

Agenda

Tameside Strategic Partnership Committee

Date: Wednesday 23rd September 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 August 2026 Paper and Action Log	Paper	Approval	Marion Colohan
4.	11:10am (10 mins)	Place Report	Paper	Information / Discussion	Marion Colohan
5.	11:20am (20 mins)	CYP Asthma Update	Paper	Information / Discussion	Philippa Robinson
6.	11:40am (20 mins)	Primary Care Capacity Scheme	Paper	Approval	Joe Corbett
7.	12pm (20 mins)	Palliative Care Offer	Paper	Information / Discussion	Philippa Robinson
Any other Business and Administration					
8.	12:20pm (10 mins)	Any other business – <i>To be notified to the Chair in advance of the meeting</i>	Verbal	To receive	Chair
9.		Date and time of next meeting: Wednesday 28 th October 2026 11-12:30pm Committee Room 1, Level 2, Tameside One	Verbal	To note	Chair

Minutes

Tameside Strategic Partnership Board

Date: 26th August 2026

Time: 11:00 -12:30pm

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

Present
Councillor Eleanor Wills – Leader of Tameside Council and Chair Councillor Teresa Smith – Lead Member for Children and Families Councillor Mike Smith – Lead Member for Population Health and Wellbeing Emma Alexander -Chief Executive, Tameside Council Dr Ali Syed Asad-Associate Joe Kelly – Strategic Director of Adult Social Care and Health, TMBC James Mallion- Director of Public Health Dr Simon Sandhu – Chief Medical Officer, Pennine Care NHS Foundation Trust Anna Hynes Action Together Tameside Director Marion Colohan – Tameside Place Director, NHS GM Jill Colbert – Strategic Director of Childrens, TMBC Victoria Leonard - Associate Director (Clinical) Improvement & Personalisation NHS GM Dr Kate Hebden - NHS GM Director, Tameside Together Ashwin Ramachandran - Associate Medical Director NHS GM Paul Buckley - Executive Director of Strategy & Partnerships Stockport NHS Foundation Trust & Tameside and Glossop Integrated Care NHS Foundation Trust Karen James – Chief Executive, Tameside Hospital and Stockport NHS Foundation Trust Pauline Thompson Business Support – minute taker
Apologies
Councillor Jackie Lane Executive Member for Adult Social Care and Inclusivity Anita Rolfe - Deputy Chief Clinical Officer NHS GM Councillor Leanne Feeley (Executive Member for Lifelong Learning and Culture) Zoe Evans – Strategic Director of Finance

Item No.	Topic	Action
1.	Welcome, Introductions and Apologies The Chair welcomed members to the meeting and noted the apologies received.	
2.	Declarations of Interest No declarations of interest were made.	
3.	Minutes of Committee Meeting in July & Action Log The minutes of the meeting held on 22 July 2026 were presented for approval. Members confirmed they were an accurate record, and the minutes were approved without amendment. The Committee reviewed the action log and received an update on outstanding actions. MC advised all actions remain on schedule, although several items remained open pending future reports allocated on the forward planner	
4.	Place Director Verbal Update – MC MC delivered a verbal update covering key developments across the health and care system and the significant pressures affecting the Northern Care Alliance industrial action across operating theatres within the organisation. MC informed members that urgent, emergency and time-critical services are being prioritised, while mutual aid arrangements are being coordinated across Greater Manchester. Action to continue to monitor impacts arising from Northern Care Alliance critical incident and provide updates to Committee as required. MC also provided an update regarding the forthcoming winter flu and COVID vaccination programme which begins on the 1 st September for pregnant women and eligible children with the school vaccination programme starting at the beginning of the new school year. From the 1 st of October, flu vaccinations will be available to older adults, people with certain long-term conditions, carers, care home residents and frontline staff. COVID-19 vaccinations will also be available from the 1 st of October and encouraged all eligible residents and staff to take up vaccination offers ahead of winter. Additional assurance was provided regarding local governance arrangements, including the operation of a dedicated Flu and COVID Vaccination Subgroup which oversees planning, accessibility and uptake that meet throughout the year. Members were informed that Anita Rolfe, NHS GM Deputy Chief Nursing Officer and Deputy Delegated Safeguarding Partner for Tameside will join the Committee membership as the NHS Greater Manchester executive representative replacing Katherine Sherrin.	

5	NHS GM CEO's Report MC provided an update with regards to the CEO report and highlighted two areas of significance. The first focused on maternity services and national reviews including Ockenden and other maternity investigations. MC explains that NHS Greater Manchester continues to work closely with providers to improve safety, reduce inequalities and ensure a more personalised maternity experience. Significant emphasis being placed on listening to women and ensuring staff receive appropriate support and training. Members recognised the scale of assurance activity that is required of maternity providers and that extensive reporting requirements are necessary to provide confidence regarding patient safety and service improvement. Members support a future presentation from maternity system leaders to provide further assurance and visibility of ongoing improvement work. Action MC to invite colleagues from the Maternity Network to a future partnership committee to give an update on their work. Confirm date for schedule. The second discussion focused on neighbourhood health implementation. MC reported that national guidance now requires integrated neighbourhood teams to be established across all areas of Greater Manchester during Quarter 3. Tameside have already commenced preparatory work through the Neighbourhood Leadership Group to respond to requirements. Questions were raised regarding mental health integration, Live Well services and wider cross-sector working. Responses confirmed that mental health providers, adult social care and community partners are actively participating in planning discussions. It was emphasised that neighbourhood teams must maximise existing resources. Discussion also referenced NHS Greater Manchester's "No Space for Racism" campaign. Members were interested in opportunities for wider partner involvement and cross-sector collaboration.	
6	Tameside Health and Care Partnership Governance Structure VL presented proposals for a revised governance structure for the Tameside Health and Care Partnership. The proposals are designed to support delivery of the recently approved Place Delivery Plan whilst aligning with emerging Greater Manchester partnership arrangements. Important discussions remain outstanding, in particular the alignment with the Health and Wellbeing Board, a stakeholder workshop is proposed to discuss this further. Members reviewed the proposed structures and discussions took place around the need to ensure clear accountability, avoidance of duplication within the Health and Wellbeing Board functions, adult social care	

	transformation, safeguarding arrangements and children's governance structures with existing statutory and governance functions, and to maintain visibility of key areas including children's services. Further discussions are required regarding alignment with the Health and Wellbeing Board and reporting arrangements; members broadly supported the proposed direction of travel and acknowledge the significant work undertaken to develop the model. Action MC/VL to progress a stakeholder workshop to refine Health and Care Partnership governance arrangements, including alignment with the Health and Wellbeing Board.	
7	Tier 2, Community Gynaecology Service Kate Hebden and Jaki Heslop presented plans for a new Tier 2 Community Gynaecology Service. MC introduced the report describing the current gap within the women's health pathway. Tameside residents currently have access to primary care and specialist hospital-based services, there has been no intermediate Tier 2 provision. This has resulted in large numbers of women being referred directly to hospital services for conditions that could be effectively managed in the community. KH explains that the new model builds on successful services already operating in GM. Evidence from Wigan demonstrates that approximately 70% of referrals currently reaching secondary care could instead be managed through enhanced community-based services delivered by suitably trained clinicians. Funding has been secured for 12 months, with an ambition to establish recurrent funding. Services will be delivered through collaboration between Tameside Together, Greater Manchester Primary Care and Tameside and Glossop Integrated Care NHS Foundation Trust. The service will address conditions including: - ○ menopause symptoms ○ menstrual disorders ○ contraceptive procedures ○ prolapse management ○ persistent vaginal symptoms. Clinics will be delivered at neighbourhood level, improving accessibility and reducing waiting times. Questions were raised regarding links with sexual health services, support for young people, promotion of the service and engagement with vulnerable women who may not routinely access healthcare. Representatives agreed to continue discussions around pathway integration and health promotion opportunities. Action to Develop and promote stronger links and communication	 TSPB 2.8.26.pptm

	between the new Community Gynaecology Service, sexual health services and children's health services to improve awareness among women and vulnerable adults	
	Questions from the Committee: Place Partnership Agreement MC updated members regarding feedback submitted to NHS Greater Manchester concerning the Place Partnership Agreement. The Committee had previously discussed concerns and questions relating to the proposed documents. MC confirms that formal feedback has now been submitted on behalf of the Committee. An update from Greater Manchester indicated that over 250 items of feedback have been received from partners across the system. Four common themes emerged:- ○ Accountability and governance clarity. ○ Practical implementation of proposals. ○ Operation and expansion of the Place Fund. ○ Meaningful partnership representation and involvement. Members welcomed the level of engagement, and evidence of strong commitment to partnership working. Discussion highlighted the need to ensure Primary Care representation remains sufficiently broad and inclusive. AR and SAA provided reassurance that work is underway to bring together a unified primary care voice across dentistry, pharmacy, general practice and optometry.	 Letter response to Place Partnership Ag
9	Tameside Locality Board Report MC presented the Locality Board report and highlighted key areas for assurance. Learning Disability (LD) Health Checks Targeted work is beginning in September, including a refreshed communications campaign to increase awareness and uptake of LD health checks. Tameside finished the previous financial year in a strong position for LD health check performance. Children and Young People's (CYP) Mental Health Services Assurance was provided that, alongside Pennine Care services, additional support is available through local community-based provision. A service review is underway to improve access, including more one-to-one appointments and measures to reduce pressure on specialist CAMHS services. Perinatal Mental Health / Parent Infant Mental Health Services 3 years of funding has been approved through the Best Start Family Hubs	

	and Healthy Babies Programme. This will support the Parent Infant Mental Health Service (PIMHS/PINS) and provide additional family hub groups to help meet national requirements. A detailed discussion took place regarding interpretation of performance data. Councillor Smith queried high prescribing rates, asking whether this reflected a concern or a positive outcome. MC advised that further work would be undertaken with medicines optimisation colleagues before providing a definitive response. Members agreed that future reporting should focus less on raw data and more on interpretation, risks, trends and evidence of improvement activity.	
10.	Any Other Business Members received a brief verbal update from JC regarding the recent Youth Justice inspection. Recognition was given to the Speech, Language and Communication Therapist funded through the ICB and the work around vulnerable children and young people received significant positive feedback within inspection findings.	
11.	Date of Next Meeting Wednesday 23rd September 11-12:30pm Committee Room 1 level 2 Tameside One	

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 (Nov update)	
2	Further consideration of governance arrangements and reporting mechanisms for SEND and neurodiversity improvement programmes.	23.07.26	04.09.26	MC		
9	Monitor impacts arising from Northern Care Alliance critical incident and provide updates to Committee as required.	26.08.26		MC	Update NCA to bring update MC has had discussions with Central Comms	
10	MC to invite colleagues from the Maternity Network to a future partnership committee to give an update on their work.	26.08.26		MC	Maternity Network – schedule for January. MC to provide contact details	
11	MC/VL to progress a stakeholder workshop to refine Health and Care Partnership governance arrangements, including alignment with the Health and Wellbeing Board and revised proposals to be developed further and returned to Committee in December 2026.	26.08.26		VL/MCJM	Due Dec 2026. HWBB – dates being scheduled and updates back to Committee	14.09.26
12	Develop and promote stronger links and communication between the new Community Gynaecology Service, sexual health services and children's health services to improve awareness among women and vulnerable adults	26.08.26		MC/JM		14.09.26

TAMESIDE STRATEGIC PARTNERSHIP COMMITTEE (TSPC)

Meeting Date	Sept 2026	Public	X	Confidential		Agenda item
Title of Report	Place Report					
Lead Director / Executive Member / Clinical Lead	Marion Colohan, Place Partnership Director - Tameside					
Author	Marion Colohan, Deputy Place Based Lead for Tameside					
Outcome Required (please indicate)	Approval ☐	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 ☐				
1 Purpose						
This paper contains summaries of local and national policies, strategies, and relevant news to ensure that the Board remains up to date on the latest developments relevant to the Tameside system.						
2 Tameside Update						
Tameside Borough Strategy 2026-2023						
The Tameside Borough Strategy is a commitment from stakeholders and organisations in the borough, including Tameside Council, health services, Greater Manchester Police, colleges, housing providers, the VCFSE sector and businesses, to transform Tameside together. Informed by a clear understanding of the views and needs of Tameside residents, evidence and data, recognition of the local, regional and national policy framework, and stakeholder knowledge and insight, the strategy is intended to: • Provide a shared framework for collaboration, ensuring that public services, businesses and voluntary and community organisations work together towards a common and agreed purpose. • Identify and make best use of collective learning and resources in order to improve outcomes for people and communities. • Empower us as a borough to meet the challenges we all face, including tackling deprivation and inequality, improving public health, protecting our shared environment, and delivering targeted and sustainable investment and regeneration. Underpinned by robust outcome measures and a performance framework tracking progress; the Borough Strategy and associated work will enable us to deliver our vision for Tameside.						

Better Care Fund 2026-27

Approval for 2026-27 plans and permission to spend NHS minimum contribution



Tameside_BCF_lette
r2026.pdf

Place Partnership Agreement

Locality Board members will recall consideration of the different elements of the ICB articulation of place working, including a place partnership agreement, a place outcomes framework, a place team concept, and a place budget (in developing building out of the Better Care Fund).

Feedback from previous locality board conversations has been provided to the ICB and a wider consultation framework has been concluded. We await final versions of documentation for the consideration of partners and hope this will be available in October or possibly November. Subject to agreement of partners we will move to recast the Locality Board to be the Place Partnership board for Tameside, and retain the work of the subgroups of the Board.

NHS GM Place Team Hosting

Locality Board members will be aware of the ICB proposal to TUPE NHS GM place-based staff to another organisation in the context of the place partnership agreement to be finalised. This work is progressing with ICFT having expressed willingness to explore hosting. Mobilisation arrangements at a GM and local level are developing.

Vaccination Access and Inequalities Funding

Many communities within Greater Manchester are impacted by health inequality and deprivation. NHS Greater Manchester (NHSGM) has a responsibility to assess the extent of these inequalities and take corrective action. Since the Covid-19 pandemic, NHS England has issued all ICBs ringfenced funding to widen access to vaccination and reduce health inequalities in communities of low engagement and lower uptake.

Tameside has £68,660 to invest this year and our four PCN's have all submitted plans to NHS GM ICB for approval.

3 NHS GM ICB Update

Supporting improvement at the Northern Care Alliance

Many colleagues across NHS Greater Manchester are continuing to support the Northern Care Alliance (NCA) as it progresses an important programme of improvement following its recent well-led inspection.

The Care Quality Commission (CQC) has issued the trust with a Section 29A warning notice, highlighting areas including risk management, patient safety, speaking up, complaints handling, workforce wellbeing and inclusion. These are areas the NCA has already identified as priorities for improvement.

The NCA, NHS England and NHS Greater Manchester are working together through a single System Improvement Board and an Integrated Improvement Plan to help drive progress and provide support and oversight.

We'd like to thank the many NHS GM colleagues who are contributing their expertise, time and commitment to this work. We also want to recognise those who supported the trust during last week's industrial action, helping to maintain safe services and ensure patients continued to receive the care they needed. Partnerships, listening and learning will be central to this improvement journey.

Changes to CYP Crisis Service operating hours

Following a review of the NHS Children and Young People (CYP) Crisis Service, from 28 September 2026 the new operating hours will be 8am - 8pm.

The new operating hours will help ensure clinical teams are available when demand is highest, allowing more young people to access timely support and reducing occasions where referrals cannot be accepted because services are at full capacity. The change follows a review which found that demand for the service was consistently very low between 8pm and 10pm, enabling resources to be focused on the times when they are needed most. The service remains available through professional referral only. Families and carers should continue to access mental health support through routes including NHS 111 and select option 2 for mental health support, contacting a GP for non-urgent concerns, or attending A&E in an emergency.

Consultation on specialist cardiac and vascular surgery services.

NHS Greater Manchester has launched two public consultations on proposals for how these specialist services could be delivered in the future. The consultations, which run until 22 September 2026, seek views on where specialist surgery would take place, while outpatient appointments, diagnostic tests and follow-up care would continue to be provided from a range of locations across Greater Manchester.

For cardiac surgery services, NHS Greater Manchester is consulting on a proposal for all adult cardiac surgery to be provided from Wythenshawe Hospital. For vascular surgery services, the consultation is seeking views on a proposal for specialist vascular surgery to be provided from Manchester Royal Infirmary (MRI). The consultations follow a review of specialist cardiac and vascular surgery services, which considered a range of factors including increasing demand on services, more complex patient needs and workforce challenges. The consultations give people the opportunity to comment on the proposals before any decisions are made. To take part in the consultation visit: <https://getinvolved.gmintegratedcare.org.uk>

4 Recommendation

The Board is asked to note the report and agree the recommendation outlined in the report.

TAMESIDE STRATEGIC PARTNERSHIP COMMITTEE (TSPC)

Meeting Date	23 rd Sept 2026	Public	X	Confidential		Agenda item
Title of Report	CYP Asthma - Protecting Little Lungs for a Lifetime of Healthy Breathing					
Lead Director / Executive Member / Clinical Lead	Marion Colohan, Deputy Place Based Lead for Tameside					
Author	Philippa Robinson. Transformation and Improvement Manager, Tameside (NHS GM ICB)					
Outcome Required (please indicate)	Approval	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:						
To provide Tameside Strategic Partnership Committee with an update and assurance on the whole-system programme of work to improve outcomes for children and young people with asthma. Asthma has been a significant area of health inequality for Tameside, with historically high rates of emergency admission. The paper describes improvement activity across primary and secondary care, schools, communities, prevention and wider determinants of health, aligned to Core20PLUS5 and the National Bundle of Care for CYP with Asthma. There is an emerging and increasingly consistent picture of improvement, with reductions in admissions and Emergency Department activity alongside improvements in national audit indicators. The paper highlights learning and impact from InHIP, development of primary care quality improvement, Asthma Friendly Schools, workforce and family education, prevention and action on wider determinants, and sets out priorities for sustaining improvement.						
Recommendations:						
Tameside Strategic Partnership Committee is asked to: 1. Note the breadth of activity underway and the encouraging emerging improvement in CYP asthma outcomes. 2. Support continued development of a whole-system approach across primary care, secondary care, schools, communities and prevention. 3. Support a continued focus on health inequalities and wider determinants, ensuring improvement reaches children and families experiencing the poorest respiratory outcomes. 4. Support transition from time-limited improvement initiatives towards sustainable delivery, including opportunities to embed asthma improvement within neighbourhood working.						

Financial implications:

There are no immediate financial decisions requested through this paper. Future sustainability and commissioning implications associated with embedding successful improvement activity, including FeNO testing, will need to be considered through appropriate planning and governance processes.

Alignment with the Joint Health and Wellbeing and Locality Plan:

The programme supports the Joint Health and Wellbeing Strategy and Locality Plan through improving outcomes for children and young people, reducing health inequalities, strengthening prevention and early intervention, and developing integrated, neighbourhood-based approaches to care.

It also aligns with Core20PLUS5, with asthma identified nationally as a priority clinical area for reducing health inequalities in children and young people.

Where issues are addressed in the paper -

	Section of paper where covered
Regulatory and legal compliance	Throughout
Sustainability (including environmental impacts)	Sections 4 and 10
Quality impacts	Throughout
Safeguarding impacts	NA
Risks	Sections 3, 9 and 10
Views and recommendations of the Clinical and Care Professional Advisory Group	Not noted in the paper
Views of the population / users	Section 7 – SEND Youth Council, parents, carers and peer support

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:

e-mail: Philippa.robinson5@nhs.net



Children and Young People's Asthma

Protecting Little Lungs for a Lifetime of Healthy Breathing

1. Purpose

Asthma outcomes for children and young people in Tameside are showing encouraging improvement, with reductions in admissions and emergency attendances alongside improvements in quality indicators. Despite this progress, asthma admission rates remain above Greater Manchester averages and significant inequalities persist. Continued partnership support is required to sustain improvement, embed successful initiatives and address wider determinants of respiratory health.

This paper provides an update to the Partnership Committee on the programme of work underway across Tameside to improve outcomes for children and young people (CYP) with asthma.

The programme brings together improvement across primary care, secondary care, schools, communities, prevention and the wider determinants of health, with a focus on reducing health inequalities and avoidable urgent and emergency care.

The paper highlights progress to date, emerging evidence of improvement in outcomes and the priorities for the next phase of work.

2. Background

Asthma is one of the five clinical areas identified within the national Core20PLUS5 framework for children and young people, reflecting both its impact on children and the inequalities associated with poor asthma outcomes.

Tameside has historically experienced the highest rate of admissions in under-19s in the country and one of the highest levels of paediatric critical care bed days for asthma. Compared to GM, Tameside has a rate of 3.6 per 1000 admissions for asthma 0-18 where the rate of admissions for 0-18 in GM is 1.4 per 1000. In terms of numbers this translates to 158 of the 1,013 admissions in GM (source:

[Characteristics Breakdown | GM ADSP](#))

In response, the Tameside Core20PLUS5 Asthma Steering Group has developed a whole-system quality improvement programme aligned to the National Bundle of Care for Children and Young People with Asthma.

The programme seeks to:

- reduce Emergency Department attendances and avoidable hospital admissions;
- reduce over-reliance on short-acting beta agonist (SABA) medication and optimise preventer medication;

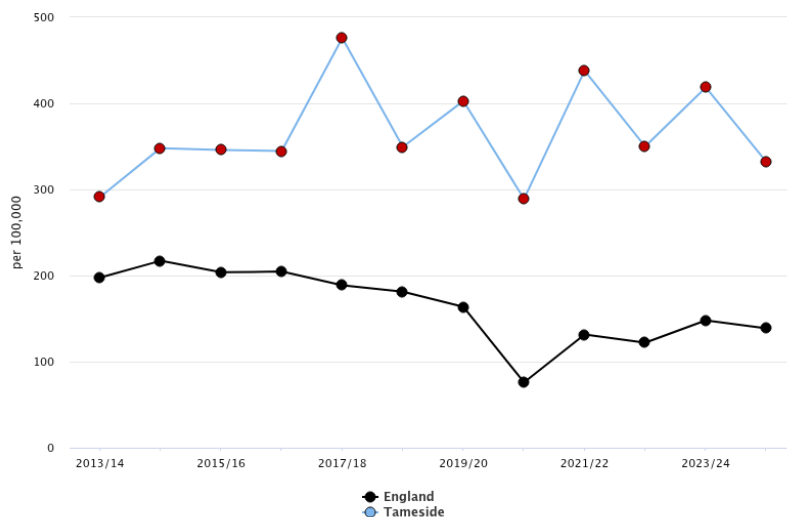
- improve the quality and consistency of asthma diagnosis and management within primary care;
- strengthen workforce knowledge and confidence;
- support schools to provide safe and effective asthma care;
- improve children and families' knowledge, confidence and ability to self-manage; and
- address wider determinants of poor respiratory health, including smoking, vaping and housing.

3. An emerging picture of improvement

There are encouraging indications that outcomes are beginning to move in the right direction.

Fingertips data for under-19 asthma admissions shows annual variation, but an overall downward trend from the peak in 2017/18. [Fingertips | Department of Health and Social Care](#)

Hospital admissions for asthma (under 19 years) for Tameside



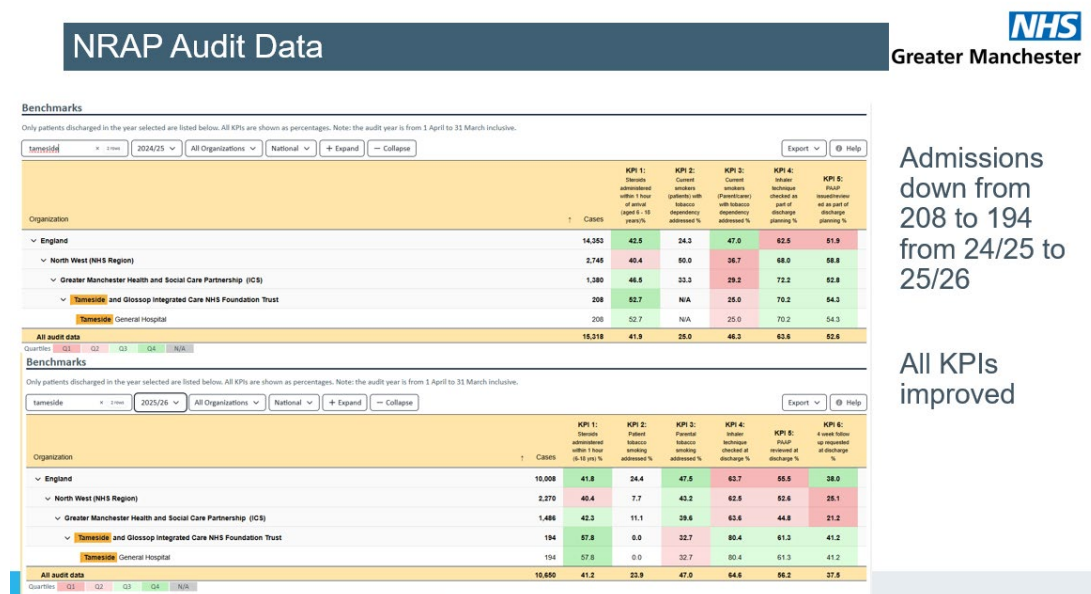
The National Respiratory Audit Programme (NRAP) dataset from May 2026 NRAP also shows admissions reducing from **208 in 2024/25 to 194 in 2025/26**, with the dataset also reporting improvement across all KPIs.

This direction of travel is supported by the InHIP evaluation. During the project period, asthma-related Emergency Department attendances reduced by **21.8% (362 to 283)** and inpatient admissions by **11.7% (205 to 181)**.

These improvements cannot be attributed to any single intervention and should be interpreted alongside factors such as seasonality and natural variation. However, the consistency across different measures is encouraging and coincides with sustained whole-system improvement across the asthma pathway.

Taken together, these measures will allow the Partnership to monitor whether improvements in service quality are translating into sustained improvements in population outcomes and reductions in inequalities.

4. Improving diagnosis and ongoing management – InHIP



A significant component of the improvement programme has been [Innovation for Healthcare Inequalities Programme \(InHIP\) Wave 2 – Protecting Young Lungs for a Lifetime of Healthy Breathing](#), delivered across Tameside between 2024 and 2026.

The programme brought together primary care networks, secondary care clinicians, specialist nurses, pharmacy and smoking cessation services to improve access to Fractional exhaled nitric oxide (FeNO) testing, strengthen asthma diagnosis and management and identify children requiring earlier intervention.

The programme reached 211 children and young people aged 5–16. Importantly, 49% of participants with complete deprivation information lived within the 20% most deprived neighbourhoods nationally, demonstrating reach into communities experiencing significant health inequalities.

Three PCNs implemented hub-based FeNO testing and 268 FeNO tests were completed. Twelve children previously recorded as having suspected asthma had FeNO

results consistent with asthma, supporting confirmation of diagnosis and earlier access to appropriate treatment and management.

Among children receiving both baseline and follow-up testing, 43% (26 of 61) showed a reduction in FeNO between weeks 4 and 10. Although the relatively small follow-up cohort means this should be interpreted cautiously, repeat testing also enabled clinicians to identify children with persistently elevated results who may require further review of adherence, inhaler technique or treatment.

The evaluation also demonstrated that FeNO can be successfully delivered within primary care where appropriate training, coordination and clinical leadership are in place, with participating clinicians reporting increased confidence and knowledge.

5. Improving quality in primary care

The programme is broader than diagnostic testing. A key priority is moving from reactive management of asthma exacerbations towards earlier identification, proactive management and prevention.

A population health management approach is being developed with primary care colleagues using locality data including asthma and suspected asthma registers, SABA and steroid prescribing and completion of asthma reviews. Particular attention is being given to children prescribed five or more SABA inhalers within the previous 12 months, as a marker for proactive review. GM data dashboards provide useful comparisons across primary care for the prevalence of asthma on GP registers and A&E attendance rate (Source [Tameside Asthma Prevalence & Secondary Care: Asthma Prevalence Rates - Tableau Cloud](#)) Appendix 1 The primary care improvement group will use this intelligence to understand variation across PCNs and practices, identify good practice and target improvement activity of local pathways.

The quality improvement approach promotes:

- proactive, high-quality annual asthma reviews;
- medication review and optimisation;
- assessment of inhaler technique;
- personalised asthma action plans which are also accessible to schools;
- appropriate diagnostic testing in line with NICE guidance;
- identification of higher-risk children;
- consideration of smoking, vaping, housing, damp, mould and air quality; and
- education and self-management support for children and families.

Work has also identified prescribing and dispensing issues which can affect children's ability to use inhalers as intended, and these concerns have been escalated through Greater Manchester pharmacy routes.

6. Supporting children within schools and communities

Children spend a significant proportion of their time within education settings and therefore improving asthma care cannot be achieved through healthcare services alone.

Tameside is exploring implementation of the Greater Manchester Asthma Friendly Schools approach. The framework is based around six standards:

- School Asthma Policy
- Asthma Register
- Emergency Inhaler Kits
- Individual Health Care Plans
- Safe recording and storage of medication
- Staff Training

The first phase will include establishing school readiness and baseline knowledge, benchmarking schools against the six standards and using local data to understand where support is most needed, including consideration of asthma-related ED use and the impact of asthma on school attendance.

The intention is to develop a sustainable model using existing relationships and expertise, including school nursing and specialist respiratory nursing, while linking with wider opportunities through Family Hubs, VCSFE partners and initiatives such as BreathChamps.

7. Building knowledge, confidence and self-management

Improving knowledge and confidence across the workforce, children and families is another important element of the programme.

Each year as a system we promote messages around Ask About Asthma, key messages ensuring that every young person has

1. **An asthma action plan** – personalised, understood by the child/family and shared with relevant settings such as school.
2. **Correct inhaler technique** – demonstrated and visually checked, rather than simply asking whether they know how to use it.
3. **An asthma review every year and after every attack** – using the attack as an opportunity to review diagnosis, control, adherence, treatment and triggers.
4. **Consideration of air quality** – including indoor and outdoor pollution and its impact on lung health.

[2024 #AAA Scarlett's Tameside Video](#)

[2025 #AAA Awareness Plea](#)

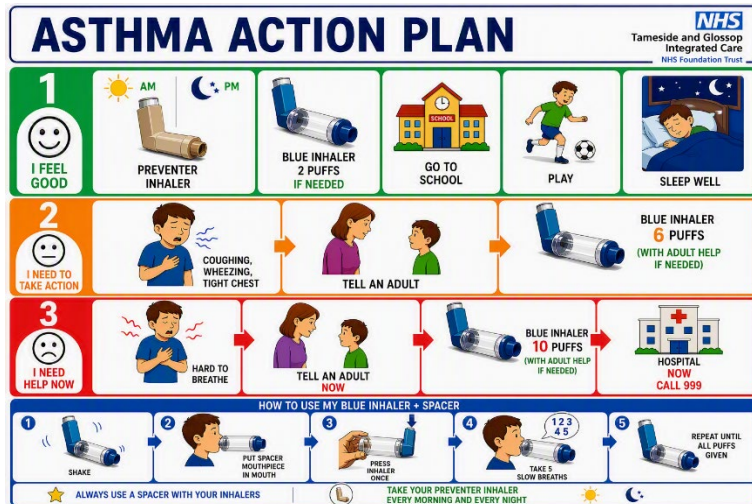
Awareness and education remain key priorities.

A back-to-school campaign in 2026 promoted adherence to preventer medication and preparation for the annual "September Spike". Asthma e-learning training continues to be promoted across families, schools and professionals through national tiered programmes.

Peer-support initiatives have demonstrated strong local engagement, with opportunities being explored alongside Asthma and Lung UK.

Work with the SEND Youth Council and parents/carers has also strengthened the accessibility of educational resources, including the development of an easy-read Asthma Action Plan.

SEND Youth Council Helps Shape Asthma Resources for Children with SEND | Health Innovation Manchester



8. Prevention, inequalities and wider determinants

Reducing inequalities is embedded throughout the programme. InHIP demonstrated strong engagement with children and families living in deprived communities while highlighting opportunities to strengthen prevention, particularly around smoking and vaping. A whole-family approach has been developed through partnership working with Health Visiting and Be Well Tameside, supporting smoke-free homes and earlier intervention.

Housing has also been identified as an important determinant of respiratory health, with health and council partners improving pathways for families experiencing issues related to damp and mould. This work reflects the wider ambition to make every contact count through the use of Very Brief Advice and to address smoking, vaping, housing and environmental factors as part of a comprehensive approach to improving respiratory health.

9. Measuring improvement

The programme is increasingly shifting from a series of improvement initiatives to a population-level, outcomes-focused approach. To support this, the group brings together local, regional and national intelligence on asthma prevalence, emergency attendances, hospital admissions, prescribing patterns and quality of care. This enables variation and outcomes to be monitored at locality, PCN and practice level, supporting targeted improvement activity and a stronger focus on reducing inequalities.

To provide a consistent assessment of programme performance, future reporting will focus on a small set of outcome and quality indicators that reflect both population health outcomes and the effectiveness of the asthma pathway

10. Priorities for the next phase

The next phase is about moving from a collection of successful improvement activities towards an embedded and sustainable whole-system approach to CYP asthma.

The priorities are to sustain and expand access to objective diagnostic testing; strengthen proactive primary care management and identification of higher-risk children; reduce unwarranted variation; continue workforce development; develop the Asthma Friendly Schools offer; strengthen peer, family and community support; address smoking, vaping and wider determinants; and improve routine outcome monitoring.

These priorities closely reflect the learning from the InHIP evaluation, which recommends sustained primary care FeNO testing, continued workforce development, proactive identification of high-risk children, stronger family and community support, improved data and outcome monitoring and alignment with neighbourhood, school and prevention initiatives.

11. Tameside Strategic Partnership Board is asked to:

Note the breadth of activity underway across Tameside to improve outcomes for CYP with asthma and the encouraging emerging improvement in outcomes.

Support the continued development of a whole-system approach spanning primary care, secondary care, schools, communities and prevention.

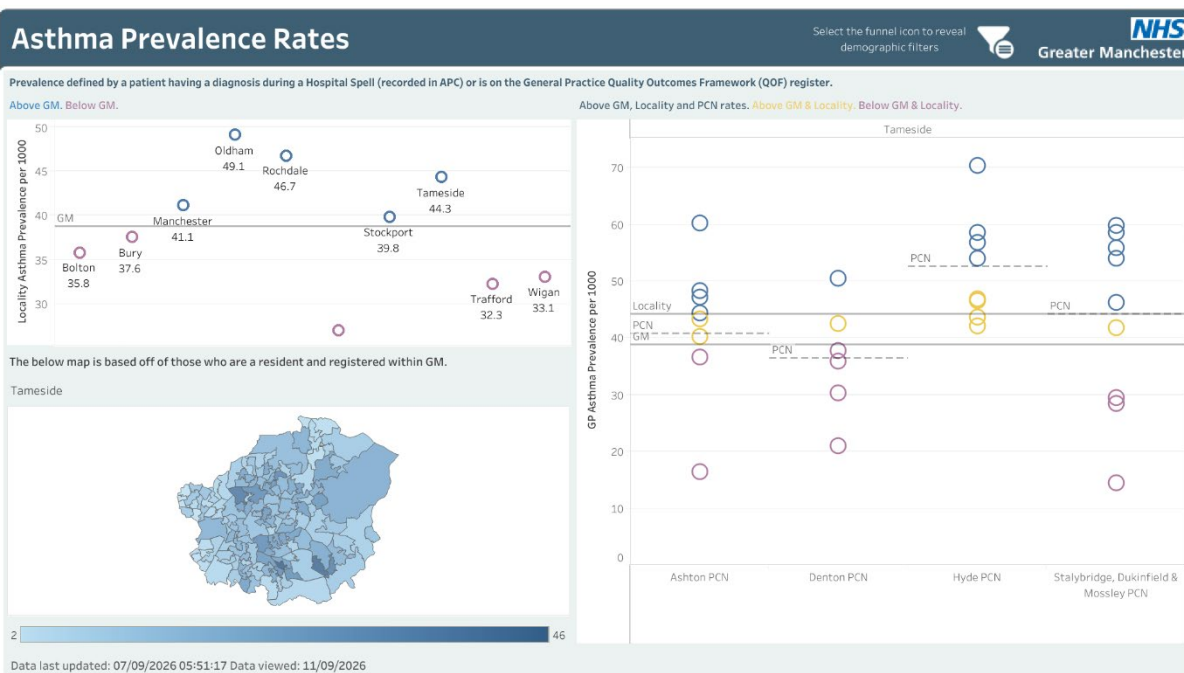
Support a continued focus on health inequalities and wider determinants, ensuring improvement reaches children and families experiencing the poorest respiratory outcomes.

Support the transition from time-limited improvement initiatives to sustainable delivery, including opportunities to embed asthma improvement within neighbourhood working

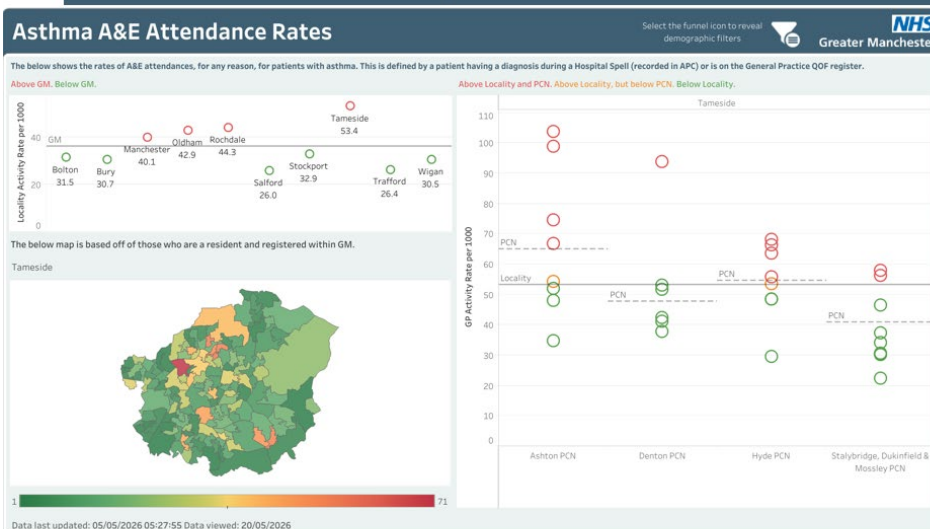
Appendix 1

The following chart shows across Greater Manchester the prevalence of asthma based on the numbers of children on asthma registers and also shows this by practice level for Tameside.

The next chart shows the Asthma attendance rate compared to GM, and by practice, which shows that Tameside has higher than average A&E activity for asthma.



Asthma A&E Attendance by PCN & GP – 0-18 Years Asthma Patients



This shows the rate of A&E attendances for any reason for patients with asthma FYTD.

TAMESIDE STRATEGIC PARTNERSHIP COMMITTEE (TSPC)

Meeting Date	23/09/2026	Public	X	Confidential	Agenda item
Title of Report	Capacity Funding – Proposed Schemes for 26/27				TBC
Lead Director / Executive Member / Clinical Lead	Marion Colohan, Place Partnership Director - Tameside				
Author	Joseph Corbett - Neighbourhood Health & Care Programme Manager Philippa Robinson – Transformation and Improvement Manager				
Outcome Required (please indicate)	Approval ☒	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:					
The purpose of this report is to update the Tameside Strategic Partnership Committee (TSPC) on locality discussion around the utilisation of Greater Manchester Integrated Care Board (GM ICB) allocated Capacity Funding. The funding is provided on a yearly basis and used to support additional seasonal pressures throughout the period of October to March. Due to the changes in financial delegation within GM ICB this funding has been discussed directly with the Tameside Locality Place Partnership Director and GM colleagues, with the intention of this allocation being allocated to out of hospital services. This is separate to funding available via Better Care Funding and other locality based financial allocations which are also discussed via TSPC. The report outlines 4 proposed schemes to create targeted additional capacity within our system based on seasonal increases in specific presentations within our health and care system. Those are as follows: 1) FeNO (Fractional Exhaled Nitric Oxide) supported Asthma Diagnosis and Enhanced Asthma Management pathway. Delivery of all age proactive management of Asthma including diagnosis. Delivered via a Primary Care Network Hub model with individual hubs in each of the 4 Tameside PCNs, operating in Core General Practice Hours. 2) Acute Respiratory Infection (ARI) Hub. Delivery of an ARI clinic co-located within the Urgent and Emergency Care environment at the Front Door of the Tameside and Glossop Integrated Care Foundation Trust (T&G ICFT) Emergency Department. Initial Triage via existing ED and UTC processes with additional capacity created through GP staffing model to support risk management and onward referral for continued management in General Practice setting, linking where appropriate with the FeNO hubs but also including					

escalation processes into (but not limited to) Virtual Ward and Children Community Nursing Services.

3) Additional Capacity within Primary Care Enhanced Access Clinics.

Targeted Enhanced Access Clinic Capacity similar to previous years models but targeted based on attendance data provided by T&G ICFT to individual PCNs to support appropriate attendance avoidance in the UEC pathway.

4) Improving Paediatric Assessment and Observations in General Practice. Purchasing of specific paediatric oxygen saturation monitoring devices for each General Practice in Tameside (31 practices). This proof of concept aims to support primary care clinicians to make better informed referral decisions and enable greater use of existing community and ambulatory capacity where this is clinically appropriate.

Following the Committee's support of the described schemes further engagement will be required with system partners to ensure viability of delivery of these schemes within the timeframes, proposed operational models and financial allocations.

Recommendations:

1. **Review and Note** the schemes listed in this report for consideration.
2. **Note** the risks associated to each scheme and associated mitigations.
3. **Support** the implementation of the schemes acknowledging that staffing models will be developed in collaboration with system partners to ensure resilient delivery within the October – March period.
4. **Support** review of the schemes at month 4 with potential need to adjust where schemes are not demonstrating benefit to patients and system flow.

Financial implications:

The GM ICB has allocated this funding to all localities via engagement with GM ICB locality staff. Underspend of this funding will need to be reviewed against potential impact of additional schemes and be subject to GM Financial Governance.

Capacity Funding into the locality is reviewed on a yearly basis and is to be utilised within the funding period of October 2026 to March 2027 inclusive.

No additional cost pressures are present based on utilisation of this funding within the locality.

Alignment with the Joint Health and Wellbeing and Locality Plan:

The NHS GM ICB and Tameside locality aim to deliver services with capacity and access at the most appropriate point of care within the Health and Care system. The utilisation of this funding will support the continue ethos of Care Closer to Home, moving from Acute to Community and from Sickness to Prevention.

Delivery within Neighbourhood footprints will look to enhance the developing Integrated Neighbourhood working models within the Tameside footprint, whilst also ensuring allocation of additional funding into Community and Primary Care.

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:



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& josephcorbett@nhs.net

1. Introduction

- 1.1 The purpose of this report is to update the Tameside Strategic Partnership Committee (TSPC) on locality discussion around the utilisation of Greater Manchester Integrated Care Board (GM ICB) allocated Capacity Funding.
- 1.2 The funding is provided on a yearly basis and used to support additional seasonal pressures throughout the period of October to March.
- 1.3 Historically this financial allocation has been allocated through Tameside member practices to ensure robust additional appointment capacity is created in relation to 'Winter Pressures'.
- 1.4 Due to the changes in financial delegation within GM ICB this funding has been discussed directly with the Tameside Locality Place Director and GM colleagues, with the intention of this allocation being allocated to out of hospital services. For clarity, this is separate to funding available via Better Care Funding and other locality based financial allocations which are also discussed via TSPC.
- 1.5 The report outlines 4 proposed schemes to create targeted additional capacity within our system based on seasonal increases in specific presentations within our health and care system. Those are as follows:
- 1.5.1 **FeNO supported Asthma Diagnosis and Enhanced Asthma Management pathway.** Delivery of all age proactive management of Asthma including diagnosis and case finding. Delivered via a Primary Care Network Hub model with individual hubs in each of the 4 Tameside PCNs, operating in Core General Practice Hours.
- 1.5.2 **Acute Respiratory Infection (ARI) Hub.** Delivery of an ARI clinic co-located within the Urgent and Emergency Care environment at the Front Door of the Tameside and Glossop Integrated Care Foundation Trust (T&G ICFT) Emergency Department. Initial Triage via existing ED and UTC processes with additional capacity created through GP staffing model to support risk management and onward referral for continued management in General Practice setting, linking where appropriate with the FeNO hubs but also including escalation processes into (but not limited to) Virtual Ward, Specialist Respiratory Teams and Children Community Nursing Services.
- 1.5.3 **Additional Capacity within Primary Care Enhanced Access Clinics.** Targeted Enhanced Access Clinic Capacity similar to previous years models but targeted based on attendance data provided by T&G ICFT to individual PCNs to support appropriate attendance avoidance in the UEC pathway.
- 1.5.4 **Improving Paediatric Assessment and Observations in General Practice.** Purchasing of specific paediatric oxygen saturation monitoring devices for each General Practice in Tameside (31 practices). This proof of concept aims to support primary care clinicians to make better informed referral decisions and enable greater use of existing community and ambulatory capacity where this is clinically appropriate.

2. FeNO supported Asthma Diagnosis and Enhanced Asthma Management Pathway

- 2.1 Building on previously implemented pilots in 3 of the 4 PCNs within Tameside locality there is a proposal to build on the existing infrastructure and experience we have developed within the staffing model.
- 2.2 The model looks to support increasing the opportunities for proactive case finding and implementation of associated management plans for an all-age cohort.
- 2.3 There is both national and local evidence which has been brought together to support this approach in collaboration between the locality and Health Innovation Manchester.
- 2.4 The model would support delivery of 432 initial appointments and 432 follow ups (864 appointments in total, based on 12 appointments per day) across all 4 PCNs leading to reduced utilisation of the UEC pathway for undiagnosed, potential high frequency users of UEC capacity. This will be measured via registered practice data, overall reduction in ED attendance and non-elective admissions.
- 2.5 Clinical and Operational Staffing Model and Costs to be discussed further with General Practice representatives whilst using existing draft business case costings as a base line.
- 2.6 Delivery of the model is via additional capacity created within the General Practice workforce. The specific delivery model is likely to be via 4 PCN hub models building on previous methodology.
- 2.7 Risks that exist in relation to this model are:

Risk	Mitigation
Lack of integrated working due to loss of identification of Frequent Attenders via existing model in ED	Identification of higher risk patients as a preventative measure in primary care.
Requires ongoing workforce and governance support.	Defined governance arrangements including interface between Primary and Secondary Care
Benefits are dependent on pathway utilisation and data collection.	Regular monitoring of activity, outcomes and return on investment as agreed as a recommendation of this paper.

- 2.8 **Recommendation** to commission the scheme via the 4 PCNs individually utilising additional nursing capacity to support case finding and reviews, building on the previous pilot and evidence base to support proactive care whilst reducing acute attendance in the UEC pathway.

3 Acute Respiratory Infection (ARI) Hub

- 3.1 Data shows us that there is an increase during the winter period in acute respiratory presentations throughout healthcare systems.

- 3.2 To support such an increase the proposal is to implement an Acute Respiratory Hub staffed by General practitioners, co-located on the T&G ICFT acute site. The reason for this location is to support safety netting and risk mitigation of patients who present via the front door of ED and UTC by reducing the need to be deflected to another location with potentially escalating respiratory distress.
- 3.3 The hub will provide a pathway from ED triage into additional GP capacity to support management and forward referral into wider community and Primary Care services for continued management while reducing the likelihood of reattendance. A visualisation of this model can be found as Appendix A of this report.
- 3.4 To ensure total Tameside registered population coverage a lead PCN or GP federation model would need to be considered if the funding was to be allocated into the Primary Care setting. An alternative model of contracting via T&G ICFT whilst secure GP staffing could be considered but would reduce the opportunities of access to GP systems within the required timeframe of delivery.
- 3.5 Risks that exist in this model are:

Risks	Mitigation
Delivery model does not deliver adequate coverage in busy periods to support management of patients within UTC/ED environment	Ability to flex other projects to support further funding if this model is perceived as successful. Will require regular review and feedback from delivery partner and T&G ICFT ED/UTC operational managers
IG challenges if PCN model is the preferred delivery partner	Seek assurance from delivery partners that this is possible should a lead PCN model be identified or that IG agreements are in place between PCNs as the providers at point of implementing
IG, Procurement and Contracting Challenges if Tameside Federation is the preferred model	Seek support from Senior UEC and Primary Care leadership within the ICB to consider potential contract approaches should this be viewed as the appropriate service provider. IG is potentially in place and would require updating following implementation of the Tier 2 Gynae service in Tameside.
Estates challenges linked to capacity to co-locate the hub model within the T&G ICFT acute estate	Engage with T&G ICFT senior leadership early in process to ensure support for this approach given estate capacity pressures
Workforce capacity	Engage with providers as soon as possible to allow time to understand interest from locality based workforce.

- 3.6 **Recommendation** is to explore options for delivery of this scheme in collaboration between T&G ICFT and Tameside GP Federation with a timeline of 2 weeks to agree feasibility of the model whilst also exploring a Lead PCN employment model.
- 4 **Additional Capacity within Primary Care Enhanced Access Clinics**

- 4.1 Tameside locality has previously implemented additional capacity clinics via the PCN Enhanced Access in each of the 4 PCNs with significant utilisation. As a locality we propose to continue with this approach on a reduced basis to allow the other schemes to be implemented.
- 4.2 These appointments would allow for clinics delivered through existing Enhanced Access infrastructure to be delivered, remove potential additional estates and I.T. costs and focusing purely on additional staffing capacity. A visualisation of the model can be found under Appendix B of this report.
- 4.3 The capacity planning for these appointments would be informed by T&G ICFT data in support of utilising the capacity at times of anticipated peak pressures within UEC pathways with some focus on increased UTC attendance.
- 4.4 The proposal is that these appointments, with the support of Primary Care clinical leadership would be staffed by Advanced Nurse Practitioners to ensure that we achieve as many additional appointments within the funding envelop as possible.
- 4.5 Risks that exist in this model are:

Risks	Mitigation
Delivery model does not deliver adequate coverage in busy periods to support management of patients within UTC/ED environment	Ability to flex other projects to support further funding if this model is perceived as successful. Will require regular review and feedback from delivery partners and T&G ICFT ED/UTC operational managers
General Practice does not engage with the additional appointment capacity provision given the reduce funding levels	Consider flexing funding model with other schemes to provide further financial incentive to engage with the product by reducing funding to other schemes to support the additional appointments scheme
Staffing capacity and referral levels - when considered with other local capacity schemes there may be challenges around the complexity of inclusion into the appointment capacity.	Ensure that appointments are clearly identified and utilisation is reviewed on a monthly basis with the providers to flex capacity

- 4.6 **Recommendation** is that this scheme is supported for implementation as soon as possible via existing Primary Care Network Enhanced Capacity Models via Advanced Nurse Practitioner workforce to support value for money. The funding split will be based on Weighted List Size with clearly defined appointment capacity requirements amongst other agreed local KPIs building on previous years GM approaches.

5 Improving Paediatric Assessment and Observations in General Practice.

- 5.1 To support safe referral into the CCNT service, children should receive a face-to-face clinical assessment prior to referral and referrals should include an appropriate working diagnosis with relevant clinical observations.

5.2 Where clinically appropriate, children can be assessed through Paediatric Observation and Assessment (O&A) or supported at home through the CCNT pathway, including review within 72 hours.

5.3 Access to appropriate paediatric monitoring equipment is understood to vary between practices. Where appropriate observations are not available to support clinical decision making, there is a risk that:

- Direct referrals to Paediatric O&A or CCNT may be delayed or declined due to insufficient clinical information
- Children may be unnecessarily directed to Paediatric ED for further assessment
- Opportunities to manage children safely in the community are missed
- Deterioration may be less readily identified

5.4 The proposal seeks to provide one device and appropriate paediatric probes/sensor equipment to each of the 31 practices, as a one off cost, as a proof of concept pilot to review impact on the quality of referrals and onward care pathway.

5.5 Risks that exist in this model are:

Risks	Mitigation
Equipment alone may not change referral behaviour if practice staff are not confident in undertaking paediatric oxygen saturation monitoring or interpreting results.	Provide a short implementation package alongside devices, including appropriate use, interpretation, escalation thresholds and links to the existing paediatric pathway.
Direct referrals could increase demand on Paediatric O&A rather than reduce pressure overall if thresholds/pathways are unclear.	Agree referral criteria with ICFT Paediatrics and Primary Care before implementation and monitor referral volumes, acceptance/rejection rates and impact on O&A capacity.
Devices may not be maintained, calibrated or available when required following the initial purchase.	Agree practice responsibility for storage, infection prevention, maintenance, replacement batteries/consumables and ongoing device checks. Clarify responsibility for future replacement costs.
Evidence of benefit is currently limited/anecdotal, creating a risk that investment does not deliver the anticipated improvement.	This is an improvement initiative with baseline and post-implementation evaluation. Monitoring rejected referrals due to absent observations (incidents), direct O&A referrals, and, if possible, case studies around avoided ED attendances.

5.6 **Recommendation** is that we support the purchase of 31 Saturation monitoring devices and paediatric probes, one in every practice. Impact will be measured by reduction of incidents recorded as well as the increase in O&A/reduction in ED for conditions that are supported by CCNT, and practice staff confidence

6 Costs

6.1 The overall budget for Tameside locality schemes is £436,238 with the proposal that this is allocated to out of hospital attendance avoidance and admission avoidance schemes.

6.2 The breakdown of the allocation across the 4 schemes is as below in table 1.

Table 1.

Scheme Name	Payment Methodology	Funding Allocation
1.FeNO supported Asthma Diagnosis and Enhanced Asthma Management pathway	125 appointments per PCN 125 follow ups plus equipment costs	13.2%
2.Acute Respiratory Infection (ARI) Hub	Practice Weighted List Size	40.4%
3.Additional Capacity within Primary Care Enhanced Access Clinics	Practice Weighted List Size	41.4%
4. Improving Paediatric Assessment and Observations in General Practice.	Each practice to receive one monitor	5.1%

6.3 The allocation of funding for scheme 1 and 4 consists of some funding of equipment costs to support the schemes. This would need to be considered around which organisation supports the purchasing of this equipment.

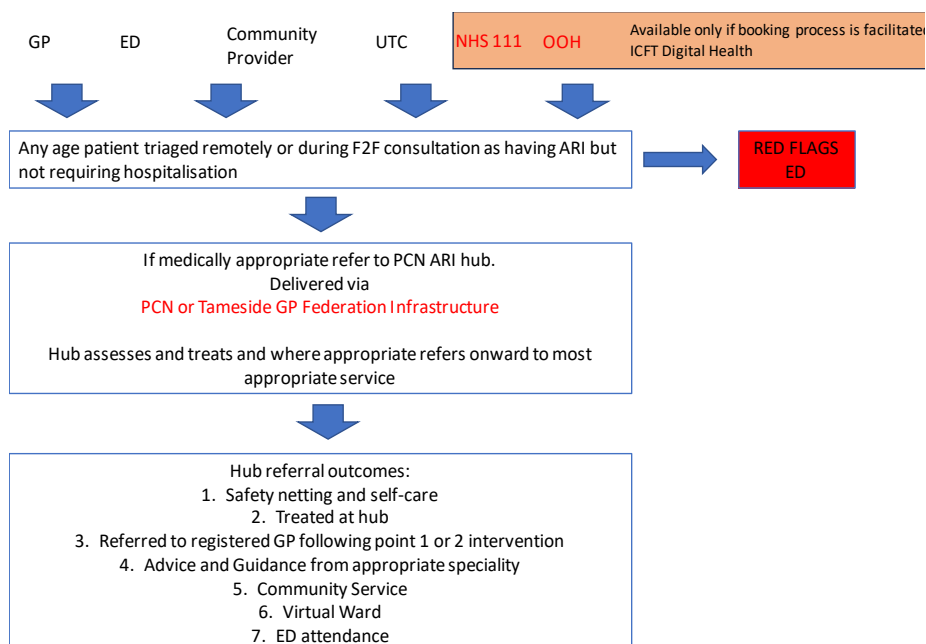
6.4 Due to the nature of the funding allocation and staff modelling of schemes 2 and 3, it would support flexing of capacity across the schemes based on review of activity and impact.

7 Recommendation

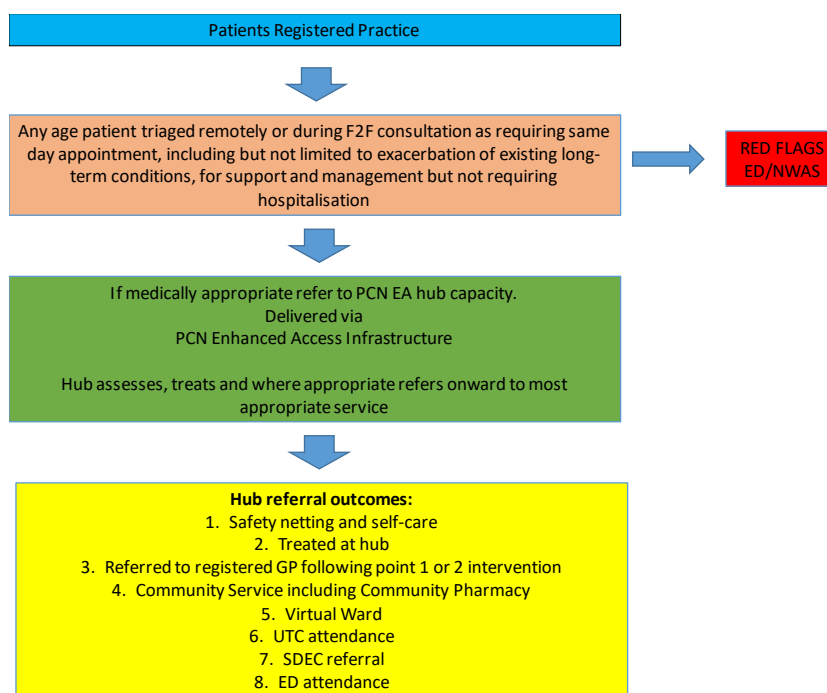
7.1 TSPC is asked to:

- Review and Note** the schemes listed in this report for consideration.
- Note** the risks associated to each scheme and associated mitigations.
- Support** the implementation of the scheme recommendations acknowledging that staffing models will be developed in collaboration with system partners to ensure resilient delivery within the October – March period.
- Support** review of the schemes at month 4 with potential need to adjust where schemes are not demonstrating benefit to patients and system flow.

Appendix A – ARI Hub Model



B – Primary Care Network Enhanced Access – Additional Capacity Model



TAMESIDE STRATEGIC PARTNERSHIP COMMITTEE (TSPC)

Meeting Date	23 rd September 2026	Public	X	Confidential	Agenda item
Title of Report	Babies, Children and Young People Palliative Care Services Update				
Lead Director / Executive Member / Clinical Lead	Marion Colohan, Deputy Place Based Lead for Tameside				
Author	Philippa Robinson, Transformation and Improvement Manager, NHS GM Tameside Place				
Outcome Required (please indicate)	Approval	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	NA		
Purpose / Summary of Report:					
To provide the Tameside Strategic Partnership Committee with assurance regarding significant improvements to children's palliative and end of life care in Tameside following previously identified gaps in specialist provision. The paper highlights the introduction of dedicated specialist palliative care nursing through the Kentown Support model, positive local evidence regarding achievement of preferred place of death, and wider Greater Manchester developments to improve coordination, equity and out-of-hours support. It also identifies the remaining work required to ensure a comprehensive and sustainable pathway, including future sustainability of the nursing model and access to specialist medical palliative care expertise.					
Recommendations:					
The Committee is asked to:					
1. Note and welcome the improvements made to children's palliative and end of life care in Tameside. 2. Recognise the contribution of the Kentown Support nursing model, Children's Community Nursing Team and wider partners in addressing a previously identified gap. 3. Note the positive local evidence regarding achievement of preferred place of death, recognising the small numbers and complexity of this cohort. 4. Note ongoing GM work to strengthen EPaCCS, single point of access, out-of-hours provision and specialist medical support.					

5. Support continued partnership working to embed, evaluate and sustain these improvements

Financial implications:

There are no immediate financial implications. The Kentown specialist nursing model is currently supported through charitable funding for three years. Future sustainability will be informed by independent evaluation and will require consideration by NHS Greater Manchester ICB. Development of a sustainable GM out-of-hours model may also require future investment; any funding requirements would be subject to separate commissioning and governance processes.

Alignment with the Joint Health and Wellbeing and Locality Plan:

The developments support local priorities to improve outcomes for children and young people, reduce health inequalities and ensure coordinated, person-centred care closer to home. Strengthening specialist palliative care provision improves equity of access across Greater Manchester and supports children and families to exercise meaningful choice about care, including at end of life.

Where issues are addressed in the paper -

	Section of paper where covered
Regulatory and legal compliance	Throughout
Sustainability (including environmental impacts)	Dedicated specialist nursing Developing a consistent out-of-hours offer Overall impact
Quality impacts	Throughout
Safeguarding impacts	None specifically
Risks	Dedicated specialist nurse capacity Developing a consistent out-of-hours offer Remaining gap – specialist medical support
Views and recommendations of the Clinical and Care Professional Advisory Group	GM CEG have given views and support throughout the development of EPaCCS and Kentown Support. Locality Palliative Care Improvement Board is sighted on developments.
Views of the population / users	Reflected through the focus on child/family choice and preferred place of care No specific engagement undertaken for this report, however experiences from across GM shaped the initial stakeholder discussions for Kentown Support

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
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Access to Information:

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

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CHILDREN'S PALLIATIVE and END of LIFE CARE – IMPROVEMENTS for CHILDREN AND FAMILIES in TAMESIDE

PURPOSE

This paper provides an update on improvements to children's palliative and end of life care in Tameside following the introduction of dedicated specialist nursing support, provides an overview of local experience and outcomes, and outlines the further developments required to establish a sustainable Greater Manchester (GM) pathway.

BACKGROUND

Children and young people with palliative and end of life care needs require coordinated, specialist and compassionate support, enabling children and families to have genuine choice about where and how care is provided.

Historically, specialist children's palliative care nursing provision was not equitable across Greater Manchester. Only two localities had access to dedicated specialist palliative care nursing, with no equivalent dedicated provision in Tameside.

This gap was identified by local nursing teams, who highlighted the impact on the Children's Community Nursing Team (CCNT), including additional pressure on existing capacity and challenges in consistently providing the level of specialist, holistic support required by children and families. The gap in local provision was also identified through the most recent Area SEND Inspection.

Although the number of children requiring palliative and end of life care is relatively small, this is a low-volume, high-complexity area of care. Activity numbers alone do not reflect the intensity of support required by individual children and families, often across multiple services and over an extended period. Ensuring high-quality care and genuine choice at end of life therefore remains an important quality and equity priority.

Dedicated Specialist Nursing for Tameside

A significant improvement has been the introduction of a **Kentown Children's Palliative Care Nurse**, aligned to the Children's Community Nursing Team within Tameside Integrated Care Foundation Trust (ICFT).

The Kentown model, supported through charitable funding for three years, has enabled Tameside to benefit from dedicated specialist palliative care nursing capacity for the first time, helping to address the previous inequity in provision across GM.

Importantly, the nurse is integrated with existing local services rather than operating as a separate service. The additional capacity brings specialist palliative care expertise alongside broader holistic and wellbeing support for children and their families. The

specialist nurses will benefit from specialist training on rotational placement at Alder Hey Hospital.

The service is also developing and utilising a GM single point of access, supporting improved navigation, reducing unnecessary duplication and contributing to a more consistent and equitable offer across Greater Manchester.

For children and families in Tameside this provides:

- dedicated specialist palliative care nursing where previously there was no dedicated provision;
- greater choice and support for children and families, including at end of life;
- improved quality, continuity and coordination of care;
- additional holistic and wellbeing support for children and their families;
- increased specialist expertise within the local system; and
- additional capacity and support for the existing Children's Community Nursing Team.

The current Kentown provision is charitably funded for three years. The ICB has made a commitment to consider sustaining the model following this period, subject to positive evaluation. Independent evaluation led by Professor Lorna Fraser at Kings College London will provide important evidence and economic evaluation regarding impact, outcomes and value, to inform future sustainability.

What are we seeing locally?

During 2025/26, all children for whom a preferred place of death had been identified were supported to die in their preferred setting, demonstrating the ability of local services to deliver personalised, family-centred care.

Six children known to local services died in this period.

Of these:

- four children died in hospital;
- two children died at home;
- for three of the children who died in hospital, hospital was their identified preferred place;
- both children who died at home had chosen home as their preferred place; and
- for one child, a preferred place discussion had not yet taken place, although this had been planned.

This is an important positive indicator of personalised care and demonstrates the commitment of local teams to supporting the wishes of children and families. Place of death should not in itself be regarded as a measure of success; the important outcome is whether children and families are supported to make an informed choice and whether services are able to respond to that choice.

There was, however, one occasion where planned overnight on-call support could not be provided due to staffing capacity. Although numbers are small, this demonstrates the fragility of current out-of-hours arrangements and reinforces the importance of developing a sustainable GM approach.

The six deaths should also not be interpreted as representing the total demand for palliative care. Children may require specialist support over months or years, including symptom management, advance care planning, coordination of care, emotional and wellbeing support and support for their wider family.

Improving shared care through EPaCCS

Alongside improvements in nursing provision, work is progressing to introduce Electronic Palliative Care Coordination Systems (EPaCCS) for children and young people, building on the approach already established for adults.

EPaCCS will enable key information about a child's palliative and end of life care needs, wishes and plans to be shared more effectively between professionals and services.

For children and families, the ambition is for this to mean less repetition, better-informed professionals and more coordinated care, particularly when accessing urgent or out-of-hours services.

It will also support more systematic advance care planning and help ensure that agreed wishes and plans are visible across organisational boundaries.

Developing a consistent out-of-hours offer

Work is underway with children's hospices across Greater Manchester to develop a more consistent and equitable out-of-hours palliative care offer.

The ambition is to reduce variation in access and ensure that children, families and professionals can access appropriate advice and support outside normal working hours, regardless of where they live, and improve their choice of place of care.

The local experience of being unable to provide planned overnight support on one occasion illustrates why this work is important.

Development of a sustainable GM out-of-hours model will require investment from NHS Greater Manchester and further work is underway with hospice providers to define the capacity and model required.

Remaining gap – specialist medical support

While significant progress has been made in strengthening specialist nursing provision, a gap remains in access to specialist consultant-level paediatric palliative care expertise within Greater Manchester.

Nurses and clinicians are currently able to access specialist expertise from Alder Hey Children's Hospital. This provides valuable clinical support but is an ad hoc arrangement and does not represent a sustainable specialist medical model for Greater Manchester. A business case identifying this gap has been considered by the GM Commissioning Development Group. The recommendation was for further consideration through Specialised Commissioning, recognising the relationship with wider specialist paediatric palliative care arrangements.

This remains an important component of developing a comprehensive and sustainable pathway.

Risks noted

Risk	Mitigation
Reduction in nursing at the end of charitable funding	Independent evaluation and ICB commitment following review
Lack of consultant provision	Escalated through specialised commissioning
Variable out-of-hours provision	GM pathway development with local hospices
Workforce resilience	Integrated nursing model with Kentown Support and GM collaboration, supported by rotational training at Alder Hey

Overall Impact for Tameside

There has been a significant change in the offer available to Tameside children and families.

Previously, Tameside had no dedicated specialist children's palliative care nurse. Existing community nursing services were absorbing additional pressure and access to specialist palliative care support varied depending on where a child lived within Greater Manchester.

Now, Tameside has dedicated specialist nursing capacity integrated with the local Children's Community Nursing Team, access to a developing GM single point of access and enhanced holistic support for children and families.

This is being complemented by work of introducing EPaCCS, strengthening out-of-hours care and addressing the remaining specialist consultant gap.

For Tameside, these developments mean better choice, quality and coordination for children and families, equity across Greater Manchester and additional specialist capacity supporting the local community nursing workforce.

GM ICB has made a commitment to continue the funding for specialist palliative care nursing following the 3 year Kentown Support project, if it is successfully evaluated by Kings College London.

There remains further work across GM to ensure that all elements of the pathway are in place. However, the progress made represents an important improvement from the position previously identified and demonstrates the benefits of partnership working between local services, NHS Greater Manchester ICB, hospice providers and the VCSFE sector.

Celebrating the impact

The development of children's palliative care with Kentown Support Model has also received wider recognition. The accompanying awards and programme video provide an opportunity to celebrate the work undertaken by teams and partners around the implementation of Kentown Support and, importantly, to demonstrate the difference that improved palliative care provision can make for children and their families.

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[Videos \(List\) | Kentown Support](#)



Recommendation

The Partnership Committee is asked to:

1. Note the significant improvements made to children's palliative and end of life care for Tameside children and families
2. Note the local position regarding achievement of preferred place of death, recognising the small numbers and complexity of this cohort
3. Support ongoing GM developments relating to EPaCCS, single point of access and a consistent out-of-hours offer.
4. Acknowledge the remaining gap in specialist consultant level provision and the recommendation for this to be considered through Specialised Commissioning.
5. Support the evaluation to sustain the Kentown model at place, providing assurance to NHS GM ICB for funding beyond the current charitable funding period
6. Support continued partnership working to embed, evaluate and sustain these improvements with continued monitoring of these developments via the Tameside Palliative and End of Life Care Improvement Group