/2025	**Action Log**	HG mentioned that an update on blood borne viruses had been provided to the PCB and it was highlighted that there is not enough capacity within the treatment pathway, which is causing the issue.	HD to pick this up with CS/JF and provide an update at the next meeting.	**~~Hannah Dobrowolska~~** **Harry Golby**	**26/02/2026**		16/06/25: HG to pick up on behalf of HD. 19/06/25: JF spoke to Mark Kellett about this a couple of weeks ago and will provide an update. 24/07/25: HG has chased and is awaiting an update. Ongoing. 23/10/25: Ongoing. 14/11/25 Internal discussion ongoing within NCA to find investment required to increase capacity in treatment pathway. **19/02/26: HG is awaiting an update from the NCA.**
191	24/07/2025	**Ingleside Update**	JC mentioned the city mayor and local MP are keen to get the unit re-opened for births. However, the report predicts that the earliest birth will take place in 2027. Occupancy review details are needed as this is a council owned building which is leased to Bolton FT.	HG to obtain details of occupancy and future proposals for births up to 2027.	**Harry Golby**	**26/02/2026**		25/09/25: HG is trying to get hold of utilisation information – ongoing. 09/10/25: Discussed at Ingleside Collaborative, chased 29/09/25, no further update as at 09/10/25. 23/10/25: Ongoing 14/11/25: HG to email Wendy Hodgson in relation to this action. 19/02/26: As above. **15/06/26: Bolton has be asked for an update.**
Actions Closed Since the Last Meeting								
225	29/01/2026	**Minutes of Previous Meeting, Action Log and Matters Arising**	PD suggested that an action is needed around this and that the Salford leaders should meet with Sam Evans/Colin Scales to discuss. We need to ensure that the money follows need.	Salford leadership to meet NHS GM colleagues in relation to the Place Grant.	**Hannah Dobrowolska**	**26/02/2026**		13/02/26: Meeting is in the process of being arranged. **15/06/26: Meeting held on 12 May.**



231	26/02/2026	**System Partner Updates**	PD mentioned that there hasn’t been any engagement with the committee on the 5-Year Plan before it was submitted. MR explained it had been submitted at a national level and that meetings with Locality Leads had taken place. However, it hadn’t been brought to this committee due to the short turn around, but it will be an iterative plan. PD stressed this needs to be engaged upon as soon as possible. It feels as though GMMH are remote on this meeting and is concerned the work previously done on the Living Well model in Salford around Mental Health may potentially be undone. This will have a significant impact on the VCSE sector.	GMMH to present the 5-Year Plan at the next meeting.	**Michelle Richards**	**26/03/2026**		**02/06/2026: The GMMH Strategy will be discussed at the June ICPC meeting.**

Salford
Integrated Care Partnership

Salford Integrated Care Partnership Committee
25 June 2026
Item 2 – Adult Mental Health Update

Item for: Decision/**Assurance/Information**

Report of:	Director of Adult Commissioning	
Date of Paper:	16 June 2026	
In case of query, please contact:	Clare Mayo clare.mayo@nhs.net Judd Skelton judd.skelton@salford.gov.uk	
System Priorities: (Please tick as appropriate)	Physical activity and movement	
	Child Friendly City	
	Live well, Neighbourhoods and Communities	
	Adults and Ageing Well	
	Preventable illness - CVD and Diabetes	
	Urgent and emergency care	
	Mental health and emotional wellbeing	X
	Triple aim – population health, performance recovery, financial sustainability	
	Other system enabler i.e. Workforce, Transformation, Digital etc.	

Purpose of Paper:

This paper provides an overview of Salford's Adult Mental Health provision. This includes key performance data, in addition to highlight reporting relating to service development and transformation.

Data sources include:

- Locally reported service level data and intelligence
- Greater Manchester (GM) Data (via GM Tableau)
- Nationally Reported Data
- Narrative data

Further information

How will this benefit the health and wellbeing of Salford residents, or the Integrated Care Partnership?	The Adult Mental Health work programme is focused on the national, GM and local delivery of services meeting the needs of the population. Targets for mental health provision, including specific areas of transformation and co-design provide opportunity to connect to locality objectives and to ensure that local people have access to high quality mental health services.
How does this paper address health inequalities and promote inclusion?	People experiencing mental health needs are recognised as being impacted by multiple health inequalities. Transformation plans and service developments offer opportunities to further address challenges relating to inclusion and focus on supporting people much closer to their homes and communities.
What risks may arise as a result of this paper and how will they be mitigated?	Where significant risks are identified, they will be highlighted through the update report as appropriate, with reference to mitigation approaches.
Does this address any existing high risks facing the organisation and how does it reduce them?	Risks relating to performance are noted in the paper and are responded to via appropriate points in the governance structures (e.g. local or GM level).
Are there any possible conflicts of interest associated with this paper?	None noted.
Will any current services or roles be affected by issues within this paper and what are they?	N/A

Note: Where appropriate, please ensure detail is provided.

Document Development

Has there been Public Engagement?	The Adult Mental Health Collaborative and the Adult Mental Health Design Team includes people with lived experience of mental health services and seeks to work in a co-design / co-ownership approach to work

	undertaken. Specific work programmes will provide additional detail of public / lived experience engagement and collaboration.
Has there been Clinical Engagement?	Clinical staff are involved in the Collaborative and the Design Team. Collaboration with clinical staff is evidenced throughout the paper.
Has the impact on Salford socially, economically and environmentally been considered?	This is included in the considerations for the programmes of work reflected in the All Age Board workplans.
Has an Equality Impact Analysis been completed?	Equality is a theme reflected throughout the work programmes. Where a further impact analysis is required, GM and local governance structures will inform how this is progressed.
Has legal advice been obtained?	N/A
Has this been to any groups or committees for engagement, comments, or approval?	Shared with Directorate Management Group. Information contained in the report is shared in highlight reporting quarterly to the Salford All Age Mental Health Board.

Note: Where relevant, please provide detail and ensure that it is clear how and when particular stakeholders were involved in this work, that there is clarity of what the key message/decision was, and whether amendments were requested about any part of the work.

Salford
Integrated Care Partnership

Adult Mental Health Update – June 2026

1. Executive Summary

The paper provides an overview and update on Salford's Adult Mental Health service provision.

This covers the following key areas:

- *Prevention*
- *Community*
- *Crisis / Crisis Alternatives*
- *Inpatient Quality Transformation*

A combination of development, transformation and performance highlights are shared. Where required, challenges are highlighted with mitigation actions.

A summary of performance information is provided in the appendix, along with an overview of GM Integrated Care Board (ICB) priority areas for Adult Mental Health delivery.

This report sits as an accompaniment to presentations providing further focused information on the following areas:

- *Strategic context for Adult Mental Health,*
- *Community Mental Health Transformation*
- *Neighbourhood Mental Health Team learning*
- *Connection to Live Well and Neighbourhood Models of Delivery*

2. Context

2.1 Priorities for Adult Mental Health are aligned to national guidance, the GM Health and Wellbeing Strategy and local intelligence / priorities.

2.2 The Salford All Age Mental Health Board has representation from across the Salford mental health system to oversee and gain assurance on a one-year action plan, with highlight and exception reporting on a quarterly basis.

2.3 Performance reporting is via a combination of national, GM and local data, combined with service intelligence and lived experience. Some performance is overseen at a GM level. A summary of the most recent performance reporting relating to Salford Adult Mental Health delivery is provided in **Appendix A.**

2.4 GM ICB Adult Mental Health priorities are summarised in **Appendix B.**

3. Community

3.1 The Community Mental Health Transformation Framework for Adults and Older Adults is a national approach to achieving the outcomes in the NHS Long Term

Plan to 'develop new and integrated models of primary and community mental health care [which] will support adults and older adults with severe mental illnesses' and a "new community-based offer [that] will include assess to psychological therapies, improved physical health care, employment support, personalised and trauma informed care".

3.2 **Adult Mental Health Community Transformation** continues to be progressed via the system-wide co-design approaches in the Collaborative and Design Team meetings. A milestone timeline is in place.

3.2.1 Referral and Assessment Hub (RAH)
The Referral and Assessment Hub (RAH) started in January 2025 and manages referrals to the Community Neighbourhood Mental Health Team (CMHT) offer and specialist team. There are no changes in referral processes for other mental health services (e.g. NHS Talking Therapies). It is recognised that there have been challenges in meeting demand. The Collaborative and Design Team have been co-designing a draft version of the future approach for the Referral and Assessment Hub. The key functions of a proposed model, informed by lived experience examples will be shared at the next Collaborative in June. Adult Social Care Mental Health input into this work will support alignment of the approach.

3.2.2 Adults Community Mental Health Access
GM reporting shows performance as 4755 people receiving two or more contacts from NHS or NHS commissioned community mental health services for adults and older adults with severe mental illness in a rolling 12-month period (based on March 2026 data). This places Salford as the highest performing locality in GM (based on rate per 1000).

3.2.3 Older Adults Community Mental Health Team
Work is ongoing to explore the number of people referred to Older Adults Community Mental Health Teams who do not need specialist Community Mental Health offers, but could benefit from Neighbourhood Mental Health Team offers. This will inform future thinking about the model, and the skills / expertise required to address any such demand.

3.3 **Mental Health Social Work / Unify Programme – Section 75 Arrangements**
Adult and Older Adult Mental Health Social Work transferred back to Salford Council on 1 June 2026 via the Unify programme. Co-location of staff across Adult Social Care and Community Mental Health services has been retained and the importance of multi-disciplinary working is also recognised. It is noted that ongoing development will be required as part of the Adult Social Care delivery model and the Community Mental Health Transformation guidance.

3.4 **Early Intervention in Psychosis (EIP)**
The national target for EIP is comprised of two elements *and both conditions must be met for the standard to be deemed to have been achieved:*

1. A maximum wait of two weeks from referral to start of treatment; and
2. Treatment delivered in accordance with National Institute for Health and Care Excellence (NICE) guidelines and quality standards for psychosis and schizophrenia – either in children and young people CG155 (2013) and QS102 or in adults CG178 (2014) and QS180.

It is noted that performance for Salford EIP is below target (42.9% against a 60% target, March 2026 Greater Manchester Mental Health [GMMH] Performance Reporting). However, GM Tableau reporting for March 2026 shows Salford performance as 60% (due to a later reporting date) and therefore achieving target. This is an improvement on the last three months. Work is ongoing at GM level to review all EIP services. Review themes include exploring workforce, capacity and outcomes from the service.

3.5 **Co-Occurring Conditions Action Plan**

Co-occurring conditions refers to people who have mental health problems and require support for drug and alcohol use. Salford has a detailed co-occurring conditions plan in place to ensure that adult mental health services and addiction services work closely together to support local people. The action plan includes a focus on joint working, with regular 'huddles' in place between Mental Health Teams and Achieve Drug and Alcohol recovery services to work collaboratively to support people with complex support needs. Drug and Alcohol and Mental Health commissioners meet regularly to discuss service alignment. The action plan is reported regularly into GM oversight governance. This has been recognised as a strong action plan, with good outcomes for local people. Following the re-tender of Drug and Alcohol services, GMMH have been confirmed as the adult provider. Following the work being undertaken by Drug and Alcohol Commissioners at the start of the new contract, the action plan is being reviewed in line with GM requirements to focus on delivery against national guidance.

3.6 **Memory Assessment and Treatment Service (MATs)**

The Salford locality has historically evidenced strong performance against the dementia diagnosis rate, with last published performance in March 2026 as 75.3%, exceeding the national target of 66.7% (GM ICB Tableau). When benchmarked against GM data, Salford was the 5th best performing locality for 2025-26.

Local MATs provision is reporting a significant drop in performance against the 18-week referral target for people receiving a dementia diagnosis, with March 2026 performance showing as 20% against the 80% target (GMMH Reporting, March 2026). This has been identified as being due to staff sickness. Additional staff have been recruited and bank / agency staff are being explored to support the service in the interim. Commissioners have requested an improvement trajectory to inform the recovery planning. A wider review of MATs provision is ongoing at a Trust / GM level.

3.7 **Home Engagement and Rehabilitation Team (HEART) – Mental Health Community Rehabilitation**

The HEART team continue to focus on supporting people who are clinically ready for discharge from adult mental health rehabilitation inpatient services to return to community support. The HEART team also provide clinical expertise into discharge planning to prevent people from needing inpatient mental health rehabilitation provision if their needs can be met in the community. GM work relating to mental health rehabilitation is underway, including a focus on the future provision to meet the needs of the population.

GMMH announced proposals to transform rehabilitation services, running a public consultation until 13 February 2026. This included reconfiguration of inpatient wards designed to improve patient flow and bring care closer to home, and the creation of new community rehab flats (located in Salford and Trafford). A full response to the consultation was provided, highlighting the broad support of the proposals (as these are

in line with the national and GM transformation plans for mental health rehabilitation), with additional focus on Local Authority considerations relating to the rehabilitation flats, which have potential implications on Section 117 responsibilities and locality resources, depending on the model of delivery. Discussions are ongoing, with an aim to jointly agree approaches to mitigate any challenges that may arise.

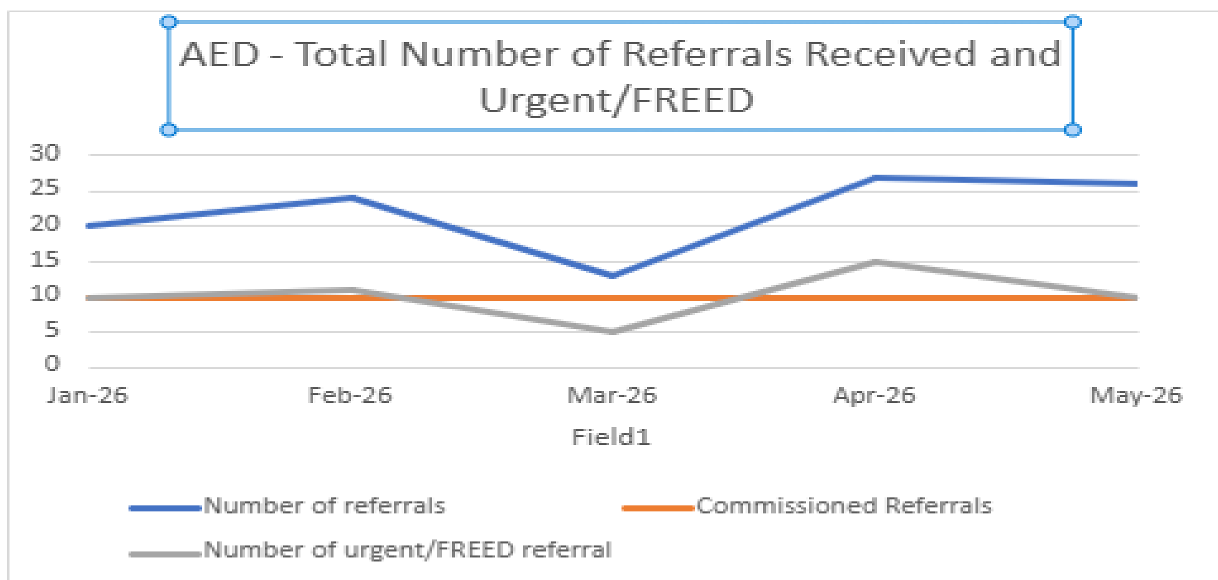
3.8 **Adult Community Eating Disorders**

The service continues to demonstrate good performance, consistently meeting First Episode Rapid Early Intervention for Eating Disorders (FREED) assessment and treatment metrics and wait times for assessment. The service is meeting 18-weeks targets for prioritised treatments. The Salford service continues to demonstrate strong performance of FREED compared to national sites in relation to waiting times for assessment and treatment.

Table 1: Wait time for assessment and Treatment

Pathway	RAG Wait Time
FREED Assessment	2 weeks*
Non-FREED Assessment	Within 4 weeks*
FREED Treatment	4 weeks*
High risk Treatment	4-8 weeks**
Medium risk Treatment	3-4 months**
Routine Groups (CBT-E and CBT-E binge eating)	3-4 months**
Routine Individual	CBT-T 4-7 months, CBT-E 6-9 months**

Referrals to the service remain over the commissioned capacity, with almost double the referrals being seen in the service. The chart below illustrates the sustained demand to the service (Quarter 4, 2025-26, GMMH Eating Disorders local reporting).



Due to demand still being high, number of complex and more acute referrals being received and the length of psychological therapies for eating disorder presentations (up to 40 sessions in Cognitive Behaviour Therapy for Eating Disorders), the pressure

remains on individual routine waiting times. June 2026 data shows that waiting times for routine referrals for more intensive cognitive behaviour therapy offers are between 7-9 months. Two mental health practitioners have started in post to add additional capacity to start to reduce waiting times in this pathway. The service continues to support over double the commissioned referrals.

The medical monitoring pathway for people with complex and severe eating disorder presentations is now fully staffed, supporting increased capacity for Medical Emergencies in Eating Disorders (MEED) risk assessments. Work continues to progress towards the establishment of the physical health clinic – communications will be developed to inform primary care once this offer is available. Advice and support for GPs and other locality teams continues to be provided by the service Consultant Psychiatrist and part time GPs with Specialist Interest.

3.9 **Adult Mental Health Supported Living Review**

A commissioning review of adult mental health supported living offers is underway to enhance existing offers and support flow through the pathway towards increased independence. This work is being undertaken in phases, with the first phase reviewing existing commissioned provision. This has led to positive work with providers to further improve the service offer and align to the strengths and needs of people requiring supported living. This work is informing a Housing and Mental Health paper to set out future strategic commissioning intentions.

Additional phases of work will see a focus on people in out of area, mental health supported living offers and the use of data and intelligence to inform work on wider housing strategies.

As part of the approach to reducing Out of Area Supported Living placements, a Supported Accommodation preferred provider framework is also being explored to support decisions on out of area placement (OAP) approval and provide a tool to inform the level of oversight required during a person's placement. This is well established for acute out of area placements and is being introduced for mental health rehab out of area placements, making the 'stop / go' approach highly replicable for supported living out of area placements. The principle being that the distance of any OAP reduces and quality improves. The framework will ensure people are admitted to providers where Salford has sufficient quality and safety oversight, as well as being closest to home. This will require implementation and oversight from the Mental Health Supported Accommodation Funding Panel. Reducing the number of people placed out of area will allow a significant opportunity to support an 'invest to save' model. This would see investment into development (either via redesign or newly specified) Salford provision to meet the needs of people currently and likely to be placed in out of area supported living offers.

Work is also underway in relation to how the current Supported Living Alliance operates to ensure that Salford provision is always the first option before looking to place someone out of area. The intention is to introduce a multi-team approach to address all areas of Mental Health Supported Accommodation. This will include:

- Timeliness of reviews of care packages and support provided. Salford alliance supported accommodation would be available if people could step down into tenancies with less support following placement reviews.
- Improving the local step-down pathway to reduce out of area placements and free up inpatient beds sooner.

- Developing a responsive mental health support offer for people living in supported accommodation, which can be flexible depending on their changing needs.
- Oversight of out of area placements and housing and quality concerns.
- Developing a shared dashboard or tracking tool to highlight voids, other issues and unblock system flow.

3.10 **NHS Talking Therapies**

NHS Talking Therapies provide evidence-based interventions for people experiencing common mental health conditions (e.g. mild-moderate anxiety, low mood, depression). Salford operates a Shared Point of Access (SPA Model). The SPA is operated by Six Degrees as the central referral point. Step 2 interventions are provided by Six Degrees, and Step 3/ 3+ interventions are provided by GMMH.

Both Step 2 and Step 3 continue to receive a higher number of referrals than they are commissioned for with the number of people accessing treatment also above commissioned levels. This is impacting on waiting times and reliable improvement and recovery.

A review is underway within Six Degrees, with early indications showing a number of factors including changes in CMHT / Referral and Assessment Hub impacting referral flows. Relatively inexperienced workforce currently in the service (some newly qualified in Summer 2025, other experienced staff changed roles / positions and 8 trainees). A sustained increase in demand, combined with increases in referrals last year around the time of the staff experience levels changing has resulted in capacity pressures.

Current performance challenges in GMMH are due to short-term pressures from staff sickness, sustained increased demand including high referral volumes and greater proportions of complex presentations. These have contributed to longer waits and impacted recovery outcomes. The 2026 improvement plan remains focused on clinical optimisation to strengthen recovery outcomes. Key priorities include reducing appointment wastage, minimising inappropriate referrals through enhanced digital screening, and reducing attrition across the pathway. The continued transition to a digital-by-default model is expected to enhance engagement, improve pathway efficiency, and contribute to steady improvements in recovery performance over the year.

This is noted at GM level.

3.11 **Community Risks and Mitigations**

RISKS:	**MITIGATIONS:**
There is a potential for the development of the new mental health Social Work model to sit separately to the requirements of the Community Mental Health Transformation Framework. This would result in a disjointed offer to Salford people. As system involvement is already in place to design and prototype Community Mental	Representation from Adult Social Care are invited to the Design Team and Collaborative with a view to supporting ongoing joint design and prototyping. This has been raised with Unify programme leads.

Health models (including Voluntary, Community and Social Enterprise [VCSE] and Lived Experience partners) there is a risk that this expertise will not feed into the development of the new mental health Social Work model.	
Neighbourhood Mental Health Team Governance meeting regularly notes that longer waits are being experienced by Primary care Networks (PCNs) without additional investment.	Clear information relating to waiting times for referrals for PCNs with and without investment have been communicated to ensure an informed position for the system and for people accessing support.
The longer-term vision for Neighbourhood Mental Health Team (Living Well) was to be part of the wider Community Mental Health Transformation work, with one seamless pathway. The Neighbourhood Mental Health Team has reached the point by which wider community transformation is vital to maintain the desired level of service delivery. This has been noted on the GMMH Board risk register and escalated to commissioners.	Ongoing community transformation focus. Implications of this are being closely monitored.
Impact of financial allocations for pay uplifts in VCSE sector have been challenging. Further risks relating to movement of budgets / resources to align with service pressures have highlighted the risks of this on VCSE providers.	This has been escalated to GM and individual discussions with providers are being undertaken. This will be picked up as part of annual reviews of specifications and service asks.
Community Eating Disorder services continue to see over double the number of commissioned referrals, putting pressure on routine referral waiting times for treatment.	This has been noted at GM level. Some additional resource has been allocated to reduce waiting times, however this is not likely to fully address the capacity challenges and it is noted that lengthy waiting times for people with eating disorder presentations can be particularly risky.
Sustained demand on the NHS Talking Therapies pathway resulting in lengthy waiting times for some parts of the pathway.	Locality work underway to support improvements. Noted at GM level for resource considerations.
Performance / capacity challenges in the MATs service.	Additional staffing to mitigate capacity challenges. Recovery trajectory requested. GM and GMMH review of MATs services.

4. Crisis and Crisis Alternatives

4.1 Mental Health Crisis Beds

Home Based Treatment (HBT) support two mental health intermediate care beds (known as crisis beds), located in Hollybank. These beds, which were commissioned by Salford Clinical Commissioning Group in 2020, prior to the Integrated Care System (ICS) transition, provide intensive, short-term support to help manage a mental health crisis in a residential setting, avoiding a hospital admission or facilitating a hospital discharge. These beds are well utilised and connected into the wider HBT offer.

4.2 Urgent Care Listening Lounge (Accident & Emergency Alternative)

The Salford 24/7 Urgent Care Listening Lounge started operation in December 2021, with a full launch in July 2022. This provides an alternative non-clinical setting to Accident & Emergency (A&E) presentations for people with mental health needs who do not have co-morbid physical health conditions or who do not require additional medical intervention.

As people present to A&E for mental health needs, they are triaged to understand if they require A&E support (and so retained in A&E), can be ‘streamed’ to a mental health support area within the hospital, or if the person is able to be seen in the Urgent Care Listening Lounge they are directed to this resource, based at Hollybank.

The Listening Lounge provides a safe space for people in mental health crisis, with the ability to undertake a mental health assessment and link people into further avenues of support. Bookable appointments can be made 24/7 with Listening Lounge Practitioners from the GMMH Home Based Treatment Team. Work is ongoing via the Mental Health Unplanned Care task group (a sub-group of the Provider Collaborative) to ensure that anyone able to be supported in the Listening Lounge space is supported to access the offer, rather than remain in A&E.

Building on the GM work in relation to crisis alternatives for blue light services, further discussions are required to support pathways with Greater Manchester Police (GMP) / Custody.

4.3 Voluntary, Community and Social Enterprise (VCSE) Crisis Alternative and Open Access Listening Lounge

The VCSE Crisis Alternative / Open Access Listening Lounge provision is delivered by two VCSE organisations: Start (providing Recovery Workers) and Mind in Salford (providing Peer Workers). They operate in partnership with GMMH’s Listening Lounge / HBT provision to ensure an integrated approach. The VCSE crisis alternative offer is delivered via two main approaches:

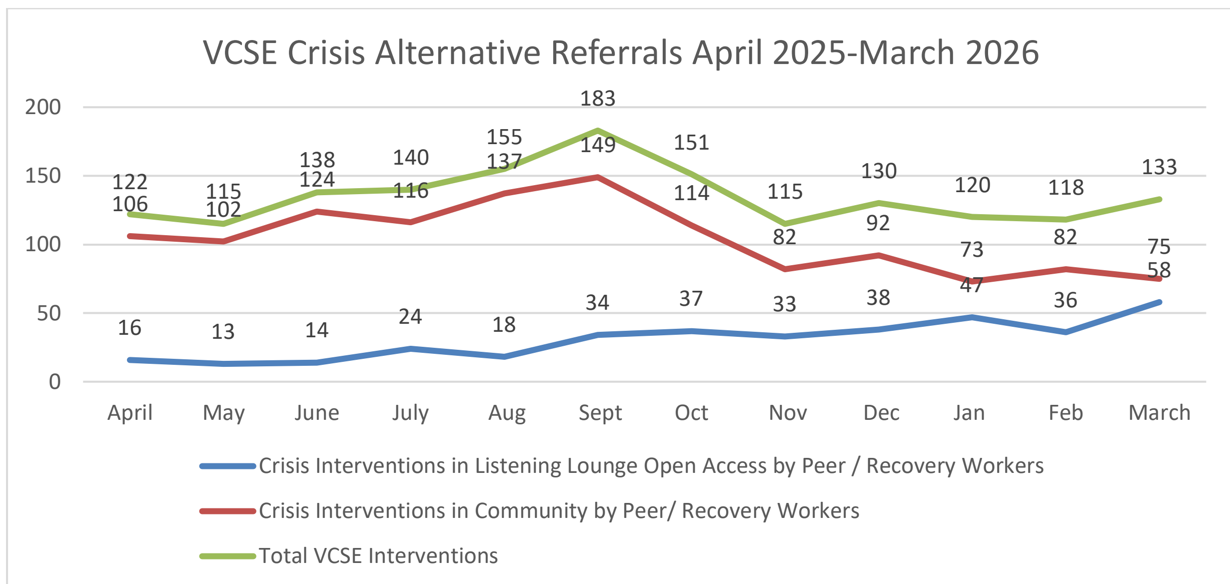
1) Open Access Listening Lounge – open access one-off sessions at the Listening Lounge (located in Hollybank) on weekday afternoons for people presenting in self-defined mental health crises.
2) Peer Worker / Recovery Worker crisis intervention in the community Neighbourhood (NH)H Mental Health pathway.

The focus of interventions include:

A listening ear and peer support:

- Coping tools
- De-escalation
- Connection to onward journey and support offers

A programme of engagement has been underway with PCNs to promote the Open Access Listening Lounge. This has included visits / presentations to GP practices and Primary Care teams to provide information on who the offer may support, in addition to communications in the Salford Primary Care Bulletin. This has seen an increase in uptake in some parts of the pathway.



1620 interventions have taken place via VCSE Crisis Alternatives between April 2025 – March 2026.

An imminent GM review of VCSE Crisis Alternative Provisions is planned as part of the annual commissioning cycle. This will look to explore alignment to the new GM specification (providing consistency across GM) and will explore development / improvement opportunities. Salford's Integrated Commissioning team will be working with local providers to inform this review, considering the rich learning from delivery to date.

4.4 **Urgent Care and Community Pathways**

Whilst pathways are in place for urgent referrals to community mental health support, same day responses are being highlighted as a challenge by Primary Care colleagues. Information has been shared to Primary Care to outline the range of services available and to reiterate the current pathways in place e.g. Mental Health Liaison in A&E, NHS 111 option 2 phone line (which is supported in GM via the mental health triage offer with mental health practitioner input), Salford Crisis Alternatives (Listening Lounge Open Access and bookable Home Based Treatment appointments). Wider work relating to same day pathways is being overseen at a GM level. In the interim, work is ongoing via the design team to jointly agree communications to Primary Care to support decision-making.

4.5 **Mental Health Liaison**

The NHS Long Term Plan set out a renewed commitment to improve and widen access to care for adults needing mental health support. Salford Clinical Commissioning Group (prior to ICB transition) invested considerably in development of its local Mental Health Liaison Service - £1.2m in 2013. Salford also secured GM transformation funds (circa £630K in Wave 1) to develop this further resulting in CORE24 compliance. However, the Salford Mental Health Liaison Team continues to see very high demand and the Salford mental Health Liaison team (MHLT) remains one of the busiest in GMMH, equaled only by central Manchester.

Performance against the 1-hour referral target was 71.8% for March 2026 (GMMH Performance Report March 2026), which is below target. However, GMMH reporting for April shows performance as 79.2% which is an improvement in performance, exceeding the 75% target (GMMH Performance Report).

Performance against the 4-hour discharge target has been on an improving trajectory, with April 2026 performance showing as 91.9% (GMMH Performance Report), just below the 95% target.

The proportion of Mental Health Liaison referrals with a decision to admit has a 6-month average conversion rate of 6.3%, which is just above the Trust target of 5%. This is an improvement on the previous 6-month average of 7.5% which can likely be attributed to strengthened gatekeeping processes and the continued development of the Senior Urgent Response Practitioner (SURP) role in Home Based Treatment.

An increase in 12-hour breaches was noted in April 2026, correlating with challenges in Trust-wide flow (Opel 4 reached). Additional work is underway to look at individuals who remain in the Emergency Department (ED) for 12+ hours (overall length of stay) to better understand this experience.

4.6 **Section 136 Suite / Health Based Place of Safety**

Salford's 136 Suite undertook a period of planned closure from 5 January 2026 for 9 weeks to complete works to improve safety and compliance with Care Quality Commission (CQC) standards, including environmental enhancements. Alternative provision in GMMH was utilised whilst the works were undertaken.

During Quarter 3 2025-26, an average of 24 people per month used the suite. Work is ongoing at GM level to collate information for 136 presentations to inform intelligence relating to use, transfer between Places of Safety and length of stay. This is anticipated June 2026.

4.7 **Home Based Treatment (HBT)**

Referrals into the team have remained stable with an average of 88 people per month. Sickness and vacancies in the service have impacted response times, however performance is now back on an upward trajectory. The HBT team manager is now in post providing additional support to the team.

4.8 Crisis Alternative Risks and Mitigations

RISKS:	MITIGATIONS:
Due to the limited space in the Listening Lounge and fluctuations in the demand during open access hours, this can result in pressures on Recovery Worker, Peer Worker and estates capacity.	This was reviewed recently and a number of actions have been undertaken to explore the capacity / demand in more detail, with a range of interim and longer-term approaches being explored. Short-term pressures remain which are being discussed with service leads to explore system support. This will be further explored within the VCSE Crisis Alternative GM Review.

5. Inpatient Quality Transformation

5.1 Inpatient Transformation Programme

5.1.1 The Transformation Programme's aim is to **support cultural change and introduce a bold, radical, reimagined model of care for the future** across all NHS-funded mental health, learning disability and autism inpatient settings.

To achieve the aim, the programme has five objectives:

1. To localise and redesign inpatient services.
2. To improve the culture within inpatient services and support people and staff to flourish.
3. To enable the least coercive care through reducing restrictive practices.
4. To support systems and providers facing immediate challenges.
5. To make oversight and support arrangement fit for the sector.

5.1.2 This update also includes a focus on the inpatient bed usage, including Out of Area Placements (OAPs) and people who are Clinically Ready for Discharge (CRFD). Out of Area Placements (OAPs) are placements (usually non-contracted, spot purchased with the independent sector) provision to support capacity where a GMMH footprint bed is not available.

To ensure commissioner oversight / approval of the use of out of area beds, a local process has been in place for circa 10 years. This process includes the use of update reports from GMMH to local Commissioners on a weekly basis. The reports include all cases where an OAP bed has been used. These reports are scrutinised and subjected to appropriate challenge from Commissioners. Consent for initial funding or funding extensions are provided by Commissioning colleagues.

5.1.3 GM ambition is for zero 'out of area' adult acute placements. Oversight of OAPs' performance at a GM level is monitored via the GM Out of Area Placement (OAP) and Clinically Ready For Discharge (CRFD) Oversight Meeting.

The national target for OAPs is zero. Additionally, GM have agreed to reducing the number of local spot purchase beds.

It is suggested that the key areas of work to achieve this will be:

- Reducing the number of CRFD bed days.
- Reducing the length of stay (LoS) for mental health adult acute, older adults and Psychiatric Intensive Care Unit (PICU) inpatient units.

Whilst the reduction of people Clinically Ready for Discharge is reviewed at a GM level for adult acute and older adults, it is recognised that localities are starting at different points, with varying levels of community pathways and system oversight to prevent admission and support swift discharge. People who are considered Clinically Ready for Discharge may experience delays in hospital discharge for a range of reasons, including waiting for placements, lack of social care capacity or delays in funding decisions. Therefore, individual locality targets have been set to reflect this. Further detail relating to the system-wide Multi Agency Discharge Event (MADE) processes in place to support swift resolution to barriers to discharge is provided in 5.3.4.

5.1.4 **2026-27 Clinically Ready for Discharge (CRFD) Targets**
CFRD targets for 2026-27 focus on Adult Acute and Older Adults (Older Adults is a new addition for this year). Salford Adult Acute target is no more than 1294 bed days lost to CRFD between April 2026-March 2027. This equates to no more than 3.5 people CRFD per day. This is a 10% reduction on last year's target. Salford Older Adults target is no more than 576.5 bed days between April 2026 - March 2027. This equates to no more than 1.6 people CRFD per day. The same methodology has been used to calculate this target as is used for Adult Acute. Rehab CRFD is not included in these targets (but should still be tracked locally). Further work is underway with Trusts and Independent Sector providers to progress towards target setting, in line with national planning.

5.2 Out of Area Placements Performance

5.2.1 Out of Area Placements (OAPs)

There has been a significant progress in the reduction of out of area placements at a GM level. The total number of active Adult Acute out of area placements in place as of 9 June 2026 across Greater Manchester is **4.** As of 9 June 2026, GM has a total number of **21** active spot purchase placements which are non-reportable OAPs.

As of 9 June 2026, Salford has 1 reportable OAP.

Salford's OAPs position is supported by robust community pathways, with strong preventative services to support people to have their needs met in the community. Salford has invested significantly into 24/7 Home Based Treatment (HBT) provision, Living Well offers and effective social care pathways to help people remain out of hospital and have their needs met in the community. This is supported by strong integrated commissioning pathways and robust approaches to staff retention in local inpatient provision.

As of 9 June 2026, Salford is using 1 spot purchase, non-contracted bed.
As of 9 June 2026, Salford is using 1 contracted bed.

It is noted that Salford is a significant net importer for other areas, meaning that people from GM who are not from the Salford locality are more likely to be placed in Salford beds. Work is ongoing to monitor this closely.

5.3 Clinically Ready for Discharge (CRFD) Performance

5.3.1 As of **9 June 2026**, Salford has:

- **1** adult in an Adult Acute bed who is CRFD over 50 days, (based on GM Tableau, local data at 5 June 2026 suggests 2 people, one under 50 days and one over 50 days).
- **0** older adults in acute beds who are CRFD (based on GM Tableau data, local data at 5 June 2026 shows 4 people under 50 days and 1 person 50+ days).

5.3.2 Whilst not included in the targets above, CRFD for other bed types is as follows (as of 9 June 2026):

- 1 person in adult Psychiatric Intensive Care Unit (PICU) bed who is CRFD, under 50 days (GM Tableau).
- 9 adults in mental health rehabilitation beds, with 3 people under 50 days and 6 people over 50 days (based on GM Tableau, local data at 5 June 2026 shows 4 people all over 50 days).

2025-26 performance for Adults of Working Age CRFD shows that Salford has seen 788 bed days lost to CRFD, which is within the Salford 973 bed days lost target.

5.3.3 2026-27 performance is showing some increase in CRFD across GM. As of 9 June 2026, Salford performance is showing:

- Adult Acute CRFD 251 YTD bed nights lots against plan of 216.
- Older Adult CRFD 108 YTD bed nights lost against plan of 96.

GM Tableau.

5.3.4 Salford's OAP and CRFD reduction plan is supported by Multi-Agency Discharge Events (MADE). A weekly MADE meeting takes place in the locality, focusing on oversight of inpatient placements, opportunities to address barriers to discharge by working with system partners and a focus on people with longer lengths of stay. Where issues and barriers to discharge are unable to be resolved, they are escalated to locality MADE escalation meetings, supported by senior leads with a view to creating innovative solutions.

Where required, issues or themes from locality MADE meetings are able to be addressed at the GM MADE meetings, which take place on a fortnightly basis. Accompanying the GM MADE meetings, commissioners and providers receive a daily tracker of OAPs and CRFD placements, generated via GM Tableau to facilitate discussions and unblock barriers to discharge.

5.4 Acute Inpatient Bed Usage

NHS England use the Perinatal Mental Health (PRAMH) methodology to calculate relative mental health need in each area. This is done at GP practice level, by age and gender, and aggregated up to give locality positions. A needs score of 1 means

average need. As an example, Manchester has a needs weighting of 1.6 for working age adults, which means 60% more mental health need than the national average, relative to population size.

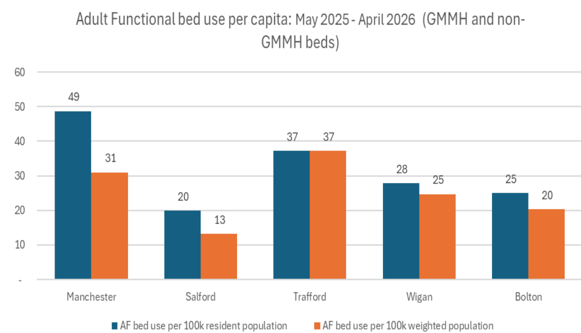
Trafford has an average needs weighting of 1 for working age adults. All other areas are above average.

When adjusted for population size and need, Trafford residents had the highest rate of bed use closely followed by Manchester. Salford patients used the fewest beds.

These figures include use of GMMH and external beds (OAPs, North West Bed Bureau etc).

The summary below shows the net position for April 2026 for adult functional bed use across the GMMH footprint, with Salford as a net importer. Salford's low bed use is supported by robust community mental health offers to prevent admission to inpatient provision where possible.

Need weighting	18-64	65+
NHS Bolton CCG	1.2	1.4
NHS Salford CCG	1.5	1.7
NHS Trafford CCG	1.0	1.2
NHS Manchester CCG	1.6	1.8
NHS Wigan Borough CCG	1.1	1.4



	April export – bed use outside own locality *i.e. "Manchester residents in GMMH beds that were not Manchester beds"*	April import – bed use by other locality patients *i.e. "People in Manchester beds who were not Manchester residents"*	Net position*
Manchester	27	21	5
Salford	4	17	-13
Trafford	4	14	-10
Bolton	4	12	-8
Wigan Borough	5	9	-4

5.5 Inpatient Community Connector Pilot

An 18-month pilot started in May 2026, embedding a Community Connector into the Meadowbrook Unit. The Community Connector will work directly with Salford people on the wards, identifying their interests and supporting social prescribing to meet their needs. This aims to support people who are ready to be discharged, building connections and supporting wellbeing. Review of the project is ongoing, utilising a partnership approach.

5.6 Risks and Mitigation for Inpatient Provision

RISKS:	MITIGATIONS:
It is useful to note that historically, PICU OAPs (Psychiatric Intensive Care Unit Out of Area Placements) have not been funded by Salford locality, and our long-standing agreement is for GMMH to fund these places, should they occur. However, there is further GM clarification required as to the future position for funding these placements.	This has been picked up through the GM GMMH Contract meeting for further clarification. In the interim, payments will be actioned to prevent delays to people requiring placements, with monitoring activity being undertaken to support any re-calculations required once the GM position has been confirmed.

6. Prevention

6.1 Suicide Prevention

6.1.1 In response to the national suicide prevention strategy, the greater manchester suicide prevention plan sets out statistics for the region and the vision for zero deaths by suicide, suicide prevention as 'everyone's business' and appropriate support for people bereaved by suicide.

Salford's local action plan is an annual plan, focused on meeting the ambitions in the GM strategy and responding to local priorities and need. Work is underway to review the action plan for 2026-27.

6.1.2 **Salford Local Suicide Audit**
In the past 9 months, a local audit of suicide deaths across the calendar years 2021-23 has been undertaken. Working in collaboration with Manchester West Coroners, data has been collected and analysed by the Public Health team and the final report will inform the refresh of the action plan for 2026-27.

6.1.3 **Support for Carers**
Following a particularly sad and distressing suicide death of a mother and her child which led to a local child safeguarding practice review (lcspr), local work is set to prioritise carers in the local suicide prevention delivery plan. This is in recognition of the unique challenges faced by carers and increased suicide risk they may be exposed to.

6.1.4 **Built Environment**
Work has taken place in recent months at a number of public locations that are identified as high-risk locations for suicide. Throughout winter, National Highways have made significant improvements to the parapets of various bridge crossings. Samaritans signage has been installed at one site, and further discussions are ongoing in relation to further parapet improvements.

6.1.5 **Men's Mental Health Commission Follow Up**
Work has recommenced on the pledges made by partners following the publication of the Men's Mental Health Commission Report. Actions taken are in response to the

recommendations made within the report. Progress updates will be made to the Suicide Prevention Partnership.

6.1.6 **Women's Mental Health Working Group**
A working group has been established to consider a range of issues that impact significantly on women's mental health and the potential resultant suicide risk. Particular consideration has been given to areas such as domestic abuse, perinatal maternal health, women subject to care proceedings, (peri)menopause, neurodiversity, etc. It is intended that this work will feed into and inform the delivery plan refresh.

6.1.7 **Men's and Women's Mental Health Grants**
Salford City Council, supported by Salford Council for Voluntary Services (CVS), has awarded a total of £36k of additional small grants to a range of local 'grass roots' projects and organisations that support the mental health of men and women in Salford.

6.2 Employment Support

6.2.1 **Skills and Work**
Discussions with Salford's Skills and Work offer have identified opportunities to further develop the relationships between mental health employment support, universal employment support offers and connection back to mental health services to support people's needs. Work is ongoing to explore potential barriers / challenges to the pathways to ensure that these are addressed.

6.2.2 **Individual Placement Support (IPS)**
Individual Placement Support is an evidence-based approach to supporting people into employment or retaining employment. It involves intensive support, placement in paid employment and time-unlimited in-work support for the employee and employer. Employment specialists are integrated into mental health services, works with people who are wanting to seek employment (not just those closest to being ready to work) and includes benefits counselling. The IPS provision across GM is focused on:

- IPS Primary Care – connecting with Primary Care pathways e.g. GPs, statutory work / employment services, and Neighbourhood Mental Health Teams (i.e. previously Living Well).
- IPS Serious Mental Illness (SMI) – Supporting people with serious mental illnesses via secondary care mental health services e.g. Community Mental Health Teams / Early Intervention in Psychosis.

IPS Primary Care data for 2025-26 shows:

- Out of work sign-up performance was 169 people, far exceeding the target of 143.
- In work sign-up performance was 57 people, far exceeding the target of 47.
- Out of work job starts performance was 67 people, against the target of 52.

Data from IPS Primary Care contract start to the end of May 2026 illustrates that Salford is the highest performing locality in GM against 'in work' sign-up targets and 'Out of work' job starts.

In 2026, stretch targets were introduced. Current performance against new targets are outlined below:

Salford
Integrated Care Partnership

- There has been 13 service starts for people out of work in April – May 2026 against a target of 16.
- There have been 7 service starts for people in work for April – May 2026, exceeding the target of 7.

IPS SMI data shows:

- 14 service starts for people out of work for April – May 2026 against the target of 15.
- 4 service starts for people in work for April – May 2026 against the target of 4.
- People have been supported into a variety of jobs, such as personal trainer, chef, cleaner, technical support analyst.
- There are strong relationships in place with Community Mental Health Teams.
- 961 people since April 2024 (contract start date) starting support with the service to enter employment, with 338 job starts.
- 286 people since the start of the contract April 2024 (contract start date) starting support to retain their job.

IPS SMI data for April and May 2026 shows the Salford provision exceeding targets for all areas:

	target	actual
Out of work access	108	119
In work access	36	38
Out of work service start	15	20
In work service start	4	5
Out of work job start	6	9
In work supported in work outcome	2	7
Out of work sustainment	5	6

A fidelity review is underway for IPS provision (both SMI and Primary Care). A local review of IPS delivery in line with the IPS model has been positive, with additional identification of areas to further develop, including increased reporting on Salford performance to support local understanding of delivery against the wider GM position, strengthened relationships with clinical teams and exploration of additional cohorts for support (e.g. people supported by mental health rehabilitation community teams, who might be furthest away from employment).

Further considerations are underway in line with community transformation, with the IPS provider supporting referrals via a triage team to best support connections with the appropriate clinical teams based on need rather than diagnosis.

6.2.3 **Talking Therapies Employment Support**

Employment support embedded in Talking Therapies operate across both parts of the Talking Therapies pathway (i.e. Six Degrees Social Enterprise offering step 2 interventions, and GMMH offering step 3 / 3+ interventions).

There are 4.6 whole time equivalent (WTE) Employment Advisors in place, supported by a Senior Employment Advisor. Recent performance is summarised in the table below:

MONTH	JANUARY	FEBRUARY	MARCH	APRIL
GMMH	31	48	34	30
SIX DEGREES	18	21	15	4
TOTAL	49	69	49	34
TARGET	64	64	64	64* TO BE AMENDED DUE TO STAFF SHORTAGE

Average waiting time for a Talking Therapies Employment Advisor is circa 2 weeks. Outcomes include:

- Support to remain in work / return from sick leave.
- Signposting / started education / training.
- Signposted or starting voluntary work.
- Setting up self-employment.
- Signposting to benefits advice or debt support.

DWP state funding will continue until 31 March 2027, however, this is subject to a review taking place in the summer of 2026 and will be based upon Employment Advisor services being compliant with their outcome measures.

6.3 Carers

Work is ongoing in relation to the Salford Carer's Strategy. Unpaid carers for people with mental health needs are reflected in the strategy.

Performance as reported via GMMH in relation to carers is shown in the table below. This is based on March 2026 reporting (GMMH Performance Report):

Performance Measure	Target	Performance
Proportion of identified carers contacted within 10 days of first contact for community services and given appropriate information	95%	**100%**
Identified carers contacted within 72 hours for Home Based Treatment and given appropriate information	95%	**94.4%**
Identified carers contacted within 72 hours for Inpatients and given appropriate information	95%	**100%**

The 95% target was not met for the proportion of carers contacted within 72 hours for Home Based Treatment teams, however performance has significantly improved from last month. Lower performance was linked to data quality issues, which have now been resolved.

6.4 Movement Transformation Steering Group

6.4.1 Active Hospitals

Active Hospitals is an initiative designed to embed movement into everyday practice within hospital settings. It represents an important step in promoting the benefits of physical activity for individuals who are hospitalised. Encouraging patients to remain as active as possible during their stay can support faster recovery, enhance both mental and physical health, and improve overall wellbeing.

Within Meadowbrook and Woodlands inpatient units, progress includes completing a stocktake of physical activity provision, establishing referral pathways to community physical activity offers, improving staff awareness of local opportunities, enabling access to the Active Lifestyles Service (including for people with SMI), and training 15 staff as Physical Activity Clinical Champions (PACC), alongside specialist training for Active Lifestyles staff.

6.4.2 Physical Activity Pathways for Mental Health

Work with Talking Therapies has focused on exploring how physical activity can be effectively integrated into psychological treatment pathways, promoting a holistic approach that recognises the connection between mind and body. It aims to embed movement within therapeutic models and examine how physical activity can complement and enhance Talking Therapies, such as Cognitive Behavioural Therapy (CBT), psychotherapy, and counselling.

As a key component of the wider Movement Transformation Programme, the following progress has been achieved to date:

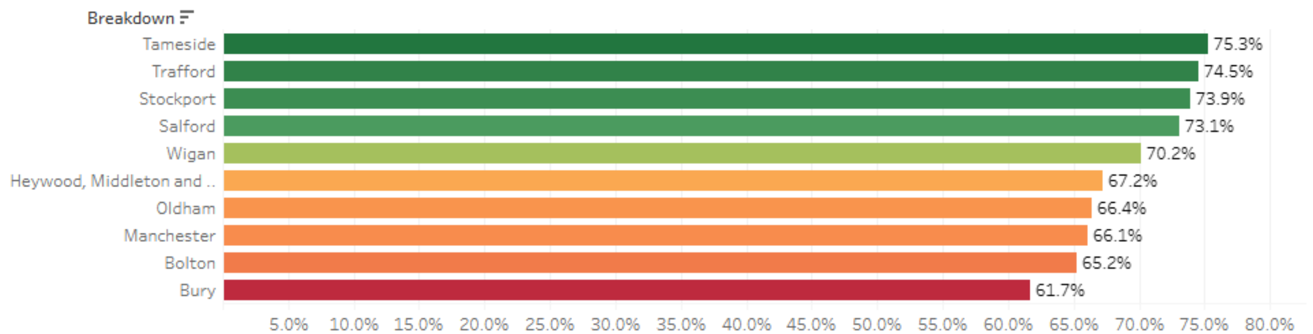
- Established referral pathways between Talking Therapies services and local community physical activity providers.
- Reviewed the local physical activity offer and provided clear guidance on access routes and signposting options.
- Enabled direct patient access to the Active Lifestyles Service.
- Delivered Physical Activity Clinical Champions (PACC) training for Talking Therapies staff. To date, 14 staff members have been trained.

This work supports the integration of movement into mental health treatment pathways, enhancing patient outcomes through a more joined-up and preventative approach.

6.5 Physical Health Checks and Serious Mental Illness (SMI)

Practices are monitored nationally against the core six requirements and locally against the nine requirements, both have a target of 60%. Performance for 2025/26 against the nine physical health checks is 66%, with only one practice not achieving the 60% target. Performance for 2025/26 against the core six requirements is 73.1%, with all practices achieving the 60% target. Average performance across GM against the six requirements was 68.7%.

Data as of March 31, 2026



A health inequalities piece of work is being trialled in one PCN to try and encourage the hard-to-reach people to attend their appointment and any learning and best practice from this will be shared across the other PCNs.

A Greater Manchester Beyond Core Contract Review (BeCCoR) GP incentive scheme was introduced in 2024/25 and expanded in 2025/26. The SMI KPI has been retained in the Salford Standard for 2026/27 as part of a larger GM (BeCCor) Locally Commissioned Scheme (LCS).

6.6 Risks and Mitigations for Prevention

RISKS:	MITIGATIONS:
DWP funding for Talking Therapies Employment Support may be subject to national change.	Being monitored by services and implications will be incorporated into planning.

7. Recommendations

7.1 The Salford Integrated Care Partnership Committee is asked to:

- note the contents of the report.

Clare Mayo
Integrated Commissioning Manager

Salford
Integrated Care Partnership

Appendices

1. Summary of Most Recent Performance Position

Salford - Oversight Metrics — Show Definitions

Domain	Code	Measure	Frequency	Date	Latest	Previous	Change	Target/Median	Numerator	Denominator	Quartile
		Dementia: Diagnosis Rate (Aged 65+)	Monthly	Mar 26	75.3%	76.10%		66.7%	1,852	2,458	Upper
		Inappropriate adult acute mental health Out of Area Placement (OAP) bed days (rolling 3 month total)	Monthly	Mar 26	650	435		0 38000.00%	N/A	N/A	Inter
		Number of MH patients with no criteria to reside - number of beds occupied by mental health patients who are ready to be discharged	Monthly	May 26	14	16		N/A	N/A	N/A	Lower
		Percentage of MH patients with no criteria to reside (NCTR)	Monthly	May 26	13.3%	16.33%		N/A	14	105	Inter
		Overall Access to Community MH Services for Adults and Older Adults with Severe Mental Illnesses	Monthly	Mar 26	4,755	4,785		4,425 443500.00%	N/A	N/A	Inter
		Talking Therapies: Access Rate	Monthly	Mar 26	1,060	870		N/A	N/A	N/A	Inter
		Women Accessing Specialist Community Perinatal Mental Health Services	Quarterly	Mar 26	230	240		N/A	N/A	N/A	Inter
		Long length of stay for adults (60+ days)	Monthly	Mar 26	12.5%	12.50%		0.% 25.00%	10	80	Upper
		Talking Therapies: Recovery Rate	Monthly	Mar 26	40.0%	29.0%		50.%	115	288	Lower
		% of people with SMI to receive all six physical health checks in the preceding 12 months.	Quarterly	Mar 26	74.0%	68.1%		60.%	2,060	2,785	Upper
		Talking Therapies: 6 Week Waits	Monthly	Mar 26	81.3%	78.0%		75.%	260	320	Lower
		Talking Therapies: 18 Week Waits	Monthly	Mar 26	100.0%	98.3%		95.%	320	320	Inter
		Talking Therapies: Second Treatment Waits	Monthly	Mar 26	32.4%	36.8%		10.%	120	370	Inter
		Access to Individual Placement and Support Services	Monthly	Mar 26	640	610		320	N/A	N/A	Upper

Oversight Scorecard | GM ADSP

Category	Indicator	Frequency	Target	Last 4 Periods				Recent Trend	GM Average
EIP	Early intervention in psychosis waiting times - % within 2 weeks	Monthly	60.00% (Mar-2026)	40.00% (Dec-2025)	50.00% (Jan-2026)	40.00% (Feb-2026)	60.00% (Mar-2026)	↑	47.62% (Mar-2026)
SMI	% of people with severe mental illness (SMI) to receive all six physical health checks in the preceding 12 months	Quarterly	60.00% (Mar-2026)	67.86% (Jun-2025)	61.40% (Sept-2024)	68.05% (Dec-2025)	73.97% (Mar-2026)	↑	69.93% (Mar-2026)
Talking Therapies	Talking therapies - 2 treatments	Monthly	(Mar-2026)	320 (Dec-2025)	330 (Jan-2026)	285 (Feb-2026)	370 (Mar-2026)	↑	260 (Mar-2026)

GM Summary | GM ADSP

Service Area	Measure	Target	Latest Performance	Comments
Physical Health and SMI	People receiving all 6 required checks	60% Cumulative Target by end of financial year (most activity anticipated in Q4)	2025-26 national performance = 73.1% with all practices achieving the 60% target. (*GM Tableau*)	Achieves target
	People receiving all 9 physical health checks	60% Cumulative Target by end of financial year (most activity anticipated in Q4)	2025-26 local performance = 66% with only one practice not achieving the 60% target. (*GM Tableau*)	Achieves target
Memory Assessment And Treatment Service (MATS)	Proportion of memory assessment service referrals receiving a diagnosis within 18 weeks of referral	80%	March 2026 data suggests performance is 20% (*GMMH Commissioner Performance Report*)	Below target. Staff sickness has impacted on the capacity within the service. Additional staffing has been recruited and bank / agency staff are being explored for additional interim support. Commissioners have requested an improvement trajectory to inform recovery planning. GM / Trust level review of MATS services underway.
	Proportion of A&E Liaison referrals seen within 1 hour of referral	75%	April 2026 performance showing as 79.2% (GMMH Commissioner Report)	Achieves target

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Mental Health Liaison	Proportion of people discharged within 4 hours	95%	April 2026 performance showing as 91.9% *(GMMH Commissioner Report)*	Below target. Showing improving trajectory.
	Number of 12 hour breaches	Zero	April 2026 performance shows 13 breaches *(GMMH Commissioner Report)*	Below target. Increased position from March 2026 which correlates with GMMH Trust-wide challenges in flow (Opel 4 reached). Work underway to explore lived experience to inform service improvement.
Out of Area Adult Acute Placements (OAPs)	Acute Adult OAPs	Zero	1 OAP, July 2026	OAPs performance is a fluctuating picture, however Salford performs consistently well in this area when benchmarked across GM.
Clinically Ready for Discharge (CRFD)	Adult Acute CRFD	No more than 1294 bed days lost to CRFD between April 26-March 27. This equates to no more than 3.5 people CRFD per day.	At 09.06.26: GM Tableau suggests: 1 person over 50 days Local Reporting suggests: 2 people, one under 50 days, one over 50 days	Variation in reporting at local vs GM level may be due to time of data flows as position can vary by hour. Targets are annual.
	Older Adult CRFD	Salford Older Adults target is no more than 576.5 bed days between April 26 - March 27. This equates to no more than 1.6 people CRFD per day	At 09.06.26: GM Tableau suggests: 0 people CRFD. Local Reporting suggests: 4 people under 50 days and 1 person over 50 days	Variation in reporting at local vs GM level may be due to time of data flows as position can vary by hour. Targets are annual.

2. Summary of GM ICB Key Adult Mental Health Programmes 2026/27

Programme area	Programme	What this will deliver
Adult MH Community and prevention	**Adult ADHD/Autism services**	Procurement of new central triage system and delivery of Adult ADHD and Autism assessments for those who meet the new clinical criteria
Adult MH Community and prevention	**Increased capacity in Talking Therapies services to meet national access and recovery targets**	Expansion of Talking Therapies will increase access and recovery for people with common mental health disorders, aligned to national targets, while complementing wider system pathways for people with severe mental illness.
Adult MH Community and prevention	**Individual Placement Support (IPS) – Employment Support**	Expansion of IPS will increase access to employment for people with mental health needs, supporting recovery and independence, with additional investment accelerating delivery at scale across GM.
Adult MH Community and prevention	**Shared Care**	Delivery of a GM Shared Care pathway test of change will strengthen Primary and Secondary Care interfaces, improve medication management and support timely step down from specialist services.
Adult MH Community and prevention	**Complex Emotional and Relational Needs pathway implementation**	Phase 2 implementation across the GMMH footprint will strengthen workforce capability, embed consistent clinical approaches and improve care for people with complex emotional and relational needs, reducing escalation and improving outcomes.
Adult MH Community and prevention	**Review of Rehabilitation services, with strengthening of community-based services**	Rebalancing rehabilitation provision through investment in community services will reduce inpatient bed use, support discharge and enable more people to receive care closer to home.
Adult MH Community and prevention	**Neighbourhood delivery models**	Expansion and transformation of the Thrive offer addressing unwarranted variation, developing a core offer across GM Embedding neighbourhood-based mental health models will strengthen prevention, early intervention and integrated working across Primary Care, VCFSE and local authority partners, reducing demand on specialist services.
Adult MH Community and prevention	**GM Inpatient Transformation and Bed Reduction**	Final year delivery of the GM MHLDA Inpatient Quality Transformation programme will focus on reducing Independent Sector reliance and sustaining the out of area position, improving length of stay and flow through strengthened discharge and community pathways, and optimising bed capacity in line with GM demand and capacity modelling. This will be underpinned by the development of a GM-wide inpatient service specification to set consistent standards, expectations and system accountability.
Crisis MH Adults	**Adults Mental Health Crisis Services**	Investment to ensure core fidelity across all Crisis Response and Home Treatment Teams (CRHTs) delivered by PCFT.
Crisis MH Adults	**Adults Community Mental Health Teams (CMHTs)**	Delivery of a GM-wide CMHT service specification will reduce unwarranted variation, clarify core functions and accountability, and strengthen interfaces with Primary Care, VCSE and local authority partners. This includes consolidation of Early Intervention standards and the development of a consistent GM Assertive Outreach model to support people with the highest complexity and reduce reliance on inpatient care.
Crisis MH Adults	**Alternatives to Inpatient Admission including Gatekeeping and IDTs**	Strengthening gatekeeping, Integrated Discharge Teams and community alternatives will reduce avoidable admissions, improve flow and ensure people are supported in the least restrictive setting, with consistent GM-wide approaches to admission decision-making and discharge.

Crisis MH Adults	Health Based Place of Safety	Improves timeliness, safety and quality of Section 136 pathways through enhanced capacity, consistent standards, and reduced police to health handover delays.
Crisis MH Adults	Digital Transformation including CPA replacement	Implementation of digital care planning tools, including DIALOG+, will modernise CPA replacement, improve clinical oversight and enable more person centred, outcomes focused community mental health care, supported by a GM-wide sustainability plan.
Crisis MH Adults	Mental Health Liaison Services	Delivers timely mental health assessment within acute hospitals to reduce Emergency Department waits, support appropriate admission and discharge, and improve patient flow.
Crisis MH Adults	Mental Health A&E, Urgent Care Centres	Strengthens mental health provision within Emergency Departments and Urgent Care Centres to reduce waiting times, improve assessment quality, and support diversion to appropriate community pathways.
Crisis MH Adults	Implementing NHS 111 and text service	Delivers a 24/7 single point of access to mental health crisis support via NHS 111 (Option 2) and text-based support, enabling timely triage, clinical response, and reducing demand on emergency services.

Adult Mental Health

ICPC

June 2026

Setting the Scene

- 3 part approach:
  - Part 1: Commissioning Context
    - Mental Health Context
    - Adult Mental Health Update
  - Part 2: GMMH Strategic Context
    - Trust Strategic Approach
    - Alignment to GM Mental Health and Wellbeing Strategy
    - Alignment to Community Mental Health Transformation Framework
  - Part 3:
    - Neighbourhood Living Well Team (previously known as Living Well)
    - Neighbourhood Models and Live Well

GM Mental Health and Wellbeing Strategy
High Level Outcomes

Greater Manchester

Personal Wellbeing | Service Performance | Community | Workforce

Greater Manchester

Mission 1 Outcomes

- Increased life satisfaction
- Decrease high levels of anxiety
- Increase hopefulness
- Increase ability to get the right help if needed
- Decrease rates of self-harm
- Increase good housing conditions
- Increase satisfaction with local area as a place to live
- Increase access to parks and green spaces
- Increase opportunity to participate in high quality culture and leisure activities
- Decrease proportion of residents economically inactive due to mental ill health

Mission 2 Outcomes

- Decrease of repeat attendees of crisis services
- Decrease number of MH related A&E attendance
- Decrease waiting times for ED attendances classed as MH
- Increase patients signposted to MH support through GM 111 Crisis Helpline
- Waiting times at health-based places of safety for patents detained under S136
- Proportion in in-patient care or home based treatment

Mission 3 Outcomes

- Increased access for underserved and marginalised populations
- Increased self decision-making among service users
- Increased choice and control among service users
- Improved mental health outcomes
- Improved physical health outcomes for people with SMI through annual health checks and follow-up interventions.
- Reduce relapse and preventable crisis episodes
- Stronger integration with VCSE and primary care, reducing fragmentation.
- Increased access to housing, education, employment, and financial support
- Reduced loneliness and social isolation

Mission 4 Outcomes

- Increase participation in population level mental health literacy programmes
- Increase participation in population level mental health literacy programmes by targeted cohorts
- Increase lived experience representation across NHS and social care workforces
- Increase uptake of Zero Alliance Training course among taxi and private hire licensees
- Increase number of pupils supported by whole school college approach
- Increase health Confidence
- Increase confidence in ability to access the right support within local area
- Increase confidence among taxi drivers and private hire licensees in identifying signs of struggles
- Improved understanding of mental health needs among school and college aged children

Mission 5 Outcomes

- Increase diversity of service workforces across Greater Manchester to be representative of communities served
- Increase participation in co-design of mental health services by marginalised groups
- Increase access to mental health services by marginalised groups
- Increase participation in training by Trainees/EMHP Workforce and Education Teams
- Reduce health inequalities across communities
- Increase satisfaction of care received among marginalised groups
- Increase diversity of service workforces across Greater Manchester to be representative of communities served

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

System Convenor – to enable delivery of the ICP strategy

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

Strategic Commissioner

Needs Assessment & Outcomes Setting

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

Strategy and Planning

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

Contracting & Evaluating Impact of System

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

Clear Accountability and Trust

Ten Integrated Place Partnerships

Local Insight-led Planning

Develop priorities and plans to address:

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

Integrated Delivery at Place

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

Aligning Partnership Incentives & Resource

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

Enablers: portfolio/s to encompass all of these functions

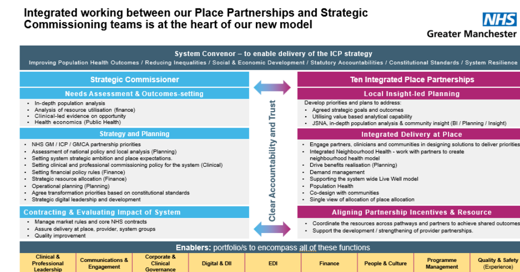
Clinical & Professional Leadership	Communications & Engagement	Corporate & Clinical Governance	Digital & DII	EDI	Finance	People & Culture	Programme Management	Quality & Safety (Experience)

The relationship between our ten Place Partnerships and our GM-wide teams will be central to our future effectiveness

NHS Greater Manchester

GM-wide teams will support our Place Partnerships through…

1. Providing **data-driven insights** via the DII, combined with community knowledge and lived experience, to help shape place priorities, delivery of Live Well and Neighbourhood health and care initiatives.
2. Allocating **funding and resources,** sharing financial insights, supporting clinical leadership, through partnership agreements to enable delivery of Place objectives.
3. Supporting **communications**, in collaboration with place partners.
4. Offering guidance and expertise from **quality assurance, quality improvement and patient safety** insight to help ensure high-quality community care, including services in primary care and care homes.
5. Commissioning **GPIT and digital solutions** to facilitate local integration and transition from analogue to digital systems. Supporting strategic estates discussions.
6. Providing expert guidance in **equality, diversity, and inclusion** to help ensure that health care services, including general practice and care homes, are inclusive, equitable, and of consistently high quality.



Place Partnerships will support GM-wide teams through…

1. We will **work in genuine partnership with communities**, building on community assets and taking a strengths-based approach where co-design and lived experience are central to everything we do.
2. **Demonstrating benefits** and delivering improved health outcomes, reduced inequalities, and enhanced prevention through delivery of Live Well and Neighbourhood Health and Care initiatives.
3. Implementing collaborative approaches to **demand management** by utilising place budgets across partners to test and scale alternative care models to systematically reduce acute expenditure.
4. Providing timely progress **updates and outcome** reports to meet governance requirements, including early escalation and mitigation of risks when necessary.
5. **Securing partner investment and commitment**, including clinical and professional leadership, transformation, and organisational development, to support achievement of key objectives.
6. Acting on strategic commissioning intent locally and **sharing local insights** to help inform strategic commissioning and strengthen performance assurance.

Adult Mental Health – Key Highlights

- Robust Community offers – NHS Talking Therapies, Neighbourhood Mental Health Teams (previously known as Living Well), Specialist Community Mental Health Teams (CMHT), Strong Mental Health VCSE provision, Supported Living,
- Sustained low use of Out of Area Acute Placements (OAPS) and Spot Purchase beds – keeps people closer to home, connected to communities, better outcomes and quality oversight, lower cost and in line with national targets.
- Crisis Alternative Offers – Home Based Treatment, Crisis Beds, VCSE Crisis Alternatives, Mental Health Liaison.
- Detailed updates on performance / transformation outlined in Adult Mental Health Update paper.

Priority 1
Delivering care that matters

Priority 2
Working together

Priority 3
Being fit for the future

Our GMMH Strategy 2025-28

Our vision	**Great places for care and great places to work**
Our purpose	**Working in partnership to improve the quality of life for all we serve**

Our strategic priorities for the next **three years** are:

Delivering care that matters	Working together	Being fit for the future
Deliver coordinated, outcome-focused, research-informed and evidenced-based care for the communities we serve.	Work together with service users, carers, our colleagues and our partner organisations to improve the health of our communities.	Make the best use of all our resources to support safe, effective and sustainable care.

Our enabling strategies

- Care strategy
- Together strategy
- Digital and data strategy
- Research and innovation strategy
- People strategy
- Medium term financial plan

Our values

- We are caring and compassionate
- We are open and honest
- We work together
- We inspire hope
- We value and respect

GMMH Priorities for the next five years

NHS
Greater Manchester
Mental Health
NHS Foundation Trust

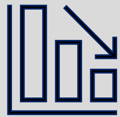
- NHS England published planning guidance October 2025, following publication of 10 Year Health Plan.
- Requirement for provider trusts, Integrated Care Boards (ICBs) and places/localities to develop five year plans setting out how they will deliver the 3 shifts in the 10 Year Health Plan and financial sustainability.

Five key priority areas identified in our plan:

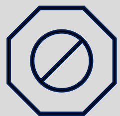
GMMH Priorities for the next five years

NHS
Greater Manchester
Mental Health
NHS Foundation Trust

1 Reducing Inpatient Bed Capacity


Improve flow, reduce length of stay, support timely discharge

Eliminate Out of Area Placements and Local Spot Purchase and reduce our bed base

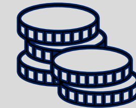

Prevent crisis admissions through proactive, co-produced crisis planning

Partnership arrangements with statutory and VCFSE sector to prevent admission and enable discharge

2 Strengthening Community Services

Transform our community services, embracing a 'community first' approach

Deliver holistic, trauma informed support to aid recovery


Invest in community workforce through the integrated fund

Work with partners to deliver innovative, digitally enhanced, people-centred services.

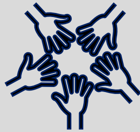
Use population health data to target areas of specific need

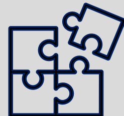
GMMH Priorities for the next five years (continued)

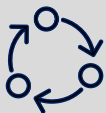
NHS
Greater Manchester
Mental Health
NHS Foundation Trust

3 Improving Quality and Culture

'Quality is everyone's business' and continuously improving our services

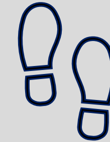

Safety, effectiveness and experience for service users and their carers


Meeting required quality, regulatory and contractual standards


Anchoring the "Living our GMMH Values" behaviour framework in everything we do.

4 Digital Enablement

Digital innovation to support all transformation to improve access and efficiency


Digitise all aspects of the service user's journey

Joint Digital and Data Strategy with Pennine Care

Digital capability to improve workforce agility and productivity

GMMH Priorities for the next five years (continued)

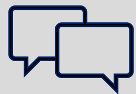
NHS
Greater Manchester
Mental Health
NHS Foundation Trust

5

Financial Sustainability

Deliver balanced financial plan, including national 2% productivity target

Strategic investment in community and digital transformation



Adding value programme to identify targeted efficiency

Estate management through rationalisation and space utilisation

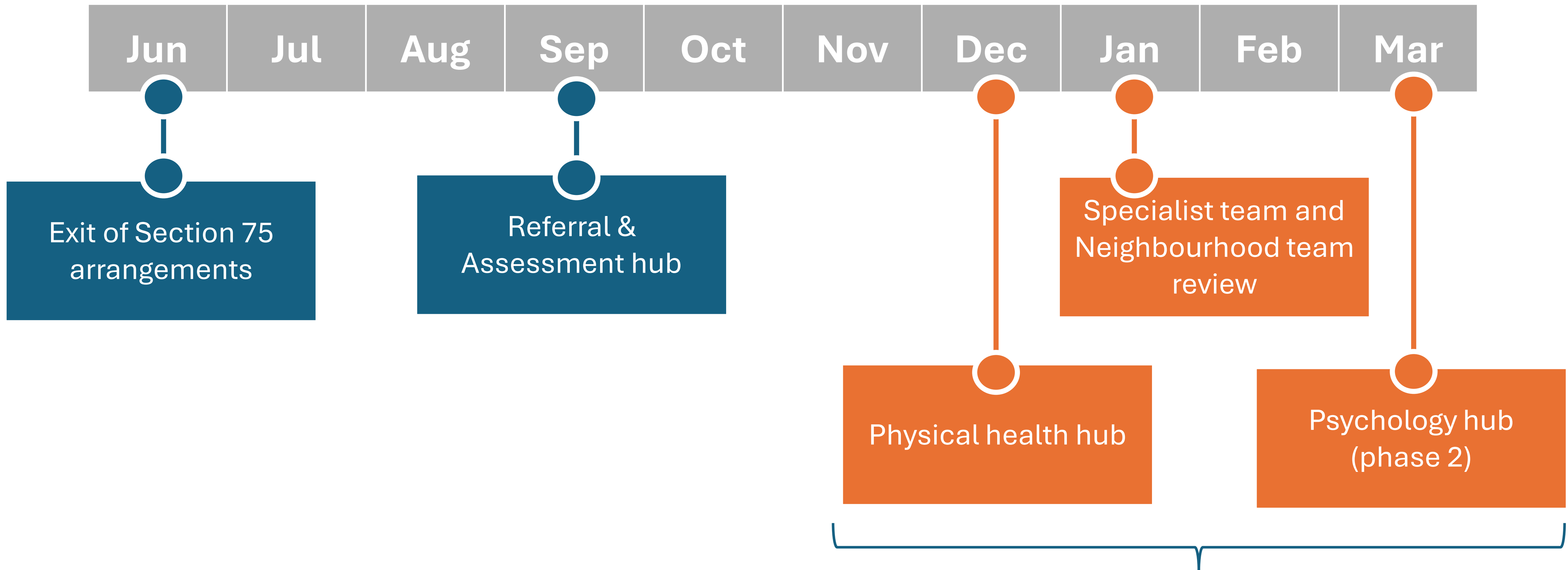
The 10 Year Health Plan makes new commitments to shifting the model of care to try to address these issues, building on the manifesto commitments

Key manifesto commitments include:

1. Provide **access in schools** to specialist mental health professionals (announced ambition to provide access to all pupils by 2029/30)
2. Increase mental health **workforce** by 8500
3. Reduce **waiting times** for access to mental health services
4. Reform **Mental Health Act**
5. Provide open access mental health **support for young people** in every community, via Young Futures Hubs
6. Reduce the **suicide rate**
7. Reform the NHS so mental health has the same attention and focus as physical health (e.g. public commitment from Secretary of State to meet MHIS in 2025/26)

Source: DHSC MH policy and strategy team

Adult Community Mental Health Transformation Draft Time Line



Background

Salford
Neighbourhood
Mental Health Service

- One of 4 national pilot sites in the UK, supported by the national Innovation Unit to undertake co-production to design the service.
- Grown from small prototypes to full £3mil business case to deliver across the city
- Based on ethnographic research and key insights from people with lived experience of mental health needs
- Integrated partnership approach to delivery: GMMH, Mind in Salford, Start, Six Degrees, Well being matters, CVS and more.

What we do

Salford
Neighbourhood
Mental Health Service

Understand "what has happened to you" through extended assessments to determine the degree and nature of complex presentations, to understand where and what support would benefit patients.

Provide psychosocial interventions to improve quality of life and to develop coping skills and autonomy.

Social connections; we introduce service users to what is available in their local area. We will support in the initial introduction to the service, but we do not regularly support service users to attend the sessions, and we do not stay with them, rather we support them through interventions to cope in social situations independently as part of other interventions delivered.

We have adopted a relational risk policy after extensive ethnographic research with experts by experienced. We look at the individual, supporting shared responsibility via safety planning and a team-based approach (support mechanisms for staff, strong reflective practice values).

Promote a strengths-based approach. Working with people to promote independence, rather than being deficit based (what people can't do).

Who we support

Salford Neighbourhood Mental Health Service

- Adults whose needs are deemed too ‘complex’ to be met in primary care, but may not meet thresholds for traditional CMHT/Specialist Team. Taking into consideration people's level of functioning, impairment and the frequency and intensity of required contacts.
- Adults with Serious Mental Illness (although SMI component is stable)
- People who require formulation and understand of their situation in a wider mental health and social context to prevent deterioration and crisis.
- Whilst the team is a recovery focussed and responsive service it does not replace urgent care service.
- The service supports the wider system to support individuals with complex mental health and other needs who use a variety of services in a non-medical framework.
- Support is offered in a culturally appropriate and sensitive way, with input from GM Lingua and understanding gained from local communities.

About the team

Our main workforce is made up of **Recovery workers (employed by START) and Peer support workers (employed by MIND and GMMH),** with Mental Health Practitioners to provide clinical support.

We have integrated staff who can provide specialist advice and support such as:

- **Senior Practitioner for Domestic Violence**
- **Psychology (Six Degrees)**
- **Specialist mental health debt advice (Mind)**
- **Housing Support (Housing Options via SCC)**
- **Mental Health Community Connector (Salford CVS).**
- Medical Expertise e.g. Consultant Psychiatrist, Specialist GP, Senior Pharmacist, Senior Nurse
- Occupational Therapist
- Senior Social Worker
- Advanced Clinical Practitioner
- **Integrated interpreting service offered by Lingua GM, who also provide peer support workers and interventions in people's native language.**

Our psychology team consist of Principal Clinical Psychologist, CAT trainee, Psychodynamic Practitioners, DBT practitioner, APPS. Our psychology team offer short-term work, such as:

- Psychological assessment
- Psychological formulation
- Brief intervention (CBT/CAT/DBT/CFT-informed, psychodynamic consultation, trauma stabilisation, readiness for therapy).
- Psychology groups, such as Emotional Skills group.

Our psychology team support our team to deliver a psychological approach through joint work, supervision (1:1 and group) these are planned and we have daily drop-ins. The NMHT do not provide any talking therapies.

Impact

- **Hope!**
- **For the person**
  - Improved outcomes – improving things for the person, based on their goals not those of the service
  - Continuity and consistency of care
  - Benefits of peer support
  - Holistic approach
  - Coherent team response to distress and complexity
- **For staff**
  - Excellent staff retention
  - Excellent staff well being and resilience
  - Workforce development pathways
- **For the system**
  - Increased social value
  - Consistent psychological formulation
  - Shared learning and understanding across the system

Learning and Innovation

Salford Neighbourhood Mental Health Service

Different ways of working: allowing services to operate differently.	Relational model	Relational risk model	Trauma informed
Hope through visible recovery.	Lived experience is key	Flexibility in service delivery	Non medicalised offer.
Seeing the person as part of their own system.	Developed partnership working offer.	Not saying 'no' or 'it's not us'. Instead asking "what can we do to help?"	

Data to support impact and learning (External evaluation: Cordis Bright)

2019-22

- Good evidence that the service is targeting the intended population
- 26% of people supported were from Asian, Black or 'other' ethnic groups. Higher proportion than 2011 census data (10%) – demonstrating excellent reach
- 59% of people saw a reliable improvement in their ReQoL score, suggesting a meaningful improvement in their recovery and quality of life
- The mean average ReQoL score between start of support and most recent scores increased from 15.3 to 20.9 (higher is better).
- A high proportion of people reported improved satisfaction regarding
  - their leisure and community activities (49% improved; 27% no change; 24% deteriorated);
  - in relation to their job / studies / other occupation (47% improved; 24% no change; 29% deteriorated)
  - in relation to their personal safety 48% improved; 41% no change; 11% deteriorated)
- 93% of people made progress towards at least 1 personal goal; 84% 2 goals; 43% towards 3. Only 3 people (5%) indicated regression towards personal goals

2024/25

- The service continues to achieve positive outcomes similar to those measured in the original Cordis Bright evaluation in 2019-2022
- 55% of people supported experience reliable improvement in their recovery and quality of life
- 100% of people agreed or strongly agreed that the support they received has improved their wellbeing
- 91% of people agreed or strongly agreed that the support received was more helpful than support received in the past.
- For those accessing the service with recorded data relating to ethnicity, this was in line with Salford population expectations
- Strong evidence of partnership working was also evidenced as follows:
  - 69% of stakeholders strongly agree or agree that partners work together to ensure that voices from across the community are heard in the co-creation of the model
  - 62% of stakeholders agree or strongly agree that increasingly, people in Salford see mental health as everyone's business
- Staff experience was also highly positive, with 94% of staff recommending their organisations as a good place to work, and 100% reporting they would be happy with the standard of care from the team if their friend or relative needed mental health support

Salford Neighbourhood Mental Health Service

Feedback from people using the service.....

Neighbourhood Models / Live Well

- Similarities with Live Well / Neighbourhood Models:
  - Ethos – holistic, no wrong front door, 'warm handovers' – connections to other services with assistance
  - Learning and prototyping journey
  - Person at the centre of the offer

- Opportunities to connect and learn
- Connections made with Proactive Care Neighbourhood Work (sharing mental health model at July meeting)
- Opportunities to consider wider connections – at the start of this journey.

Salford
Integrated Care Partnership

Salford Integrated Care Partnership Committee
25 June 2026
Item 3 (b) – Place Lead Report

Item for: Decision/Assurance/**Information**

Report of:	Place Lead	
Date of Paper:	18 June 2026	
In case of query, please contact:	Gina Magson Gina.magson@nhs.net	
System Priorities: (Please tick as appropriate)	Immunisations	✓
	Physical activity and movement	✓
	Child Friendly City	✓
	Live well, Neighbourhoods and Communities	✓
	Adults and Ageing Well	✓
	Preventable illness - CVD and Diabetes	✓
	Urgent and emergency care	✓
	Mental health and emotional wellbeing	✓
	Triple aim – population health, performance recovery, financial sustainability	✓
	Other system enabler i.e. Workforce, Transformation, Digital etc.	✓

Purpose of Paper:

This paper provides a summary of local and national policies, strategies, and relevant news to ensure that members of the Salford Integrated Care Partnership Committee (ICPC) remain up to date on the latest developments relevant to the health and care sector in Salford.

Salford
Integrated Care Partnership

Further information

How will this benefit the health and wellbeing of Salford residents, or the ICS?	By ensuring that members of the Salford Integrated Care Partnership Committee are aware of the most up-to-date information available.
How does this paper address health inequalities and promote inclusion?	N/A
What risks may arise as a result of this paper and how will they be mitigated?	N/A
Does this address any existing high risks facing the organisation and how does it reduce them?	N/A
Are there any conflicts of interest associated with this paper?	As decisions made may affect provider organisations represented on this board, conflicts of interest are not entirely avoidable, and will be managed in line with NHS Greater Manchester (GM) policy.
Will any current services or roles be affected by issues within this paper and what are they?	N/A

Note: Where appropriate, please ensure detail is provided.

Document Development

Has there been Public Engagement?	N/A
Has there been Clinical Engagement?	N/A
Has the impact on Salford socially, economically and environmentally been considered?	N/A
Has there been an analysis of any impacts on equality?	N/A
Has legal advice been obtained?	N/A
Has this been to any groups or committees for engagement, comments, or approval?	Approved by Place Lead and Deputy Place Lead on 18 June 2026.

Note: Where relevant, please provide detail and ensure that it is clear how and when particular stakeholders were involved in this work, that there is clarity of what the key message/decision was, and whether amendments were requested about any part of the work.

Salford
Integrated Care Partnership

Place Lead Report

1. Executive Summary

This paper provides a summary of local and national policies, strategies, and relevant news to ensure that members of the Salford Integrated Care Partnership Committee (ICPC) remain up to date on the latest developments relevant to the health and care sector in Salford.

2 Greater Manchester (GM) and National Update

2.1 Workwell Partnership Vanguard

You will be aware that in October 2024, we commenced England's largest WorkWell Partnership Vanguard aimed at supporting people with health needs to remain in or return to good employment.

The initial vanguard came to an end on 31 March 2026 and has now been scaled up nationally for a further three years. In Greater Manchester (GM) the funding has been included in the Integrated Settlement, and the model we have developed will now form part of more comprehensive locality employment support models going forward, rather than sitting as a standalone project.

Key headlines for GM are as follows:

- With your local leadership and support we co-produced and established separate vanguards across each of the localities, building upon the assets that existed and the needs of specific populations. It was the largest, most complex and most sustainable of the 15 national vanguards.
- We stood up an integrated pan-GM programme management function, led by the ICB and in partnership with the Combined Authority and Local Authority colleagues.
- Over the 18-month pilot, the vanguards provided support to **6,084 people** in GM for whom health was a significant barrier to employment. This is by far the largest number of any of the 15 national vanguards.
- This drew **£6.6million** of external grant funding into the GM system.

This is a great example of a GM-enabled, locally led approach and I am incredibly proud of the work that the team undertook and the impact it had.

2.2 NHS Greater Manchester invests £3.2m to improve Attention Deficit Hyperactivity Disorder (ADHD) and Autism Support

NHS Greater Manchester is investing £3.2 million to improve ADHD and Autism support for children and young people under 18, helping families access the right help earlier and more fairly.

From April 2026, a new GM-wide approach was introduced which hopes to ensure all children and young people can receive support with or without a diagnosis, with those who have the greatest needs prioritised for specialist care. Every child will now receive a personalised offer of support based on a full understanding of their needs. This may include tailored advice, school and home tools, parent workshops, and access to a new online hub with resources and guidance. The aim of this change is to reduce delays, prevent avoidable harm and ensure children get help when they need it. Find out more here.

2.3 Urgent Emergency Care – Accident & Emergency (A&E) Experience

Nationally, demand on A&E is challenging and in many places exceeding the capacity available.

This is placing pressure on NHS trusts which is impacting the standard of which 95% of patients who attend A&E need to be admitted, transferred or discharged within 4 hours of arrival.

NHS Greater Manchester's current performance remains below the target (78%) and we would like to understand why this may be. NHS Greater Manchester is inviting colleagues across the GM health and care system and your families to share your experiences if you have visited A&E within the last 18 months.

Rising demand for urgent care is a challenge across the region. Your feedback will help us understand what people experience when attending A&E, whether they felt it was the right place for their needs, and what alternatives they considered. This insight will inform future work to reduce avoidable A&E attendances and strengthen local urgent care options.

The survey is quick, confidential and open to anyone who has recently used A&E. Please take a moment to complete it and share widely with friends, family and community networks.

Together, we can help improve urgent care for Greater Manchester.

2.4 Greater Manchester Highlights Progress on Neighbourhood Health

Colleagues from across Greater Manchester welcomed Dr Claire Fuller, NHS England's National Medical Director for a constructive and forward-looking visit focused on strengthening neighbourhood health.

We shared our ambition for integrated, community-based care through our long-standing partnership approach and shared our strategic plans for delivering more preventative, equitable services.

Discussions explored how our vision for neighbourhood health is being translated into practice, including the role of place partnerships, integrated neighbourhood teams and population health approaches such as BeCCoR.

Colleagues shared real examples of progress in areas including mental health transformation, outpatient redesign and provider collaboration, alongside the challenges of workforce, consistency and scaling impact across all 10 GM places. Roundtable discussions enabled open dialogue on local delivery, innovation and learning, with a strong emphasis on evaluation and continuous improvement.

The visit concluded with a shared commitment to accelerate progress, build on GM's strong foundations and continue working collaboratively to improve outcomes for local people.

2.5 Farewell to Sir Richard Leese

Sir Richard Leese, Chair of NHS Greater Manchester and Co-Chair of the Integrated Care Partnership will retire later this month, marking the end of more than 50 years of public service. Sir Richard has played a pivotal role in shaping NHS GM and strengthening collaboration across the city-region.

In the meantime, Jackie Njoroge, Deputy Chair will step in as Acting Chair. Jackie joined the Board in January and brings over 20 years' experience in strategy and data leadership, alongside a strong background in public sector governance. We thank Richard for his dedication and wish him a very happy retirement.

2.6 Farewell to Mark Fisher

You will be aware Mark Fisher, Chief Officer had been away from work following a whistleblowing concern. I am pleased to say that in February the process was concluded, and Mark was free to return to work. However, as previously planned, Mark was due to retire at the end of March and therefore chose not to resume his role.

Mark wanted me to pass on his thanks to all of you for your support over the past four years.

2.7 New Chief Executive Officer appointed at Greater Manchester Mental Health (GMMH)

Chris Oliver is the new Chief Executive Officer of Greater Manchester Mental Health NHS Foundation Trust (GMMH). Chris joins from Lancashire and South Cumbria NHS Foundation Trust, where he has served as Chief Executive Officer since 2022. He brings a wealth of experience from previous senior leadership roles, including Chief Operating Officer at Mid Cheshire Hospitals NHS Foundation Trust and Director of Operations at Wirral University Teaching Hospital NHS Foundation Trust. The appointment follows a rigorous recruitment process, which took place between March and May.

2.8 Health Service Journal (HSJ) Digital Awards – Recognition for Greater Manchester

NHS organisations across Greater Manchester have been recognised at the HSJ Digital Awards for excellence in digital innovation. Health Innovation Manchester and NHS Greater Manchester won Digital Team of the Year for the GM Care Record programme, which connects health information for around three million people to improve care co-ordination and decision-making.

3 Salford Updates

3.1 Six Degrees win at NatWest Social Enterprise Impact Pioneer Awards

I am delighted to share that Six Degrees were shortlisted in the NatWest Social Enterprise Impact Pioneer Awards 2026 in the Diversity Pioneers and they won!

Six Degrees have also been recognised in the first-ever NatWest Social Enterprise 100 Pioneering Impact Leaders list. The judges recognised their commitment to designing and delivering services through an intersectional lens, which enables them to understand people's lives in complex and nuanced ways by recognising that aspects of identity such as age, gender, race, class, and migration status are not experienced as discrete categories.

The panel focused on strengths such as recruiting from the communities they serve ensuring the workforce reflect the population, first-language therapists to reduce barriers and preserve dignity, and the ongoing commitment to addressing the structural barriers that prevent or exclude communities from accessing brief psychological support preventing further distress, harm and inequity.

This award reflects the commitment shown across Six Degrees every day to deliver inclusive, culturally responsive and community-rooted support that genuinely impacts lives.

3.2 Healthwatch Salford

The findings from the work with the Salford Armed Forces Community will be published shortly. Healthwatch will be at the Armed Forces Day event on 27 June 2026 to share more information on this and will circulate wider publicly too.

At the end of June, Healthwatch will also be publishing their annual report.

The Healthwatch Health fair is on 7 July 2026, 12 – 3 pm at the Old Town Hall in Eccles. It would be great to see you there.

3.3 Change of Northern Care Alliance Chief Executive

Dr Owen Williams, Chief Executive Officer of Northern Care Alliance (NCA) has announced that he will be leaving the NCA in September.

During his five years with the NCA, Owen has played a pivotal role in strengthening clinical leadership, leading major improvement and transformation programmes, stabilising finances and setting a clear direction for a more sustainable future.

I will keep you updated in the coming months with regards to the recruitment of Owen's replacement.

3.4 Changes to the Mayoral Team

City Mayor Paul Dennett has announced changes to his Mayoral Team. The changes reflect the breadth of skills, experience and dedication we have across our Councillors and combines strong leadership with deep knowledge, ensuring we can continue to deliver for our communities in Salford and give a balanced, city-wide representation so that every part of our city is heard and supported. Read the changes in full.

3.5 Welcome to Nicola Hepburn

Nicola Hepburn will temporarily be the NHS GM Chief Officer link for Salford. Nicola is interim Chief Officer for Reform, covering for Colin Scales whilst he is interim Chief Officer. Colin has said he is keen to stay close to Salford, as much as he can, however in terms of attending our formal meetings, this will be Nicola for the foreseeable future.

Nicola was previously a Deputy Place Lead (DPL) in Oldham, and has more recently been in a GM role, supporting Colin and Kathy lead financial and performance recovery work. It will be great to have her join Team Salford.

4. Recommendations

4.1 The Salford Integrated Care Partnership Committee is asked to:

- note the contents of the report.
- disseminate and cascade the necessary key messages and information as appropriate.

Stephen Young
Chief Executive, Salford City Council and
Place Lead for Health and Care Integration, Salford