Agenda

Tameside Strategic Partnership Committee

Date: Wednesday 28th October 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 Sept 2026	Paper	Information / Discussion	Chair
4.	11:10am (30 mins)	Final Place Health & Care Partnership document suite and next steps	Paper	Information / Discussion / Signatories to be received	Marion Colohan
5.	11:40am (10 mins)	Place Report	Paper	Information / Discussion	Marion Colohan
6.	11:50am (20 mins)	Population Health & Neighbourhood for PCN Plans	Paper	Approval	Christopher Martin
7.	12:10pm (15 mins)	Neighbourhood Leadership Group Development Integrated Team update	Paper	Information /Discussion	Marion Colohan
Any other Business and Administration					
8.	12:25pm (5 mins)	Any other business – *To be notified to the Chair in advance of the meeting*	Verbal	To receive	Chair
9.		Date and time of next meeting: Wednesday 2026 11-12:30pm Committee Room 1, Level 2, Tameside One	Verbal	To note	Chair

Minutes

Tameside Strategic Partnership Board

Date: 23rd September 2026

Time: 11 -12:30pm

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

PRESENT
Marion Colohan – Place Partnership Director – Tameside – Chair Councillor Teresa Smith – Lead Member for Children and Families Councillor Mike Smith – Lead Member for Population Health and Wellbeing Dr Ali Syed Asad-Associate Medical Director / Clinical Director representative Joe Kelly – Strategic Director of Adult Social Care and Health James Mallion- Director of Public Health Councillor Leanne Feeley (Executive Member for Lifelong Learning and Culture) Councillor Jackie Lane Executive Member for Adult Social Care and Inclusivity Jill Colbert – Strategic Director of Childrens Paul Buckley Executive Director of Strategy & Partnerships Stockport Ashwin Ramachandran - Clinical Director (NHS GM Place Partnership) Anita Rolfe - Deputy Chief Clinical Officer (Nursing and Nurse Advisor to the Board) NHS GM ICB Joe Corbett - Neighbourhood Health & Care Programme Manager (NHS GM Place Partnership) Philippa Robinson - Transformation and Improvement Manager (NHS GM Place Partnership) Victoria Leonard - Associate Director (Clinical) Improvement & Personalisation (NHS GM Place Partnership) Pauline Thompson Business Support

APOLOGIES
Councillor Eleanor Wills – Leader of Tameside Council and Chair Dr Simon Sandhu – Chief Medical Officer, Pennine Care NHS Foundation Trust Karen James – Chief Executive, Tameside Hospital and Stockport NHS Foundation Trust Emma Alexander -Chief Executive, Tameside Council and Tameside Place Lead Jacqui Burrows

Item No	Topic	Action
1.	**Welcome, Introductions and Apologies** MC welcomed members to the meeting and confirmed apologies from the Chair Councillor Eleanor Wills and will be chairing today's meeting. Other apologies noted above. MC introduces Anita Rolfe's role as Deputy Chief Clinical Officer, highlighting her responsibilities across quality assurance, safeguarding, maternity, infection control and Deputy Designated Safeguarding Partner functions, her attendance reflects the importance of strengthening the ICB's executive representation within the Committee. AR queried quoracy due to several apologies and low attendance. Concerns were raised regarding whether the number of attendees would allow formal approval of recommendations later in the meeting. It was agreed that where necessary, decisions would be supported in principle and followed up through the appropriate governance processes.	
2.	**Declarations of Interest** A declaration of interest was made later in the meeting by Anita Rolfe, who advised members that she serves as Chair of Trustees for My Cancer Support. No other declarations were recorded.	
3.	**Minutes of Committee August 2026 & Action Log** The minutes of the meeting held on 26th August 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. All updates noted on the Action Log.	
4.	**Place Report** MC presented the Place Report and provided updates on a number of strategic developments affecting Tameside. Discussion focused on the launch of the Tameside Borough Strategy, which sets out a shared whole-borough commitment across the Council, NHS organisations, housing and education partners, Greater Manchester Police, the voluntary sector and local businesses.	

	The strategy provides a common framework for collaboration and shared accountability, supporting coordinated action on deprivation, inequality, economic development and population health outcomes. The Committee welcomed confirmation that Tameside's Better Care Fund plan had received approval from NHS England. Members heard that this would support the continuing development of place-based working and the gradual expansion of the Place Budget beyond the Better Care Fund over time. An update was provided on the Place Partnership Agreement. Following extensive engagement across GM, final documentation is expected later in the year. Subject to partner agreement, proposals remain on track to transition the current Strategic Partnership Committee into a new Tameside Place Partnership Board from January 2027. Members were also informed that work continues regarding potential hosting arrangements for NHS Greater Manchester Place staff, with Tameside and Glossop Integrated Care NHS Foundation Trust exploring arrangements for hosting local place teams. The Committee received positive news regarding vaccination inequality funding. Tameside has secured approximately £68,660 to support targeted work in communities where vaccination uptake remains lower. Plans have been submitted by all four Primary Care Networks. Additional verbal updates were provided regarding SEND improvement work. Members welcomed confirmation that additional investment had been secured to support children experiencing long waits for community paediatric assessments, particularly in the 3-5 year age group. Resources would also be prioritised towards children with continence needs and those facing the longest waiting times. Discussion also focused on system support being provided to the Northern Care Alliance following regulatory concerns and improvement notices. Members sought assurance that support being provided by Tameside organisations would not negatively affect local services. NHS and Trust representatives confirmed that mutual aid arrangements were being delivered through additional capacity and would not disadvantage Tameside residents. For information there has been changes to the CYP crisis service operating hours and a consultation being launched on Specialist cardiac vascular surgery services.	
5.	**CYP Asthma Update** PR presented an update on Tameside's whole-system CYP asthma programme, developed in response to historically high under-19 admission rates and involving primary and secondary care, schools, public health, housing and community services. Evaluation showed emergency department attendances reduced by over 20% and hospital admissions by almost 12%. Members attributed progress to the programme's combined interventions, including FeNO testing, proactive reviews, improved prescribing, smoking prevention, housing improvements and school support. Members requested deeper analysis of admission patterns and frequent attenders to better target support, and emphasised embedding effective	

	interventions in routine neighbourhood services rather than short-term pilots, supported by a long-term investment case.	
6.	**Primary Care Capacity Scheme** JC and PR presented proposals for the allocation of winter capacity funding. Members were informed that £400,000 plus had been allocated to Tameside to support seasonal pressures between October and March. Unlike previous years, earlier confirmation of funding had created an opportunity to invest in preventative and proactive schemes rather than purely reactive measures. Four schemes were proposed: **Proposed Schemes** • FeNO-supported Asthma Diagnosis and Enhanced Asthma Management • Acute Respiratory Infection Hub • Additional Primary Care Enhanced Access Capacity • Paediatric Assessment and Monitoring Equipment for General Practice Discussion focused on the value of investing in preventative interventions that could reduce future hospital attendance and admissions. Members welcomed the shift towards early intervention and community-based care and viewed the proposals as a practical example of moving care closer to home. Several contributors stressed the importance of robust evaluation. Members recognised that funding remains non-recurrent and therefore strong evidence of benefits would be essential to support future investment. Questions were also raised about implementation risks, particularly the proposed Acute Respiratory Infection Hub, where estate capacity, workforce availability and operational delivery still required further discussion. The Committee broadly supported the proposals while recognising that final operational details would continue to be refined.	
7.	**Palliative Care Offer** PR reported significant improvements in children's palliative and end-of-life care. With support from the Kentown Support charity, Tameside now has a specialist children's palliative care nursing service integrated with the Children's Community Nursing Team, providing nursing, counselling, emotional wellbeing and sibling support. Charitable funding has secured the service for three years. EPaCCS is also being developed to improve information sharing and coordination, and all children with a recorded preferred place of death during the reporting period were supported in their chosen setting. Members welcomed the progress, particularly in light of previous SEND inspection findings, while noting risks around sustainable funding, consistent out-of-hours provision across Greater Manchester and gaps in consultant-level paediatric palliative care expertise.	
8.	**Any Other Business**	

	No additional business was raised by members, and no public questions were received.	
9.	**Date and time of next meeting:** Wednesday 28th October 2026, 11-12:30pm, Tameside One.	

TAMESIDE STRATEGIC PARTNERSHIP COMMITTEE (TSPC)

Meeting Date	28/10/2026	Public	X	Confidential		Agenda item
Title of Report	Place Health and Care Partnership Document Suite and Confirmation Statement					TBC
Lead Director / Executive Member / Clinical Lead	Marion Colohan, Place Partnership Director - Tameside					
Author	Marion Colohan, Place Partnership Director - Tameside					

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

Purpose / Summary of Report:

The Greater Manchester proposals position Place Health and Care Partnerships as the principal forum through which NHS organisations, local authorities, primary care, the voluntary, community, faith and social enterprise sector and other partners work together to improve outcomes for their local population. The framework connects strategic commissioning at Greater Manchester level with local insight, neighbourhood delivery and collective stewardship of resources.

The Partnership Agreement is the anchor document. It sets the shared purpose, behaviours, responsibilities and governance principles for partners, while making clear that the partnership is not a separate legal entity and does not displace the statutory accountabilities or decision-making authority of any sovereign organisation.

The purpose of this paper is to update the Tameside Locality Board on the suite, invite continued support for its direction and establish the safeguards and further work for partner signatures in November 2026.

Recommendations:

1. Record the Committee's comments on the direction of travel and any further matters to be addressed.
2. Complete the final document revisions with NHS Greater Manchester, drawing together the issues raised through the partner workshops and detailed review.
3. Circulate the revised suite to partner organisations for final assurance and preparation for their respective approval routes.
4. Confirm with each proposed party its formal approval route, authorised signatory and requirements for consultation with constituent bodies, and maintain a consolidated approval and signature schedule.
5. Return the final signed suite and proposed Tameside confirmation statement to the Locality Committee in November 2026.
6. Proceed to formal organisational approvals and signature collection, subject to Committee agreement

Financial implications:
Financial Implications This paper does not seek approval for any transfer of budgets, delegation of financial responsibility or amendment to existing financial arrangements. The proposed Place Fund represents a strategic approach to collective stewardship of resources, with 2026/27 operating as a shadow year. Any future arrangements relating to pooled budgets, hosting, risk-sharing, gain-share mechanisms, management of overspends and underspends, or variations to existing Section 75 arrangements will require separate financial appraisal, due diligence and approval through the relevant governance processes of partner organisations. Tameside partners will require assurance that financial liabilities remain proportionate to delegated authority and decision-making responsibility.
Alignment with the Joint Health and Wellbeing and Locality Plan:
The proposals in this paper align directly with the Tameside Joint Health and Wellbeing Strategy and Locality Plan by strengthening neighbourhood-based delivery, advancing prevention and early intervention, and supporting collective action on the wider determinants of health. The emerging Partnership Agreement, Outcomes Framework and Place Team model reinforce Tameside's priorities around reducing inequalities, improving population health, and delivering integrated care through the Live Well Tameside approach, ensuring that system partners work together with shared accountability for outcomes.

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	Throughout
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:

e-mail: marion.colohan@nhs.net

1.0 EXECUTIVE SUMMARY

1.1 NHS Greater Manchester ICB has developed a suite of documents intended to establish a consistent framework for the operation of Place Health and Care Partnerships across Greater Manchester. The suite comprises the Partnership Agreement, Outcomes Framework, Place Fund, Place Team Approach and Governance Framework, and is intended to provide a single operating model for partnership working at Place level.

1.2 Following a programme of partner workshops, engagement and detailed review, Tameside partners have broadly supported the direction of travel while identifying a number of issues requiring further development before formal approval can be sought.

1.3 The proposals are intended to strengthen partnership working across Tameside by supporting collaborative leadership, neighbourhood delivery, prevention, improved population health outcomes and more effective stewardship of collective resources. The arrangements seek to bring together NHS organisations, Tameside Metropolitan Borough Council, primary care, the voluntary, community, faith and social enterprise sector and other partners around a shared set of outcomes whilst retaining the sovereignty, statutory responsibilities and decision-making authority of each individual organisation.

1.4 This paper does not seek approval of the final document suite, nor does it seek approval of any transfer of budgets, delegation of statutory functions, workforce arrangements, hosting arrangements, contractual commitments or amendments to existing Section 75 agreements. Any such arrangements will remain subject to separate due diligence, assurance and formal approval through the governance arrangements of the relevant organisations.

1.5 The paper therefore seeks endorsement of the direction of travel whilst recognising that further work is required to address outstanding governance, financial, legal, operational and workforce considerations. It also sets out the proposed process for assurance, approval and formal sign-off by partner organisations before any Tameside confirmation statement is submitted to NHS Greater Manchester.

2.0 BACKGROUND AND PURPOSE

2.1 NHS Greater Manchester ICB proposals position Place Health and Care Partnerships as the principal forum through which NHS organisations, local authorities, primary care, the voluntary, community, faith and social enterprise sector and other partners work together to improve outcomes for their local population. The framework connects strategic commissioning at Greater Manchester level with local insight, neighbourhood delivery and collective stewardship of resources.

2.2 The Partnership Agreement is the anchor document. It sets the shared purpose, behaviours, responsibilities and governance principles for partners, while making clear that the partnership is not a separate legal entity and does not displace the statutory accountabilities or decision-making authority of any sovereign organisation.

2.3 The purpose of this paper is to update the Committee on the, invite continued support for its direction and establish the safeguards and further work required before the final documents are presented for approval in November 2026.

3.0 THE DOCUMENT SUITE

Document: Partnership Agreement Purpose: The overarching framework for shared intent, principles, roles, governance and ways of working. Draft Position Statement: Broad direction supported; final approval deferred pending local completion and assurance. Actions: Stakeholders to confirm organisational governance and anticipated timeframes.

Document: Outcomes Framework Purpose: Defines the shared outcomes and the measures through which progress and accountability will be tracked. Draft Position Statement: Shared outcomes and structure noted; measures, baselines and ownership to be completed before approval. Actions: Explore through planned Tameside Locality Board and Health & Wellbeing Board symposium a shared outcomes framework and connectivity of Live Well Tameside outcomes and associated metrics.

Document: Place Fund Purpose: Sets the direction for financial stewardship, visibility of resources and alignment with prevention and neighbourhood delivery. Draft Position Statement: Principles noted; detailed financial and governance work required before any commitment. Actions: Consider governance arrangements in place to have sight of the Place Fund and its relationship to existing Section 75 arrangements.

Document: Place Team Approach Purpose: Describes the purpose, capabilities, membership and possible configuration of the multi-partner Place Team. Draft Position Statement: Direction supported; the Tameside operating model and partner contributions to be developed through implementation planning. Actions: Schedule a Task & Finish Group, building on previous Governance Task & Finish Group discussions, to determine definition and make-up of the Place Team – linked to existing place hosting mobilisation work.

Document: Place Governance Purpose: Appraises mechanisms linking NHS GM, the Place Fund and Place Team, including relevant partner organisations. Draft Position Statement: Options and principles noted; formal legal decisions reserved to the relevant organisations. Actions: Agree Terms of Reference for the Tameside Place Health & Care Partnership Board. Ongoing review/audit of Better Care Fund and Section 75 and contractual routes, including completion of 26/27 Deed of Variation.

4.0 ASSESSMENT OF THE PROPOSALS – PLACE PARTNERSHIP AGREEMENT

4.1 The Place Partnership Agreement (PPA) provides a sound basis for local partnership working. It commits partners to act on a “best for place” and “best for GM” basis, supports consensus as the default approach to decisions and retains reserved matters and statutory accountability within each organisation. It also links the Outcomes Framework, Place Fund and Place Team into one coherent arrangement.

4.2 Before final adoption, the Tameside version of the PPA will need local nuances inserting (naming conventions, vision, parties, commencement). The remaining Section 75 arrangements, schedules and terms of reference should also be integrated into the new PPA appropriately – with advice being sought on how to do this clearly and effectively. These matters will be considered through the final revision process and must be resolved, or clearly identified for subsequent local implementation, before formal approval is sought.

4.3 Confirmation of signatories to the PPA is required from existing members of Committee. An agreed position on signatories to the PPA is to be agreed in principle ahead of presenting the final suite of documents at the November Board meeting.

5.0 OUTCOMES FRAMEWORK

5.1 The framework proposes four shared outcomes:
narrowing inequalities in healthy life expectancy while improving outcomes overall; increasing care delivered in neighbourhood settings; improving staff wellbeing and retention; and making more effective use of collective resources through continuous improvement.

5.2 The proposed metric library covers access, cancer, children and young people, community services, elective care, end of life, experience, financial sustainability, long-term conditions, mental health, quality, inequalities, immunisation, urgent care and workforce. However, the current schedule remains developmental. It contains a significant number of “TBC” entries, incomplete baselines and targets, and some measures without confirmed leads. The final framework should be focused enough to drive decisions rather than become an exhaustive list of performance metrics. Due consideration to the emergent Live Well Tameside outcomes and associated metrics and their inclusion in the Outcomes Framework should be clarified.

6.0 PLACE FUND

6.1 The Place Fund proposals support a clearer view of resources, collective stewardship and a planned shift towards prevention, early intervention and neighbourhood delivery. The current proposition describes 2026/27 as a shadow year in which NHS Greater Manchester continues to hold the fund centrally while places work with the wider financial picture and influence decisions within agreed rules.

6.2 The Board is asked to note the strategic direction, not to approve a transfer of budgets or liabilities through this paper. Any pooling, delegation, hosting, risk sharing or change to existing Section 75 arrangements must be supported by detailed financial, legal and governance advice and approved through the relevant partner processes.

7.0 PLACE TEAM APPROACH AND GOVERNANCE

7.1 The proposed Place Team is a virtual, multidisciplinary resource drawn from partners. Its role is to connect strategy to neighbourhood delivery and bring together leadership, analysis, improvement, programme management, finance, clinical and care expertise and community engagement. The model expressly allows local flexibility, ranging from integrated and hybrid teams to dispersed or fluid matrix arrangements.

7.2 This flexibility is appropriate for Tameside given current arrangements. Support for the direction of travel should not predetermine a host or employment model. The next phase should define the functions Tameside needs, the capacity each partner will contribute, the accountabilities for hosted or ring-fenced roles and the practical relationship between the Place Team, the Board and delivery arrangements. The Governance Task & Finish Group has agreed to a separate meeting of partners to work through the definition of the Place Team, reporting back to the Board appropriately.

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

7.4 The Locality Board is invited to note that core principle while recognising that the final instruments will depend on confirmed hosting decisions, due diligence and the respective powers and approvals of the parties.

7.5 Consideration of this update should not be interpreted as advance approval of a new or varied Section 75 agreement, contract, staff transfer or delegation. Nothing within the proposed arrangements transfers statutory functions, legal responsibilities, organisational sovereignty or decision-making authority from any partner organisation unless subject to separate formal approval through the relevant governance arrangements.

8.0 FUTURE TAMESIDE CONFIRMATION STATEMENT

8.1 The final paper will include a proposed Tameside confirmation statement for consideration. The current working form is below:

"The Tameside Locality Board confirms its agreement to the core direction, shared outcomes and operating principles set out in the Place Health and Care Partnership document suite. This confirmation is made on the basis that each partner retains its statutory functions, sovereignty and internal approval requirements; that outstanding Tameside-specific content and technical detail will be completed; and that any subsequent legal, financial, employment, hosting or delegation arrangements will be subject to the appropriate due diligence and formal decisions of the relevant organisations."

8.2 Partner confirmation will need to be explicit and recorded. Where a representative cannot bind their organisation, the local process will need to obtain confirmation from the appropriate accountable body or authorised officer. Submission of the Tameside statement will only follow the Board's consideration of the final suite and completion of the agreed partner approval routes (November 2026).

9.0 FORMAL APPROVAL AND SIGNATURE BY PARTNER ORGANISATIONS

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

9.2 The proposed process is:

1. Local process and assurance: The final suite is circulated to all proposed parties, with a standard assurance template asking each organisation to confirm any remaining concerns, its approval route, the authorised signatory and the date by which approval can be secured.
2. Locality Board consideration: The final suite, proposed Tameside confirmation statement, schedule of resolved and outstanding matters, and partner approval plan return to the Committee in November 2026. The Board considers whether the suite is ready to proceed into formal organisational approval and signature.
3. Constituent-body approval: Each party follows its own governance process. Partner representatives should be given sufficient opportunity to consult and obtain the necessary mandate from their relevant trust, board, member practices or other constituent bodies. Other partners should follow their equivalent authorised route.
4. Formal signature: Signatures are collected only after the relevant approvals have been obtained. A single controlled final version will be used, supported by a signature schedule recording the approving body, decision date, signatory and any conditions or reservations.
5. Confirmation and implementation: The Tameside confirmation statement is submitted to NHS Greater Manchester only when the agreed threshold for partner approval has been

met and the Board is satisfied that any remaining qualifications are explicit. Material legal, financial, workforce, hosting or delegation arrangements should continue through separate due diligence and approval processes.

10.0 KEY MATTERS TO COMPLETE BEFORE IMPLEMENTATION

10.1 Complete the Tameside-specific Partnership Agreement, including parties, vision, term, schedules and terms of reference.

10.2 Confirm the concise set of oversight measures, baselines, ambitions, reporting frequency, data ownership and named leads.

10.3 Agree the local contribution and accountability model for the Place Team, including any hosted, assigned, seconded or ring-fenced capacity.

10.4 Confirm current Place Fund proposition, including scope, decision rights, controls, risk and gain share, treatment of overspends and underspends contained within the existing Section 75 agreement via confirmation of the 26/27 Deed of Variation.

10.5 Complete legal, financial, procurement, VAT, workforce, information governance and equality assurance for any formal implementation arrangements.

10.6 Produce an implementation plan with accountable leads, milestones, dependencies, risks and reporting arrangements.

11.0 IMPLICATIONS FOR TAMESIDE PLACE

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

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

11.3 Workforce and Place Team Implications The Place Team model aligns with Tameside's ambition to deliver integrated services through collaborative leadership and neighbourhood-based delivery. Further work is required to determine the functions, capacity, partner contributions and accountability arrangements needed to support the Tameside model. Any future decisions relating to hosting, recruitment, secondment, assignment or employment

responsibilities will remain subject to detailed workforce, organisational development and legal consideration by the relevant partner organisations.

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

11.5 Strategic and Service Delivery Implications The proposed framework supports Tameside's existing commitment to integrated working, prevention, neighbourhood delivery and reducing health inequalities. The final Outcomes Framework should demonstrate clear alignment with Tameside priorities, including the Live Well Tameside agenda, wider determinants of health, community wellbeing and neighbourhood outcomes. The framework should support delivery across the whole health and care system rather than focusing solely on NHS performance measures.

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

12.0 RISKS AND AREAS REQUIRING FURTHER ASSURANCE

12.1 Key Risks and Mitigations

Risk: Lack of clarity on decision-making and delegated authority Potential Impact: Uncertainty regarding accountability and delays in decision-making

Mitigation: Final document suite to include clear governance, delegation and escalation arrangements.

Risk: Financial governance and risk-sharing arrangements not fully defined Potential Impact: Potential exposure to unknown liabilities and reduced partner confidence

Mitigation: Detailed financial framework and any changes to Section 75 arrangements to be subject to separate due diligence and approval.

Risk: Place Team model and hosting arrangements remain unresolved Potential Impact: Unclear workforce, accountability and employer responsibilities

Mitigation: Completion of Place Team design work and formal options appraisal before implementation.

Risk: Outcomes Framework not sufficiently developed Potential Impact: Difficulty measuring delivery, impact and partner accountability

Mitigation: Agree a focused set of outcomes, baselines, targets and accountable leads prior to approval.

Risk: Insufficient partner representation and organisational sign-off Potential Impact: Delays to implementation and risk of incomplete system commitment

Mitigation: Confirm partner representation, approval routes and authorised signatories through a formal assurance process.

Risk: Misalignment between GM requirements and Tameside priorities Potential Impact: Reduced ability to deliver local outcomes and respond to local need

Mitigation: Ensure alignment with Tameside priorities, Live Well Tameside ambitions and wider locality plans through the final document suite.

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

13.0 NEXT STEPS

1. Record the Board's comments on the direction of travel and any further matters to be addressed.
2. Complete the final document revisions with NHS Greater Manchester, drawing together the issues raised through the partner workshops and detailed review.
3. Circulate the revised suite to partner organisations for final assurance and preparation for their respective approval routes.
4. Confirm with each proposed party its formal approval route, authorised signatory and requirements for consultation with constituent bodies, and maintain a consolidated approval and signature schedule.
5. Return the final suite and proposed Tameside confirmation statement to the Locality Board in November 2026, together with a schedule of resolved and outstanding matters.
6. Proceed to formal organisational approvals and signature collection, subject to Board agreement.

APPENDIX A – SUMMARY OF THE TAMESIDE PLACE HEALTH & CARE PARTNERSHIP DOCUMENT SUITE

Purpose: To provide a concise overview of each component of the document suite and its intended function within the Tameside Place operating model.

A1. Partnership Agreement

- Establishes shared purpose, principles, behaviours and governance arrangements.
- Confirms that the partnership is not a legal entity and does not displace statutory accountabilities.
- Sets out roles, responsibilities, decision-making principles and reserved matters.
- Tameside version requires insertion of local naming conventions, parties, commencement date and integration of Section 75 schedules.

A2. Outcomes Framework

- Defines shared outcomes for Tameside Place.
- Four GM outcomes: inequalities, neighbourhood care, workforce wellbeing, stewardship of resources.

- Metric library remains developmental; baselines, targets and leads to be confirmed.
- Alignment with Live Well Tameside outcomes required.

A3. Place Fund

- Strategic mechanism for visibility and stewardship of resources.
- 2026/27 is a shadow year with NHS GM retaining central control.
- No approval of budget transfers sought at this stage.
- Any future pooling or hosting arrangements require separate due diligence.

A4. Place Team Approach

- Virtual, multidisciplinary team connecting strategy to neighbourhood delivery.
- Flexible configuration appropriate for Tameside.
- Further work required to define functions, partner contributions, accountability and hosting implications.

A5. Governance Framework

- Sets out mechanisms linking NHS GM, the Place Fund, Place Team and partner organisations.
- Section 75 preferred where Tameside Council hosts the Place Fund; contractual route preferred where an NHS trust hosts the Place Team.
- No hosting decision is made through this paper.

APPENDIX B – TAMESIDE-SPECIFIC REQUIREMENTS FOR FINALISATION

B1. Partnership Agreement

- Insert Tameside naming conventions, parties and commencement date.
- Integrate Section 75 schedules and terms of reference.
- Confirm signatories from all partner organisations, including primary care professions.

B2. Outcomes Framework

- Confirm baselines, targets, reporting frequency and data ownership.
- Align with Live Well Tameside outcomes and neighbourhood priorities.
- Identify accountable leads for each metric.

B3. Place Fund

- Confirm scope, decision rights, controls, risk/gain share and treatment of overspends/underspends.
- Finalise Section 75 Deed of Variation for 2026/27.
- Ensure financial liabilities remain proportionate to delegated authority.

B4. Place Team

- Define functions, capacity, partner contributions and accountability arrangements.
- Confirm any hosted, assigned, seconded or ring-fenced roles.
- Complete workforce, legal and organisational development considerations.

B5. Governance

- Clarify collective vs organisational decision rights.
- Confirm escalation and dispute resolution arrangements.
- Ensure alignment with Tameside governance structures (Locality Board, Place Leadership Group, Governance Task & Finish Group).

APPENDIX C – RISK REGISTER EXTRACT (TAMESIDE PLACE)

Risk: Lack of clarity on decision-making and delegated authority Potential Impact: Delays, uncertainty, reduced accountability Mitigation: Final suite to include clear governance, delegation and escalation arrangements.

Risk: Financial governance and risk-sharing arrangements not fully defined Potential Impact: Exposure to unknown liabilities Mitigation: Detailed financial framework and Section 75 changes subject to due diligence.

Risk: Place Team model and hosting arrangements unresolved Potential Impact: Unclear workforce and employer responsibilities Mitigation: Complete Place Team design and options appraisal.

Risk: Outcomes Framework insufficiently developed Potential Impact: Difficulty measuring delivery and impact Mitigation: Agree focused outcomes, baselines, targets and leads.

Risk: Insufficient partner representation and sign-off Potential Impact: Delays and incomplete system commitment Mitigation: Confirm representation, approval routes and authorised signatories.

Risk: Misalignment between GM requirements and Tameside priorities Potential Impact: Reduced ability to deliver local outcomes Mitigation: Ensure alignment with Live Well Tameside and locality plans.

APPENDIX D – PROPOSED TAMESIDE CONFIRMATION STATEMENT (DRAFT)

“The Tameside Locality Board confirms its agreement to the core direction, shared outcomes and operating principles set out in the Place Health and Care Partnership document suite. This confirmation is made on the basis that each partner retains its statutory functions, sovereignty and internal approval requirements; that outstanding Tameside specific content and technical detail will be completed; and that any subsequent legal, financial, employment, hosting or delegation arrangements will be subject to the appropriate due diligence and formal decisions of the relevant organisations.”

APPENDIX E – PARTNER ASSURANCE AND APPROVAL ROUTE TEMPLATE

Organisation name:

Key contact:

Approval route (committee, board, governing body, etc.):

Required consultation (e.g., member practices, trust board, VCSE forum):

Authorised signatory:

Date approval expected:

Any conditions, reservations or outstanding matters:

APPENDIX F – IMPLEMENTATION PLANNING REQUIREMENTS

The final implementation plan will include:

- Accountable leads.
- Milestones and timeline.
- Dependencies.
- Risks and mitigations.
- Reporting arrangements.
- Alignment with Tameside neighbourhood delivery and Live Well Tameside priorities.

APPENDIX G – GLOSSARY OF TERMS (TAMESIDE VERSION)

Place Partnership Agreement – The overarching framework for shared intent, principles, roles, governance and ways of working at Tameside Place.

Outcomes Framework – The shared outcomes and metrics used to track progress and accountability.

Place Fund – The mechanism for visibility and stewardship of resources at Place level.

Place Team – The virtual, multidisciplinary team connecting strategy to neighbourhood delivery.

Section 75 – Legal mechanism enabling pooled budgets and joint commissioning between NHS and local authorities.

Deed of Variation – Formal variation to an existing Section 75 agreement.

Live Well Tameside – Tameside's overarching health and wellbeing framework and outcomes.

Neighbourhood model – Tameside's approach to locality-based, integrated service delivery.

Stewardship of resources – Collective responsibility for the effective use of financial and non-financial resources.

Collective accountability – Shared responsibility for outcomes across partner organisations.

APPENDIX H – DOCUMENT SUITE DEPENDENCIES MAP (NARRATIVE SUMMARY)

- The Partnership Agreement provides the overarching governance framework and links the Outcomes Framework, Place Fund and Place Team.
- The Outcomes Framework depends on agreed metrics, baselines and leads, and must align with Live Well Tameside.
- The Place Fund depends on Section 75 arrangements, Deed of Variation and agreed financial governance.
- The Place Team depends on agreed functions, capacity, hosting arrangements and workforce considerations.
- The Governance Framework depends on confirmed delegation, escalation and dispute resolution arrangements, and alignment with NHS GM governance.

APPENDIX I – TAMESIDE PARTNER LIST (FOR SIGNATURE SCHEDULE)

- NHS Greater Manchester ICB
- Tameside Metropolitan Borough Council
- Tameside & Glossop Integrated Care Foundation Trust
- Pennine Care Foundation Trust
- Tameside Primary Care Alliance
- Action Together

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Place Health and Care Partnership Document Suite

Summary Slides

Part of Greater Manchester Integrated Care Partnership

About This Document and Contents

This summary explains how the coordinated Place Health and Care Partnership document suite turns the Greater Manchester operating model into practical arrangements for Place partnerships, teams, host employers and local authority partners. Together, the documents define shared purpose, outcomes, resources, decision-making, hosting, transfer and accountability.

1. **Executive Summary and Introduction:** Summarises how PHCPs enable Greater Manchester to deliver reform through prevention, neighbourhood care and system-wide collaboration.
2. **Partnership Agreement:** Sets the shared intent, principles, governance and mutual accountability for how Place partners work together.
3. **Place Outcomes Framework:** Defines the outcomes PHCPs seek to improve and the shared basis for measuring progress and collective assurance.
4. **Place Fund:** Sets out the 2026/27 Better Care Fund scope, financial stewardship, accountability and decision-making arrangements.
5. **Place Team and Hosting Arrangements** Defines the Place Delivery & Integration Service, the wider multidisciplinary Place Team and the arrangements that support workforce integration and neighbourhood working.
6. **Governance, Accountability, Oversight and Assurance Framework:** Sets the common three-layer architecture, retained accountabilities and approach to Place assurance and improvement.

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Executive Summary and Introduction

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Foreword

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

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

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

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

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

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

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

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

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

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



Professor Colin Scales
Acting Chief Executive
NHS Greater Manchester



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

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

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System Convenor – to enable delivery of the ICP strategy

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

Strategic Commissioner

Needs Assessment & Outcomes Setting

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

Strategy and Planning

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

Contracting & Evaluating Impact of System

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

ClearAccountabilityandTrust

Ten Integrated Place Partnerships

Local Insight-led Planning

Develop priorities and plans to address:

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

Integrated Delivery at Place

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

Aligning Partnership Incentives & Resource

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

Enablers: portfolio/s to encompass all of these functions

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

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

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

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



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

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

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Introducing the PHCP Document Suite

How the core operating-model documents work together

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Partnership Agreement

The principal partnership framework: purpose, membership, outcomes, decision architecture, accountabilities and relationships between partners and NHS Greater Manchester.

Place Fund

For 2026/27, comprises agreed Better Care Fund services operating through existing Section 75 and BCF arrangements.

Supports joint oversight and influence; it is not a delegated budget.

Place Outcomes Framework

Defines the outcomes the partnership is collectively seeking to improve.

Provides the organising framework for evidence, Place assurance and improvement.

Place Delivery & Integration Service

Dedicated hosted capacity supporting the Partnership and neighbourhood delivery.

Forms part of the wider multidisciplinary Place Team.

Place sets priorities; NHS GM commissions and funds; the host remains employer.

Governance, Accountability, Oversight & Assurance

Links partnership governance, resources and hosting, and assurance of outcomes.

Sets a consistent GM core with local flexibility.

Recognises statutory, financial, contractual, quality and employment accountabilities.

Logic Model - Place Delivery

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Inputs

Governance inputs:
- PartnershipAgreement
- Place Fund
- Place Team
- Place Governance

Investments into:
- Place Delivery & Integration Service
- Place Grants
- Neighbourhood services through contracts

Key Activities

Activity in Live Well Centres and Spaces

Primary Care activity

Integrated Neighbourhood Team Activity

Demand Management Initiatives

Community Services Activity and Access

Metrics and Outcomes

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

Delivery Measures: Uniform across the 10 localities

Place Specific

Supported by measures to show demand reduction and cost avoidance

Contributing to GM Strategy

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

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

Leading to Change in Place and System

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

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Partnership Agreement

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Integrated Care Partnership

Partnership Agreement

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- Acts as the **overarching agreement** for the PHCP document suite
- Sets the **shared intent and principles** for Place Partnership working
- Provides **a stable, common foundation** for collaboration across the system
- Aligns partners to **collective action that adds value beyond single organisations**
- Is a formal document but **does not create a legal entity** or alter statutory accountability
- Is the **primary document for formal place sign-off**

Partnership Agreement: Structure by section

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

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

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

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

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

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

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

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

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

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

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

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

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Place Outcomes Framework

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Place Outcomes Framework

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

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

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

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

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

Place Outcomes Framework – Linking delivery measures to outcomes

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Outcome 1
Keeping people healthy and preventing ill health

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

Outcome 3
Supporting staff wellbeing and retention

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

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

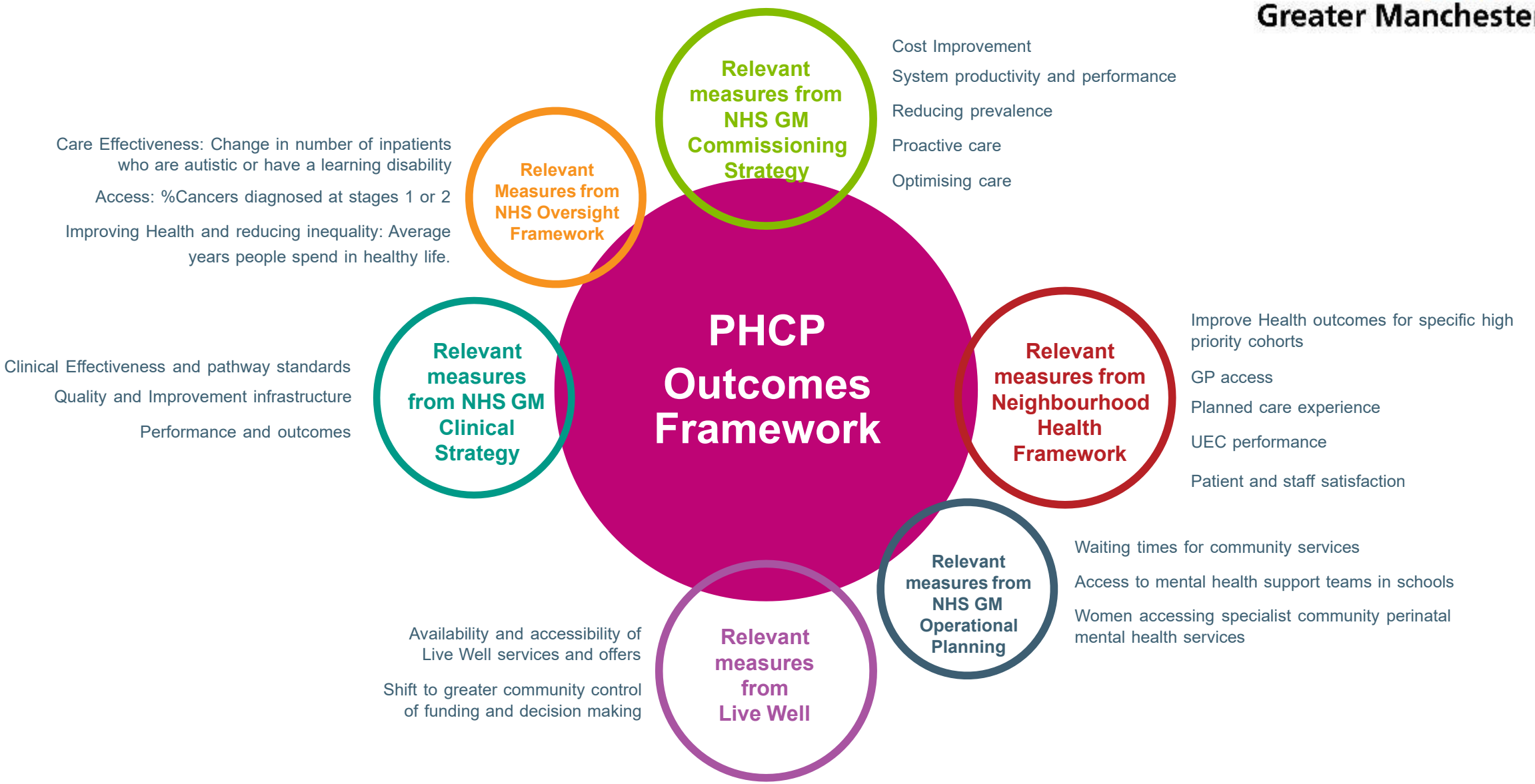
Uniform across all 10 PHCPs

Delivery measures

PHCP Specific

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

Outcomes Framework composition



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Place Fund

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Place Fund

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Agreed BCF services only. This is the Place Fund scope for 2026/27.

Existing legal mechanism. The Fund operates through Section 75 and Better Care Fund arrangements.

Not a delegated budget. The Place Partnership Board has joint oversight and influence, not delegated financial authority.

Authorised decisions. Formal decisions remain with the relevant ICB or local authority decision-maker.

Wider spend stays outside. Aligned expenditure may inform the Place picture but remains under its existing governance.

Shadow year, no formal change. 2026/27 supports learning and stronger controls; it does not set a future delegation timetable.

Future additions need approval. Scope, funding, decision rights, impacts, governance and transaction routes must be agreed first.

The Place Fund supports collective stewardship while preserving the statutory, financial and contractual accountability of the organisations that hold and transact funding.

What is included in the Place Fund?

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2026/27 Place Fund – agreed scope

Agreed Better Care Fund services only.
Established and transacted through existing Section 75 and BCF arrangements.

- Not a delegated budget; the Partnership Board provides joint oversight and influence.
- Formal decisions remain with authorised ICB or local authority decision-makers.

Aligned expenditure – outside the Fund

Wider place-relevant spend may inform the overall financial picture but is not part of the 2026/27 Place Fund.
It remains subject to the relevant organisation's governance and accountability.

- Current exclusions include, for example core primary care, continuing healthcare, children's social care and specified mental health services.

Potential future additions

Any proposal from 2027/28 is subject to separate design, stakeholder agreement and formal approval.

Before inclusion it must define:

- Scope, funding flows and decision rights
- Financial impacts, with transition arrangements
- Governance, assurance and the transaction mechanism

Future change is not pre-authorised: timing, scale and destination require separate assessment and approval, without destabilising existing services.

Place Fund: How this works in 2026/27

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2026/27: Shadow Year for the Place Fund

The agreed BCF services operate through existing Section 75 and Better Care Fund arrangements.

“Shadow year” does not confer delegated financial authority.

The Partnership Board shapes priorities and recommendations; formal decisions remain with authorised ICB or local authority decision-makers.

Financial information, approvals, actions and escalations must provide a clear, auditable trail.

Wider aligned expenditure remains outside the Fund and under existing organisational governance.

Learning and Development In-Year

During 2026/27 partners may use learning to:

Confirm the operating arrangements, governance and controls for the agreed BCF scope

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

Strengthen reporting, assurance and record keeping

No future delegation or launch date is committed; any later model requires separate agreement and approval.

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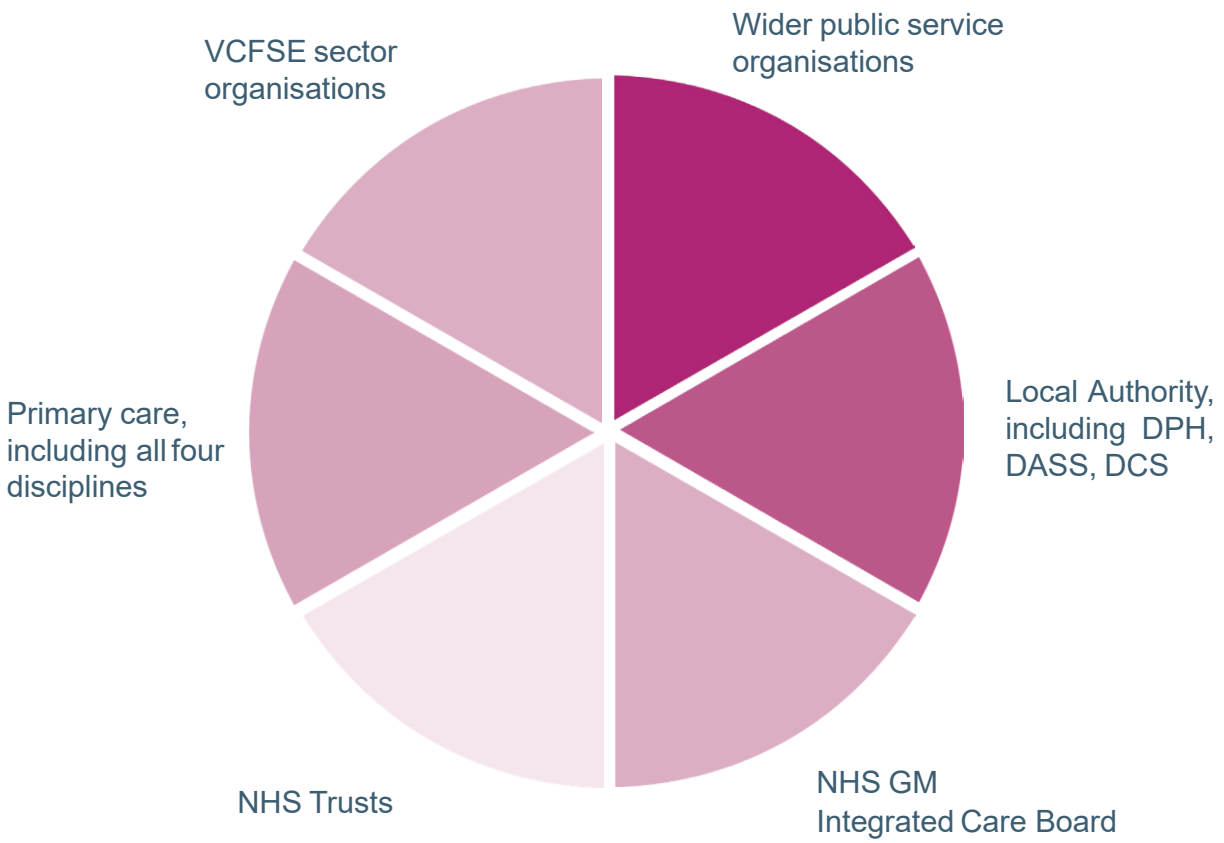
Place Team

including Place Delivery & Integration Service (providing dedicated hosted capacity for delivery, integration, improvement, performance, risk and assurance).

Part of Greater Manchester Integrated Care Partnership

The Place Delivery and Integration Service forms part of the wider multidisciplinary Place Team: Place governance sets priorities, NHS GM commissions and funds the service, and the NHS host remains the employer.

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Creating success through:

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

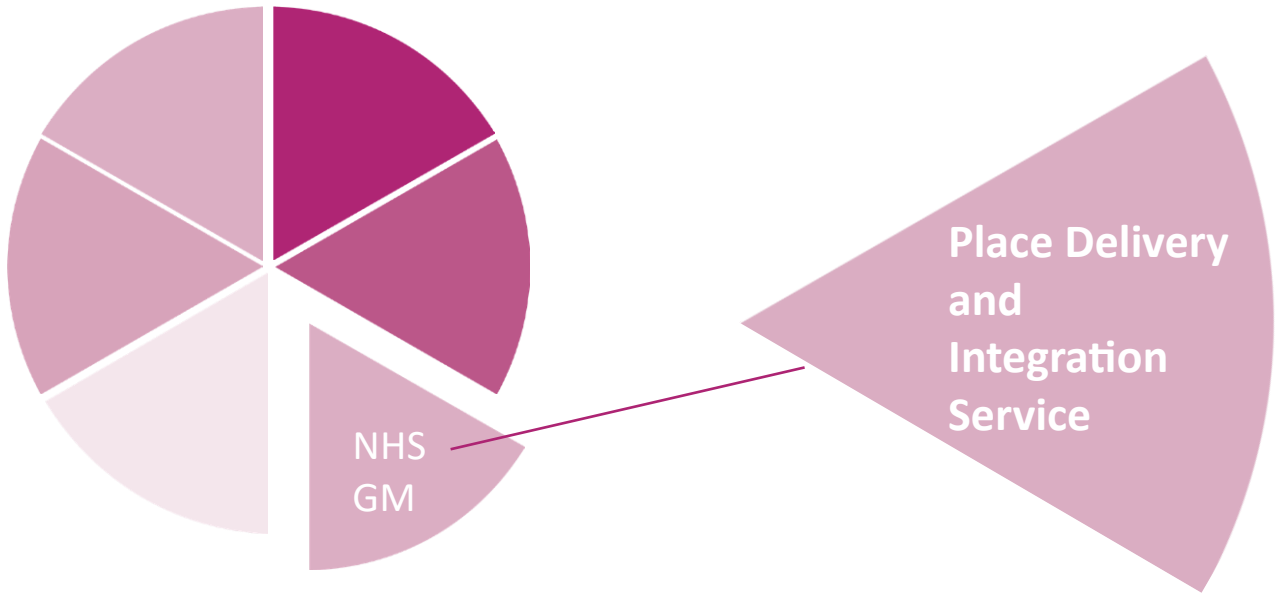
NHS GM contributes to the Place Team through leadership aligned to national policy, with specific investment in people and leadership roles to enable and drive integration, tailored to the local place context.

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NHS GM contributes alongside all partners

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

Components of the NHS GM Model Place Team



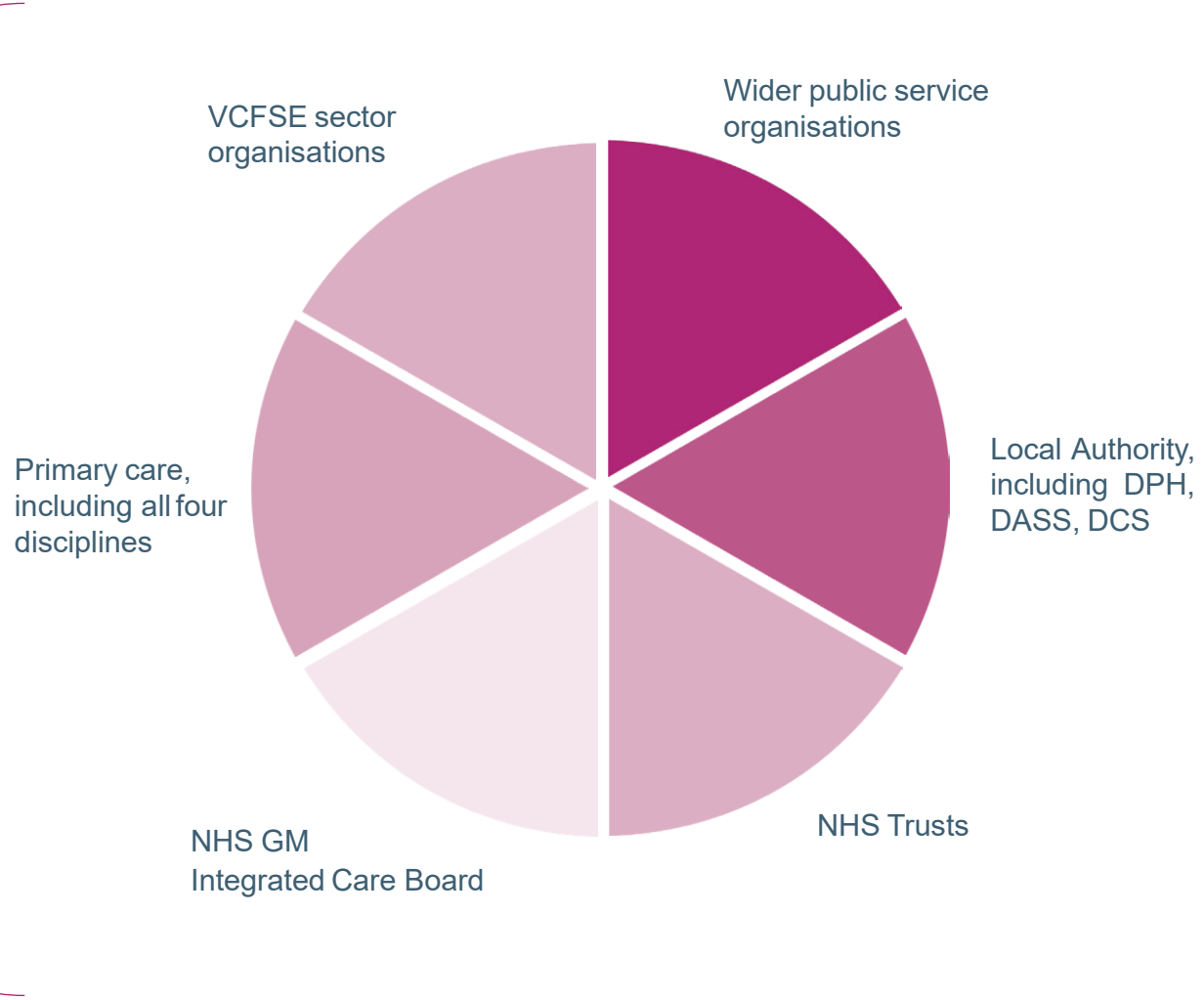
- Place Leadership & Integration
- Live Well & Neighbourhood health and care
- Pathway development & demand management
- Place governance and administration
- Clinical and care leadership

Setting up Place teams will be informed by context in each place rather than a one-size-fits-all.

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A series of potential scenarios is featured below:

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



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Governance

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Governance, Accountability, Oversight and Assurance Framework

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- The framework links three layers: partnership governance; resources and hosting; and accountability, oversight and assurance of outcomes.
- It establishes a consistent Greater Manchester core with local flexibility while preserving each organisation's retained statutory and contractual responsibilities.

Element	Arrangement	Governance
Outcomes & assurance	Place Outcomes Framework	Partnership Board owns the collective Place assurance position
Place Fund	2026/27 agreed BCF scope Operates through existing Section 75 arrangements	Authorised ICB / local authority decisions
Place Delivery & Integration Service	NHS GM commissions and funds NHS Trusts hosts the dedicated service Wider Place Team remains multi-partner	Place oversight; host retains employer duties Retained organisational accountabilities continue

The framework does not itself transfer statutory functions, create a separate legal entity or replace operative agreements. Detailed authority and obligations remain in the Partnership Agreement, Terms of Reference, Section 75 and hosting arrangements.

Layer 3 turns shared outcomes into accountable action

One governed evidence base drives Place judgement, named action and proportionate escalation - without diluting partners' retained duties.

1 EVIDENCE	2 INTERPRET	3 PLACE JUDGEMENT	4 ACT & RECOVER	5 ESCALATE / CLOSE
Agreed outcomes, neighbourhood intelligence, delivery updates and risks form one governed evidence pack.	Expert review tests trends, inequalities, variation, partner contribution and improvement confidence .	The Partnership Board records assured, partially assured or not assured—and the rationale.	Each action has an owner, deadline and milestones; support or a deep dive is used only where it adds value.	Material issues and themes move through GM and partner routes, with review dates and explicit de-escalation criteria.

ACCOUNTABILITY AND DECISION RIGHTS

- **Partnership Board** owns the collective assurance position for agreed Place outcomes and partner contributions.
- **Place Lead and delivery leads** convene the system and own operational action, improvement and review.
- **Partner organisations** retain statutory, financial, contractual, clinical, quality, safeguarding and employment duties; authority exists only through formal delegation.

REPORTING AND RECENT ACTIVITY

- **Routine reporting** quarterly review using one Place narrative: outcomes, inequalities, risks, actions and confidence.
- **Open design** metrics/data owners/thresholds, expert-review cadence and the detailed GM reporting route.

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

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Narrative Overview: Place Partnership Agreement

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

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

Definitions and Glossary

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

“Accountability”

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

“Agreement”

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

“Best for Place”

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

“Best for GM”

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

“Commissioning Organisation”

The organisation holding statutory or delegated responsibility for commissioning functions relevant to this Agreement (e.g. NHS GM or the local authority).

“Delivery Board”

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

“GM Operating Model”

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

“Greater Manchester (GM) Strategy”

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

“Integrated Neighbourhood Team (INT)”

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

“Local Care Organisation (LCO) / Provider Collaborative”

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

“Neighbourhood”

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

“Place Outcomes Framework”

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

“Partner” or “Partners”

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

“Partnership Board”

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

“Partnership Board Terms of Reference”

means the terms of reference for the Partnership Board, drawn up in accordance with section 8 of this Agreement, an initial example of which is at Schedule 4, as may be amended from time to time.

“Place”

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

“Place Funding Framework”

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

“Place Neighbourhood Plan(s)”

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

“Place Health and Care Partnership or PHCP”

The Partners working together in accordance with this Agreement.

“Population Health Management”

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

“Primary Care in Place”

Primary Care in Place, represented by an agreed mechanism determined locally (e.g., PCN Clinical Directors, GP Federation, Pharmacist, Optometrist or Dentist, or a democratically appointed representative(s)).

The representative(s) acts on behalf of the primary care sector, not solely their employing organisation, and holds a mandate defined in the Partnership Board Terms of Reference.

“Reserved Matters”

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

“Responsibility”

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

“VCFSE”

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

1. Purpose, Parties and Status of the Agreement

1.1 Context and Purpose

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

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

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

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

1.2 Parties

This Agreement is made between the following Partners:

- NHS Greater Manchester (NHS GM)
- [Name] Council
- [Acute Provider(s)]
- [Mental Health Provider(s)]
- [Community Provider(s) / LCO / Provider Collaborative]
- [Primary Care in Place]
- Voluntary, Community, Faith and Social Enterprise (VCFSE) partners
- Healthwatch [name]

Any additional organisations admitted by mutual agreement of all existing Partners.

1.3 Principles of Partnership

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

- collaboration is essential to improving outcomes;

- no Partner may be required to act unlawfully or contrary to statutory duties;
- decisions should be made collectively;
- representatives hold a formal right of objection to decisions that would create an unfunded transfer of workload or financial liability to their organisation/sector, without their explicit agreement; and
- trust, transparency and shared accountability are essential to success.

1.4 Status of the Agreement

The PHCP is not a legal partnership or a legal entity and cannot bind Partners or enter into contracts.

This Agreement is not an NHS Contract, nor is it a legal binding contract. However, the Partners do intend for it to be formally adopted as a clear expression of shared intent, setting out the commitments, behaviours and governance arrangements that all Partners agree to follow in exercising their respective roles within the PHCP.

Being a signatory to this Agreement does not create legal or financial liability beyond existing statutory responsibilities. Signatories commit to active participation, transparency, and stewardship of shared priorities.

Each Partner remains a sovereign organisation, retaining its own statutory duties, legal responsibilities, accountabilities, governance arrangements and decision-making authority.

Where any collective decision, recommendation or position of the PHCP conflicts with a Partner's statutory, contractual, fiduciary or governance responsibilities, the Partner's sovereign responsibilities shall take precedence. Partners will explain the basis of any such conflict and work collaboratively to identify alternative solutions that remain lawful and deliverable.

Decisions of the Partnership Board are advisory and influential rather than legally binding. Partners will give due regard to collective decisions but retain full authority to determine whether and how such decisions are implemented within their own organisations.

This Agreement supplements and aligns with but does not replace or supersede:

- Greater Manchester Strategy
- NHS GM Strategic Commissioning Strategy
- NHS GM Clinical Strategy
- Place Neighbourhood Plan(s)

- Services contracts
- Section 75 agreements
- Partnership Board and LCO / Provider Collaborative Terms of Reference

1.5 Inclusion of New Parties

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

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

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

2. Commencement and Term

2.1 Context

The PHCP operates within a dynamic environment where responsibilities, statutory frameworks and system priorities continue to evolve.

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

Partners recognise that maintaining the relevance, integrity and effectiveness of this Agreement is a shared responsibility. The commitments in this section ensure that the Agreement remains a living framework, actively stewarded, periodically reviewed, and updated in a way that strengthens collaboration rather than diluting it.

2.2 Term

- The Agreement takes effect from [date] and continues until [date] ("the Term"), unless terminated earlier by agreement of all the Partners.
- The Agreement will be reviewed periodically, ensuring it remains aligned with the Place Outcomes Framework, the GM Operating Model, Greater Manchester Strategy (GMS) and the needs of residents and communities.
- Partners will consider renewal, extension or variation no later than six months before the end of the Term, allowing sufficient time for internal governance processes across all Partners, as sovereign organisations.
- The Agreement may be updated at any time to reflect:
- changes in legislation or statutory responsibilities;
- developments in strategy, governance or delegated functions;
- material changes in the scope, ambition or operating model of the Place Health and Care Partnership.
- Any updates or variations will be agreed collectively through the Partnership Board and approved through each Partner's internal governance arrangements as necessary.
- Variations to this Agreement require:
- recommendation by the Partnership Board;
- approval through each Partner's sovereign governance;

- publication of an updated version and change log.

2.3 Withdrawal

A Partner may withdraw from this Agreement by giving a minimum of 6 months written notice to the Partnership Board, unless agreed otherwise by the Partnership Board. The transition arrangements will be agreed collectively by the Partnership Board to ensure continuity of Place responsibilities and avoid operational disruption.

3. Shared Vision, Purpose and Strategic Context

3.1 Why this matters

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

3.2 Greater Manchester Strategic Context

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

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

It also supports the wider Greater Manchester Combined Authority vision:

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

3.3 Place Vision

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

3.4 Purpose of the Agreement

This Agreement exists to:

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

4. Strategic Priorities and Place Outcomes Framework

4.1 Context

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

4.2 Strategic Priorities

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

- Strengthening our communities
- Helping people get into, and stay, in good work
- Recovering and improving core NHS and care services
- Helping people stay well and detecting illness earlier
- Supporting our workforce and carers
- Achieving financial sustainability
- Ensuring the best start in life for children and young people

4.3 Place Outcomes Framework

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

- **A narrowing of the healthy life expectancy gap between the most and least advantaged communities, alongside a general uplift for all residents,** measuring this through locally meaningful indicators of inequality, prevention, including giving children and young people the best start in life and early years development, anchored in what matters to people, such as "I feel supported to live a healthier life where I live.", and also ensuring the future sustainability of the NHS and support economic growth.
- **Increased proportion of care delivered in Neighbourhood settings,** reducing health inequalities, reliance on crisis services and enabling earlier support**.**

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

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

4.4 How the Place Outcomes Framework will be used

The Place Outcomes Framework will:

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

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

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

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

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

4.5 Place Outcomes Framework Principles

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

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

4.6 Place Outcomes Framework Structure

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

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

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

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

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

Delivery Measures: Uniform across the 10 Places

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

Delivery Measures: Place Specific

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

5. System Characteristics, Leadership and Culture

5.1 Context

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

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

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

5.2 Leadership Characteristics

Partners will adopt leadership behaviours that:

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

5.3 Cultural Characteristics

Partners will foster a culture that:

- **Places outcomes and tackling inequalities at the centre of decision-making**, ensuring all actions contribute to improved health, wellbeing and equity.
- **Recognises and addresses wider social, economic and commercial determinants of health**, working with partners beyond traditional health and care boundaries.
- **Uses shared data, intelligence and insight** to drive improvement, learning and prioritisation.
- **Engages residents and communities meaningfully**, ensuring lived experience shapes design, delivery and evaluation.
- **Communicates clearly, inclusively and transparently**, supporting trust, alignment and shared understanding.
- **Values the strengths of each Partner**, recognising that the diversity of organisations, skills and perspectives is a core asset of the PHCP.
- **Values an equal balance of influence across sectors,** ensuring that acute, community, mental health, primary care, VCFSE and commissioner partners contribute equitably to decision-making.
- **Recognise where organisational priorities may compete**, they will utilise the Best for Place, Best for GM principles to identify shared solutions and avoid unilateral decisions that undermine collective outcomes.
- **Supports matrix working**, enabling staff to collaborate across organisational lines with clarity, purpose and mutual respect.

5.4 The Place Team

The PHCP will operate through a Place Team; a virtual, multi-disciplinary team drawn from across all Partners. The Place Team:

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

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

5.5 Hosted and Ringfenced Roles

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

These roles may:

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

Where roles are designated as ringfenced, Partners will ensure that:

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

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

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

5.6 Application

These characteristics will be reflected in:

- **Leadership development**, ensuring leaders at all levels understand and model system behaviours.

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

6. Roles, Responsibilities and Collective Capability

6.1 Context

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

This Agreement strengthens neighbourhood integration, shared planning, and coordinated delivery. It is not intended to alter contractual obligations but provides a framework for joint working, shared intelligence, and aligned resource deployment.

6.2 Place Lead

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

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

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

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

6.3 Collective Resource and Capability Commitments

Partners agree that the PHCP is the primary forum through which the Partners will:

- **Develop a consistent and shared understanding** of what is meant by neighbourhood team working.
- **Align and coordinate resources** including financial, workforce, estates, digital and community assets to support shared priorities where appropriate and/or possible.
- **Deploy capabilities and expertise** from across organisations to support integrated delivery, transformation and improvement.

- **Share skills and leadership capacity**, recognising that no single organisation holds all the capabilities required to deliver population-level change.
- **Develop joint teams and shared functions** where appropriate and/or possible, particularly in areas such as neighbourhood delivery, analytics, transformation, programme management and community engagement.
- **Support workforce mobility and integration**, enabling staff to work across organisational boundaries where lawful and appropriate.
- **Maximise the contribution of the VCFSE sector**, recognising its unique reach, trust and insight within communities.
- **Strengthen analytical and improvement capability**, using shared data, intelligence and evaluation to drive decision-making.

6.4 Operationalising Shared Capability

To make this real, Partners will:

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

6.5 Hosted, Assigned and Ringfenced Workforce Arrangements

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

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

- roles that are formally hosted by one Partner on behalf of the PHCP;
- staff who are assigned, seconded or functionally aligned to Place delivery while remaining employed by their substantive organisation;
- capacity that is ringfenced, in full or in part, to support agreed Place programmes or functions; and/or
- the establishment of joint teams or shared functions, drawing on staff from across multiple organisations.

In all cases:

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

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

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

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

6.6 Commitment to Continuous Development

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

- Regularly review the skills, capacity and capability required to deliver the Place Outcomes Framework.
- Identify gaps and agree how these will be addressed collectively.
- Invest in leadership development and system behaviours.
- Support the development of a shared culture of improvement, where learning is openly shared and used to strengthen practice.

6.7 Collaboration Matrix

The PHCP will be supported by a clear and consistently applied Collaboration Matrix, which provides a shared understanding of how functions, duties and activities are distributed across the system. The matrix is a practical tool that translates the principles of shared accountability into an operational framework, ensuring that all Partners understand their respective roles.

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

reviewing the skills, capacity and capability required to deliver the Place Outcomes Framework."

The Collaboration Matrix is not a static document. It will be reviewed periodically to ensure it remains aligned with the GM Operating Model, delegated functions, and the evolving needs of residents and communities. Updates will be agreed collectively through the PHCP's governance arrangements and reflected in the Partnership Board Terms of Reference.

7. Place Funding

7.1 Context

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

7.2 The Place Funding Framework

Partners agree to operate within the shared Place Funding Framework (Schedule 2), which:

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

7.3 Principles of Place funding

The Place Funding Framework is underpinned by the following principles:

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

- **Alignment with GM:** Place funding arrangements operate within the wider GM financial framework, ensuring consistency and coherence.

7.4 Application

The Place Funding Framework will be used to:

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

7.5 Decision-making

Decision-making relating to the Place funding will follow the shared governance principles set out in this Agreement, as described in Section 8.

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

Where funds are hosted by a Partner organisation, the host will administer the funds but will not supersede the authority of the Partnership Board in determining their use, subject to statutory constraints, contractual or reserved matters.

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

Risk-sharing arrangements will be agreed collectively, including how financial pressures, overspends or savings are managed across Partners.

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

8. Governance and Decision-Making

8.1 Context

Effective governance is essential to the success of the PHCP. It provides the structure through which Partners exercise shared leadership, make collective decisions, and hold themselves to account for delivering improved outcomes for residents. Governance must be clear, transparent and

proportionate, enabling timely decision-making while respecting the statutory duties and sovereign responsibilities of each Partner.

The governance arrangements set out in this section 8 ensure that the PHCP operates with discipline, clarity and shared purpose. They also ensure alignment with the Greater Manchester Operating Model and wider system governance, creating a coherent framework from neighbourhood to GM level.

8.2 Governance Structure

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

- **A Partnership Board**

  The strategic leadership forum responsible for setting direction, agreeing priorities, overseeing the Place Neighbourhood Plan(s), and ensuring alignment with the GM strategy and the Place Outcomes Framework.
- **A Delivery Board** (e.g. LCO Board / Provider Collaborative Board)

  The operational leadership forum responsible for delivery of the Place Business Plan, management of performance, quality and risk, and coordination of integrated delivery across providers.
- **Supporting groups**

  Thematic groups for finance, quality, workforce, neighbourhoods, transformation and other functions as required, providing assurance, insight and operational coordination.
- These components operate as a single, coherent governance system.

  The detailed governance diagram, membership, reporting lines and operating model will be set out in the appropriate Terms of Reference.

8.3 Health and Wellbeing Board

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

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

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

8.4 Decision-Making

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

- **Consensus is the default**

  Decisions will be made by consensus wherever possible, reflecting the shared commitment to act in the best interests of residents and the system as a whole. Consensus means that no voting Partner formally objects to the proposed decision after reasonable discussion.

- **Best for Place, Best for GM principle**

  Partners will act in accordance with the Best for Place, Best for GM principle, ensuring that decisions are guided by outcomes, equity and the needs of communities.

- **Respect for statutory duties**

  No Partner will be required to act unlawfully, contrary to statutory duties, or in a way that compromises its organisational responsibilities. Where any collective decision, recommendation or position of the PHCP conflicts with a Partner's statutory, contractual, fiduciary or governance responsibilities, the Partner's sovereign responsibilities shall take precedence. Partners will explain the basis of any such conflict and work collaboratively to identify alternative solutions that remain lawful and deliverable.

- **Organisational sovereignty**

  Decisions of the Partnership Board are advisory and influential rather than legally binding. Partners commit to giving due regard to collective decisions, but retain full authority to determine whether and how such decisions are implemented within their own organisations.

- **Reserved matters**

  Certain decisions remain the responsibility of individual Partners, as sovereign organisations. These Reserved Matters will be respected and handled transparently within the governance process, documented with the Partnership Terms of Reference.

- **Conflicts of interest**

- All actual or potential conflicts of interest will be declared and managed in accordance with the PHCP's agreed process, ensuring impartiality and protecting the integrity of decision-making.
- **Disagreements**
- Where a Partner does not support a collective decision, they will set out their rationale, including any statutory or operational constraints, and work with Partners to mitigate impacts on shared priorities.
- **Clarity of escalation**
  Where consensus cannot be reached, issues will be escalated in line with the dispute resolution process set out in Section 11.

8.5 Accountability

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

- **The Partnership Board is collectively accountable**
  The Partnership Board is accountable to all Partners for the delivery of the Place Outcomes Framework, the Place Neighbourhood Plan(s), and the effective oversight of resources.
- **Sovereign accountability remains unchanged**
  Each Partner remains accountable to its own Board or Cabinet for the discharge of its statutory duties, financial responsibilities and organisational performance.
- **Accountability for hosted and ringfenced roles**
  Where staff or functions are hosted by a Partner or ringfenced to support Place delivery, Partners agree that:
    - statutory and organisational accountability remains with the employing organisation, unless explicitly varied through formal arrangements;
    - individuals may operate to Place-aligned objectives and priorities, agreed through the Partnership's governance structures;
    - governance arrangements will ensure clarity of reporting, decision-making and escalation routes, avoiding duplication or ambiguity; and
    - no arrangement under this Agreement shall be interpreted as transferring statutory duties, legal accountability or employer

liability between Partners, unless separate arrangements are formally agreed.

- **Mutual assurance**
  Partners will provide assurance to one another through transparent reporting, shared intelligence and open dialogue, ensuring that risks, issues and performance concerns are surfaced early and addressed collectively.

9. Transparency, Information and Learning

9.1 Context

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

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

Partners will operate a shared data-sharing protocol, in accordance with applicable data protection legislation and relevant guidance, covering what data is shared, how often, for what purpose, and under what safeguards.

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

9.2 Commitments

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

- **Communicate transparently with stakeholders and communities**
  Ensure that information about performance, outcomes and progress is communicated clearly and accessibly to residents, staff, Partners and wider stakeholders, supporting accountability and trust.
- **Share information openly and proactively**
  Provide each other with timely, accurate and relevant information required to deliver the Place Outcomes Framework, monitor performance, manage risk and support effective planning.
- **Ensure compliance with legal and regulatory requirements**
  Handle all information in accordance with data protection legislation,

information governance standards, Freedom of Information requirements, and competition law.

- **Protect commercially sensitive information**
  Identify and manage commercially sensitive information appropriately, ensuring it is shared only where necessary, with suitable safeguards, and in a manner that does not compromise legal or competitive obligations.
- **Promote a culture of learning and improvement**
  Foster an environment where learning is openly shared, mistakes are used constructively, and insights from residents, staff and partners inform continuous improvement.
- **Use shared data and intelligence to drive decision-making**
  Work collaboratively to develop and maintain shared analytical capability, ensuring that decisions are informed by robust evidence, population health insight and real-time system intelligence.
- **Support joint review and reflective practice**
  Participate in joint reviews, after-action learning, peer support and cross-organisational improvement activity, recognising that shared reflection strengthens system resilience.

9.3 Safeguards and Responsibilities

Partners acknowledge that:

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

9.4 Commitment to System Learning

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

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

10. Clinical Strategy

10.1 Clinical Governance

The PHCP will operate in full alignment with:

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

Partners agree to work together to:

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

Clinical governance at Place will focus on:

- Supporting the delivery of the GM Clinical Strategy at neighbourhood and Place level.
- Facilitating multi-professional clinical leadership and engagement in the development of pathways, redesign work and preventative models.
- Ensuring clinical quality, safety and learning are embedded in transformation and commissioning decisions.

Supporting INTs with structured clinical input and clear professional leadership connections to provider and NHS GM governance.

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

- Not duplicate provider clinical governance committees or NHS GM governance structures.
- Provide a shared space for coordination, visibility and joint action on cross-system clinical issues.
- Ensure a coherent two-way link with NHS GM's Clinical Governance Framework to support escalation, learning, risk management and clinical leadership.

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

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

10.2 Quality Oversight & Assurance

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

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

The PHCP will support quality by:

- Providing a shared space to triangulate data, intelligence and feedback from across primary care, community, acute, mental health, VCFSE and social care.

- Enabling early escalation of cross-system quality risks through existing NHS GM and provider governance routes.
- Promoting joint learning and improvement where themes affect multiple partners (e.g., interface safety issues, safeguarding learning, transitions of care, medicines-related harm).
- Ensuring quality is embedded in commissioning, transformation and service redesign decisions at Place.

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

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

Quality insight will be routinely fed into Place governance structures and used to inform priority-setting for INTs, Neighbourhood delivery, pathway redesign and resource allocation.

11. Problem Resolution and Escalation

11.1 Context

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

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

11.2 Principles

When managing disagreements, Partners will:

- seek to resolve issues informally and promptly, avoiding unnecessary escalation;
- ensure that discussions are timely, evidence-based and respectful;
- recognise that no Partner may be required to act unlawfully or contrary to statutory duties;

- ensure that escalation is used only when necessary, and in a way that supports resolution rather than blame;
- maintain continuity of services and minimise disruption to residents; and
- not cause unnecessary delay and will seek to complete the relevant stage of dispute resolution as promptly as is reasonably possible.

11.3 Place Approach

If a disagreement arises between Partners:

1. **Local Resolution**
    - Partners will first seek to resolve the issue informally between the individuals or teams directly involved.
    - Where appropriate, this may include facilitated discussion, joint review of evidence, or clarification of roles and responsibilities.
2. **Escalation to Operational Leadership**
    - If the issue cannot be resolved informally, it will be escalated to the relevant operational leads or senior managers within the organisations concerned.
    - These leaders will work together to agree a resolution, ensuring that all relevant information is shared transparently.
3. **Escalation to Partnership Governance**
    - If operational resolution is not possible, the matter may be escalated to:
        - the Delivery Board (for operational, performance or delivery issues);
        - the Partnership Board (for strategic, financial or system-wide issues).
    - The relevant Board will consider the matter in line with the PHCP's principles and agreed priorities.
4. **Escalation to Statutory Bodies**
    - Where the issue relates to statutory responsibilities, legal obligations, or matters that cannot be resolved within Place governance, the matter may be escalated through existing governance routes within:
        - NHS GM;
        - [INSERT NAME] Council;
        - or other relevant statutory bodies.
    - Partners will notify each other in writing if such escalation is required.

5. **Formal Dispute Resolution**

- If the issue remains unresolved after the above steps, the matter may be escalated through the formal dispute resolution process as follows:

a. Independent Facilitator

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

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

b. Mediation

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

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

c. Exit, termination or non-resolution

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

- that the Partner(s) involved in the dispute can withdraw from the PHCP;
- to terminate this Agreement in whole or in part; or
- that the issue need not be resolved.

11.4 Commissioning Level Disputes

Where a Commissioning Organisation is both:

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

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

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

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

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

11.5 Commitment to Learning

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

12. Review, Variation and Evolution

12.1 Context

The PHCP operates in a complex and continually changing environment. Legislation evolves, responsibilities shift, and new opportunities emerge as

our system matures. To remain effective, this Agreement must be treated as a living framework, actively stewarded, regularly reviewed, and adapted in a way that strengthens collaboration rather than diluting it.

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

12.2 Commitments

Partners agree that:

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

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

12.3 Transparency and communication

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

13. Signatures

(Signature blocks adapted for each Place.)

Schedule 1 - Place Outcomes Framework

Schedule 2 - Place Funding Framework

Schedule 3 - Place Team Approach

Schedule 4 -Example Terms of Reference for Partnership Board

Terms of Reference

[Place] Partnership Board

PROPOSED REVISED TEMPLATE

Template status: This document is a template Terms of Reference. Each Place must complete the locally variable provisions and secure approval through the governance arrangements of all Partners before adoption.

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1. Introduction

These are the Terms of Reference for the [Place] Partnership Board (the Board), which is the strategic leadership forum for the [Place] Place Health and Care Partnership (PHCP).

Unless otherwise stated, capitalised terms used in these Terms of Reference have the meanings given to them in the [Place] Place Health and Care Partnership Agreement (the Agreement).

These Terms of Reference set out the purpose, accountabilities, responsibilities, membership and decision-making arrangements required to enable the PHCP to work together to improve health and care for residents of [Place].

These Terms of Reference are aligned with the Agreement, the Place Fund, the Place Outcomes Framework, the Place Neighbourhood Plan(s), the GM Operating Model and any applicable Section 75 agreements.

2. Status and authority of the Board

The Board is not a separate legal entity and cannot bind a Partner, enter into contracts or exercise a Partner's statutory authority unless that authority has been expressly and lawfully delegated through a separate formal arrangement.

Decisions of the Board are advisory and influential rather than legally binding, except to the extent that a specific decision-making function has been expressly and lawfully delegated to the Board. Partners will give due regard to collective decisions while retaining authority over implementation within their own organisations.

Each Partner remains a sovereign organisation and retains its own statutory duties, legal responsibilities, accountabilities, contractual and fiduciary obligations, governance arrangements and decision-making authority. Where a collective decision conflicts with those responsibilities, the Partner's sovereign responsibilities take precedence.

Any formal delegation to the Board must be recorded in Appendix 3, including the delegating body, scope, financial limit, conditions, duration and reporting route. No delegation will be inferred from participation in the PHCP or from these Terms of Reference alone.

3. Purpose

Integrated health and care within local and Neighbourhood footprints provides a foundation for improving outcomes for communities and residents.

The PHCP is collectively responsible for improving outcomes, reducing inequalities and creating the conditions for people to live well.

The Board will set the strategic direction for health and care in [Place], agree priorities, oversee the Place Neighbourhood Plan(s), and support alignment with the Greater Manchester strategy for health and care and the Place Outcomes Framework.

The PHCP and the Board will promote equally shared leadership, distributed accountability and clear lines of sight between strategy, delivery and work undertaken at neighbourhood level.

4. Accountabilities

The PHCP is collectively responsible for coordinating the design and delivery of the Place Neighbourhood Plan(s), stewardship of Place-level resources and pursuit of the Place Outcomes Framework, subject to each Partner's statutory duties, contractual obligations, governance arrangements and decision-making authority.

The PHCP is accountable to all Partner organisations. Each Partner remains accountable through its own sovereign governance arrangements.

The Board is accountable for:

- aligning Partners around a shared set of outcomes;
- strengthening collaboration and shared accountability;
- ensuring children and young people are explicitly considered in strategy, priority-setting, outcomes and service planning;
- providing oversight and making decisions in relation to budgets only where shared financial authority has been expressly and lawfully delegated;
- overseeing the delivery of outcomes and any responsibilities expressly delegated to the Board under a documented and lawfully approved delegation;
- leading and influencing the shift towards prevention, early intervention and neighbourhood-based delivery;
- ensuring coherence between [Place] priorities and the strategic ambitions for Greater Manchester;
- providing clear and transparent reporting across Partners, with a focus on delegated accountabilities and responsibilities; and
- respecting each Partner's statutory duties, sovereign governance and Reserved Matters.

5. Responsibilities and duties

The Board will lead, monitor and track delivery of the PHCP's responsibilities, whether established through formal delegations or agreed by all Partners.

The Board is responsible for:

- setting the strategic direction of the PHCP;
- ensuring local communities can influence strategy and local service provision;
- ensuring the voices and needs of children, young people, families and carers inform strategy, delivery and evaluation;
- agreeing health and care-related strategies and plans for [Place], where these fall within the Board's authority;
- collective stewardship of financial sustainability and the PHCP's governance and risk management processes;
- overseeing any agreed arrangements for underspends, overspends, risks and gains, subject to the relevant legal and financial framework;
- modelling collaborative behaviours and integrated working;
- sharing best practice and supporting continuous learning and improvement;
- agreeing [Place]-specific metrics for Neighbourhoods and hyper-local areas within the flexibility permitted by the Place Outcomes Framework;
- using data, analysis and appropriate decision-making tools to support resilience, improvement and prioritisation;
- ensuring approaches extend beyond the NHS and social care alone;
- maintaining the relevance, integrity and effectiveness of the Agreement; and
- providing assurance to Partners, delegating bodies and other relevant parties.

6. Membership and chairing

Membership will comprise nominated strategic representatives of the Partners, including NHS Greater Manchester, the Local Authority, acute, mental health and community providers, Primary Care in Place, VCFSE Partners and Healthwatch, together with any additional Partners admitted in accordance with the Agreement.

The membership table below must distinguish between Partners, who are signatories to the Agreement, and any stakeholders or additional participants who attend but are not Partners.

Partner or sector	Nominated member	Approved substitute	Voting entitlement	Term
[Insert]	[Insert]	[Insert]	[Insert]	[Insert]
[Insert]	[Insert]	[Insert]	[Insert]	[Insert]
[Insert]	[Insert]	[Insert]	[Insert]	[Insert]

Primary Care in Place will be represented through the locally agreed mechanism. The representative will act with the mandate described in these Terms of Reference and will not be treated as having authority to bind individual practices or contractors unless expressly authorised.

The Chair and Deputy Chair will be appointed by [insert appointing body/process] for a term of [insert term]. [Insert whether the Chair and Deputy Chair have a vote and whether any casting vote applies]. If the Chair is absent or has a conflict of interest, the Deputy Chair or another member agreed by the Board will chair the relevant meeting or item.

7. Quoracy and decision-making

The Board will be quorate where at least two-thirds of voting members are present, including representation from [insert required Partners or sectors]. Approved substitutes count towards quoracy. A member who cannot participate in an item because of a conflict of interest will not count towards quoracy for that item.

Consensus is the preferred basis for decision-making. Consensus means that no voting Partner formally objects to the proposed decision after reasonable discussion. Abstention does not constitute agreement.

Where consensus is not achieved, and the matter is within the Board's authority and is not a Reserved Matter, it may be put to a vote. A decision will require two thirds of voting Partners present and entitled to vote. Each Partner will have one vote, as set out below.

Partner	Number of votes	Special conditions
VCFSE	1	[Insert]
Primary Care	1	[Insert]
Local Authority	1	[Insert]
Community & acute NHS Trust	1	[Insert]
Mental Health NHS Trust	1	[Insert]
NHS GM	1	[Insert]
Other – where relevant	1	[Insert]

Reserved Matters are listed in Appendix 2. They are outside the Board's authority and must be referred to the relevant Partner's sovereign governance arrangements. Appendix 2 will also identify any matters requiring unanimous approval by all Partners.

A representative may formally object to a proposed decision that would create an unfunded transfer of workload or financial liability to their organisation or sector without explicit agreement. The objection and supporting rationale will be recorded in the minutes. The proposed decision will not take effect for the objecting Partner unless expressly approved through that Partner's governance arrangements. The Board will consider mitigations or an alternative proposal.

Where consensus cannot be reached, the disagreement, rationale and any statutory, contractual, financial or operational constraints will be recorded and escalated through the problem resolution process in the Agreement. Pending resolution, no Partner will be committed to the disputed proposal, without prejudice to any existing statutory, contractual or regulatory duty.

All members will seek decisions that improve outcomes, reduce inequalities and support the wellbeing of residents in [Place], balancing Place priorities with organisational responsibilities and the ambitions and operating model of Greater Manchester.

8. Funding, Section 75 agreements and the Better Care Fund

Where the Board has a role in relation to the Place Funding Framework, a Section 75 agreement or the Better Care Fund, that role will be exercised only within the authority, financial limits, conditions, contractual requirements, Reserved Matters and governance arrangements expressly set out in the relevant agreement or formal delegation.

The Board will not be treated as having authority to allocate, reallocate or commit funds solely because a funding arrangement is referenced in these Terms of Reference.

Any locally applicable financial decision-making arrangements, risk and gain-sharing provisions, approval thresholds and reporting requirements must be recorded in Appendix 3 or cross-referenced to the relevant formal agreement.

9. Frequency and operation

The Board will meet no fewer than six times each year. Additional meetings may be convened by the Chair where required.

Agendas and papers will normally be circulated at least five working days before the meeting. Urgent or late business may be accepted by the Chair where necessary, with the reason recorded in the minutes.

Meetings will be held in public except where confidential, personal, commercially sensitive or legally privileged business requires an item to be considered in private. Each Place will ensure

this approach aligns with the governance requirements of any statutory body through which the Board reports.

The Board will work in close alignment with the local Health and Wellbeing Board, recognising its statutory role in setting the strategic direction for population health and tackling inequalities. Local arrangements must specify whether the Board is a formal subgroup, an advisory forum or a separate partnership body, together with the reporting and escalation route.

[Insert arrangements for decisions outside meetings, including circulation, response period, required threshold and subsequent recording.]

10. Reporting and information sharing

Partners will provide assurance to one another through transparent reporting, shared intelligence and open dialogue, ensuring risks, issues and performance concerns are surfaced early and addressed collectively.

Appendix 4 will specify reporting to Partner organisations, delegating bodies, the Health and Wellbeing Board and any relevant Section 75 governance, including frequency, information required, escalation thresholds and the responsible officer.

The Board will support lawful and proportionate information sharing through the PHCP's agreed data-sharing protocol. These Terms of Reference do not create a separate lawful basis for sharing personal, confidential or commercially sensitive information.

Draft minutes, decisions and actions will be prepared within ten working days and made available to Board members. Agreed records may be used by members to report through their own statutory or organisational governance processes.

11. Confidentiality and conflicts of interest

Effective partnership working depends on transparency, openness and trust, supported by appropriate confidentiality and information governance arrangements.

All Board members and participants are expected to act professionally and with integrity, having regard to their own codes of conduct and confidentiality obligations.

All actual, potential and perceived conflicts of interest will be declared, recorded and managed under the PHCP's agreed conflicts-of-interest process and, where applicable, the relevant Partner's policy. The Chair will determine appropriate management action, including withdrawal from discussion or decision-making. Where the Chair is conflicted, the Deputy Chair or another non-conflicted member will determine the action.

A register of interests and the management action taken will be maintained by the secretariat.

12. Administration and support

The PHCP will designate [insert lead organisation or shared secretariat arrangement] to coordinate agenda planning, papers, minutes, decision records, action tracking, publication and maintenance of the conflicts-of-interest register.

Where staff or functions are hosted, assigned or ringfenced to support Place delivery, governance arrangements will provide clear reporting, decision-making and escalation routes without transferring statutory duties, legal accountability or employer liability between Partners unless separate formal arrangements provide otherwise.

Partners will contribute proportionately and equitably to the administration and support of the Board, as agreed locally.

13. Review and effectiveness

These Terms of Reference will be reviewed at least every 12 months and earlier where there is a material change to legislation, delegations, governance, funding arrangements or the Agreement.

The Board will undertake an effectiveness review every 12 to 18 months, either as a focused review of these Terms of Reference or as part of a wider system governance review.

Any amendment must be approved through the same governance arrangements used to approve these Terms of Reference and recorded in a version-controlled change log.

Appendix 1: Document approval and version control

Field	Detail
Place	[Insert]
Version	0.3 proposed revised template
Approval body/bodies	[Insert]
Approval date	[Insert]
Effective date	[Insert]
Review date	[Insert]
Document owner	[Insert]

Appendix 2: Reserved Matters

Each Place must complete this appendix before adoption. Reserved Matters are decisions or responsibilities that remain solely within the statutory or sovereign authority of an individual Partner and cannot be delegated or determined collectively by the Board.

Reserved Matter	Responsible Partner/governance body	Required approval	Notes
[Insert]	[Insert]	[Insert]	[Insert]
[Insert]	[Insert]	[Insert]	[Insert]
[Insert]	[Insert]	[Insert]	[Insert]

Appendix 3: Delegations and financial authority

Delegating body	Delegated function or decision	Financial limit	Conditions and Reserved Matters	Duration	Reporting route
[Insert]	[Insert]	[Insert]	[Insert]	[Insert]	[Insert]
[Insert]	[Insert]	[Insert]	[Insert]	[Insert]	[Insert]

Appendix 4: Reporting and assurance schedule

Recipient/body	Report or assurance required	Frequency	Escalation threshold	Responsible officer
[Insert]	[Insert]	[Insert]	[Insert]	[Insert]
[Insert]	[Insert]	[Insert]	[Insert]	[Insert]

Appendix 5: Change log

Version	Date	Summary of change	Approved by
0.3	17 September 2026	Proposed amendments following review comments on the Partnership Agreement, including clarification of status, definitions, sovereignty, delegations, consensus, voting, Reserved Matters, financial authority, reporting and conflicts of interest.	Draft for review

Outcomes Framework: Narrative Introduction

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

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

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

Metric Ref	National framework/GM framework/ICB team	Metric Description	Rationale	Metric Type
		Reduce inequality		
Live Well/EX1	Live Well	% residents who feel confident in knowing where to go in their local area to access support for everyday needs	Deliver equity of access	Annual Oversight
PH2	ICB Team	Reduce smoking rates for adults: a rate of less than 5% by 2030 compared to the 2023 level of 12.5%	Healthy life for longer (relative to England as a whole) and we will reduce the gap in healthy life between the richest and poorest communities	Annual Oversight
LW2	Live Well	Reduce the percentage of adults who are obese	Healthy life for longer (relative to England as a whole) and we will reduce the gap in healthy life between the richest and poorest communities	Annual Oversight
PH1	ICB Team	Reduction in gap between lowest and highest IMDs for age of onset of multiple long term conditions (currently 15yr gap in gm)	To address health inequalities	Annual Oversight
OV8	Strategic Commissioning Plan	To improve Healthy Life Expectancy (HLE) (male/female/all) in GM so that it at least matches the NW of England by 2030	To address health inequalities	Annual Oversight
OV9	Strategic Commissioning Plan	To reduce the gap in HLE between most and least advantaged areas in GM in line with a 10-year ambition to at least halve that gap by 2035 (10 Year Health Plan ambition)	To address health inequalities	Annual Oversight
OF2073	NOF 26/27	Deprivation and ethnicity gap in pre-term births	To address health inequalities	Annual Oversight
OF0117	NOF 26/27	Deprivation gap in lipid and hypertension management	To address health inequalities	Annual Oversight
OF2056	NOF 26/27	% of eligible people supported by obesity prevention programmes	To address health inequalities	Annual Oversight
		Children and Young People		
EX5.1	Live Well	% young people who, through #BeeWell schools survey, agree they have hope and feel optimistic about their future.	Improve health outcomes with specific focus on children and young people as a high-priority cohort	Annual Oversight
E.A.6	Op Plan	Expand coverage of mental health support teams (MHSTs) in schools and colleges (including teams in training)	Improve health outcomes with specific focus on children and young people as a high-priority cohort	Delivery Metric - consistent across place
EH15	Op Plan	Number of women accessing Specialist Community Perinatal Mental Health Services (12-month rolling metric)	Improve health outcomes with specific focus on children and young people as a high-priority cohort	Delivery Metric - consistent across place
Chil1	ICB Team	Reduction in dental extractions in children due to dental cavities	Improve health outcomes with specific focus on children and young people as a high-priority cohort	Annual Oversight
Chil2	ICB Team	Reduction in high/very high unmet need for children with asthma (beccor)	Improve health outcomes with specific focus on children and young people as a high-priority cohort	Annual Oversight
Chil3	ICB Team	Reduction in smoking in pregnancy rates	Improve health outcomes with specific focus on children and young people as a high-priority cohort	Annual Oversight
LW8	Early Years Foundation Stage	School readiness as measured by the proportion of children achieving a GLD	Improve health outcomes with specific focus on children and young people as a high-priority cohort	Annual Oversight
LW2	Live Well	Reduce the percentage of children who are obese	Healthy life for longer (relative to England as a whole) and we will reduce the gap in healthy life between the richest and poorest communities	Annual Oversight
Live Well/AD4	Live Well	(a) No. of children re-referred into children’s social care within 12 months (b) No. of children stepped up from Early Help to Social Care*	A successful LW approach will strengthen and enrich existing approaches to early and targeted family help, providing early intervention for families experiencing challenges, helping children thrive within their own homes and reducing the need for intensive social care interventions Measures reflect success in	Delivery Metric - consistent across place
		Cancer		
OF0009	NHSOF	Percentage of all cancers diagnosed that are diagnosed at stage 1 or 2	Improve health outcomes for people with cancer through early diagnosis and treatment	Delivery Metric -
Can1	ICB Team	Cancer Screening rates	Improve health outcomes for people with cancer through early diagnosis and treatment	Delivery Metric -
		Long Term Conditions		
LiveWell/AD2	Live Well	% patients with long-term conditions repeatedly not taking up offers of support who are then identified and helped (“Missingness” positively addressed)	Improve health outcomes for people long term conditions - Initial phases focused of cardio-vascular disease, diabetes and respiratory conditions. Scope for wider expansion to a range of other long-term	Delivery Metric - consistent across place
OF0054	NHSOF	Percentage of patients with GP recorded CVD who have their cholesterol levels managed to NICE guidance	Improve health outcomes for people with CVD through improved diagnosis and treatment	Delivery Metric - consistent across place
OF0053	NHSOF	Percentage of hypertension patients treated to target	Improve health outcomes for people with hypertension through improved diagnosis and treatment	Delivery Metric - consistent across place
LD/SMI1	ICB Team	Increasing the proportion of people with Learning Disabilities (aged 14 and over) who receive an annual health check and personalised care plan	Improve health outcomes for people with Learning Disabilities through improved access to annual health checks and personalised care plans	Delivery Metric - consistent across place

SMI1	ICB Team	Increasing the proportion of people with SMI (aged 18 and over) who receive an annual health check and personalised care plan	Improve health outcomes for people with SMI through improved access to annual health checks and personalised care plans	Delivery Metric - consistent across place
		Imms		
Imms2	ICB Team	Childhood vaccinations	Improve health outcomes with specific focus on children and young people as a high-priority cohort	Delivery Metric -
Imms3	ICB Team	Winter illness vaccination rates	Improve health outcomes by prioritising individuals who benefit from vaccination as a key cohort	Delivery Metric -

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

National framework/GM framework/ICB team	Metric Description	Rationale	Metric Type
	Access to General Practice		
Live Well	% residents who say it is easy to contact their GP practice (GP Patient Survey)	Improve access to general practice so people can see their GP in a timely, high-quality way	Delivery Metric - consistent across place
National Neighbourhood Framework	90% of clinically urgent patients on the same day by March 2027	Improve access to general practice so people can see their GP in a timely, high-quality way	Delivery Metric - consistent across place
	CHC		
NHSOF	Percentage of continuing healthcare referrals completed in 28 days	Better co-ordination of care for high-priority cohorts	Delivery Metric - consistent across place
	Children and Young People		
National Neighbourhood Framework	Reduce acute outpatient appointments for children under the age of 16 by 10%	Improve quality and access to care for children and young people by enhancing paediatric expertise across the pathway, including primary care	Delivery Metric - consistent across place
National Neighbourhood Framework	Reduction of community waits for children, as part of delivering Medium Term Planning Framework success measures	Improve quality and access to care for children and young people by enhancing paediatric expertise across the pathway, including primary care	Delivery Metric - consistent across place
	Community		
National Neighbourhood Framework / NHSOF	For those adult patients not discharged on their DRD, the average (mean) number of days from the DRD to discharge	Ensure there is better co-ordination of discharge process and capacity planning across health and care services, enabling patients to be discharged efficiently and effectively. Contribute to an improvement in the average length of discharge delay	Delivery Metric - consistent across place
National Neighbourhood Framework	The proportion of adult patients discharged from acute hospitals on their discharge ready date (DRD)	Ensure there is better co-ordination of discharge process and capacity planning across health and care services, enabling patients to be discharged efficiently and effectively. Contribute to an improvement in the average length of discharge delay	Delivery Metric - consistent across place
Op Plan	Increased utilisation of Pharmacy First, Hypertension Case Finding, Contraception services	Better access in community and reduce reliance on others services	Delivery Metric - consistent across place
Op Plan	Reduction of community waits for adults, as part of delivering Medium Term Planning Framework success measures	Better access in community	Delivery Metric - consistent across place
	Elective		
ICB Team	A&G: deliver a 10% increase in requests for Advice & Guidance over 25/26 baseline in 2026/27	Improve experiences of planned care and support delivery of the referral to treatment (RTT) standard	Delivery Metric - consistent across place
ICB Team	Community: work with elective programme and local trust to design and implement a local community / Tier 2 provision for ENT and Gynaecology specialties in 2026/27 [Suggested Change to expand scope and longevity - Work with Elective programme and Trust to implement community/Tier 2 provision through 2026/27]	Deliver more follow-up outpatient care in neighbourhoods	Delivery Metric - consistent across place
ICB Team	Referral rates: reduce referrals by 5% across 10 specialties in 2026/27 vs 2025/26 baseline, in line with BeCCoR EQIS scheme	Improve experiences of planned care and support delivery of the referral to treatment (RTT) standard	Delivery Metric - consistent across place
National Neighbourhood Framework	Follow-up appointments: work with local Trust to redesign outpatient model to support reduction in follow-up appointments by at least 10% by March 2027	Improve experiences of planned care and support delivery of the referral to treatment (RTT) standard	Delivery Metric - consistent across place
	End of Life		
National Neighbourhood Framework	Better identify people coming to the end of life and improve access to services so people can die in a place of their choosing by increasing the number of people identified as approaching end of life by 10%	Better identify people coming to the end of life and improve access to services so people can die in a place of their choosing	Delivery Metric - consistent across place
National Neighbourhood Framework	Reduce non-elective admissions and bed days of one day or over by 10% for the end of life cohort by March 2029	Better identify people coming to the end of life and improve access to services so people can die in a place of their choosing	Delivery Metric - consistent across place
	Harm		
ICB Team	Reduction in medicines related harm through neighbourhood approaches	Improve safety of care	Delivery Metric - consistent across place
	Long Term Conditions		
National Neighbourhood Framework	Improvement of at least 10% in evidence-based clinical outcomes, measured through quality and outcomes framework standards for CVD, diabetes, COPD, mental health conditions and dementia	Better diagnosis and treatment for people with long-term conditions	Delivery Metric - consistent across place

ICB Team	Reduction in those with high/very high unmet need (CVD, Diabetes, Asthma, COPD) through neighbourhood approaches (beccor)	Improve health outcomes for people with long term conditions	Delivery Metric - consistent across place
NHSOF / National	Percentage of diabetes patients to receive all eight care processes	Better diagnosis and treatment for people with long-term conditions	Delivery Metric - consistent across place
Op Plan	Reducing the number of admissions to inpatient settings and reducing length of stay for people with learning disability and/or autism	Improved provision and co-ordination of care people with mental illness. Ensure there is better co-ordination of discharge process and capacity planning across health and care services, enabling patients to be discharged efficiently and effectively.	Delivery Metric - consistent across place
NHSOF	Percentage change in the number of inpatients who are autistic or have a learning disability	Improving lives of those with LD and/or autism	Delivery Metric - consistent across place
Op Plan	Reduce admission rates to mental health hospitals for people with a learning disability and autistic people	Improving lives of those with LD and/or autism	Delivery Metric - consistent across place
	Mental Health		
SCGCSINAWG	Average LOS (physical and mental health) to be improved	Improved provision and co-ordination of care people with mental illness. Ensure there is better co-ordination of discharge process and capacity planning across health and care services, enabling patients to be discharged efficiently and effectively.	Delivery Metric - consistent across place
ICB Team	Reducing the number of people presenting to A&E in mental health crisis (all age)	Improved provision and co-ordination of care people with mental illness. Ensure there is better co-ordination of discharge process and capacity planning across health and care services, enabling patients to be discharged efficiently and effectively.	Delivery Metric - consistent across place
ICB Team	Reduction in CRFD for adults, older adults and rehab patients in MH inpatient settings	Improved provision and co-ordination of care people with mental illness. Ensure there is better co-ordination of discharge process and capacity planning across health and care services, enabling patients to be discharged efficiently and effectively.	Delivery Metric - consistent across place
	UEC		
National Neighbourhood Framework	Reduce category 3 and 4 ambulance conveyances in high-priority cohorts (those with mid to severe frailty, in a care home or housebound and end of life) by March 2029	Have fewer ambulance call-outs for the least urgent cases, with appropriate diversion to relevant urgent care provision in the community.	Delivery Metric - consistent across place
National Neighbourhood Framework	Reduce non-elective admissions and bed days of one day or over by 10% for people with mild to severe frailty, in a care home or housebound by March 2029	Help people with mid to severe frailty, in a care home or housebound, to stay healthier, manage escalating conditions and maintain greater independence for longer.	Delivery Metric - consistent across place
National Neighbourhood Framework	Keep growth flat and work towards an overall reduction in non-elective admissions for high priority cohorts	Better co-ordination of reactive care for high-priority cohorts (those with mid to severe frailty, in a care home or housebound and end of life), increasing use of urgent care provision in the community. For example, by making	Delivery Metric - consistent across place
National Neighbourhood Framework	Contribute to an overall reduction in type 1 ED attendances for high priority cohorts	Better co-ordination of reactive care for high-priority cohorts (those with mid to severe frailty, in a care home or housebound and end of life), increasing use of urgent care provision in the community. For example, by making	Delivery Metric - consistent across place
	Live Well infrastructure		
Live Well	% of neighbourhoods in each locality with a Live Well access point (Centres and Spaces) % LW centres offering: I. Employment support pathway II. Housing support and advice III. **Mental health & wellbeing support** IV. **Primary care** V. Debt advice & income support*	The ambition through LW is for residents to be able to access support in their local area, with "priority offers" available through their local access points. The metric reflects the five proposed priority offers at the time of writing	GMS Implementation monitoring

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

Metric Ref	National framework/GM framework/ICB team	Metric Description	Rationale	Metric Type
		Workforce		
Live Well/WOW 3	Live Well	% of frontline workers in Live Well roles reporting feeling fully integrated into the wider health, care and other public services in their area	Improve staff satisfaction	Delivery Metric - consistent across place
OF0082	NHSOF	Staff sickness rate	Improve staff satisfaction - drawn from across the entire partnership from several inputs to provide the most accurate picture	Delivery Metric - consistent across place
OF0061	NHSOF	Staff survey – raising concerns sub-score	Improve staff satisfaction - drawn from across the entire partnership from several inputs to provide the most accurate picture	Delivery Metric - consistent across
OF0084	NHSOF	Staff survey engagement theme score	Improve staff satisfaction - drawn from across the entire partnership from several inputs to provide the most accurate picture	Annual Oversight
Ref TBC	NHSOF	Staff survey - We are compassionate and inclusive headline metric score	Improve staff satisfaction, wellbeing and retention drawn from across the entire partnership from several inputs to provide the most accurate	Annual Oversight
Ref TBC	WRES	WRES indicator 5 - %staff experiencing harassment, bullying or abuse from patients/relatives/public	GM agreement via the ICP to combat racism and support staff and communities.	Annual Oversight
Ref TBC	WRES	WRES indicator 6 - %staff experiencing harassment, bullying or abuse from colleagues, managers	GM agreement via the ICP to combat racism and support staff and communities.	Annual Oversight
Ref TBC	WRES	WRES indicator 8 - %staff experiencing discrimination at work from managers, team leaders, colleagues	GM agreement via the ICP to combat racism and support staff and communities.	Annual Oversight
Ref TBC	NHSOF	Staff mix - agency spend as % of total temporary staffing/ Bank vs agency spend split	Improve staff retention	

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

Metric Ref	National framework/GM framework/ICB team	Metric Description	Rationale	Metric Type
		Experience		
Nat20B	National Neighbourhood Framework	By 2027 95% of people with complex needs will have an agreed care plan	Take a proactive approach, where the patient feels in control of their care	Delivery Metric - consistent across place
OV12	Hospital experience scores to be improved	Hospital experience scores to be improved	Improve patient satisfaction with NHS services	Annual Oversight
Nat10	National Neighbourhood Framework	Improve patient satisfaction with GP access	Improve access to general practice so people can see their GP in a timely, high-quality way	Annual Oversight
ICB	Local	Improve shared decision making	Improve satisfaction with NHS services	Annual Oversight

Team				
OV13	Strategic Commissioning Plan	Mental Health services experience scores to be improved	Improve patient satisfaction with NHS services	Annual Oversight
		Financial stability and productivity		
ICB Team	ICB Team	Place delivers a level of financial efficiency, which a minimum will be the national efficiency requirement (set annually)	To deliver financial stability	Delivery Metric - consistent across place
ICB Team	ICB Team	Place delivers an improvement in productivity and accessibility for the services within the scope of the Place Fund – specific metrics TBC	To deliver financial stability	Delivery Metric - consistent across place
ICB Team	ICB Team	Place delivers at least a balance position with the funding available via the Place Fund (set annually)	To deliver financial stability	Delivery Metric - consistent across place
ICB Team	ICB Team	Place delivers non-financial savings through demand management initiatives - specific metrics TBC	To deliver financial stability	Delivery Metric - consistent across place
NEW	ICB Team/Place Partnership	Clearly identified opportunities to increase and deliver more through the Place Fund).	Over time, and subject to agreed processes, additional budgets may be aligned into the Place Fund using a consistent GM-wide methodology.	Delivery Metric - consistent across place
LW /WOW4	Live Well	Shift to greater community control of funding and participation in decision-making around how public money is spent Share of implementation support funding to VCFSE	This aligns with the Strategic Financial Framework's emphasis on: A further key pillar of LW is: "a resilient VCFSE ecosystem" – creating the conditions for a resilient and connected VCFSE sector resourced to respond to what matters to people, with community-led approaches at its heart. This metric speaks to the central ambition of LW to promote a shift to greater control of funding.	GMS Delivery Monitoring
		Quality		
IMPR1	ICB Team	Increase in QI capabilities (as evidenced by QI skills question on staff survey)	Embed quality improvement methodology	Annual Oversight

TAMESIDE STRATEGIC PARTNERSHIP COMMITTEE (TSPC)

Meeting Date	Oct 26	Public	X	Confidential		Agenda item
Title of Report	Place Report					
Lead Director / Executive Member / Clinical Lead	Marion Colohan, Deputy Place Based Lead for Tameside					
Author	Marion Colohan, Deputy Place Based Lead for Tameside					

Outcome Required (please indicate)	Approval	Assurance	Discussion	Information
			x	x
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 Committee remains up to date on the latest developments relevant to the Tameside system.

2 Updates

Tameside Update

2.1 Neighbourhood Integration – GM Assurance Cycle

Tameside has completed its October submission for the GM Neighbourhood Integration Assurance Cycle, which reviews maturity across:

- Multi-disciplinary team functioning
- Data-enabled population health management
- Community asset mobilisation
- Early help and prevention alignment
- GM feedback highlights Tameside's strong MDT model and recommends further development of shared digital tools and neighbourhood-level outcomes dashboards.

2.2 Tameside Urgent & Emergency Care (UEC) – GM Winter Readiness Review

Following GM's October UEC Board review, Tameside has been asked to:

- Increase same-day emergency care (SDEC) throughput by 12% by January 2027
- Expand frailty virtual ward capacity to support winter admission avoidance
- Strengthen community-based respiratory pathways in line with GM's winter respiratory strategy

These actions align with GM's system-wide winter resilience plan.

2.3 Tameside Primary Care – GM Access & Modernisation Programme

GM's Primary Care Board has confirmed that Tameside will be part of the next wave of:

- Digital telephony upgrades
- Advanced care navigation training
- Access improvement collaboratives

Tameside practices have been selected for GM's October pilot on appointment data transparency, enabling real-time publication of available slots.

2.4 Tameside Mental Health & LD – GM Collaborative Priorities

The GM Mental Health & LD Collaborative has issued new October priorities:

- Expansion of community crisis alternatives
- GM-wide rollout of the Trauma-Informed Workforce Framework
- Strengthening transitions between CYP and adult mental health services

Tameside is contributing to the GM pilot on trauma-informed neighbourhoods.

3 NHS GM ICB Update

3.1 GM Quality & Performance Report – October 2026

Key GM-wide issues highlighted in the October Quality & Performance Report include:

- Cancer 62-day performance remains below national trajectory, with GM launching a targeted improvement programme focusing on diagnostics and pathway redesign.
- Category 2 ambulance response times have improved slightly but remain challenged; GM is scaling up community falls response models.
- Elective recovery continues to stabilise, with GM achieving its target for reducing 65-week waits.

3.2 GM Finance Committee – October Position

The GM Finance Committee reports:

- A system deficit position driven by acute provider pressures, agency spend and inflationary impacts.
- GM-wide controls on non-essential recruitment and discretionary spend.
- A new GM programme on financial sustainability at Place, requiring each locality to produce a Place-level financial improvement plan by December 2026.

3.3 GM Workforce & OD Board – October Workforce Themes

The October Workforce Board highlights:

- Continued pressure in district nursing, mental health inpatient staffing, and sonography.
- GM-wide rollout of the Integrated Workforce Hub Model, supporting shared recruitment, rotational posts and cross-provider workforce planning.

- Launch of the GM Retention Framework, focusing on flexible working, wellbeing, and career development.

3.4 GM CYP Transformation Board – October Priorities

New GM CYP priorities include:

- Implementation of the GM CYP Access & Flow Model, improving referral pathways and reducing waiting times.
- Expansion of school-based mental health support teams, with GM aiming for full coverage by 2028.
- GM-wide review of SEND neurodevelopmental pathways, with a new commissioning framework due in early 2027.

3.5 GM ICPB – October Strategic Themes

The GM Integrated Care Partnership Board (ICPB) October meeting focused on:

- GM's role as a Prevention Demonstrator under the new devolution arrangements
- Development of the GM 10-Year Health & Wellbeing Strategy
- Strengthening Place-level autonomy and accountability
- A new GM commitment to neighbourhood-level public service integration, spanning health, social care, early help, policing, housing and VCFSE partners

3.6 GM Joint Forward Plan – October Refresh

The October refresh of the GM Joint Forward Plan introduces:

- A new GM-wide Long-Term Conditions Improvement Framework
- A revised GM Digital & Data Strategy, including shared care record enhancements and neighbourhood-level data tools
- A GM commitment to expand community rehabilitation, with a new model to be implemented from April 2027

3.7 GM Public Health & Prevention – October Publications

GM's October prevention publications highlight:

- A GM-wide Healthy Weight Strategy, including targeted interventions for children and young people
- A new GM Tobacco Control Programme, aiming to reduce smoking prevalence to below 10% by 2030
- Expansion of the GM Active Travel & Physical Activity Framework, with neighbourhood-level delivery expectations.

3. Recommendations

The Committee is asked to:

- **Note** the updates contained within the report
- **Note** implications for Tameside, particularly relating to:
  - GM winter readiness requirements

- GM financial sustainability expectations
- GM prevention demonstrator opportunities
- Workforce pressures and neighbourhood integration priorities

Access to Information:

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

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e-mail: marion.colohan@nhs.net

TAMESIDE STRATEGIC PARTNERSHIP COMMITTEE (TSPC)

Meeting Date	28 October 2026	Public		Confidential		Agenda item
Title of Report	Beyond Core Contract (Beccor) Neighbourhood Health and Population Plan – Tameside Approach					
Lead Director / Executive Member / Clinical Lead	Marion Colohan					
Author	Christopher Martin					

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 paper sets out the PCN submissions of the Prevention, Population Health and Neighbourhoods action plan to support review of the six priority cohorts within this section of the Beccor scheme and the assurance process followed with Tameside Place once the submissions were received.

Recommendations:

To note the plans submitted by each PCN and the assurance process by Tameside Place officers.

Financial implications:

Alignment with the Joint Health and Wellbeing and Locality Plan:

Where issues are addressed in the paper -	
	Section of paper where covered
Regulatory and legal compliance	
Sustainability (including environmental impacts)	
Quality impacts	
Safeguarding impacts	
Risks	
Views and recommendations of the Clinical and Care Professional Advisory Group	
Views of the population / users	

The paper relates to the following CQC domains and Locality priorities - ✓			
X	Safe	X	Effective
X	Caring	X	Responsive
X	Well-Led	X	Use of Resources
	Joint Health & Wellbeing Strategy & Locality Plan	X	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: Christopher Martin

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e-mail: christopher.martin4@nhs.net

1. INTRODUCTION

1.1 The Beyond Core Contract (Beccor) scheme is a programme of work commissioned by the Greater Manchester primary care team. It consolidates and replaces each individual Place's Locally Commissioned Services, except for some locally retained elements.

1.2 The scheme contains the following five sections:

- **1.2.1** General Practice Quality and Sustainability
- **1.2.2** Elective Transformation
- **1.2.3** Prevention, Population Health and Neighbourhoods
- **1.2.4** Medicines Optimisation
- **1.2.5** Locality Retained Elements (Tackling Inequalities, Neighbourhoods and Supporting Demand Management in Place)

1.3 This paper focuses on the Place responsibilities and requirements within section 3 – Prevention, Population Health and Neighbourhoods.

2. PREVENTION, POPULATION HEALTH AND NEIGHBOURHOODS SECTION OF BECCOR

2.1 The aim of section 3 is to implement at scale a combined Population Health Management and Neighbourhood/Live Well model that:

- **2.1.1** Identifies and prioritises people with high unmet clinical need across selected long-term condition cohorts, leading to optimised clinical care
- **2.1.2** Supports completion of high-impact cohort-based reviews and optimisation actions to prevent worsening ill health and reduce avoidable urgent care use (including avoidable ED attendances)
- **2.1.3** Further strengthens existing neighbourhood partnerships and Live Well pathways to improve engagement and holistic support for people who are not engaging and/or have additional non-medical needs that impact health outcomes.

2.2 It consists of the following three sections:

2.2.1 Section 3a – outlines the cohorts for an enhanced review. The scheme details what must be contained within that review with the aim being to focus on conditions that drive significant morbidity, urgent and emergency care use and health inequalities. The cohorts are:

2.2.1.1 CVD and Diabetes High Need (core)

2.2.1.2 CVD and Diabetes High Need + ACR (stretch)

2.2.1.3 Primary Prevention – High QRISK

2.2.1.4 COPD High Need

2.2.1.5 Adult Asthma High Need

2.2.1.6 CYP Asthma High Need

2.2.2 Section 3b – Agreeing a Beccor Neighbourhood Action Plan with neighbourhood partners. The aim of this plan is for agreed neighbourhood focused interventions to overcome identified barriers to accessing clinical care for hard-to-reach people within the cohorts described in the above section.

2.2.3 Section 3c – this is a funding stream called the Neighbourhood Prevention Allocation, which is designed to support PCNs. This can be disbursed at practice level or at PCN level. Following a process of engagement where PCNs engaged with their member practices, this element is being delivered at PCN level in Tameside Place. This process was discussed at Tameside Strategic Partnership Board in June 2026.

2.3 The deadline for submitting the action plans via the Beccor landing page within the GM ADSP was 30 September 2026. All four Tameside PCNS submitted their plans within this timescale.

2.4 The management of this element of Beccor sits within each Place, rather than at Greater Manchester. A Neighbourhood Plan Review Panel of Place officers took place on 7 October 2026 to review and assure the plans. This consisted of officer of Tameside Place.

2.5 The plans and the assurance process were discussed at the Tameside General Practice Alliance (TGPA) on 7 October 2026, after the Review Panel had taken place. This fulfilled the requirement within the specification that Place GP boards, which is the role the TGPA has in Tameside Place, should be involved in the assurance process. Feedback from that

2.6 meeting was that the TGPA should be involved in the review panel should the same format be required within 2027/2028 Beccor, which was accepted.

2.7 Plans need to be reviewed on the following criteria:

2.7.1 Good value for money

2.7.2 A focus on improvement outcomes for the core cohorts (with potential for wider benefit)

2.7.3 Co-designed and delivered with neighbourhood partners

2.7.4 Supporting neighbourhood working and key strategic priorities

2.8 Submitted plans from each PCN are embedded within Appendix One.

2.9 The Neighbourhood Plan Review Panel was assured that the submitted plans complied with the criteria described above and this has been shared with GM colleagues, within the terms of the Beccor specification. This has been communicated to the four Tameside PCNs.

3. RECOMMENDATIONS

3.1 To note the submitted plans and the Place process for assuring them.

APPENDIX ONE

Ashton PCN Plan



260928.Ashton.Com
pleted.Submission.p

Denton, Audenshaw and Droylsden PCN Plan



260930.DAD.Submis
sion.pdf

Hyde PCN Plan



260928.Hyde
Completed Submissi

Stalybridge PCN Plan



260917.Stalybridge.
Submitted.Plan.pdf

View results

Respondent

4 Anonymous

46:38
Time to complete

About this submission

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

1

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

Ashton Neighbourhood: Reaching the Unreachable to meet their unmet Long-Term Condition Needs

2

Who is submitting this plan? *

- PCN
- Single practice
- Group of practices not submitting as a PCN

3

Name of the submitting PCN or practice(s) *

Ashton Pcn

4

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

Dr R B Jha - PCN Clinical Lead
Gemma Douglas - PCN Lead Nurse
Shabeel Ahmad - PCN Lead Pharmacist
Suzanne Rowell - PCN Business Manager

5

Name of the neighbourhood *

6

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

Ashton Neighbourhood Group and Ashton Primary Care Network Board Meetings

7

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

02/09/2026 and08/09/2026

Core cohort and target group

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

8

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

Ashton-Under-Lyne

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

9

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

Not applicable

10

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

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

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

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

11

Which population or inequality characteristics actively shape the plan? *

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

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

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

12

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

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

The target group is people registered with Ashton PCN practices who fall within the selected cardiovascular, diabetes, kidney disease, adult and childhood asthma, COPD and high QRISK BeCCoR cohorts. Priority will be given to people with missing or overdue reviews, repeated non-attendance, outstanding treatment optimisation, multiple long-term conditions, frailty, high deprivation scores or newly diagnosed conditions requiring optimisation. The plan will particularly focus on people living in areas of higher deprivation and those whose access or engagement is affected by health literacy, language, employment, caring responsibilities, housing, income, mental health, social isolation or other wider determinants of health. This includes working-age adults who struggle to attend daytime appointments, children and families who may be reached through schools and family settings, housebound or high-risk patients, and people experiencing homelessness or other inclusion-health needs. Cohorts will be identified and refreshed monthly using the GM Intelligence Hub and GP IT searches, with data-quality support for validation and prioritisation.

13

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

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

11720

Please enter a whole number

Need, barriers, intended improvement and measurement

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

14

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

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

Ashton-under-Lyne has areas of high deprivation alongside higher smoking prevalence and high rates of cardiovascular disease, diabetes and COPD. The neighbourhood plan identifies lower engagement with routine reviews, unmet need among people with multiple long-term conditions and avoidable urgentcare use or unplanned admissions. Long-term condition outcomes are affected not only by clinical need but also by housing, income, employment, health literacy, language barriers, mental health, loneliness, caring responsibilities and access to support. Existing practice-based recall and daytime appointment models do not reach everyone consistently.

Neighbourhood working offers an opportunity to combine clinical reviews with trusted community routes and wider support. Ashton PCN practices can use common cohort searches and prioritisation, while local authority teams, Be Well, Live Well, social prescribing, VCFSE organisations, school nurses, community pharmacies and specialist services contribute local insight, accessible venues, engagement and onward support. Outreach in community settings, schools, workplaces and patients' homes, together with evening and walk-in access, is intended to reach people who have not responded to standard approaches.

The approach will prioritise patients with the greatest combination of unmet clinical need and inequality. It will use data to identify cohorts, but will remain flexible so delivery can be adjusted in response to partner feedback, patient experience and learning during implementation.

15

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

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

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

16

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

Select the one measure that best shows whether the main improvement is being achieved.

If you select "Other", type the primary measure in the text box that appears.

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

17

What is the current baseline for the primary measure? *

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

Practice average baseline 23.94%

18

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

These are other things not selected as your primary measure above that you would want to measure as the project progresses. These might help show wider benefit (secondary measures) or possible unintended effects (balancing measures). Do not repeat the primary measure and leave blank if none.
For each additional aim try to ensure it is Specific , Measurable, Achievable, Realistic and Timebound

1. By 31 March 2027, monitor the number and proportion of the defined target group with missing or overdue reviews, comparing monthly extracts with the agreed baseline.

2. By 31 March 2027, monitor the number and proportion of reviewed patients for whom clinical action is completed, treatment is optimised or the patient is treated to target.

3. Monitor monthly uptake of Live Well, social-prescribing or community support following neighbourhood activity, alongside the number of outreach contacts, evening or walk-in attendances and home visits as supporting activity measures.

19

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

Using the baseline above, state the intended amount or direction of change for the defined target group. Where relevant, identify any part of the target group for whom improvement is particularly important.
Example: "Reduce the proportion of [target group] with a missed or overdue review from 25% to 15% by 31 March 2027, with a particular focus on people living in areas of higher deprivation."

By 31 March 2027, Ashton-Under-Lyne neighbourhood aims to complete at least 80% of the required BeCCoR reviews or relevant key checks for the identified cohorts, where achievable within available capacity and agreed scheme requirements. Progress will be measured against the validated baseline established from the BeCCoR dashboard or GP IT searches. Particular focus will be placed on people with high unmet need, missed reviews, multiple long-term conditions, frailty and those living in areas of higher deprivation. Delivery and the trajectory will be reviewed regularly so that outreach locations, contact methods and clinic capacity can be adjusted in response to uptake and learning.

Co-design, delivery and neighbourhood fit

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

20

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

Describe the activities or changes in approach, including any targeted outreach, changes to access or recall, clinical action, referral pathways or wider support.
Explain how these respond to the needs and barriers identified above.

Cohorts will be identified monthly through the GM Intelligence Hub and GP IT searches. Patients with high unmet need, deprivation, multiple long-term conditions, frailty, missed reviews or new diagnoses requiring optimisation will be prioritised.
Delivery will combine practice-based and neighbourhood access. Rotating outreach clinics will be developed with partners in Community settings, places of worship, food banks and homelessness services. Sessions may include BeCCoR reviews, blood pressure checks, inhaler technique, smoking-cessation support and links to Live Well or wider services. Alongside this, staff will be able to directly book appointments into Ashton Extended Access Clinics. Additional evening and walk-in sessions at the EA Hub will improve access for working people and those who find booked daytime appointments difficult.
Targeted telephone contact, with the help of bilingual General Practice and community staff where appropriate, evening or weekend options, and home visits for high-risk or housebound patients will support people who do not respond to routine recall. School nurses will help coordinate childhood asthma reviews, inhaler education, action plans and parent engagement. Family routes such as schools, maternity services, parent groups and play settings will be explored. Workplace activity will be targeted where cohort intelligence indicates it is likely to reach working-age patients.
Live Well, social prescribing and VCFSE partners will help identify barriers and trusted venues as well as providing support for housing, debt, welfare, mental health, employment, loneliness and smoking. Community pharmacy and specialist respiratory, diabetes and CVD services will support medicines optimisation, prevention and pathway advice.
Activity will be reviewed regularly using completion, outreach and referral measures, patient feedback and partner learning. The approach will remain flexible so locations, communication routes and delivery models can be adapted.

21

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

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

Additional call and recall sessions including patient education and bilingual conversations - £50,000
Additional General Practice sessions - £25,000
Additional Extended Access sessions - weekends and evenings - £5000
Outreach delivery - Community Settings - £20,000
Testing and prevention - consumables including Blood pressure machines and feno filters with consumables - £10,000
Promotion, Engagement and inclusion staffing costs - £5,000
Consumables including promotional leaflets, posters - £5,000
Home outreach - Additional home visits - £8,000
Administration - Searches, data collection, reporting and updates - £3,000

22

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

Not applicable

23

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

The proposed spend is directed towards additional activity for patients with identified unmet clinical need, rather than duplicating routine practice work. It uses existing PCN, practice and partner infrastructure wherever possible, including the EA Hub, community venues, school links, social prescribing, Live Well, community pharmacy and VCFSE relationships. Funding will therefore be concentrated on the extra clinical sessions, outreach capacity, accessible venues, engagement support and testing required to reach people who are not well served by standard recall and daytime appointments.
Value will be assessed through the number and proportion of the defined target group completing BeCCoR reviews or relevant checks, together with treatment optimisation, reductions in outstanding reviews, support referrals and activity delivered. Cohort intelligence will be used before workplace or venue-based activity is commissioned so that resources are placed where they are most likely to reach eligible patients.
Joint delivery enables a clinical review to be combined with support for smoking, housing, debt, welfare, employment, mental health or loneliness, reducing fragmented contacts and improving the likelihood that non-medical barriers are addressed.

24

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

- [x] Please state the partners if you select other
- [x] Practice team
- [x] PCN / MDT
- [x] Neighbourhood / INT team
- [x] Local authority
- [x] Social prescribing
- [x] VCFSE / community groups
- [x] Mental health services
- [x] Secondary care / specialist services
- [x] Other

25

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

The draft has been developed around a shared neighbourhood approach involving Ashton PCN practices and proposed input from Neighbourhood teams, Be Well and Live Well services, social prescribing, Action Together, VCFSE organisations and community pharmacies. The plan reflects the need to involve partners at the insight-gathering stage, not only when clinics are delivered.
The proposed approach has been shaped around the barriers identified locally: community and partner routes will help identify trusted venues and communication methods; school nursing and family settings will support childhood asthma engagement; employers and trade-based venues may reach working-age adults; Live Well, social prescribing and VCFSE partners will connect patients with housing, debt, welfare, employment, mental health and loneliness support; and community pharmacy and specialist teams will contribute to prevention, inhaler technique, medicines optimisation and pathway support.
The plan deliberately keeps the activity list flexible. Partner and community feedback will be used to confirm locations, outreach methods and contributions, and learning from attendance and patient feedback will be used to adjust delivery. The Plan including updates, feedback and any revisions required will be discussed at the monthly PCN and neighbourhood meetings

26

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

- Yes
- No

27

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

The outreach, evening access, community engagement and strengthened referral pathways may also benefit people outside the defined core cohort. Community testing may identify previously unrecognised hypertension, cardiovascular risk or respiratory need. Asthma education, inhaler support, smoking cessation and health-literacy activity can support families and carers as well as eligible patients. Stronger links between general practice, Live Well, social prescribing, community pharmacy, VCFSE organisations, schools and local authority services may create more accessible routes for other residents with wider health or social needs. Learning about trusted venues, communication methods and barriers can also inform future neighbourhood prevention work.

Funding, value for money and confirmation

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

28

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

£44,777.29

29

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

£0

30

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

£79,109.16

31

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

No answer provided.

32

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

BeCCOR Pillar 3C

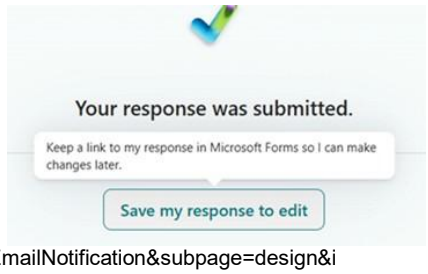
Four Assessment Criteria

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

◉ Yes

33

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



No answer provided.https://forms.cloud.microsoft/pages/designpagev2.aspx?analysis=true&origin=EmailNotification&subpage=design&id=slTDN7CF9UeyIge0jXdO…

View results

Respondent

5 Anonymous

27:07
Time to complete

About this submission

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

1

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

Denton Audenshaw
Droylsden PCN

2

Who is submitting this plan? *

- (●) PCN
- ( ) Single practice
- ( ) Group of practices not submitting as a PCN

3

Name of the submitting PCN or practice(s) *

Denton
PCN

4

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

Dr Ehsan Rafiq CD – Jen Burns

5

Name of the neighbourhood *

Denton, Audenshaw & Droylsden,

6

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

Network/Board meeting

7

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

2th September 2026

Core cohort and target group

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

8

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

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

9

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

N/A

10

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

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

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

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

11

Which population or inequality characteristics actively shape the plan? *

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

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

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

12

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

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

We are targeting the High Risk CVD Patients, particularly those who haven't had a review in the past 1 year. We feel that using this approach has highlighted health inequalities. We can then compare outcomes between groups based on socioeconomic status, ethnicity, age, sex, geography and other factors, showing which populations experience poorer CVD outcomes. We feel that patients not attending may be complex patients who do not engage with primary care services and are high risk.

We also aim to target Learning Disabilities patients who are eligible for CVD High Risk Reviews and SMI patients too. We have LD groups within the PCN footprint and have local community groups, including Sports Trust facilities that these groups regularly attend. We aim, through neighbourhood working to building relationships with these vulnerable patients in non-clinical settings.

We feel that this community approach will guide better services: Evidence from reviews can help healthcare providers design targeted interventions, such as improving cardiovascular screening in underserved communities or increasing access. It will also ensure we are utilising the full Neighbourhood approach by integrating with services that these hard to each patients may have links with i.e community groups/sports trust etc.

13

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

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

145

Please enter a whole number

Need, barriers, intended improvement and measurement

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

14

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

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

We have Identified patients who are high CVD Risk – Missing Reviews via ReID

Of the above 903 not had a

We believe a whole-neighbourhood approach is particularly effective for people at the highest risk of often the least likely to respond to traditional invitations for review, particularly those who haven't

Our neighbourhood-based approach helps to address these challenges by bringing healthcare closer to engage

15

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

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

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

16

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

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

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

17

What is the current baseline for the primary measure? *

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

As at 9/9/2026 on the BeCoRR Re-ID dashboard has identified the following patients are High CVD Need – Missing Review. Total reviews 1454 - Number not had a review since April 25 - 903. • Our Emis search has further confirmed we have 903 patients haven’t had a health check in the last year these patients will be our priority.

18

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

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

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

From the Re-ID Dashboard data shows that of the patients who are CVD High Risk Missing Reviews (1456) – 903 of these are male (54%)

We therefore would like to introduce a 12-month social prescribing engagement plan for men, with a focus on attending community sessions and converting engagement into referrals.

1. Increase awareness and engagement

In this financial year, we will attend at least 2 community-based sessions per month in settings where men are likely to engage, such as sports groups, community centres, workplaces, gyms, and men's groups.

Aim to engage with at least 8 men per month through this pathway, recording attendance and basic engagement data.

2. Increase social prescribing referrals

Increase the number of social prescribing referrals for men by a minimum of 89 (compared with the previous 12-month baseline: 2025 40 referrals/2024 14 referrals

Review referral numbers monthly to identify trends and adjust outreach activity where necessary.

3. Convert community engagement into referrals

Within 12 months, achieve a target of at least 10% of men engaged through community sessions being offered or referred to social prescribing, where appropriate to their needs.

Record the number of men engaged, those expressing an interest, and completed referrals after each session.

4. Build sustainable community partnerships

Establish relationships with at least 5 community organisations or groups that have regular contact with men within the first 6 months, with the aim of developing ongoing referral pathways.

By month 12, ensure that at least 5 partners are regularly promoting or referring to social prescribing.

5. Improve repeat engagement

By the end of 12 months, ensure that at least 30% of men who initially engage through a community session receive a follow-up contact or invitation to another activity, supporting continued engagement and progression towards referral.

6. Improve accessibility of outreach

Within the first 3 months barriers will be identified by running searches with a view to identifying any commonalities within the patient cohort. Where no commonalities across the cohort, or in subsets of patients contained therein, can be identified individual patient records will be reviewed. Implement changes and review their impact at 6 and 12 months.

7. Measure the effectiveness of community sessions

Collect attendance, engagement and referral data from 100% of outreach sessions and complete a quarterly review to identify which locations, activities and approaches generate the highest levels of engagement and referrals.

19

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

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

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

903 patients haven’t attended in the last year we aim to focus on reducing this number by 25% (226 patients) by March 2027.

Clearly identify patients in order of highest CVD Risk – Missing Reviews first via ReID dashboard – total number identified 1454.

We will continue to work with the community partners i.e. community groups/faith groups etc attending their sessions on a bi-monthly basis. Any patients identified will be referred to appropriate service providers and continued to be worked with either in primary care or the community. We will ensure the location of our community events/sessions meets the needs of the targeted population. Our social prescribers will be in attendance at the forthcoming events and will be liaising with patients on an individual basis in order to provide a holistic support inclusive of opportunities of support from community partners and ensure a single point of contact for continuity of care.

Co-design, delivery and neighbourhood fit

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

20

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

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

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

We have identified High Risk CVD patients eligible for review and have already commenced a neighbourhood approach and targeted outreach as drivers for the CVD High Risk Reviews for Missing Patients as follows:

- High Risk CVD for SMI patients – Dedicated health and wellbeing practitioner to work in conjunction with Pennine Care to attend clinics to do bloods for any ofour SMI patients attending Pennine clinics but not attending primary care. (We have done this previously and were able to see a few hard to reach. List of hardto-reach patients sent to Pennine Care and initial meeting has taken place.
- High Risk CVD for LD patients – Dedicated health and wellbeing practitioner has contacted MENCAP and VENTURE (Denton based) and Live Active, MedlockSports Centre, Droylsden and have booked clinics at these sites to undertake the health checks. Live Active staff working in conjunction with the PCN staff to target individuals who attend their sites but have not had review in the past 1 year.

- We will utilise the SMI and LD Health Checks as locally retained services from BeCCoR as an additional supportive approach to engaging with and reaching thiscohort, helping to improve access and uptake among those who may otherwise be harder to engage.

- Both the above will work as drivers to achieve each requirement. This would be an holistic approach using all drivers available.

- For CVD High Risk Reviews – we have produced a poster with QR displayed in Live Active Sites (Denton Wellness and Medlock Sports) offering them healthchecks (if eligible) patients).
- We have introduced a new pathway (with Active) for: Any new members at Active if they have long term condition to be discussed the benefits of annual checkand as for their consent for PCN to contact them to make appointment for annual review.
- With Active we are targeting eligible patients who we know attend their sites but don't engage with primary care – we will be present at sites toopportunistically offer reviews for eligible patients. In conjunction with the Sports Trust we will be offering gym day passes/swimming passes for those having reviews
- We have ensured that additional appointments for Reviews are available within practices both in hours and out of hours (i.e. during Extended Access additionalappointments available evenings and weekends)
- Working with VCFSE/Community Groups – PCN staff attending Andy's Man Club Droylsden/Denton and community faith groups to stress importance of healthchecks/annual review if long term condition and book them into appointments
- To provide "Low-Fat Cookery Sessions with Health Advice" aimed at vulnerable high risk CVD patients. Food is Mood is an 8 session cooking course combiningcooking, food hygiene, and potential work experience, along with a good dose of fun and team building in the kitchen.
- Chef Noel Goulding from the Veterans Food Company has been offering support to vulnerable/socially excluded patients and this Plan would aim to continuethese.
- To utilise existing MDT meetings to target individual eligible patients for discussion with Neighbourhood services i.e. District Nursing may have contact with the household of an eligible patient not engaging so use of 'other' services to have such discussions etc. Offer of PCN staff accompanying DNs to particular households if appropriate to do joint visit.

21

- Venue
- Poster
- QR
- Saturday events- EA
- Gym/swimming passes to
- Low fat
- LD patients with diabetes –
- Practices – will need

The £84k allocated to this PCN £58,000 will be distributed to the practices on a WLS £26,000 will be used for venue costs/printing/providing community sessions and

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

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

22

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

All available funding will be utilised. Additional community sessions/activities will be provided to ensure the funding allocation is used in its entirety.

23

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

Value for Money – Community CVD/LD/SMI Sessions

The proposed community-session investment represents value for money by targeting a clearly defined population of patients at increased risk of poor physical health outcomes, including those with high CVD risk, raised LDL/LD and serious mental illness (SMI) who are overdue or have not engaged with routine review pathways. Local neighbourhood data will be used to quantify the eligible cohort, current review uptake and the identified gap in provision.

Over 12 months, the programme will deliver 22 community sessions, with an expected reach of approximately 40 people per session. This provides a clear and measurable relationship between expenditure and benefit. Based on an estimated total programme the cost per community contact would be approximately £5.

[KH4.1][SS4.2](This is based on Venue costs against number of patients attending)

The proposed costing is based on staff working in normal hours. If the community session was out of hours staff hourly rates/local venue costs/travel/materials], with each session would be factored in. The intervention will also maximise existing neighbourhood resources, including primary care staff capacity, patient registers and recall systems, existing community venues and established voluntary, community and social enterprise (VCSE) relationships. This ensures that funding is directed primarily towards the additional resource required to reach and engage patients who are less likely to access conventional practice-based services, rather than duplicating existing provision.

Value will be monitored through agreed measures including number of sessions delivered, people reached, eligible patients identified, reviews booked and completed, and clinical issues identified or interventions initiated. Data will be reviewed quarterly, allowing resources to be redirected towards the community settings and engagement approaches demonstrating the greatest reach and increase in completed reviews. The investment therefore provides a proportionate, measurable approach to improving preventative care, reducing inequalities and increasing engagement among a higher-risk population.

24

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

Please state the partners if you select other

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

25

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

All 6 practices are totally on board with this Plan. They are providing additional appointments for Reviews in clinics both in hours and via Extended Access. They have prioritised searching and messaging patients eligible, particularly those who haven't had a check in the last year. Practices have also offered clinic rooms for the 4 PCN Health and Wellbeing Practitioners to run weekly clinics at to increase uptake.

Live Active (Sports Trust) have agreed to support by promoting to new members the importance of reviews(if eligible) by use of a new poster being displayed at their sites in Denton and Droylsden which contains a QR code for easy access of appointments

They are also discussing with any new members of introduction the importance of regular checks if called by their practice.

Pennine Care are working with the PCN to support the hard to reach Mental Health patients and offering joint clinics at their sites. PCN One Stop Clinics in the community with the full neighbourhood teams are being organised monthly.

We have had an initial meeting with Tameside Radio who are promoting the above and the importance of attendance for reviews if called. This is also going into the Tameside Reporter on a regular basis.

We are working with community groups including Andy's Man Club and displaying posters/attending their regular groups and inviting vulnerable eligible patients into the groups for Reviews (as appropriate).

All the above are being discussed at Denton Neighbourhood Delivery group – All neighbourhood service leads attend and the above will develop over the next few months.

26

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

- (●) Yes
- ( ) No

27

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

As a result of the above we aim to increase Social Prescribing Referrals particularly in men These are a cohort we historically have low referrals from as they don't engage. - Last year through a local LCS we had an increase of 89 referrals into social prescribing as a result of community working. We again would like to achieve at least this target so 100% achievement (89 new referrals 26/27) .

Social prescribing can be a powerful tool for reducing health inequalities among men, particularly because this group is often less likely to engage with traditional health services, more likely to delay seeking help, and may experience significant social, economic, and mental health pressures. [england.nhs.uk],

[gov.uk]

We have found through our work with Andy's Man club that many men in this age group face challenges such as:

- Poor mental health and stress related to work, finances, relationships, or unemployment.
- Higher rates of risk-taking behaviours such as smoking, alcohol misuse, gambling, or substance use.
- Social isolation despite being employed or in relationships.
- Lower uptake of preventative healthcare and health checks.
- Reviews and are more likely to experience barriers linked to deprivation, ethnicity, language, digital exclusion, mental health, work commitments, or low healthliteracy and we believe Neighbourhood working with trusted professionals will alleviate these barriers.

Funding, value for money and confirmation

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

28

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

£58,0

29

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

• Staff costs associated with conducting reviews • Additional phlebotomy appointments • Additional pharmacist follow-up appointments • Increased referrals to secondary care

30

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

£26,000

31

Any other comments. Please use this space to indicate if you are going to submit supporting documentation via email (e.g. costing template). If sending additional documentation please send through to gmicb-tameside.primarycareteam@nhs.net No answer provided.

https://forms.cloud.microsoft/pages/designpagev2.aspx?analysis=true&origin=EmailNotification&subpage=design&id=slTDN7CF9UeyIge0jXdO…

32

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

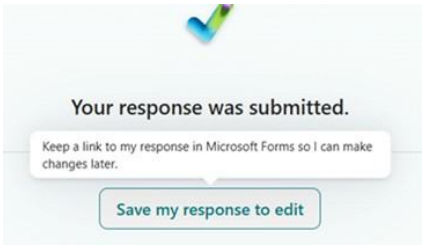
BeCCOR Pillar 3C
Four Assessment Criteria

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

◉ Yes

33

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



Yes

View results

Respondent

3 Anonymous

28:36
Time to complete

About this submission

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

1

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

BeCCoR Neighbourhood
Asthma Plan

2

Who is submitting this plan? *

- (●) PCN
- ( ) Single practice
- ( ) Group of practices not submitting as a PCN

3

Name of the submitting PCN or practice(s) *

Hyde
PCN

4

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

Sam Rothwell - PCN Business Manager
Dr Jane Harvey - PCN Clinical Director
Dr Qazi Alam - PCN Clinical Director

5

Name of the neighbourhood *

Hyde

6

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

PCN Board meeting, and system partners. (Active Tameside, Be Well, Resp Consultant)

7

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

10/09/2026

Core cohort and target group

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

8

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

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

9

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

No answer provided.

10

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

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

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

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

11

Which population or inequality characteristics actively shape the plan? *

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

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

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

12

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

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

Our target group is patients aged 5 and over, registered with one of Hyde PCN's eight practices in Tameside, with a coded asthma diagnosis and a high risk of poor outcomes, who are not being reached by routine review.

Of 5,785 patients on the QOF asthma register, 3,408 meet BeCCoR high-need criteria. We will prioritise 453 patients with six or more SABA prescriptions in 12 months and no MART/AIR, 646 with no inhaled corticosteroid in the last six months, and 520 with no complete review in 18 months.

The unmet need is reliever over-reliance without a structured review, personalised asthma action plan or inhaler technique check. This leaves patients at risk of preventable exacerbations, A&E attendance and admission.

Within this cohort we will focus on those facing the greatest inequalities: children and young people in the most deprived areas (Core20), South Asian and Eastern European communities where language and cultural barriers limit engagement, people in damp or poor-quality housing, smokers and households with smokers, and patients with co-existing mental health conditions.

Patients will be identified through EMIS searches and BeCCoR dashboards, and reached through practices, schools, pharmacies and community venues across the Hyde neighbourhood.

13

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

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

3408

Please enter a whole number

Need, barriers, intended improvement and measurement

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

14

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

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

Asthma is the most common long-term condition in children and one of the most common in adults, and outcomes are consistently worse where deprivation is higher. Tameside is one of the most deprived areas in England, and several Hyde practice areas sit in the top two national deprivation deciles.

Our own data shows a large group not receiving the basics of good asthma care. Of 5,785 patients on the QOF register, 3,408 meet BeCCoR high-need review criteria. Within that, 453 have had six or more SABA prescriptions in 12 months without MART/AIR, 646 have had no inhaled corticosteroid in the last six months, and 520 have had no complete review in 18 months. So far this year (to August 2026), 1,364 reviews have been completed (24% of the register) and 1,198 patients have a personalised asthma action plan (21%), while 746 have been issued three or more SABAs. Heavy reliever use without a review or selfmanagement plan is a patient safety concern and a driver of avoidable A&E attendance and admission.

Performance also varies sharply between practices. Review completion ranges from 12% of the register at Clarendon to 39% at Awburn. Hattersley has the highest proportion of patients issued three or more SABAs (26% of its register) and the lowest action plan coverage (17 plans across 368 patients). This suggests there is room to lift lower-performing practices by working to a shared model.

The register also does not reflect who is most affected. South Asian and other ethnic minority communities are under-represented in our structured review data, and language barriers affect Eastern European communities. Children in deprived areas are more exposed to damp housing, poor air quality and smoke, and patients with co-existing mental health conditions are often disengaged from long-term condition management.

Most of what drives poor asthma control sits outside the consulting room: housing, smoking, language and school. No single practice or organisation holds all of those levers, and eight practices are currently tackling the same problem with different results. Neighbourhood working gives us the scale and the partners to change that. We can:

Share one register and dashboard, and use PCN pharmacist capacity to review high-SABA patients across all eight practices.
Reach patients in trusted places through schools, pharmacies, Action Together and social prescribers, rather than waiting for them to book.
Extend the Asthma Friendly Schools programme, which already runs in other GM areas, into Tameside.
Agree clear pathways with the Tameside Respiratory service for complex cases and post-A&E follow-up.

This fits the Live Well GM neighbourhood model and the BeCCoR focus on reaching people who don't engage with routine care.

15

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

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

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

16

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

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

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

17

What is the current baseline for the primary measure? *

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

3408

18

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

These are other things not selected as your primary measure above that you would want to measure as the project progresses. These might help show wider benefit (secondary measures) or possible unintended effects (balancing measures). Do not repeat the primary measure and leave blank if none. For each additional aim try to ensure it is Specific , Measurable, Achievable, Realistic and Timebound

1. Personalised asthma action plan (PAAP) coverage (secondary)

Increase the proportion of patients on the asthma register with a coded PAAP from 21% (1,198 of 5,785, August 2026) to 40% by 31 March 2027. Progress will be reported monthly from an EMIS search.

2. Reviews in priority inequality groups (secondary)

By 31 October 2026, establish the proportion of children aged 5-16 and of South Asian and Eastern European patients with a completed review in the last 12 months. By 31 March 2027, halve the gap between each group and the PCN average. Data will come from EMIS age and ethnicity coding, reported quarterly.

3. Clinical safety after treatment step-down (balancing)

Keep the proportion of patients whose treatment is stepped down who then need an oral steroid course or have an unplanned asthma attendance within three months below 5%. This will be audited quarterly by clinical record review, starting Q3 2026/27.

19

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

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

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

Reduce the proportion of high-need asthma patients with no complete review in the last 18 months from 15.3% (520 of 3,408) to 7.5% (around 255) by 31 March 2027. This means completing approximately 265 additional structured reviews across the eight practices, about five per practice per month.

We will focus particularly on practices with the highest proportion of overdue patients (Hattersley 23%, Smithy 21%, Donneybrook 19%) and on children aged 516, South Asian and Eastern European patients, and people living in the most deprived areas. Baseline is the BeCCoR AST07 search as of 31 March 2026, to be rerun on the same definition at year end.

Co-design, delivery and neighbourhood fit

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

20

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

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

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

Delivery follows the 3C model (Clinical, Community, Coordination). The two PCN Clinical Directors are accountable, the PCN clinical pharmacist leads SABA review, and each practice has a named asthma lead.

Clinical: find, review and treat

Monthly EMIS and BeCCoR searches give each practice a list of overdue patients. Those with six or more SABA prescriptions, no inhaled corticosteroid or a recent A&E attendance are recalled first.
All eight practices use one structured review template covering the RCP 3 Questions, ACQ/ACT score, inhaler technique, smoking status and a personalised asthma action plan (PAAP). Every review therefore delivers the same core elements.
The PCN pharmacist reviews high-SABA patients across the neighbourhood, stepping treatment up or down in line with BTS/SIGN/NICE, or referring on. Children aged 5-16 are reviewed with priority given to those with school absence or A&E attendance.

Anyone attending A&E with asthma is contacted within five working days for an urgent review.

Community: reach people who don't come to us

Quarterly drop-in sessions in two initial non-clinical venues, such as a library or community centre, run with Action Together. They offer review and inhaler checks outside the appointment system, with scope to extend into mosques and other trusted settings.
Community pharmacies are briefed on SABA over-reliance and use an agreed inhaler technique protocol, so they can spot patients and refer them back for review.
We will approach primary and secondary schools to introduce the Asthma Friendly Schools programme, already running elsewhere in GM. School nurses will help identify children with uncontrolled asthma.
Asthma self-management information will be produced in plain English, Urdu, Bengali and Polish, and shared through Core20PLUS5 connectors and community champions.
Live Well social prescribers, the council smoking cessation service and housing and environmental health teams will address housing, smoking and poverty as drivers of poor control.

Coordination: hold it together

A quarterly Neighbourhood Asthma MDT (GP, pharmacist, school nurse, social prescriber, VCFSE representative) reviews progress and complex cases.
A shared practice-level dashboard shows review rates, SABA prescribing and A&E attendances each month, so we can target lower-performing practices.
A referral pathway for complex or difficult-to-control asthma will be agreed with the Tameside Respiratory service.
Progress is reported monthly to PCN governance, and the plan is aligned to our BeCCoR QI submission and the Live Well neighbourhood plan.

How this responds to need

Overdue reviews and high SABA use are addressed through proactive searches and pharmacist-led review.
Under-representation and language barriers are addressed through community venues, multilingual resources and trusted connectors.
Non-medical drivers are addressed through social prescribing and council services.
Variation between practices is addressed through the shared template and dashboard.

21

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

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

Allocation by practice (list size split, 60% staffing / 30% operating costs / 10% administrative costs)

Awburn: Total £11,816.85 | Staffing £7,090.11 | Operating costs £3,545.06 | Administrative costs £1,181.68
Brooke: Total £34,867.68 | Staffing £20,920.61 | Operating costs £10,460.30 | Administrative costs £3,486.77
Clarendon: Total £12,579.69 | Staffing £7,547.82 | Operating costs £3,773.91 | Administrative costs £1,257.96
Donneybrook: Total £14,645.26 | Staffing £8,787.15 | Operating costs £4,393.58 | Administrative costs £1,464.53
Dukinfield: Total £19,241.41 | Staffing £11,544.84 | Operating costs £5,772.42 | Administrative costs £1,924.15
Haughton/Thornley: Total £21,357.93 | Staffing £12,814.76 | Operating costs £6,407.38 | Administrative costs £2,135.79
Hattersley: Total £8,208.10 | Staffing £4,924.86 | Operating costs £2,462.43 | Administrative costs £820.81
Smithy: Total £6,883.08 | Staffing £4,129.85 | Operating costs £2,064.92 | Administrative costs £688.31

TOTAL: £129,600.00 | Staffing £77,760.00 | Operating costs £38,880.00 | Administrative costs £12,960.00

22

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

N/A

23

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

The proposed £129,600 is a targeted investment in a defined, high-risk group, and it builds on capacity we already have rather than creating new structures.

Size and need. The spend is focused on the 3,408 patients on our register who meet BeCCoR high-need review criteria. Within that group, 453 patients have had six or more SABA prescriptions without MART/AIR, 646 have had no inhaled corticosteroid in six months, and 520 have had no complete review in 18 months. These patients are at greatest risk of preventable exacerbations, A&E attendance and admission, so an effective review is worth more here than anywhere else in the register.

Unit costs. The allocation equates to £38.03 per high-need patient, £22.40 per patient on the asthma register and £1.59 per registered patient across the PCN. Our target is to reduce the number of high-need patients with no complete review in 18 months from 520 to around 255. The funding also supports SABA review, action plans, community outreach and schools work.

Expected reach and benefit. Benefits include:

Structured reviews with inhaler technique checks and personalised asthma action plans, reducing reliever over-reliance.
Access for people who don't attend routine appointments, through drop-in sessions in community settings, pharmacy referrals and multilingual resources.
Fewer avoidable A&E attendances and admissions, which cost the system far more than a review. Consistent practice, using one review template and a shared dashboard across all eight practices.

Costing basis. The allocation is shared between practices in proportion to registered list size (81,378 patients). Each practice's share is split 60% staffing, 30% operating costs and 10% administration. This keeps the allocation transparent and weights funding to where patient numbers, and therefore workload, are highest. Administration is held to 10% so that 90% of the spend goes directly into delivery.

Existing resources. We are not paying for infrastructure that already exists. The PCN clinical pharmacist, practice asthma leads, EMIS searches and BeCCoR dashboards are already in place. Live Well social prescribers are already embedded in the PCN, and Action Together, community pharmacies, the council smoking cessation service and the Asthma Friendly Schools programme add capacity at no cost to this allocation. Practices completed 1,364 reviews in the first five months of this year, so the funding adds to existing delivery.

24

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

Please state the partners if you select other

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

25

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

The plan has been led by the two PCN Clinical Directors, working with the Business Manager. It is built on practice-level data from all eight practices, drawn from BeCCoR asthma searches and QOF register and activity data. This showed us where need and variation sit, including the differences in review completion and action plan coverage between practices, and it shaped both our priority groups and the decision to use one shared review template across the PCN.

The draft plan was shared with practice managers and clinical leads for comment in the September PCN Board meeting.

Live Well social prescribers are already embedded in the PCN, and the plan builds on their existing role in addressing housing, smoking and poverty.

Engagement with wider partners is at an earlier stage. Action Together Tameside, community pharmacies, schools, the Tameside Respiratory service and Core20PLUS5 connectors are identified partners, with initial contact planned for [month]. Their views will directly shape delivery, including:

the choice of drop-in venues, the languages and formats of self-management materials, how pharmacy referrals work in practice.

Patient and community views will be gathered through [method, e.g. feedback at drop-in sessions and the annual patient survey]. They will be reviewed at the quarterly Neighbourhood Asthma MDT, and the plan will be updated in March 2027.

26

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

- (●) Yes
- ( ) No

27

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

The work should benefit the wider asthma population beyond the high-need group. The 5,785 patients on our register will gain from the shared review template, the neighbourhood dashboard and clearer referral pathways to the Tameside Respiratory service.

Asthma Friendly Schools will support all children with asthma in participating schools, and smoking cessation and housing support will benefit other household members. Community pharmacy inhaler checks and multilingual resources will reach people who have not yet been identified as high need, and patients with overlapping COPD.

The MDT, shared dashboard and community drop-in model can later be applied to other long-term conditions. Fewer avoidable A&E attendances and admissions will also ease pressure on urgent care and general practice.

Funding, value for money and confirmation

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

28

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

£0

29

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

£0

30

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

£129,60

31

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

N/A

32

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

BeCCOR Pillar 3C
Four Assessment Criteria

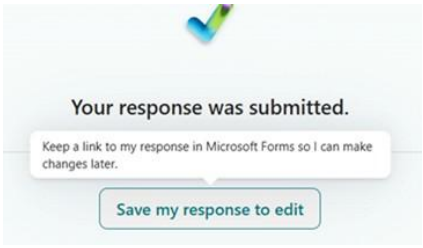
- Represent good value for money;
- Focus on improving outcomes for the identified BeCCoR core cohort, while recognising any potential wider benefit;• Have been co-designed and will be delivered with relevant neighbourhood partners;
- Support neighbourhood working and relevant local strategic priorities.

◉ Yes

https://forms.cloud.microsoft/pages/designpagev2.aspx?analysis=true&origin=EmailNotification&subpage=design&id=slTDN7CF9UeyIge0jXdO…

33

IMPORTANT - PLEASE NOTE When you have submitted this form- please then click on **'save my response to edit'**. This will then give you an internet link that you need to save somewhere, which will then allow you to to re-edit your response at any future date. No answer provided.



View results

Respondent

2 Anonymous

62:17
Time to complete

About this submission

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

1

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

No answer provided.

2

Who is submitting this plan? *

- (●) PCN
- ( ) Single practice
- ( ) Group of practices not submitting as a PCN

3

Name of the submitting PCN or practice(s) *

Stalybridge, Dukinfield & Mossley PCN

4

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

Dr Grace Choi (Clinical Director); Martin Turner (Business Manager); Suzanne

5

Name of the neighbourhood *

Stalybridge, Dukinfield & Mossley

6

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

Stalybridge, Dukinfield & Mossley Forum

7

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

09/07/2

Core cohort and target group

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

8

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

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

9

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

No answer provided.

10

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

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

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

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

11

Which population or inequality characteristics actively shape the plan? *

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

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

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

12

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

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

The target group is patients within the Stalybridge, Dukinfield & Mossley neighbourhood who have an identified cardiovascular need but do not routinely engage with their GP practice for health reviews, monitoring and optimisation.

This includes people with hypertension, atrial fibrillation, diabetes, CKD/albuminuria and those requiring secondary prevention or lipid optimisation, particularly where key checks, readings or reviews are missing or overdue, or where there has been repeated non-attendance or limited response to routine invitations.

The group is likely to include working-age adults who may face practical barriers to attending during usual practice hours, as well as older people, people living with frailty, and those experiencing deprivation or other inequalities that can make accessing and prioritising preventative healthcare more difficult. Ethnicity, disability, learning disability/autism and mental health may also influence engagement and access for some individuals.

Deprivation is a particular consideration within the neighbourhood, with areas of Stalybridge, Dukinfield and Mossley containing LSOAs within the most deprived 20% nationally.

The project will therefore focus on taking proactive CVD prevention and optimisation closer to the communities and people who are least likely to engage with conventional practice-based services, rather than relying solely on patients to attend their GP practice.

13

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

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

1338

Please enter a whole number

Need, barriers, intended improvement and measurement

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

14

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

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

Just over 1,300 patients have been identified within the CVD need cohorts who live within the neighbourhood’s identified ward postcodes, including areas containing LSOAs that are among the most deprived nationally. This represents a significant population with identified cardiovascular health needs who may benefit from a more proactive and targeted approach to prevention, monitoring and optimisation.

Neighbourhood data and our experience of working within these communities indicate that people living in areas of higher deprivation can experience greater health inequalities and may face multiple barriers to accessing routine healthcare. These barriers are not simply related to GP practice access and can include limited or unreliable transport, the financial cost of travelling to appointments, work or caring commitments, competing socioeconomic pressures, and differences in health education, health literacy and awareness of the importance of preventative care.

There are also important demographic and cultural considerations. Ethnicity and cultural differences may influence how individuals access and engage with healthcare, including awareness of available services, communication, health beliefs and confidence in navigating healthcare systems. These factors can overlap with deprivation and other characteristics such as age, frailty, disability, learning disability/autism and mental health, potentially creating multiple barriers for some individuals.

The group has therefore been prioritised because there is both identified clinical need and evidence of potential barriers to engagement. A neighbourhood approach provides an opportunity to move beyond relying on patients to attend traditional practice-based appointments and instead take CVD prevention and optimisation into the communities where unmet need has been identified.

By using targeted outreach, the neighbourhood can provide more accessible opportunities for assessment, education and intervention, with the aim of reducing inequalities, improving engagement with preventative healthcare and identifying cardiovascular risk or unmet clinical need earlier.

15

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

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

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

16

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

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

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

17

What is the current baseline for the primary measure? *

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

133 patients identified as requiring some or all CVD need review within the 5 8 neighbourhood ward locations identified.

18

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

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

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

1. Number and proportion of outreach attendees who were previously non-engaged or overdue for routine CVD review
2. Number of patients identified through outreach requiring onward action

19

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

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

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

By 31 March 2027, we aim for at least 60% of identified CVD need elements within the targeted outreach cohort to have been completed or addressed through the programme, representing a significant reduction in outstanding or overdue reviews.

The 60% target is intended as a realistic and measurable neighbourhood outreach ambition, while contributing towards the wider 80% BeCCoR target for completion of relevant CVD care elements. Particular focus will be given to patients experiencing additional inequalities, including those associated with deprivation, ethnicity, age and frailty.

This change will be achieved through targeted outreach clinics and opportunistic health assessment sessions delivered within or close to communities where barriers to accessing healthcare have been identified. These opportunities will also support improved health education, cardiovascular health awareness and digital literacy, helping patients to understand and manage their cardiovascular health and access appropriate services.

Progress will be monitored by comparing the number of outstanding CVD need elements at baseline with those remaining at 31 March 2027, alongside recording the proportion of identified needs addressed through outreach.

The overall aim is to reduce unmet CVD need, improve engagement and access, and increase completion of required cardiovascular reviews and care elements, particularly among patients who are less likely to engage with traditional practice-based services.

Co-design, delivery and neighbourhood fit

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

20

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

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

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

The programme will bring cardiovascular prevention and optimisation closer to where people live, work and access their communities, rather than relying solely on attendance at GP practices.

Targeted outreach clinics and opportunistic health-check sessions will be delivered at accessible community locations within the neighbourhood, particularly in areas where deprivation and barriers to accessing routine healthcare have been identified. The exact

locations and sessions will be informed by neighbourhood intelligence and engagement with local communities.

Where appropriate, outreach will be co-located with existing community activities and events to maximise engagement and reduce the need for patients to make a separate journey specifically for a healthcare appointment. We will work with partners including Active Tameside, RidgeHill Together and other community and voluntary sector organisations to identify suitable venues, events and opportunities to reach the target population.

We will also coordinate with the local council to align with planned community events and high-footfall activities, creating additional opportunities for opportunistic CVD health checks, education and signposting. This will allow the PCN to reach people who may not routinely engage with primary care but who are already accessing other community services.

The outreach offer will focus on identifying and addressing outstanding CVD care needs, including relevant clinical checks and reviews, alongside health education, prevention advice and support to improve health awareness and digital confidence. Where a clinical need is identified that cannot be addressed within the outreach setting, patients will be supported and signposted back into the appropriate practice or wider healthcare service for follow-up.

Delivery will therefore combine targeted outreach with existing community activity, using local partnerships and neighbourhood intelligence to maximise reach, improve accessibility and reduce inequalities in cardiovascular care.

21

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

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

Practice Total allocation 70% Staffing 20% Operating costs 10% Administrative
Lockside £13759.49 £9,631.64 £2,751.90
Staveleigh £14,605.88 £10,224.12 £2,921.18
King Street £5,535.25 £3,874.68 £1,107.05
St Andrews £10,636.08 £7,445.26 £2,127.22
Town Hall £4,995.96 £3,497.17 £999.19
Grosvenor £10,823.33 £7,576.33 £2,164.67
Mossley £3,775.06 £2,642.54 £755.01
Pike £5,482.82 £3,837.97 £1,096.56
Millbrook £5,295.57 £3,706.90 £1,059.11
TOTAL £74909.44 £52,436.61 £14981.89

22

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

N/

23

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

The proposed spend represents good value for money because it is targeted at a clearly identified population of just over 1,300 patients with CVD need living within identified neighbourhood areas where deprivation and barriers to accessing healthcare are more significant. The funding will therefore be directed towards a population with both demonstrable clinical need and potential unmet need, rather than providing a universal intervention to a low-risk population.

The programme will prioritise preventative care and early intervention through targeted outreach, opportunistic health checks and patient education. This provides an opportunity to identify and address outstanding CVD care elements, optimise treatment and support patients to better understand and manage their conditions before they deteriorate or require more intensive healthcare intervention.

The total allocation of £74,909.44 equates to approximately £58 per identified patient across the 1,300-patient target population, providing a significant opportunity for population-level impact. The proposed 60% project target for addressing identified CVD need through outreach would represent a substantial improvement in engagement and completion of required care elements, while contributing towards the wider 80% BeCCoR ambition.

Working across a neighbourhood footprint allows the PCN to achieve economies of scale and use resources efficiently, rather than each practice developing separate outreach arrangements. At the same time, the model does not seek to replace the patient's usual GP practice. Where a patient is registered with a practice within the neighbourhood, continuity with their own practice and clinical team is maintained, with appropriate information and outcomes shared back to the practice for ongoing management and follow-up. This combines the efficiency of a neighbourhood approach with the continuity and familiarity of practice-based care.

The costing is based on an agreed allocation between participating practices according to their weighted-list share, with 70% allocated to staffing, 20% to operating costs and 10% to administration and coordination. This provides flexibility to use existing clinical and administrative infrastructure while directing the majority of funding towards frontline delivery.

The programme will also make use of existing community assets and partnerships, including community organisations, Active Tameside and local council events, reducing the need to establish new standalone services or venues. Co-locating outreach with existing community activity should increase reach while minimising additional infrastructure costs.

In the longer term, investment in preventative care and patient education should support better-managed cardiovascular conditions, improved health literacy and greater patient self-management. This has the potential to reduce avoidable deterioration, repeated consultations and associated healthcare costs, supporting a more sustainable model of care beyond the funding period.

24

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

Please state the partners if you select other

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

25

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

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26

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

- (●) Yes
- ( ) No

27

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

Yes. Although the programme has a defined core target group, the visibility and presence of the clinical outreach team within local communities is expected to benefit a wider population.

Outreach sessions and community events will provide opportunities for residents beyond the identified CVD cohort to engage with healthcare professionals, ask questions, receive health education and improve awareness of cardiovascular health and prevention. Where appropriate, opportunistic health checks or advice can also identify previously unrecognised risk or unmet healthcare needs, enabling people to be appropriately signposted or referred for further assessment.

The programme will therefore contribute to wider community health awareness and engagement, particularly through its presence at existing local events and high-footfall community settings. No resident will be turned away from appropriate care simply because they fall outside the defined target cohort.

Funding, value for money and confirmation

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

28

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

£74,909.

29

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

£0.00

30

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

£0.00 - Utilising existing infrastructure

31

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

N/

32

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

BeCCOR Pillar 3C
Four Assessment Criteria

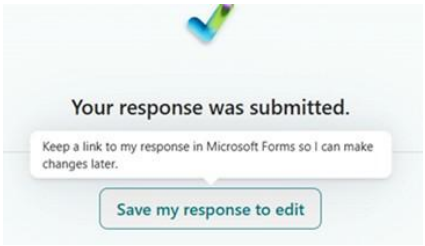
- Represent good value for money;
- Focus on improving outcomes for the identified BeCCoR core cohort, while recognising any potential wider benefit;• Have been co-designed and will be delivered with relevant neighbourhood partners;
- Support neighbourhood working and relevant local strategic priorities.

Yes

https://forms.cloud.microsoft/pages/designpagev2.aspx?analysis=true&origin=EmailNotification&subpage=design&id=slTDN7CF9UeyIge0jXdO…

33

IMPORTANT - PLEASE NOTE When you have submitted this form- please then click on **'save my response to edit'**. This will then give you an internet link that you need to save somewhere, which will then allow you to to re-edit your response at any future date. No answer provided.



TAMESIDE STRATEGIC PARTNERSHIP COMMITTEE (TSPC)

Meeting Date	28.10.26	Public	X	Confidential		Agenda item
Title of Report	Tameside Integrated Neighbourhood Teams – Implementation and Governance Update					
Lead Director / Executive Member / Clinical Lead	James Mallion, Director of Public Health Marion Colohan, Place Partnership Director – Tameside					
Author	James Mallion, Director of Public Health Marion Colohan, Place Partnership Director – Tameside					

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:

The purpose of this report is to update the Tameside Strategic Partnership Committee (TSPC) on the development and implementation of **Integrated Neighbourhood Teams (INTs)** across Tameside, aligned with the Greater Manchester Live Well Neighbourhood Model and the Tameside Borough Strategy 2026–2030.

The report summarises:

- The GM-wide framework for neighbourhood integration and the Tameside model for four INTs.
- The governance arrangements underpinning INTs, including the Neighbourhood Leadership Group and Neighbourhood Management Groups.
- The initial operational focus on cohorts at high risk of urgent care attendance, identified through the T&G ICFT AI model.
- The five-stage INT pathway: *Identify, Engage, Assess, Shared Care Plan, Manage*.
- The alignment of INTs with wider system priorities for prevention, early intervention, and care closer to home.

The report provides assurance that the INT model is progressing toward full implementation, with clear governance, baselined capability, and evaluation mechanisms in place.

Recommendations:

1. Note the progress made in developing the Tameside Integrated Neighbourhood Team model.

2. Endorse the proposed governance and reporting arrangements between INTs, Neighbourhood Management Groups, and the Neighbourhood Leadership Group.
3. Support continued development of neighbourhood intelligence and data tools to inform population health management.
4. Acknowledge the next phase of implementation focusing on high-risk urgent care cohorts and subsequent expansion to wider population groups.

Financial implications:

Development of INTs is supported through existing locality resources and GM ICB investment in neighbourhood infrastructure. No additional cost pressures are identified at this stage. Future funding alignment will be reviewed through GM ICB and Place Partnership financial governance processes.

Alignment with the Joint Health and Wellbeing and Locality Plan:

The INT model directly supports the **Care Closer to Home**, **Prevention**, and **Health Inequalities** priorities within the Tameside Borough Strategy and GM Health and Wellbeing Framework. It strengthens integrated working across health, care, and VCFSE partners, improving outcomes through neighbourhood-based delivery.

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	Noted through INT development process
Views of the population / users	Reflected through Live Well and VCFSE engagement

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

Tameside Integrated Neighbourhood Teams

Tameside Strategic Partnership Committee
28th October 2026

James Mallion, Director of Public Health
Marion Colohan, Deputy Place Based Lead

Tameside Metropolitan Borough

Neighbourhoods are a critical delivery platform for our GM Plan

NHS Greater Manchester

Our 10 Places and 67 neighbourhoods are where many of the changes needed to improve outcomes, performance and sustainability will ultimately need to come together.

National neighbourhood health expectations directly support some of our biggest planning priorities, including:

- reducing non-elective admissions and bed days
- improving access to general practice
- reducing avoidable outpatient activity
- improving urgent and emergency care
- improving coordination and experience of care

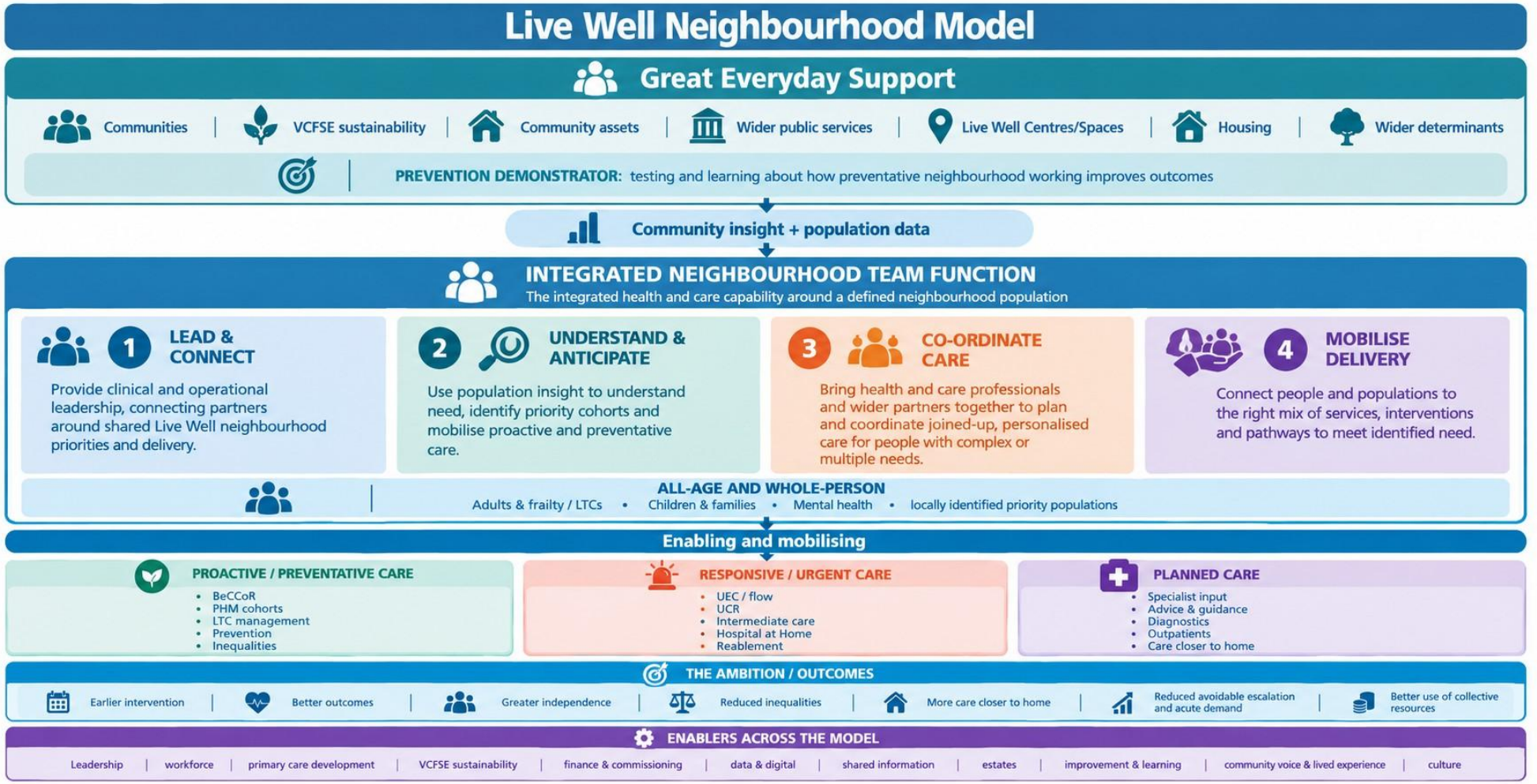
In GM, we are developing this through Live Well, bringing health and care together with wider public services and VCFSE support around communities and neighbourhoods.

The planning implication: Neighbourhood Health is not another programme. Mature place and neighbourhood working will be an important enabler of successful delivery across several of our pan-GM programmes.

Operationalisation of this model and conversion into planning currency is complex and challenging…

We are developing a consistent model across GM

NHS Greater Manchester



But the capability we are relying on is not yet consistently in place

NHS Greater Manchester

We are developing a clearer picture of what a **mature neighbourhood system** needs to look like in practice.

This includes the capability to bring partners and services together around a shared population, supported by:

- clinical and managerial leadership
- coordination of multidisciplinary working and delivery
- population insight, risk stratification and data
- proactive and preventative approaches
- connections across NHS, care, public services, communities and VCFSE
- the ability to understand and demonstrate impact

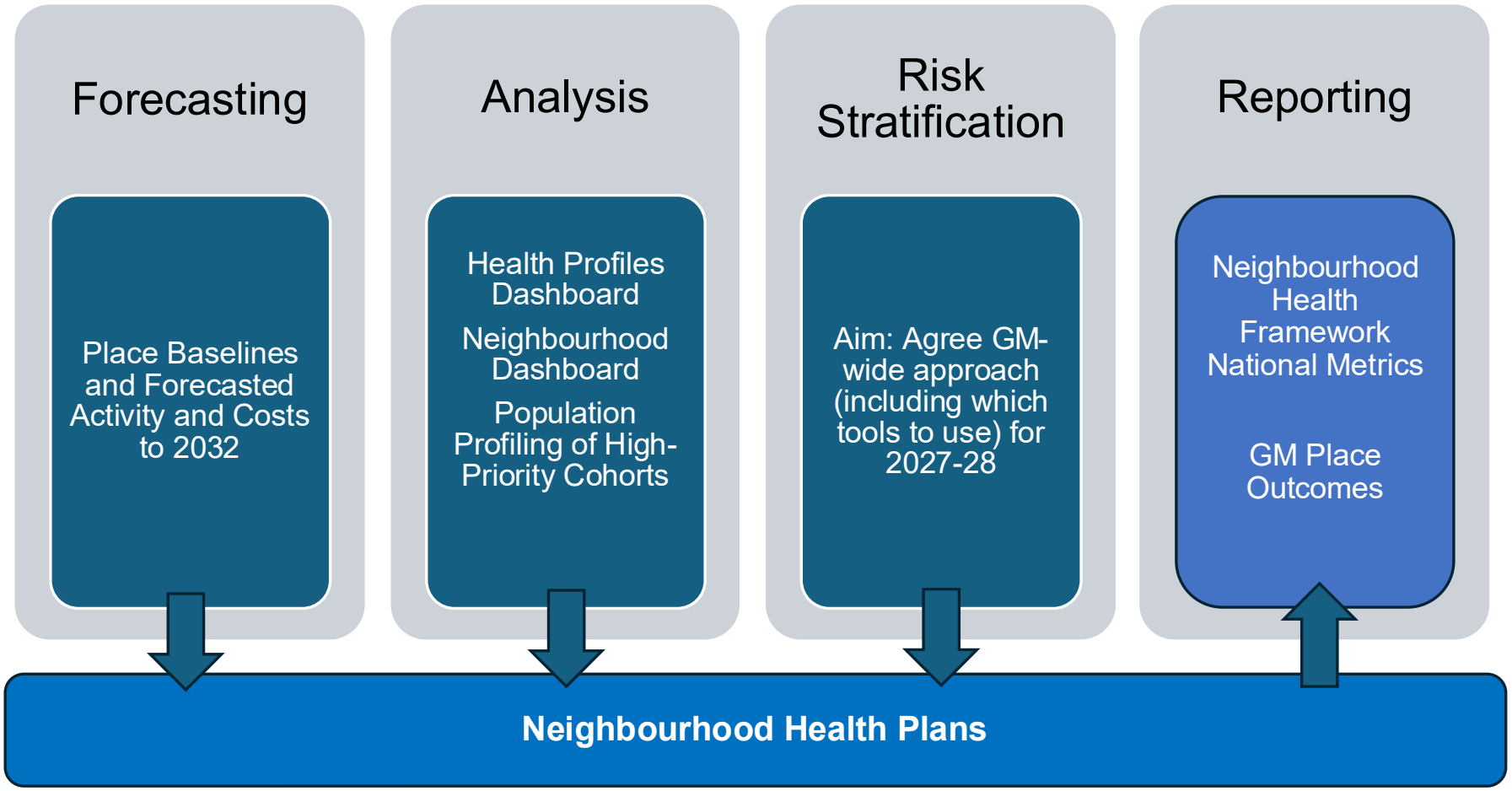
Our starting point is variable. There are significant differences in current capability, infrastructure and investment across GM across all relevant provision, and, most relevantly for this conversation, in the infrastructure necessary to support integrated neighbourhood teams.

What we are doing now

We are **baselining existing capability, investment and scope,** alongside developing a clearer view of the capability required and the impact a mature neighbourhood system could enable.

This includes significant work to develop the data tools and approaches to understand our communities and impact

NHS Greater Manchester



How do we get a stronger connection between GM and Place planning?

NHS Greater Manchester

GM programmes

Need to be explicit about:

- what they need places and neighbourhoods to support successful delivery of
- what capability and capacity is assumed available
- what should be consistent across GM
- how expected impact is reflected in planning assumptions

Place Partnerships

Need to be able to:

- describe current capability, capacity and gaps
- understand our local systems and interdependencies – to help ensure GM solutions can be adapted
- shape GM programmes that will operate locally
- identify locally led contributions to the same outcomes
- demonstrate their contribution and impact

Our shared task: Develop one plan in which pan-GM programmes and place/neighbourhood delivery are designed together, with a shared understanding of dependencies, capability and contribution. Understand the constraints and complexities.

Dependencies: What needs to happen through and with place and neighbourhoods for our major programmes to succeed? What is the cumulative capacity needed for this transformation work? What are the rate limiting factors?

Capability and capacity: What needs to be consistently available to enable that delivery, and where are the gaps? What does that tell us about what is possible and what is needed?

Mutual responsibility: How do we routinely bring GM and Place planning together so that plans are developed, resourced and delivered jointly? How do we learn and improve together?


Building the Bridge Between Need and Activity
Two legitimate ways of forecasting the future. One shared framework for neighbourhood planning.
"The issue isn't conflicting numbers. They're answering different questions."
NHS
Better health for brighter futures
People. Places. Healthier Together.
Population Health Perspective
"Given the population we have, what future demand should we expect?"
Population
Our communities today and tomorrow
Need
Health needs across the life course
Risk
Identifying future risk
Expected Demand
Anticipating future need
Prevention | Earlier intervention | Healthier communities
Unmet Need
Investment Decisions
Access Inequalities
Service Redesign
Strategic Commissioning
Understanding the gap between need and activity
Capacity Constraints
Clinical Priorities
Operational Planning Perspective
"Based on current activity, what future capacity should we plan for?"
Current Activity
What services people use today
Trends
How activity is changing
Utilisation
Making the best use of resources
Future Capacity
Planning sustainable service provision
Efficient services | Sustainable capacity | Meeting patient need
INSIGHTS FROM POPULATION HEALTH STRONGER COMMUNITIES
EVIDENCE FROM OPERATIONAL DELIVERY ACCESSIBLE SERVICES BETTER OUTCOMES
How We Bridge The Gap
Population need and observed activity will never perfectly align.
Strategic commissioning bridges the gap by understanding the forces that shape demand, utilisation and outcomes.
UNMET NEED
ACCESS INEQUALITIES
PREVENTION IMPACT
WORKFORCE AVAILABILITY
REALITY
Multiple forces shape the relationship between need and activity
CLINICAL CHANGE
WAITING LISTS
BEHAVIOURAL RESPONSES
CAPACITY CONSTRAINTS
FUNDING DECISIONS
Healthier neighbourhoods
Fairer access
Stronger communities
Brighter futures
Without Strategic Commissioning
Different teams. Different numbers. Limited progress.
Population Team
We've identified 10,000 people at risk.
≠
Operational Team
We only see 4,000 people attending.
The result:
Debate about numbers
Delayed decisions
Fragmented planning
Unclear priorities
With Strategic Commissioning
A shared framework. Better decisions. Greater impact.
Need
Population health intelligence
Strategic Commissioning
Understanding and interpreting
Activity
Operational planning and delivery
Different numbers. Shared understanding.
The result:
Shared interpretation
Better resource allocation
Aligned neighbourhood planning
Improved outcomes
What Success Looks Like
From insight to action. A healthier tomorrow.
Population Health Intelligence
"What future need is emerging?"
Strategic Commissioning
"What should we do about it?"
Operational Planning
"What capacity will be required?"
Neighbourhood planning is not about reconciling need and activity. It is about making informed decisions in the space between them.
NHS
Integrated Care | Healthier People | Stronger Places | Fairer Futures
Working together for healthier neighbourhoods

TAMESIDE INTEGRATED NEIGHBOURHOOD MODEL

Joining up reform to improve health and wellbeing and reduce inequalities

STRATEGIC ALIGNMENT

- Better health and wellbeing
- Care closer to home
- Reduced inequalities
- Stronger communities
- Tameside Borough Strategy 2026–2030
- Building Back Fairer, Stronger, Together (Tameside Joint Health and Wellbeing Strategy and Locality Plan)

GM Strategy
NHS 10 Year Health Plan
GM Prevention Demonstrator

LIVE WELL

The connecting neighbourhood infrastructure

All ages • Universal prevention • Wider determinants of health • Community power • "No wrong door"

- Live Well Centres
- Live Well Spaces & Offers
- VCFSE & communities
- Enhanced Live Well (support for people facing multiple disadvantage)

Housing
Work & skills
Money & debt
Wellbeing
Social connection
Prevention

FAMILIES FIRST REFORMS

Children, young people & families

Integrated family support and safeguarding response

- Family Help
- Multi-agency child protection
- Family network support
- Best Start / Family Hubs
- Links to education, health & SEND

Primary reform vehicle for integrated support to children and families



PEOPLE & COMMUNITIES AT THE CENTRE

Co-production • Choice
Personalised support
Outcomes that matter

INTEGRATED NEIGHBOURHOOD HEALTH & CARE (INTs)

Adults with health & social care needs

Integrated Neighbourhood Teams bringing together health, care and community partners

- Primary care
- Community health
- Adult social care
- Mental health
- VCFSE / social prescribing
- Acute specialists where needed

INITIAL FOCUS IN TAMESIDE: adults with complex / escalating health and social care needs

WHY THIS APPROACH?

- Different reforms address different parts of need across the life course.
- Families First strengthens integrated support for children and families.
- Integrated Neighbourhood Teams focus on adults where fragmentation and unmet need are greatest opportunity for impact.
- Live Well provides the universal infrastructure that connects people to support and the wider determinants of health.
- Together this builds prevention, improves outcomes and reduces pressure on acute and social care services.

SHARED NEIGHBOURHOOD ENABLERS

- Population health management & data
- Workforce development & cultural shaping
- Co-location & estates
- Digital & shared care information
- Neighbourhood leadership & governance
- Personalised care & co-production
- Health inequalities & inclusion
- Home First / intermediate care & urgent neighbourhood response

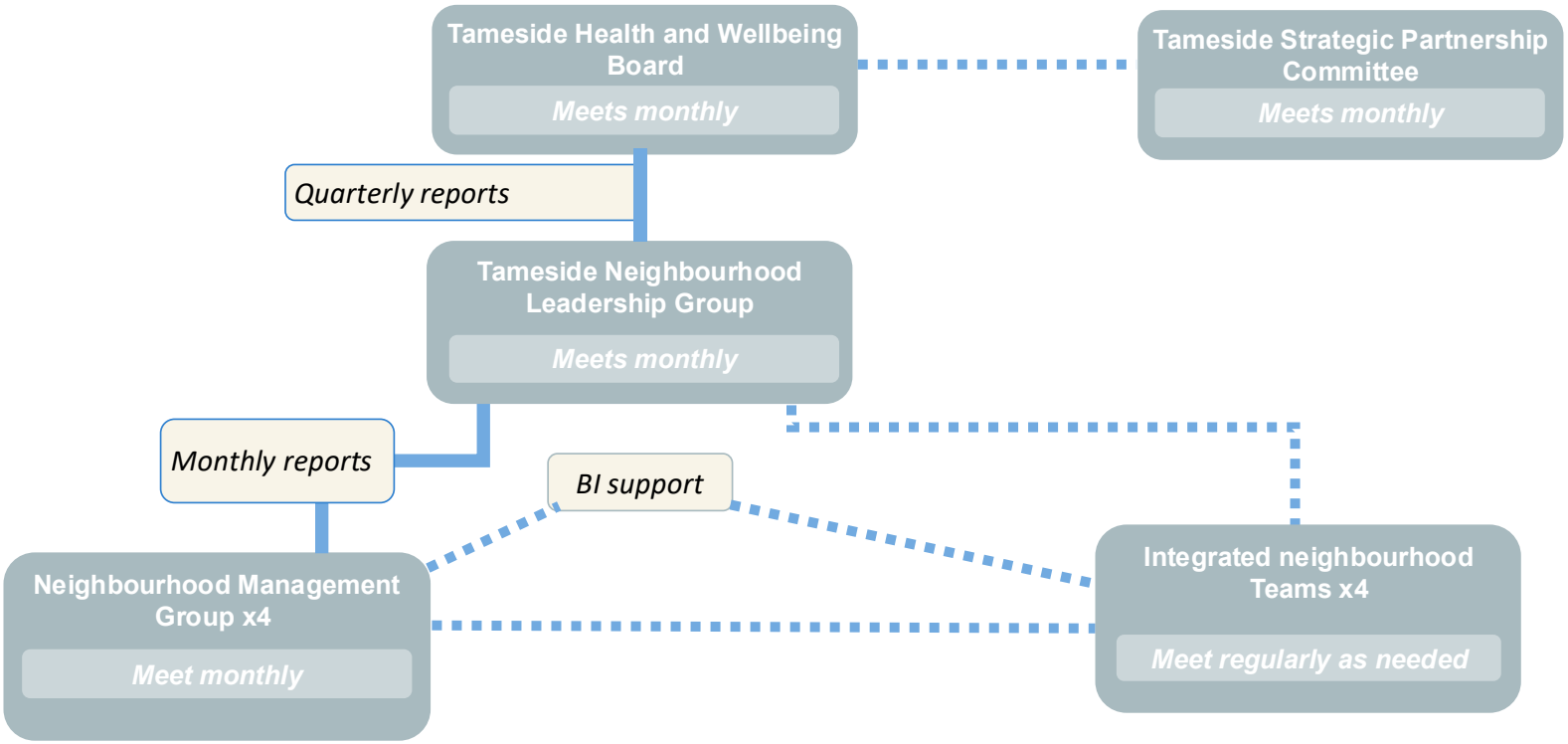
WHO WORKS TOGETHER?

- NHS (Providers & ICB)
- Tameside Council (Adult Services, Children's Services & Public Health)
- Greater Manchester (Functions & Support)
- VCFSE & Communities
- People with lived experience
- Primary Care Networks
- Neighbourhood Teams

Four neighbourhood groups across Tameside with a Neighbourhood Leadership Group bringing partners together.

Sources: GM Live Well Strategy • Families First Reform • NHS Neighbourhood Health Framework • NHS Guidance on Neighbourhood MDTs for Children and Young People • NHS Medium Term Planning Framework

Governance: Reporting lines



- **Terms of Reference** for the Neighbourhood Management Group. The Terms of Reference will be the same across each neighbourhood with the exception of the membership which is tailored to the priority group focused on by that neighbourhood, and their specific role.
- Develop a **reporting template** which is intended to be used for monthly reporting into the NLG Group, this will require BI support around KPI reporting

Tameside Metropolitan Borough

Integrated Neighbourhood Teams (INTs)

- INTs should bring together expertise from **primary care, community health, social care, mental health, VCFSE and wider partners** around a shared population (Neighbourhood Health Guidelines 2025/26).
- They should provide **proactive, planned and responsive care**, particularly where people have complex health, care or social needs requiring multiple organisations.
- Functions include holistic joint assessment, multidisciplinary case review, coordinated provision, medicines review, LTC care planning, personalised care and support planning/social prescribing, comprehensive geriatric assessment and advance care planning.
- So an Integrated Neighbourhood Team is **more than an MDT meeting**. The direction of travel is towards an enduring, operational **"team of teams"** working around a defined neighbourhood population.

Governance for the Neighbourhood programme: A central oversight group and neighbourhood INTs

Tameside Neighbourhood Leadership Group

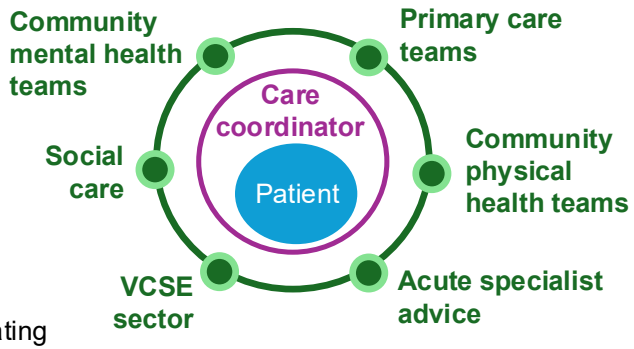
- Bringing together **Local Authority, ICB, NHS health providers and VCFSE**, amongst others
- **Senior oversight** of PHM programme, helping **troubleshoot issues and providing a point of escalation**
- **Reviewing programme implementation and impact** using KPI dashboards – accountable for outcomes and tracking benefits

Neighbourhood Management Group x4

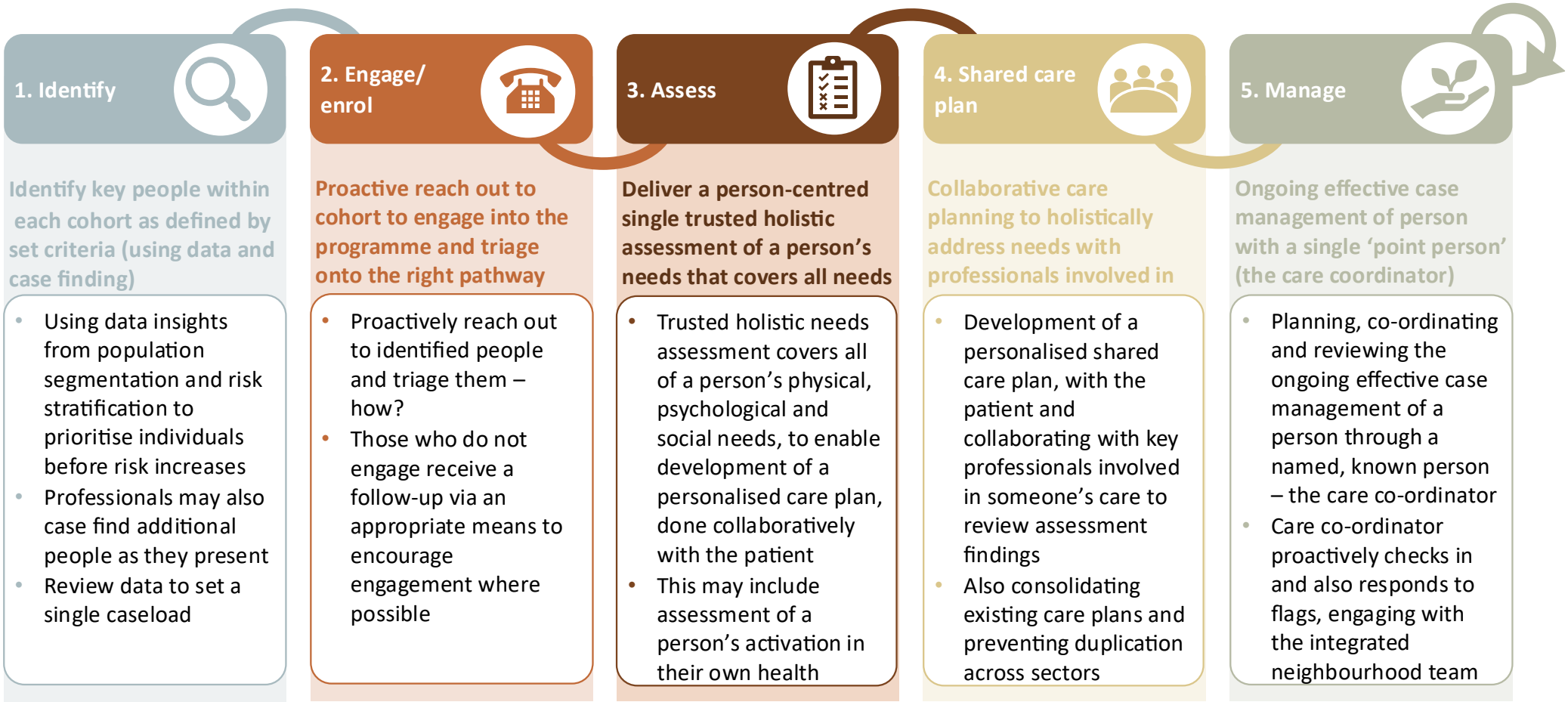
- **Oversees and is accountable for decision-making and management** of Neighbourhood management including operational oversight (e.g. reviewing caseload management)
- Include a **senior clinical lead**, **neighbourhood-wide operational lead**, **specialist care worker*** and **Local Authority**. Others will likely attend meetings.
- **Could be district nurse/occupational therapist for older age models, or Early Help for CYP*

Integrated neighbourhood teams (INTs) x4

- Multiple sectors and care settings collaborating across a neighbourhood to **provide a holistic, joined up approach that addresses all of a person's needs**
- **Responsible for delivering the PHM pathway** and creating **shared ownership across sectors** for proactively managing their population
- The integrated neighbourhood team is **empowered to make day-to-day decisions about the PHM pathway**



Each INT follows the same five stages but tailored to the local priority population



Next steps: developing Integrated Neighbourhood Teams

- The **Neighbourhood Leadership Group** will apply the Integrated Neighbourhood Team model to design and establish **four neighbourhood teams** across Tameside.
- The first priority cohort will be people identified as being at **high risk of attending urgent care services within the next 7 or 28 days**.
- The cohort will be identified using the innovative **Tameside and Glossop Integrated Care NHS Foundation Trust AI model**, which analyses existing patient data to predict the likelihood of urgent care reattendance and highlights the factors contributing to that risk.
- The intelligence will support the Integrated Neighbourhood Teams to identify people who may benefit from **proactive, coordinated intervention**, while supporting rather than replacing professional judgement.
- Risk of urgent care attendance provides a useful initial proxy for people with **complex, unmet or poorly coordinated needs**, where earlier neighbourhood support may improve outcomes and prevent escalation or crisis.
- Learning from this first phase will inform implementation and evaluation, with **further priority cohorts identified as the four integrated neighbourhood teams develop**.

Tameside Metropolitan Borough