

Agenda

Salford Integrated Care Partnership Committee

Date: 22 October 2026

Time: 9.00 am to 12.00 pm

Venue: Salford Suite, Civic Centre & Microsoft Teams

Item No.	Time	Duration	Subject	Paper/ Verbal	For Approval/ Discussion/ Information	By Whom
1.	9.00	5 mins	Welcome, Introductions and Apologies	Verbal	Discussion	Chair – Paul Dennett
2.	9.05	10 mins	Anonymised Story / Case Study	Verbal	Information	Healthwatch
3.	9.15	5 mins	Declarations of Interest	Verbal	Discussion	Chair
4.	9.20	10 mins	Minutes of Previous Meeting, Action Log and Matters Arising	Paper	Approval	Chair
5.	9.30	1 hour	Regular Reports VCSE Strategic Update	Presentation	Information	Chief Executive, Salford Community & Voluntary Services
6.	10.30	25 mins	Annual Reports Urgent & Emergency Care / Winter Planning	Paper	Assurance	Associate Director Transformation & Improvement, NHS Greater Manchester (Salford)
7.	10.55	1 hour	System Updates a) Place Health and Care Partnership Update	Paper	Information	Place Partnership Director, NHS Greater Manchester (Salford)
			b) Northern Care Alliance Integrated Improvement Plan Update	Paper	Information	Chief Nursing Officer, Northern Care Alliance

			c) System Partner Updates	Verbal	Information	All
8.	11.55	5 mins	Any Other Business	Verbal	Discussion	All
9.	12.00		Date and Time of Next Meeting: 9.00 am - 12.00 pm 17th December 2026			

Minutes

Salford Integrated Care Partnership Committee

Date: 25 June 2026

Time: 9.00 am to 10.20 am

Venue: Microsoft Teams / Salford Suite

Present	
- Tom Regan, Associate Clinical Director, NHS Greater Manchester (<i>Chair</i>) (TR) - Becky Wilkinson, Executive Director for Adult Social Care & Health Partnerships, Salford City Council (BW) - Ben Whalley, Chief Executive Officer, Gaddum (BWh) - Bruce Poole, Senior Strategic Lead for Health and Social Care, Salford CVS (<i>attending on behalf of Alison Page</i>) (BP) - Claire Vaughan, Associate Director of Clinical Leadership & System Integration (Salford), NHS Greater Manchester (CV) - Liz Calder, Director of Strategy, Greater Manchester Mental Health (LC) - Luvjit Kandula, Wider Primary Care Representative (<i>attending on behalf of Elliott Patrick</i>) (LK) - Hannah Dobrowolska, Delivery Director for Health and Care Integration (Salford), NHS Greater Manchester (HD) - Harry Golby, Associate Director of Delivery and Transformation (Salford), NHS Greater Manchester (HG) - Jane Hamilton, Executive Support Member for Social Care and Public Health (JH) - Jim Cammell, Lead Member for Children's and Young People's Services (JC) - Juliette Cosgrove, Chief Nursing Officer, Northern Care Alliance (JCo) - May Moonan, Director of Healthcare, Public Health, Salford City Council (<i>attending on behalf of Gillian McLauchlan</i>) (MM) - Melissa Caslake, Executive Director of Children's Services, Salford City Council (MC) - Sam Cook, Chief Officer, Healthwatch Salford (SC) - Tracy Kelly, Statutory Deputy City Mayor and Lead Member for Adults Social Care and Health, Salford City Council (TK) - Victoria Halliwell, Dean / Professor of Industry Collaboration in Health Care Education, School of Health and Society, University of Salford (VH) - Elaine Redwood, Admin Support, NHS Greater Manchester (Minutes) (ER)	- Abbie Holland, Neighbourhood Mental Health Team (AH) - Markus Greenwood, CEO, MIND in Salford (MG) - Nicola Swann, Strategic Lead in MH and Wider Wellbeing, Salford CVS (NS) - Martyna Swieczkowska, 6 Degrees Social Enterprise (MS) - Mel Safari, Co-founder, Lingua Linguistic Services (MSa) - Wendy Broderick, Neighbourhood Mental Health Team (WB)
Guests for Item 2 – Mental Health Update - Clare Mayo, Integrated Commissioning Manager, Adult Mental Health (Salford), Salford City Council / NHS Greater Manchester Integrated Care (CM) - Judd Skelton, Director of Adult Commissioning, Salford City Council and NHS Greater Manchester (JS) - David Chambers, Head of Operations for Salford and Trafford Community, GMMH (DC)	Observing - Anu Balaji, Product Manager, CyberLiver Limited (member of public) - Joanne Farrell, Head of the City Mayor's Office (observing) (JFa) Apologies - Alison Page, Chief Executive, Salford Community & Voluntary Services (AP) - Elaine Vermeulen, Associate Director of Finance (Salford), NHS Greater Manchester (EV) - Elliott Patrick, Wider Primary Care Services Representative (EPa) - Gillian McLauchlan, Interim Director of Public Health, Salford City Council (GMC) - Kelly Hylton, Managing Director, Six Degrees (KH) - Nicola Hepburn, Acting Chief Reform and Improvement Officer, NHS Greater Manchester (NH) - Paul Dennett, City Mayor (PD) - Rachel Rosewell, Chief Finance Officer (S151), Salford City Council (RR) - Samuel Russell, Strategic Head of Finance for People (Children's and Adults) (SR) - Sapna Tandon, Primary Medical Services Representative (ST) - Stephen Young, Chief Executive and Place Lead, Salford City Council (SY) - Vannamalar Selvaraasan, Primary Medical Services Representative (VS)

Item No.	Topic	Action
1.	Business As Usual a) Apologies and Declarations of Interest TR welcomed everyone to the meeting and the above apologies were noted. TR reminded board members of their obligation to declare any interest they may have on any issues arising at the meeting which might conflict with the business of the Locality. None were declared. b) Minutes of Previous Meeting The minutes from the meeting held on 26 February 2026 were approved. c) Action Log and Matters Arising It was noted that updates had been provided against the outstanding actions on the log. HD mentioned that updates had since been provided in relation to HIV Testing and she will ensure the log is updated accordingly. There were no matters arising.	
2.	General Items – Adult Mental Health Update CM, supported by JS, LC and members of the Neighbourhood Health Team presented a comprehensive update on Salford's Adult mental health services, outlining the strategic context, delivery models, performance, and transformation work, with a focus on supported living, inpatient care, crisis alternatives, and suicide prevention. Highlights included: - o Strategic Frameworks and Priorities: CM explained that Salford's Adult mental health work is guided by the national 10-year plan and the Greater Manchester (GM) mental health and wellbeing strategy, which includes five priority missions. The indicators for these missions are aligned with GM mental health programmes and system priorities, including prevention agendas, and the ICB delivery model integrates GM-level oversight with local partnership and insights. - o Supported Living and Commissioning Review: The committee was informed about ongoing strategic commissioning reviews of mental health supported living, including improvements to existing provision, efforts to keep people closer to home, and the transition of some provision back into council management. The work is linked to Salford council's Housing Strategy and aims to support people towards greater independence. - o Inpatient Care and Community Offer: CM highlighted Salford's strong performance in minimising out-of-area placements and reducing hospital stays, supported by a robust community offer. An 18-month test of change is embedding an inpatient Community Connector at Meadowbrook to support discharges, with ongoing evaluation to inform future practice. - o Crisis Alternatives and Suicide Prevention: The update covered the use of crisis beds, Mental Health Liaison, Home-based Treatment, and the Voluntary Sector's Listening Lounge as alternatives to A&E. Suicide Prevention efforts include partnership	

	action plans, improvements to high-risk locations, and targeted work with men's and women's mental health groups, with a refresh of the action plan underway. Summary of discussion points: TR highlighted that the work is making a real difference to the people of Salford and is a really good alternative to attendance at A&E. JC raised concerns about support for young adults (18–25), particularly regarding employment and transition from Children's to Adult services. CM confirmed the existence of an All-age Mental Health Board and committed to sharing information and strengthening links with children's commissioning colleagues. BW mentioned the risks around UNIFY in terms of GMMH and the need to collaborate more. The challenge around the VCSE is also really important to note. We need to be honest around how we take this forward and need to build on our strengths. Supported Living also needs to be considered in terms of market management. There needs to be more joined up working between Children's and Adults mental health services in order to support the whole family. In terms of the Urgent Care element, as the Northern Care Alliance is moving into its new Clinical Leadership Model, consideration needs to be given towards how we commission with two mental health providers (GMMH and Pennine) spanning the Four Localities Partnership footprint. It was agreed this would be an action for the All-Age Mental Health Board. Greater Manchester Mental Health (GMMH) Strategy: LC presented the Trust's three-year strategy, focusing on community-based, trauma-informed care, quality improvement, digital integration, and financial sustainability, and discussed the alignment with national and regional plans, as well as the need for system-wide collaboration and learning. Highlights included: - o Strategy Development and Ambitions: LC described the GMMH Strategy as rooted in feedback from service users, aiming for ambitious community-focused care while addressing basic improvement needs. The strategy is structured around delivering care that matters, working together with stakeholders, and being fit for the future, including the introduction of trauma-informed care and a focus on clinical standards and research translation. - o Transformation Programmes and Community Focus: GMMH is implementing transformation programmes in inpatient, community, and rehabilitation services, with a goal to reduce inpatient bed use and strengthen community services. The trust is leveraging integrated funds to reinvest savings from reduced out-of-area placements into community support. - o Quality, Culture, and Digital Integration: Quality assurance and culture of care initiatives are underway, including the adoption of NHS patient safety approaches and staff engagement. A joint digital and data strategy with Pennine Care is being developed to standardise systems and practices across providers. - o Financial Sustainability and System Learning: Efforts to improve productivity include optimising estate use, reducing delayed discharges, and meeting NHS productivity indicators. LC emphasised the importance of sharing Salford's successful	
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	practices with other areas and learning from system-wide data. - o Future National Developments: LC outlined upcoming national changes, including a new Mental Health Act, the development of mental health emergency departments, 24/7 Neighbourhood Mental Health hubs, and new service frameworks for Severe Mental Illness, Frailty, Dementia and Children & Young People. Summary of discussion points: BP highlighted the fantastic work being done by the VCSE with GMMH in terms of the Community Connector and queried how this can be taken to the next level i.e. out into the community. It was noted there is an issue in terms of PCN funding to neighbourhood health teams. JCo highlighted that the Crisis Assessment Centres are a good alternative to A&E and provide a better experience for patients. JS highlighted that some good work had already been done with the Gaddum around the community. BWh will share the evaluation around the return on investment. TR highlighted the need to share good practice across the conurbation. Neighbourhood Mental Health Teams (Living Well) Model and Impact: Members of the Neighbourhood Mental Health Team detailed the origins, multidisciplinary structure, trauma-informed and relational approach, and positive outcomes of the Living Well model, addressing questions about service scope, funding, and integration with other local initiatives. The following were highlighted: - o Model Origins and Partnership Working: The Neighbourhood Mental Health Team, formerly Living Well, was established as a national pilot funded by the National Lottery and designed through ethnographic research and co-production with partners including GMMH, Mind, Start, Six Degrees, Wellbeing Matters, and CVS. The model emphasises partnership and continuous development. - o Trauma-Informed, Relational, and Holistic Care: The team employs a strengths-based, trauma-informed, and solution-focused approach, prioritising independence and whole-person care. The model integrates clinical and non-clinical staff, including peer support workers, social workers, housing and welfare advisors, and Community Connectors, to address both mental health and social determinants. - o Impact and Outcomes: External evaluations have shown significant positive outcomes. The model supports visible recovery, staff wellbeing, and high retention. The team's integrated approach reduces reliance on crisis services and supports sustainable recovery. - o Service Scope, Funding, and Access Challenges: Committee members raised concerns about 'mission creep' into more severe mental illness and the impact of Primary Care Network (PCN) disinvestment, leading to postcode differences and increased waiting times in some areas. The team acknowledged increased demand and resource pressures, and ongoing efforts to maintain value and address system-wide challenges. - o Integration with Other Services and Data Sharing: The team described close integration with welfare, housing, and employment services, and discussed the need for improved data sharing and connectivity across services, including community pharmacy and prevention initiatives. Ongoing collaborative forums and transformation programmes aim to address these integration and access issues.	
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	VCSE Integration and Investment Task and Finish Group: BWh expressed that there is a need to ensure that there is proper space for this consideration as we move forward with a better system strategy and thinking around VCSE involvement. BWh would be happy to Chair / facilitate this, and would be keen to be involved. Actions: All Age Mental Health Board Membership: Share the membership details of the All-Age Mental Health Board with children's services colleagues to strengthen relationships and integration. GMMH Representation on Families First Partnership Board: Nominate and arrange for a GMMH delivery manager with decision-making authority to attend the Families First Partnership Board chaired by MC. Sharing Good Practice Across GMMH Footprint: Facilitate discussions to share Salford's good practice in reducing inpatient bed days and out-of-area placements with colleagues in other GMMH areas to support wider replication. Neighbourhood Mental Health Team and Live Well Model Interface: Initiate discussions between Live Well leads and Neighbourhood Mental Health Team leads to clarify and formalise how the two models will interface and collaborate. Mission Creep and Investment Disparity Review: Use the mental health collaborative and design team forum to address concerns about mission creep in the Living Well model and review the impact of PCN investment disparities, including gathering relevant data. TR will contact Tom Tasker in relation to this.	CM CM LC CM TR
3.	System Updates a) System Partner Updates - LC mentioned that GMMH's current Chief Executive is retiring at the end of June and Chris Oliver is joining on 1st July. - JCo provided an update on the Northern Care Alliance (NCA), addressing recent NHS England undertakings due to quality governance concerns, while other partners discussed leadership changes, new appointments, and the need for improved communication and partnership working. The following were discussed: NCA Quality Governance and Improvement Actions: JCo reported that the NCA is under NHS England undertakings due to concerns in spinal and gynaecology services, and is receiving additional support and clinical leadership. The trust is focusing on quality governance improvements, staff engagement, and preparing for a CQC well-led inspection, with a commitment to transparency and partnership working. Partner Support and Collaboration: Committee members offered practical support to the NCA and discussed the importance of embedding new leadership models, strengthening relationships, and considering roundtable discussions to address both Salford-specific and system-wide challenges. - BP mentioned that Salford CVS have recruited two new Strategic Leads. One is around Place (particularly Pride in Place) and the other is for	

	housing and social. b) Place Lead Report HD presented the paper and the following were discussed: • GM ADHD and Autism Funding Concerns: Questions were raised about the distribution and impact of the £3.2 million GM ADHD and Autism investment, with concerns about long waiting lists, unclear prioritisation, and outdated information on available support courses, particularly for working parents. Action: HD will look into this and update JC. • Healthwatch Salford Service User Stories: SC offered to provide service user stories or advice and signposting updates at future meetings, to enhance the committee's understanding of lived experience and service impact. It was agreed this would be helpful. The committee: • <i>noted the contents of the report.</i> • <i>agreed to disseminate and cascade the necessary key messages and information as appropriate.</i>	HD
4.	Any Other Business None. The meeting closed at 10.46 am.	

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

No	Date	Section	Details of the issue	Details of action agreed	Action Lead	Timescale / Deadline	Status	Update
237	25/06/2026	Place Lead Report	GM ADHD and Autism Funding Concerns: Questions were raised about the distribution and impact of the £3.2 million GM ADHD and Autism investment, with concerns about long waiting lists, unclear prioritisation, and outdated information on available support courses, particularly for working parents.	HD will look into this and update JC.	Hannah Dobrowolska	22/10/2026		13/10/26: Ongoing. Information shared in relation to non working hours support for parents. Information awaited with regard to funding and impact on waiting list/times.
Actions Closed Since the Last Meeting								
172	27/03/2025	Place Lead Report	GMC mentioned that the expansion of the blood borne viruses testing is good, but she highlighted that there are different funding streams for each and we need to recognise this and the different patient pathways.	GMC to contact Jane Pilkington around this.	Gillian McLauchlan	26/02/2026		17/4/25 - Jane Pilkington now left NHSE so GM will pick up conversations with Alison Pye at GM 24/4/25 - In respect of blood borne viruses Salford Royal Emergency Department tested for Hepatitis C but not Hepatitis B because of pathways and capacity. A solution for this was being discussed with the Greater Manchester team. The action was ongoing. 22/05/25: GMC mentioned that Salford were the last to roll out HIV testing. We can now test for HIV, Hepatitis B and Hepatitis C, however there is an issue at SRFT in relation to managing the demand. We need to push this with the ICB. 23/10/25: Ongoing. 18/01/26 – Opt out testing in ED is a ICB commissioned service and responsibility. Locality team to action with respective team in the GM team. Note this is a risk as likely to be affected by reforms 02/07/26: Update – Longer term funding reportedly secured from NHSE, potentially until 2030, single payment scheme for all 3 blood borne viruses (HIV, HCV, HBV).
179	22/05/2025	Action Log	HG mentioned that an update on blood borne viruses had been provided to the PCB and it was highlighted that there is not enough capacity within the treatment pathway, which is causing the issue.	HD to pick this up with CS/JF and provide an update at the next meeting.	~~Hannah Dobrowolska~~ Harry Golby	26/02/2026		16/06/25: HG to pick up on behalf of HD. 19/06/25: JF spoke to Mark Kellett about this a couple of weeks ago and will provide an update. 24/07/25: HG has chased and is awaiting an update. Ongoing. 23/10/25: Ongoing. 14/11/25 Internal discussion ongoing within NCA to find investment required to increase capacity in treatment pathway. 19/02/26: HG is awaiting an update from the NCA. 02/07/26: Update – Hepatology capacity at Salford had deterred from introduction of HBV testing in Salford. 12 months interim arrangement in place with MFT accepting newly diagnosed HBV patients from Salford. HBV testing therefore included in Salford test panel from May 2026. Clinical group for surgery progressing discussions regarding longer term solution.

191	24/07/2025	Ingleside Update	JC mentioned the city mayor and local MP are keen to get the unit re-opened for births. However, the report predicts that the earliest birth will take place in 2027. Occupancy review details are needed as this is a council owned building which is leased to Bolton FT.	HG to obtain details of occupancy and future proposals for births up to 2027.	Harry Golby	26/02/2026		25/09/25: HG is trying to get hold of utilisation information – ongoing. 09/10/25: Discussed at Ingleside Collaborative, chased 29/09/25, no further update as at 09/10/25. 23/10/25: Ongoing 14/11/25: HG to email Wendy Hodgson in relation to this action. 19/02/26: As above. 15/06/26: Bolton has been asked for an update. 07/10/26: Colin Scales wrote to key stakeholders with an update in September 2026.
232	25/06/2026	Adult Mental Health Update	All Age Mental Health Board Membership	Share the membership details of the All-Age Mental Health Board with children's services colleagues to strengthen relationships and integration.	Clare Mayo	22/10/2026		07/10/26: Membership details are shared with Children's services and regular attendance is in place from Children's services via Debbie Blackburn, Emily Edwards and CYP mental health providers (NHS Trust and VCSE).
233	25/06/2026	Adult Mental Health Update	GMMH Representation on Families First Partnership Board	Nominate and arrange for a GMMH delivery manager with decision-making authority to attend the Families First Partnership Board chaired by MC.	Lee Calvert	22/10/2026		07/10/26: Invites have been shared with GMMH and attendance is progressing. Adult MH Commissioning link also now connected into the work.
234	25/06/2026	Adult Mental Health Update	Sharing Good Practice Across GMMH Footprint	Facilitate discussions to share Salford's good practice in reducing inpatient bed days and out-of-area placements with colleagues in other GMMH areas to support wider replication.	Clare Mayo	22/10/2026		07/10/26: This has been regularly shared with GMMH and GM colleagues and is routinely reported in Salford's Adult MH Highlight reports via the AAMHB which is attended by GMMH leads.
235	25/06/2026	Adult Mental Health Update	Neighbourhood Mental Health Team and Live Well Model Interface	Initiate discussions between Live Well leads and Neighbourhood Mental Health Team leads to clarify and formalise how the two models will interface and collaborate.	Clare Mayo	22/10/2026		22/09/26: CM has picked this action up and linked into the pro-active care meetings. 07/10/26 - MH representation will be included in the forthcoming NH Model events planned by Satty Boyes / Claire Vaughan.
236	25/06/2026	Adult Mental Health Update	Mission Creep and Investment Disparity Review	Use the mental health collaborative and design team forum to address concerns about mission creep in the Living Well model and review the impact of PCN investment disparities, including gathering relevant data. TR will contact Tom Tasker in relation to this.	Tom Regan	22/10/2026		07/10/26: A focus of the Adult MH Design Team and Collaborative includes work relating to NH MH Team and ongoing transformation of community mental health offers, including PCN impact. Tom Tasker is the Chair of the Design Team and is linked into this work. 07/10/26: TR has emailed TT asking to provide details of any issues.

Salford Integrated Care Partnership Committee

22 October 2026

Item 6 – Urgent & Emergency Care / Winter Planning

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

Report of:	Associate Director Transformation & Improvement, NHS Greater Manchester (Salford)	
Date of Paper:	15 October 2026	
In case of query, please contact:	Stephen Tilley, Transformation and Improvement Programme Manager (Salford) stephen.tilley@nhs.net	
System Priorities: (Please tick as appropriate)	Physical activity and movement	
	Child Friendly City	
	Live well, Neighbourhoods and Communities	
	Adults and Ageing Well	
	Preventable illness - CVD and Diabetes	
	Urgent and emergency care	✓
	Mental health and emotional wellbeing	✓
	Triple aim – population health, performance recovery, financial sustainability	✓
	Other system enabler i.e. Workforce, Transformation, Digital etc.	
Purpose of Paper: To provide the Salford Integrated Care Partnership Committee with an update on urgent and emergency care (UEC) performance heading into winter 2026/27 and assurance regarding winter planning across the Salford UEC system.		

Further information

How will this benefit the health and wellbeing of Salford residents, or the Integrated Care Partnership?	Ensuring resilient services for the winter period.
How does this paper address health inequalities and promote inclusion?	In reviewing the organisational individual winter plans, the Salford Place Team noted that there is specific consideration of ensuring that health inequalities are addressed and that inclusion is promoted through the delivery of the plans.
What risks may arise as a result of this paper and how will they be mitigated?	Robust winter planning aims to mitigate the risks to the health and social care system over the winter period.
Does this address any existing high risks facing the organisation and how does it reduce them?	Failure to achieve system performance measures is a risk and the report provides information on plans over winter that help to mitigate that risk.
Are there any possible conflicts of interest associated with this paper?	No
Will any current services or roles be affected by issues within this paper and what are they?	Effective winter planning and response will reduce the pressure on much of the Salford health and care system over the coming months.

Note: Where appropriate, please ensure detail is provided.

Document Development

Has there been Public Engagement?	N/A
Has there been Clinical Engagement?	There is clinical representation on the Salford UEC Group.
Has the impact on Salford socially, economically and environmentally been considered?	N/A
Has an Equality Impact Analysis been completed?	No, however, in reviewing the individual organisational winter plans, the Salford Place Team was assured that equality impact has been considered.
Has legal advice been obtained?	N/A
Has this been to any groups or committees for engagement, comments, or approval?	No

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

Urgent and Emergency Care Winter Planning Update

1. Executive Summary

This report outlines current urgent and emergency care (UEC) performance heading into winter 2026/27. Assurance regarding winter planning across the Salford UEC system is also provided.

2. UEC Performance

- 2.1 There are three key NHS indicators that are used as overarching UEC metrics in Greater Manchester (GM):
- The 4-hour target, which measures the percentage of Accident & Emergency (A&E) attendances that wait less than 4 hours before admission, discharge or transfer.
 - The number of attendances at A&E.
 - Days Kept Away from Home (DKAFH). This indicator shows when patients are medically fit to be discharged but, for various reasons, remain in a hospital bed.
- 2.2 Reorganisation of the Northern Care Alliance (NCA) and the transfer of adult social care services back under the direct management of Salford City Council has resulted in many staff changes and new senior managers leading UEC across the Salford system. The first quarter of 2026/27 saw Salford consistently reaching an average of 69% of A&E attendances waiting less than 4 hours. This has been harder to maintain over the last 3 months as the changes described started to be implemented. The second quarter saw an average of 67.8%, but overall the average over the first 6 months of the year was 68.4% compared to 65.2% in 2025/26, so there are signs of improvement. There is every indication that there will be further improvement in October 2026 as Salford is achieving 69/70% regularly. Whilst this is still short of the overall target of 78%, the winter plans described in this paper are designed to address this discrepancy.
- 2.3 A&E attendance levels have stayed consistent month-on-month. Unlike some other GM localities, Salford has not seen great fluctuation in attendances from month to month this year, but overall Salford has seen an increase in attendances this year which is reflected across Greater Manchester. 2026/27 has seen, on average, over 10,000 patients per month. This is up on last year as the average monthly attendance in 2025 was 9931. Measures to reduce attendances and manage those numbers more effectively are contained in the winter plans.
- 2.4 The DKAFH indicator continues to be challenging, but there has been a steady decrease quarter on quarter and when compared to last year. A sustained focus on speeding up the discharge of patients when they are fit for discharge has seen the quarterly average fall from 19.6% in Quarter 1 to 16.4% in Quarter 2. The appointment of a dedicated site manager, coupled with weekly DKAFH meetings and the establishment of a Board Round Steering Group has helped the system to drive improvement.

- 2.5 Many of the schemes that support these metrics are listed in the winter plans of the different partners.

3. Salford UEC System Winter Plans

- 3.1 Salford locality partners continue to work more closely in creating a connected approach to winter planning. This approach has helped to support additional monies being allocated to Salford to support discharge and flow through the NHS Greater Manchester Capacity Fund.
- 3.2 Salford was the only GM locality to have all proposed Capacity Fund projects supported for this coming winter in the context that funding was reduced for other localities across Greater Manchester. £921,393 was awarded for the delivery of an anticipated 24,247 additional general practice appointments over the winter period. Acute and mental health provider schemes form the remainder of the fund which will be evaluated later in 2026/27 to inform 2027/28 planning.
- 3.3 A Salford UEC Group is now established with attendance from key partners from across the city. This group allows winter plans from each provider to be shared across the stakeholders for comment and input. In addition, the plans will be regularly reviewed by this group at its monthly meetings, with risks/challenges shared so that support can be provided from across the city to ensure that targets are on track.
- 3.4 The UEC Group has agreed to establish a Winter Escalation Meeting, to tackle issues arising and ensuring defined escalation procedures are being followed. The recent appointment of a hospital site manager in Salford adds additional value to this meeting, and it will be supported through the Place Team and all place partners are expected to take part.
- 3.5 The existing NHS Greater Manchester escalation policies are being reviewed and existing plans will be reissued until any changes are introduced.
- 3.6 Salford will actively support all winter workshops arranged by NHS Greater Manchester or NHS England with appropriate representation.
- 3.7 The remainder of this paper will provide an overview of the winter plans developed by:
- The Northern Care Alliance
 - Salford Primary Care Together
 - North West Ambulance Service
 - Salford Adult Social Care
 - Greater Manchester Mental Health

Individual primary care providers and Primary Care Networks will undertake their own winter planning, largely related to the additional appointments made available through the GM Capacity Fund. Whilst the Voluntary, Community and Social Enterprise (VCSE) sector in Salford do not have a specific winter plan, they contribute to numerous schemes which support initiatives to support health and wellbeing over the winter months, including vaccine uptake and combatting loneliness and social isolation.

Northern Care Alliance (NCA)

- 3.8 The NCA winter plan is more comprehensive than last year, with a winter planning group meeting since July 2026 and greater input from clinical groups, estates & facilities, workforce wellbeing, intermediate care and other stakeholders. Monitoring and assurance have been strengthened, with an action plan progressing through the Planning and Performance Group and onward to the NCA's Board.
- 3.9 The winter plan sits in the wider context of NCA objectives to deliver against key performance metrics including a reduction in average length of stay, and an increase in use of key community services that avoid hospital admission and enable earlier discharge.
- 3.10 Figure 1 represents the NCA's winter plan.

Figure 1: NCA Winter 'Plan On A Page'



- 3.11 Specific schemes and objectives to support acute services at the Salford Royal site include:

- Standardise Call Before Convey across the NCA.
- Enhance Front Door Streaming, including Bury and Rochdale Doctors on Call (BARDOC), Salford Primary Care Together (SPCT) and Go To Dot (GDT)

- Implementation of Extended Emergency Medicine Ambulatory Care (EEMAC) model at each A&E.
- Values Shift Programme – Acute Medicine – Length of Stay (LoS), Workforce, Capacity and Demand.
- A&E & Acute Medicine Capacity and Demand Modelling Getting it Right First Time (GIRFT) supporting.
- Capital Schemes - Oldham £4.9m build starting April 2027, Salford £2.7m Build starting TBC
- Review of attendance presentations for walk-in – Themes.
- Implementation of Get It Right First Time (GIRFT) Standards – Corridor Care/Clinical Operational Standards.
- NCA Safer Sooner Collaborative – Length of Stay (LoS) Acute Medicine.
- Implementation of Hot Clinics.
- Same Day Emergency Care (SDEC) workshop with stakeholder involvement.
- Review of all pathways across A&E with all other Clinical Groups (Medicine, Surgery, Neuro, Community) with trusted assessor model.
- GIRFT support for Oldham Site start date started August 2026 review schemes and the scheme finding will be used to improve all NCA sites including Salford.
- UEC and Community Improvement Collaborative started with key leads for our priority projects 2-day Quality Improvement away day 2nd and 6th October with Commissioning Support Units (CSUs).
- Values Shift Programme – ED – LoS, Workforce, Capacity and Demand starting October 2026.

3.12 Specific schemes and objectives to support Salford community services include:

- Discharge planning from admission.
- In-reach and discharge direct from the Emergency Department (ED), supported by community.
- Navigation of referrals via Single Points of Access (SPOA) directing low-medium acuity to Urgent Community Response (UCR), Hospital at Home (H@H) and Care Home teams.
- Preparing in advance for day of discharge, criteria-led discharge, early-in-day discharge and use of step-down discharge, pathway optimisation.
- Wider system calls between ICB, council, social care to support increased DKAFH numbers and reduce pathway oversubscription.
- 80% utilisation of H@H across all four localities. Focus on respiratory, heart failure and frail patients.
- 90% of 2-hour UCR patients are seen by referral via self-referral, 111, GP referral. Community teams to support reduction of Emergency Department (ED) attendances from care homes and patient homes.
- Step up and step-down Intermediate Care Capacity (IMC).
- Re-ablement services and IMC at home.
- GP/Advanced Clinical Practitioners (ACP) led care home rounds.

3.13 Seasonal pressures in paediatric services, usually as a result of respiratory disease amongst children, tend to manifest earlier in the year than in other services. The NCA plan includes mitigations specifically around paediatrics. For Salford, pressures will manifest in the Paediatric Assessment and Decision Area (PANDA) unit, the Place

Team have established processes to monitor PANDA opening hours and have appropriate escalations in place if the service comes under pressure.

Salford Primary Care Together (SPCT)

3.14 SPCT will continue to deliver and develop the range of services covered under the EPiC 24 contract providing alternatives to the Emergency Department, thus supporting the NCA to better manage winter pressures.

3.15 Working with the NCA, the streaming service at the front door of ED has been improved by providing a clearer pathway for patients. A dedicated waiting area has now been provided, with defined allocated consultation rooms available for service delivery. Over 2000 patients are seen each month by the Urgent Treatment Centre/streaming service. In September 2026 (which was typical of other months), of the 2200 patients seen by the service:

- 69% needed no further follow up and were directed to self-care.
- 17.5% were referred to hospital specialities.
- 6.2% were referred back to the ED.
- 6.8% were referred to other services.

It is anticipated that this clearer pathway will help to better support increased demand over the winter period.

3.16 SPCT's Local Clinical Assessment Service accepts rerouted calls from NHS 111 for an assessment of what support the patient requires. In September 2026, SPCT took 739 calls with only 16.4% being referred on to the ED. SPCT, NHS 111 and NHS Greater Manchester continue to refine the Directory of Services system to ensure that appropriate patients can access this service.

3.17 The North West Ambulance Service (NWAS) and SPCT continue to refine the Single Point of Access offering to ambulance teams who need support in deciding whether to convey a patient to ED or whether there are suitable alternative services which can support their needs. In September 2026, 312 calls were made from ambulance crews, of which 214 did not need a trip to ED but instead required self-care or a more appropriate service. NWAS and SPCT will continue to support training to ambulance crews on this service to ensure a wider use where appropriate over the winter period.

3.18 SPCT will continue to deliver the Out of Hours service which is a key part of the urgent care system. They will work closely with NHS Greater Manchester in building and delivering a consistent offer across the whole of the Greater Manchester region.

3.19 SPCT this winter will focus on:

- Demand forecasting
- Flexible rotas
- Targeted staffing at pressure points
- Staff wellbeing and work to reduce avoidable conveyance to A&E

North West Ambulance Service (NWAS)

- 3.20 NWAS are in the process of signing off their 2026/27 winter plan which will be presented at the next Salford Urgent & Emergency Care (UEC) Group meeting.
- 3.21 NWAS have indicated that key areas of focus will be:
- Additional tactical command capacity
 - Targeted extra ambulance hours
 - Restructure of annual leave for staff
 - Subcontracted capacity
 - Greater use of community alternatives
 - Handover improvement
- 3.22 Extensive work has already started with NHS GM, NWAS and the NCA to improve ambulance handover times at Salford Royal. The patient pathway for ambulance arrivals has been redesigned with more Rapid Access and Treatment cubicles available and a permanent senior clinician on duty in that area to support quicker decisions. In addition, a series of meeting to enhance co-operation between NCA and NWAS staff have taken place to improve working relationships.
- 3.23 This work is being reflected in the September numbers:
- Decrease in ambulance handover from 22:25 to 20:43.
 - Decrease in average daily >45 min handovers from 6.1 per day to 4 per day.
 - Moved from 7th to 6th within GM.
 - Reduction of average daily ambulance attendances from 70 to 69.

Adult Social Care (ASC)

- 3.24 Adult Social Care colleagues have made the following plans to support winter pressures These include:
- Highest referring wards on the Salford Royal site will have an allocated social care officer to attend board rounds and to act as an urgent contact for early intervention to support flow.
 - Active-duty services of 2 social care officers to support the HomeFirst Hub process and support unallocated ward referrals (Monday-Friday). This arrangement will also support staffing gaps such as annual leave and illness absences.
 - 2 team managers and 2 advanced practitioners available on site to support escalation processes.
 - Team manager presence at all Days Kept Away from Home meetings to support any blockages and ensure flow is not disrupted.
 - Team managers will support weekly meetings for 'out of authority' hospitals for Salford residents to support flow.
 - Principal Manager/Head of Service oversight throughout the winter period. A response has also been requested from the Equipment Loan Store but at the time of writing this has not been agreed

Greater Manchester Mental Health (GMMH)

3.25 GMMH have outlined their aims which are to:

- Maintain patient safety and high quality of care for all services during periods of peak demand.
- Ensure timely access to urgent and crisis mental health support.
- Protect patient and staff wellbeing during seasonal pressures.
- Minimise avoidable hospital admissions and delayed discharges.
- Ensure equitable access to mental health support across all communities.
- Contribute to wider system resilience across the Integrated Care System.
- Reduce the burden on partner agencies.
- Ensure timely flow into GMMH services to prevent delays for service users.

3.26 There are clear areas of focus to achieve these aims:

- Programmes for workforce wellbeing and resilience.
- Enhanced demand planning using historical data and predictive analysis.
- Business continuity planning is a key component of winter preparedness and ensures that essential mental health services can continue to operate safely during periods of disruption.
- A 'senior gatekeeper' role supporting a community first approach.
- Enhanced approach to bed meetings, Multi Agency Discharge Event (MADE) and Super Multi Agency Discharge events.
- Greater use of the Mental Health Urgent Triage Team and the North West Bed Bureau.
- Criteria led discharges support safe and timely discharges across all seven days of the week.
- A 72-hour purposeful admission approach to ensure every inpatient admission has a clear therapeutic objective and planned outcome from the outset.
- Continued development of Crisis Cafes and Listening Lounges.
- Continued rollout of Chat Health, providing an additional access route for people seeking urgent mental health support.
- Increase substantive staffing across community teams to support greater community provision.
- Reviewing and streamlining section 136 pathways.
- To maintain a 24-hour, seven-day service, GMMH operates an effective on-call process with an enhanced weekend offer to assure effective service delivery.

4. Recommendations

4.1 The Salford Integrated Care Partnership Committee is asked to:

- note the content of the report.
- agree that the measures outlined in the paper are reasonable and sufficient to prepare for and respond to expected winter pressures.

Stephen Tilley
Transformation and Improvement Programme Manager (Salford)

Salford Integrated Care Partnership Committee

22 October 2026

Item 7 (a) – Place Health and Care Partnership Update

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

Report of:	Place Partnership Director (Salford)	
Date of Paper:	15 October 2026	
In case of query, please contact:	Hannah Dobrowolska Hannah.dobrowolska@nhs.net	
System Priorities: (Please tick as appropriate)	Physical activity and movement	✓
	Child Friendly City	✓
	Live well, Neighbourhoods and Communities	✓
	Adults and Ageing Well	✓
	Preventable illness - CVD and Diabetes	✓
	Urgent and emergency care	✓
	Mental health and emotional wellbeing	✓
	Triple aim – population health, performance recovery, financial sustainability	✓
	Other system enabler i.e. Workforce, Transformation, Digital etc.	✓
Purpose of Paper: To provide an update on the Place Health and Care Partnership (PHCP) document suite across NHS Greater Manchester (GM), confirm support across Salford for the broad direction of travel, set out further work currently ongoing, outline the expected approval process of the partnership agreement in Salford and next steps locally.		

Further information

How will this benefit the health and wellbeing of Salford residents, or the Integrated Care Partnership?	Greater clarity in relation to partnership working will help the system work collaboratively to achieve its objectives.
How does this paper address health inequalities and promote inclusion?	The suite places reducing inequalities and improving population outcomes at its centre.
What risks may arise as a result of this paper and how will they be mitigated?	The principal risks are seeking confirmation before the suite is complete, unclear decision rights, over-complex metrics, insufficient partner commitment and financial or workforce arrangements proceeding without full assurance. Realistic timescales to return the final suite through the proper partner governance routes is intended to manage those risks.
Does this address any existing high risks facing the organisation and how does it reduce them?	Many of the risks facing the system cannot be resolved by one organisation alone, this partnership approach will support collaborative working.
Are there any possible conflicts of interest associated with this paper?	None identified.
Will any current services or roles be affected by issues within this paper and what are they?	The work of the NHS Greater Manchester (GM) Place Team in particular will support delivery, complemented by resource from across the system.

Note: Where appropriate, please ensure detail is provided.

Document Development

Has there been Public Engagement?	Not to date. However, effective implementation will require continued co-production with partner organisations, primary care, Voluntary, Community, Faith and Social Enterprise (VCFSE) representatives, Healthwatch, staff, residents, service users and carers.
Has there been Clinical Engagement?	Yes, through the period of engagement.
Has the impact on Salford socially, economically and environmentally been considered?	Not explicitly, however given this is an evolution of our existing partnership arrangements, no significant risks are anticipated in this regard.
Has an Equality Impact Analysis been completed?	An Equality Impact Assessment was completed on the NHS GM Operating Model work. This work turns that model into

	practice, adding greater detail but is in line with the overarching model.
Has legal advice been obtained?	Yes, NHS GM has been supported by legal expertise. The Partnership Agreement is intended to express shared intent rather than create a new legal entity. Formal instruments, including any Section 75 variation or contract, will require separate legal advice prior to approval.
Has this been to any groups or committees for engagement, comments, or approval?	Earlier drafts have been shared with the Integrated Care Partnership Committee (ICPC) and others across Salford as part of the engagement process.

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

Place Health and Care Partnership Update

1. Executive Summary

NHS Greater Manchester has developed a connected suite of documents to clarify how Place Health and Care Partnerships will operate within the Greater Manchester model. The suite brings together the Partnership Agreement, Outcomes Framework, Place Fund, Place Team Approach and Governance Framework. The documents are intended to be read as a single operating framework rather than as separate initiatives.

Since the earlier drafts were prepared, partners have had the opportunity to undertake detailed reviews of the proposals. That work has helped to test the overall model and identify the issues that need to be resolved before organisations can give formal approval. The documents are now undergoing final changes with NHS Greater Manchester and are expected to be finalised and shared in October or November 2026.

The purpose of this paper is therefore to provide an update rather than seek sign-off. It retains the substantive content so that partners can see the intended direction and the work still required. The aim is to reach a final suite to which all organisations can sign up through their own governance routes, with confidence that the matters have been addressed.

2. Background and Purpose

- 2.1 The Greater Manchester proposals position Place Health and Care Partnerships as the principal forum through which NHS organisations, local authorities, primary care, the voluntary, community, and social enterprise sector and, where relevant, other key 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 Salford Integrated Care Partnership Committee (ICPC) on the developing suite and invite continued support for its broad direction.

3. The Document Suite

3.1

Document	Purpose	Proposed Position
Partnership Agreement	The overarching framework for shared intent, principles, roles, governance and ways of working.	Broad direction supported; approval deferred pending availability of final version

Outcomes Framework	Defines the shared outcomes and the measures through which progress and accountability will be tracked.	Shared outcomes and structure noted; measures, baselines and ownership to be completed.
Place Fund	Sets the direction for financial stewardship, visibility of resources and alignment with prevention and neighbourhood delivery.	Principles noted; detailed financial and governance work required.
Place Team Approach	Describes the purpose, capabilities, membership and possible configuration of the multi-partner Place Team.	Direction supported; the Salford model and partner contributions to be developed.
Place Governance	Appraises mechanisms linking NHS GM, the Place Fund and Place Team, including Section 75 and contractual routes.	Options and principles noted; formal legal decisions reserved to the relevant partner organisations.

4. Assessment of the Proposals

4.1 Partnership Agreement

- 4.1.1 The agreement 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.
- 4.1.2 Before final adoption, the Salford version will need the local place name, vision, parties, commencement and term completed. The remaining drafting points on agreement precedence, Section 75 arrangements, schedules and terms of reference should also be closed. These matters are being considered through the final revision process and will be resolved, or clearly identified for subsequent local implementation, before formal approval is sought.

4.2 Outcomes Framework

- 4.2.1 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.
- 4.2.2 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 draft schedule remained developmental. The final framework will be focused enough to drive decisions rather than become an exhaustive performance compendium.

4.3 Place Fund

- 4.3.1 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.
- 4.3.2 The committee is asked to note the strategic direction, but is not asked to approve a transfer of budgets or liabilities through this paper. Any pooling, delegation, hosting, risk sharing or change to existing Section 75 arrangements will be supported by detailed financial, legal and governance advice and approved through the relevant partner processes. It is expected that this will take place after the PHCP Agreement is finalised.

4.4 Place Team Approach

- 4.4.1 The proposed Place Team is a virtual, multi-disciplinary 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.
- 4.4.2 This flexibility is appropriate for Salford. Support for the direction of travel should not predetermine a host or employment model. The next phase will define the functions Salford needs, the capacity each partner will contribute, the accountabilities for hosted or ring-fenced roles and the practical relationship between the Place Team, the committee and delivery arrangements. It is expected that this will evolve after the PHCP Agreement is finalised.

4.5 Governance

- 4.5.1 The governance appraisal considers internal Integrated Care Board (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 clearly remain with the Place Partnership rather than the host organisation.
- 4.5.2 The committee 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 involved. Consideration of this update should not be interpreted as advance approval of a new or varied Section 75 agreement, contract, staff transfer or delegation.

5. Documents

- 5.1 These documents will be available after they have been approved by the Executive Committee of NHS GM, which comprises the 10 Place Leads and NHS GM's Chief Officers. This meeting took place on Wednesday 14 October 2026. At the time of writing this report, I am not aware of the outcome of this meeting. If it is possible before our ICPC meeting to share the full suite of documents, these will be shared

separately to the papers, for clarity and because they are detailed and lengthy. Even if the full suite is shared, we recognise it will not be possible for all colleagues to have digested this in full before the IPCP meeting.

5.2 Prior to this, the following are available and included as appendices.

- a. Updated PHCP Document Suite summary slide deck
- b. A timeline which shows key steps and changes from now until 1 April 2027.
- c. Salford's ICPC response to the engagement
- d. Engagement feedback outcome reports (short read slide deck) the long-read paper is available on request from elaine.redwood@nhs.net

6. Future Salford Confirmation Statement

6.1 The final paper will include a proposed Salford confirmation statement for consideration. The current working form is provided below to show the intended approach, but it is not presented for approval at this meeting:

"The Salford Integrated Care Partnership Committee 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 Salford-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."

6.2 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. Confirmation of the Salford statement will only follow the committee's consideration of the final suite and completion of the agreed partner approval routes.

7. Formal Approval and Signature by Partner Organisations

7.1 The final Partnership Agreement will require formal commitment by the named parties. Attendance at the committee, 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.

7.2 It is recognised that ICPC representatives are likely to need to take the final suite back through the relevant trust, board or constituent-body arrangements before a signature can be given on behalf of the organisation or sector.

7.3 The proposed process is:

- I. Finalisation: NHS Greater Manchester and the Salford Place Partnership Director complete the revised document suite.
- II. Local assurance: the final suite is circulated to all proposed parties, with a standard assurance template asking each organisation to confirm within 10 working days its approval route, the authorised signatory and the date by which

approval can be secured, and if relevant any remaining concerns. Assuming no or minor remaining concerns, Salford will progress to step IV in this process, if significant concerns are raised step III will be undertaken.

- III. Committee consideration: the final suite, proposed Salford confirmation statement, and partner approval plan return to ICPC in December 2026. The committee considers whether the suite is ready to proceed into formal organisational approval and signature.
- IV. Constituent-body approval: each party follows its own governance process. Partner and sector representatives should be given sufficient opportunity to consult and obtain the necessary mandate from their relevant trust, board, member practices or other constituent bodies.
- V. Formal signature: signatures are collected only after the relevant approvals have been evidenced. 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. The status of each partner's support will be clearly recorded to ensure transparency and avoid asking an individual to give a commitment beyond their authority. This will be administered by the Place Partnership Director or members of her team.
- VI. Confirmation and implementation: the Salford confirmation statement is submitted to NHS Greater Manchester only when the agreed threshold for partner approval has been met and the committee is satisfied that any remaining qualifications are explicit. Material legal, financial, workforce, hosting or delegation arrangements will continue through separate due diligence and approval processes.

8. Next Steps

- 8.1 Record the committee's comments on the direction of travel and any further matters to be addressed.
- 8.2 Complete the final document revisions with NHS Greater Manchester including Salford specific information such as parties, vision, term, schedules and terms of reference.
- 8.3 Circulate the revised suite to partner organisations for their respective approval routes.
- 8.4 Confirm with each proposed party its formal approval route and timeline, authorised signatory and requirements for consultation with constituent bodies, and maintain a consolidated approval and signature schedule.
- 8.5 If material concerns are raised, return the final suite and proposed Salford confirmation statement to the committee in December 2026. This step is not anticipated to be required.
- 8.6 If no material concerns are raised, secure and document confirmation from each Salford partner through its authorised route, with a target date of 17 December 2026.

9. Recommendations

- 9.1 The Salford Integrated Care Partnership Committee is asked to:
 - note the progress made in developing the Place Health and Care Partnership document suite following the partner engagement and opportunity for detailed review.

- note that the documents are undergoing final revision with NHS Greater Manchester and will be shared with committee members as soon as available, expected in October 2026.
- note that the document suite is expected to include some elements that remain for local implementation, and these will be completed by the Place Partnership Director prior to sharing.
- endorse the broad direction, shared outcomes and proposed Operating Model described in the suite as the basis for completing the remaining work, without sharing or therefore seeking approval of the final documents at this stage.
- agree that all partner organisations will aim to be in a position to sign up to the final suite through their own governance arrangements, subject to satisfactory resolution of the outstanding legal, financial, governance, workforce and operational matters before or at the Integrated Care Partnership Committee meeting on 17 December 2026.
- agree that formal signature of the final Partnership Agreement should follow evidence of approval from each party through its appropriate governance route, including constituent-body consideration where representatives are not authorised to commit their organisation or sector directly.
- receive a further paper presenting the final document suite, the proposed Salford confirmation statement and partner approval confirmation at the next ICPC meeting in December. This will allow the formal signing of the PHCP agreement at or before the December 2026 ICPC meeting.
- note that any subsequent legal, financial, workforce, hosting or delegation arrangements will remain subject to separate due diligence and formal approval by the relevant organisations.

Hannah Dobrowolska
Place Partnership Director (Salford)

Appendix C

Salford's ICPC Response to the Engagement

I am making these comments on behalf of the health and care system across Salford, based on conversations with individuals and groups locally. They have been agreed by our Place Lead, Stephen Young.

Overall Salford welcomes the PHCP approach, as an evolution of our existing strong place level collaboration across our health and care system, which have long had a focus on prevention and early intervention. We are supportive of the strategic direction around neighbourhood health, and excited by the opportunities this shift could bring for the ways of working of our staff and for the outcomes for our population.

We are largely supportive of the Operating Model and associated suite of documents, recognising that this significant change in focus across the system will require shared commitment to deliver upon.

We have a few areas that we would welcome amendments to the document to improve/address:

- Greater attention should be given to addressing inequalities across GM in health outcomes, this should prominently drive our decision making in line with our agreed Fairer Health for All approach. We note there is considerable work to address inequalities in health service provision across GM, however this must evolve to actively address health inequalities through purposeful, needs based, resource allocation.
- Children should be given a higher profile.
- The positives that a more equal power balance between different sectors at place brings should be emphasised.
- Greater commitment and clarity on the leadership and capacity at GM in relation to enablers such as data, digital and estates are needed for neighbourhood delivery.
- There are many strengths across our 10 GM places, more could be done to identify and share good practice to support rapid spread/adoption.
- More recognition should be given to provider complexity for place-based working in places operating with multi footprint providers (e.g. Northern Care Alliance (NCA), Greater Manchester Mental Health) and/or care pathways with providers outside the place (e.g. maternity care, children's services).

Finally, we recognise the current challenges within our Salford health and care system, including the significant improvement journeys required for adult social care and across the NCA. We are pleased that neighbourhood working, and the important role of place, is embedded in the approach being taken with the relevant improvement plans. Greater support and/or amended timelines may be required within places impacted by such challenges.

Submitted by Hannah Dobrowolska, Place Partnership Director to NHS GM on 21 August 2026

Place Health and Care Partnership Document Suite

Engagement Feedback Outcomes Report

September 2026

1. Introduction

1.1 Background

Place Health and Care Partnerships bring together local authorities, NHS organisations, primary care, the voluntary, community, faith and social enterprise sector, wider public services and communities. Their shared purpose is to improve health and wellbeing, reduce inequalities and support more coordinated health and care for local people.

During 2026, NHS Greater Manchester developed a suite of documents to provide a clearer and more consistent framework for Place partnership working across Greater Manchester. The documents cover the principles and arrangements through which partners work together, agree priorities, oversee shared outcomes, use Place resources and support local delivery.

The draft suite was developed within the wider context of NHS reform, the future role of NHS Greater Manchester as a strategic commissioner and the continued importance of Place and neighbourhood working. It was intended to provide a common Greater Manchester framework while recognising the different relationships, arrangements and levels of maturity within each Place.

1.2 Purpose of the engagement

NHS Greater Manchester invited partners and stakeholders to review the draft document suite during June, July and August 2026. The purpose was to test whether the proposed arrangements were:

- clear and understandable;
- workable in practice;
- appropriately representative of the organisations and communities involved;
- sufficiently clear about accountability and decision-making;
- aligned with statutory and organisational responsibilities; and
- capable of supporting effective Place and neighbourhood delivery.

The engagement was also intended to identify areas where further detail, safeguards or supporting arrangements were required before the documents progressed towards approval and implementation.

1.3 Purpose of this report

This report explains:

- how the engagement was undertaken;
- the breadth and volume of feedback received;
- the principal themes raised by contributors;
- how the feedback was reviewed and considered;
- the main changes made to the document suite;
- the resulting final document suite; and
- how the documents will now support Place transition and mobilisation.

This report provides an account of the engagement, the principal themes raised and the changes made to strengthen the Place Partnership arrangements.

A concise summary slide pack is also available. It provides a visual overview of the engagement, the main feedback themes, the changes made and the next steps for use in briefings and presentations.

The reporting package

Outcome Report	The overall narrative and thematic account.
Summary slide pack	A concise visual briefing.
Final document suite	The resulting Place Partnership arrangements.

1.4 Scope of the report

This report focuses on the system engagement on the Place Partnership document suite and the changes made in response. The wider NHS Greater Manchester organisational change process and the separate formal employment consultation relating to affected staff are covered through their respective formal processes and documentation.

These processes are connected, particularly where the Place Team, hosting and mobilisation arrangements are concerned. This report therefore refers to the wider transition context where it is relevant to understanding the Place Partnership arrangements.

2. The engagement process

2.1 How the engagement was undertaken

Engagement on the draft Place Partnership document suite took place during June, July and August 2026. Contributors were invited to consider the individual documents and the extent to which the suite worked as an integrated framework.

Feedback was received through several routes, including:

- formal written submissions;
- Place and partnership forums;
- professional and representative groups;
- meetings and workshops;
- direct correspondence;
- discussions with Place and system leaders; and
- engagement with the organisations and teams affected by, or responsible for implementing, the proposed arrangements.

This mixed approach enabled organisations to provide detailed written comments while also allowing issues to be explored through discussion and professional challenge.

2.2 Who was involved

Feedback was received from across the Greater Manchester health and care system. Contributors included representatives of:

- Place Health and Care Partnerships;
- local authorities;
- NHS trusts and foundation trusts;
- general practice and the wider primary care family;
- Local Medical Committees;
- mental health services;
- children's services;
- the voluntary, community, faith and social enterprise sector;
- professional and clinical groups;
- finance, legal, workforce, governance and assurance functions;
- providers working across more than one Place;
- wider public services and partnership bodies; and
- Place and system leadership teams.

Some submissions represented the collective view of a board, partnership, provider collaboration, professional group or wider team. The number of people whose views informed the engagement was therefore greater than the number of formal submissions received.

The engagement brought together different organisational perspectives and responsibilities. In some areas, contributors expressed different preferences about how the arrangements should operate. These differences were an important part of the review because they highlighted where the final documents needed to distinguish more clearly between collective partnership working and the responsibilities retained by individual organisations.

2.3 Engagement at a glance

280 distinct feedback points	26 formal submissions and source documents	24 organisations, Places and teams represented
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Several submissions represented wider boards, partnerships, professional groups or provider collaborations. Some source documents contained multiple detailed points. Each distinct issue was recorded separately so that the full breadth of feedback could be reviewed.

2.4 Key stages

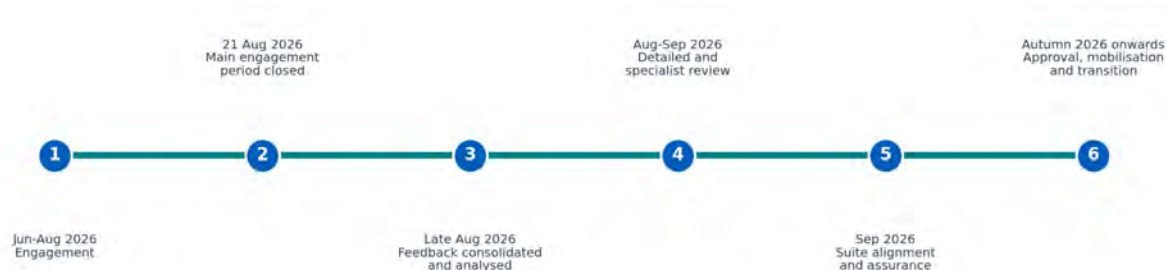


Figure 1. Key stages in the engagement and review process.

The timeline summarises the principal stages from engagement through to approval and mobilisation.

3. What we heard

3.1 Overall picture

The feedback was detailed, constructive and wide-ranging. It demonstrated strong support for effective Place partnership working but also identified areas where the original proposals needed greater clarity, stronger safeguards or more practical detail.

Contributors were particularly interested in how the arrangements would work in practice. Many comments focused on who would make decisions, how partners would be held to account, how statutory and organisational responsibilities would be protected, how financial resources and risks would be managed, how different partners would have meaningful influence, what capacity and support would be available to Place, how outcomes would be measured and assured, and how the arrangements would be implemented without creating gaps, duplication or unintended consequences.

The feedback did not present one single view. Contributors approached the documents from different legal, financial, organisational, professional and community perspectives. Some supported greater consistency across Greater Manchester, while others emphasised local flexibility. Some sought stronger collective authority at Place, while others stressed the need to protect the lawful authority and responsibilities of individual organisations.

The review therefore needed to balance these perspectives rather than simply adopt one organisational preference. The final suite aims to establish a clear common framework while preserving appropriate local flexibility and retained organisational accountability.

3.2 Main feedback themes

Governance, accountability and decision-making

This was the most frequently raised area. Contributors asked for clearer decision rights, delegations, reserved matters and lines of accountability between NHS Greater Manchester, Place Partnerships and individual organisations. There was a strong expectation that partnership working should not dilute or override statutory, contractual, financial, clinical, professional, safeguarding or regulatory responsibilities. Contributors also asked for practical arrangements for recording decisions, managing disagreement, resolving disputes and escalating matters to the organisation or forum holding the appropriate authority.

Partner representation and meaningful involvement

Contributors wanted representation to provide genuine influence rather than attendance alone. Feedback sought clearer and more meaningful roles for local authorities and elected members; general practice, primary care and Local Medical Committees; NHS providers; mental health and children's services; the voluntary, community, faith and social enterprise sector; residents, patients, carers and communities; providers working across several Places; and wider public services and statutory partnerships. Contributors also recognised that partners operating across several Places may need coordinated and proportionate arrangements rather than identical representation in every local structure.

Place Fund, Finance and Section 75 arrangements

Financial governance was a significant area of feedback. Contributors asked for greater clarity about the scope and status of the Place Fund, the use of Section 75 arrangements, formal financial authority, overspends and underspends, risk allocation and potential gain-share, reporting and audit trails, Place-related resources, and protection against unfunded work or unilateral risk transfer. Feedback also highlighted the need to distinguish the immediate arrangements from longer-term ambitions to align or pool additional resources.

Outcomes, experience and assurance

Contributors supported a shared focus on outcomes but asked for the framework to be more balanced and meaningful. Feedback sought greater focus on outcomes rather than activity; stronger recognition of prevention, inequalities, mental health and children's outcomes; greater prominence for resident, patient

and carer experience; recognition of neighbourhood variation and wider determinants; fewer and more purposeful measures; and proportionate assurance that uses existing reporting wherever possible.

Prevention, Live Well and wider determinants

Contributors asked for greater alignment with Live Well and a more consistent commitment to prevention, early intervention, health equity and neighbourhood working. They also emphasised the influence of housing, employment, skills, transport, community resilience and other wider determinants on health and wellbeing.

Place Team, hosting and workforce arrangements

Feedback sought clearer definitions of the Place Team and the workforce and service intended to transfer. Contributors asked for clarity about the roles of NHS Greater Manchester, Place leadership and the receiving organisation; host responsibilities; workforce protection and deployment; delivery accountability; employment consultation; funding and liabilities; access to enabling services; conflicts of interest; and safeguards against redirection to unrelated organisational priorities.

Enabling functions and capacity

Places asked for confidence that they would have access to data, digital, finance, estates, clinical and professional leadership, quality and safeguarding expertise, workforce support, programme support and engagement capability. Contributors recognised that not every specialist function could be replicated in every Place, but asked for clear service interfaces and realistic access to the required support.

Local flexibility within a consistent Greater Manchester framework

Feedback generally supported a common Greater Manchester framework but asked for clearer application of subsidiarity and space for local relationships and arrangements. Contributors wanted the suite to distinguish between minimum expectations, matters requiring consistent legal or governance treatment, and areas where Places can design arrangements around local context.

Implementation and transition

Contributors asked for realistic sequencing and greater clarity about how the suite would move from policy into practice. Feedback highlighted the need to align governance, financial, contractual and workforce changes; protect staff and service continuity; avoid governance gaps; complete schedules and Terms of Reference; manage approvals; communicate clearly; test readiness; and retain opportunities for learning and improvement.

3.3 Relative prevalence of the themes

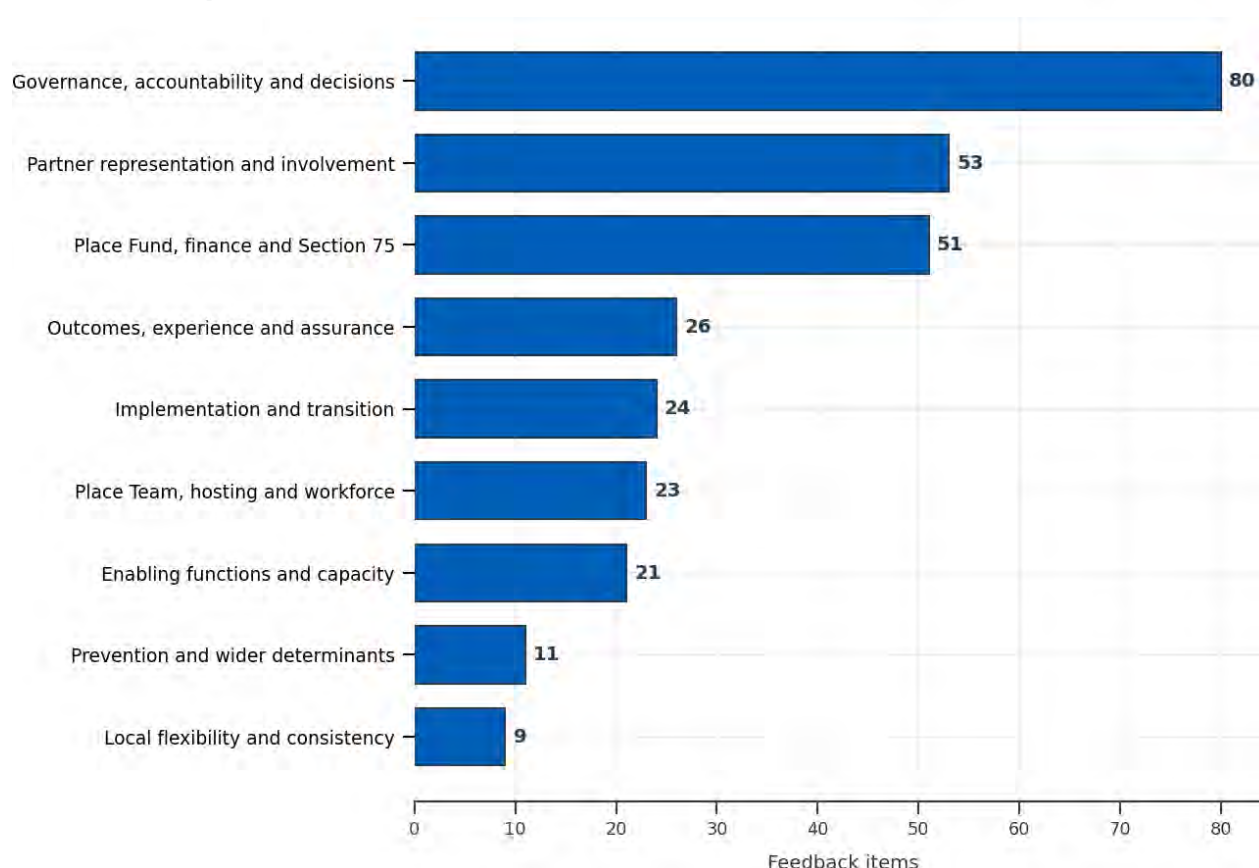


Figure 2. Relative prevalence of the principal feedback themes.

Method note: some feedback points related to more than one theme and are therefore reflected in more than one category. The figures illustrate the relative prevalence and breadth of the themes and are not intended to sum to the 280 distinct feedback points.

3.4 Interconnected nature of the feedback

Many comments could not be resolved within one document alone. Financial decision-making depended on the Place Fund, Section 75 arrangements, partnership governance and formal delegations. Workforce hosting depended on employment arrangements, the service specification, governance and contractual safeguards. Outcome assurance depended on the Outcomes Framework, governance arrangements, access to evidence and the contribution of partner organisations.

Primary care feedback affected representation, retained commissioner responsibilities, contractual safeguards, clinical leadership and local delivery. Children's services feedback affected representation, outcomes, statutory interfaces, safeguarding and wider partnership working. The final review therefore considered the suite as a connected framework rather than treating each document in isolation.

4. How the feedback was considered

4.1 A structured review

All feedback received through the engagement was brought together into a single record. Each distinct point was logged alongside its source, the document or documents to which it related and the proposed response.

The feedback was then grouped by theme and allocated to the area of expertise best placed to consider it. This included input from colleagues with expertise in partnership and Place leadership; governance and assurance; legal arrangements; finance and Section 75 agreements; workforce and employment; clinical and professional leadership; quality and safeguarding; outcomes, data and intelligence; primary care; children's services; local government; hosting and service arrangements; and transition and mobilisation.

The purpose was not simply to count how often an issue was raised. Each point was considered in relation to its substance, the responsibilities of the organisations involved and its implications for the wider suite.

4.2 How decisions were reached

For each feedback point, the review considered:

- the issue being raised;
- whether similar or related feedback had been received elsewhere;
- the intended purpose of the relevant document;
- applicable statutory, contractual and governance requirements;
- financial, workforce and service implications;
- the impact on other documents within the suite;
- whether a common Greater Manchester position was required;
- whether the matter should be determined locally;
- whether further engagement or specialist advice was needed; and
- whether the issue related to immediate implementation or future development.

This led to several possible outcomes:

1. A change to the relevant document.
2. A change across more than one document.
3. Additional clarification or supporting documentation.
4. An implementation or mobilisation action.
5. Further specialist review or targeted engagement.
6. No change, where the existing position remained appropriate or the proposal could not be adopted.

Where feedback did not result in a direct change, the reason was recorded. This may have been because the matter was already addressed, sat outside the purpose or legal status of the document, needed to remain subject to local determination, required a separate agreement or approval, related to future development, conflicted with a statutory responsibility, or could not be resolved without further design, evidence or agreement.

4.3 Review across the document suite

A central part of the process was checking the effect of proposed changes across the full suite. Partnership

documents describe shared intent and ways of working. Terms of Reference set out membership and decision-making arrangements. Section 75 agreements govern legally operative financial arrangements. Hosting and service documents set out employer and provider responsibilities. The governance and assurance framework explains how the different arrangements connect.

A change made in one document therefore needed to be checked against the others to avoid inconsistent terminology, conflicting responsibilities, duplicate governance routes, gaps in decision-making authority, unintended financial or employment implications, and differences between the partnership narrative and legally operative arrangements.

The review included cross-document consideration of legal, financial, workforce, governance, assurance and implementation matters. A final consistency and legal review was then used to identify any remaining areas requiring clarification before approval and execution.

4.4 Targeted follow-up

Some feedback required further discussion rather than an immediate drafting decision. This was particularly relevant where contributors raised material concerns about financial responsibilities and risk; primary care and general practice representation; the relationship between Place and retained NHS Greater Manchester functions; children's services and statutory interfaces; clinical, quality and safeguarding accountability; employment and hosting safeguards; and local implementation arrangements.

Where appropriate, these matters were considered through targeted discussions with relevant professional, organisational and subject matter leads. Some detailed arrangements will continue to be completed through legal drafting, local approvals and mobilisation activity.

4.5 Principles applied throughout the review

Listen to the substance of the feedback	Comments were considered for their implications, not only by the number of times they appeared.
Protect statutory and organisational responsibilities	Collective partnership working should strengthen coordination but should not obscure or transfer responsibilities without lawful agreement.
Make accountability clear	The documents should explain who decides, who delivers, who provides assurance and where concerns are escalated.
Use the right document for the right purpose	Detailed legal, financial and employment requirements should sit in the documents capable of giving them effect.
Balance consistency and local flexibility	All Places should operate within a clear common framework, while retaining appropriate flexibility for local context and relationships.
Avoid unnecessary duplication	Existing governance, evidence and assurance processes should be used wherever possible.
Be clear about what is agreed and what remains in development	The final suite should not imply that future delegation, pooling or service changes have already been agreed.
Support safe and practical implementation	Changes should be capable of being mobilised, supported by appropriate approvals and managed without avoidable gaps in authority or service continuity.

4.6 How feedback informed the final suite



Figure 3. How feedback informed the final document suite.

5. Feedback and changes by document

The following chapters describe the principal feedback received on each document or linked group of documents and the changes made in response. They focus on the matters specific to each part of the suite. Cross-cutting themes, including accountability, retained organisational responsibilities, local flexibility and implementation, are referenced where they have a direct bearing on the document concerned.

5.1 Place Partnership Agreement

Feedback on the Place Partnership Agreement focused on its purpose and status, collaborative decision-making, partner sovereignty, local flexibility, representation and the relationship with the wider document suite. The Agreement and the template Terms of Reference for the Place Partnership Board were revised together to provide a clearer and more balanced framework for partnership working.

A consistent theme was the need for greater clarity about the purpose and status of the Agreement, the responsibilities of signatories and the relationship between collective partnership decisions and the statutory, contractual and sovereign responsibilities of individual organisations. The revised Agreement makes these boundaries clearer. Participation in the Partnership does not transfer or override partners' legal duties, contracts or accountabilities, and signing the Agreement does not mean that every partner endorses every subsequent decision. We have also strengthened the provisions covering conflicts of interest, amendment, variation, withdrawal and termination so that the processes and responsibilities are easier to understand.

We heard a strong call for decision-making to be collaborative, transparent and capable of resolving disagreement fairly. The Agreement now contains clearer provisions for recording decisions, managing differing views and escalating or resolving disputes. These arrangements are intended to apply equitably across the partnership and to respect the contractual and statutory position of every partner. We have therefore not created separate veto or dispute processes for individual sectors or organisations. Instead, safeguards have been strengthened so that no partner should be subject to an uncontracted transfer of work or an unfunded liability without explicit agreement, while each organisation retains the right to act in accordance with its statutory and legal responsibilities.

Feedback also emphasised the importance of balancing consistency across Greater Manchester with local flexibility. The final drafting gives greater prominence to the principle of what is best for Place and what is best for Greater Manchester, recognising that decisions should be taken at the most appropriate level and informed by local need, existing strengths and established partnerships. The Agreement establishes a common set of principles and expectations, but it does not prescribe identical membership, representation or delivery arrangements in every Place. Detailed governance, membership and decision-recording arrangements will be set out through local Terms of Reference and supporting documentation. To support Places in applying these arrangements consistently and make the overall suite easier to use, we have also developed a template Terms of Reference for the Partnership Board to sit alongside the Agreement. This has been updated to reflect the changes made to the Agreement, including clearer provisions on partner sovereignty and Reserved Matters, membership, collective decision-making, objections to unfunded impacts, escalation, information sharing and links with Health and Wellbeing Boards.

Representation and meaningful influence were prominent themes. We have strengthened recognition of general practice and the wider primary care family, the VCFSE sector, residents and communities, local authorities, providers operating across more than one Place, and wider public service partners. We have also strengthened references to children and young people and the importance of ensuring that families, children's services leaders and wider partners are appropriately reflected within Place arrangements and delivery priorities. The Agreement supports inclusive and proportionate participation, while allowing each Place to determine the arrangements that best reflect its population, priorities and partner landscape. Local Medical Committees have an important representative and advisory role in relation to general practice, but the mechanism for consultation and for identifying representatives will remain locally determined. The revised drafting also provides greater clarity regarding primary care representation, consultation and influence, while recognising that existing contractual, statutory and professional responsibilities remain with the relevant organisations and representative bodies. Similarly, co-option may be appropriate for some organisations, but it will not be the only route to involvement. The final arrangements should enable

residents, communities and VCFSE partners to influence priorities, delivery and evaluation, not simply contribute as delivery partners. The most appropriate way to reference the VCFSE Accord will be confirmed through the remaining legal and partner review rather than predetermined in this response.

The engagement also reinforced the importance of shared leadership, equitable partnership behaviours and collective stewardship of resources. Contributors also emphasised the importance of prevention, Live Well, mental health and children and young people being reflected consistently within the Partnership's purpose, priorities and approach to improving outcomes. The Agreement has been strengthened to reflect co-production, evidence-led and equitable decision-making, financial sustainability, risk awareness and the need to manage organisational pressures without undermining shared Place priorities. It provides for collective visibility and oversight of relevant risks and financial pressures, while recognising that organisations holding or hosting resources remain accountable for them. Detailed financial transactions, hosting responsibilities and formal assurance mechanisms sit within the relevant Section 75, hosting and governance arrangements and are cross-referenced rather than duplicated in the Partnership Agreement.

Finally, contributors asked for clearer links between NHS Greater Manchester, Place Partnerships, provider and commissioning arrangements, Health and Wellbeing Boards and partners' sovereign governance. The Agreement has been revised alongside the wider Governance, Accountability, Oversight and Assurance Framework so that these relationships and retained responsibilities are clearer. It also gives greater recognition to the enabling capabilities partners contribute, including data, digital, estates, finance, strategic commissioning and specialist expertise. Some detailed local schedules, Terms of Reference and implementation arrangements will continue to be completed through mobilisation and the final legal and consistency review. This does not diminish the feedback received. It reflects the need to place detailed provisions in the document or governance mechanism where they can operate most effectively and be maintained over time.

5.2 Place Outcomes Framework

Feedback on the Place Outcomes Framework focused on its breadth, balance and practical value. Contributors asked for a stronger focus on mental health, prevention, inequalities, children and young people, resident experience, wellbeing and the wider determinants of health, alongside a more focused and proportionate set of measures.

A consistent message was that the framework should reflect the full breadth of what Place Partnerships are seeking to achieve. This includes not only health service activity and physical health outcomes, but also mental health, prevention, inequalities, children and young people, resident experience, wellbeing and the wider determinants of health. The overall balance of the framework has therefore been reviewed, incorporating relevant updated national outcomes measures and strengthening its alignment with Live Well and other established Greater Manchester and national frameworks, as better data becomes available. The metric set has also been rationalised to remove avoidable duplication and ensure it remains focused on the measures that best demonstrate progress against shared outcomes.

Resident, patient and carer experience has been given greater prominence. Activity and performance measures alone cannot tell us whether people experience care and support as accessible, joined up and responsive to what matters to them. The framework includes measures relating to access, personalised care, shared decision-making and experience. It also considers people's experience of neighbourhood care, ease of navigating services, involvement in decisions and the experience and wellbeing of unpaid carers.

The revised approach also recognises that reductions in referrals, attendances, admissions or conveyances must represent better outcomes and earlier support rather than new barriers to access. These measures should therefore be understood alongside appropriate balancing information on access, outcomes, inequalities and experience. Wherever the underlying data allows, outcomes should also be examined by neighbourhood, population group, protected characteristic and service pathway so that overall improvement does not obscure unequal access or outcomes.

The framework is intended to provide a consistent GM-wide core, but it must also recognise that population needs, starting points and levels of system maturity differ across the ten Places. Baselines, trajectories and implementation will therefore need to be considered proportionately and in local context. Places can and should supplement the shared framework with locally agreed measures that reflect their own priorities,

partnerships and population needs. This local flexibility is intended to complement the GM-wide framework, rather than create ten separate or competing approaches.

Some of the measures and analytical capabilities needed to realise the full ambition of the framework are still developing. The framework will continue to align with existing system dashboards and intelligence, including relevant work on neighbourhoods, prevention, wider determinants and digital exclusion, rather than recreating reporting that already exists. Where consistent data is not yet available, limitations will be made clear and the framework will be strengthened as the quality, availability and interoperability of data improve.

The Place O y conditions or limits, and the person or body accountable for implementation. Financial information, approvals, actions and escalations should provide a clear and auditable trail, supported by regular reporting on expenditure, forecasts, delivery, outcomes, risks and mitigations. These provisions strengthen transparency and collective stewardship while retaining the statutory, financial and contractual accountability of the organisations that hold and transact the funding.

Feedback also asked for greater visibility of Greater Manchester-held and Place-related budgets and clearer routes for Place partners to influence resource decisions. We recognise the importance of this ambition. The revised document provides a clearer baseline for the agreed Better Care Fund services and explains the common categorisation applied across all ten Places. It also makes clear that the Place Fund does not provide a complete Place-level view of all health and care expenditure. Existing NHS Greater Manchester reporting and published accounts remain important, but further development would be required to provide a consistent and sufficiently detailed Place-level view of wider budgets. The current document therefore does not imply that resources outside the Better Care Fund have been delegated to, or are controlled by, the Place Partnership Board.

Several contributors raised concerns about the treatment of financial risk, overspends, gain-share, reinvestment and the possibility of unilateral risk transfer. These are important issues, but many relate to services and funding outside the agreed 2026/27 Place Fund. Within the current scope, partners are expected to operate through the existing Better Care Fund and Section 75 arrangements and manage expenditure within available resources. Continuing healthcare, jointly funded packages, Section 117 outcomes Framework should therefore not be viewed as a fixed or final product. It provides a common starting point for shared accountability, learning and improvement, and it will be kept under review as priorities change, new evidence becomes available and our collective capability develops. In particular, we intend to review the framework towards the end of this financial year, alongside the wider Neighbourhood workstream, to consider its alignment with the developing approach to neighbourhood metrics and any further refinements needed for the next financial year. Thereafter, we propose to undertake a proportionate review at least annually, while retaining the flexibility to consider material updates sooner where significant changes in policy, evidence, data or delivery arrangements make this necessary. This review approach will allow the framework to evolve without creating unnecessary reporting or redesign activity. The feedback received has already helped shape that next stage of development.

5.3 Place Fund and Section 75 arrangements

Feedback on the Place Fund and Section 75 arrangements focused on scope, financial authority, transparency, risk and the distinction between the immediate arrangements and possible future development. Th

e revised framework provides a clearer and more appropriately bounded description of the 2026/27 position.

A consistent message was that the scope and status of the Place Fund needed to be clearer. The revised document now confirms that, for 2026/27, the Place Fund comprises the agreed Better Care Fund services and is established and transacted through existing Section 75 and Better Care Fund arrangements. It is not a delegated budget, and the Place Partnership Board does not hold delegated financial authority. Place partners will provide joint oversight and influence within the agreed arrangements, but formal decisions must remain with an authorised NHS Greater Manchester or local authority decision-maker acting through the authority and governance applicable to the funding concerned. The term shadow year has also been clarified so that it does not imply a commitment or timetable for future delegation.

We heard a strong call for greater clarity about how financial decisions will be made, recorded and assured. The revised framework now states that decisions must identify the responsible decision-maker, the authority relied upon, the funding affected, an

arrangements, core general practice funding, specialist mental health services and wider pooled commissioning matters remain subject to their existing statutory, contractual and governance routes. This boundary is intended to avoid the Place Fund inadvertently changing existing responsibilities, funding splits or liabilities. More detailed risk-sharing or gain-sharing arrangements would need to be agreed for any future services before they were brought within the Fund.

We also recognise the concern that reclassification of expenditure could be interpreted as a reduction in services or the withdrawal of investment. The revised document makes clear that reclassification does not, in itself, stop the funding or activity. Where spend has moved outside the Better Care Fund, it remains within the relevant NHS Greater Manchester budget line and continues to be managed through the applicable commissioning, contractual and governance arrangements. The revised wording therefore distinguishes more clearly between improving the consistency and transparency of the Better Care Fund baseline and making a substantive change to service funding.

The ambition to support prevention, neighbourhood delivery and a sustainable shift towards community-based care remains important. However, the revised framework does not present future pooling, delegation or resource transfer as already agreed. During 2026/27, partners may use learning from operation of the Place Fund to strengthen governance, controls, reporting and assurance and to inform future proposals. Any addition of services or budgets from 2027/28 will require separate development with relevant partners, a clear assessment of financial and service impacts, agreed decision rights, transition and risk arrangements, and approval through the legal and governance mechanisms applicable to the funding concerned. The Place Fund and Section 75 arrangements will continue to be aligned with the Partnership Agreement and the wider Governance, Accountability, Oversight and Assurance Framework.

5.4 Place Team, Hosting and Transfer arrangements

Feedback on the Place Team, Hosting and Transfer arrangements focused on the definition of the Place Team, the role of the host, workforce safeguards, accountability, capacity and the relationship between partnership leadership and employer responsibilities. The Place Team document and associated arrangements were substantially clarified in response.

A consistent message was that the term Place Team needed much greater definition. The revised document now distinguishes between the wider multidisciplinary Place Team, the NHS Greater Manchester-funded Place Delivery and Integration Service, the host provider, the Place Health and Care Partnership and NHS Greater Manchester as commissioner and funder. The wider Place Team is a collaborative, multi-organisational model rather than a separate legal entity or employing body. The Place Delivery and Integration Service is the identifiable service and dedicated workforce intended to transfer, while staff and expertise contributed by other partners remain employed and accountable through their substantive organisations unless a separate arrangement is expressly agreed.

We also heard the need for greater clarity about the hosting and employment model. The revised framework now describes the host as the substantive employer of the transferring workforce and sets out its responsibilities for employment, workforce support, digital services, information governance, estates, equipment and agreed corporate infrastructure. At the same time, the Place Delivery and Integration Service will remain a defined and ring-fenced Place resource. It should not be absorbed into the host's wider establishment, redirected to unrelated organisational priorities or included in cost-improvement activity unless this is expressly agreed through the relevant governance, contractual and workforce processes. The detailed employee transfer arrangements, including assignment, consultation, due diligence and applicable employment protections, will be confirmed through the formal workforce process through the formal workforce process.

Feedback raised an important concern that hosting could inadvertently give the host greater authority over Place priorities or make it accountable for matters beyond the hosted service. The revised document makes clear that hosting does not confer additional partnership decision rights. The Place Health and Care Partnership will continue to agree local priorities and oversee delivery, while the host retains the legal and

regulatory responsibilities that come with being the employer and contracted service provider. NHS Greater Manchester remains the commissioner and funder of the Service and retains its statutory, strategic commissioning, financial, contractual, quality and assurance responsibilities. The host is not responsible for the whole multidisciplinary Place Team, the Place Fund or all Place outcomes. Where a proposed decision creates an employment, legal, regulatory, financial or safety concern, it will be considered through the agreed governance and escalation arrangements.

Contributors also asked for clearer expectations about capacity, capabilities and partner contributions. The revised document sets out the broad capabilities required, including Place leadership, clinical and professional leadership, neighbourhood development, population health intelligence, programme and transformation support, commissioning, finance, governance, engagement, workforce, digital, data, information governance and estates. These capabilities may be provided through dedicated Place roles, partner contributions, footprint-based services or Greater Manchester-wide functions. Not every organisation will be expected to replicate specialist capacity within every Place. Participation should be purposeful and proportionate, recognising the position of providers and partners operating across several Places, while local arrangements should make contributions sufficiently clear to avoid unfunded expectations, gaps in support or over-reliance on the host organisation.

The revised framework also strengthens the distinction between partnership leadership, day-to-day deployment and formal employer accountability. The Place Partnership Director will lead the Place Delivery and Integration Service and coordinate the wider Place Team, with priorities and expected outcomes set through Place partnership arrangements. The host will retain responsibility for formal employment decisions and employer duties. Staff contributed by other organisations will retain their existing employment, professional accountability and line-management arrangements unless separately agreed. The associated contract and local governance documentation will set out reporting, performance requirements, establishment controls, liabilities, change control, escalation, dispute resolution and exit arrangements, together with the relationship between the hosted Service, the Place Fund and relevant Section 75 arrangements.

Some feedback concerned matters that cannot be resolved through a single common document, including the preferred host in an individual Place, detailed local reporting lines, exact partner contributions, local clinical leadership arrangements and the timing or sequencing of mobilisation. These matters will be determined through local approvals, due diligence, workforce consultation and mobilisation within the common Greater Manchester framework. Host suitability, conflicts of interest and ongoing assurance will be addressed through the contractual and governance arrangements, with appropriate review and escalation rather than ad hoc judgement. The documents will continue to be aligned with the Partnership Agreement, Place Fund and the wider Governance, Accountability, Oversight and Assurance Framework.

5.5 Place Governance, Accountability, Oversight and Assurance

Feedback on Place Governance, Accountability, Oversight and Assurance highlighted the need to move beyond an options appraisal and explain how the proposed model will operate in practice. The integrated framework, Place Lead role and accountabilities, supporting governance arrangements and mobilisation approach were developed further in response.

A consistent theme was the need for clearer accountability between NHS Greater Manchester, Place Partnerships, Place leadership and individual partner organisations. The revised framework now distinguishes more clearly between collective accountability for agreed Place outcomes and the statutory and organisational responsibilities retained by individual partners. These include statutory, contractual, financial, clinical, quality, professional, safeguarding, employment and regulatory accountabilities. The framework does not itself delegate statutory functions or give one organisation or individual authority to direct another outside formally agreed arrangements. Delegations and decision-making authority will continue to be set out through the appropriate Terms of Reference, schemes of delegation, Section 75 arrangements, hosting agreements and organisational governance.

Feedback also highlighted the need for greater clarity about where decisions are made and how Place governance connects with Health and Wellbeing Boards, NHS Greater Manchester and partners' sovereign governance. The revised approach establishes a common core for Place Partnership governance, centred

on an effective Place Partnership Board, appropriate delivery arrangements and clear interfaces with statutory and organisational forums. Health and Wellbeing Boards retain their independently established statutory role and local democratic accountability. Places will continue to have flexibility to reflect local relationships, priorities, capacity and maturity, but should be able to demonstrate clearly how decisions, referrals, assurance and escalation operate and how unnecessary duplication is avoided.

A further theme was the need to strengthen the relationship between Place and NHS Greater Manchester. The revised framework therefore describes assurance as a reciprocal process. Place provides local intelligence, evidence, challenge and escalation in relation to shared priorities and outcomes, while NHS Greater Manchester provides transparency on strategic commissioning intentions, assurance on functions it retains, enabling support and a clear response to matters raised through Place. Where Place advice or recommendations are not taken forward, the rationale and any mitigating action should be communicated through the appropriate governance route. This is intended to strengthen local influence and collective problem-solving while maintaining NHS Greater Manchester's statutory commissioner responsibilities and the responsibilities of other partners.

The revised arrangements also provide greater clarity on outcome ownership, recovery, escalation and assurance. Agreed Place outcomes provide the basis for collective oversight. Existing governed evidence should be considered alongside neighbourhood intelligence, inequalities information, lived experience, delivery knowledge and clinical and professional insight to develop a rounded understanding of progress, risk and the action required. The Place Partnership Board has a role in testing this position collectively and agreeing appropriate actions, which may include action by individual partners, collective recovery activity, additional support or escalation through the relevant organisational or Greater Manchester route.

An important principle is that Place assurance should add value rather than create an additional reporting system. The intention is therefore to reuse existing evidence, governance and assurance mechanisms wherever possible. Material themes, strategic risks, support requirements and learning arising through Place can then inform wider Greater Manchester oversight and assurance through agreed routes. This should support a proportionate approach that combines formal evidence with local intelligence and professional judgement while avoiding unnecessary duplication.

Feedback particularly emphasised the importance of maintaining clarity around clinical, professional, quality and safeguarding accountability. The framework makes clear that Place Partnerships can consider how these issues affect shared outcomes, convene partners, identify cross-system concerns and support collective learning and improvement. They do not, however, assume or replace the statutory, professional or regulatory responsibilities of NHS Greater Manchester, providers, local authorities or other organisations. The same principle applies to organisational performance, contracts, finance, workforce and employment responsibilities. Concerns should be managed and escalated through the route appropriate to the issue, with differences in assurance judgement recorded transparently alongside the evidence, rationale and action required.

The Place Lead role has also been revised to align with the framework. It distinguishes the Place Lead's system leadership and convening responsibilities from the collective responsibilities of the Place Partnership Board, operational accountability for delivery and any functions formally delegated by NHS Greater Manchester. The role supports partners to work collectively around shared priorities and outcomes, strengthens the connection with neighbourhood delivery and supports effective stewardship of Place capacity and resources. It also supports reciprocal assurance between Place and NHS Greater Manchester. The Place Lead does not, however, have authority to bind partner organisations outside agreed governance arrangements or assume responsibilities that have not been formally delegated.

Finally, feedback highlighted the importance of aligning implementation across governance, delegation, Section 75 arrangements, hosting and employment arrangements. Some elements of the future model remain subject to formal decisions, legal drafting and local or organisational approval processes. These dependencies will therefore be managed through an integrated mobilisation approach, with sequencing, transitional risks and interim controls considered together. Formal implementation will need to be supported by clear approval routes and appropriate arrangements remaining in place until replacement arrangements are confirmed.

Overall, the feedback has helped strengthen the proposed model and provide greater clarity on how Place Partnerships operate within the wider Greater Manchester system. The revised framework is intended to

support clearer accountability, stronger reciprocal relationships, proportionate assurance and effective local partnership working while preserving the statutory and organisational responsibilities of individual partners. The framework and supporting products will continue to be refined through final legal, governance, consistency and implementation review.

6. The final position

6.1 A clearer and more connected framework

The engagement and review process has resulted in a clearer, stronger and more coherent framework for Place partnership working across Greater Manchester.

The final document suite establishes a common foundation while recognising that each Place has different population needs, relationships, structures and levels of maturity. It provides greater clarity about the arrangements that should be consistent across Greater Manchester and the areas in which local flexibility remains appropriate.

The suite is designed to be read as a connected framework. Each document has a distinct purpose:

- the Place Partnership Agreement establishes the shared principles, commitments and ways of working between partners;
- the Place Partnership Board Terms of Reference set out the core governance, membership and decision-making arrangements;
- the Place Outcomes Framework provides a shared basis for understanding progress, inequalities, experience and improvement;
- the Place Fund and Section 75 arrangements describe the scope, governance and operation of the agreed financial arrangements;
- the Place Team, Hosting and Transfer arrangements define the service, workforce, host and partner responsibilities;
- the Place Governance, Accountability, Oversight and Assurance Framework explains how accountability, assurance, escalation and retained responsibilities connect across the wider system; and
- the Place Lead role and accountabilities set out the system leadership, convening and assurance responsibilities associated with the role.

Together, these documents provide a more complete account of how Place Partnerships will operate, how decisions will be made and recorded, how resources and responsibilities will be managed, and how partners will work collectively around shared outcomes.

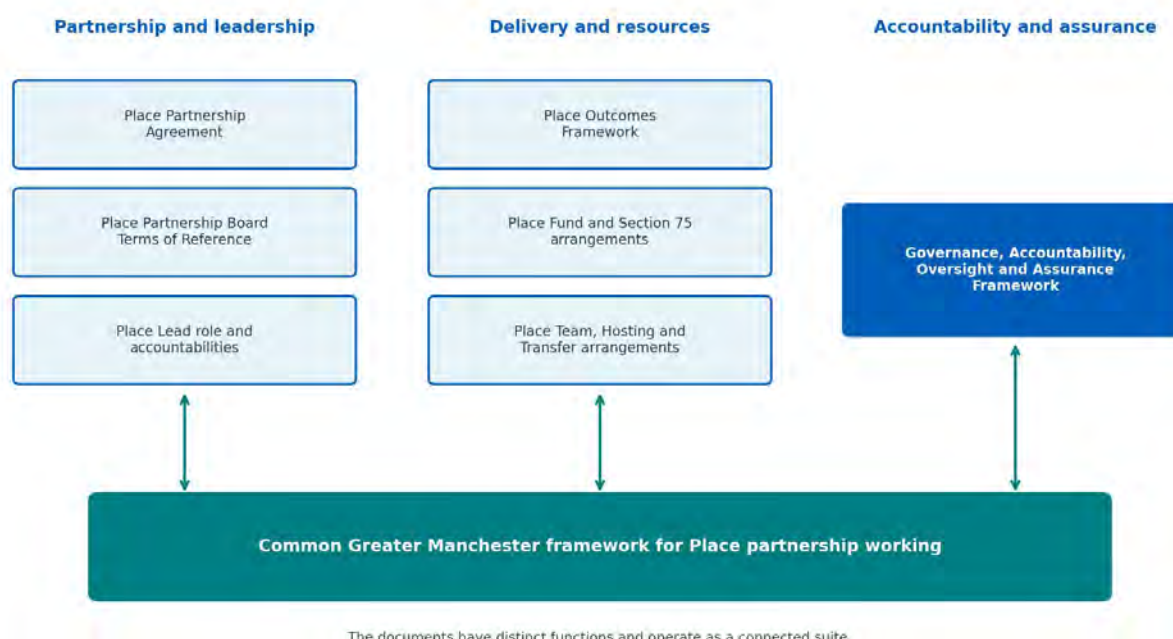


Figure 4. How the Place Partnership document suite fits together.

6.2 Clearer accountability and decision-making

A central outcome of the review is a clearer distinction between collective partnership working and the statutory, contractual and organisational responsibilities retained by individual partners.

Place Partnerships provide a forum through which partners can agree priorities, coordinate delivery, oversee shared outcomes, consider risks and support collective improvement. They do not replace the lawful authority, governance or accountability of the organisations involved.

The final arrangements make clearer:

- which matters can be considered and agreed collectively;
- where formal authority remains with an individual organisation or authorised decision-maker;
- how decisions and the authority supporting them should be recorded;
- how objections, disagreements and conflicts of interest should be managed;
- how concerns should be escalated through the appropriate route; and
- how statutory, financial, clinical, professional, safeguarding, employment and regulatory responsibilities are protected.

This provides a stronger basis for collaboration without creating ambiguity about who remains responsible for formal decisions, resources, services or organisational duties.

6.3 Stronger and more meaningful participation

The final suite gives greater recognition to the breadth of partners and communities involved in Place working.

This includes clearer consideration of:

- local authorities and elected members;
- general practice and the wider primary care family;
- Local Medical Committees;
- NHS providers, including those operating across several Places;
- mental health and children's services;
- the voluntary, community, faith and social enterprise sector;
- residents, patients, carers and communities;
- clinical and professional leadership; and
- wider public services and statutory partnerships.

The arrangements support meaningful and proportionate participation rather than prescribing one identical model for every Place. This allows local membership and engagement routes to reflect the population, partner landscape and established relationships within each Place.

Participation should enable partners and communities to influence priorities, decisions, delivery and evaluation. It should also recognise that organisations operating across several Places may need coordinated arrangements that provide effective involvement without unnecessary duplication.

6.4 A balanced approach to consistency and local flexibility

The final suite establishes a common Greater Manchester framework while preserving appropriate local flexibility.

Consistency is particularly important where arrangements concern:

- statutory and organisational accountability;
- formal financial authority;
- decision-making and record keeping;

- employment and host responsibilities;
- quality, safeguarding and professional accountability;
- assurance and escalation; and
- transparency about the status and scope of the arrangements.

Local flexibility remains important in areas such as:

- detailed membership and participation routes;
- local delivery and supporting governance structures;
- engagement with residents and communities;
- partner contributions and service interfaces;
- locally agreed outcomes and measures;
- clinical and professional leadership arrangements; and
- the sequencing of local mobilisation.

This approach supports subsidiarity by enabling decisions and delivery to take place at the most appropriate level while maintaining the safeguards and consistency required across Greater Manchester.

6.5 A stronger focus on outcomes and improvement

The final arrangements strengthen the collective focus on improving outcomes for local people rather than concentrating only on organisational activity or performance.

The Place Outcomes Framework gives greater prominence to:

- prevention and early intervention;
- reducing inequalities;
- mental health;
- children and young people;
- resident, patient and carer experience;
- neighbourhood variation;
- wider determinants of health; and
- the contribution of communities and the voluntary, community, faith and social enterprise sector.

The framework also recognises the importance of interpreting individual measures in context. Changes in demand, referrals, attendances or admissions need to be considered alongside information about access, experience, outcomes and inequalities.

Place assurance will draw on existing governed evidence wherever possible, supplemented by neighbourhood intelligence, lived experience, clinical and professional insight, and local delivery knowledge. This is intended to provide a rounded understanding of progress and risk without creating an additional or duplicative reporting system.

6.6 Clear boundaries around resources and hosting

The final suite provides greater clarity about the present scope of the Place Fund and the arrangements for the Place Delivery and Integration Service.

For 2026/27, the Place Fund comprises the agreed Better Care Fund services and operates through the applicable Better Care Fund and Section 75 arrangements. It is not a delegated budget, and the Place Partnership Board does not hold delegated financial authority. Formal financial decisions remain with the authorised NHS Greater Manchester or local authority decision-maker responsible for the funding concerned.

The final arrangements do not assume that wider budgets, services or financial risks have transferred to Place. Any future proposal to add services or resources will require separate development, assessment,

agreement and approval.

The Place Delivery and Integration Service is the identifiable NHS Greater Manchester-funded service and workforce intended to transfer to the agreed host. The host will become the substantive employer and contracted service provider but will not acquire additional authority over Place Partnership priorities.

The Service will remain a defined Place resource. The host, NHS Greater Manchester, the Place Partnership and the Place Partnership Director each have different and complementary responsibilities. These distinctions provide safeguards for staff, partners and participating organisations while supporting coordinated Place delivery.

6.7 What remains locally determined or subject to mobilisation

The final suite provides the common framework but does not attempt to prescribe every aspect of local operation.

Some detailed arrangements continue to be completed through mobilisation and the relevant local, organisational and statutory processes. These include, where applicable:

- local Terms of Reference and supporting schedules;
- detailed governance and reporting routes;
- the identification and approval of host arrangements;
- workforce consultation and transfer activity;
- due diligence and contractual documentation;
- detailed service specifications and performance arrangements;
- local partner contributions and service interfaces;
- clinical and professional leadership arrangements;
- information, digital, estates and corporate support arrangements;
- local implementation sequencing; and
- transitional controls and readiness activity.

These matters will be progressed within the agreed Greater Manchester framework. They do not alter the principles, boundaries or responsibilities established through the final suite.

7. Next steps

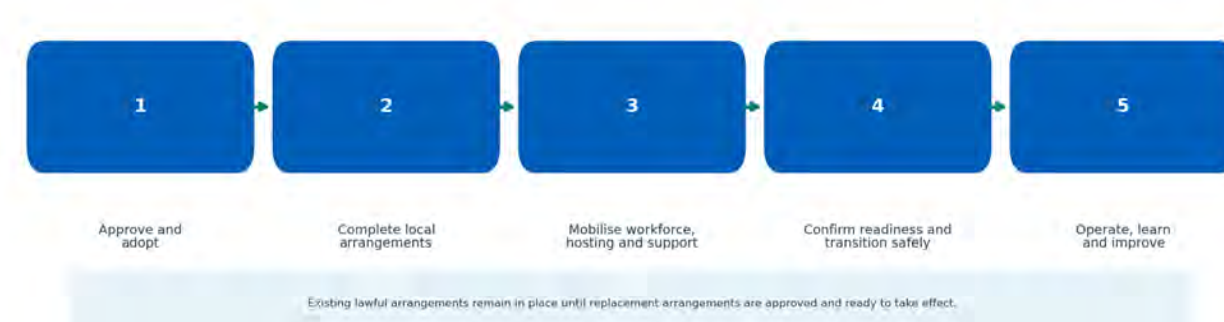


Figure 5. Approval, mobilisation and implementation pathway.

7.1 Approval and adoption

The final document suite will progress through the governance and approval routes applicable to each document and participating organisation.

Different parts of the suite have different legal and governance functions. The approval route for a partnership agreement or Terms of Reference is not necessarily the same as the route required for a Section 75 agreement, hosting contract, workforce transfer or formal delegation.

Approval activity will therefore be coordinated while respecting the decision-making requirements of the organisations involved. This will include ensuring that:

- the correct organisations and decision-makers consider each document;
- statutory and organisational governance requirements are met;
- any required legal agreements and schedules are completed;
- dependencies between documents are identified and managed; and
- the final versions remain aligned through approval and execution.

Existing lawful arrangements will remain in place until replacement arrangements have been approved and are ready to take effect.

7.2 Local mobilisation

Each Place will use the common framework to complete its local mobilisation arrangements.

This will include translating the document suite into practical operating arrangements that reflect local relationships, structures and priorities. Local mobilisation is expected to cover:

- confirmation of Place Partnership governance and membership;
- completion of the Place Partnership Board Terms of Reference;
- clarification of decision, referral, assurance and escalation routes;
- confirmation of partner participation and representation;
- alignment with Health and Wellbeing Boards and other relevant statutory partnerships;
- confirmation of the local outcomes and assurance approach;
- preparation for operation of the Place Fund within the agreed scope;
- completion of hosting and service arrangements;
- confirmation of enabling support and service interfaces; and
- communications with staff, partners and wider stakeholders.

Mobilisation plans will need to address local dependencies while remaining consistent with the common Greater Manchester framework.

7.3 Workforce, hosting and service transition

The transfer of the Place Delivery and Integration Service will be progressed through the formal workforce, legal, contractual and organisational processes.

This will include:

- workforce consultation and engagement;
- confirmation of the staff and roles within scope;
- employment and assignment information;
- organisational and workforce due diligence;
- confirmation of host responsibilities and liabilities;
- completion of the service specification and hosting contract;
- establishment and funding controls;
- digital, information governance, estates and equipment arrangements;
- performance, assurance and reporting arrangements;
- change control, escalation and dispute resolution processes; and

- continuity and transition planning.

The workforce process will determine the detailed employment arrangements and applicable protections. Place mobilisation and workforce transition will be coordinated so that governance, service and employment changes remain aligned.

7.4 Enabling support and system interfaces

Effective Place working depends on access to appropriate enabling capabilities and clear interfaces with functions retained by NHS Greater Manchester and other partners.

Further mobilisation activity will clarify how Places access support relating to:

- finance;
- data, insight and intelligence;
- digital and information technology;
- information governance;
- estates and equipment;
- workforce and organisational development;
- quality and safeguarding;
- clinical and professional leadership;
- strategic commissioning;
- programme and transformation support; and
- communications and engagement.

Support may be provided through dedicated Place capacity, partner contributions, services operating across more than one Place or Greater Manchester-wide functions. The aim is to provide clear and proportionate access to the capabilities required without unnecessarily replicating specialist functions in every Place.

7.5 Readiness and transition assurance

Readiness will be considered across the full set of governance, financial, contractual, workforce and delivery arrangements.

This will include consideration of whether:

- the required approvals have been obtained;
- decision-making and escalation routes are clear;
- necessary contracts, schedules and Terms of Reference are in place;
- workforce and host arrangements are ready;
- financial controls and reporting arrangements are established;
- statutory and organisational responsibilities remain protected;
- enabling support and service interfaces are understood;
- staff and partners have received appropriate communication;
- transitional risks and dependencies are being managed; and
- service continuity and safe operation can be maintained.

Where an element is not ready to transition, the appropriate existing or interim arrangement will remain in place until the required conditions have been met.

7.6 Learning, evaluation and ongoing development

The document suite provides the framework for implementation, but effective Place working will continue to

develop through experience and learning.

Operation of the arrangements will provide an opportunity to test:

- whether decision-making routes are sufficiently clear;
- whether partners and communities have meaningful influence;
- whether assurance is proportionate and adds value;
- whether Places can access the required enabling support;
- whether hosting arrangements protect the Place resource and support delivery;
- whether the Outcomes Framework provides a balanced and useful picture of progress;
- whether the Place Fund arrangements provide appropriate transparency and control; and
- whether the balance between Greater Manchester consistency and local flexibility is working as intended.

Learning will be considered through the relevant Place and Greater Manchester governance routes. Material issues may lead to clarification, supporting guidance, changes to implementation arrangements or formal amendments where the appropriate approvals are obtained.

The Place Outcomes Framework will be reviewed periodically to reflect developing neighbourhood measures, data availability, evidence and delivery priorities. Any wider development of the Place Fund, delegations or pooled arrangements will be treated as a separate proposition and will require appropriate engagement, assessment and approval.

7.7 Maintaining transparency

The Outcome Report, summary slide pack and final document suite together provide a transparent account of the engagement and its outcomes.

The Outcome Report explains the principal themes and resulting changes. The summary slide pack provides a concise briefing, while the final document suite sets out the arrangements themselves.

These products will support continued communication with the organisations, partnerships, staff and communities involved as the arrangements move into mobilisation and implementation.

8. Conclusion

The engagement generated detailed and constructive feedback from across the Greater Manchester health and care system. Contributors supported the importance of effective Place partnership working while asking for clearer accountability, more meaningful participation, stronger safeguards and greater practical detail.

The review has resulted in a more coherent and appropriately bounded document suite. The final arrangements provide greater clarity about collective partnership working, retained organisational responsibilities, financial authority, outcomes, hosting, workforce arrangements, assurance and local flexibility.

Not every issue can or should be resolved through a single common document. Some matters remain subject to local determination, formal workforce processes, contractual arrangements, organisational approvals or future development. The suite now makes these boundaries clearer and provides the framework within which the remaining work will be completed.

The next phase is to translate the agreed framework into safe, practical and locally effective arrangements. This will require coordinated approval, mobilisation and transition activity, supported by clear communication, appropriate assurance and continued partnership working.

The resulting framework provides a stronger foundation for Place Partnerships to work collectively around local priorities, improve outcomes, reduce inequalities and support coordinated health and care for the people and communities of Greater Manchester.

Place Health and Care Partnership Document Suite

Engagement Feedback Outcomes

SUMMARY SLIDE PACK

What we heard, what changed and what happens next

This summary connects the engagement, the changes and the resulting arrangements

Engagement undertaken

1

Who contributed and the scale of the response

What we heard

2

The strongest recurring messages from partners

How feedback was considered

3

A structured review, assurance and alignment process

What changed

4

The most significant changes across the suite

Resulting position

5

What is now clearer, and what has not changed

Next phase

6

Approval, mobilisation, readiness and improvement

The full Outcome Report provides the detailed narrative and rationale. The PHCP Overview Summary Pack explains the operating model and how the document suite fits together.

Engagement reached across the Greater Manchester partnership



Greater Manchester

A broad and multi-disciplinary response informed the review of the full document suite.

280

distinct feedback points

26

formal submissions or source documents

24

organisations, Places or teams
represented

Contributors included



Place Health and Care Partnerships



Local authorities



NHS trusts and foundation trusts



General practice and wider primary care



Mental health and children's services



VCFSE organisations



Clinical and professional groups



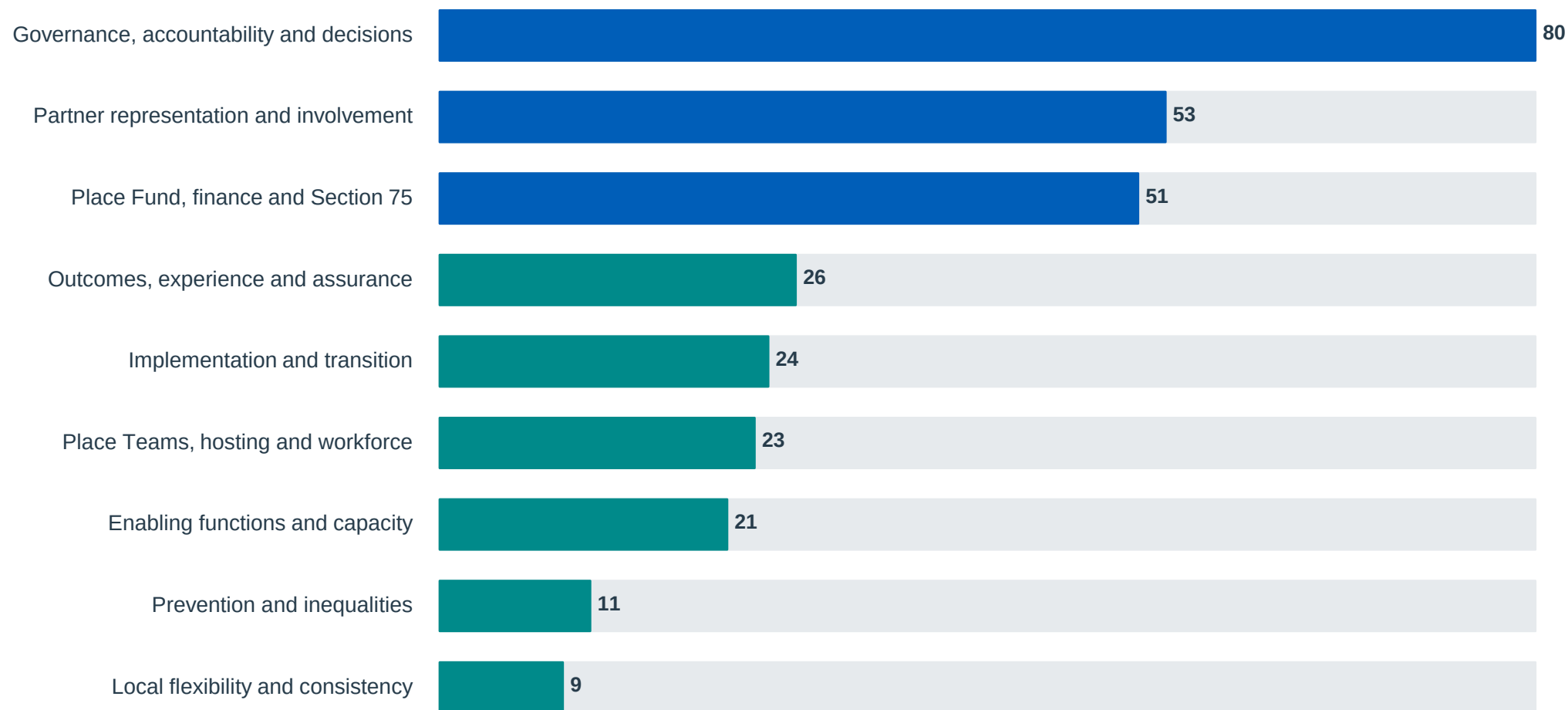
Finance, legal, workforce and governance
teams



Wider public service partners

Accountability, participation and finance dominated the feedback

The prevalence chart shows the relative volume of themes identified across the feedback received.



Key message: practical clarity and safeguards mattered most.

The central message was support for Place working, coupled with a call for greater practical clarity

Strong support for Place working

Partners consistently supported effective Place partnership working as a means of improving outcomes, reducing inequalities and supporting neighbourhood delivery.

Greater practical clarity was needed

Contributors sought clearer arrangements for decision-making, accountability, finance, workforce, representation and assurance.

Retained responsibilities must remain visible

Collective working should strengthen collaboration without diluting statutory, contractual, professional or organisational accountabilities.

Consistency and flexibility must work together

A common Greater Manchester framework should preserve appropriate flexibility for local relationships, priorities and delivery arrangements.

Overall, feedback was detailed, constructive and wide-ranging. The strongest request was not for a different direction, but for a clearer and more operationally useful framework.

Feedback was considered through a structured six-stage review and assurance process



Each point was assessed on its own merits, then considered across the whole suite so that individual changes did not create contradictions elsewhere.

Engagement strengthened the entire document suite

Clearer accountability

A sharper distinction between collective Place working and retained organisational responsibilities.

More meaningful participation

Stronger recognition of local authorities, primary care, providers, VCFSE partners, residents, patients, carers and communities.

Clearer financial boundaries

The Place Fund is more clearly defined, with stronger transparency, reporting and governance arrangements.

Stronger focus on outcomes

Greater prominence for prevention, inequalities, mental health, children and young people, experience and wider determinants.

Clearer workforce and hosting

Improved definition of the Place Team, hosted service, employer responsibilities and workforce safeguards.

More coherent assurance

Stronger links between outcomes, governance, resources, assurance and escalation.

The revised suite is clearer about both what it enables and what it does not change

NOW CLEARER

- ✓ How collective decisions relate to formal authority
- ✓ How disagreements and disputes are managed
- ✓ How financial governance operates
- ✓ How hosting arrangements work
- ✓ How partners influence priorities and delivery
- ✓ How assurance and escalation operate
- ✓ Where consistency is required and local flexibility remains

NOT CHANGED THROUGH THE SUITE ALONE

- ✗ Statutory responsibilities have not automatically transferred
- ✗ The Partnership Board does not hold delegated financial authority
- ✗ The Place Team is not a separate legal entity
- ✗ Hosting does not give the host authority over the whole partnership
- ✗ Wider budgets have not automatically become part of the Place Fund
- ✗ Future delegation or pooling has not already been agreed

Changes were made across every key document

Partnership Agreement & Board Terms of Reference

- Clearer status and purpose
- Stronger decision-making arrangements
- Improved representation and participation
- Clearer escalation and dispute processes

Place Outcomes Framework

- Greater focus on prevention and inequalities
- Stronger mental health and children's outcomes
- More prominence for experience
- More focused and meaningful measures

Place Fund & Section 75 Arrangements

- Clearer 2026/27 scope
- Stronger financial governance and transparency
- Clearer risk and accountability boundaries
- Clearer approach to future development

Place Team, Hosting & Transfer Arrangements

- Clearer wider Team and hosted-service distinction
- Stronger workforce safeguards
- Better-defined host responsibilities
- Stronger delivery and accountability arrangements

Governance, Accountability, Oversight & Assurance

- Clearer accountabilities and decision routes
- Stronger NHS GM and Place links
- More proportionate assurance
- Clearer escalation and system leadership

The resulting framework is clearer, more connected and more operationally useful



Greater Manchester

1

A clearer and more connected framework

The documents now operate more effectively as a single integrated suite.

2

Clearer accountability and decisions

Roles, responsibilities and decision routes are more explicit.

3

Stronger participation

The breadth of partners and communities is more clearly recognised.

4

Consistency with local discretion

A common Greater Manchester framework with appropriate local flexibility.

5

Stronger focus on outcomes

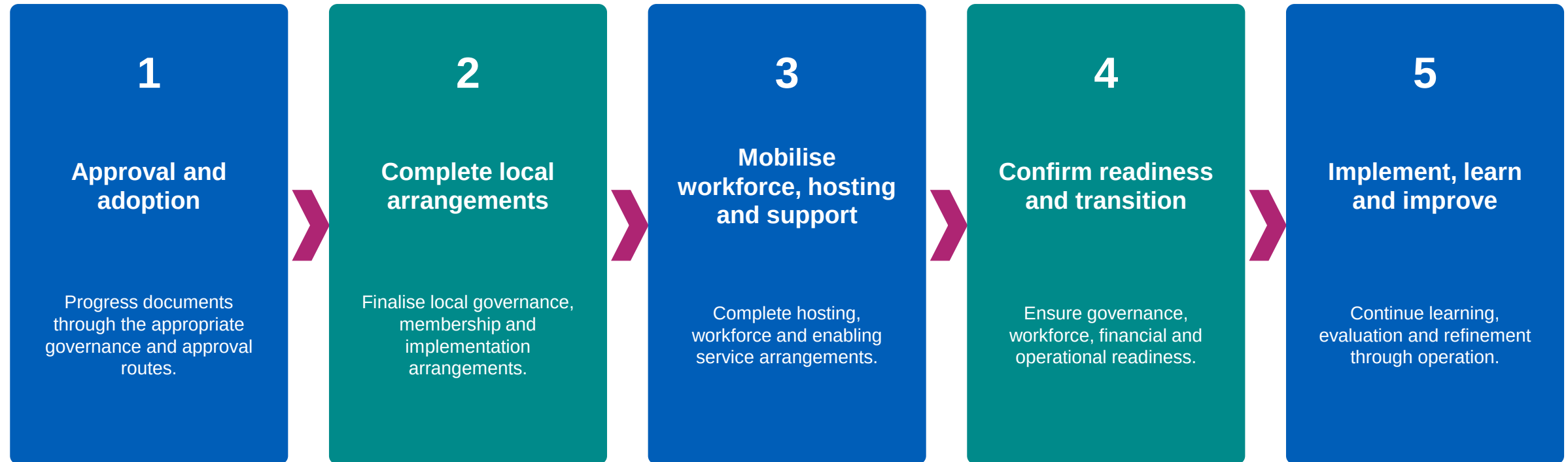
More emphasis on prevention, experience, inequalities and neighbourhood delivery.

6

Clearer resources and hosting boundaries

Financial and workforce arrangements are more clearly defined.

The next phase moves from document finalisation to approval, mobilisation and improvement



Key principle: existing lawful arrangements remain in place until replacement arrangements have been approved and are ready to take effect.

Further information is available through the wider reporting package

PHCP Overview Summary Pack

To understand the operating model

Explains the role of Place Partnerships and how the document suite works together.

Engagement Feedback Outcomes Report

To understand the engagement process

Provides the full narrative, analysis and rationale for the changes made.

Final Place Partnership Document Suite

To understand the final arrangements

Sets out the approved arrangements supporting implementation and mobilisation.

Together, these products provide the operating model, the evidence of engagement and the final arrangements.

Place Health and Care Partnership Document Suite Summary Slides

About This Document and Contents



Greater Manchester

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.

Executive Summary and Introduction

Foreword

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.



Greater Manchester

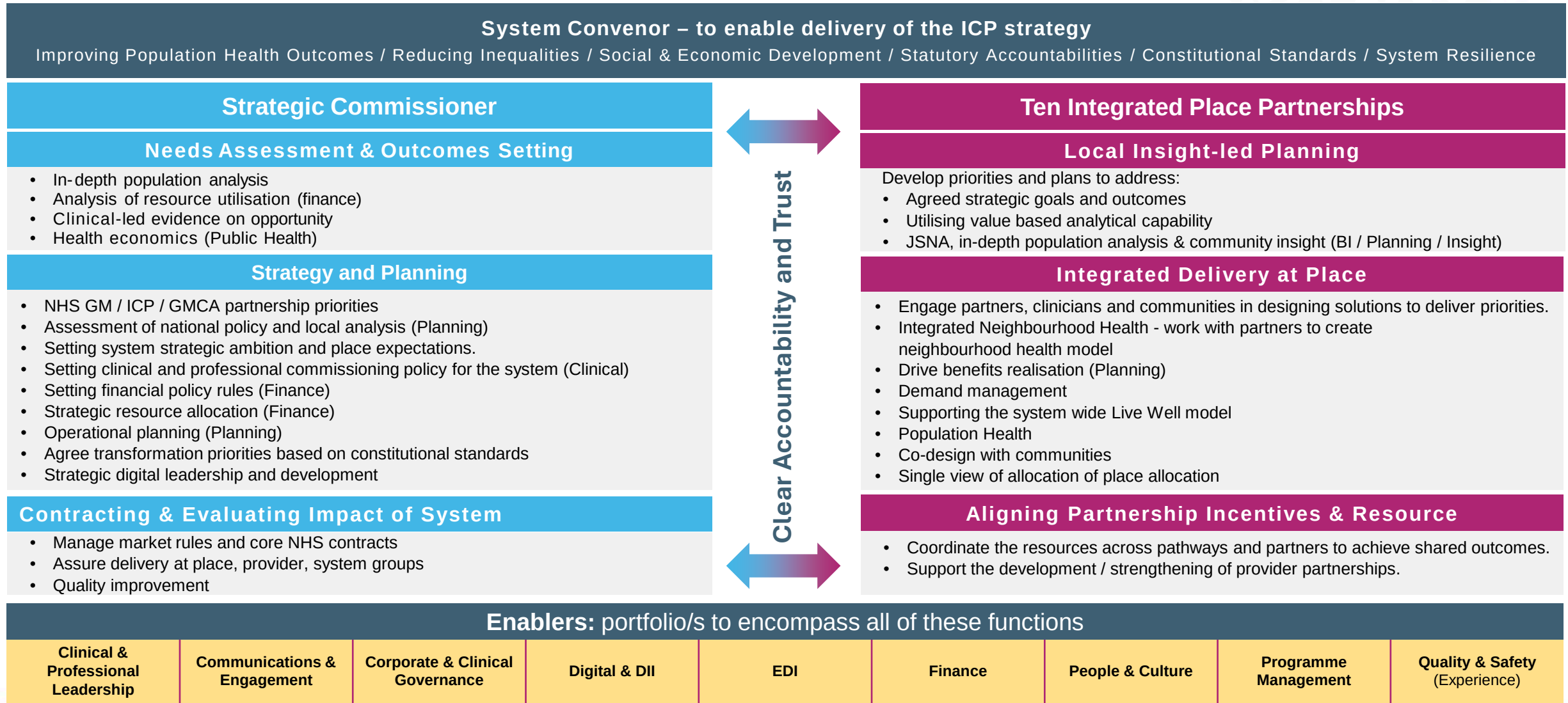


Professor Colin Scales
Acting Chief Executive
NHS Greater Manchester



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



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

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



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.

Introducing the PHCP Document Suite

How the core operating-model documents work together



Greater Manchester

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



Greater Manchester



Partnership Agreement

Partnership Agreement



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

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.

Place Outcomes Framework

Place Outcomes Framework



Greater Manchester



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

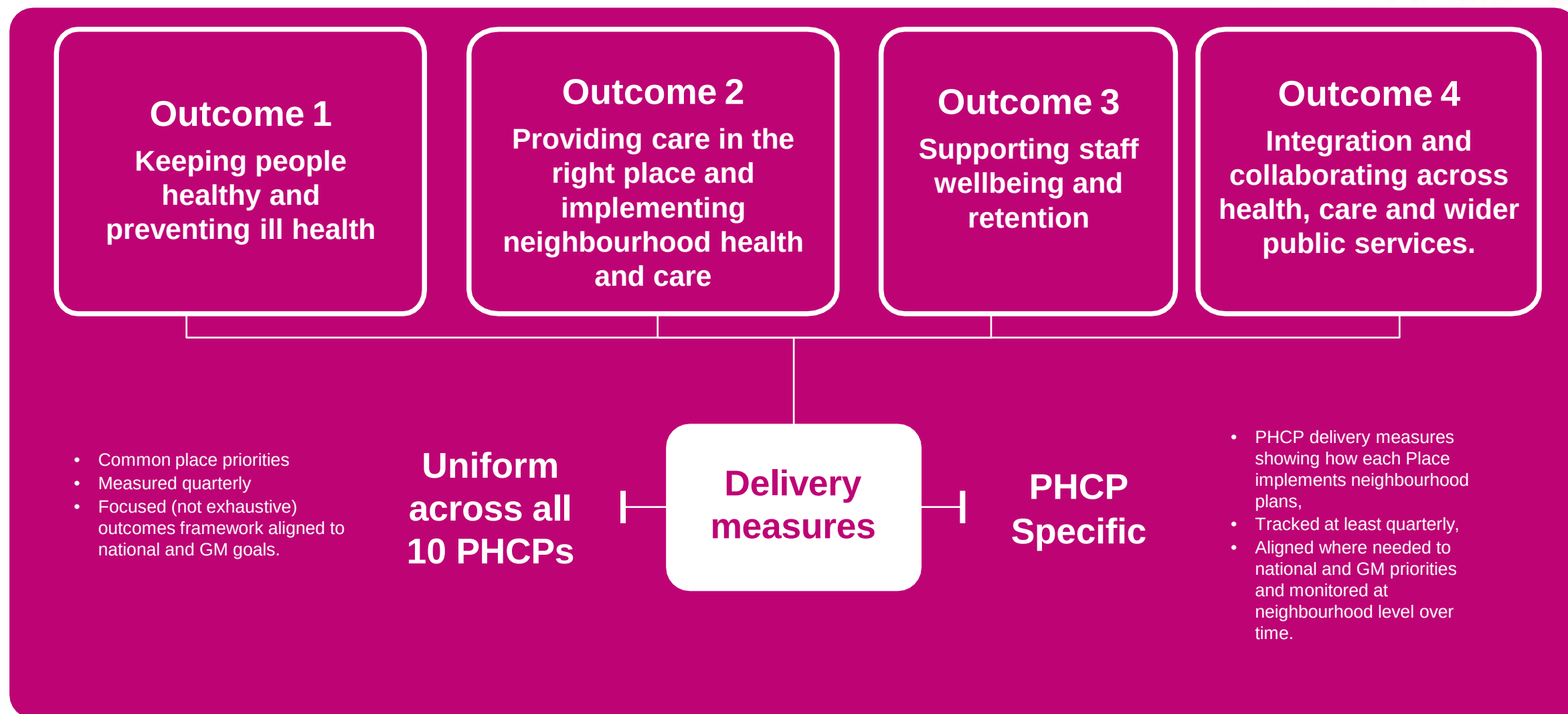


Focuses on **impact rather than activity**, with transparent tracking of progress

Place Outcomes Framework – Linking delivery measures to outcomes



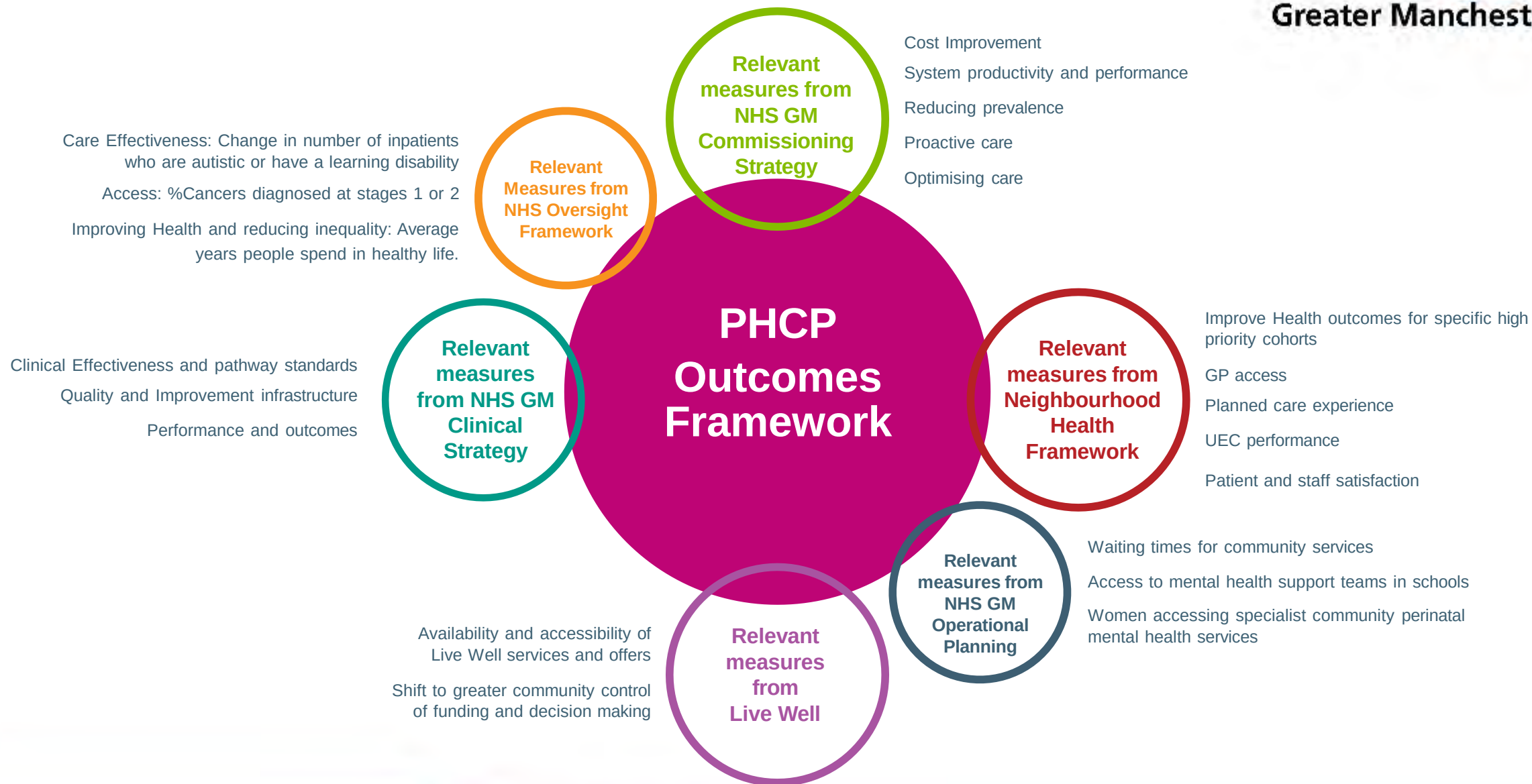
Greater Manchester



Outcomes Framework composition



Greater Manchester



Place Fund



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?



Greater Manchester

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.

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

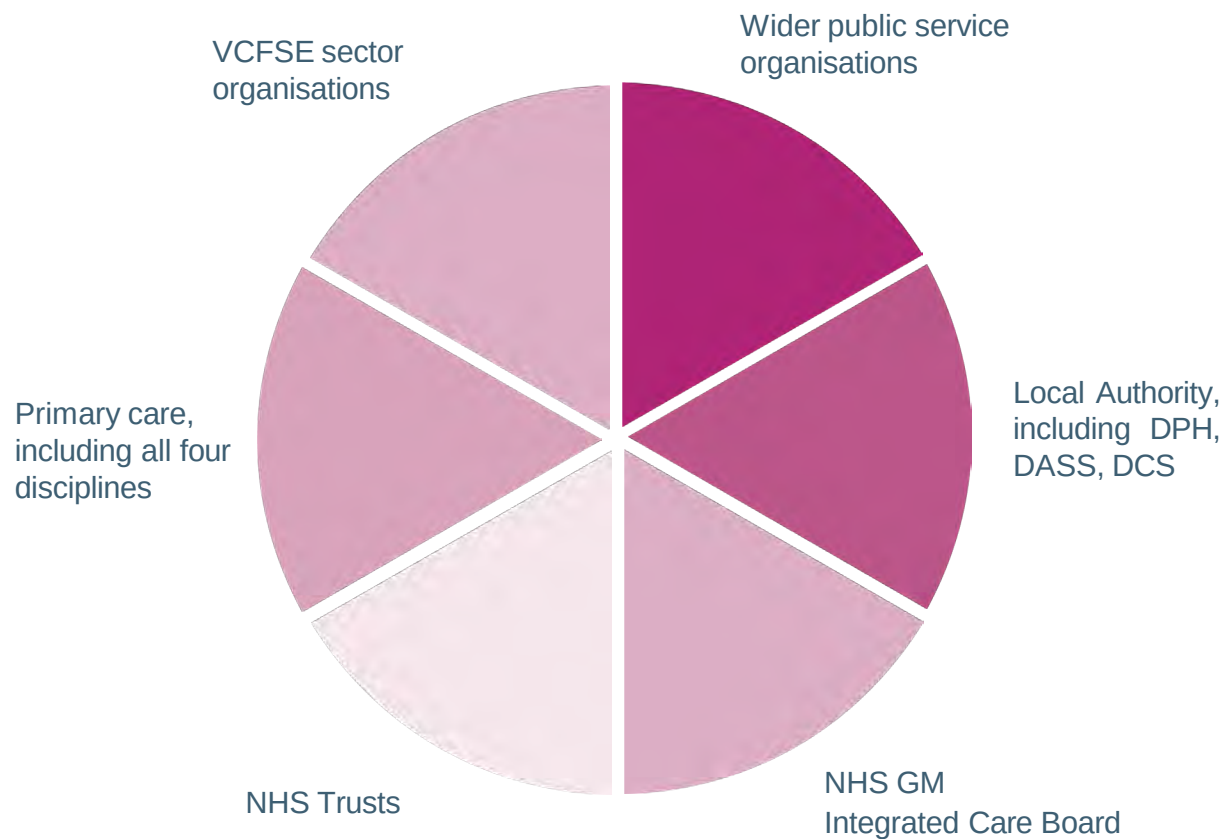
Strengthen reporting, assurance and record keeping

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

Place Team

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

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.



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.

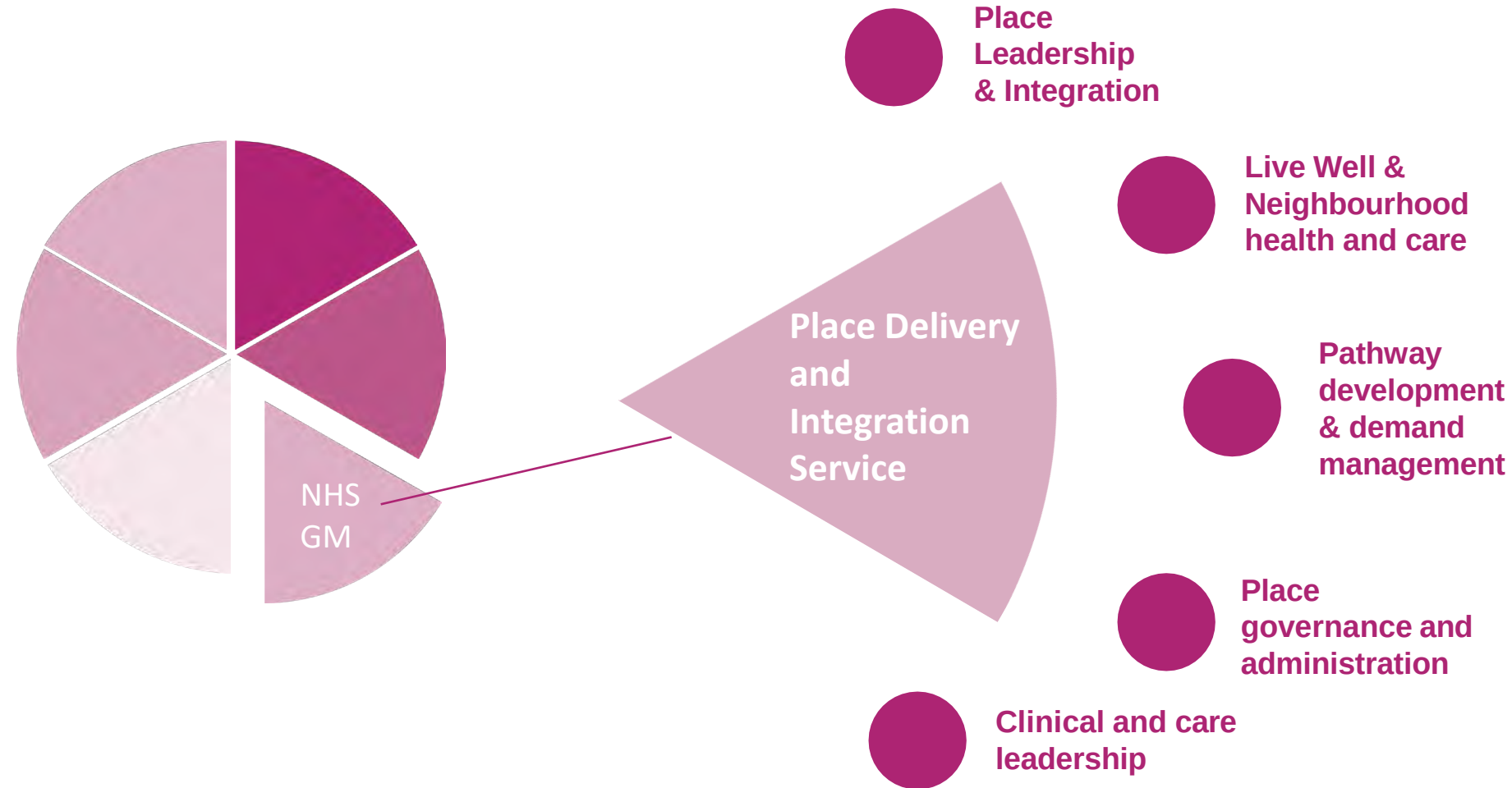


Greater Manchester

NHS GM contributes alongside all partners

Components of the NHS GM Model Place Team

- 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

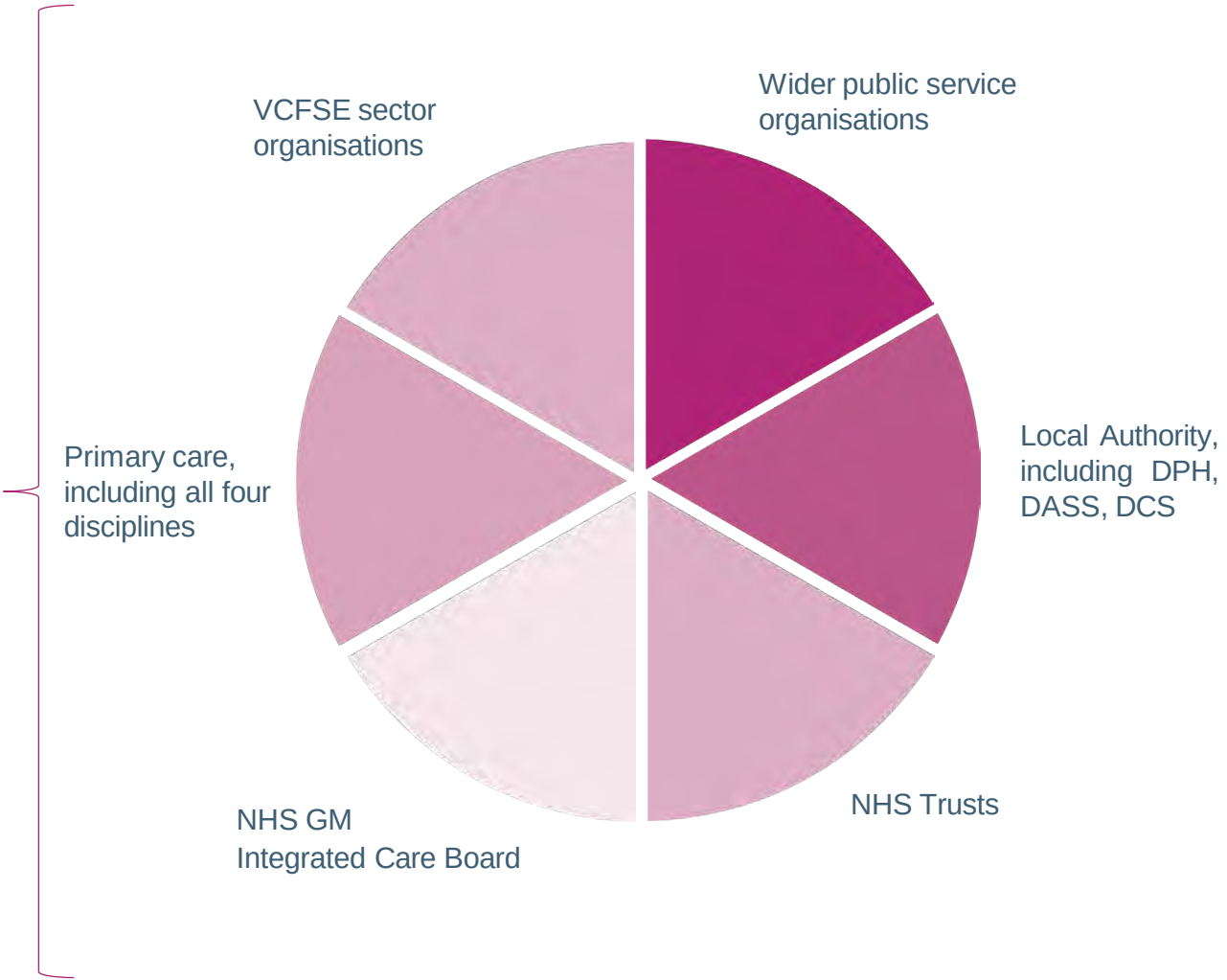


Setting up Place teams will be informed by context in each place rather than a one-size-fits-all.



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.



Governance

Governance, Accountability, Oversight and Assurance Framework

- 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



Greater Manchester

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.

Place Partnerships Mobilisation Swimlanes

Employment, contractual and governance milestones | September 2026 to 1 April 2027

Programme activity / preparation	Provisional / decision required	Confirmed / stated milestone	Risk / adverse consequence
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Swimlane	Sep 2026	Oct 2026	Nov 2026	Dec 2026	Jan 2027	Feb 2027	Mar 2027	1 Apr 2027
EMPLOYMENT	Confirm host-employer model scope, transfer dependencies and required legal, organisational, tax and VAT review.	Develop transfer arrangements, hosted-service contract and accountability provisions.	Confirm intended employment transfer timing and alignment with governance changes. Latest date for start of consultation for Jan 1st Transfer	Prepare workforce transition arrangements and identify delegation or voting impacts.	Any pre-April transfer must preserve NHS GM governance legitimacy. Review Locality Board membership, quorum and NHS GM representation requirements before implementation. Interim arrangements may be required where PPDs transfer before governance changes take effect.	Complete consultation, approvals and mobilisation required by the agreed transfer approach. Latest date for start of consultation for Apr 1st Transfer	Alternative transfer 31 March/1 April. PROVISIONAL. This would align employment change with formal go-live.	Place Teams operate through agreed Foundation Trust host-employer and hosted-service arrangements.
CONTRACTUAL	Confirm scope of Place Fund and hosting arrangements, including relationship with existing BCF Section 75 agreements.	BCF Phase 1: review agreements, map Locality Board responsibilities and obtain initial legal advice.	Agree amendment scope and future governance model. Map Local Authority and ICB approval routes.	BCF Phase 2: draft revised Section 75 agreement, governance schedules and financial schedules.	Complete legally reviewed first draft. Develop Place Fund transaction and host-governance arrangements. Confirm whether specific BCF / Section 75 governance requirements require continued formal governance arrangements beyond Place Partnership Board recommendations. (Jan to Feb)	Complete partner engagement, resolve material issues and finalise legal amendments. Agreement ready for approval.	Secure Place Partnership, Local Authority and ICB approvals. Execute revised Section 75 agreements.	Revised BCF / Section 75 and Place Fund arrangements go live. Formal transactions follow host governance.
GOVERNANCE	Finalise the three-layer framework, minimum governance expectations, accountability and assurance products.	Map Locality Board responsibilities, governance gaps, schemes of delegation and transition controls.	NHS GM decision on future Place Partnership governance. Confirm shadow and formal implementation model.	Prepare revised terms of reference, governance documents, delegations, assurance routes and transition plan.	Place Partnership Boards operate in shadow form from January to March 2027. Locality Boards remain formally constituted NHS GM sub-committees until 31 March 2027 to maintain BCF / Section 75 governance and audit assurance. Review Locality Board Terms of Reference, quorum requirements and NHS GM membership implications arising from workforce transfers (Jan - Feb) Develop and agree future BCF and Place Fund governance arrangements, including assurance, decision-making and transaction routes required from 1 April 2027 (Jan - Mar)	Progress Local Authority approval routes. Test reporting, assurance, escalation and decision interfaces.	Complete terms of reference, schemes of delegation and replacement arrangements for Locality Board functions.	Place Partnership Boards and new Place governance become formally operational.

Salford Integrated Care Partnership Committee

22 October 2026

Item 7 (b) – Northern Care Alliance Integrated Improvement Plan Update

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

Report of:	Chief Nursing Officer, Northern Care Alliance	
Date of Paper:	16 October 2026	
In case of query, please contact:	Juliette Cosgrove Juliette.cosgrove@nca.nhs.uk	
System Priorities: (Please tick as appropriate)	Physical activity and movement	
	Child Friendly City	
	Live well, Neighbourhoods and Communities	
	Adults and Ageing Well	
	Preventable illness - CVD and Diabetes	
	Urgent and emergency care	✓
	Mental health and emotional wellbeing	
	Triple aim – population health, performance recovery, financial sustainability	
	Other system enabler i.e. Workforce, Transformation, Digital etc.	
Purpose of Paper: The Northern Care Alliance is responding to quality challenges and increased regulatory oversight and the Board now needs one integrated view of whether improvement is real, sustained and evidenced. The attached presentation provides details in relation to the Northern Care Alliance's Integrated Improvement Planning and gives details of the drivers behind the work, the current position and the future aims.		

Northern Care Alliance (NCA) Integrated Improvement Planning (IIP)

September 2026

Northern Care Alliance is responding to quality challenges and increased regulatory oversight. The Board now needs one integrated view of whether improvement is real, sustained and evidenced.

DRIVERS

- Better Patient Care
- Embedding our new Organisational Structure : CLM
- Providing sustainable services in every sense
- Regulatory Concerns : NHSE Undertakings (May 2026); CQC s29a notices (Sept 2025 and Aug 2026).

CURRENT REALITY

- Early diagnosis identifies fragmented governance, unclear prioritisation, variable delivery discipline and limited line of sight from action to outcomes.
- Partners, patients and communities have highlighted similar concerns and opportunities for improvement
- Developing an Integrated Improvement Plan which will focus on root cause themes
- Engagement started with our clinical leaders

FUTURE STATE - RESULT

- One integrated approach linking risks, priorities, delivery and outcomes
- A single evidence base to provide credible and consistent assurance of progress to stakeholders.
- Shared System Responsibility for Sustainable Outcomes

Board ambition: able to demonstrate from one source that the organisation is improving for patients, colleagues, strengthening partnerships and meeting regulatory expectations

Stage 1 – Stabilising

- Immediate safety and regulatory risks addressed
- Clear executive ownership and accountability
- Reliable governance and assurance
- Disciplined delivery against agreed priorities

Stage 2 – Optimising

- Leadership and management capability strengthened
- Operational, quality and financial performance improving consistently
- Organisational learning becomes routine

Stage 3 – Transforming

- Improvement becomes business as usual
- Strategic transformation delivered
- Strong system partnerships
- Continuous improvement embedded across the organisation

The IIP is designed not simply to deliver today's recovery actions, but to grow and embed the organisational capability required to sustain improvement long after regulatory oversight has reduced.

Improvement Themes

Six themes focus our collective improvement effort

01 Safe & Effective Care

02 People & Culture

03 Governance

04 Digital, Data & Information

05 Operational Delivery

06 Financial Sustainability

Improvement Themes & Year 1 Programmes

Safe & Effective Care	People & Culture	Governance	Digital, Data & Information	Operational Delivery	Financial Sustainability
Quality Governance Patient Safety, Complaints & Learning Gynaecology Services Spinal Services	Executive & Senior Leadership effectiveness Clinical Leadership & medical engagement Culture, speaking up & Inclusion Colleague Health, attendance & wellbeing	Risk Management & Assurance Integrated Planning, Performance & Improvement Governance	Digital Safety & Infrastructure Data Quality & Information Management	UEC and Patient Flow Access and waiting time recovery	Financial Recovery Underlying Deficit & Cost Improvement Productivity

Year 1 Priorities — Safe & Effective Care



Year 1 Programme focus

Quality governance

Patient safety, complaints & learning

Gynaecology improvement

Spinal improvement

YEAR 1 OUTCOMES

Improved assurance • Embedded learning • Sustainable quality improvement

Year 1 Priorities — People & Culture



Year 1 focus

Executive & senior leadership effectiveness

Clinical leadership & medical engagement

Culture, speaking up & inclusion

Workforce health, attendance & wellbeing

YEAR 1 OUTCOMES

Stronger accountability • Better staff experience •
Reduced sickness absence • Workforce resilience

Year 1 Priorities — Governance



Year 1 focus

Risk management & assurance

Integrated planning, performance & improvement
governance

YEAR 1 OUTCOMES

Clear accountability • Stronger assurance • Improved
Board confidence

Year 1 Priorities — Digital, Data & Information



Year 1 focus

Digital safety & infrastructure resilience

Data quality & information management

YEAR 1 OUTCOMES

Reliable digital services • Greater data confidence •
Better management information

Year 1 Priorities — Operational Delivery

EXECUTIVE LEAD

COO

Deliver timely, efficient services
through collaboration.

Year 1 focus

Urgent & emergency care and patient flow

Access & waiting time recovery

YEAR 1 OUTCOMES

Improved flow performance • Reduced delays • Better access

Year 1 Priorities — Financial Sustainability



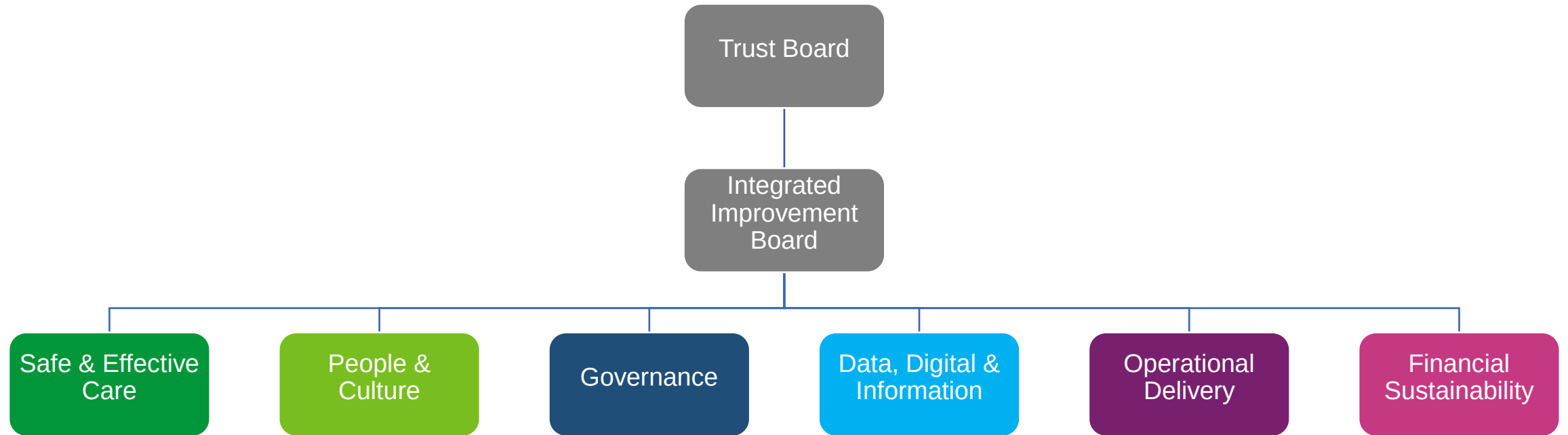
Year 1 focus

- Financial recovery
- Underlying deficit & cost improvement
- Productivity

YEAR 1 OUTCOMES

- Improved financial position
- Better resource use
- Sustainable efficiencies

Integrated Improvement Plan Governance



IIP Delivery Governance

Executive Lead:



EXEC LEAD: CNO



EXEC LEAD: CEO



EXEC LEAD: CEO



EXEC LEAD: CDIO



EXEC LEAD: COO



EXEC LEAD: CFO

Delivery
Portfolio:

Safe and Effective Care	People and Culture	Governance	Data, Digital and Information	Operational Delivery	Financial Sustainability
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Programme /
Project:

Gynaecology Improvement Exec Sponsor: CMO	Executive & Senior Leadership Effectiveness Exec Sponsor: CEO	Risk Management & Assurance Exec Sponsor: CNO	Digital Safety & Infrastructure Resilience Exec Sponsor: CDIO	Urgent & Emergency Care & Patient Flow Exec Sponsor: COO	Financial Recovery Exec Sponsor: CFO
Spinal Improvement Exec Sponsor: CMO	Clinical Leadership & Medical Engagement Exec Sponsor: CMO	Integrated Planning, Performance & Improvement Governance Exec Sponsor: TBC	Data Quality & Information Management Exec Sponsor: CDIO	Access & Waiting Time Recovery Exec Sponsor: COO	Underlying Deficit & Cost Improvement Exec Sponsor: CFO
Quality Governance Exec Sponsor: CNO	Culture, Speaking Up and Colleague Experience Exec Sponsor: CPO				Productivity Exec Sponsor: CFO
Patient Safety, Complaints & Learning Exec Sponsor: CNO	Workforce Health, Attendance & Wellbeing Exec Sponsor: CPO				