



HMR Integrated Care Partnership Committee

Meeting information

Date and time of meeting: Tuesday, 27 October 2026 at 2.00 pm

Venue: Hollingworth - (Room 108AB), First Floor, Number One Riverside, Smith Street, Rochdale, OL16 1XU

Agenda items

1. APOLOGIES

To receive any apologies for absence.

2. URGENT ITEMS OF BUSINESS

To determine whether there are any additional items of business which, by reason of special circumstances, the Chair decides should be considered at the meeting as a matter of urgency.

3. DECLARATIONS OF INTEREST

Members are required to declare any disclosable pecuniary, personal or personal and prejudicial interests they may have and the nature of those interests relating to items on this agenda and/or indicate if S106 of the Local Government Finance Act 1992 applies to them.

4. ITEMS FOR EXCLUSION OF PRESS AND PUBLIC

To determine any items on the agenda, if any, where the public are to be excluded from the meeting.

5. MINUTES (Pages 7 - 17)

To approve the minutes of the Heywood, Middleton and Rochdale Locality Board meeting held on 29 September 2026.

6. PUBLIC QUESTIONS

To note public questions received since the last meeting of the Board.

7. GM VERBAL UPDATE

To receive a verbal update from the NHS GM Integrated Care Representative and the Place Based Lead – Item for information.

8. ASSURANCE

8a. NCA Improvement Plan Update

Report to follow.

8b. NHS - Performance Update (Pages 18 - 28)

To receive an update on performance from the Associate Director of Integration and Delivery (Heywood, Middleton and Rochdale).

8c. Prevention Demonstrator

To receive a verbal update from the Director of Public Health and Communities

8d. Strategic Priority Update - Carers

To receive a verbal update on the Strategic Priorities of Adult Social Care.

9. EXCLUSION OF PRESS AND PUBLIC

To consider that the press and public be excluded from the remaining part of the meeting pursuant to Section 100(A)4 of the Local Government Act 1972 on the grounds that discussions may involve the likely disclosure of exempt information as defined in the provisions of Part 1 of Schedule 12A to the Local Government Act 1972 and public interest would not be served in publishing the information.

10. FINANCE, PERFORMANCE AND RISK

10a. Intermediate Care at Home Offer (Pages 29 - 54)

To receive a presentation on the progress of the Intermediate Care at Home Offer.

11. SECTION 75 - DECISION

11a. Place Health and Care Plan Update (Pages 55 - 60)

To consider a report of the Strategic Director of Commissioning and the Director of Adult Social Care

11b. Commissioning Intentions for Prevention Contracts (Stepping Stones, Bond Board, and Women's Housing Action Group – WHAG): Proposal to remodel and procure services (Pages 61 - 75)

To consider a report from the Assistant Director for Commissioning and Prevention of Adult Social Care

11c. Approval of BeCCoR neighbourhood plans (Pages 76 - 87)

To consider a report from the Associate Director of Integration and Delivery (Heywood, Middleton and Rochdale), GM ICB

Committee Members

Councillors Mayer (Chair), Ali, Chauhan, Hamilton, Hubbard, Jones, Lake, Massey, Murphy, Gertie, Shahid, Tamanis, Wardle and Wazir

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Quick Guide to Declaring Interests at Rochdale Borough Council Meetings

This is a summary of the rules around declaring interests at meetings. It does not replace the Member's Code of Conduct, the full description can be found in RBC Constitution Part 9 [Councillors and Co-opted Members Code of Conduct](#)

Within 28 days' of becoming a councillor or co-opted member, you must notify the Monitoring Officer of any 'disclosable pecuniary interests'.

You are also legally bound to disclose Disclosable Pecuniary Interests relating to:

1. You, and your partner's business interests (eg employment, trade, profession, contracts, or any company with which you are associated).
2. You and your partner's wider financial interests (eg trust funds, investments, and assets including land and property).
3. Any sponsorship you receive.

Failure to disclose this information is a criminal offence.

In addition to the disclosable pecuniary interests notifiable, you must, within 28 days of becoming a councillor notify the Monitoring Officer in writing of the details of your **other personal interests**.

You have a **personal interest** in any business of your authority where it relates to or is likely to affect:

1. Any bodies of which you are in a position of general control or management and to which you are appointed or nominated by the Council.
2. Your membership of bodies exercising functions of a public nature, including charities, societies, political parties, trade unions including one of whose principal purposes includes the influence of public opinion or policy (including any political party or trade union), of which you are in a position of general control or management.

The interests of any person from whom you have received a gift or hospitality with an estimated value of at least £50

Step One: Establish whether you have an interest in the business of the agenda

1. If the answer to that question is 'No' then that is the end of the matter.
2. If the answer is 'Yes' or 'Very Likely' then you must go on to consider if that personal interest can be construed as being a prejudicial interest.

Step Two: Determining if your interest is prejudicial

A personal interest becomes a prejudicial interest:

1. Where the wellbeing, or financial position of you, your partner, members of your family, or people with whom you have a close association (people who are more than just an acquaintance) are likely to be affected by the business of the meeting more than it would affect most people in the area.
2. The interest is one which a member of the public with knowledge of the relevant facts would reasonably regard as so significant that it is likely to prejudice your judgement of the public interest.

For a non-prejudicial interest, you must:

1. Notify the committee officer for the meeting as soon as you realise you have an interest.
2. Inform the meeting that you have a personal interest and the **nature of the interest**.

To note: You may remain in the room and speak and vote on the matter.

For prejudicial interests, you must:

1. Notify the committee officer for the meeting as soon as you realise you have a prejudicial interest (before or during the meeting).
2. Inform the meeting that you have a prejudicial interest and the **nature of the interest**.
3. Leave the meeting while that item of business is discussed.

4. Make sure the interest is recorded on your annual register of interests form if it relates to you or your partner's business or financial affairs. If it is not on the Register update it within 28 days of the interest becoming apparent.

To note:

Where you have a prejudicial interest in any business of the Council, you may attend a meeting but only for the purpose of making representations, answering questions or giving evidence relating to the business, provided that the public are also allowed to attend the meeting for the same purpose, whether under a statutory right or otherwise and you leave the room where the meeting is held immediately after making representations, answering questions or giving evidence.

You must not:

1. Participate in any discussion of the business at the meeting.
2. Participate in any vote or further vote taken on the matter at the meeting.

Interests arising in relation to overview and scrutiny committees:

If at the time a decision was made or action was taken, you were a member of the executive, committee, sub-committee, joint committee or joint sub-committee and you were present when that decision was made or action was taken, you may attend the meeting of the overview and scrutiny committee for the purpose of explaining the reasons for the decision, or answering questions or giving evidence relating to the business, but you cannot participate otherwise in the discussion or in any vote on the matter.

Assistants to Portfolio Holders may not be members of an Overview and Scrutiny Committee when that Committee is considering business relating to the responsibility of their Portfolio Holder.

Where an Overview and Scrutiny Committee is scrutinising an executive decision made by a Township Committee or Sub-Committee, any Member of that Township Committee or Sub-Committee present when the decision was made shall not be involved in the scrutiny of that decision, in accordance with the Code of Conduct for Councillors.

Agenda Item 5

HMR INTEGRATED CARE PARTNERSHIP COMMITTEE

MINUTES OF MEETING Tuesday, 29 September 2026

PRESENT: Mrs. Chris Mayer CBE (Independent Chair), Councillor Daalat Ali (Portfolio Holder for Health), Councillor S. Wazir (Portfolio Holder for Adult Care and Wellbeing), Councillor Rachel Massey (Portfolio Holder for Children's Services and Education), J. Murphy (Rochdale Borough Council Chief Executive / Place Lead), D. Hamilton (NHS GM HMR Locality Representative), Claire Lake (Greater Manchester Integrated Care Board Representative), Dr S. Shahid (Associate Medical Director for HMR), Nicola Tamanis (Pennine Care NHS Foundation Trust Representative), Dr Zahid Chauhan - (Chief Executive BARDOC)

OFFICERS: Kuiama Thompson (Director of Public Health and Communities), S. Hubber (Director of Children's Services), Sam Smith (Director of Corporate Services and Chief Finance Officer), Paul Moore (Chair of Strategic Estate Group and Assistant Director for Economy), N. Dove (Associate Director of Transformation and Delivery (Heywood, Middleton and Rochdale), NHS Greater Manchester Integrated Care), Alison Kelly (Locality Associate Director Nursing, Quality and Safety), Steve Taylor (Executive Lead Neighbourhood Health and Care), and Fabiola Fuschi (Senior Governance and Committee Officer).

50 APOLOGIES

Apologies for absence were received from Kate Jones (HealthWatch Rochdale), Cllr. Wardle (Cabinet Member for Finance and Growth), Maddy Hubbard (Action Together), Katie Robinson (Deputy Chief Nursing Officer Northern Care Alliance NHS Foundation Trust)

The Chair welcomed Steve Taylor, Executive Lead for Neighbourhood Health and Care, and Claire Lake, GM ICB Representative, to the meeting.

51 URGENT ITEMS OF BUSINESS

There were no items of urgent business.

52 DECLARATIONS OF INTEREST

No declarations of interest were received.

53 ITEMS FOR EXCLUSION OF PRESS AND PUBLIC

The Committee noted that Items 11a, 12a and 12b would be considered following the exclusion of the press and public.

54 MINUTES

Resolved that the minutes of the Heywood, Middleton and Rochdale Locality Board meeting held on 25th August 2026 be agreed as a correct record.

55 PUBLIC QUESTIONS

No public questions were received.

56 GM VERBAL UPDATE

The GM ICB representative provided an update on progress relating to the Place Partnership arrangements.

Members were thanked for their contributions to the consultation, which had closed in August. It was reported that the feedback received had been collated and was being analysed, with appropriate action being taken in response to the points raised.

A final consultation report would be shared, summarising the feedback received and the resulting changes. Updated documentation was being reviewed by Chief Officers and, once finalised, would be progressed through the appropriate arrangements and communicated more widely during the following month.

Members were advised that further information would be provided during the private part of the meeting under Item 12b.

Resolved that the update be noted.

57 FINANCE PERFORMANCE AND RISK

58 APPROVAL OF OUT-OF-AREA PLACEMENT GUIDANCE AND TOP-UP POLICY (SEC 75)

The Committee considered a report of the Director of Integrated Care and Health (DASS) and Place Partnership Director, which sought approval of the Out-of-Area Placement Guidance and Care Home Top-Up Policy.

The Director of Commissioning Adult Social Care and Prevention presented the report and responded to questions and comments from Committee Members.

The Senior Officer informed that the documents established a clear, consistent and legally compliant framework for managing out-of-borough care arrangements and top-up fee arrangements, including those linked to cash budgets (direct payments).

Together, the documents would strengthen the Council's approach to managing placement and funding decisions, ensuring alignment with statutory duties, improving transparency, and supporting consistent and defensible decision-making.

The report also set out a change in practice in relation to how the Council managed the cost of out-of-area care arrangements where individuals chose higher-cost provision outside Rochdale, including residential placements and services arranged through cash budgets (direct payments), where suitable provision exists in-borough.

Resolved:

1. That the adoption of the Out-of-Area Placement Guidance and Care Home Top-Up Policy as formal Adult Social Care policy be agreed;

2. That it be agreed that the change in practice whereby, where an individual chooses an out-of-area care arrangement that is more expensive than Rochdale's standard rate and their needs can be met in-borough, the additional cost is managed through a top-up rather than being met by the Council;
3. That it be agreed that this approach would apply to new arrangements only and would not be applied retrospectively to existing out-of-area care arrangements;
4. That delegated authority be given to the Director of Health and Care Integration, in consultation with the Cabinet Member for Adult Care and Wellbeing, to finalise and implement the documents.

Reason for decision:

Recent legal advice and operational experience have identified the need for clearer, up-to-date policy frameworks to support decision-making in complex care placement scenarios. Out-of-area arrangements present challenges in relation to ordinary residence, funding responsibility and dispute management, whilst top-up arrangements require consistent and compliant application to avoid unlawful charging and reduce the risk of challenge. The proposed guidance and policy address these issues by establishing a clear legal and operational framework, defining roles and responsibilities, and supporting consistent application of statutory duties across Adult Care.

Alternatives considered and rejected:

Maintaining the current position has been considered. However, this would retain variation in practice, limited clarity in decision-making, and continued exposure to financial pressure and legal challenge arising from inconsistent application of policy.

An alternative approach would be to not apply a top-up to the difference between Rochdale's standard rate and host authority rates for out-of-area placements. While this would maintain simplicity, it would not address the underlying issue of funding higher-cost, preference-based placements and would continue to create avoidable financial pressure.

A further alternative would be to apply this approach retrospectively and require individuals currently in out-of-area placements to meet the additional cost through a top-up. This has not been recommended as individuals were not consistently offered a choice of suitable in-borough provision at the time of placement, and top-up arrangements were not applied consistently historically. Applying this retrospectively would therefore create inequity and increase the risk of challenge. On this basis, maintaining the current position or adopting either of the above alternatives is not recommended.

59 BETTER CARE FUND Q1 - SEPTEMBER 2026

The Committee considered a report of the Director of the Director of Integrated Care & Health (DASS), Place Partnership Director, which sought to inform of the latest position of the Better Care Fund performance to date.

The Assistant Director of Commissioning Adult Social Care and Prevention presented the report and responded to questions and comments from Committee Members.

The Senior Officer informed that The Committee was advised that the total Better Care Fund (BCF) income for 2026/27 was £57.024 million, with expenditure of £13.879 million at the end of Quarter 1, representing 24.3% of the annual plan.

It was noted that the BCF for 2026/27 included an NHS Additional Contribution, comprising funding for community equipment, hospice care and community nursing. This did not represent new funding but reflected the alignment of existing funding streams within the BCF to support greater consistency across Greater Manchester. As a result, NHS Greater Manchester was contributing above the mandatory minimum. Discussions were ongoing with NHS Greater Manchester to clarify expectations relating to these funding elements and associated services.

In relation to performance, Members were informed that the target for emergency admissions for residents aged 65 and over had been achieved, with Quarter 1 recording the lowest number of admissions for any quarter during the previous three years. Performance against the three measures relating to discharge delays was, however, slightly behind plan. There had been 70 long-term admissions to residential and care homes for people aged 65 and over by Month 3, compared with an annual plan of 263. Although this was slightly higher than at the equivalent point in 2025/26, the previous year's trajectory suggested that performance could remain within the annual plan.

The Committee also noted a 11.2% reduction in permanent admissions to nursing or care homes for people aged 65 and over, alongside a 15% increase in people returning home following a hospital stay and a 15% increase in care-at-home services. Use of the Short Term Assessment and Reablement Service (STARS) had also increased and was supporting a wider age range. In particular, community referrals to STARS had increased by 32%, demonstrating a shift towards the service being accessed from the community as well as through hospital discharge pathways.

The Chair welcomed the improvements outlined in section 1.5 of the report and noted that performance appeared to be moving in the right direction. However, concerns were raised regarding some of the performance measures set out in Table 2. It was confirmed that these areas would be considered as part of winter planning.

An update on performance and the position in relation to winter planning to be provided to the Committee at its next meeting.

Resolved:

1. That the position versus the delivery of quarter 1 metrics be noted;
2. That, specifically, the excellent position with regard to emergency admissions both in terms of delivery of the quarter 1 metric be noted but also the fact that emergency admissions for over 65s are they lowest

- they have been in the past 3 years and await confirmation of outstanding metrics in a future report;
3. That the off plan performance in terms of discharge to month 3 be noted. It be also noted that investigation is taking place as to why performance is off target and an update on performance and the position in relation to winter planning be provided to the Committee at its next meeting.

Reason for decision:

The formal sign off of the BCF quarterly return and narrative document by the appropriate body (ICPC) is a condition of the grant funding. Whilst arrangements for this year do not require this for quarter 1, the locality wishes to keep the same arrangements in place locally.

Alternatives considered and rejected:

There are no known alternatives, as failure to complete, return or approve the BCF quarterly return and narrative document in previous years would result in loss of funding. Whilst arrangements for this year do not require this for quarter 1, the locality wishes to keep the same arrangements in place locally.

60 ASSURANCE

61 NCA UPDATE - IMPROVEMENT PLAN

The Committee received a presentation on the Improvement Plan of the Northern Care Alliance NHS Foundation Trust (NCA), following regulatory and inspection activity during 2026. As representatives of the NCA were unable to attend the meeting, the update was presented by the Director of Integrated Care and Health (DASS) and Place Partnership Director.

The Committee was informed that the NCA was developing an Integrated Improvement Plan, bringing together the requirements arising from NHS England undertakings, the Care Quality Commission Section 29A Warning Notice and Well-Led feedback, together with findings from internal reviews and other identified areas for improvement. The Plan would include actions, responsible leads, milestones, measures of success and assurance arrangements.

Key areas of focus included patient safety and quality, governance and risk, complaints, Freedom to Speak Up, workforce wellbeing and inclusion, alongside arrangements to strengthen incident management, investigation, organisational learning and escalation. A new Clinical Leadership Model had also been introduced to provide greater clinical involvement in safety, quality and improvement decisions.

Members noted that a System Improvement Board had been established to oversee the improvement programme, with delivery also subject to oversight by the Trust Board, executive team and system partners. The importance of partnership working was recognised, with the NCA committing to regular updates to stakeholders through Greater Manchester and locality partnership arrangements.

During discussion, Members acknowledged that improvements had begun and welcomed the increased engagement between partners. It was recognised, however, that achieving sustained improvement would take time and that immediate priority needed to remain on patient safety and the delivery of safe services, alongside understanding and addressing the issues which had led to the current position.

Significant concern was expressed regarding the need for a cultural shift within the organisation, both internally and in its relationships with external partners. Members considered that changes to leadership arrangements alone would not be sufficient and emphasised that meaningful and sustainable improvement required a clear understanding of the underlying issues and active engagement with stakeholders.

Members sought greater clarity on how the Committee and wider system would be able to measure progress and obtain assurance that improvements had been achieved, observing that much of the update concerned processes and planned arrangements rather than evidence of their impact.

The importance of a whole-system approach was repeatedly emphasised. Members considered that solutions could not be delivered by the NCA in isolation and sought further information on how the Trust intended to work with partners across the health and care system.

Concern was also expressed regarding corridor care, and Members stressed that the patient voice and patient experience needed to be at the heart of the improvement programme. It was emphasised that commitments within the Plan needed to translate into demonstrable actions and improved outcomes for patients.

Members further highlighted the importance of primary care within the system, particularly in relation to hospital discharge, the completeness and timeliness of information shared following discharge, waiting times and preparations for winter. Strong partnership working between acute services, primary care and other system partners was considered essential.

The Committee acknowledged the seriousness of the position and noted that the System Improvement Board had only recently commenced its work. It was agreed that feedback to the NCA should reflect Members' concerns regarding accessibility and transparency of information, the need for a system-wide response, patient safety and patient voice, the role of primary care, and the need for stronger connectivity between the NCA, the Committee and system partners.

Resolved:

1. That the update be noted;
2. That a further, more detailed update on the NCA Improvement Plan and progress against its actions and milestones be requested for a future meeting, taking account of the issues and concerns raised by the Committee.

62 HMR WINTER PLAN 2026/27 SUMMARY REPORT

The Committee received a report and presentation from the Director of Integrated Care & Health (DASS) and Place Partnership Director, which provided an overview of the 2026/27 Winter Plan for the Borough.

Representatives from Urgent Care, NHS Greater Manchester Integrated Care, and the Northern Care Alliance NHS Foundation Trust attended the meeting to present the information and respond to questions and comments from Committee Members.

The Committee was informed that the Winter Plan had been developed collaboratively across the local health and care system and was intended to provide a whole-system response to winter pressures. The approach focused on three key priorities: reducing avoidable demand and admissions, improving patient flow through hospitals, and accelerating discharge, with an increased emphasis on prevention and providing appropriate alternatives to hospital care within neighbourhoods.

Members noted the progress made during winter 2025/26, while recognising that demand for urgent and emergency care remained high in parts of the Borough and that levels of demand varied across communities.

The 2026/27 Winter Plan therefore proposed a more targeted, neighbourhood-based approach, with a focus on reducing avoidable hospital attendance and admission, improving patient flow and discharge, and supporting people to remain well and independent within their communities.

The Committee was advised that delivery would be supported through a range of health, care and voluntary sector initiatives across primary, community and hospital services.

Particular emphasis would be placed on providing alternatives to hospital attendance and admission, strengthening community-based support and improving arrangements for timely discharge.

Members noted that winter capacity funding for 2026/27 had reduced compared with the previous year. Progress and performance against the Plan would be monitored through the established urgent and emergency care governance and escalation arrangements.

Key risks identified included reduced winter capacity funding, workforce pressures and sickness, potential flu and RSV surges, shortages affecting care packages and medicines, delayed hospital discharges, widening health inequalities, provider capacity and the potential for delay-related harm. Mitigating actions and escalation arrangements had been identified within the Plan.

Members discussed the implications of corridor care and emphasised the importance of understanding the experience of people who had received care in this way. It was considered important that the impact on quality, safety and

safeguarding was properly understood and that appropriate quality assurance arrangements were in place. Members also highlighted the importance of “getting it right first time” and considering the wider knock-on consequences that corridor care could have for patients and services.

Further consideration to be given to how the experiences of people who had received corridor care could be captured and used to inform quality assurance and service improvement.

The Committee discussed the contribution of the VCFSE sector to managing winter pressures. It was reported that VCFSE representatives had presented their offer at the Winter Pressures Planning meeting and that there had been a positive response to the potential for community-based provision to strengthen existing referral pathways and provide an important preventative role over the winter period.

However, concerns were raised that the process for accessing funding to increase VCFSE capacity had been complex and difficult for the sector to access, with funded schemes consequently appearing to be predominantly focused on statutory health and care provision. Members heard that the sector would welcome the opportunity to support additional community capacity over winter, but that greater clarity regarding requirements and flexibility within the funding process would be necessary to enable resources to be directed effectively to areas of need.

It was explained that there was now less local control over some funding arrangements and that assumptions had initially been made that the same schemes as the previous year would continue, which was not the case. Where funding remained subject to local discretion, consideration could be given to how this could be used in partnership with other organisations.

A further conversation to take place with relevant partners regarding the opportunities available to support VCFSE and community capacity through discretionary winter funding.

Members welcomed the Winter Plan and discussed how its success would be measured. While recognising the importance of targets and measurable outcomes relating to acute services, members considered that a significant focus locally should also be placed on effective discharge and the wider impact of winter initiatives across the health and care system.

An update to be presented to the Committee in December, setting out how the winter schemes had been mobilised, progress against the intended outcomes and any barriers encountered in their implementation.

Resolved:

1. That the Winter Plan and associated delivery programmes be noted;
2. That the neighbourhood-based approach to reducing demand and inequalities be endorsed;
3. That the mobilisation and monitoring of winter capacity schemes through the HMR UEC Programme Group be noted.

4. That an update to be presented to the Committee in December, setting out how the winter schemes had been mobilised, progress against the intended outcomes and any barriers encountered in their implementation.

63 PREVENTION DEMONSTRATOR

The Director of Public Health and Communities and the Head of Neighbourhoods Development Bridging Team – Heywood, Middleton & Rochdale LCO presented an update on the development of the Prevention Demonstrator, including the Greater Manchester logic model and the emerging Rochdale model.

The Committee was advised that the overarching ambition was to move from managing increasing demand to preventing demand through a more integrated system, built around community, preventative and protective capacity.

The key points highlighted were:

- The Greater Manchester model focused on strengthening community capacity, early preventative intervention and protective support, supported by integrated neighbourhood teams, data and intelligence, flexible funding, the voluntary, community, faith and social enterprise sector, and evaluation and learning.
- Rochdale was developing its own logic model to reflect the borough's Co-operative Communities approach. In particular, greater emphasis had been placed on community wealth, community power and community voice, alongside community teams. This included strengthening local decision-making, community ownership, the local economy, social value and opportunities for residents, enterprises and co-operatives.
- The local model sought to embed earlier identification and intervention, integrated neighbourhood working, trusted key workers, whole-household approaches and better coordination between services, with the aim of supporting residents before needs escalated to crisis.
- Work was continuing to develop the outcomes and impact framework, with measures grouped around residents' experiences, patterns of activity and demand, and changes in ways of working. The approach would combine quantitative measures with qualitative evidence, including resident and community voice.
- The intended longer-term impact included improved outcomes and resilience for residents and communities, reduced inequalities and poverty, increased good employment, more sustainable public and VCFSE services, reduced crisis demand and a more integrated, preventative and trust-based relationship between public services and communities.
- A number of risks and dependencies had been identified, including workforce capacity and culture, sustainable funding, effective data sharing, equitable access to services, clear governance and accountability, service quality, community trust and effective integration across organisations. Mitigating work was being developed across these areas.

- Regional and national discussions were continuing, including work to demonstrate the impact of prevention against wider priorities such as welfare reform and young people not in education, employment or training (NEET), and to share learning across the four Prevention Demonstrator sites and the ten Greater Manchester localities.
- The next stage would include finalising the logic model following Greater Manchester feedback, aligning it with Live Well and neighbourhood health and care plans, obtaining approval through the Neighbourhood Board, and moving towards implementation and delivery planning for 2027/28.

Resolved that the update be noted.

64 EXCLUSION OF PRESS AND PUBLIC

Resolved that, in accordance with the provisions under Section 100(A) (4) of the Local Government Act 1972, as amended, the press and public be excluded from the meeting during the consideration of the following items of business. Reason for the Decision: Should the press and public remain during consideration of the items, there may be a disclosure of information that was deemed to be exempt under Part 3 of Schedule 12A of the Local Government Act 1972.

65 FINANCE PERFORMANCE AND RISK

66 PRIVATE APPENDIX TO BETTER CARE FUND Q1 - SEPTEMBER 2026

Resolved that the private appendix to the Better Care Fund Q1 – September 2026 report be noted.

67 ASSURANCE

68 STRATEGIC ESTATES GROUP (SEG) COMMITTEE ASSURANCE REPORT

The Committee received the private Strategic Estates Group Committee Assurance Report, which provided an update on the work of the Strategic Estates Group and developments relating to the strategic management and utilisation of the health and wider public estate across the borough.

The Chair of the Strategic Estates Group and the Assistant Director for Economy attended the meeting to present the report and responded to questions and comments from Committee Members.

The Committee noted that there were no matters for escalation and no decisions required during the reporting period. Members were advised that work continued to progress the development and effective utilisation of the local estate, alongside wider strategic planning and prioritisation activity.

The report highlighted progress in relation to estate utilisation and modernisation initiatives, including schemes intended to improve the use and capacity of existing health facilities. The Committee also noted ongoing work concerning future neighbourhood health provision, estate priorities and

opportunities to align health infrastructure with wider regeneration and public estate objectives.

Members noted the key risks associated with the ongoing development of the strategic approach to the estate, including the importance of ensuring that future investment and estate decisions remained aligned with agreed strategic priorities and that appropriate capacity was available to support delivery.

Resolved:

1. That the HMR Integrated Care Partnership Committee note the contents of the Strategic Estates Group (SEG) Committee Assurance Report be noted;
2. That the health schemes proposed for inclusion on the Top Ten Prioritisation List (appendix to the report) be noted.

69 PLACE HEALTH AND CARE PARTNERSHIP CONSULTATION

The Committee received a presentation from the Greater Manchester Integrated Care Board (GM ICB) representative, which provided an update on the outcome of the consultation on the Place Health and Care Partnership document and outlined the next steps.

The GM ICB representative presented the information and responded to questions and comments from Committee Members. Members were advised that an updated set of presentation slides, including additional information, would be circulated following the meeting.

The GM ICB representative commended the work undertaken by the team throughout the consultation process.

Resolved that the information be noted.

Agenda Item 8b



Report title: Performance Update

Report to: HMR Integrated Care Partnership Committee

Date of meeting: Tuesday 28th October

Cabinet Portfolio Holder: Councillor Daalat Ali, Deputy Leader and Cabinet Member for Health

Report of: Nadia Dove Associate Director GM ICB

Public or private: Public

Key Decision:TBC

Published on the Forward Plan:

1. Report summary

- 1.1 Following the NHS Reforms, there is now no business intelligence resource in the ICB place based team.
- 1.2 This report summarises the approach that the place team are taking to performance management and outlines high level what performance information is available currently in place.
- 1.3 The appendix of this report outlines a snapshot of current performance and information where it is held locally. The finalisation of the Place Health and Care Partnership document suite will enable the development of a performance management process in place.

2. Recommendations

The Board is asked to note

- 2.1 The content of the report
- 2.2 The fact that once the place health and care outcome measures and the place health and care delivery plan are finalised, performance reporting arrangements will be put in place on an ongoing basis with a clear reporting schedule.

3. Reason for recommendation

- 3.1 The place health and care Partnership Plans have been in development in 2026/7. Until these are finalised reporting arrangements cannot be confirmed.
- 3.2 There is no dedicated data and intelligence resource in the place based team, the data in this report has been provided as a bespoke ask. This reflects back on a range of areas that were reported in previous financial years . Not all of the areas in this report will be place based outcomes and therefore may not be part of the future reporting schedule. When the Place Health and Care Partnership Agreement document suite is finalised, the NHS GM Data and Intelligence team will be able to advise on resource to support in place.
- 3.3 Where work is underway in place to support specific areas this is provided in the narrative of the appended report.

4. Alternatives considered

- 4.1 It is not viable to continue with the reporting process that was in place in previous years due to significant changes across the ICB and wider health and care partners. Support has been provided to develop the information provided with this report.

5. Key information

5.1 Background and Strategic Context

NHS Reforms have seen the reshaping of NHS GM with a clear refocus on strategic commissioning. Alongside this shift in focus, significant cost reductions has impacted the resource infrastructure across the organisation, including within the HMR place team.

5.2 Place Health and Care Outcomes Framework



Figure 1

The first draft of the Place health and care document suite came to the ICPC in July 2026 as part of the NHS GM ICB consultation process. Part of this consultation is the place outcomes.

Work has taken place in HMR to categorise the outcomes against the key ICB objectives and to develop high level delivery plans to support these objectives.

The high level categories within the draft delivery plan are as follows

- Prevention and reducing health inequalities
- Scheduled care and long term conditions
- Urgent and Emergency Care and Intermediate care
- Neighbourhood health
- Children Young People and Families
- Mental Health

Attached to this report is a high level overview of the performance available for each of these areas and within it there is a note as to whether this is a local place based linked outcome (based on the draft outcomes received to date)

The report identifies whether an indicator has been included in the current place outcome framework.

There is limited information included to support the data at this stage. Following

the development of a performance framework for the Neighbourhood Health and Care plan a reporting schedule will be provided for the committee to agree.

6. Legal

6.1 N/A

7. Clinical impact

7.1 N/A

8. Human resource

8.1 There is a risk relating to capacity to support performance reporting . As stated in section 5 once the Place Health and Care Partnership Agreement is finalised a reporting schedule will be developed and shared with the committee.

9. Equality impact

9.1 Ensuring the mechanisms are in place to support performance reporting against delivery of outcomes, reduce inequalities especially those facing multiple disadvantage and protected characteristics.

10. Other considerations (corporate priorities, environmental impacts, risks

Background Papers:

Appendix 1 – Performance update

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Cancer Performance Report (Prevention)

July 2026 compared to June 2026

Cancer Screening	Bowel Cancer Screening		Breast Cancer Screening		Cervical Cancer Screening	
	Target 58%		Target 70%		Target 75%	
FIT Test	Age 50-59	Age 60-74	Age 50-70		Age 24-42	Age 50-64
	52.3%	77.4%	67.8%		66.8%	68.7%
Waiting times	5/10 in GM	6/10 in GM	2/10 in GM		4/10 in GM	
	Faecal Immunochemical Test		Attendances		Admissions	
	Target 80%		455 per 1,000		151 per 1,000	
	86.1%	4/10 in GM	56 more than GM average		27 more than GM average	
	28 Day Diagnosis		31 Day Decision to Treat		62 Day Faster Diagnosis	
	Target 75%		Target 96%		Target 85%	
	75%	9/10 in GM	95.7%	6/10 in GM	74.3%	5/10 in GM

Key messages

Aim: Improve our cancer screening rates to support earlier detection and lower cancer related mortality, with more equitable access to early detection and treatment.

- **Bowel screening uptake - Management at Place:** 50-59 year olds has improved significantly, increasing from 38.8% to 52.3%. Performance has now achieved the programmes acceptable standard and demonstrates continued improvement within the recently expanded cohort.
- Bowel screening uptake among 60-74 year olds remains strong at 77.4%, substantially exceeding the programme's achievable standard of 60%.
- **Breast Screening Uptake - Management at Place:** Although breast screening uptake remains below the national target, Rochdale ranks 2nd out of 10 Greater Manchester localities. This reflects comparatively strong performance while highlighting that achieving the screening standard remains a challenge across Greater Manchester.
- **Cervical Screening Uptake - Management at Place:** Cervical screening coverage has fallen to 68.7%, a decrease of 7.3% over the last six months. Performance remains below the 75% target, and Rochdale's relative position among Greater Manchester localities has declined.
- **Faecal Immunochemical Test (FIT):** Performance against the Faecal Immunochemical Test (FIT) indicator remains strong, supporting appropriate referrals into cancer pathways.
- **28-Day Faster Diagnosis:** Performance has improved compared to the previous month but has achieved the target only once in the last four months. Achievement of the relatively new 80% target remains challenging across Greater Manchester, with most localities performing below target.
- **31-Day Waits After Decision to Treat:** Performance was marginally below the 96% target at 95.7%; however, this represents continued strong performance, with the target being achieved more consistently than in previous years.
- **62-Day Waits from Referral to Treatment:** Performance remains below the national target of 85%, with Rochdale ranked 5th out of 10 Greater Manchester localities. However, performance has improved compared to last year, and no Greater Manchester locality is currently achieving target.

Scheduled Care Performance Report

July 2026 compared to June 2026

Referral To Treatment	Total waits 31,892 ↓ referrals 3/10 in GM	52+ week waits 870 ↓ referrals 7/10 in GM	65+ week waits 33 ↑ referrals 7/10 in GM	78+ week waits 1 ↑	104+ week waits 0 referrals
Outpatient	First Outpatient Appointments ↓ 6,033		Follow up Outpatient Appointments ↓ 9,990		
Diagnostics	Diagnostics 6+ week wait Target <1% waiting 6 wks+ 14.6% ↓ 6/10 in GM			Advice & Guidance	Specialist Advice & Guidance Requests 30.78 per 1,000 GM av. 32.53 per 1,000 6/10 in GM

Key messages

Aim: To decrease waiting lists and waiting times for elective care and diagnostics. Increase Advice and Guidance (A&G) for specialist advice to prevent referral to hospital.

- **Referral to Treatment (RTT) Elective Waiting List:** The acute hospital waiting list has reduced significantly from 33,495 to 31,892, representing one of the largest reductions since the COVID-19 pandemic. The number of patients waiting more than 52 weeks has also fallen below 1,000 for the first time since 2020, which demonstrates continued recovery in elective care. 33 HMR patients remain on pathways exceeding 65 weeks and one patient has waited more than 78 weeks.
- **Diagnostic Activity:** Activity will continue to be monitored as refreshed data becomes available. Although the proportion of patients waiting more than six weeks for a diagnostic test has improved to 14.6%, performance remains well above the target of less than 1%, with HMR ranked 6th out of 10 GM localities.
- **Outpatient Activity:** First outpatient appointments increased by 5.8%. This highlights the challenge of balancing waiting list recovery with the longer-term objective of reducing demand on hospital services.
- **Advice & Guidance (A&G) Uptake in HMR: [Management at the Place/Four Localities Partnership](#):** The use of Advice & Guidance has increased substantially over the last year, with referral rates rising from 17 to 32 requests per 1,000 population. This equates to approximately 200 additional referrals being managed through A&G pathways and reflects growing adoption across the locality.

Urgent Care (UC) Performance Report

August 2026 compared to July 2026 (1 of 2)

North West Ambulance Service	Ambulance Response Category 2 Target 30 mins 36 mins	Care Homes	Care Home Calls to NWAS 192 -18 2/10 in GM	NWAS Care Home See & Treat 55 -3	NWAS Care Home See & Convey 98 -23
Rapid Response	Referrals to Rapid Response 442 +89	Rapid Response Referrals Accepted 393 +60		Rapid Response - 2 Hour Waits Target 70% 89%	
A&E Attends	Total A&E Attendances 9,858 -815 3/10 in GM	Type 1&2 Attendances 5,347 -469 3/10 in GM	Type 3&4 Attendances 4,511 -443 3/10 in GM	Children's Attendances 1,962 -488 6/10 in GM	
A&E waits	4 Hour Waits Target - 78% 76.3% 1/10 in GM		12 Hour Waits Target <10% 5.13% 5/10 in GM		

Key messages

Aim: To reduce A&E attendances and hospital admissions, improving patient flow when people are admitted and supporting care homes.

- **NWAS and Care Homes:** HMR is performing well for ambulance calls from care homes. In August, conveyances to hospital reduced by 23 compared with July, while 29% of incidents were managed within the care home, supporting residents to remain in the care home where appropriate.
- **2-hour Urgent Community Response (UCR)- Management at Place:** Referrals are significantly higher than last year showing the service is being well utilised, exceeding the current national target. Senior clinicians are overseeing triage to ensure safe and timely decision-making, and we have seen an increase in the number of accepted referrals. We are continuing to promote step-up and step-down pathways and exploring further opportunities around falls.
- **A&E Attendances - Management at Place:** Overall A&E demand continues to reduce, with year-to-date attendances 3.25% lower than the previous year (1,741 fewer attendances). This improvement has been driven by a reduction in Type 1 (Major A&E) attendances, which is significant as reductions are typically seen within Type 3 and 4 activity rather than major emergency attendances. The greatest reduction has been within the frailty cohort, reflecting the positive impact of neighbourhood-based frailty interventions delivered through the National Neighbourhood Health Improvement Programme (NNHIP).
- Type 3 and Type 4 activity (urgent care attendances) has increased overall; however, this is largely attributable to coding changes at Fairfield Hospital from Aug 2025 rather than a genuine increase in demand. In contrast, attendances at Rochdale Infirmary reduced by 805 over the same period, reflecting the continued positive impact of the different admission avoidance schemes such as UCR service and additional capacity in primary care including Primary care hubs, GP out of hours and NHS111 Directory of service profiling.
- **A&E Waits:** 76.3% of patients attending A&E were seen within 4 hours. Although performance is slightly below the 78% target, it has consistently exceeded 70% throughout the year and HMR continues to rank first among Greater Manchester localities.

Urgent Care Performance Report

August 2026 compared to July 2026 (2 of 2)

Non-Elective Admissions	Total Non Electives 3,483  +54 6/10 in GM				0 Day Length of Stay 1,684  +122 10/10 in GM				1+ day Length of Stay 1799  +176 3/10 in GM				21+ day Length of Stay 83  +2 2/10 in GM			
	Number of Patients 37.4  -4 1/10 in GM				% Occupied Bed Days 9.4%  3/10 in GM				Average Length of Stay (days) 8.8  -1.2 3/10 in GM				Excess Bed Days 327  -90 3/10 in GM			
	Virtual Ward Occupancy Target 80% 83.2%  4/10 in GM				HIU High Intensity Users 55 patients  Cost £293k 3/10 in GM				SDEC Same Day Emergency Care (SDEC) 963  -168							

Key messages

- **Non-Elective Admissions (Emergency Admissions) - Management at Place:** Non-elective admissions continue to show an upward trend, particularly over the last three months. Admissions have increased by 1,180 compared to last year, with growth evident across all providers and most age groups. Part of this increase is attributable to a rise in zero-day admissions (+633), driven by higher levels of Same Day Emergency Care (SDEC) activity. SDEC admissions now frequently exceed 1,000 per month, compared to around 700 previously. This reflects greater use of faster pathways that enable patients to be treated and discharged on the same day.
- The total number of admissions with a length of stay of one day or more have increased overall (+556). This represents a shift from the pattern seen in recent years, when admissions with a 1+ length of stay had generally been declining in HMR. The increase is evident across all age groups and providers. It should be noted that although the overall admissions are increasing, the data for the Neighbourhood programme shows a reduction in admissions for the frailty cohort.
- **Days Kept Away From Home (DKAFH)/Delayed Discharges - Management at Place:** Performance on delayed discharges remains strong. The average length of stay has fallen to below 10 days, while excess bed days attributable to delayed discharges have reduced from 599 in April to just over 400 in recent months, demonstrating improved patient flow and discharge processes.
- **Virtual ward** utilisation exceeded the 80% target in August, reaching 83.2%. HMR ranks 4th out of 10 Greater Manchester localities, reflecting strong use of virtual wards, which support patients to receive care at home while helping to reduce pressure on hospital services.
- **High Intensity Users:** HMR has 55 patients with 20 or more A&E attendances during 2025/26, with an estimated cost of £293k. HMR ranks 3rd lowest among the 10 Greater Manchester localities. Work is underway linked to the development of Multi Agency Teams/HIU programme to support this cohort.

Neighbourhood Health

August 2026 compared to July 2026 (unless noted)

GP Appointments

Appointments

No Target

107,206

7/10 in GM



% of appointments within 14 days

No Target

84.1%

3/10 in GM



Did Not Attend (DNA)

No Target

6,865

2/10 in GM



% of Patients Describing Their Overall Experience of Making a GP Appointment as Good

80.1%

4/10 in GM



Vaccinations

Covid-19 (All adults)

Data unavailable until
October 2026

Covid-19 (Over 75 years)

Data unavailable until
October 2026

Flu (All adults)

Data unavailable until
October 2026

Flu (Over 75 years)

Data unavailable until
October 2026

Key messages

Aim: Ensure timely access to high-quality primary care services while improving preventive care, performance, and reducing missed appointments (DNAs).

- **GP Appointments - Management at Place:** Demand for primary care remains high, with 107,206 attended appointments recorded in July, 5,788 more than the same month last year. Note that the data does not include additional appointments commissioned via primary care networks and urgent care hubs. Although HMR ranks 7th out of 10 localities, activity has continued to increase throughout 2025/26, with year-to-date appointments up by 7.7% (28,813 appointments), reflecting growing utilisation of GP services.
- **DNA (Did Not Attend): Management at Place:** Missed GP appointments increased by 249 compared to July last year, reaching 6,865. However, this follows a period where DNA levels remained below the previous year's figures. HMR continues to compare favourably across Greater Manchester, ranking fourth lowest for GP DNAs.
- **Patient Experience of Booking a GP Appointment:** Patient experience has improved, with 80.1% of respondents rating their experience of booking an appointment as good in the latest GP Patient Survey. This represents an increase of 4.9 percentage points compared with the previous year and places HMR in the middle of Greater Manchester localities.
- **Vaccination Rates:** Updated data will be available post October.

Children and Young People Mental Health Performance Report

July 2026 Compared to June 2026

CAMHS

Access to CYP
Mental Health
Services
4,470 ↓
6/10 in GM

% CYP receiving 1st
assessment within
12 weeks ↓
84.1%
7/10 in GM

% CYP receiving 1st
treatment within
18 weeks ↓
76.4%
8/10 in GM

Neuro

ADHD CYP Average Wait
(referral to Assessment)
89.5weeks ↓
8/10 in GM

Autism Average Wait
(referral to Assessment)
89.32 weeks ↓
3/10 in GM

Key messages

Aim: to maintain or increase the number of CYP accessing CAMHS, improving emotional wellbeing through timely, effective, and person-centred mental health support.

- **Access to CAMHS:** Performance has deteriorated against the Access to CYP Mental Health Services indicator. Activity remains significantly below the level reported during the same period last year, with 3,265 fewer CYP accessing services between April and July. In addition, more than 1,200 children and young people are reported to be waiting over 104 weeks for mental health treatment. Work is underway at NHS GM to redesign access to CAMHS services.
- **Community Waiting Times for ADHD and Autism:** The average waiting time for children's ADHD and autism assessments is 89 weeks. This represents an improvement compared to last year, when waiting times exceeded 100 weeks. HMR continues to rank relatively low for ADHD assessment waiting times (8th of 10 Greater Manchester localities), while autism assessment performance is stronger, ranking 3rd. A triage process has been put in place including the CAMHS and Community paediatric services to review referrals. Further information is awaited around plans to support improvement.

Adults Mental Health Performance Report

July 2026 compared to June 2026

Talking Therapies

No. of People Accessing Talking Therapies

155
-40 ↓

6 Week Waits
Target 75%

23% ↓

Second Treatment Waits
Target <10% waiting 90+ days

61.3% ↑

% less than 18 weeks 1st treatment

Target 95%
95.2% ↑

Completed Treatments
No longer reported

Reliable Recovery
Target 48%
51% ↑

Reliable Improvement
Target: 67%
67% ↑

MH Inpatients

Clinically Ready for Discharge - Bed Days
Target <124

80 ↓

Clinically Ready for Discharge - Patients

6 ↓
5/10 in GM

Long Length of Stay (+60 days)

23.5% ↓
-4.3%
3/10 in GM

Out of Area Placements
Target: 0

1

A&E

A&E Attendances for people with a Mental Health Condition

Target 310
290

Key messages

Aim: Increase the number of patients accessing Talking Therapies and reduce the length of time they wait for treatment. Reduce the number of patients who are clinically ready for discharge and the total number of delayed bed days. Eliminate Out of Area Placements. Reduce the number of patients accessing A&E for Mental Health related attendances.

- **Talking Therapies:** The service presents a mixed picture. The number of patients entering treatment is the lowest across Greater Manchester. Waiting times also remain a challenge, with the six-week standard not being met, although 95% of patients continue to start treatment within 18 weeks. Recovery rates continue to meet target, demonstrating that the service is effective once patients are engaged. Work is underway led by NHS GM to support service improvement for the service.
- **Clinically Ready for Discharge (CRFD) - Management at Place:** Six mental health inpatients were recorded as CRFD (Clinically Ready for Discharge), meaning they are ready to leave hospital but are awaiting onward care, support or accommodation. This places HMR 5th out of 10 GM localities, with delayed discharge levels remaining broadly stable in recent months.
- **A&E (Mental Health) - Management at Place:** A&E attendances relating to mental health conditions remain stable at approximately 290 per month. Pennine Care NHS Foundation Trust have launched a new crisis support service. This has been shared with the Clinical and Care Professional group and is aimed to reduce presentations at A&E for those in mental health crisis.

Agenda Item 10a

By virtue of paragraph(s) 3 of Part 1 of Schedule 12A
of the Local Government Act 1972.

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Agenda Item 11a

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Agenda Item 11b

By virtue of paragraph(s) 3 of Part 1 of Schedule 12A
of the Local Government Act 1972.

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Agenda Item 11c

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