Agenda

Tameside Strategic Partnership Committee

Date: Wednesday 26th August 2026

Time: 11-12:30pm

Venue: Committee Room 1, Level 2, Tameside One

Item No.	Time	Subject	Paper/ Verbal	For Approval/ Discussion/ Assurance/ Information	By Whom
1.	11 am	Welcome, Introductions and Apologies	Verbal	Information	Chair
2.		Declarations of Interest	Verbal	Information	Chair
Items for Approval / Information / Discussion					
3.	11:05am (5 mins)	Minutes of Committee 22nd July 2026 /Action Log	Paper	Approval	Chair
4.	11:10am (5 mins)	Place Director Update	Verbal	Information	Marion Colohan
5.	11:15am (5 mins)	NHS GM CEO's Report	Paper	Information / Discussion	Marion Colohan
6.	11:20am (15 mins)	Tameside Health and Care Partnership Governance Structure	Paper	Approval	Vic Leonard
7.	11:35am (20 mins)	Tier 2, Community Gynaecology Service	Paper	Information	Kate Hebden / Jaki Heslop
8.	11:55am (15 mins)	Questions from the Committee: Place Partnership Agreement	Verbal	Information /Discussion	Marion Colohan
9.	12:10pm (15 mins)	Tameside Locality Board Report	Verbal	Information	Marion Colohan
Any other Business and Administration					
10	12:25pm (5 mins)	Any other business – *To be notified to the Chair in advance of the meeting*	Verbal	To receive	Chair
11		Date and time of next meeting: Wednesday 23rd September 2026 11-12:30pm Committee Room 1, Level 2, Tameside One	Verbal	To note	Chair

Minutes

Tameside Strategic Partnership Board **– Part B and Development Session**

Date: 22nd July 2026

Time: 11:00

Venue: In Person – Committee Room 1, Level 2, Tameside One, Ashton-U-Lyne

Present
Councillor Eleanor Wills – Leader of Tameside Council and Chair Councillor Mike Smith – Lead Member for Population Health and Wellbeing Claire Williams – Executive Support Team – Minute Taker Emma Alexander -Chief Executive, Tameside Council Karen James – Chief Executive, Tameside & Glossop Integrated Care NHS Foundation Trust and Stockport NHS Foundation Trust Dr Simon Sandhu – Chief Medical Officer, Pennine Care NHS Foundation Trust Councillor Leanne Feeley (Executive Member for Lifelong Learning and Culture) Anna Hynes - Action Together Tameside Director Chris Martin- Senior Program Manager, Neighbourhood Health and Care NHS GM. Victoria Leonard – Associate Director (Clinical) Improvement & Personalisation NHS GM. Marion Colohan – Deputy Place Based Lead NHS GM Tameside Jill Colbert – Strategic Director of Childrens Joanne Street - Programme Director- Transition NHS GM Dan Clarke – The Christies - Programme Manager for Neighbourhoods and Cancer Paul Buckley - Executive Director of Strategy & Partnerships Stockport NHS Foundation Trust and Tameside and Glossop Integrated Care NHS Foundation Trust
Apologies
Apologies were received from Joe Kelly, Catherine, Sharon, Ben Smith, and Katherine Sheerin.

Item No.	Topic	Action
1.	**Welcome, Introductions and Apologies** The Chair welcomed attendees and noted the presence of several new members around the table. A brief round of introductions was undertaken.	
2.	**Declarations of Interest** No declarations of interest were made.	

3.	**Minutes of Previous Meeting and Matters Arising** The minutes of the meeting held on 24 June 2026 were approved as an accurate record. No matters arising were raised.	
4.	**Place Report** MC presented the Place Report highlighting considerable progress across children's services. Members noted the introduction of enhanced children's community palliative care arrangements funded through a three-year programme, the successful launch of the Tameside Neurodiversity Hub delivered by Barnardo's, and developments to address CAMHS waiting lists through additional triage and assessment capacity. The Neurodiversity Hub had supported approximately 150 children and families during its first three months despite not yet being fully staffed. Members welcomed the range of workshops, youth groups, family events, and information sessions being delivered. An update was provided regarding the Health Innovation Manchester asthma programme. Early evidence indicated improvements in admissions and diagnostic pathways, although funding for the initial pilot had ceased, and discussions were ongoing regarding sustainability. The Committee congratulated Pennine Care NHS Foundation Trust following its improved CQC rating from Requires Improvement to Good. Members also noted promotion of the Meningitis B vaccination campaign targeted at eligible young people entering higher and further education. **ACTION**: MC to bring a detailed Neurodiversity Hub update, including outcome data and case studies, to a future meeting during Autumn 2026. **ACTION:** Further consideration to be given to governance arrangements and reporting mechanisms for SEND and neurodiversity improvement programmes.	
4.	**NHS Greater Manchester Strategic Objectives 2026-2031** JS presented NHS Greater Manchester's five-year strategic objectives, outlining the organisation's revised focus following NHS reform. Priorities include preventative and proactive neighbourhood care, reducing inequalities, system transformation, and delivery of statutory responsibilities. Members discussed the importance of retaining flexibility to respond to local needs and ensuring that Tameside priorities continue to influence Greater Manchester commissioning decisions. Discussion focused on healthy life expectancy, reducing inequalities, and ensuring local risks and challenges are reflected appropriately within strategic planning processes.	
5.	**Tameside Place Delivery Plan** VL presented the draft Tameside Place Delivery Plan, mapping local priorities against Greater Manchester strategic objectives. The document outlined delivery ambitions around neighbourhood development, population health management, integration, mental health, and transformation programmes.	

	Members welcomed the increased level of detail and noted the need to review governance, workforce capacity, and collective partnership resources to support delivery. The Committee approved the overall direction of travel and noted that the document would continue to evolve as governance arrangements mature. **ACTION:** Place Team to continue development of governance arrangements and reporting structures supporting delivery of the Place Plan. **ACTION:** Future iterations of the plan to include clearer consideration of collective partnership resources and workforce capacity.	
6.	**Cancer Programme Update and Forward Plan** DC presented an update regarding cancer services and neighbourhood delivery. Early diagnosis performance improved and continued to show positive progress. The Cancer Alliance has aligned its approach with neighbourhood working, supporting prevention, early diagnosis, personalised care, and community-based support. Members welcomed plans to utilise local funding to strengthen neighbourhood delivery models and voluntary and community sector engagement. The important contribution already being made by VCSE organisations in supporting patients and families affected by cancer was recognised by the Committee.	
7.	**Place Partnership Framework Feedback** MC facilitated discussion regarding feedback on the Place Partnership Framework documentation. Members reflected discussions held at the June meeting and subsequent conversations within partner organisations. Key themes included governance and accountability arrangements, financial risk management, outcomes frameworks, performance reporting, local intelligence, and maintaining local influence over commissioning decisions. The Committee agreed that a formal response should be submitted on behalf of Tameside before the consultation deadline. **ACTION:** MC to draft and coordinate the formal Tameside response to the Place Partnership Framework consultation and circulate for partner input prior to submission.	
8.	**Any Other Business** EA informed the committee MC had been appointed permanently to the Tameside Place Director role. Members welcomed the announcement and congratulated Marion on her appointment.	
9.	**Date of Next Meeting** 26 August 2026	

Log No	Action	Date Added	Deadline	Responsibility	Update	Date Closed
1	Neurodiversity Hub update to return as a substantive agenda item with outcome data and case studies.	23.07.26	November Partnership Committee 2026	MC	Detailed Hub data will be available by the end of Q2 2026/27	
2	Further consideration of governance arrangements and reporting mechanisms for SEND and neurodiversity improvement programmes.	23.07.26	04.09.26	MC / ICB DII Team	SEND Board Report for health data being produced for September SEND Board	
3	Continue development of **governance arrangements and reporting structures** supporting delivery of the Place Plan.	23.07.26	Ongoing (Q3–Q4 2026)	Place Team	Agenda August 2026 TSPC	
4	Future iterations of the Place Delivery Plan to include clearer consideration of collective partnership resources and workforce capacity.	23.07.26	Next iteration of Plan (Late 2026)	Place Team / HR Leads		
5	Explore links between childhood asthma outcomes and wider determinants of health.	23.07.26				
6	Strengthen visibility of strategic risks alongside NHS GM strategic objectives.	23.07.26				
7	Re-establish the Mental Health Partnership Group from September 2026.	23.07.26		JV/PT	currently arranging for the 17th September this date my need to be changed due to room availability.	
8	MC to Draft and submit a formal Tameside response to the Place Partnership Framework consultation by 21 August 2026. Continue seeking partner feedback on the Place Partnership Framework prior to submission.	23.07.26	Consultation deadline 21st August 2026.	MC	Complete response sent from Cllr Wills	

NHS
Greater Manchester

ACTING CEO'S REPORT TO THE BOARD
JULY 2026

Part of Greater Manchester
Integrated Care Partnership

Board

15 July 2026

Report for Information

Required information.	Details.
Title of report.	Acting CEO's Report to the Board
Author.	Jenny Noble on behalf of Professor Colin Scales
Presented by.	Professor Colin Scales
Contact for further information.	gmhscp.gmicb.corporate@nhs.net
Executive summary.	The paper details updates from the Acting CEO with reference to the national, regional and local system positions.
The benefits that the population of Greater Manchester will experience.	The NHS Greater Manchester (GM) response to NHS Reform, with consideration being made through the necessary due diligence.
How health inequalities will be reduced in Greater Manchester's communities.	Proactively responding to the independent review into maternity and neonatal services at Nottingham University Hospitals NHS Trust.
The decision to be made and/or input sought.	The Board is asked to note the contents of the CEO's Report to the Board. Also, disseminate and cascade the necessary key messages and information as appropriate.

How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	Delivering key messages in the context of NHS Reform which is BAF SR10.
Key milestones.	Key messages in the context of NHS Reform.
Leadership and governance arrangements.	For consideration and dissemination by the Board.
Engagement* to date. ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	Engagement has already commenced with the GM system's key stakeholders and NHS GM staff in response to NHS Reform. Any formal decisions to be taken, will proceed through the necessary governance routes.
Financial or Legal Implications	NHS GM proceeding with the organisational change programme in response to NHS Reform.

Public engagement	**Clinical engagement**	**Sustainability impact**	**Financial advice**	**Legal advice**	**Conflicts of interest**	**Report accessibility**
No	No	No	No	No	No	No

Introduction

1.1. The paper details updates from the Acting CEO with reference to the national, regional and local system positions.

National and Regional Updates

1.2. This section of my report is aimed to update the Board on the key areas of development from a national and regional position, since the last Acting CEO's Report to the Board in May.

1.3. Board members will be aware that Donna Ockenden has published the independent review into maternity and neonatal services at Nottingham University Hospitals NHS Trust.

1.4. This is a deeply distressing report. It describes years of serious and repeated failures in care, including poor leadership and culture, a lack of accountability, unacceptable racism and discrimination and women and families being disbelieved or dismissed. It also describes extremely serious failings in post death care – failures that caused grieving families further pain and trauma at a time when they should have been treated with the utmost care, dignity and compassion.

1.5. All of our thoughts are with the women, babies and families who were harmed, bereaved and let down, and with those who have fought for years to be heard. Every woman, baby and family has the right to safe, compassionate, personalised and equitable care, and to be listened to and taken seriously when they raise concerns.

1.6. The review has taken a continuous learning approach. Nottingham University Hospitals NHS Trust has responded to findings as they emerged and has already taken steps to improve care. However, the report shows the scale of what still needs to change.

1.7. One of the most important steps the Trust has taken is to listen to women and families, and every service in the NHS must do the same. Previous reviews have repeatedly shown that women and families must be heard, believed and have their concerns taken seriously and acted on. It is more important than ever that you work closely with your maternity and neonatal voices partnerships lead and local communities to ensure your services are set up to do this well to achieve this.

1.8. The Government has announced immediate action in response to the review including roll out of Martha's Rule to all maternity and neonatal settings in England, strengthening candour and cooperation in future reviews, and Human Tissue Authority (HTA) action requiring all Trusts to review mortuary records.

1.9. I've attached a Stakeholder Briefing with an update on work to improve neonatal care services in the North West, issued on behalf of North West Safe and Sustainable Specialised Health Services for Babies & Children programme which will be reviewed by Chief Officers at their meeting on 8th July and a verbal update will be provided at Board.

Office for Pan ICB Commissioning (OPIC) – National Context and North West Arrangements

1.10. The Office for Pan ICB Commissioning (OPIC) is a new national model mandated by NHS England (NHSE) and the Department of Health and Social Care (DHSC) to be led by Integrated Care Boards (ICBs) in regions in taking on a wider strategic commissioning role. As confirmed in national guidance and the 2 March 2026 letter (Direct commissioning update), the majority of NHSE's direct commissioning functions—including specialised services, health and justice services, and vaccination and screening—are expected to transfer to ICBs from April 2027, subject to legislation.

1.11. To enable this transition to an ICB-led OPIC model while maintaining consistency and expertise, NHSE requires the establishment of seven OPICs, one in each NHS region. OPICs will operate as regional centres of commissioning excellence, enabling collaboration between ICBs to plan and commission services at scale, improve equity and outcomes, and ensure resilience in delivering complex and high cost services. National requirements specify that each OPIC must be hosted by a single ICB on behalf of all ICBs in the region, operate through formal joint ICB governance arrangements (such as a joint committee), and support both ICB strategic and operational commissioning in a region. While OPICs will facilitate collective decision making, statutory accountability will remain with individual ICBs.

1.12. In the North West, NHS Lancashire and South Cumbria (LSC) ICB has been collectively agreed as the host organisation for OPIC, working in full partnership with NHS Greater Manchester (GM) ICB and NHS Cheshire and Merseyside (CM) ICB, which was formalised in May this year. The three ICBs, supported by the NHSE North West regional team, have established a collaborative programme to design and implement OPIC arrangements. This includes the North West OPIC Programme Development Board, which brings together senior leaders across the partner organisations to oversee delivery, linking with ICB Executive level oversight and governance arrangements. ICB Boards and related Transition Committees have been regularly informed of these developments.

1.13. The North West OPIC will initially focus on delivering the nationally mandated "OPIC Core" functions, including specialised commissioning, health and justice services, vaccination and screening, and Child Health Information Services, with the potential to extend to additional "OPIC Plus" services where this adds value in the region. The OPIC ICB partnership aims to strengthen strategic commissioning capability in line with the Model ICB Blueprint of May 2025, improve consistency and equity of services, and maximise the effective use of public resources across the region, aligned to the national NHSE Strategic Commissioning Framework.

1.14. Implementation will follow a phased approach. A “shadow” OPIC is planned to be in place by autumn 2026 to test governance, operating models and ways of working, ahead of the formal transfer of functions and staff from NHSE North West Specialised Commissioning to LSC as host ICB in April 2027 in partnership with CM ICB and GM ICB. New joint governance arrangements will also be established to reflect the expanded scope of commissioning responsibilities with consideration of revised arrangements through the current North West Specialised Commissioning Joint Committee.

1.15. Overall, the establishment of OPIC represents a significant step in enabling ICBs to act as strategic commissioners for their local populations, supported by strong regional collaboration and national standards, with the North West partnership working collectively to deliver these ambitions.

Greater Manchester (GM) System Updates

2.0 This section of my CEO Report is specifically focussed on what is happening here within the GM system.

The NHS GM Board

2.1. Since the last Board meeting in May, Sir Richard Leese has retired as Chair of NHS GM’s Board. Since taking up the role of Designate Chair on 1 November 2021, and subsequently being appointed as substantive Chair on the establishment of NHS Greater Manchester ICB on 1 July 2022, he has provided committed and thoughtful leadership through a period of significant change. He has played a central role in establishing the Board, appointing and developing a diverse membership, and creating the conditions for strong partnerships with local government, the voluntary, community and social enterprise sector, and wider system partners.

2.2. He has also led the organisation through a demanding period of formal undertakings, organisational reform and financial challenge, providing steady leadership and constructive challenge at a time when the system has needed clarity, resilience and a continued focus on its responsibilities to the Greater Manchester population. His consistent focus on the wider determinants of health, joined-up care and support within neighbourhoods and communities has helped establish a strong foundation for the next phase of delivery, including implementation of the 10 Year Health Plan. I am sure the Board will join me in thanking him for his leadership, commitment and the time he has dedicated to supporting health and care across Greater Manchester.

2.3. Recruitment to appoint Sir Richard's successor is still under way. As announced earlier this year, this role is expected to also take on the Health Commissioner responsibilities for Greater Manchester, working closely with the Mayor. In light of the recent Makerfield by-election and upcoming election for the Mayor of Greater Manchester, the recruitment process has paused temporarily noting that we’re in the pre-election period right now. In the interim, our Deputy Chair and Non-Executive Director, Jackie Njoroge, has

stepped into the role of Acting Chair. Jackie joined the NHS GM Board in January and brings over 20 years' senior strategy and data leadership experience, alongside a strong record of public sector non-executive governance.

2.4. There is another change to notify the Board of, which is in relation to Kathy Roe, who has been appointed as Acting Deputy Chief Executive, as well as being our Chief Finance Officer. This will provide invaluable support to me as Acting Chief Executive.

2.5. New Board and Committee arrangements have now been operational for three months and a governance and leadership review is currently underway as well as Committee Development. Board development has largely been paused until we have a substantive Chair and Chief Executive in post.

NHS Reform

2.6. The 1st July marked an important milestone in our reform journey, with the vast majority of colleagues taking up their new roles in the structures. This means that we are now much more materially able to work in ways which align to our new operating model. Although it is important for the Board to recognise that there is still change taking place for colleagues, as they settle into new teams and new roles. Our 2 year OD plan is in place to support our organisation through this period. We also must stay aware to the fact that a small number of staff have now entered a significantly unsettled period where they are displaced and are currently being supported to find suitable alternative employment. Every effort is being made to find alternative roles for these colleagues, but we must not under-estimate the impact this has on individuals and on line managers.

2.7. Another milestone was reached in June, when we created a set of documents that will support the bringing to life of our Place Health and Care Partnerships (PHCPs). Known as the 'document suite', the documents collectively provide the practical framework for bringing PHCPs together around our shared priorities to improve healthy life expectancy, close the HLE gap and raise the healthiest generation of children. The document suite includes a partnership agreement, an outcomes framework, the place fund, the place team and a governance options appraisal. We have entered a period of engagement on these documents to ensure that final drafting responds to feedback from partners and stakeholders.

Neighbourhood Health

2.8. We had a successful System Leaders Group event on 29th June on Neighbourhood Health as part of Live Well. This was the culmination of our system engagement on Neighbourhood Health over the last two months. Over that period, we have met with a range of partners from across the Greater Manchester system to discuss how we can accelerate our progress on

Neighbourhood Health. This included a visit from the NHS England National Lead on Neighbourhood Health (Dr Claire Fuller) on 11th June.

2.9. The key action from the engagement was for us to produce a Strategic Commissioning Framework for Neighbourhood Health – and we will take a first draft of this to NHS GM Executive Committee on 8th July and follow this up with an item at today's Board.

2.10. Over the summer, Place Leads will lead the work to finalise Neighbourhood Health Implementation Plans for each of the 10 localities – set in the context of the new Strategic Commissioning Framework. As per the National Framework , these plans will run through to March 2028 in line with the national framework with clear stepped improvements and quantifiable impact. This will include a commitment for a GM-wide launch of Integrated Neighbourhood Teams in all 10 places from the start of Q3. We will present the outputs of this work to September Board.

#NoSpaceforRacism campaign launches

2.11. The second phase of the Greater Manchester-wide No Space for Racism campaign has now launched publicly, featuring health and care staff from across our system sharing their personal experiences of racism in the workplace.

2.12. The campaign has been developed in response to evidence that around one in four health and care staff in Greater Manchester report experiencing racism at work. Incidents range from racist language and exclusion to threats and, in some cases, physical abuse. These experiences can come from patients, visitors and colleagues and can have a profound impact on wellbeing, confidence and staff's ability to provide the best possible care.

2.13. At the heart of this phase is a public-facing film featuring staff from a range of professions across health and social care, including general practice, nursing, surgery, ambulance services and social care. By sharing their lived experiences, the campaign aims to increase public understanding of the impact of racism, encourage respectful behaviour towards staff and empower colleagues and members of the public to challenge racism when they witness it.

2.14. However, the awareness campaign is only one element of a much wider programme of work. As with many of our campaigns, it is the action that sits behind the communications that will ultimately deliver lasting change.

2.15. Across Greater Manchester, partners are working together to strengthen and simplify reporting mechanisms for staff who experience racism, building on the significant progress many organisations have already made. There is also a collective commitment to present a clear and consistent anti-racism position across the health and care system, ensuring that staff, patients and communities receive the same message wherever they access services.

2.16. Work is also underway to improve how incidents that meet the threshold for hate crime are identified and escalated, with closer collaboration taking place with Greater Manchester Police. Alongside this, enhanced training and support are being developed to help staff respond confidently to incidents, whether they are directly affected or acting as active bystanders supporting colleagues.

2.17. This work complements and builds on the recommendations of the Mann Review, supporting a coordinated system-wide approach to creating a more inclusive and supportive working environment for all staff.

MenB vaccine to be offered to thousands of young people

2.18. Thousands of young people will receive protection against MenB vaccination through a one-off programme launching ahead of the 2026 academic year.

2.19. Eligibility includes those born between the 1 September 2007 and the 31 August 2008, students turning 25 after 31 December 2026 entering higher or further education for the first time, and international students under 25 starting university.

2.20. The programme will start later this month with the first dose being offered from mid-July and the second being offered in August. A new Q&A blog and eligibility asset are available, with a full communications toolkit to follow before England's booking system opens on Monday 13 July.

Health Innovation Manchester (HInM) Update

2.21. As reported at the last meeting, the HInM Strategy has recently been refreshed to respond to national and local strategic drivers in health and life sciences and HInM colleagues were invited to attend our Board strategy session in June to present this including how their plan relates to the Strategic Commissioning Strategy which was well received.

Health and Safety Oversight

2.22. I have previously committed to updating the Board on matters relating to health and safety through a standing item within my report. Since the last update to the Board, there has not been a further meeting of the Health and Safety Oversight Group. However, work on reviewing how our health and safety arrangements are delivered following organisational reform is ongoing.

2.23. Progress has also been made in implementing the outstanding recommendations from the Mersey Internal Audit Agency (MIAA) Health and Safety Audit – this includes further progress on the implementation of our new incident reporting system, which we hope to have in place by the summer, as well as reviewing our first aider and fire warden coverage following changes to our organisational structures as part of reform. Implementing these recommendations remains an important area of focus as we continue to

strengthen our organisational arrangements and respond to the changes arising from reform.

2.24. The next meeting of the Health and Safety Oversight Group is scheduled to take place in August, following which a further update will be provided to the Board.

Recommendations

3.0 The NHS GM Board is asked to:

3.1. Note the contents of the Acting CEO's Report to the Board.

3.2. Provider feedback on any future topics they wish to be covered within the Acting CEO's Report to the Board in September 2026.

Stakeholder Briefing - Update

2 July 2026

An update on improving neonatal care services in the North West

Background

The NHS has been looking at how to improve neonatal care for babies and their families across the North West. This work is being led by the North West Safe and Sustainable Specialised Health Services for Babies and Children programme, on behalf of the three NW ICBs including NHS Cheshire and Merseyside, NHS Greater Manchester, and NHS Lancashire and South Cumbria.

Although neonatal staff are working hard and provide lots of great care, at the moment the majority of neonatal units in the region do not meet national minimum activity standards in terms of the number of babies they care for.

This matters because evidence shows that babies receive better health outcomes and are less likely to develop life-long disabilities when their neonatal care is provided by a very specialised team, who perform the same procedures more frequently.

There is also too much variation in the levels of specialist care being provided by different neonatal units in the region, and the number of cots provided does not match current or expected future levels of demand for care.

The NHS wants to improve the quality and consistency of neonatal services to ensure that they are sustainable for the future, and that all babies and families receive the same high quality of care, wherever they live or are treated in the North West.

What has happened so far?

Although it's likely that changes will need to be made as a result of this review work, it's important to stress that this improvement work is still at an early stage of development, and there are no plans or proposals for any service changes just yet.

An updated Case for Change document was developed and published in December 2025, which describes the challenges facing the region's neonatal services in more detail.

You can read the full version of the Case for Change, as well as a summary version and an Easy Read version here: NHS England — North West » Improving neonatal services in the North West

Staff and parent/carer engagement

Following the publishing of the Case for Change, a staff engagement period was held between January and March 2026.

A series of staff listening sessions were delivered, which focused on hearing from NHS staff with experience of working in or alongside neonatal care services in the North West, in order to understand their thoughts and views on the issues set out in the case for change.

In March and April 2026, the programme also held a series of focus groups and one-to-one discussions with parents and carers who have used neonatal services in the North West, in order to hear their reflections on the case for change and learn more about their own experiences of care – including what currently works well, and what could be better for families.

The findings highlighted a broad level of support for the case for change and the principle of delivering more centralised care from fewer, more specialist units, especially if it meant that care was made better, safer and more consistent for babies.

However, most parents felt that careful thought needed to be given to how changes could be made without disadvantaging families or requiring them to carry extra burdens such as further travel and accommodation costs, or more separation.

The findings of this insight work have been summarised into a report, which is available to read on NHS England North West's website here:

North-West-Neonatal-Critical-Care-Review-Parent-Carer-Engagement-June-2026-FINAL.pdf

Next steps

Feedback gathered from these staff, parent and carer discussions will be used to help inform the next phase of planning and development.

This will include a number of workshop events which will be held over summer to help develop a long-list of potential options for how neonatal services could look in the future and then refine this into a short-list.

We continue to be committed to involving staff, families and wider stakeholders at every stage as this work progresses – and we will keep you updated about further key developments.

If you have any further questions in the meantime, please contact the programme team via: england.nw-specialisedbabieschildren@nhs.net

Note*:* On Amos Report

We also note the publication of the Baroness Amos report this week and welcome its findings. Whilst many of the recommendations fall outside the scope of this programme of work, we are committed to considering any relevant findings where appropriate.

Responsibility for taking forward improvements to neonatal services will sit with Operational Delivery Networks (ODNs) and provider Trusts, who are best placed to implement changes at a service level.

TAMESIDE STRATEGIC PARTNERSHIP COMMITTEE (TSPC)

Meeting Date	August 2026	Public	X	Confidential		Agenda item
Title of Report	Tameside Place Partnership Governance					
Lead Director / Executive Member / Clinical Lead	Marion Colohan, Place Director Tameside					
Author	Victoria Leonard , Associate Director (Clinical) Improvement & Personalisation.					

Outcome Required (please indicate)	Approval X	Assurance	Discussion	Information
Approval Only: Please indicate whether this is required from the pooled budget (s75) budget or non-pooled budget	Pooled budget	Non-Pooled Budget		

Purpose / Summary of Report:

This report presents a proposed governance framework for the emerging Tameside Place Health and Care Partnership, designed to support delivery of the Tameside Joint Health & Wellbeing Strategy and Locality Plan 2023-2028 and align with the emerging Greater Manchester Place Health and Care Partnership (PHCP) model.

The proposed arrangements build on existing locality governance structures whilst strengthening strategic oversight, simplifying decision-making and providing clear accountability for outcomes, delivery and resource stewardship

The report seeks endorsement of the proposed governance principles and architecture and agreement to further develop the detailed roles, responsibilities and reporting relationships across the revised governance structure, including the relationship between the Health and Wellbeing Board and the emerging Place Partnership arrangements

Recommendations:

Financial implications:

N/A

Alignment with the Joint Health and Wellbeing and Locality Plan:

The proposed governance framework supports delivery of the Tameside Joint Health & Wellbeing Strategy and Locality Delivery Plan by aligning oversight and accountability to the key priorities of children and families, mental health and wellbeing, staying well and ageing well,

stronger communities and reducing inequalities. The model promotes prevention, neighbourhood-based delivery, integrated working and improved outcomes across health, care, local authority, primary care and VCFSE partners.

Where issues are addressed in the paper -	
	Section of paper where covered
Regulatory and legal compliance	Throughout
Sustainability (including environmental impacts)	Throughout
Quality impacts	Throughout
Safeguarding impacts	Throughout
Risks	Throughout
Views and recommendations of the Clinical and Care Professional Advisory Group	Throughout
Views of the population / users	Not noted in the paper

The paper relates to the following CQC domains and Locality priorities - ✓			
✓	Safe	✓	Effective
✓	Caring	✓	Responsive
✓	Well-Led	✓	Use of Resources
✓	Joint Health & Wellbeing Strategy & Locality Plan	✓	Helps to reduce Health Inequalities
✓	Equality and Diversity Impacts Assessment	✓	Clinical Engagement
		✓	Public Engagement

The background information relating to this report can be inspected by contacting the report writer:

Telephone: 07340475951
e-mail: marion.colohan@nhs.net & Victoria.leonard3@nhs.net

Tameside Place Partnership Governance

Tameside Integrated Care Partnership

Part of Greater Manchester Integrated Care Partnership

Presentation by:
Victoria Leonard
Associate Director (Clinical) Improvement & Personalisation (Tameside)

Tameside Health and Care Partnership Governance

Tameside
Integrated Care Partnership

This presentation outlines a proposed governance framework that will provide the mechanism through which the Tameside Place Partnership delivers the ambitions of the Joint Health & Wellbeing Strategy and Locality Plan 2023-2028, alongside the emerging Greater Manchester Place Health and Care Partnership (PHCP) model.

The governance structure is aligned to the NHS Greater Manchester operating model and the Local Health and Wellbeing Board reporting arrangements.

The framework is designed to strengthen integrated working across health, care, local government, primary care, voluntary sector and community partners, ensuring collective leadership and accountability for improving outcomes, reducing inequalities and delivering neighbourhood-based care.

This paper proposes a governance model that:

- Aligns directly to the GM PHCP operating model
- Retains existing strengths within Tameside
- Simplifies governance where possible
- Ensures all strategic pillars are represented
- Avoids duplication through excessive enabling boards
- Establishes clear accountability between strategy, delivery and assurance.

Summary

Tameside
Integrated Care Partnership

The development of Place Health and Care Partnerships across Greater Manchester presents an opportunity to refresh the current locality governance arrangements and ensure they are fit for the next phase of neighbourhood health, prevention, primary care modernisation and strategic commissioning.

Tameside already has a mature governance framework comprising locality, provider, quality, neighbourhood, primary care and programme-specific groups operating under the Tameside Strategic Partnership Committee and Health and Wellbeing Board arrangements.

As part of this governance review, a stakeholder workshop will be convened to formally explore and clarify the respective roles, responsibilities, accountabilities and governance relationship between the Tameside Place Partnership Board and the Health and Wellbeing Board, ensuring alignment with statutory responsibilities, place-based priorities and emerging Greater Manchester Place requirements.

Summary

Tameside
Integrated Care Partnership

….**However, the emerging GM Place model introduces additional responsibilities around:**

- Place Outcomes Framework
- Place Fund stewardship
- Neighbourhood Health delivery
- Population Health Management
- Strategic Commissioning
- Primary Care Modernisation
- Integrated Neighbourhood Teams
- Collective accountability for outcomes and resources.

Governance Principles

Tameside
Integrated Care Partnership

The revised governance structure

- Ensures governance arrangements support delivery of the five priority areas within the Joint Health & Wellbeing Strategy and Locality Delivery Plan.
- Ensures alignment with Health and Wellbeing Board priorities and statutory functions (recognising the need to formally explore and define the relationship, accountabilities, and governance arrangements between the Health and Wellbeing Board and the Place Partnership).
- Support a whole-system approach to addressing the wider determinants of health and reducing inequalities.
- Aligns to the GM Place Partnership model
- Supports strategic commissioning intentions
- Uses neighbourhoods as the primary delivery vehicle
- Supports integrated care delivery
- Enables Primary Care Modernisation
- Supports robust oversight of outcomes
- Supports Place Fund stewardship
- Strengthens quality and clinical governance
- Reduces duplication
- Minimises additional meetings
- Uses existing leadership capacity wherever possible.

Proposed Governance Structure

Tameside Integrated Care Partnership

Tameside Place & Partnership Board

Strategy, Outcomes & Accountability.
Relationship with Health & Wellbeing Board to be defined

Delivery Oversight, performance, resources & assurance.
**** Finance relationship to be defined***

Tameside Place & Partnership Executive

Strategic Estates Group

Quality, Clinical Leadership & Improvement Group

Neighbourhoods, Prevention & Population Health & Transformation Portfolio

Primary Care Transformation Portfolio

Pathways & System Flow Portfolio

Mental Health, Learning Disabilities and Autism Portfolio

Maternity, Children & Young People Portfolio

Portfolios represent the principal domains of the Tameside Place Partnership Delivery Plan.

Neighbourhood Leadership Group

Primary Care Modernisation Group

General Practice Alliance

UEC Group

Long Term Conditions & Planned Care Group

Primary & Secondary Care Interface Group

All Age Mental Health & LD/A Group

Learning Disability & Autism Partnership Board

Local Area SEND

Childrens Improvement Board

CYP Transformation Group

Groups collectively support delivery across the life course with focus on reducing inequalities, improving outcomes and strengthening communities.

KEY

- Demonstrates Delivery Portfolios
- Delivery Groups
- Groups across other governance

Proposed Governance Structure

Tameside
Integrated Care Partnership

Group	Purpose
Tameside Place Partnership Board	The **Place Partnership Board** will act as the strategic leadership forum for the Place Health and Care Partnership. Its responsibilities will include: ▪ Approval of Place priorities ▪ Oversight of Place outcomes ▪ Approval of major investment decisions ▪ Stewardship of the Place Fund ▪ Assurance regarding delivery against neighbourhood plans ▪ Escalation into NHS GM where required ▪ Oversight of system partnership performance

Proposed Governance Structure

Tameside Integrated Care Partnership

Group	Purpose
Place Delivery Executive ** To establish and agree the role of the Health and Wellbeing Board in providing strategic oversight, accountability, and assurance for Better Care Fund and Place Fund arrangements*	The **Place Delivery Executive** will act as the operational leadership forum for the Place Partnership and will be responsible for coordinating delivery across five delivery portfolios. The Executive will ensure collective oversight of Cross-Cutting Enabling Functions (intelligence , outcomes and performance, quality, workforce, *****finance, digital and estates transformation, population health and inequalities) whilst maintaining line of sight to delivery of the Joint Health & Wellbeing Strategy priorities, Place Outcomes Framework and neighbourhood health ambitions. Its role will be to • Coordinate delivery across all portfolios • Oversee transformation programmes • Manage delivery risks • Monitor place outcomes , performance, quality and finance • Address delivery challenges and barriers • Consider investment proposals • Prioritise resource • Escalate major decisions to the Partnership Board • Ensure alignment across all portfolios The **Quality, Clinical Leadership & Improvement Group** will operate as a cross-cutting Place forum, providing assurance, professional leadership and improvement support across all delivery portfolios. The Group will ensure that quality, safety, patient experience, clinical effectiveness and continuous improvement remain central to the delivery of Place priorities, whilst providing a mechanism for identifying shared risks, reducing unwarranted variation and embedding learning across the whole health and care system. The **Strategic Estates Group** will provide strategic leadership and oversight for the development, utilisation and optimisation of health, care and community estate across Tameside. The Group ensures that estate investment and asset planning support the delivery of neighbourhood health, primary care modernisation, integrated care and improved population outcomes through effective use of public sector assets and collaborative place-based planning

Proposed Governance Structure

Tameside
Integrated Care Partnership

Group	Purpose
Strategic Delivery Portfolios	Five delivery portfolios will collectively provide strategic leadership and oversight for the Place Partnership's priority areas, ensuring delivery of neighbourhood health, prevention, primary care modernisation, mental health, pathway transformation, children and young people's services, quality improvement and population health outcomes. Together, they bring partners across health, care, local government, primary care and the voluntary sector into a coordinated delivery framework, supporting integrated working, reducing duplication and providing clear accountability for delivery of the Place Outcomes Framework and the ambitions of the Tameside Place Partnership.
1. Neighbourhoods, Prevention & Population Health Transformation Portfolio	The **Neighbourhood Leadership Group** provides strategic oversight and coordination of neighbourhood health and care delivery across Tameside, ensuring that partners work collectively to improve population health, reduce inequalities and deliver integrated, person-centred care closer to home through neighbourhood-based models of care.
2. Primary Care Transformation Portfolio	The **Primary Care Modernisation Group** will provide leadership and oversight for the transformation and integration of primary care services across Tameside, ensuring primary care is at the heart of neighbourhood health, prevention, population health management and care closer to home. The **General Practice Alliance** provides collective leadership for general practice across Tameside, bringing practices together to improve outcomes, reduce inequalities, strengthen resilience and support the consistent delivery of high-quality primary care. Acting as the unified voice of general practice within the Place Partnership, the Alliance works collaboratively to reduce unwarranted variation, develop services at scale and support workforce sustainability and practice development.

Proposed Governance Structure

Tameside
Integrated Care Partnership

Group	Purpose
3. Pathways & System Flow Portfolio	The **UEC Delivery Group** will collaborate across portfolios to transform local services (primary, community and secondary health and care) to deliver capacity and resilience of urgent and emergency care closer to home and provide a strategic co-ordinated leadership approach for the performance improvement plan as part of the GM single system improvement plan. The **LTC and Planned Care Group will** provide strategic leadership for the prevention, management and transformation of long-term conditions and planned care services across Tameside. The Group will drive improvements in outcomes, tackle health inequalities, support elective recovery and pathway redesign, and promote earlier intervention through a coordinated, population health-based approach across health and care partners. The **Primary and Secondary Care Interface Group** will provide strategic oversight of the interfaces between general practice, community services and secondary care, promoting collaborative pathway redesign, reducing unwarranted variation and improving the experience of patients moving between services. The Group will support demand management, elective recovery, referral optimisation, shared care arrangements and service integration, ensuring care is delivered in the most appropriate setting and aligned to neighbourhood health and care closer to home ambitions.
4. Mental Health , Learning Disabilities & Autism Portfolio	The **All-Age Mental Health, Learning Disability and Autism Group** provides strategic oversight, planning and direction for the delivery of mental health, learning disability and autism priorities across Tameside. The group will coordinate transformation, improve outcomes, address inequalities and maintain oversight of service performance, quality and capacity, ensuring people receive timely, effective and person-centred support throughout the life course.

Proposed Governance Structure

Group	Purpose
5. Maternity , Children & Young People Portfolio	Children and Young People's governance arrangements reflect the breadth and complexity of statutory responsibilities, improvement programmes and partnership arrangements operating across Tameside. The development of the Tameside Place Partnership presents an opportunity to simplify governance, strengthen strategic oversight and establish a clearer distinction between statutory assurance and delivery functions. It is proposed that children's programmes are

Conclusion

Tameside
Integrated Care Partnership

The proposed governance framework represents an evolution of the current Tameside locality governance arrangements rather than a wholesale redesign.

It builds upon established partnerships and governance structures whilst aligning with the future Greater Manchester Place Health and Care Partnership model.

The proposed arrangements provide a clear line of sight from the Tameside Joint Health & Wellbeing Strategy and Locality Plan through to operational delivery, ensuring that neighbourhood health, prevention, reducing inequalities and improving outcomes remain central to the work of the Place Partnership

Recommendation

Tameside
Integrated Care Partnership

The TSPC is asked to

- Endorse the proposed governance principles
- Agree the proposed Place Partnership governance architecture
- Clarify and formalise the roles, responsibilities, reporting lines, and relationships between the Health and Wellbeing Board, Strategic Partnership Board, delivery portfolios, and wider partnership governance arrangements to ensure effective coordination and accountability

Tier 2, Community Gynaecology Service

Meeting Date	August 2026	Public	X	Confidential		Agenda item
Title of Report	Tameside Tier 2 Community Gynaecology Service					
Lead Director / Executive Member / Clinical Lead	Marion Colohan, Deputy Place Based Lead for Tameside					
Author	Joseph Corbett Neighbourhood Health & Care Programme Manager.					

Outcome Required (please indicate)	Approval	Assurance	Discussion	Information
				X
Approval Only: Please indicate whether this is required from the pooled budget (s75) budget or non-pooled budget	Pooled budget	Non-Pooled Budget		

Purpose / Summary of Report:

This report is to update TSPC members on the development and progress of a Tier 2 Community Gynaecology Service delivered in line with the GM Community Gynaecology Service Specification listed in Appendix 1 of this document.

The report outlines the locality approach and discussions which have taken place between key stakeholders in support of implementing this model by early Q3 of 26/27.

Recommendations:

TSPC is asked to:

1. Note the GM service specification listed in Appendix 1 and the intention to implement this model of delivery for Tameside registered patients within 26/27 financial year.
2. Note the intention to support contracting through an established GM provider model via GM Primary Care CIC.
3. Agree to a review of the outcomes of this model in Q4 of 26/27 to support ongoing commissioning models moving into 27/28 financial year.

Financial implications:

Additional resource capacity has been supported through GM Elective Care Reform Governance with budgets agreed in support of expected activity levels with the identified provider.

Alignment with the Joint Health and Wellbeing and Locality Plan:

The NHS GM ICB and Tameside locality planning processes support the delivery of GM ICB strategic objectives, including those outlined in the Joint Forward Plan, in the NHS 10-Year Plan and with close alignment to the Tameside commissioning intentions paper for 2026/27. The

provision of this activity supports delivery of those objectives and priorities outlined at national, regional and place level.

Where issues are addressed in the paper -	
	Section of paper where covered
Regulatory and legal compliance	Throughout
Sustainability (including environmental impacts)	N/A
Quality impacts	Throughout
Safeguarding impacts	NA
Risks	Throughout
Views and recommendations of the Clinical and Care Professional Advisory Group	Not noted in the paper
Views of the population / users	Not noted in the paper

The paper relates to the following CQC domains and Locality priorities - ✓			
	Safe	✓	Effective
	Caring	✓	Responsive
✓	Well-Led	✓	Use of Resources
✓	Joint Health & Wellbeing Strategy & Locality Plan		Helps to reduce Health Inequalities
✓	Equality and Diversity Impacts Assessment		Clinical Engagement
			Public Engagement

Access to Information: The background information relating to this report can be inspected by contacting the report writer:

Telephone: 07340475951
e-mail: marion.colohan@nhs.net & josephcorbett@nhs.net

1. SUMMARY

This report updates TSPC members on the development and progress of a Tier 2 Community Gynaecology Service delivered in line with the GM Community Gynaecology Service Specification listed in Appendix 1 of this document.

The report also outlines the locality approach and discussions which have taken place between key stakeholders in support of implementing this model by early Q3 of 26/27.

2. ESTABLISHING NEED AND PURPOSE

In support of additional capacity in relation to Tier 2 Gynaecology delivery at locality level, NHS GM ICB have reviewed existing waiting times across all localities and identified the need to support Tier 2 level interventions whilst recognising the opportunity to implement the NHS 10 Year Health Plans intention around “left shift, specifically around Hospital to Community.

With the above in mind NHS GM ICB have developed a Memorandum of Understanding (MoU) to support this approach, which requires sign off at locality level. The MoU outlines the key activity of commissioning new and existing community services in support of this “left shift” with Gynaecology identified as a priority area across all GM localities and the need for locality system partners to explore opportunities and strengths to deliver a sustainable model.

It is acknowledged that although important, the MoU does not serve as a legally binding agreement and does not create enforceable legal obligations between parties of the agreement.

The aim is to reduce wait times for the identified cohort of Tameside registered patients following clinical review and transfer of care to the identified provider.

3. FINANCE

NHS GM ICB has agreed a level of funding for 2026/27 which has been allocated based on the modelled need at a locality basis. This was agreed at GM Elective Board in May 2026.

The agreed allocation in support of the service is £478,061.00 to treat a minimum of 1,594 new pathways.

4. IMPLEMENTATION

As outlined in section 1 of this paper the expectation is that the service will be deployed and undertaking activity as of early Q3 26/27.

Key milestones for delivery will be agreed between T&G ICFT and the identified provider with updates on delivery into to be agreed Tameside Locality governance and support the review into TSPC at the end of Q4 26/27.

The locality will need to consider in year the impact of the implementation of the Elective Care Single Point of Access (SPoA) model as it develops in Tameside Locality and how this will influence future year approaches in supporting this additional capacity.

5. RECOMMENDATIONS

TSPC is asked to:

1. Note the GM service specification listed in Appendix 1 and the intention to implement this model of delivery for Tameside registered patients within 26/27 financial year.

2. Note the intention to support contracting through an established GM provider model via GM Primary Care CIC.

3. Agree to a review of the outcomes of this model in Q4 of 26/27 to support ongoing commissioning models moving into 27/28 financial year.

Appendix 1

GM Community Gynaecology Service Specification

Service Specification No.	
Service	GM Community Gynaecology Service
Commissioner Lead	
Provider Lead	
Period	
Date of Review	

1. Population Needs
National context Although women in the UK live longer on average than men, the evidence shows they spend a greater proportion of their lives in ill-health or disability when compared with men (Health state life expectancies, UK - Office for National Statistics). Based on evidence from the government's 'Women's Health Strategy: Call for Evidence', and feedback from local systems, there are a number of issues with women's health services. These include the fragmented commissioning (for example, some by local authorities and some by the NHS) and a lack of service integration, where women are required to attend a range of different services which do not provide holistic care for the issues they face. There are 750,105 women waiting for secondary care gynaecology services in England, with an average referral to treatment time of 15.4 weeks (Royal College of Obstetricians and Gynaecologists RCOG Waiting times). Women experiencing both primary and secondary dysmenorrhea are more likely to miss work due to period-related symptoms, on average: • Women with severe period pain miss 18 days of work per year. • Women with heavy periods miss 11 days of work each year. • Women with secondary dysmenorrhea miss 16 days of work per year due to their symptoms. • 30 per cent of those experiencing endometriosis take more than three days off per month due to period pain, compared to 6 per cent of those who do not experience endometriosis. Overall, the economic impact of absenteeism due to severe pain during periods is estimated at £3.7 billion per year, due to heavy periods at £4.7 billion per year, and due to secondary dysmenorrhea at £2.2 billion per year. Presenteeism is also highlighted as an issue, costing £291.9 million per year for severe period pain, £418.1 million per year for heavy periods, and £173 million per year for secondary dysmenorrhea.

Looking elsewhere in the life-course, unemployment due to menopause symptoms has a direct economic impact of approximately £1.5 billion per year with approximately 60,000 women in the UK not being in employment due to menopause symptoms.

Pelvic organ prolapse and urinary incontinence are symptoms of pelvic floor dysfunction which significantly impact upon women's quality of life. While the prevalence of these conditions is poorly understood due to reporting issues, a questionnaire study of women attending primary care settings in the UK established that 46% of women reported urinary incontinence within the past month (Shaw et al, 2006). Furthermore, 58% of women had not sought treatment despite experiencing daily urinary leakage (Shaw et al, 2006). Prolapse is also very common with 50% of women found to have prolapse on examination but only 10-20% of these seeking treatment (Barber and Maher, 2013). It has been suggested that many women with prolapse or urinary incontinence avoid seeking treatment due to embarrassment or because they believe it is an inevitable consequence of aging or childbirth (Buurman and Lagro-Janssen, 2013 and Vasconcelos et al, 2019).

It is widely recognised that many of these women could have their needs effectively met through a community-based service. The goal of this service is to reduce health inequalities by bringing care closer to home, improving access, and reducing fragmentation within women's healthcare. A central objective will be to enhance the integration of key women's health services across the entire system, fostering more collaborative ways of working between primary and secondary care. This approach will ensure that women receive the coordinated and continuous support they need including considering any safeguarding concerns.

Local context

Gynaecology has been highlighted as an area of high cost, high demand and high activity across GM. There are a number of opportunities to reduce referrals to secondary care by utilising opportunities within General Practice for low complexity gynaecology conditions. This community gynaecology service will build on the Wigan GP Led Gynaecology Service and Women's Heath Hub's in localities for a General Practice Gynaecology Service Specification regarding a community-based service. The service will support the mitigation of workforce challenges within secondary care.

There is a shared commitment across Greater Manchester to improve care for women's health. This commitment reflects the ambition within the Health and Care Service Programme Review to support the delivery of the sustainability plan, delivering system efficiencies, ensuring that we deliver safe, effective services.

Everyone has the right to live their lives safely and free from abuse, harm and neglect. NHS Greater Manchester (GM) Integrated Care Board (ICB) commits to working in collaboration with partner agencies including health, police, local authorities and education to keep all those living in our communities safe.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

This service specification follows the national requirements of The NHS Outcomes Framework (NHSOF) About the NHS Outcomes Framework (NHS OF) - NHS Digital

Domain 1	**Preventing people from dying prematurely**	
Domain 2	**Enhancing quality of life for people with long-term conditions**	
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	

Domain 4	**Ensuring people have a positive experience of care**	*****
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	*****

2.2 By providing services within a community gynaecology service we aim to deliver the locally defined outcomes:

- Reducing time to treatment
- Reducing secondary care gynaecology referrals which will result in reduced wait times and less patients on waiting lists to support elective recovery.
- Reducing demand on secondary care diagnostic services
- Improving opportunities for financial sustainability
- Increasing opportunities for shared decision making and therefore increasing patient understanding of their condition, treatment, and after-care.
- Improving access of care including preventative healthcare and early intervention and reduced unmet need for healthcare.
- Improving access to health information, in a range of formats, and supported patient self-management where appropriate
- Improving patient quality of life, and return to work or normal social function
- Improving timeliness of administrative process including appointment timeliness and discharge information flows.
- Improving patient experience, with care being delivered in one appointment where possible.
- Improving health outcomes and reduced health inequalities
- Delivering a consistent provision for all Greater Manchester patients.

3. Scope

3.1 Aims and objectives of the service

This specification builds on work already in place across GM to provide primary care gynaecology services across Greater Manchester. The desired outcome is that all localities across Greater Manchester will eventually provide the services outlined in this specification by putting local arrangements in place. The mode of delivery will be for local determination but must ensure full population coverage and collaboration across GM Primary Care organisations.

The model is based on the Wigan GP Led Gynaecology Service which launched in February 2020 via a Locally Commissioned Service (LCS). Their service specification is intended to cover the enhanced aspects of clinical care of the patient, which are presumed to be beyond the scope of essential services and the quality and outcomes framework.

The Wigan LCS specification has been commissioned to provide, as a minimum:

Investigation of and/or treatment for common gynaecological conditions, including (but not limited to) the management of patients presenting with:

- Menorrhagia/ Dysmenorrhea/ Period Problems;
- Menopausal symptoms;
- Vulvo-vaginal symptoms;
- Vulvo-vaginal lesions;
- Pelvic pain;
- Vaginal discharge;
- Polycystic Ovarian Syndrome;

- Urinary incontinence/ prolapse
- Heavy menstrual bleeding through the fitting of Mirena coil.

A recent audit of gynaecology referrals into Wrightington, Wigan and Leigh NHS Teaching Hospital Foundation Trust which could have been treated in the GP Led Gynaecology Service were attributed to three main areas in over 70% of cases, mainly

- Menorrhagia / Dysmenorrhea / Period Problems.
- Management of prolapse including assessment of first pessary fit and subsequent changes.
- Management of patients presenting with menopause symptoms.

The scope of this service specification will focus on these three areas and the specification will expand to align with the Wigan specification eventually after the service has been evaluated and reviewed.

3.2 Population coverage

The provider will accept referrals for all patients registered with a GP practice within Greater Manchester The service will be accessed by patients following assessment by their registered GP.

3.3 Service Description

The service will:

- Provide a team of appropriately qualified clinicians, including but not limited to, GPs with administrative support who will triage then assess, treat and review specific patients. Clinical governance will be delivered by the service provider.
- Be delivered from community facilities across Greater Manchester in locations suitable for community gynaecology services. Clinics should be located to ensure that there is Greater Manchester wide access to the service.
- Have in place clear protocols for the discharge of patients from the service back into primary care (or onward to secondary care if appropriate), ensuring that the patient is fully aware of how to access on-going support for their condition and that the patient's GP is fully aware of this.
- Have in place protocols to ensure that the service is open and accessible to all patients including appointments outside of standard working hours of 09.00-17.00 Monday to Friday.
- Offer patients a first appointment within four weeks of referral.
- Operate a one-stop-shop model wherever possible to minimise follow-ups and provide a better service for patients.
- The service will ensure there are robust recall systems in place where follow up is required, for example pessary changes

3.4 Community Gynecology Service

3.4.1 Conditions in Scope

The service will provide a community service for gynaecology presentation needing investigation or treatment as detailed in the inclusion criteria below. The service will therefore cover the following areas:

- Management of patients presenting with menopause symptoms
- Menorrhagia / Dysmenorrhea / Period Problems
- IUS/IUD for Heavy Menstrual Bleeding (HMB) – provided there's no indication for biopsy
- Period Problems – beyond the scope of core Primary Care
- Management of prolapse
- Pessaries – first-time fittings and replacement
- Vaginal discharge – beyond the scope of core Primary Care and Sexual Health Services

A chaperone should be available to patients as standard practice in all cases.

If a locality has an existing vaginal pessary change service commissioned in primary care patients on the waiting list (if clinically appropriate) can be transferred to the service.
Suspected malignancy will not be included in the service, but it is recognised that some malignancies may be identified or suspected once assessment has taken place. Clinical pathways must ensure that patients are fast tracked into the relevant cancer pathway and multidisciplinary teams within secondary care.

The fitting of the pessary should happen in the first appointment following clinical assessment however it is recognised that on some occasions this may not be clinically appropriate, and this could be fitted in a follow up appointment.

3.4.2 Acceptance criteria

The service will accept referrals for women, trans men and non-binary people registered female at birth age 14+ years for those with a gynaecology presentation that have been referred to a Trust and who are waiting over 18 weeks, needing investigation or treatment, that can be managed within the scope of the waiting list gynaecology Service.

3.4.3 Exclusion criteria
The service scope does not include any conditions not listed in the Conditions in Scope and the following as a separate services already exist:

- Colposcopy.
- Termination of Pregnancy.
- Sterilisation.
- Cervical lesions requiring colposcopy or cryotherapy.
- Infertility.
- Patients requiring emergency or acute hospital admission.
- Patients where cancer is thought to be the most likely diagnosis – patients with suspected cancer must follow the urgent suspected cancer pathway NB: All 2 Week Wait (2WW) referrals should be directly referred on the 2WW pathway.
- Patients aged under 14 years for a gynaecology presentation needing investigation or treatment.
- Patients with accessibility differences who's needs could not be met within a community setting (to be determined at point of triage)
- Pregnancy related issues.

3.4.4 Referral
Referrals will be electronic ideally via e-RS, however this will be determined by the locality and approved by NHSGM depending on the functionality/capability of EMIS/System One or another portal securely via a standardised template. This will vary depending on the locality, but will meet all Information Governance (IG) requirements

The patient's GP will determine whether referral to the Community Gynaecology Service is clinically appropriate. It is not for urgent suspected cancer referrals or for patients that will need a hysteroscopy. The referring GP will explain to the patient that the referral to the Community Gynaecology Service is for triage to the most appropriate pathway so that patients are clear from the beginning that they may not be offered an appointment by the Community Gynaecology Service.

3.4.5 Triage Service:

This service will provide:

- Virtual triage of referrals received to ensure the referral meets the criteria outlined in this service specification and ensures the most appropriate service for the patient.

- Virtual triage will be undertaken by an appropriately skilled GP from the Community Gynaecology Service or other suitably qualified health professional such as a specialist nurse.
- Referrals for urgent suspected cancer referrals should follow the GM two week wait pathway.
- The service will have clear processes in place to ensure that all referrals into the Community Gynaecology Service are reviewed within five working days of receipt.

3.4.6 Service hours and response times

The service should include access beyond (Mon-Fri, 9am-5pm) including evening and/or weekend appointments.

3.5 Interdependencies

It is essential that the provider develops strong relationships with:

- Primary care: ensuring timely communications and support with local GP Practices and Community Pharmacies
- Secondary care: ensuring timely onward referral and avoiding duplication
- Community providers: including, but not limited to, psychology services, physiotherapy and diagnostic services.
- Social sector: Reaching out to local support networks.
- Patients and citizens: raising awareness and supporting self-help groups.

As a GP led service, it is critical that good working relationships are formed, with open dialogue with secondary and primary care colleagues, as well as colleagues from related community services, to ensure that patients receive the best care in the most appropriate setting. In particular, the Provider will liaise closely with primary care and secondary care gynaecology departments to ensure that there is clarity regarding the referral pathways. To this end, the Provider is required to agree with local GPs and GP networks suitable referral and discharge pro-formas whilst engaging with secondary care providers to ensure duplication of activity is prevented.

Patients and their carers should be provided with timely and appropriate health information materials to enhance health knowledge, skills and behaviours, and to enable informed health decisions. The service must use education and agreed self-management plans to promote the use of patient self-care. Such plans need to be owned and bought into by the patient, and their carer where appropriate, (and not merely imposed). Primary Care clinicians should be supported to deliver effective care in Primary Care, resulting in patients being given appropriate information and management early in the patient pathway.

The service should work towards a safe discharge of patients after effective care where clinically appropriate. On discharge from the service, patients should receive care planning advice, supported by a self-management care plan, which should be agreed with the patient. This will describe the patient's self-care action plan and a copy will be held by the patient, the registered GP as well as the service. The self-care plan should be inclusive of management advice (as appropriate).

The provider should develop or signpost patients, carers and healthcare professionals to education tools, such as information leaflets, videos, telephone support, exercise information, signposting e.g. to Health and Wellbeing services, smoking cessation, addiction support and exercise referral schemes. These should be patient friendly, written in plain language with availability of translation services when required.

In addition, to help improve referral behaviour and unwarranted variation in the health economy, and to improve the skill level of GPs the service is required to offer advice, support and education to the PCN GPs, supporting the management of patients within their GP Practice where appropriate.

3.6 Sub-contractors

The Commissioner acknowledges that the provider may sub-contract material parts of the services to third parties, including sub-contractors.

The provider will remain fully responsible for the provision of services provided by any sub-contractors they appoint to meet requirements detailed within this service specification and those obligations described by the contract.

In particular, the provider must ensure that any sub-contracted clinicians are fully qualified and accredited to undertake the work expected of them and that they are included within the provider's governance and reporting frameworks.

4.0 Service Standards

4.1 Applicable national standards e.g. NICE

- NICE – Heavy menstrual bleeding (QS47) Overview | Heavy menstrual bleeding | Quality standards | NICE
- NICE – Heavy menstrual bleeding assessment and management (NG88) Overview | Heavy menstrual bleeding: assessment and management | Guidance | NICE
- NICE- Menopause (QS143) Overview | Menopause | Quality standards | NICE
- NICE – Menopause (NG23) Overview | Menopause: identification and management | Guidance | NICE
- NICE- Urinary incontinence and pelvic organ prolapse in women: management NICE guideline [NG123] Overview | Patient experience in adult NHS services | Quality standards | NICE
- NICE – Patient experience in adult NHS Services (QS15) Overview | Patient experience in adult NHS services | Quality standards | NICE
- NICE safeguarding guidance. https://www.nice.org.uk/guidance/health-and-social-care-delivery/safeguarding/products?ProductType=Guidance&Status=Published

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

- British Menopause Society guidelines. British Menopause Society | For healthcare professionals and others specialising in post reproductive health
- United Kingdom Continence Society https://www.ukcs.uk.net/UK-Pessary-Guideline-2021
- Faculty of Sexual and Reproductive Healthcare Intrauterine contraception guideline fsrh-clinical-guideline-intrauterine-contraception-mar23-amended.pdf

4.3 Applicable Local standards

4.3.1 Information Management and Technology (IM&T)

Providers:

- Should make the most of digital referral methodologies available in EMIS, System One and other primary care digital solutions.
- Must submit information to Secondary User Service (SUS) as required.
- Must use e-RS when referring to secondary care.
- Should make every effort to ensure diagnostic tests are not repeated.
- Should have in place appropriate IM&T Systems and infrastructure to support the delivery of the specified services, management of patients' care, contract management and business processes and comply with specific requirements and the underpinning information standards and technical specifications expected for NHS service provision.
- Must ensure they have effective systems in place for handling information securely and confidentially and that they have appropriate sharing agreements in place with all partner organisations.

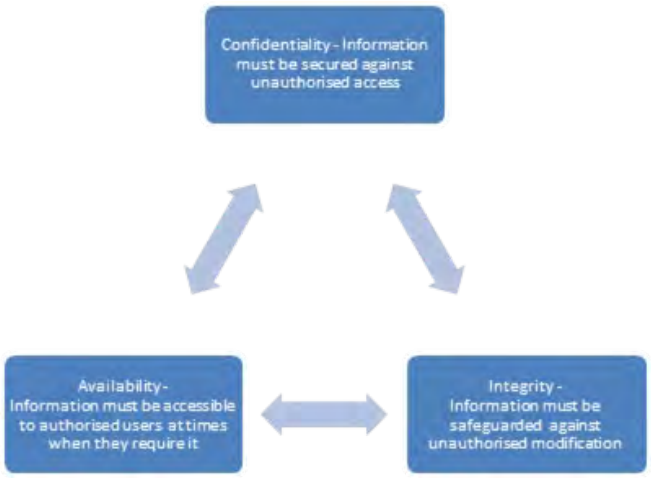
- Should be prepared where required to implement new infrastructure; systems and procedures to ensure ongoing compliance with NHS standards and requirements.
- Should, in the event of cancellation of the contract (for whatever reasons), maintain systems to allow continued access, in a timely manner, to all patient information and associated patients' records.
- Should ensure there is a commitment to the integration of electronic care records to bring relevant health and social care information relating to patients to clinicians at the point of care whenever it is required.
- Should ensure that correspondence generated by Providers following clinical encounters with patients will be transmitted electronically back to referrers for merging with clinical records systems.

4.3.2 Information Governance (IG)

There is a clear recognition of the importance of information in the delivery of a healthcare system and a commitment to ensure all services comply with all relevant laws and regulation and meet the highest standard in terms of the collation, use, sharing, storing and destruction (collectively known as processing) of all information, but in particularly business confidential and personal confidential data.

The principles of information governance and information security require that all reasonable care is taken to prevent inappropriate access, modification or manipulation of data from taking place. In the case of the NHS, the most sensitive of data is patient record information.

In practice, this is applied through three cornerstones - confidentiality, integrity and availability:



Information Governance is there to ensure these principles are upheld by setting clear policy and guidance for all NHS.

It is expected that service Providers should be:

- Providing appropriate tools to employees to enable them to best support the patient, ensuring physical resources including Information and Communication Technology (ICT) is appropriately protected, secure and fit for purpose;
- Ensuring all employees are adequately trained and kept informed in IG related matters, consummate to their role and function;
- Ensuring all services comply with all relevant information law and the required information governance (IG) standards, including successful completion of the Data Security and Protection Toolkit on an annual basis;

- Ensuring that they take IG seriously and evidentially embed IG principles and processes throughout the service and the organisation.

The Provider is required to have in place:

- Clear organisational and integrated governance (including clinical governance) systems and structures with clear lines of accountability and responsibilities for all functions.
- A professional head of service/clinically accountable person with responsibility for operational and clinical governance within the service including clinical management and quality assurance.
- A robust system in place to deal with Serious Untoward Incidents (SUIs), near misses, adverse incidents, complaints and concerns.
- Arrangements to ensure that they are fully compliant with the most recent IG guidance.
- Standard operating procedures for handling patients' confidential information securely.

In addition Providers should:

- Ensure that all patient and carer information and data gathered in the course of delivering the service is only used in pursuance of delivering the NHS services and is not held or used for any other purpose;
- Understand that all patients' records (in any format) gathered in the course of delivering the service remain the property of the NHS and should be surrendered to the Commissioner at any time on request, and in any case at the end of the contract.

4.3.3 Safeguarding

The Provider shall comply with all relevant national and local safeguarding legislation, procedures, and guidance aimed at protecting children, young people, and vulnerable adults, including adults at risk.

In regard to local safeguarding guidance, the Provider must follow the policies and directives issued by local Safeguarding Boards. Resources including;

Safeguarding | Greater Manchester Integrated Care Partnership

Keeping you safe | Greater Manchester Integrated Care Partnership

The Provider is required to maintain up-to-date safeguarding policies and procedures. These policies must be clearly communicated to all staff and thoroughly understood. They must also include specific procedures covering domestic abuse (with a focus on staff responsibilities for identification, referral, and support), consent processes (including assessments of Gillick competence in children and young people), and safeguarding protocols for vulnerable adults and adults at risk. In addition, the Provider must have clear procedures in place for identifying and responding to concerns related to Female Genital Mutilation (FGM), in line with national statutory guidance and mandatory reporting duties.

All staff must undergo safeguarding training aligned with locally agreed standards. This training must be refreshed regularly to ensure ongoing compliance. In addition, the Provider must complete the annual safeguarding assurance tool to demonstrate compliance with local safeguarding standards and a commitment to fulfilling any resulting action plans within agreed timeframes.

All personnel who have direct contact with children, young people, or vulnerable adults must have appropriate Disclosure and Barring Service (DBS) checks in place. The Provider must also ensure full compliance with all relevant legislation concerning safeguarding and safer recruitment practices.

4.3.4 GP Engagement

As GP practices/PCNs will be the referrers for the Community Gynaecology Service it is essential that the Provider works collaboratively with referrers to:

- Develop standard referral guidance;
- Develop a standard referral template;
- Support appropriate referral through contribution to the provision of GP information and training;
- Co-produce clinical pathways and guidelines applicable to the service area.

The Provider will be expected to undertake GP engagement via a survey to capture GPs' experience/satisfaction with the existing services.

4.3.5 Workforce

Assessment and treatment should always be provided by staff that are either suitably registered or are supervised by a suitably registered practitioner and who are appropriately trained, qualified and experienced. Individual providers will be responsible for ensuring that the clinical staff are appropriately skilled to deliver the required services. It is the responsibility of the provider to ensure that individuals are compliant with all professional standards to undertake their clinical duties. Ensuring appraisal and /or revalidation is in place as appropriate as per regulatory body.

Staff are expected to be qualified as follows:

- One of the following:
  - DRCOG (DRCOG: Our Diploma exam | RCOG); or
  - CoSRH Diploma (DCSRH) https://www.cosrh.org/Public/Public/Education-and-Training/diploma.aspx?hkey=a0866fac-54d4-4a38-8f70-cdbd7eaca7f7; or
  - Experience in Gynaecology department within a Secondary Care environment for a minimum of 3 years at ST3 or above and evidence of CPD.

- If the clinician is fitting coils or implants they are required to have:
  - Letter of Competence Intrauterine Techniques (Loc IUT) (https://www.fsrh.org/education)-and-training/letter-of-competence-intrauterine-techniques-loc-iut/)
  - Letter of Competence Subdermal Contraceptive Implants Techniques Insertion and Removal (LoC SDI-IR) (https://www.fsrh.org/education-and-training/letter-of-competence-subdermal-implants-loc-sdi/)

- Any clinicians working in the service managing menopause are required to have Advanced Menopause Qualifications (or evidence working towards):
  - BMS Management of the Menopause Certificate; or
  - BMS PPMC (The Principles and Practice of Menopause Care) Advanced Certificate; or
  - FSRH Menopause Care Professional Certificate (MCPC); or
  - FSRH Menopause Care Professional Diploma (MCPD); or
  - RCOG Advanced Training Skills Module (ATSM) in menopause care; or
  - FSRH Advanced Certificate in Menopause Care;
  - FSRH Community Sexual & Reproductive Healthcare (CSRH) curriculum, obtaining the Certificate of Completion of Training (CCT), or reaching the equivalent standard as assessed by the GMC and awarded a CESR in CSRH
  - An equivalent qualification (e.g. menopause and POI module of the subspecialty training programme in reproductive medicine).

Primary Care Nurses and General Practitioners offering pessary management must comply with their own professional standards to ensure that they are working within their own scope of practice and they receive training that is compliant with professional guidance.

- A record of training and competence must be maintained in the individual's personal file.
- Pessary insertion should be within the practitioner's job description.
- The practitioner must be aware of any changes to the recommendations and changes to national Guidance.
- It is the responsibility of the individual to maintain and improve their professional knowledge and skills in this area of practice

Where providers wish to deviate from this it should be agreed in writing by Commissioners.

4.3.6 Medicines Management

Any treatments must be delivered in line with Greater Manchester Medicines Management Formulary http://gmmmg.nhs.uk/html/formulary_bnf_chapters.html and the GM-HRT-Guidance-for-Menopause-Management-final-v1.0-approved-for-GMMMG-website.pdf

The service will liaise with the referring practice for any new medications or amendment of dose. The service will be able to issue prescriptions for drugs and medication related to their presenting gynaecological symptoms. However, the ongoing prescribing of any medication will be the responsibility of the referring GP.

The service may stock medicines and devices to be used on the day of the patient's appointment in order to deliver a one stop service. Any new prescribing requirements should be sent through to the referring GP for prescribing.

Device costs can be claimed back by the provider via an FP10 or FP34D.

The provider should:

- Provide assurance of actions/learning from medication incidents and sharing of intelligence to improve medication safety via medication safety reports as requested to NHSGM.
- Provide assurance and audit to NHSGM as requested.
- Where applicable ensure, robust systems and policies are in place to ensure the safe and efficient management of medicines. This should include implementation of CAS (Controls Assurance Standards) alerts, MHRA (Medicine and Healthcare products Regulatory Agency) alerts and error reporting as well as patient safety events through the Learning from Patient Safety Events (LFPSE) service.
- Where applicable, ensure compliance with the legal frameworks governing medicines usage including ordering, recording, handling, safe keeping, safe administration, and disposal of medicines used in relation to the service(s).

4.3.7 Clinical Governance

The provider must ensure that a clear governance structure is in place, which will provide clinical leadership, education and development. The service must provide a high quality, safe, equitable co-ordination of care throughout the pathway ensuring all have the required information in the manner which allows appropriate decisions/ care are provided in a timely and secure way with patient consent, decisions and outcomes at the heart of the service. The service must ensure it is sustainable (economically and environmentally) and keeps social values at the forefront on the design of the service.

Clear management arrangements should be in place to ensure the workforce is of sufficient size to have the capacity and capability to meet the range of services effectively and efficiently. There must be clearly defined structures of accountability and responsible safe service delivery.

The provider is required to demonstrate to Commissioners that a robust Clinical Governance framework is in place through audits to promote continued organisational and clinical development. In addition, lessons

learnt from Serious Untoward Incidents and the actions taken must be communicated promptly to commissioners.

4.3.8 Clinical Diagnostics

The service requires the following diagnostic tools to be provided as part of the service:

- Pelvic Ultrasound Scanning
- Transvaginal Ultrasound Scanning
- Access to microbiology and pathology
- Access to cytology

However, with clear clinical pathways a significant number of these investigations will be made before referral.

4.3.9 Equity of access

The Provider will need to recognise and address other factors that influence access to healthcare facilities and services, such as:

- Socio-economic status;
- Social isolation;
- People from non-English speaking backgrounds and cultural and religious beliefs;
- Access to technology.

Ensuring that all patients, especially those with communication needs, have access to safe and effective healthcare is a key safeguarding priority. The use of interpretation and translation services is vital in protecting patients' rights, supporting their autonomy, and safeguarding their well-being. It is essential that services are provided in a way that is accessible and responsive to the individual needs of patients, helping to prevent misunderstandings and ensuring that all individuals, regardless of language or communication barriers, are treated with dignity and respect. The Provider must be committed to ensuring that all patients are protected and supported throughout their care journey.

4 Quality Assurance requirements

5.1 Complaints & incident reporting

The Provider must:

- Have formal complaints policies and procedures through which patients and their representatives can raise issues with the service.
- Respond to complaints in line with the NHS complaints procedure.
- Provide to Commissioners a summary of all complaints, responses, lessons learnt and actions taken on a quarterly basis.
- Have a process in place for Serious Incidents, near misses and adverse incidents.
- Have a formal policy / procedure through which all adverse incidents are appropriately reported and investigated using root cause analysis in line with NHS SI Framework.

5.2 Patient Engagement

The Provider will:

- Undertake patient surveys which will include questions around access, communication, quality and overall experience.
- Actively ensure all methods of collating patients' and carers' experience are accessible and reflect any reasonable adjustments required under the Equality Act 2010.
- Record and monitor levels of patients' and carers' experience with the service and identify themes, trends, areas for improvement and actions taken.
- Supply the results of surveys in full along with action plans for service improvement based on the outcome of surveys to the Commissioner.
- Comply with the NHS duty to involve users and stakeholders, and to undertake involvement under sections 242 and 244 of the NHS Act 2006, and subsequent legislation.
- Ensure that arrangements are made to secure the involvement of patients and their representatives in the planning and development of services and in any proposals for changes in the way services are provided and/or in decisions that affect the operation of services.

5 Location of Provider premises

The service will be delivered from a location/locations which meets CQC requirements agreed by representatives from NHSGM and the provider.
The provider will inform the commissioner if any clinic location changes.

Consideration to:

- A dedicated waiting area
- Private facilities for giving patient information
- Adequate toilets
- Adequate storage
- Good Transport Links
- Parking
- Meeting the needs of people with disabilities including but not limited to, accessible parking and lifts.

6 Data Collection and Evaluation

The provider should collect and report on the measure below.

Waiting List Support

- No of patients triaged
- No of first appointments
- No. of follow up appointments
- Waiting times by site from triage
- No. of onward referrals to hospitals
- No. of patients discharged at first appointment
- No. of patients discharged at follow up
- Total DNAs:
    - % DNAs for 1st appointment
    - % DNAs for follow up appointment
- Number of IUS fitted
- Number of IUS removed
- Number of IUS replaced
- Number of IUS failed to be fitted

- Number of pessaries fitted
- Number of pessaries renewal
- Number of pessaries removed
- Number of opportunistic cervical screenings

Community Gynaecology Service

Activity measures

- Number of referrals received
- Number of face-to-face appointments
- Number of telephone appointments
- Number of first appointments to follow up
- Number of onward referrals to Secondary care split by reason for referral
- % Onward referred to Secondary Care
- Number of patients discharged at first appointment
- Number of patients discharged at follow up
- Number of patients currently in the service. Split by:
    - new patients waiting to be seen and
    - active follow ups

- Total DNAs:
    - % DNA 1st Appointment
    - % DNA Follow up Appointment

- Current waiting times by site and rationale
- Number of IUS fitted
- Number of IUS removed
- Number of IUS replaced
- Number of IUS failed to be fitted
- Number of IUS fitted for gynaecology purposes only
- Number of IUS fitted both gynaecology and contraceptive purposes
- Number of pessaries first fits
- Number of pessaries renewal
- Number of pessaries removed
- Number of opportunistic cervical screenings

Pathway measures

- Number of patients referred for diagnostics but currently still under the care of the Community Gynaecology Service
- Number of patients discharged back to referring clinician with Advice and Guidance
- Number of patients discharged per month by clinical condition

General measures for both services

Clinical measures

- Number of incidents
- Number of near misses

Patient experience measures

- Number of complaints
- Patient Survey

All patients will be asked to complete the agreed patient survey
The expectation there is a 20% response rate to the survey.

Partnership measures

- Meetings with local secondary care providers
- Meetings with local primary care providers/education sessions

Note: These could be virtual MDT meetings to discuss particular cases

Audit and evaluation for the Community Gynaecology Service
The provider will support the six-monthly evaluation of the service in a chosen area that could focus on ensuring that the service is accessible, efficient, and effective in meeting the needs of patients. This could include assessing patient access, quality of care, efficiency of service delivery, impact on health outcomes, and integration with other healthcare services. Any results of these to be shared with NHSGM on request.

Tameside Locality Board Report August 26

Data Source: PIA Locality Report: Views - Tableau Server

Part of Greater Manchester Integrated Care Partnership

Tameside Integrated Care Partnership

Prepared by: Lead Intelligence Analyst
Fiona Haworth

Data extracted: 11th June 2026

Tameside - Oversight Metrics

Show Definitions

Domain	Code	Measure	Frequency	Date	Latest	Previous	Change	Target/Median	Numerator	Denominator	Quartile
Mental Health & Learning Disabilities	N/A	Adult inpatients with autism only	Monthly	Jun 26	4	4	→	3	N/A	N/A	N/A
	N/A	Adult inpatients with LD and LDA	Monthly	Jun 26	1	1	→	3	N/A	N/A	N/A
	S030a	% of patients aged 14+ with a completed LD health check	Monthly	Jun 26	11.6%	5.99%	↗	75.%	176	1,519	Lower
	EH09	Access to Children and Young Peoples Mental Health Services	Monthly	Jun 26	4,850	4,925	↓	5,200	N/A	N/A	Inter
	EAS01	Dementia: Diagnosis Rate (Aged 65+)	Monthly	Jun 26	73.2%	72.30%	↗	66.7%	1,765	2,412	Upper
	S086a	Inappropriate adult acute mental health Out of Area Placement (OAP) bed days (rolling 3 month total)	Monthly	Jun 26	365	460	↓	0	N/A	N/A	Inter
	N/A	Number of MH patients with no criteria to reside - number of beds occupied by mental health patients who are ready to be discharged	Monthly	Jul 26	8	9	↓	N/A	N/A	N/A	Inter
	N/A	Percentage of MH patients with no criteria to reside (NCTR)	Monthly	Jul 26	12.3%	14.06%	↓	N/A	8	65	Inter
	S110a	Overall Access to Community MH Services for Adults and Older Adults with Severe Mental Illnesses	Monthly	Jun 26	2,160	2,090	↗	4,430	N/A	N/A	Lower
	S081a	Talking Therapies: Access Rate	Monthly	Jun 26	450	340	↗	N/A	N/A	N/A	Inter
	S131a	Women Accessing Specialist Community Perinatal Mental Health Services	Quarterly	Jun 26	225	220	↗	N/A	N/A	N/A	Lower
	S125a	Long length of stay for adults (60+ days)	Monthly	Jun 26	50.0%	40.00%	↑	0.%	25	50	Lower
	N/A	Proportion of routine eating disorder referrals cases entering treatment within four weeks, aged 0-18	Monthly	May 26	50.0%	67.00%	↓	N/A	50	N/A	Lower
Cancer	N/A	Cancers Diagnosed at an Early Stage (12-month rolling): All Tumours Staged within RCRD	Monthly	Mar 26	60.5%	61.64%	↓	N/A	563	931	Inter
Primary Care	S053b	% of hypertension patients who are treated to target as per NICE guidance	Annual	Mar 25	68.0%	65.73%	↗	77.%	26,865	39,535	Lower
	S053c	% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins	Quarterly	Dec 25	69.6%	69.08%	↗	64.07%	7,000	10,060	Upper
	S129a	GP appointments - percentage of regular appointments within 14 days	Monthly	Jun 26	77.4%	79.11%	↓	81.46%	87,668	113,323	Lower
Quality	S042a	E. coli blood stream infections	Monthly	Jun 26	224	223	↑	N/A	N/A	N/A	Inter
	S044a	Antimicrobial resistance: total prescribing of antibiotics in primary care	Monthly	Jun 25	80.2%	80.86%	↓	87.1%	N/A	N/A	Inter
	S044b	Antimicrobial resistance: proportion of broad-spectrum antibiotic prescribing in primary care	Monthly	Jun 25	5.9%	5.93%	↓	10.%	6,383	107,942	Upper
	S037A	% of patients describing the overall experience of their GP practice as good	Annual	Mar 23	71.4%		→	73.90%	N/A	N/A	N/A

Tameside

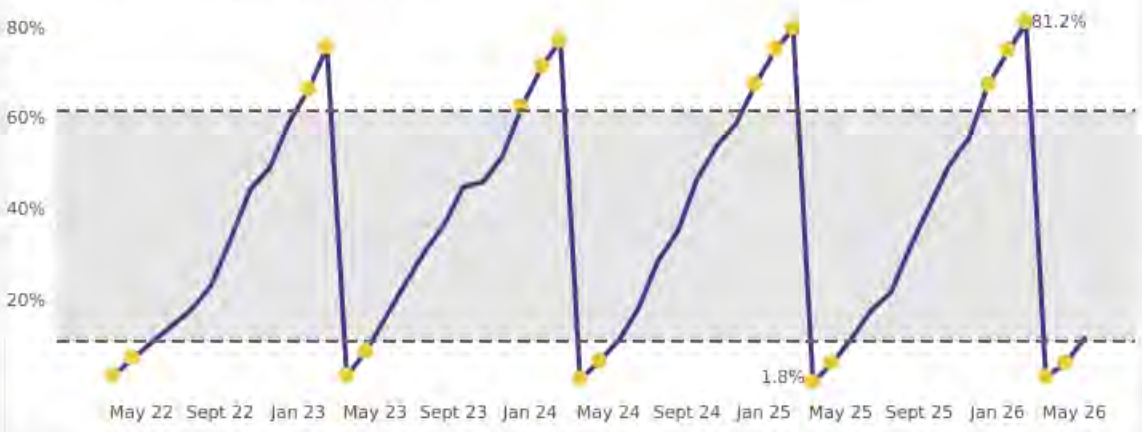
% of patients aged 14+ with a completed LD health check

The % of people on the QOF Learning Disability Register who received an annual health check between the start of the financial year and the end of the reporting period

Source: Learning Disabilities Health Check Scheme (Monthly)

11.6%	6.0%	81/106	75.%
June 2026	May 2026	National Rank Lower Quartile	National Target

more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	3.3%	7.1%	10.8%	14.3%	17.9%	23.3%	33.4%	44.4%	49.1%	59.3%	66.6%	75.8%
2023-24	3.3%	8.5%	16.1%	23.4%	30.6%	36.7%	45.0%	46.0%	51.7%	62.8%	71.5%	77.3%
2024-25	2.4%	6.5%	11.2%	18.0%	28.6%	35.1%	46.6%	54.0%	58.9%	67.6%	75.3%	79.9%
2025-26	1.8%	6.0%	11.5%	17.6%	21.6%	31.9%	40.8%	49.9%	55.6%	67.6%	74.9%	81.2%
2026-27	2.8%	6.0%	11.6%									

Selected measure at June 2026 has continuously increased for 2 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities

2	Trafford	21.6%
12	Stockport	18.5%
14	Wigan	17.8%
21	Bury	16.7%
26	Manchester	15.9%
43	Rochdale	13.8%
59	Oldham	13.1%
67	Bolton	12.7%
81	Tameside	11.6%
93	Salford	10.3%
6	NHS Greater Manchester Integrated Care Board	15.2%

Narrative

Latest data: **June 26 – 11.6%** of patients aged 14+ have a completed LD HC. This is a cumulative year to date figure.

Tameside is 9th **in GM and 81st Nationally** for this metric.

The end of FY target is 75%.

Targeted work to begin September 26 including an update and re-launch of the communications campaign and resources which significantly increased uptake of health checks as previously reported.

Tameside

Access to Children and Young Peoples Mental Health Services

Access to Children and Young Peoples Mental Health Services

Source: Published MHSDS (Monthly)

4,850	4,925	74/115	6,200
June 2026	May 2026	National Rank Inter Quartile	National Median

more than 1 standard deviation from the mean

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2022-23				4,185	4,295	4,450	4,605	4,745	4,795	4,895	4,960	5,095
2023-24	5,170	5,160	5,050	5,130	5,085	5,075	5,070	5,100	5,140	5,140	5,130	5,065
2024-25	4,670	4,715	4,745	4,795	4,770	4,865	5,035	5,040	5,060	5,070	5,090	5,070
2025-26	5,020	5,010	5,015	4,895	4,880	4,850	4,865	4,900	4,885	4,885	4,900	4,875
2026-27	4,930	4,925	4,850									

Selected measure at June 2026 has continuously decreased for 2 period(s) of time

Latest Value GM Benchmarking

Rate per 1000 | Count (National Rank based on count)

Manchester	110.6	16,060 (21)
Tameside	101.7	4,850 (74)
Trafford	95.5	5,085 (69)
Bury	82.5	3,680 (95)
Salford	78.2	5,145 (68)
Rochdale	78.2	4,570 (79)
Stockport	69.4	4,615 (77)
Oldham	68.5	4,310 (84)
Wigan	64.6	4,535 (81)
Bolton	54.9	4,200 (86)

The rate is calculated using the 0-17 registered population figure for each locality | Tameside: 48,000

Narrative

Latest data: **June 26 – 4,850** Access to Children and Young Peoples Mental Health Services.

Tameside is ranked 2nd **in GM (rate per 1,000) and 74th Nationally (out of 115).** The national ranking is based on count and not a rate, so is not representative are area size.

Mental Health Support Teams in schools expanding to all Tameside Schools by 2029

In addition to Pennine Care CAMHS support; TOGS Mind Community Hive Service for CYP low level Mental Health Support, extended to March 2028. Following a service review changes have been made to improve access e.g. more 1:1 bookable appts. Access to immediate support for CYP through Community Hive reduces some pressure on CAMHS services

Tameside

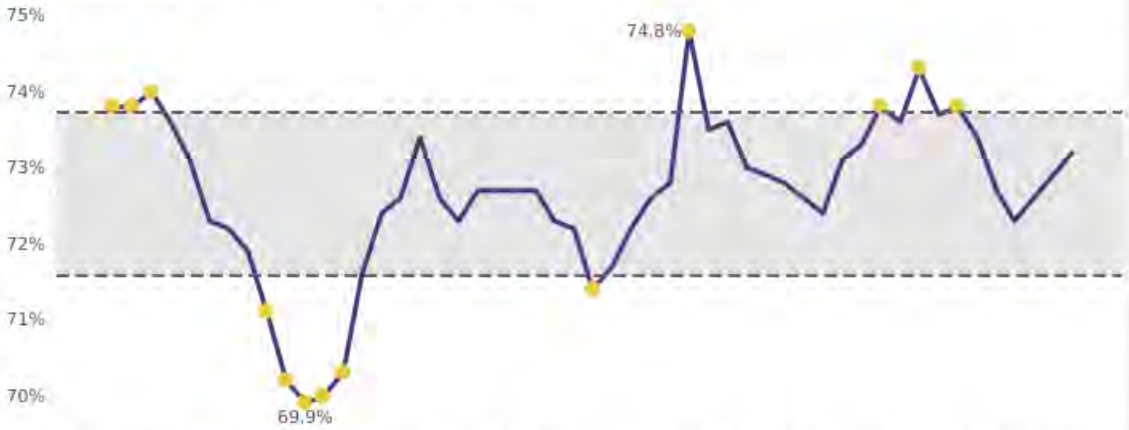
Dementia: Diagnosis Rate (Aged 65+)

Diagnosis rate for people aged 65 and over, with a diagnosis of dementia recorded in primary care, expressed as a percentage of the estimated prevalence based on GP registered populations.

Source: Primary Care Dementia Data (Monthly)

73.2%	72.3%	22/106	66.7%
June 2026	March 2026	National Rank Upper Quartile	National Target

more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	73.8%	73.8%	74.0%	73.6%	73.1%	72.3%	72.2%	71.9%	71.1%	70.2%	69.9%	70.0%
2023-24	70.3%	71.6%	72.4%	72.6%	73.4%	72.6%	72.3%	72.7%	72.7%	72.7%	72.7%	72.3%
2024-25	72.2%	71.4%	71.7%	72.2%	72.6%	72.8%	74.8%	73.5%	73.6%	73.0%	72.9%	72.8%
2025-26	72.6%	72.4%	73.1%	73.3%	73.8%	73.6%	74.3%	73.7%	73.8%	73.4%	72.7%	72.3%
2026-27			73.2%									

Selected measure at June 2026 has continuously increased for 1 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities

5	Bury	77.2%
9	Rochdale	76.4%
11	Manchester	76.0%
13	Salford	75.5%
14	Oldham	75.3%
17	Stockport	74.5%
22	Tameside	73.2%
32	Trafford	71.1%
33	Wigan	70.9%
39	Bolton	69.7%
3	NHS Greater Manchester Integrated Care Board	73.8%

Narrative

Latest data: **June 26 – 73.2%** Dementia: Diagnosis rate (Aged 65+). This remains significantly above the national target of 66.7%.

Tameside is ranked **7th in GM and 22nd Nationally.**

Work will be undertaken to restart work on the Dementia Strategy post NHS Reforms. The Dementia Steering Group will be engaged for feedback and comments on the different strands within the dementia strategy to fill in gaps especially newly emerged neighbourhood working, which will now be included. Once undertaken, the strategy will be presented to TSPC for further feedback and comments.

Tameside

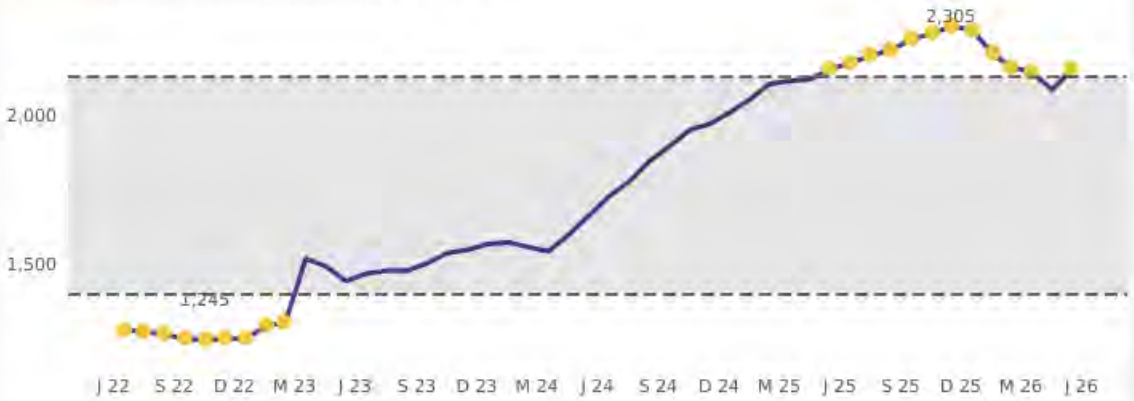
Overall Access to Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses

Number of people who receive two or more contacts from NHS or NHS commissioned community mental health services (in transformed and non transformed PCNs) for adults and older adults with severe mental illnesses, in a rolling 12 month period

Source: Published MHSDS (Monthly)

2,160	2,090	92/115	4,490
June 2026	May 2026	National Rank Lower Quartile	National Median

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2022-23				1,280	1,275	1,265	1,250	1,245	1,250	1,250	1,295	1,305
2023-24	1,520	1,495	1,445	1,470	1,480	1,480	1,505	1,540	1,550	1,570	1,575	1,560
2024-25	1,545	1,600	1,665	1,730	1,780	1,850	1,900	1,955	1,975	2,015	2,060	2,110
2025-26	2,120	2,125	2,160	2,180	2,205	2,225	2,260	2,280	2,305	2,290	2,210	2,165
2026-27	2,150	2,090	2,160									

Selected measure at June 2026 has continuously increased for 1 period(s) of time

Latest Value GM Benchmarking

Rate per 1000 | Count (National Rank)

1	Salford	18.2	4,685 (56)
2	Bury	14.3	2,380 (85)
3	Manchester	13.7	8,215 (38)
4	Trafford	13.1	2,535 (80)
5	Tameside	12.0	2,160 (92)
6	Bolton	11.7	3,025 (71)
7	Rochdale	11.7	2,285 (89)
8	Wigan	10.9	3,085 (69)
9	Oldham	9.6	1,965 (96)
10	Stockport	9.0	2,375 (86)

The rate is calculated using the 18+ registered population figure for each locality | Tameside: 180,620

Narrative

Latest data: **June 26 – 2,160** Access to community mental health services for adults and older adults with SMI.

Tameside are ranked **5th in GM** by rate and **92nd nationally.**

This is below average when looking at data from Sept 23.

Tameside

Women Accessing Specialist Community Perinatal Mental Health Services

Women Accessing Specialist Community Perinatal Mental Health Services (Rolling 12 mths)

Source: Published MHSDS (Quarterly)

225	220	82/107	No Target
June 2026	May 2026	National Rank Lower Quartile	

Outliers more than 1 standard deviation from the mean

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2021-22				135	145	155	165	170	185	190	190	200
2022-23	200	195	200	210	205	205	200	195	200	185	180	160
2023-24	155	165	160	155	160	155	160	165	160	165	170	180
2024-25	180	175	180	180	200	215	220	215	215	225	215	215
2025-26	220	225	225	225	230	225	220	220	220	215	215	215
2026-27	215	220	225									

Selected measure at June 2026 has continuously increased for 2 period(s) of time

Latest Value GM Benchmarking

Rate per 1000 | Count (National Rank)

1	Stockport	5.3	335 (59)
2	Bury	5.0	205 (87)
3	Tameside	4.9	225 (82)
4	Rochdale	4.5	230 (80)
5	Trafford	3.9	185 (92)
6	Wigan	3.9	260 (75)
7	Oldham	3.6	200 (89)
8	Salford	3.0	240 (76)
9	Bolton	2.9	195 (91)
10	Manchester	2.7	535 (39)

The rate is calculated using the 15-44 female population figure for each locality | Tameside 45,783

Narrative

Latest data: **June 26 – 225** Women Accessing Specialist Community Perinatal MH Services.

Although Tameside are in the lower quartile Nationally, this is based on a count. When rated against per 1,000 registered patients Tameside are 3rd (out of 10) in GM.

The latest position remains above last years average of 203.

3 Year funding approved from Best Start Family Hubs and Healthy Babies national Programme for Tameside proposal of 2026-29 Tameside Parent Infant Mental Health Service (PIMHS) Offer; additional groups in Family Hubs to meet the national requirements.

Workforce development is a significant area of focus, with improvements reported from practitioners, including Midwifery, Early Start facilitators and wider partnership colleagues.

Tameside

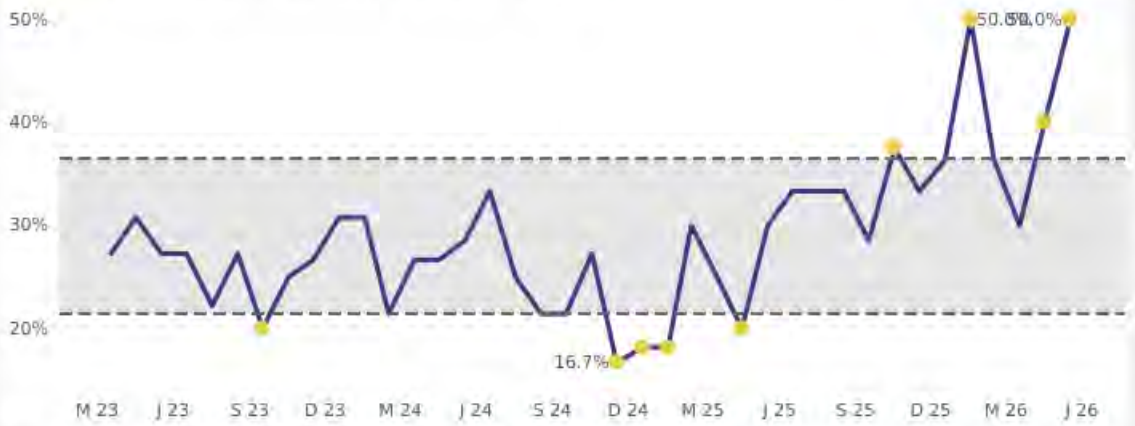
Long length of stay for adults (60+ days) - Mental Health Patients

Proportion of all discharges from adult acute and older adult acute beds, with a length of stay of over 60 days

Source: Published MHSDS (Monthly)

50.0%	40.0%	101/101	0.%
June 2026	May 2026	National Rank Lower Quartile	National Target

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2023-24	27.3%	30.8%	27.3%	27.3%	22.2%	27.3%	20.0%	25.0%	26.7%	30.8%	30.8%	21.4%
2024-25	26.7%	26.7%	28.6%	33.3%	25.0%	21.4%	21.4%	27.3%	16.7%	18.2%	18.2%	30.0%
2025-26	25.0%	20.0%	30.0%	33.3%	33.3%	33.3%	28.6%	37.5%	33.3%	36.4%	50.0%	36.4%
2026-27	30.0%	40.0%	50.0%									

Selected measure at June 2026 has continuously increased for 2 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities

18	Salford	17.6%
49	Oldham	23.8%
66	Bolton	27.3%
70	Rochdale	27.8%
73	Stockport	29.4%
	Wigan	29.4%
79	Bury	30.8%
93	Trafford	36.4%
95	Manchester	38.2%
101	Tameside	50.0%
33	NHS Greater Manchester Integrated Care Board	30.8%

Narrative

Latest data: **June 26 – 50.0%** Long length of stay for adults (60+ days) - MH Patients.

Tameside are 10th (out of 10) in GM and 101 out of 101 Nationally.

Tameside

Proportion of routine eating disorder referrals cases entering treatment within four weeks, aged 0-18 - Mental Health Patients

Proportion of all discharges from adult acute and older adult acute beds, with a length of stay of over 60 days

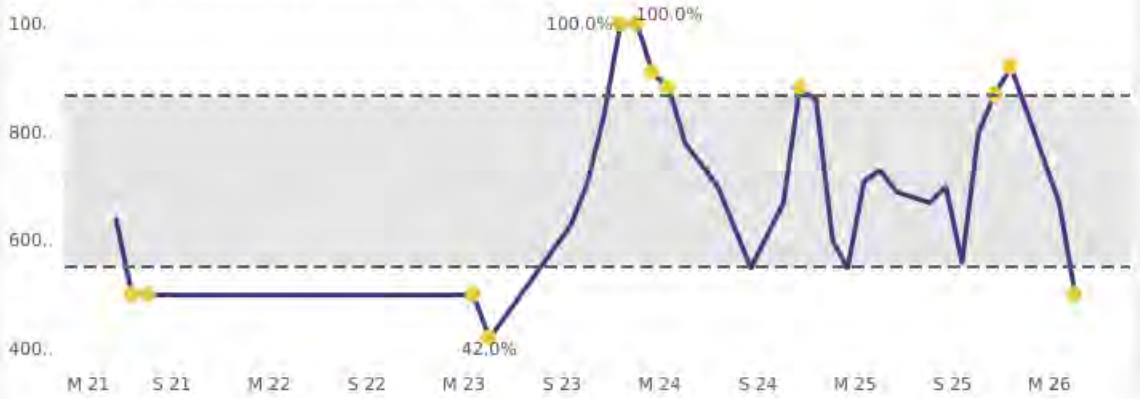
Source: Published MHSDS (Monthly)

50.0%
May 2026

67.0%
April 2026

98/111
National Rank
Lower Quartile

more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2021-22			64.0%	50.0%	50.0%							
2023-24	50.0%	42.0%					63.0%	71.0%	83.0%	100.0%	100.0%	91.0%
2024-25	88.0%	78.0%		70.0%		55.0%		67.0%	88.0%	86.0%	60.0%	55.0%
2025-26	71.0%	73.0%	69.0%		67.0%	70.0%	56.0%	80.0%	87.0%	92.0%		
2026-27	67.0%	50.0%										

Selected measure at May 2026 has continuously decreased for 2 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities

8	Salford	100.0%
	Wigan	100.0%
30	Stockport	91.0%
49	Manchester	82.0%
54	Trafford	79.0%
72	Oldham	60.0%
85	Bury	67.0%
98	Rochdale	50.0%
	Tameside	50.0%
109	Bolton	25.0%
23	NHS Greater Manchester Integrated Care Board	77.0%

Narrative

Latest data: **May 26 – 50%** Proportion of routine eating disorder referrals cases entering treatment within 4 weeks, ages 0-18 – MH Patients.

Tameside is ranked **9th in GM** and **98 Nationally** (out of 111).

Work is underway following the updated methodology for measuring access and waiting times for CYP ED from April 2026 and a deep dive into CYP ED by PCFT. Guidance is being reviewed internally to ensure operational processes and recording reporting mechanisms are aligned with the guidance.
Ongoing dialogue with locality system partners and GM Business Intelligence colleagues to develop a collaborative understanding of the impact of methodology changes on how data presents externally.

Work is ongoing with GM to develop a joint ARFID pathway across local providers.

Tameside

% of hypertension patients who are treated to target as per NICE guidance

% of hypertension patients who are treated to target as per NICE guidance

Source: NHS Quality Outcome Framework (Annual)

68.0%	65.7%	95/106	77.%
March 2025	March 2024	National Rank Lower Quartile	National Target

more than 1 standard deviation from the mean

	Mar
2021-22	60.3%
2022-23	65.9%
2023-24	65.7%
2024-25	68.0%

Selected measure at March 2025 has continuously increased for 1 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities

2	Salford	77.7%
3	Wigan	75.8%
12	Stockport	73.7%
56	Bury	70.6%
59	Rochdale	70.5%
65	Bolton	70.0%
67	Trafford	70.0%
86	Oldham	68.8%
95	Tameside	68.0%
101	Manchester	67.4%
12	NHS Greater Manchester Integrated Care Board	71.2%

Narrative

Latest data: May 26 – 79.0% GP Appointments - % of regular appointments within 14 days. This is 10% higher than the data for March 26

Tameside are 7th (out of 10) in GM, which is an improvement on March 26 data where it was 9th.

This metric includes regularly scheduled appointments.

Tameside

% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins

% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins

Source: CVD Prevent (Quarterly)

69.6%	69.1%	11/106	64.1%
December 2025	September 2025	National Rank Upper Quartile	National Median

more than 1 standard deviation from the mean

	Jun	Sept	Dec	Mar
2022-23	65.9%	66.8%	67.0%	68.2%
2023-24	68.9%	67.1%	68.9%	69.7%
2024-25	69.4%	69.2%	68.6%	68.9%
2025-26	68.5%	69.1%	69.6%	

Selected measure at December 2025 has continuously increased for 2 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities

3	Oldham	71.2%
9	Manchester	70.3%
11	Tameside	69.6%
13	Rochdale	69.1%
22	Trafford	67.4%
23	Salford	67.1%
42	Stockport	65.1%
44	Wigan	65.0%
45	Bury	65.0%
56	Bolton	63.8%
4	NHS Greater Manchester Integrated Care Board	67.3%

Narrative

Latest data: **May 26 – 50%** of patients identified as having 20% or greater 10 year risk of CVD are treated with statins.

Tameside are in the top quartile nationally, they are ranked **3rd in GM** and **11 Nationally** (out of 106).

Tameside

GP appointments - percentage of regular appointments within 14 days

Percentage of appointments where the time between booking and appointment was 'Same day', '1 day', '2 to 7 days' or '8 to 14 days'

Source: Appointments in General Practice (Monthly)

77.4%	79.1%	91/106	81.5%
June 2026	May 2026	National Rank Lower Quartile	National Median

Outliers more than 1 standard deviation from the mean

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	82.0%	83.7%	81.6%	82.3%	82.0%	82.4%	84.1%	83.4%	81.1%	82.7%	83.8%	82.4%
2022-23	80.4%	81.7%	79.2%	81.0%	80.4%	79.3%	81.4%	80.9%	82.8%	84.5%	82.7%	80.1%
2023-24	77.1%	79.1%	79.4%	79.1%	79.7%	78.0%	77.2%	78.3%	79.1%	78.9%	80.0%	79.7%
2024-25	78.5%	79.2%	77.9%	79.1%	81.0%	80.5%	79.3%	79.1%	80.7%	81.5%	80.7%	79.9%
2025-26	77.7%	79.4%	79.6%	79.9%	78.3%	78.1%	76.6%	78.6%	78.8%	79.8%	80.9%	81.2%
2026-27	78.3%	79.1%	77.4%									

Selected measure at June 2026 has continuously decreased for 1 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities

18	Manchester	86.6%
26	Rochdale	84.6%
31	Wigan	83.9%
32	Oldham	83.6%
53	Trafford	81.5%
55	Bury	81.3%
56	Salford	81.3%
57	Stockport	81.1%
60	Bolton	80.9%
91	Tameside	77.4%
10	NHS Greater Manchester Integrated Care Board	82.8%

Narrative

Latest data: **June 26 – 77.4%** of regular GP appointments within 14 days.

Tameside are in the lower quartile nationally, they are ranked **10th in GM** and **91 Nationally** (out of 106).

Tameside

E. coli blood stream infections

12-month rolling counts of E. coli blood stream infections

Source: National Statistics: E. coli bacteraemia: monthly data by location of onset (Monthly)

224	223	42/107	No Target
June 2026	May 2026	National Rank Inter Quartile	

outliers more than 1 standard deviation from the mean

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	142	153	147	151	153	159	161	170	171	180	179	189
2022-23	181	173	179	172	174	172	174	171	167	162	165	168
2023-24	176	184	182		189	189	190	195	194	193	184	188
2024-25	183	178	184	186	194	191	202	196	204	209	218	218
2025-26	221	224	216	221	225	225	218	214	213	213	210	219
2026-27	218	223	224									

Selected measure at June 2026 has continuously increased for 2 period(s) of time

Latest Value GM Benchmarking

Rate per 1000 | Count (National Rank)

Salford	0.54	175.0 (26)
Rochdale	0.55	140.0 (16)
Bury	0.56	119.0 (9)
Wigan	0.58	203.0 (32)
Bolton	0.61	204.0 (33)
Oldham	0.63	170.0 (23)
Manchester	0.62	464.0 (69)
Stockport	0.80	264.0 (48)
Trafford	0.85	210.0 (35)
Tameside	0.98	224.0 (42)

The rate is calculated using the registered population figure for each locality | Tameside: 228,657

Narrative

Latest data: **June 26 – 224** E. coli blood stream infections.

Tameside is ranked **10th in GM** (rate per 1,000) and **42nd Nationally** (out of 107). The national ranking is based on count and not a rate, so is not representative are area size.

Tameside

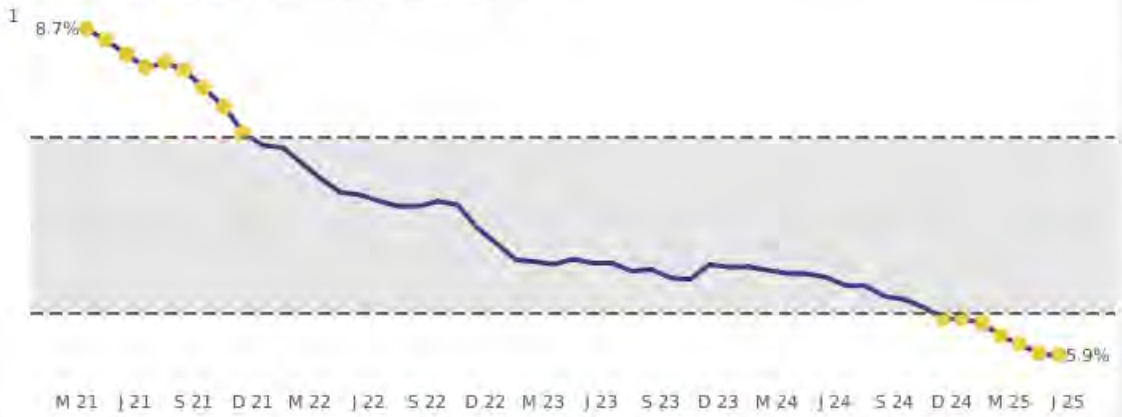
Antimicrobial resistance: proportion of broad-spectrum antibiotic prescribing in primary care

The number of broad-spectrum antibiotic (antibacterials) items from co-amoxiclav, cephalosporin class and fluoroquinolone class drugs as a percentage of the total number of antibacterial items prescribed in primary care.

Source: EPACT Prescribing Data (Monthly)

5.9%	5.9%	20/113	10.%
June 2025	May 2025	National Rank Upper Quartile	National Target

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	8.7%	8.6%	8.5%	8.3%	8.4%	8.3%	8.2%	8.0%	7.8%	7.7%	7.7%	7.5%
2022-23	7.4%	7.3%	7.3%	7.2%	7.2%	7.2%	7.2%	7.2%	7.0%	6.9%	6.7%	6.7%
2023-24	6.7%	6.7%	6.7%	6.7%	6.6%	6.6%	6.6%	6.6%	6.7%	6.7%	6.7%	6.6%
2024-25	6.6%	6.6%	6.6%	6.5%	6.5%	6.4%	6.4%	6.3%	6.2%	6.2%	6.2%	6.1%
2025-26	6.0%	5.9%	5.9%									

Selected measure at June 2025 has continuously decreased for 5 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities

14	Oldham	5.5%
15	Bury	5.6%
19	Bolton	5.9%
20	Tameside	5.9%
22	Rochdale	6.0%
43	Manchester	7.4%
51	Stockport	7.6%
74	Salford	8.4%
79	Trafford	8.6%
100	Wigan	9.6%

Narrative

Latest data: **June 26 – 5.9%** proportion of broad spectrum antibiotic prescribing in primary care.

Tameside continues to demonstrate strong performance in antimicrobial stewardship, with broad-spectrum antibiotic prescribing reduced to 5.9% against a national target of <10%, placing the locality in the top quartile nationally. This improving trend has been supported through delivery of the BeCCoR Antimicrobial Stewardship programme, which focuses on optimising antibiotic prescribing, reducing unwarranted variation and strengthening adherence to antimicrobial stewardship principles across primary care. Practice-level review, targeted prescribing support and ongoing clinician engagement are helping to ensure antibiotics are used appropriately, contributing to improved patient safety and supporting wider efforts to reduce antimicrobial resistance

Oversight Metrics Glossary

Domain	Code	Measure	Description	Data Source	Frequency	Latest	Updated	RAG rated against	Desired Direc
Cancer	N/A	Cancers Diagnosed at an Early Stage (12-month rolling): All Tumours Staged within RCRD	12-month rolling count of cancers diagnosed at stages 1 and 2 divided by 12-month rolling count of cancers diagnosed at stages 1, 2, 3, and 4	Rapid Cancer Registration Data (RCRD) at Tumour Level	Monthly	Dec 25	2nd Thursday	National Target	Increase
	S086a	Inappropriate adult acute mental health Out of Area Placement (OAP) bed days	Inappropriate Out of Area Placements	Out of Area Placements in Mental Health Services Official Statistics	Monthly	May 26	2nd Thursday	National Target	Decrease
	S081a	Talking Therapies: Access Rate	Number of people accessing first treatment	Improving Access to Psychological Therapies Data Set	Monthly	May 26	2nd Thursday	No Target	Increase
	EAS01	Dementia: Diagnosis Rate (Aged 65+)	Dementia: Diagnosis Rate (Aged 65+)	Primary Care Dementia Data	Monthly	Mar 26	2nd Thursday	National Target	Increase
	S030a	% of patients aged 14+ with a completed LD health check	% of patients aged 14+ with a completed LD health check	Learning Disabilities Health Check Scheme	Monthly	May 26	2nd Thursday	National Target	Increase
	S110a	Overall Access to Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses	Number of people who receive two or more contacts from NHS or NHS commissioned community mental health services (in transformed and non-transformed PCNs) for adults and older adults wit..	Published MHSDS	Monthly	May 26	2nd Thursday	National Median	Increase
	S125a	Long length of stay for adults (60+ days)	Number of people for a given CCG discharged from an adult acute inpatient bed with a hospital spell over 60 days (calculated from the point of admission to the point of discharge)	Published MHSDS	Monthly	May 26	2nd Thursday	National Target	Decrease
	EH09	Access to Children and Young Peoples Mental Health Services	Number of CYP aged 0-17 supported through NHS funded mental health services receiving at least one contact.	Published MHSDS	Monthly	May 26	2nd Thursday	National Median	Increase
	S131a	Women Accessing Specialist Community Perinatal Mental Health Services	Number of women accessing specialist community PMH and MMHS services in the reporting period	Published MHSDS	Quarterly	May 26	2nd Thursday	No Target	Increase
	N/A	Number of MH patients with no criteria to reside (NCTR)	Number of MH patients with no criteria to reside	GM Admissions - Local	Monthly	Jun 26	1st	No Target	Decrease
	N/A	Percentage of MH patients with no criteria to reside (NCTR)	Percentage of MH patients with no criteria to reside	GM Admissions - Local	Monthly	Jun 26	1st	No Target	Decrease
	N/A	Proportion of routine eating disorder referrals cases entering treatment within four weeks, aged 0-18	Proportion of referrals with eating disorders categorized as routine cases entering treatment within four weeks in RP, aged 0-18	Published MHSDS	Monthly	May 26	2nd Thursday	National Target	Increase
Primary Care	S053b	% of hypertension patients who are treated to target as per NICE guidance		NHS Quality Outcome Framework	Annual	Mar 25	2nd Thursday	National Target	Increase
	S129a	GP appointments - percentage of regular appointments within 14 days	Percentage of appointments where the time between booking and appointment was 'Same day', '1 day', '2 to 7 days' or '8 to 14 days'	Appointments in General Practice	Monthly	May 26	Last Thursday	National Median	Increase
	S053c	% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins	% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins	CVD Prevent	Quarterly	Dec 25	2nd Thursday	National Median	Increase
Quality	S037A	% of patients describing the overall experience of their GP practice as good	The weighted percentage of people who report through the GP Patient Survey their overall experience of their GP practice as 'very good' or 'fairly good'	GP Patient Survey	Annual	Mar 23	2nd Thursday	National Median	Increase
	S042a	E. coli blood stream infections	12-month rolling counts of E. coli	National Statistics: E. coli bacteraemia: monthly data by loc..	Monthly	May 26	1st Wednesday	No Target	Decrease
	S044b	Antimicrobial resistance: proportion of broad-spectrum antibiotic prescribing in primary care	The proportion of broad-spectrum antibiotic prescribing in primary care	EPACT Prescribing Data	Monthly	Jun 25	2nd Thursday	National Target	Decrease
	S044a	Antimicrobial resistance: total prescribing of antibiotics in primary care	The proportion of antibiotic prescribing in primary care	EPACT Prescribing Data	Monthly	Jun 25	2nd Thursday	National Target	Decrease

Sight Metrics Glossary

Domain	Code	Measure	Description	Data Source	Frequency	Latest	RAG rated against	Target/National
Elective Care	EB20	RTT incomplete: 65+ week waits		Consultant-led RTT Waiting Times data collection (National Statistics).	Monthly	May 26	National Target	0.
	EB28	Diagnostic 6ww: All	% of Patients waiting over 6 weeks for a diagnostic test or procedure	Monthly Diagnostics Waiting Times and Activity Return - DM01	Monthly	May 26	National Target	1.%
	EB28x	Diagnostic 6ww: All	% of Patients waiting over 6 weeks for a diagnostic test or procedure	Monthly Diagnostics Waiting Times and Activity Return - DM01	Monthly	May 26	National Target	1.%
Cancer	S012a	28 Day Wait from Referral to Faster Diagnosis (Monthly): All Patients	Count of patients told cancer diagnosis outcome within 28 days divided by total count of patients told cancer diagnosis outcome following their urgent referral for suspected cancer, referral for breast symptoms, or urgent screening referral	National Cancer Waiting Times Monitoring Data Set (CWT)	Monthly	May 26	National Target	80.%
Materni..	S022a	Number of stillbirths per 1,000 total births	Count of cancers diagnosed at stages 1 and 2 divided by count of cancers diagnosed at stages 1, 2, 3, and 4	MBRRACE-UK - Perinatal Mortality Surveillance Report	Annual	Dec 24	National Median	3
	S104a	Number of neonatal deaths per 1,000 total live births	Number of neonatal deaths per 1,000 total live births	MBRRACE-UK - Perinatal Mortality Surveillance Report	Annual	Dec 24	National Median	1
Screening and Immunisations	S047A	Seasonal Flu Vaccine Uptake: 65 years and over	number of people over 65 who received the seasonal influenza vaccination divided by the number of eligible people who are aged 65 and over	Seasonal influenza vaccine uptake in GP patients: monthly data, 2022 to 2023	Monthly	Feb 26	National Target	85.%
	S046a	COVER immunisation: MMR2 Uptake at 5 years old	% children whose fifth birthday falls within the time period who have received two doses of MMR vaccination	Cover of vaccination evaluated rapidly (COVER) programme	Quarterly	Mar 26	National Target	95.%
	S050a	Females, 25-64, attending cervical screening within target period (3.5 or 5.5 year coverage, %)	% of females, age 25-64 yrs, attending cervical screening within target period (3.5 yrs if aged 24-49 or 5.5 yrs if aged 50-64)	Cervical Screening Programme - Coverage Statistics [Management Information]	Quarterly	Jun 24	National Target	80.%
	S049a	Breast screening coverage, females aged 53-70, screened in last 36 months	% women eligible for screening who have had a test with a recorded result at least once in the previous 36 months	Fingertips, Public Health Data, Public Health Outcomes Framework	Annual	Dec 25	No Target	
Commu..	N/A	% 2-hour Urgent Community Response (UCR) first care contacts	Percentage of 2-hour Urgent Community Response referrals subject to the 2-hour standard where care was provided within two hours	Community Services Data Set (CSDS)	Monthly	Apr 26	National Target	
						May 26	National Target	

Tameside Locality Board Report – Section 2
August 26

Data Source: PIA Locality Report: Views - Tableau Server

Part of Greater Manchester Integrated Care Partnership

Tameside Integrated Care Partnership

Prepared by: Lead Intelligence Analyst
Fiona Haworth

Data extracted: 11th June 2026

Tameside - Oversight Metrics

Show Definitions

Domain	Code	Measure	Frequency	Date	Latest	Previous	Change	Target/Median	Numerator	Denominator	Quartile
Mental Health & Learning Disabilities	EAS02	Talking Therapies: Recovery Rate	Monthly	Jun 26	50.0%	51.0%	↓	50.%	105	210	Inter
	EH13	% of people with SMI to receive all six physical health checks in the preceding 12 months.	Quarterly	Mar 26	76.1%	63.0%	↑	60.%	1,160	1,525	Upper
	OF0111	% of people with SMI to receive all six physical health checks in the preceding 12 months.	Quarterly	Mar 26	76.1%	63.0%	↑	60.%	1,160	1,525	Upper
	EH01	Talking Therapies: 6 Week Waits	Monthly	Jun 26	86.4%	88.1%	↓	75.%	190	220	Inter
	EH02	Talking Therapies: 18 Week Waits	Monthly	Jun 26	100.0%	100.0%	–	95.%	220	220	Upper
	EH21	Talking Therapies: Second Treatment Waits	Monthly	Jun 26	41.2%	45.0%	↑	10.%	105	255	Lower
	EH10	CYP Eating Disorders: Routine - % within 4 weeks	Quarterly	Mar 23	84.6%	84.6%	–	95.%	33	39	Inter
	EH11	CYP Eating Disorders: Urgent - % within 1 week	Quarterly	Mar 23	66.7%	70.0%	↓	95.%	6	9	Lower
	EH34	Access to Individual Placement and Support Services	Monthly	Jun 26	390	380	↑	336	N/A	N/A	Inter
	N/A	Percentage of CYP receiving Autism assessment within 18 weeks of referral	Monthly	Jun 26	0.0%	0.0%	–	N/A	0	8	N/A
	N/A	Percentage of CYP receiving ADHD assessment within 18 weeks of referral	Monthly	Jun 26	0.0%	0.0%	–	N/A	0	11	N/A
	N/A	Autism average wait in weeks from referral to first assessment	Monthly	Jun 26	157	156	↓	N/A	N/A	N/A	N/A
	N/A	ADHD average wait in weeks from referral to first assessment	Monthly	Jun 26	146	129	↓	N/A	N/A	N/A	N/A
Community	ET02	Total Patients on the CHS Waiting Lists (T&G ICO FT)	Monthly	Jun 26	4,941	5,099	↑	N/A	N/A	N/A	N/A
	ET02a	Total CYP on the CHS Waiting Lists (T&G ICO FT)	Monthly	Jun 26	1,003	1,001	↓	N/A	N/A	N/A	N/A
	ET02b	Total Adults on the CHS Waiting Lists (T&G ICO FT)	Monthly	Jun 26	3,938	4,098	↑	N/A	N/A	N/A	N/A
	ET9	Total Patients Waiting 52+ Weeks on the CHS Waiting Lists (T&G ICO FT)	Monthly	Jun 26	1	0	↓	N/A	N/A	N/A	N/A
	ET09	Total Patients Waiting 52+ Weeks on the CHS Waiting Lists (T&G ICO FT)	Monthly	Jun 26	1	0	↓	N/A	N/A	N/A	N/A
	ET09b	Total Adults Waiting 52+ Weeks on the CHS Waiting Lists (T&G ICO FT)	Monthly	Jun 26	0	0	–	N/A	N/A	N/A	N/A
	ET09a	Total CYP Waiting 52+ Weeks on the CHS Waiting Lists (T&G ICO FT)	Monthly	Jun 26	1	0	↓	N/A	N/A	N/A	N/A
	OF0999	% of CHC referrals completed within 28 days	Quarterly	Jun 26	100.0%	90.5%	↑	80.%	27	27	Upper
	N/A	% of DST carried out in acute setting	Quarterly	Jun 26	0.0%	0.0%	–	N/A	0	22	Lower
Primary Care	ED19	Appointments in general practice	Monthly	Jun 26	113,323	98,146	↑	215,902	N/A	N/A	Lower
	S001a	Number of GP appointments per 10,000 weighted patients	Monthly	Jun 26	4,956	4,292	↑	5,233	113,323	228,657	Inter
	N/A	Number of prescriptions dispensed per 1000 patients	Monthly	Jul 25	1,099	1,033	↓	N/A	N/A	N/A	Lower
Adult Social Care	N/A	Number of people in Care Homes	Weekly	Aug 26	1,275	1,270	↓	N/A	N/A	N/A	N/A
	N/A	Number of people in Home Care	Weekly	Aug 26	1,978	1,990	↓	N/A	N/A	N/A	N/A
	N/A	Percentage of Care Homes rated Good or Outstanding	Monthly	Jul 26	73.5%	72.7%	↑	N/A	25	34	N/A
	N/A	Care home beds vacancy rate	Weekly	Aug 26	7.1%	7.4%	↓	N/A	98	1,373	N/A
	N/A	Number of vacant care home beds	Weekly	Aug 26	98	101	↓	N/A	N/A	N/A	N/A

Tameside

Talking Therapies: Recovery Rate

The proportion of people who complete treatment who are moving to recovery

Source: Improving Access to Psychological Therapies Data Set (Monthly)

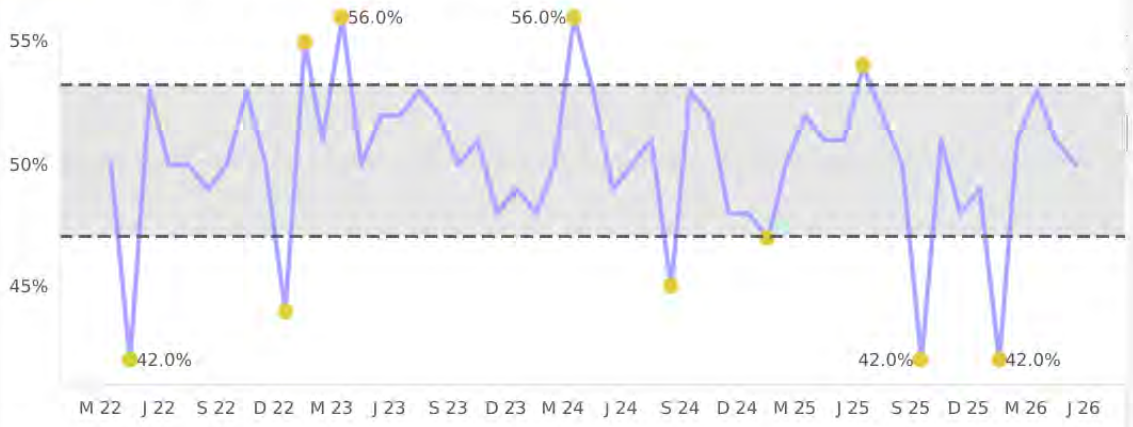
50.0%
June 2026

51.0%
May 2026

59/110
National Rank
Inter Quartile

50.%
National Target

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	50.0%	42.0%	53.0%	50.0%	50.0%	49.0%	50.0%	53.0%	50.0%	44.0%	55.0%	51.0%
2023-24	56.0%	50.0%	52.0%	52.0%	53.0%	52.0%	50.0%	51.0%	48.0%	49.0%	48.0%	50.0%
2024-25	56.0%	53.0%	49.0%	50.0%	51.0%	45.0%	53.0%	52.0%	48.0%	48.0%	47.0%	50.0%
2025-26	52.0%	51.0%	51.0%	54.0%	52.0%	50.0%	42.0%	51.0%	48.0%	49.0%	42.0%	51.0%
2026-27	53.0%	51.0%	50.0%									

Selected measure at June 2026 has continuously decreased for 2 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities

Narrative

Latest data: **June 26 – 50%** of people who complete treatment wo hare moving to recovery..

Tameside are **4th in GM** and **59/110 Nationally.**

Tameside

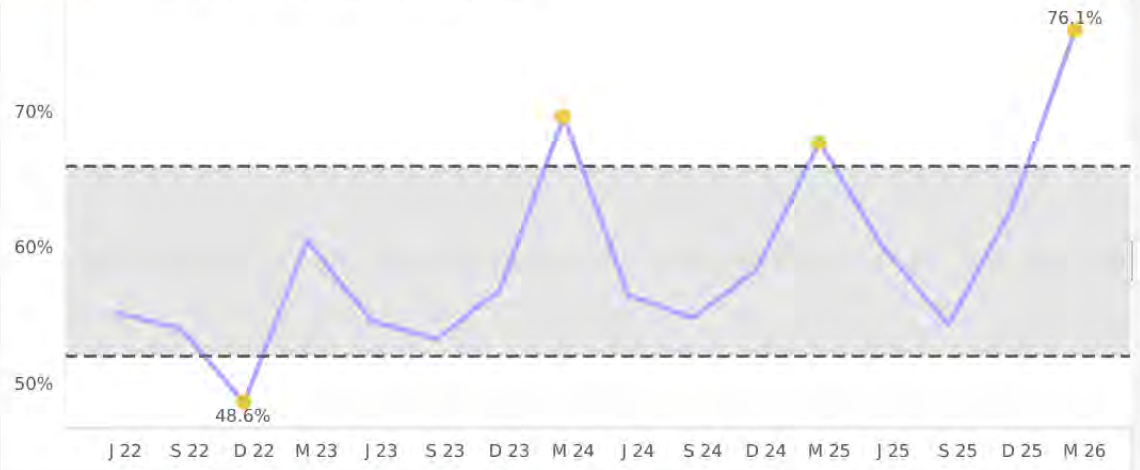
% of people with SMI to receive all six physical health checks in the preceding 12 months. - Mental Health Patients

People with severe mental illness receiving a full annual physical health check and follow up interventions

Source: Physical Health Checks for people with Severe Mental Illness (Quarterly)

76.1%	63.0%	5/106	60.%
March 2026	December 2025	National Rank Upper Quartile	National Target

Outliers more than 1 standard deviation from the mean



	Jun	Sept	Dec	Mar
2022-23	55.2%	54.1%	48.6%	60.5%
2023-24	54.6%	53.3%	56.9%	69.7%
2024-25	56.5%	54.8%	58.4%	67.8%
2025-26	59.9%	54.3%	63.0%	76.1%

Selected measure at March 2026 has continuously increased for 2 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities

5	Tameside	76.1%
6	Trafford	75.0%
10	Stockport	74.3%
11	Salford	74.0%
12	Wigan	73.8%
33	Oldham	68.3%
34	Rochdale	68.0%
38	Bolton	67.3%
42	Manchester	66.7%
69	Bury	61.3%
6	NHS Greater Manchester Integrated Care Board	69.9%

Marrative

Latest data: **July 26 – 161%** of people with SMI to receive all 6 PHCs in the preceding 12 months.

The National target of 60% is based on the NHS Long Term Plan.

This scheme was incorporated into Beccor in August 2026.

Targeted work to begin September 26 including an update and re-launch of the communications campaign and resources which significantly increased uptake of health checks as previously reported.

Tameside

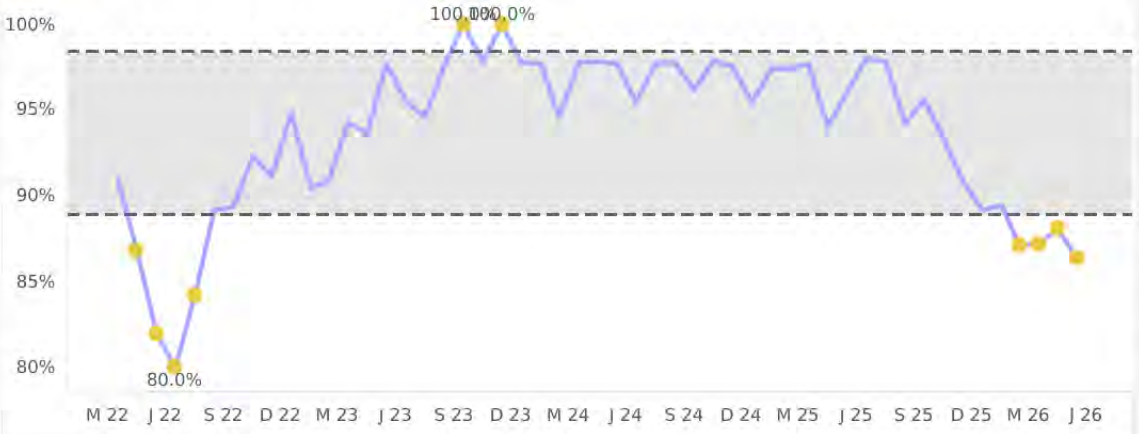
Talking Therapies: 6 Week Waits

The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period.

Source: Improving Access to Psychological Therapies Data Set (Monthly)

86.4%	88.1%	62/110	75.%
June 2026	May 2026	National Rank Inter Quartile	National Target

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	90.9%	86.8%	82.0%	80.0%	84.2%	89.2%	89.4%	92.3%	91.2%	94.9%	90.5%	90.9%
2023-24	94.3%	93.6%	97.7%	95.6%	94.6%	97.6%	100.0%	97.8%	100.0%	97.8%	97.7%	94.6%
2024-25	97.8%	97.8%	97.7%	95.5%	97.7%	97.8%	96.2%	97.9%	97.6%	95.5%	97.4%	97.4%
2025-26	97.7%	94.0%	96.1%	98.0%	97.8%	94.2%	95.7%	93.3%	90.9%	89.2%	89.5%	87.1%
2026-27	87.2%	88.1%	86.4%									

Selected measure at June 2026 has continuously decreased for 1 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities

37	Oldham	94.7%
62	Tameside	86.4%
73	Salford	79.4%
75	Wigan	78.0%
77	Bolton	77.6%
86	Stockport	72.9%
92	Manchester	68.7%
97	Trafford	66.7%
101	Bury	61.5%
108	Rochdale	30.0%
32	NHS Greater Manchester Integrated Care Board	72.6%

Narrative

Latest data: **June 26 – 86.4%** of people wait six weeks or less from referral to entering a course of IAPT treatment.

Tameside are **2nd in GM** and **62/110 Nationally.**

Tameside

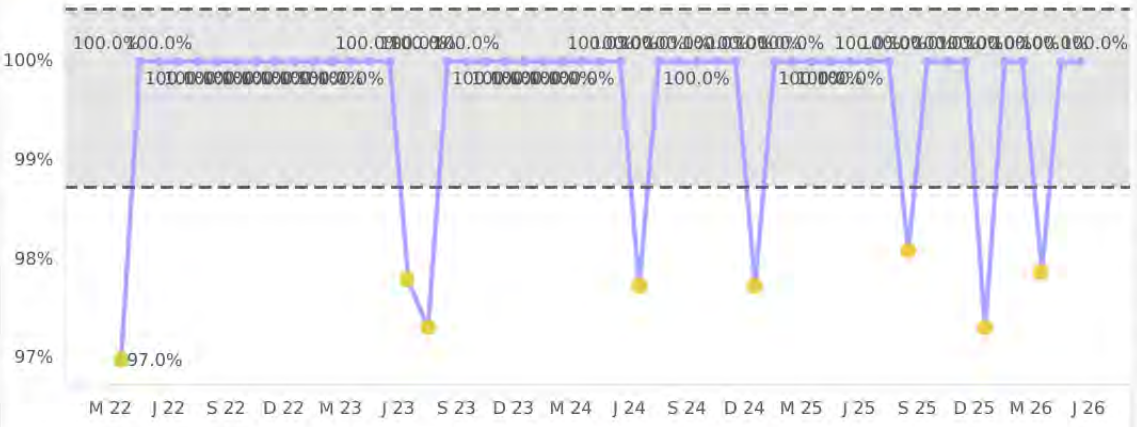
Talking Therapies: 18 Week Waits

The proportion of people that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period.

Source: Improving Access to Psychological Therapies Data Set (Monthly)

100.0%	100.0%	3/110	95.%
June 2026	May 2026	National Rank Upper Quartile	National Target

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	97.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
2023-24	100.0%	100.0%	100.0%	97.8%	97.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
2024-25	100.0%	100.0%	100.0%	97.7%	100.0%	100.0%	100.0%	100.0%	100.0%	97.7%	100.0%	100.0%
2025-26	100.0%	100.0%	100.0%	100.0%	100.0%	98.1%	100.0%	100.0%	100.0%	97.3%	100.0%	100.0%
2026-27	97.9%	100.0%	100.0%									

Selected measure at June 2026 has continuously for 1 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities

3	Bury	100.0%
	Oldham	100.0%
	Stockport	100.0%
	Tameside	100.0%
	Wigan	100.0%
84	Salford	98.5%
85	Bolton	98.5%
86	Manchester	98.5%
92	Trafford	97.8%
97	Rochdale	96.7%
25	NHS Greater Manchester Integrated Care Board	98.9%

Narrative

Latest data: **June 26 – 100%** of people wait 18 weeks or less from referral to entering a course of IAPT treatment.

Tameside

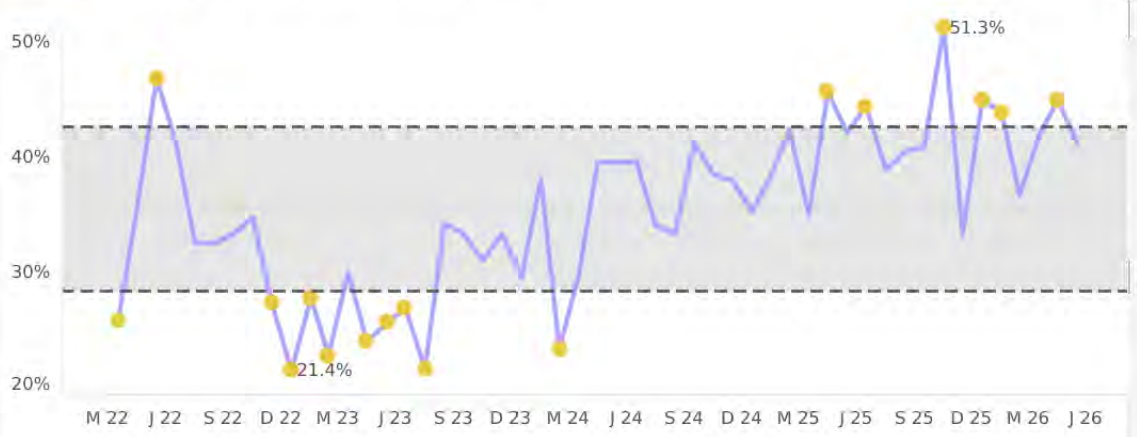
Talking Therapies: Second Treatment Waits

The proportion of people that waited more than 90 days from their first treatment appointment to their second treatment appointment.

Source: Improving Access to Psychological Therapies Data Set (Monthly)

41.2%	45.0%	84/105	10.%
June 2026	May 2026	National Rank Lower Quartile	National Target

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	25.7%	35.6%	46.8%	41.5%	32.5%	32.5%	33.3%	34.8%	27.3%	21.4%	27.8%	22.7%
2023-24	30.0%	23.9%	25.6%	26.8%	21.6%	34.3%	33.3%	31.0%	33.3%	29.5%	38.1%	23.3%
2024-25	29.8%	39.6%	39.5%	39.6%	34.1%	33.3%	41.3%	38.5%	37.9%	35.3%	38.5%	42.4%
2025-26	35.0%	45.7%	42.1%	44.4%	38.9%	40.5%	40.9%	51.3%	33.3%	45.0%	43.9%	36.7%
2026-27	41.9%	45.0%	41.2%									

Selected measure at June 2026 has continuously decreased for 1 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities

67	Oldham	32.4%
73	Manchester	34.5%
77	Salford	38.7%
84	Tameside	41.2%
87	Trafford	42.6%
88	Wigan	43.1%
90	Stockport	43.4%
93	Bolton	51.5%
96	Bury	59.5%
97	Rochdale	61.5%
36	NHS Greater Manchester Integrated Care Board	43.2%

Narrative

Latest data: **June 26 – 41.2%** of people wait more than 90 days from the first treatment appointment to their second.

Tameside are **4th in GM** and **84/101 Nationally.**

Tameside

% of CHC referrals completed within 28 days

Percentage of referrals completed (including discounted referrals) within 28 Days

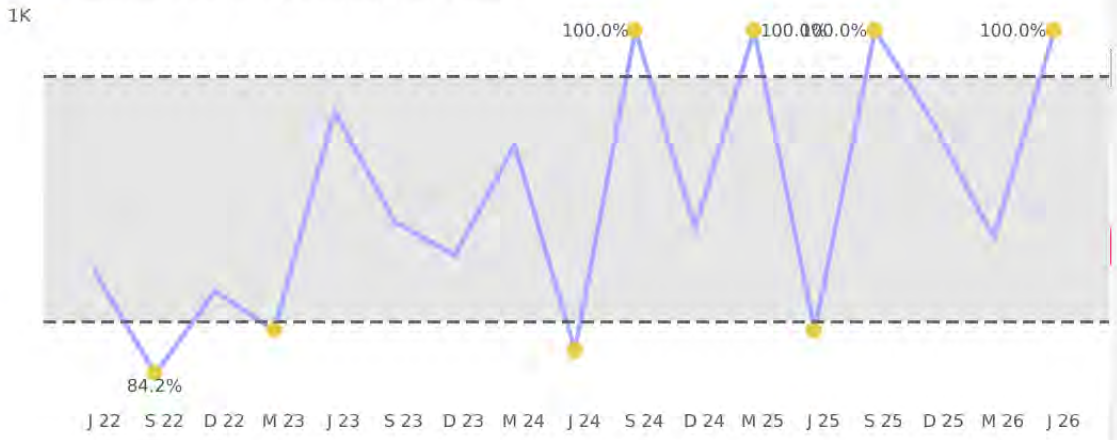
Source: Continuing Healthcare and NHS-funded Nursing Care quarterly published figures (Quarterly)

100.0%
June 2026

90.5%
March 2026

1/106
National Rank
Upper Quartile

Outliers more than 1 standard deviation from the mean



	Jun	Sept	Dec	Mar
2022-23	88.9%	84.2%	88.0%	86.2%
2023-24	96.3%	91.2%	89.7%	94.7%
2024-25	85.3%	100.0%	90.9%	100.0%
2025-26	86.2%	100.0%	95.7%	90.5%
2026-27	100.0%			

Selected measure at June 2026 has continuously increased for 1 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities

Narrative

Latest data: **June 26 – 100%** CHC referrals completed within 28 days.

Tameside are **1st in GM** and **1/106 Nationally.**

Tameside

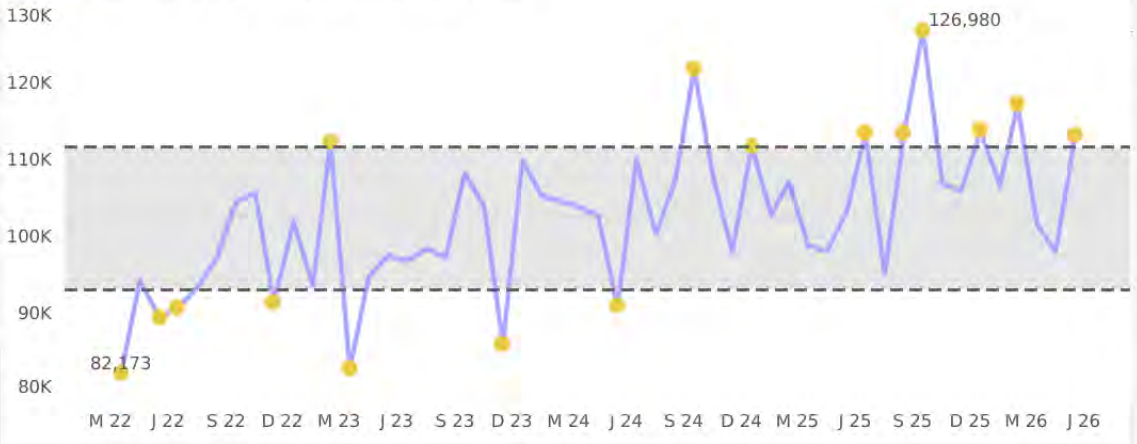
Appointments in general practice

Planned number of general practice appointments as per https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice

Source: Appointments in General Practice (Monthly)

113,323	98,146	84/106	215,902
June 2026	May 2026	National Rank Lower Quartile	National Median

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	82,173	94,334	89,567	90,853	93,437	97,404	104,538	105,770	91,493	101,994	93,726	112,538
2023-24	82,841	94,820	97,581	96,870	98,484	97,322	108,342	103,993	86,018	109,990	105,403	104,693
2024-25	103,970	102,795	90,908	110,229	100,433	107,351	121,974	107,603	98,107	111,911	102,915	107,174
2025-26	98,916	98,194	103,139	113,531	95,208	113,583	126,980	107,063	106,017	113,891	106,753	117,294
2026-27	101,614	98,146	113,323									

Selected measure at June 2026 has continuously increased for 1 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities

36	Manchester	323,428
61	Bolton	174,822
63	Stockport	168,940
65	Salford	164,963
68	Wigan	154,319
76	Oldham	124,762
81	Rochdale	118,230
84	Tameside	113,323
90	Trafford	103,647
96	Bury	87,819

Narrative

Latest data: **June 26 – 113.323** Number of GP appointments.

Tameside are 8th **in GM and 84/106 Nationally.**

There has been an increase of 15,177 since the last reporting period. This exceeds seasonal trends over the past few years.

Tameside

Number of prescriptions dispensed per 1000 patients

Number of prescriptions dispensed per 1000 patients

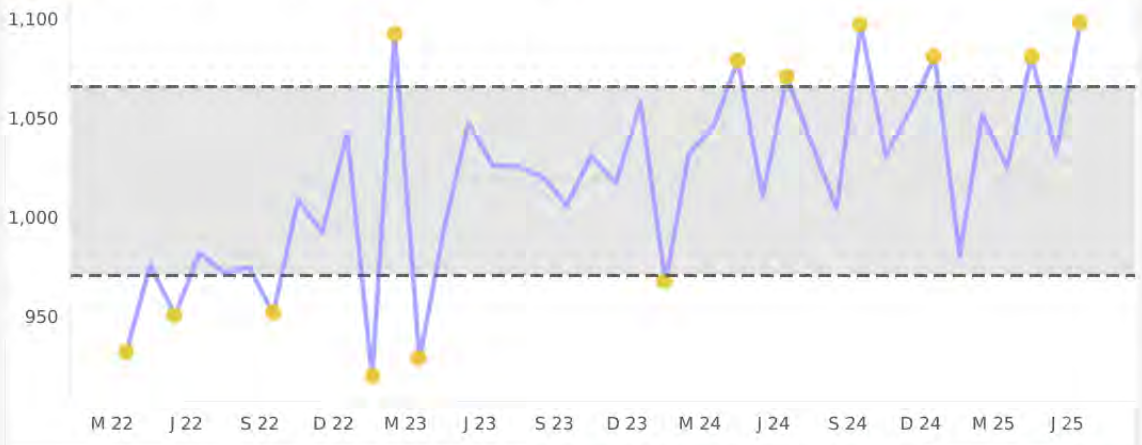
Source: Patient Level Prescribing Data (Monthly)

1,099
July 2025

1,033
May 2025

116/117
National Rank
Lower Quartile

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	932.6	976.5	951.5	982.7	973.1	975.4	952.4	1,009.4	993.2	1,043.0	920.6	1,093.1
2023-24	929.0	993.9	1,048.8	1,026.8	1,026.2	1,021.2	1,006.9	1,031.9	1,017.7	1,058.4	968.0	1,032.5
2024-25	1,046.8	1,079.7	1,011.4	1,071.2	1,037.7	1,005.2	1,098.2	1,032.0	1,054.4	1,081.7	981.5	1,052.5
2025-26	1,025.6	1,081.6	1,033.4	1,098.6								

Selected measure at July 2025 has continuously increased for 1 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities

107	Manchester	825
108	Bolton	856
109	Salford	902
110	Bury	909
111	Rochdale	924
112	Wigan	984
113	Oldham	986
114	Trafford	995
115	Stockport	1,042
116	Tameside	1,099
39	NHS Greater Manchester Integrated Care Board	932

Narrative

Latest data: **July 26 – 1,099** Number of prescriptions dispensed per 1,000 patients.

Tameside are **10th in GM and 116/117 Nationally.**