NHS
Greater Manchester
Integrated Care

NHS Greater Manchester Annual Report

1 July 2022 – 31 March 2023

Contents

This is the 2022/23 Annual Report and Accounts for NHS Greater Manchester Integrated Care Board (NHS GM) covering the period from 1 July 2022 to 31 March 2023.

NHS GM is a statutory NHS organisation leading integration across the NHS, managing the NHS budget and arranging for the provision of health services across Greater Manchester. It supports ten place-based integrated care partnerships within Greater Manchester as part of a well-established way of working to meet the diverse needs of our citizens and communities.

*It should be noted that throughout the document there are links to the websites of external organisations and information outside NHS GM. These are included to provide further background for readers who want to access it. This information should not be interpreted as having been audited by our auditors (Grant Thornton) unless expressly stated.

Foreword

It has been a huge privilege for us both to have been appointed as the first Chair and Chief Executive of NHS Greater Manchester and to oversee our historic first nine months as a statutory organisation.

In July 2022, 12 organisations came together to establish NHS Greater Manchester. This was a huge undertaking and our People and Culture Team continue to work closely with our trade union colleagues to support our workforce through a complex organisational change process. Our team have continued to do fantastic job in supporting both the organisation and the wider health and care system during this period of change, which is testament to their commitment to the work we do.

NHS Greater Manchester is our city region's Integrated Care Board (ICB). It's a statutory part of our Integrated Care System (ICS), which is called the Greater Manchester Integrated Care Partnership, and is overseen by a Board comprising people from across the system championing joined up working to help people live independent, active and healthy lives, all while making the system work better for the public and professionals who serve it.

Greater Manchester pioneered the development of integrated care systems and, with a population of 2.8 million, we are one of the largest in the country. What makes us unique in Greater Manchester is our history of devolution, which has been in place since 2014. This inheritance of closer working – particularly between the NHS, local government and, since 2017, the Mayor of Greater Manchester– has been instrumental in shaping the design of these new national partnerships to support local health and care needs.

And our deep and strong connections started to deliver real health improvements to a population where too many still spend too much of their lives in poor health. Greater Manchester has some of the lowest life expectancy in England. People living in more affluent areas of the region are living up to 9.5 years longer than those in our poorer communities. In some pockets of the region, this gap is as big as 17 years.

The pandemic set our progress back, with the longstanding inequalities in our region meaning we were affected more deeply, and for a longer time, by Covid than other areas. But we now have a real opportunity to make further change: to better address health inequalities, further improve clinical outcomes, and contribute to the wider social and economic development of Greater Manchester.

In March 2023, we published our first Integrated Care Partnership (ICP) Strategy setting out our ambition for the next five years. Local Health and Well Being strategies for the 10 localities were reviewed as part of the development of the ICP strategy and used to inform its content, and the strategy itself was developed with the Health and Wellbeing Boards (HWBBs) in Greater Manchester and their views were sought on an engagement draft in early 2023.

Our vision is the one which many partners across the city region have collectively adopted: for Greater Manchester to be a place where everyone can live a good life; growing up, getting on

and growing old in a greener, fairer more prosperous city-region. To achieve this, our strategy sets out six missions: to strengthen our communities; help people get into – and stay in – good work; recover core NHS and care services; help people stay well and detect illness earlier; support our workforce and our carers; and achieve financial sustainability.

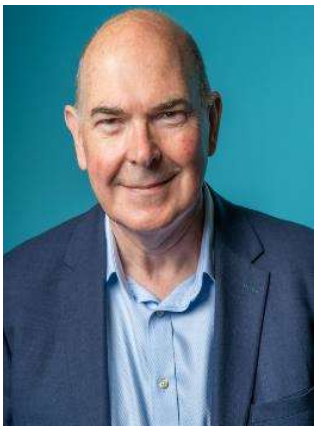
Realising this ambition means taking on the more immediate challenges that we – like many other integrated care systems – are facing. We have significant performance and finance pressures. The health and care needs of people in Greater Manchester are changing. We are living longer with more multiple long-term conditions like asthma, diabetes and heart disease, and many people are waiting for hospital and community care and support. In October 2022, Greater Manchester was highlighted nationally with areas of growing concern, particularly around elective recovery, cancer, urgent and emergency care, as well as finance, against the NHS Oversight Framework 2022/23.

But we won't be overcome by these challenges, with additional support from NHS England and our partners, Greater Manchester will come together with common purpose. Our task is nothing less than to mobilise all the resources at our disposal and point them to improving the health and wellbeing of our population.

It is from the diverse and vibrant communities of Greater Manchester that comes the incredible team of NHS and care staff, unpaid carers and volunteers who have gone well above and beyond in very difficult circumstances over the last few years. We have had the privilege of meeting many of them and, what always stands out, is the incredible passion for the NHS and tireless work ethic.

This, coupled with the strong relationships we have here in Greater Manchester, gives us a great foundation to confront these longstanding challenges. We are incredibly proud to be leading this organisation and be part of one of the most ambitious integrated care systems in the country.

Sir Richard Leese
Chair



Mark Fisher
Chief Executive

PERFORMANCE REPORT

Mark Fisher

Accountable Officer

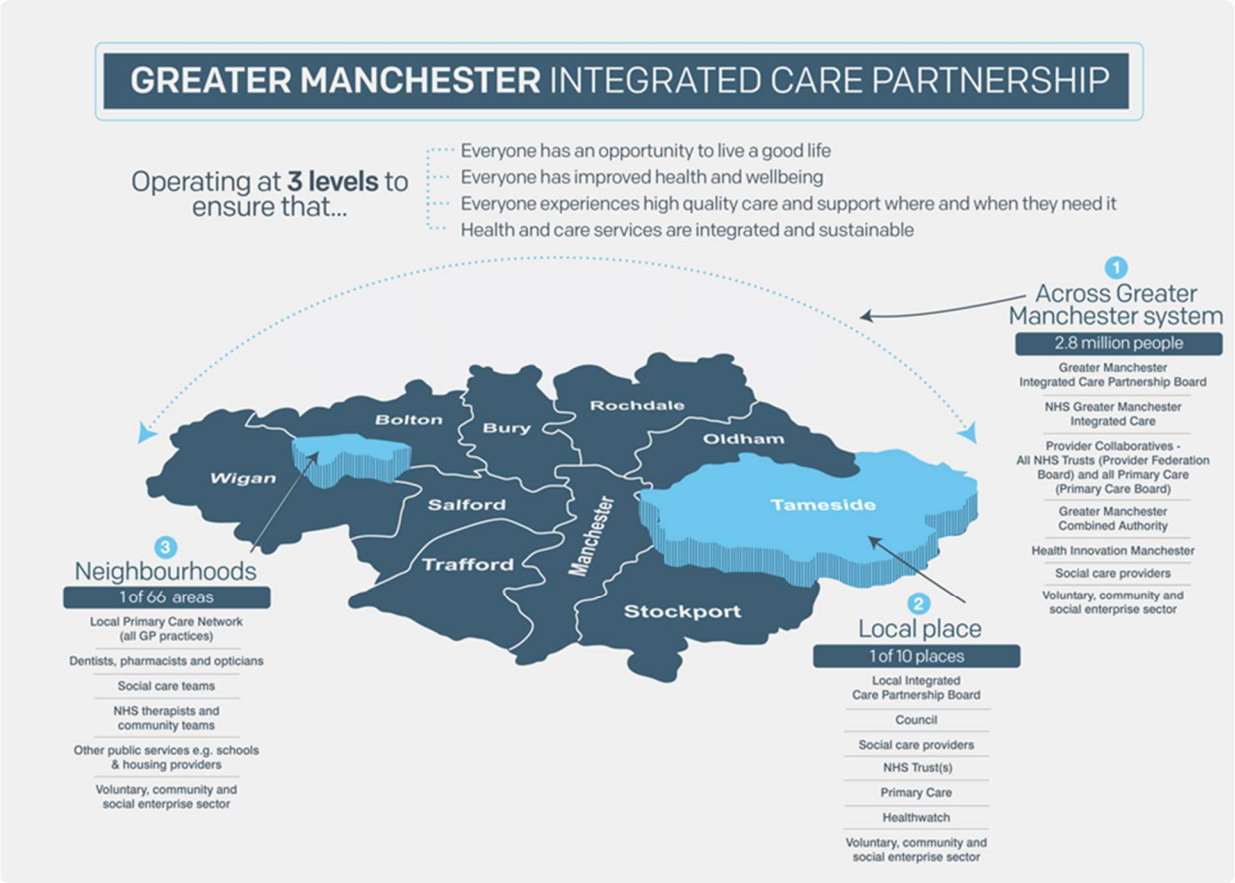
28 June 2023

Performance Overview

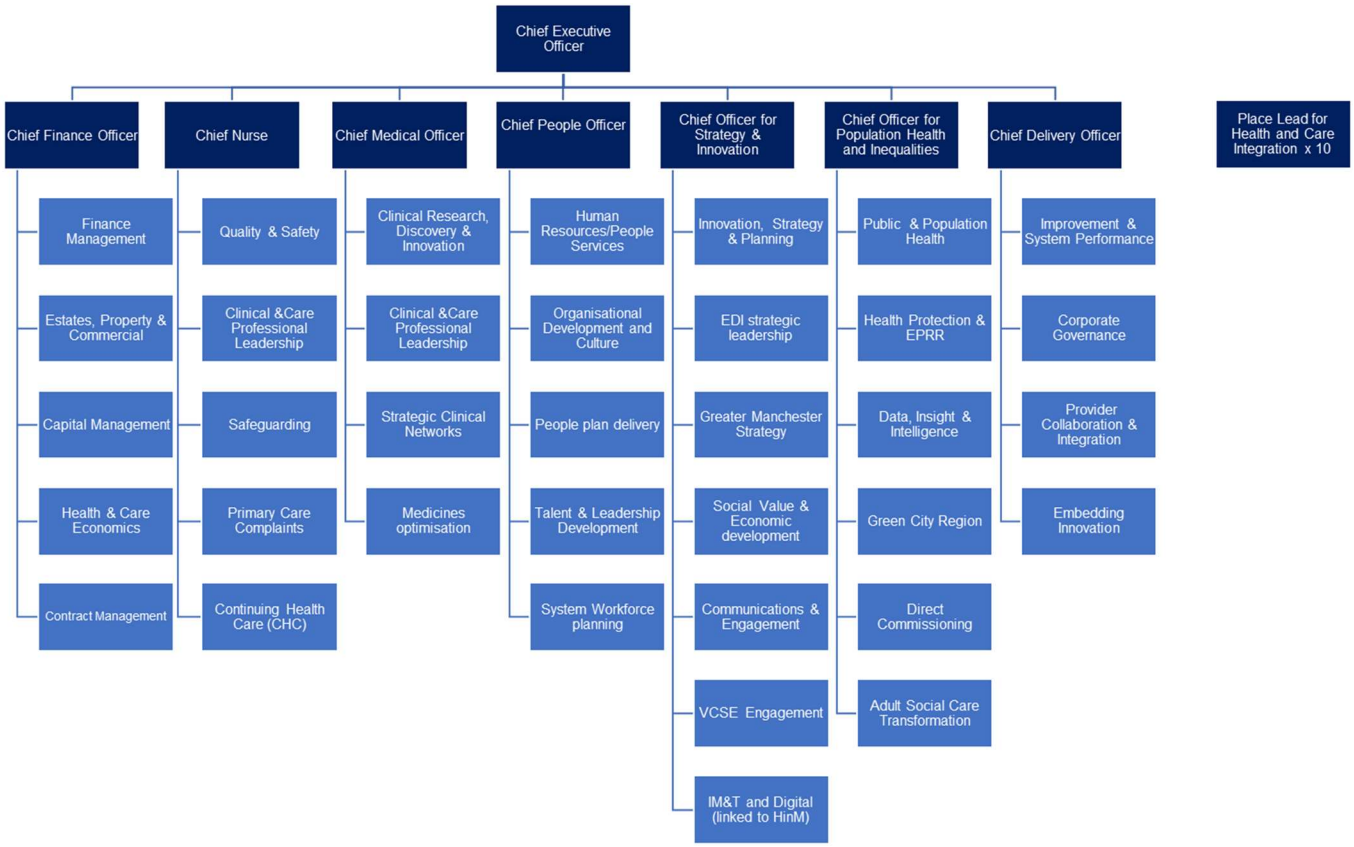
NHS Greater Manchester is part of the Greater Manchester Integrated Care Partnership. Our partnership is made up of:

- The Greater Manchester Integrated Care Partnership (this is the name of our Integrated Care System (ICS)) which connects NHS Greater Manchester Integrated Care, the Greater Manchester NHS trusts and NHS providers across the whole of primary care with Councils, the Greater Manchester Combined Authority (GMCA), and partners across the Voluntary Community Social Enterprise (VCSE) sector, Healthwatch and the trades unions
- NHS Greater Manchester Integrated Care, or NHS Greater Manchester (our Integrated Care Board) is a statutory NHS organisation leading integration across the NHS, managing the NHS budget and arranging for the provision of health services in a geographical area. It supports ten place-based integrated care partnerships in Greater Manchester as part of a well-established way of working to meet the diverse needs of our citizens and communities. The ICB has a role in the delivery of the NHS constitutional standards and statutory duties of the GM ICS, which is made up of the ICB and the nine NHS providers in GM
- Greater Manchester Integrated Care Partnership Board is a statutory joint committee made up of NHS Greater Manchester Integrated Care and 10 councils within Greater Manchester. It brings together a broad set of system partners to support partnership working and it is the responsibility of this Board to develop our integrated care strategy - a plan to address the wider health, and care needs of the population

The diagram overleaf illustrates how partners across health and care, wider public services and the VCSE work together as part of integrated neighbourhood teams across our ten localities in place-based partnerships and, where appropriate, across the whole of Greater Manchester to ensure consistency of access and experience and pursue improvements at scale.



Our leadership team comprises chief officers leading our key organisational functions and place-based leads overseeing health and social care integration in our 10 localities:



In March 2023, we published our first five-year strategy for the Integrated Care Partnership.

Our Vision

As partners in Greater Manchester, we share the overarching Greater Manchester Strategy (GMS) vision of wanting Greater Manchester to be a place where everyone can live a good life, growing up, getting on and growing old in a greener, fairer, more prosperous city-region.

Specifically, we as an integrated care system want to see a Greater Manchester where:

- Everyone has an opportunity to live a good life
- Everyone has improved health and wellbeing
- Everyone experiences high quality care and support where and when they need it
- Health and care services are integrated and sustainable prosperous city-region

To achieve these outcomes we will:

- Ensure our children and young people have a good start in life
- Support good work and employment and ensure we have a sustainable workforce
- Play a full part in tackling poverty and long-standing inequalities
- Help to secure a greener Greater Manchester with places that support healthy and active lives
- Help individuals, families and communities feel more confident in managing their own health
- Make continuous improvements in access, quality, and experience – and reduce unwarranted variation
- Use technology and innovation to improve care for all
- Ensure all our people and services recover from the effects of the COVID-19 pandemic as effectively and fairly as possible
- Manage public money well to achieve our objectives
- Build trust and collaboration between partners to work in a more integrated way

We are responding to the challenges that Greater Manchester faces by:

<u>Embedding the Greater Manchester Model for Health</u>

Our Model for Health sets out how we will work together, with our communities, to enable the conditions for good lives, prevent poor health and ensure support is available before crises occur and to provide consistent and high-quality care wherever it is accessed. This is a social model for health, rather than a predominantly medical one, so focuses on the role of people and communities as well as health and care services.

<u>Acting on our missions</u>

Our strategy sets out the following missions, which are our priority actions in response to the current challenges:

- Strengthening our communities
- Helping people get into, and stay in, good work

- Recovering core NHS and care services
- Helping people stay well and detecting illness earlier
- Supporting our workforce and our carers
- Achieving financial sustainability

Elective

GM trusts have undertaken an initial assessment of the number of patients who have already or will tip into the 65 week wait cohort in 2023/24. This totals 458,000 patients.

A detailed review of available capacity through mutual aid across GM and through the independent sector has also been undertaken to understand how this can support the 65 week wait position and further reduce the projected figure.

Due to the nature of some of our 65 week wait cohort, there is a proportion (986) that will need to be part of a wider planning conversation at NW and national levels. This replicates the position we had with the 78 week wait cohort where capacity was successfully identified at Alder Hey to support specialist paediatric patients who could not be treated in other parts of the GM system.

The GM ambition is still to achieve a zero position and GM will continue to have detailed planning discussions around this remaining cohort to explore all possible options. This will be supported through the NW Mutual Aid process and the weekly meetings.

The development of the detail operational plan to ensuring the collaborative approach to mutual aid and the use of Independent Sector (IS) capacity will be managed through the GM Chief Operating Officers and Elective Operational Group.

GM has put in place a system wide approach to support the delivery of the ambition to eliminate long waits and in particular those who have waited over 65 weeks. This includes:

- The establishment of a GM approach to mutual aid which has supported both the 104 and 78 week wait cohorts
- The GM Programme Director for Operations will take a lead role in ensuring the necessary mutual aid to achieve the 65 week wait position will be put in place within GM where possible
- Our approach to mutual aid has also been formalised through the GM Operational Group which brings together the elective operational leads form all trusts
- Regular reporting is undertaken through to the GM Chief Operating Officers and the GM Elective Recovery and Reform Board
- The use of surgical hub capacity is reported on a weekly basis to the GM Operational Group
- All trusts in GM (except for The Christie who do not have any long wait patients) have signed up to the national Digital Mutual Aid System (DMAS). This has been utilised for the 78 week wait cohort and will continue to be used for the 65 week wait cohort
- A collaborative approach to the use of available independent sector capacity and insourcing has been put in place to bolster at risk areas. Reporting on activity under these arrangements is taken to the GM Independent Sector Group

- Plans to achieve 85% theatre capacity are in place in all trusts by March 2023.
- Outpatient transformation activity is a key pillar of the GM Elective Recovery Strategy and is focused on improving first outpatient appointment activity levels whilst exploring options for reducing follow up outpatients
- Overall referral levels and variation in referrals across GM are being addressed through the GM Elective Primary Care group to identify opportunities for improvement. This will include the use of advice and guidance and alternatives to referral such as care navigation hubs which support people in a community setting where appropriate

Dermatology and gynaecology have been agreed as at-risk areas and action is being taken to ensure their sustainability. A GM dermatology programme has been operational in the latter half of 2022/23 to support the 78 week wait cohort and is also now progressing the development of sustainability options for 2023/24. Gynaecology has also been identified as an at-risk area. To support this, a GM taskforce group has been established with representation from across the GM system and the NW regional office to identify options for improvement.

Long wait cohorts are reported through GM governance on a weekly basis and escalated on a fortnightly basis to the GM Elective Recovery and Reform Board.

To further support the delivery of elective recovery, and in particular the 65 week wait position, the GM 65 week wait modelling tool will be developed further to estimate the amount of diagnostic activity required. Although this will utilise estimates and assumptions, it will enable us at the GM level to understand if the ongoing activity in diagnostics is sufficient to support recovery and therefore be able to predict potential backlogs.

Outpatients

The GM 2023/24 plan achieves a reduction of 11% on follow up activity. The significant backlog in follow up outpatient activity, driven in part by focusing capacity on delivering the long wait priorities, is contributing to this position. This risk in relation to this cohort is increased for those who have previously been seen via virtual appointments during the COVID-19 period. A clinical review would be required before patients in this cohort can be discharged.

Outpatient activity was raised through the GM Confirm and Challenge sessions and it is recognised this target is challenging to achieve but does not at this point reach the national ambition of 25%.

Outpatient improvement, and further embedding / improving our primary and secondary care interface, will be key to supporting the delivery of the operational plan. The GM system will focus on working towards key trajectories in a range of areas, including increased use of Patient Initiated Follow Up (PIFU), increase utilisation of Specialist Advice, DNAs and cancellations, one-stop clinics, and improving equity of access (remote consultation and online forms). This will include engaging with resources and taking part in Regional and National initiatives (such as 'Action on Outpatients').

Our outpatient improvement activity will also include reviewing our data to identify big impact areas/specialities to focus on. A GM Outpatient Transformation Working Group will be

established to ensure there is a consistent approach to improvement and develop shared solutions to improve our outpatient services across the system, where possible.

A recent Outpatient Improvement Session was held across the GM system and attended by over 70 people as well as the Regional Outpatients team. This session was focused on sharing best practice and learning from across other areas outside GM. This will form the basis of how we will continue to work and will support the delivery of the stretched ambition for outpatient transformation.

There is an external review of productivity and efficiency in the GM system currently underway. Outpatients and follow up outpatients will form part of this. Where opportunities to improve the reduction in follow up activity are identified these will be considered and the trajectories refreshed.

Cancer

For patients waiting over 62 days, the target position for end of March 2024 is 1,051. This requires three trusts to maintain their current position, one trust to make a marginal improvement, and three trusts to make significant improvements compared to their current position (c50% improvement).

The provider trajectories show that delivery of the target would be achieved at system level, and in all but one provider in terms of the individual recovery requirements. This is heavily dependent on an increase in diagnostic activity, and reduced waiting times for diagnostics and increased theatre capacity. Full triangulation between cancer, diagnostics, elective, workforce, finance, Urgent and Emergency Care (UEC) will be undertaken through a confirm and challenge process to understand how the planned reduction will be delivered. Key GM led actions will include:

- GM systemwide action plan, agreed at system level
- Focussed work on first attendance ‘offer’ and ‘day 7’
- Best Practice Timed Pathways (BPTP) project delivery and compliance monitoring
- Full roll out of tele-dermatology and Faecal Immunochemical Testing (FIT) and compliance monitoring
- Continued education and support to primary care, with conversion rate monitoring by PCN and GP practice
- Collaborative work with elective programme on referral options (urgent non-cancer capacity)
- Consolidation of oncology appointments (single queue)
- Ongoing work with the Imaging Network, Endoscopy Network, Pathology Network and Community Diagnostic Centre (CDC) programme to improve waiting times for diagnostics and reporting for patients on suspected cancer pathways.
- Diagnostics focus – March 2023 initiative
- Single queue work programme for specialist and niche diagnostics
- Focussed work on surgical treatment. Proposed pilot for high volume procedure ‘hub’
- Mutual aid offer for specialist surgery

- Work programme of targeted interventions by speciality within the Cancer Alliance work programme
- Expansion of the ‘one stop model’ beyond lung cancer
- Rapid Diagnostic Centre (RDC) – Non Specific Symptoms (NSS) pathway
- Embed Faster Diagnostic Standard (FDS) principles in all site specific pathways with appropriate investment
- Targeted improvement initiatives – focus fortnight, Heparin-Induced Thrombocytopenia / Thrombosis (HiTT) lists etc
- Workstream to improve reflex testing timeframes
- Roll out and compliance with Personalised Stratified Follow-Up (PSFU) – to release clinical team to be re-invested in front end pathway improvement

The Cancer Alliance has a programme of work scheduled for 2023/24 to improve the early diagnosis of cancer, towards the long-term plan ambition of 75% diagnosed at stage 1 and 2 by 2028. The work on early cancer diagnosis, particularly the work with primary care/Primary Care Networks and the patient/public facing messages on timely presentation will have a positive impact on the Faster Diagnosis Standard.

Urgent and emergency care

GM have a well-established GM Urgent and Emergency care, Improvement and Transformation Board (GM UECITB). The Board is co-chaired by the ICB Exec Senior Responsible Officer (SRO) and the Provider Federation Board (FPB) Exec SRO, to ensure a whole system approach. The Board is made up of the chairs from each locality Urgent Care Board and key sector leaders, to ensure that the improvement plans for GM are connected to locality work and improvement is monitored across GM. To support this governance structure, the GM UEC Programme has several key workstreams, with steering groups that provide regular highlight reports to the Board and equally have good GM wide representation from both providers and ICB locality representatives.

The system has reviewed the GM position against the national UEC recovery plan, with key deliverables of what is required to be achieved over and above existing workstreams.

The system is working collectively with all key partners including ICB, providers, VCSE, social care and primary care to ensure connectivity and a joined-up approach. This is being managed through the GM UECITB.

The achievement of UEC recovery is heavily dependent on the ability to achieve the UEC investment fund, which will enable key admission avoidance and capacity schemes to be sustained throughout the year.

Maternity

The Greater Manchester and Eastern Cheshire (GMEC) Local Maternity and Neonatal System (LMNS) developed a Maternity Equity and Equality Action Plan between 2021 and 2022. The plan was carefully co-designed and co-produced with the people we serve, by establishing Core and Task and Finish groups with a broad range of stakeholders across the LMNS, Integrated Care System (ICS) and other sectors.

In collaboration with the Strategic Clinical Network (SCN), the North West Regional Chief Midwife Office, the North West Neonatal Operational Delivery Network, the voluntary sector and Public Health colleagues, the LMNS will use this action plan over the next five years to reduce health inequalities and improve equity in maternity and neonatal services across GMEC.

In 2022 the GM Equity and Equality steering group was established which brings together clinical, VCSE, education colleagues to oversee and deliver the LMNS Maternity Equity and Equality Action Plan. The group is established within the ICB governance via the GMEC Maternity Programme Board, where regular updates and discussion occur. The group has already delivered on improvements identified in the plan, including the development of Black and Asian Maternity Equity Standards, public facing information materials, working with Maternity Action to support pregnant women at work and the commencement of a student mentor scheme.

Locality updates

NHS GM operated at three main levels – GM, locality, and neighbourhood. Following the establishment of NHS Greater Manchester on 01 July 2022, all 10 of our localities (operating as place-based integrated care partnerships) have continued to develop and embed new collaborative arrangements within the ICS, including how finance and governance works and how we work together to recover from COVID-19.

The pandemic and cost of living crisis have created new challenges for all localities that we need to address as a partnership of health and care providers. Population health has deteriorated, mortality is higher than before the pandemic and a larger proportion of people are economically inactive because of mental and physical health issues. This has created an imbalance between demand and service provision that is reflected in longer waiting times and is causing significant issues across the system.

While each locality undoubtedly has had its challenges - some shared across GM while others localised – the focus for them all during our first nine months has been to ensure the continued provision of safe and effective services for our population whilst the organisational changes were underway. We are pleased to be able to share the following highlights from each locality.

Bolton

- Agreed locality governance structure with the Local Authority, Bolton NHS Foundation Trust and partners, which will help deliver the long-term strategic aims of health and social care in Bolton
- Developed system wide delivery plans to improve outcomes, performance and efficiencies across Mental health, Learning Disabilities, Careers, Planned care, Urgent Care, Children and Young People, Neighbourhoods and Communities
- Maintained out-of-hours provision of care via primary care through innovation and tested integrated delivery of Urgent treatment Centres and focused on reducing ambulance handover times
- Demonstrated excellent locality working with the Local Authority and Bolton FT by jointly planning our winter response.
- Implemented the Extended Access Services as part of the Primary Care Network (PCN) Direct Enhanced Service contract to ensure that Bolton residents could access services.
- Delivered a successful Covid vaccination programme, using innovative approached to ensure the furthest reach and uptake

Bury

- Implemented and agreed the further iteration of the Locality Plan with all partners to the Bury Integrated Partnership. It confirms high level objectives and ways to secure better outcomes, address health inequality, improve access and quality of services received and to support residents to be well, independent, connected to their communities and in control of the circumstances of their care and lives.

- Produced a new draft Mental Health Strategy for Bury, marking a major step forward in Bury's determination to deliver the national requirements of the NHS Long Term Plan for mental health and set out the actions required to improve services
- Through the Bury GP Leadership Collaborative, developed a new Primary Care Strategy (with a focus on general practice), reflective of the wider "blueprint" Greater Manchester Primary Care Strategy
- Welcomed the GM Cancer Network who hosted a review meeting in Bury to assess progress on key outcomes on cancer services where the work in Bury implementing the eDerma scheme – which is having a significant impact on two-week wait targets for dermatology, and on the cancer inequalities strategy and implementation – was particularly commended
- Collaborative work as a system to manage the urgent care pressures on a daily basis at Fairfield General and North Manchester Hospitals through Bronze and Silver Command meetings and through the implementation of an urgent care improvement plan, owned by all system partners
- Continued to work collaboratively on addressing the elective recovery position. Partners across the Northern Care Alliance footprint submitted a joint Elective Recovery Fund proposal to NHS GM which was reflective of both the need for additional capacity in delivery and also new models of intervention earlier in the pathway supporting primary care to respond to patient needs without adding to elective waiting lists

<u>Heywood, Middleton and Rochdale</u>

- Significant work has taken place to collectively, and collaboratively, develop a number of strategies, including workforce, prevention, dementia and SEND (Special Educational Needs and Disabilities) and workforce
- As a result of the work to develop and launch the SEND Strategy, the Raising Rochdale Integrated SEND Team and the Council for Disabled Children won the Public Sector Children's Team Award, at the Children Young People Now Awards
- Significant work has taken place regarding the Preparing for Adulthood programme Strategy, including the refresh of the Adult Social Care vision
- Reduced waiting times for echocardiograms from 17 weeks to 13 weeks through improvements to the pathway.
- Introduced Patient Initiated Follow Up pathways ensuring patients can access support when they need it and reduce hospital waiting times by reducing unnecessary appointments
- Cataract treatment is now available in the community where clinically appropriate and 533 patients have been through the post cataract service, where they will have had their follow up appointment in a community setting. This has released much needed secondary care capacity to offer appointments to more complex patients
- Non-recurrent investment and the work of the Children's Community Health Teams means no children are waiting more than 18 weeks for Occupational Therapy and Physiotherapy

- Our Same Day Emergency Care unit has led to an increase in access to the Urgent Treatment Centre at Rochdale Infirmary, reducing length of stay and unnecessary admissions. Ambulance transfer times have also reduced.
- Reduced demand on primary and urgent care through improved provision of community care for children.
- Opened an Enhanced Primary Care Hub in Heywood and continued with our Whitehall Street Hub, with provision now available weekends 8am - 8pm. Since December 2022, the hubs have delivered an extra 80 face-to-face appointments per week
- Developed the Whole School Approach (WSA) to mental health model to ensure children in school are getting the mental health support they need. In addition, support to school settings to develop emotionally friendly schools
- Introduced local 'Listening Lounges' to support individuals who are experiencing emotional distress and provide a Wellbeing Plan with signposting
- Progressed development of the neighbourhoods' model, ensuring local councillors are engaged with the neighbourhood approach to ensure that constituents voices are represented in the work we do. Prevention Networks have been set up in 3 of our neighbourhoods to bring together voluntary care sector groups with patient insight to support prevention across the Borough.
- Launched a new poverty programme, with half a million pounds of investment from the Winter Capacity funding, to support residents in housing related poverty who needed help with warmth and shelter. We have setup 45 warm spaces across the borough, which in some areas have seen up to 100 people access the spaces each month. The warm spaces have distributed 500 winter warmth packs containing warm clothes, duvets and dried food
- Established a Reactive Falls Scheme, which takes referrals from care homes, NWAS and Pendant alarm providers, responding within 2 hours of contact. During the first two months 37 patients had been supported to stay at their residence, providing better patient experience and reduced pressure on ambulances and A&E

<u>Manchester</u>

- Over the last two years, through our Primary Care team working with the 14 PCNs, approximately 360 additional staff are now employed (160 in 2022/23) into general practice through the Additional Roles Reimbursement Scheme (ARRS), across various roles including pharmacists, physiotherapists, physician associates and social prescribing link workers.
- The Primary Care team worked with wider partners to deliver safe and effective care for the increasing number of migrants living in Manchester. This included mobilising at short notice hotel-based accommodations providing temporary residence for people who are on the Afghan Relocations and Assistance Policy (ARAP), Afghan Citizens Resettlement Scheme (ACRS), and asylum seekers living in Asylum Seeker Contingency accommodation (ASC).
- Work continued at pace towards the achievement of our vision for neighbourhoods (13 across the city) where *'Everyone in Manchester is able to live a healthy, happy and independent life in a thriving community with integrated public services working'*. The Neighbourhood approach in Manchester has been developed through 'Bringing Services

Together for People in Places' and ensures that all partners across public services come together through our Teams around the Neighbourhood. The Manchester Local Care Organisation is the delivery vehicle for health, care and wellbeing, delivered through the Integrated Neighbourhood teams.

- Community Health Equity Manchester (CHEM) was set up in 2020 to inform our response to COVID-19, and the widening impact gap on different communities; its focus has grown and now includes the indirect consequences of the pandemic and broader social, health and wellbeing priorities for their communities. It has representation from groups and communities across the city and has become a critical part of our system infrastructure for addressing health inequalities.
- Manchester Lung Health Checks (LHC) service and targeted lung cancer screening was launched in North Manchester in April 2019. Outcomes up to October 2022 show that 190 lung cancers were diagnosed, more than 80% of which were at early stage, and 85% of patients receiving radical / curative treatment. Patients with identified lung disease were referred to primary care for treatment to reduce risk of severe disease.
- Greater Manchester Mental Health NHS Foundation Trust began the construction of its new state-of-the-art mental health inpatient unit on the North Manchester General Hospital site, marked by a 'groundbreaking' ceremony in November 2022. This £105.9 million unit will replace the existing Park House mental health inpatient unit and transform the mental health inpatient experience. It is due to be complete in late 2024.
- The new Manchester Acute Respiratory Infection Service delivered an additional 33,930 primary care appointments between December 2022 and March 2023.
- Implemented digital consultations service (Livi), delivering 17,705 additional video consultation appointments between May 2022 and March 2023.
- Patient waiting times have improved - the number of patients waiting more than 78 weeks for elective care has reduced to 332 compared to over 1200 during the same period in the previous year. Patients are receiving faster access to cancer services following GP referral – over 80% within 2 weeks and getting diagnosed faster, 72% within 28 days. In the final quarter of the year, the 4-hour wait in A&E improved, the number of ambulance handovers exceeding an hour reduced, and those within 15 minutes increased.
- Established the Making Manchester Fairer Programme, the city's new action plan to tackle health inequalities.

<u>Oldham</u>

- Significantly increased mental health capacity working at a neighbourhood level in the locality through dedicated PCN-based roles for mental health providers, mental health community navigators, link workers, peer support workers and wellbeing practitioners.
- In November 2022, NHS England approved and accredited Oldham's urgent care service model, which includes a Pre-ED service, minor injuries unit at Royal Oldham Hospital and urgent care hub at Oldham Integrated Care Centre
- Commissioned extra services to support patients during high pressure periods, such as winter, within urgent and emergency care. This included putting extra beds in place in the community, extra staff placed across many providers, and a new pathway introduced for patients to receive the best care possible during challenging times, in addition to a 'falls

pick up service', which works directly with the ambulance service to get to people early who have fallen and called 999. The service to date has supported 60 people to remain out of the 999/hospital attendance system

- Commissioned an all-age service designed to meet the needs of the varied demographics of Oldham's population. The service provides holistic and comprehensive support to individual adults, children, young people, and families – allowing residents to make and maintain healthy behaviours to improve their health and wellbeing through early intervention and prevention. The service provides individualised packages of support dependent on the need of the client
- A 'Dementia Hub' was set-up at Dr Kershaw's Hospice, which provides an extremely popular drop-in service where service users can take part in a memory assessment and/or talk to someone about their concerns
- Launched Disabilities and Autism Champions with one in each general practice, whose role it is to help ensure that these patients are receiving the help they need in the way they need it from their GPs, and that they feel comfortable visiting the practices
- Opened a brand new £10 million Community Diagnostic Centre, designed to tackle waiting lists and COVID-19 backlogs by helping more than 30,000 patients a year. As one of the first six centres in the region and one of the country's largest out-of-hospital diagnostic centres, the centre is a one-stop shop for checks, scans and tests.
- Maintained a high level of access for cancer routine first appointments for dermatology, with performance for a '2 week-wait' for skin lesions diagnostics and a 62 day wait for treatment at 93.2% (against a 93% target) and 95.2% (against 85% target), respectively (as of February 2023)
- The Oldham Scheduled Care team won silver in the 'best diabetic foot intervention' category at the Journal of Wound Care awards for work around meeting NICE inpatient foot guidance. An assessment was received by all patients within six hours of admission. As a result, diabetes foot assessments completed in 24 hrs increased from 37% to 91%, and there was a 57% reduction in hospital acquired pressure ulcers

<u>Salford</u>

- Significant improvements towards eliminating waiting times of more than 78 weeks, reducing from 713 in December 2022 to 59 at the end of March 2023
- Two-Week Wait performance for cancer referral improved from 61.1% in December 2022 to 84.4% in February 2023, while the percentage of patients waiting more than six weeks for a diagnostic test reduced from 31% in September 2022 to 20% in February 2023
- Primary Care Network (PCN) Level Community Diagnostic Centres (CDC) have now been mobilised across all five neighbourhoods in Salford. In addition, the Salford CDC business case for establishment of a large CDC hub has been approved by the National CDC panel providing additional diagnostic capacity and improving access for Salford patients from September 2023
- The Salford Lung Health Check programme has now been completed across four of the five PCNs in Salford and currently operating in Broughton, the fifth and final neighbourhood. Up to January 2023, 93 patients have been diagnosed with lung cancer and 21 patients have been diagnosed with other cancers. Positively over 83% of lung

cancers have been diagnosed in the early stages, increasing the chances of successful treatment

- Continued to develop the Salford Urgent Care Listening Lounge, which is an alternative to A&E operating 24/7, to incorporate a partnership VCSE offer. Referrals are being tracked and referral routes are being developed, with a view to progress towards open access
- The number of people with a severe mental illness (SMI) receiving a full annual physical health check has improved, but at 44.1% is still below the national target of 60%. As part of a GM piece of work, Mind have employed an engagement worker with Salford to focus on increasing access to physical health checks. Swinton PCN is the first area of focus and local data will be used to inform a city-wide approach
- For Improving Access to Psychological Therapies (IAPT), performance regarding waiting times for March 2022 showed that:
    - Salford continues to meet the 18 Week Referral to Treatment target with local March 2023 data year-to-date showing performance at 97.9%
    - 6 Week Referral to Treatment target was not meeting target at 62.2% local March 2023 data, compared to 75% target
    - The monthly prevalence target of 2.08% was not met with local March 2023 data at 1.95%
- New community optometry services have been commissioned and are delivering improved services
- Safer Salford entered its sixth year, and the programme continues to drive a system wide approach to improving quality and safety. Work progressed during the CCG/ICS transition year to ensure it can continue beyond March 2023
- The Salford Locality System Quality Group has commenced in line with ICS guidance and the NHS Patient Safety Strategy Safer culture, safer systems, safer patients. This group brings together place-based partners from across health, social care and wider to share insight and intelligence into local quality matters, identify opportunities for improvement and concerns/risks to quality, and develop place-based responses to support ongoing quality improvement

<u>Stockport</u>

- Refreshed the One Health and Care plan to reflect the GM strategy and ICS changes
- A SEND re-inspection in late 2022 evidenced significant progress and strong joint working to improve outcomes for children, young people and families.
- Continued to strengthen primary care services through the PCNs who provided enhanced case management and joined-up care for those in need in the community
- Significant improvements in Stockport's Urgent and Emergency Care CQC ratings, which saw ratings go from inadequate to good
- Plans to spend more than £30 million on a new emergency and urgent care building were approved by NHS England and the Department of Health and Social Care. Building began on site in August 2022, and when finished (towards the end of March 2024), the campus will provide new assessment, treatment and consultation areas for several key emergency and urgent care services, including the children's emergency department, mental health, and medical same day emergency care

- Provided funding for more than 150 warm spaces, providing information to residents about dealing with the rising cost of living and providing support to existing small businesses through extension funding
- Stockport became one of just 12 areas across the country to be awarded funding from the Government's Family Hubs Transformation Fund to help improve the way family help services are run in the borough for children, young people, and families.
- Launched the Neighbourhoods and Prevention Programme in recognition that people are more than just their health conditions or care needs. Implemented a new neighbourhood model that recognised wider factors such as education, housing, employment, environment, and social connectedness to put people at the heart of services and tailor care to individual needs by creating the conditions for individuals, communities, services and professionals to work together
- Established the People and Community Voice Subgroup to provide a dedicated forum to support and deliver engagement across the locality and ensure the community voice is included in the development of the One Stockport Health and Care Partnership

<u>Tameside</u>

- Successfully ensured the smooth transition of Glossop to Derbyshire ICS, following boundary changes
- Established a governance structure with the Local Authority, Tameside and Glossop Integrated Care NHS Foundation Trust and partners to help drive the strategic aims and principles agreed for Tameside
- Established the General Practice Alliance (TGPA) bringing together 31 general practices, four PCNs, clinical leads from across Tameside and the totality of their workforce to develop quality healthcare services and work to ensure equity of offer by removing unwarranted variation across member practices.
- Tameside and Glossop Integrated Care Foundation Trust secured £16.3 million of national capital funding for the redevelopment of the Urgent and Emergency Care facilities at Tameside General Hospital
- Tameside & Glossop Integrated Care NHS Foundation Trust opened a new mammography suite providing much improved facilities for diagnostic tests
- Met the national requirement to have eliminated waits of more than 78 weeks for elective procedures by March 2023.
- The multi-disciplinary Integrated Urgent Care Team achieved two key NHS long-term plan commitments for community care; providing crisis response within two hours of referral, and re-ablement to people in their own home within two days. Also supporting a system approach to the reduction of patients in hospital with no criteria to reside, by providing the initial wrap-around care for people in their own homes
- Delivered above target on Learning Disability Severe Mental Illness Health Checks
- Suicide prevention programme led to a reduction of suicide levels
- Expanded digital care model to support development of virtual wards, which is aimed at admission avoidance and supporting discharge from hospital

- Following additional investment in 2022/23 on average 90% of children & young people across physiotherapy, occupational therapy, speech and language, dietetics and paediatrics now have their first appointment within 18 weeks.
- Launched our Special Educational Needs and Disability (SEND) family VCSE Health Navigator service in July 2022 there are now approximately 400 families registered with the service with over 5000 contacts for advice support

Trafford

- Made significant progress to develop local governance arrangements to both enable us to deliver against delegations from the ICB and continue to develop integrated health and care arrangement to support better outcomes for our residents
- Despite ongoing financial challenges across GM, delivered against our locality budget, as of March 2023
- Uptake of annual health checks for people with learning disabilities and severe mental illness was above the 75% national target, making Trafford one of the best performing localities in the country
- Achieved local target for the number of personal health budgets (PHBs), 557 against a target of 523
- The Trafford Urgent Care Review is a collaborative, system led programme of work bringing together a wide range of partners to co-design a simple to navigate, joined up urgent care offer which meets the needs of all of Trafford's population. This has involved the creation of a Needs Assessment to identify the needs of the population, a Critical Appraisal to map our current Urgent Care Services offer, as well as an in-depth resident survey supported by an additional 16 face to face engagement sessions with residents and voluntary groups to understand awareness, usage, and satisfaction with urgent care services across our borough. Our work to understand residents' viewpoints has involved working closely with Healthwatch Trafford and has ensured we are working with our diverse communities to help plan and design future urgent care services that appropriately meet the needs of Trafford people

Wigan

- Delivered Living Well Wigan Borough, a new community mental health service in partnership helping people who need more support for their mental health but a bit less than provided by a Community Mental Health team
- Continued work to implement a single queue referral and triage system based at Wigan and Leigh Hospice, as part of the Wigan End of Life Strategy Group.
- Continued to work with system partners to develop urgent care services. Same Day Emergency Care (SDEC) is now operational seven days a week, for 12 hours Monday to Friday and 11am until 7pm weekends and bank holidays, and has capacity for 32 patients. The expansion of the service has led to improved patient flow from A&E and a further extension to pathways available in the community preventing unnecessary A&E attendances

- Wigan Infirmary was successful in implementing a frailty SDEC service at the end of 2022 / 23 for five days a week. The service has been able to see on average ten patients per day, with many patients being discharged home on the same day with support in place to keep them safe at home.
- Developed Surgical Ambulatory Emergency Care (SAEC), based on Orrell Ward at Wigan Infirmary, which accepts surgical referrals from A&E and GPs. The development of this surgical pathway has enhanced flow from A&E and provides GPs with direct access to a surgical pathway without their patients attending A&E
- Continued to develop the Wigan System Quality Group, with representatives from local NHS services, independent and voluntary sector providers, and patient and resident representatives. Specific quality improvement activity and good practice has also been shared including the improvements being made in diabetes care and the development and implementation of the Multi-Agency Resource Panel for Children and Young People
- 98% of GP practices across the borough are rated either ‘Good’ or ‘Outstanding’ following Care Quality Commission inspections
- More than one million consultations were completed in general practice, 71% of these were face-to-face, and over 4.5 million medications were issued
- Digital technologies continue to be used to underpin GP practice working, with innovation supporting new models of care and access to services. For example, over 430,000 online consultation results have been completed during the period giving patients access to their practice in a more suitable and convenient way
- Our Enhanced General Practice Specification has focused on reducing unwarranted variation, collaboration between practices, and the delivery of care processes to patients with diabetes. Significant improvements have been made as a result and 6,200 more patients have received all eight processes relating to good diabetes care in comparison with the previous 12 months, with the proportion of patients with well controlled blood pressure and blood glucose increasing by 10%
- Aspull Health and Wellbeing Centre was completed during February 2023, providing GP and Community Services and giving space to support local neighbourhood services from Wigan Council, GMMH, and VCFSE.

Performance analysis

Ensuring and driving quality, performance and improvement

In July 2022, twelve organisations (10 Clinical Commissioning Groups (CCGs), Greater Manchester Shared Services (GMSS) and the Greater Manchester Health and Social Care Partnership (GMHSCP)) came together to form one single statutory organisation, the Greater Manchester Integrated Care Board (ICB). At this time, the ICB assumed responsibility for performance, improvement and assurance working closely with regional teams and delivery partners including hospital trusts. The focus for 2022/23 has been on improving performance against the delivery metrics set out in the NHS Oversight Framework with a GM Performance and Quality Committee established to oversee progress, risks, assurance and improvement plans.

The NHS Oversight Framework (SOF) 2022/23 provides a single, consistent NHS monitoring framework with the flexibility to support different system delivery and governance arrangements, as well as local partnership working. The framework takes account of:

a) the establishment of statutory ICBs (and disbandment of CCGs) with commensurate responsibilities
b) NHS England's duty to undertake an annual performance assessment of these ICBs
c) early learning from the implementation of the System Oversight Framework during 2021/22
d) NHS priorities as set out in 2022/23 planning documentation.

Ongoing oversight continues to focus on delivering the priorities set out in NHS planning guidance, the overall aims of the NHS Long Term Plan and the NHS People Plan, as well as the shared local ambitions and priorities of individual ICSs. To achieve this, the NHS Oversight Framework is built around:

a) Five national themes that reflect the ambitions of the NHS Long Term Plan and apply across trusts and ICBs: quality of care, access and outcomes; preventing ill-health and reducing inequalities; people; finance and use of resources; and leadership and capability
b) A set of high-level oversight metrics, at ICB and trust level, aligned to these themes
c) A sixth theme, local strategic priorities. This reflects the ICB's contribution to the wider ambitions and priorities
d) A description of how ICBs will work alongside NHS England to provide effective, proportionate oversight for quality and performance across the NHS
e) A three-step oversight cycle that frames how NHS England teams and ICBs will work together to identify and deploy the right delivery support and intervention to drive improvement and address the most complex and challenging problems, respectively

Throughout 2022/23, the ICB and regional teams have worked together on providing oversight of NHS providers, assessing delivery against these domains, working through provider collaborative where appropriate. ICBs and regional teams supported those providers requiring more formal intervention, this has been seen in Greater Manchester's Mental Health Services and some of our acute trusts.

In October, due to increasing pressures in urgent, elective and cancer services in Greater Manchester ICB was placed in segmentation 3 of the NHS Oversight Framework. Delivering

the 2022/23 financial plan was also a risk at this time. This provided the ICB with access to additional support and expertise to expedite improvements against these key delivery areas.

The organisation remains committed to improvement performance and over the coming year the ICB will be strengthening its Performance, Improvement and Assurance function.

New ways of working will incorporate the requirements of the 2023/24 NHS Outcome Framework (still waiting publication at the time of writing this report.) It will also take account of The Health and Care Act 2022, which places new duties on the CQC to conduct reviews of the provision of health and adult social care in each ICS and assess the functioning of the ICS, including how its ICB, local authorities and registered service providers work together. NHS England and CQC will continue to work together to ensure synergy between the ICS reviews undertaken by CQC and the ICB assessments undertaken by NHS England.

System Oversight Framework (SOF) 2022/23

GM has developed a bespoke SOF report to monitor performance, reporting to the Quality and Performance Committee. A copy of the latest SOF is available below.

GM has a number of performance challenges, many of which are legacy from the COVID-19 pandemic. During this time, elective activity reduced and waiting lists for diagnostic tests and procedures increased as a result. There are also challenges with meeting the national cancer standards as demand for cancer services recovered and exceeded pre-pandemic levels. As usual, the Urgent Care System was tested over winter and demand for health and care services significantly increased. This year there were additional pressures with peaks in COVID-19 and flu activity, demand for children's services and industrial action.

Through the annual planning round, GM is working with providers and localities to develop plans for 2023/24 to improve performance in all areas of the SOF and against wider priorities. A brief summary of performance in each of the key programme area follows, and these are the focus of the monthly performance report to the GM Quality and Performance Committee:

<u>Elective</u>

At the end of March, in GM there are 24 patients who waited 104 weeks or more, these were mostly people who had chosen to wait or were medically unfit for their treatment. At the end of March, in GM there are 1,297 patients who have been waiting 78 weeks or more, again the majority of these had chosen to wait or are medically unfit for their treatment. There are 77 patients we did not have capacity to treat.

A number of initiatives are taking place to achieve further improvements in the waiting list. Additional capacity is being sought in the independent sector, along with sourcing mutual aid from hospitals where this is possible. A model has been developed to monitor long waiters and will help to identify issues as they arise. There is a goal to increase productivity in surgical hubs, and to safely reduce referrals, which will reduce numbers being added to the lists in the future.

<u>Diagnostics</u>

On the SOF, GM is generally ranked highly for diagnostic activity; this is due the number of diagnostic tests that are undertaken in GM. Waiting times for these tests are more of a challenge. Similar to elective waiting lists, the system relies on mutual aid between organisations providing diagnostic tests across Greater Manchester. The newly established Community Diagnostic Centres also provides additional capacity and swifter access. New ways of working are also being considered, which would standardise referral processes.

Cancer:

GM did not achieve cancer backlog reduction trajectories by March 2023. The Cancer Alliance continues to implement its system cancer improvement plan, including site-specific programmes of work to further improve early identification and treatment.

Mental health:

In 2022/23 GM Mental Health was ranked in the top 25% in the country for the number of people accessing Talking Therapies (formally known as “Improving Access to Psychological Treatment”), work continues to improve waiting times and recovery rates where we are below the national standard. GM has been able to demonstrate robust plans for delivering the mental health standards for the coming year with two risks, out of area placements and access to perinatal services. A new project group has been set up to progress the plans.

The proportion of expenditure incurred by the ICB and the predecessor CCGs in relation to mental health is as follows:

Financial Years	**2021/22 (£m)**	**2022/23 (£m)**	**2022/23 *Adjusted (£m)**
Mental Health Spend	£560	£597	£597
ICB/CCG Programme Allocation	£6,281	£6,644	*£6,441*
Mental Health Spend as a proportion of ICB Programme Allocation	8.9%	9.0%	9.3%

*__Note__: 2022/23 Allocation sum also includes £203m of new Pharmacy, Ophthalmology and Dental delegated responsibilities that were not part of CCG's. Adjusting for these would indicate a more comparable like-for-like MH proportion spend of 9.3% in 2022/23.

The increase in mental health baseline expenditure is achieving the Mental Health Investment Standard (MHIS) target set, with the target covering the whole financial year of 2022/23 and measured as an ICB target (including Q1 expenditure in the predecessor CCGs). The MHIS minimum spend target was £593m for 2022/23, against which NHS GM has reported an achievement of £4m greater than target, which will be subject to external audit validation in 2023/24. These investments have been made in accordance with the Five Year Forward View and NHS Long Term Plan.

Learning Disability and Autism

There are two indicators for Learning Disability and Autism on the SOF and one of these, at the time of writing this report, has only been published for Q2 2022/23. This indicator, S030a, is the "proportion of people aged 14 and over with a learning disability on the GP register receiving an annual health check", GM is progressing well against the national standards. The number of inpatients with a learning disability has been more of a challenge in 2022/23, but GM does plan to reach the NHSE targets by March 2024. To support this ambition a GM hub is in development to support the timely review of people in hospital and at risk of admission and new national guidance is being embedded throughout GM.

Urgent and Emergency Care (UEC)

There are two indicators for UEC in the SOF. GM has been ranked in the top 25% for bed occupancy and is performing around the national average for "no criteria to reside". In the 2023/24 plans, GM has ambitious intentions to achieve the national standard of 76% of patients being seen in A&E within 4 hours, which will be supported by bed occupancy reducing to 92%.

GM works closely with North West Ambulance Service and monitors the ambulance call out time. There have been challenges throughout 2022/23 with waiting times in emergency departments, which has been compounded by the number of patients with "no criteria to reside" occupying beds in the hospitals and restricting flow. Turnaround times of ambulances in emergency departments has been challenged over winter with some improvements in March.

Generally, in March 2023 there has been improvements noted in performance statistics, but activity and acuity remain high. The system is using additional monies allocated as part of the Urgent Care Recovery Fund to plan early for winter. Programmes are already in place to roll out best practice models including virtual wards and those aimed at speeding up discharge from hospital.

People and culture

NHS GM has had a higher sickness rate than the national average during 2022/23 and has performed around the national average for the other indicators in the "People" category of the SOF. In March 2023, GM (as a system) launched a People and Culture Strategy 2022-25, to support delivery of our ICP Strategy and tackle our workforce challenges. The strategy will be delivered at system, sector, locality and organisation level and overseen by the GM People Board. GM has created a "retention steering group" for workforce, tasked with looking at retention work and themes across all sectors of health and care. GM has also developed a visualisation product to monitor the quality and performance required to deliver the new People and Culture strategy.

Maternity

The maternity indicators on the published SOF contain data from the calendar year 2020 (which is the most recent data in the published SOF dashboard) for still births and neonatal deaths per 1,000 births. GM was at 3.88 still births per 1,000 and fell in the bottom 25th

percentile nationally for this indicator. Improvement work is continuing with the Providers via the GM Local Maternity and Neonatal System to support implementation of Saving Babies Lives Bundle, aiming to further reduce perinatal mortality.

Primary care

Generally, GM has performed well in the primary care elements of the SOF in 2022/23. We are delivering year on year increases in the number of GP appointments delivered although we recognise that rising demand means that further work is required in this area. In the NHS 2023/24 planning round, GM has submitted a plan to achieve the national standard for GP appointments. Dental services continue to recover following the pandemic, with GM sitting in the upper quartile of ICBs in terms of our performance. We plan to deliver a programme to further increase access to NHS Dentistry during 2023/24, recognising that this is a particular issue and priority for our citizens.

NHS SYSTEM OVERSIGHT FRAMEWORK (SOF) - GREATER MANCHESTER

March 2023

Code	Category, subcategory and indicator Description	Aggregation Source	Eng Rank	Change from previous period	3 period continuous change	Period / Frequency	Period	GM	National	Standard
	Leadership and Capability									
	Leadership									
S060a	Aggregate score for NHS staff survey questions that measure perception of leadership culture (out of 10)	ICB	33/42	▲		Annual	2022	6.87	6.94	
	People									
	Belonging in the NHS									
S072a	Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age	ICB	28/42	▼		Annual	2022	55.4%	56%	
	Growing for the future									
S074a	FTE doctors in general practice per 10,000 weighted patients	ICB	22/42	▼		Month	202303	5.88	5.79	
S075a	Direct patient care staff in GP practices and PCNs per 10,000 weighted patients	ICB	40/42	▲		Quarter	22 Z3 Q3	4.37	5.95	
	Looking after our people									
S063a	Proportion of staff who say that they have personally experienced harassment, bullying or abuse at work from managers	ICB	27/42	▼		Annual	2022	11.7%	11.1%	
S063b	Proportion of staff who say that they have personally experienced harassment, bullying or abuse at work from other colleagues	ICB	13/42	▼		Annual	2022	17.8%	20%	
S063c	Proportion of staff who say that they have personally experienced harassment, bullying or abuse at work from	ICB	6/42	▼		Annual	2022	24.5%	28%	
S067a	Leaver rate	ICB	12/42	▼		Month	202302	8.13%	8.60%	
S068a	Sickness absence rate	ICB	42/42	▲		Month	202212	7.8%	6.4%	
S069a	Staff survey engagement theme score (Out of 10)	ICB	36/42	▼		Annual	2022	6.70	6.79%	
	Preventing ill health and reducing inequalities									
	Prevention and long term conditions									
S051a	Number of people supported through the NHS diabetes prevention programme as a proportion of patients profiled	ICB	33/42	▲		Quarter	22/Z3 Q3	24.8%	41.5%	
S053a	Proportion of people with CVD treated for cardiac high risk conditions	SUB-ICB	22/42	▲		Annual	2021-22	88.8%	89.0%	90.0%
S053b	% of hypertension patients who are treated to target as per NICE guidance	SUB-ICB	26/42	▲		Annual	2021-22	59.5%	60.4%	80.0%
S053c	% of patients identified as having 20% or 10 year greater risk of developing CVD are treated with statins	SUB-ICB	6/42	▲		Month	2022-23 Q3	62.7%	58.6%	45.0%
S055a	Number of referrals to NHS digital weight management services per 100k head of population	SUB-ICB	27/42	▲		Quarter	22 Z3 Q4	37.2	54.8	
S115a	Proportion of diabetes patients that have received all eight diabetes care processes	ICB	38/42	▲	▲	Quarter	21 Z2 Q4	38.5%	46.7%	
S116a	Proportion of adult acute inpatient settings offering smoking cessation services	ICB	26/42			Month	202302	10.0%	24.5%	100.0%
S116b	Proportion of maternity inpatient settings offering smoking cessation services	ICB	4/42	▲		Month	202302	50.0%	22.0%	100.0%
S117a	Proportion of patients who have a first consultation in a post covid service within six weeks of referral	Provider	10/24	▲		Month	202303	61.5%	50.8%	
	Screening, vaccination and immunisation									
S046a	Population vaccination coverage - MMR for 2 doses (5 year olds)	ICB	32/42	▲		Quarter	2022/23 Q3	84.9%	85%	95%
S047a	Proportion of people over 65 receiving a seasonal flu vaccination	SUB-ICB	35/42	▲	▲	Month	202302	78.0%	79.9%	85%
S50a	Cervical screening coverage - % females aged 25 - 64 attending screening within the target period	SUB-ICB	33/42	▼		Quarter	22 Z3 Q2	68.6%	69.7%	75.0%
	Quality of care, access and outcomes									
	Cancer									
S010a	Total patients treated for cancer compared with the same point in 2019/20	ICB	35/42	▲		Month	202303	97%		100%
S011a	Total patients waiting over 62 days to begin cancer treatment compared with baseline	Provider	14/42	▼		Weekly	w/e 26/03/2023	6.93%	7.53%	
S012a	Proportion of patients meeting the cancer faster diagnosis standard	ICB	19/42	▲		Month	202303	73%	75%	75%
	Elective Care									
S007a	Total elective activity undertaken compared with 2019/20 baseline	ICB	40/42	▲	▲	Month	202301	91.8%		104%
S007b	Elective activity: Completed pathway elective activity growth	ICB	39/42	▼		Month	202303	91.7%		110%
S009a	Total patients waiting more than 52 weeks to start consultant-led treatment	Provider	42/42	▼		Month	202303	47,194	344,234	
S009a	Total patients waiting more than 52 weeks to start consultant-led treatment	SUB-ICB	42/42	▼		Month	202303	36,143	327,558	
S009b	Total patients waiting more than 78 weeks to start consultant-led treatment	Provider	42/42	▼		Month	202303	1,358	10,217	
S009b	Total patients waiting more than 78 weeks to start consultant-led treatment	SUB-ICB	41/42	▼		Month	202303	1,054	10,278	
S009c	Total patients waiting more than 104 weeks to start consultant-led treatment	Provider	40/42	▼		Month	202303	36	455	0
S009c	Total patients waiting more than 104 weeks to start consultant-led treatment	SUB-ICB	39/42	▼		Month	202303	37	515	0
S013a	Diagnostic activity levels: Imaging	Provider	1/42	▼		Month	202303	138.8%	105.7%	120.0%
S013a	Diagnostic activity levels: Imaging	SUB-ICB	7/42	▼		Month	202303	115.2%	106.5%	120.0%
S013b	Diagnostic activity levels: Physiological measurement	Provider	13/42	▼		Month	202303	114.4%	103.8%	120.0%
S013b	Diagnostic activity levels: Physiological measurement	SUB-ICB	36/42	▼		Month	202303	85.9%	104.0%	120.0%
S013c	Diagnostic activity levels: endoscopy	Provider	3/42	▼		Month	202303	150.4%	94.0%	120.0%
S013c	Diagnostic activity levels: endoscopy	SUB-ICB	11/42	▼		Month	202303	108.0%	92.6%	120.0%
S013d	Diagnostic activity levels: Total	Provider	1/42	▼		Month	202303	137.5%	104.7%	120.0%
S013d	Diagnostic activity levels: Total	SUB-ICB	7/42	▼		Month	202303	112.1%	105.2%	120.0%
	Learning disabilities and autism									
S029a	Inpatients with a learning disability and/or autism per million head of population	ICB	33/42	▼		Quarter	22/Z3 Q4	49	42	30
S080a	Proportion of people aged 14 and over with a learning disability on the GP register receiving and annual health check	ICB	15/42	▲		Quarter	22/Z3 Q3	49.4%	47.9%	100.0%
	Maternity and children's health									
S022a	Stillbirths per 1,000 total births	ICB	37/42	▲		Annual	2020	3.9	3.3	
S104a	Neonatal deaths per 1,000 total births	ICB	12/42	▲		Annual	2020	1.26	1.50	
	Mental health services									
S081a	Number of people accessing IAPT services as a % of trajectory	ICB	9/42			Month	202212	80.2%		100.0%
S084a	Number of children and young people accessing mental health services as a % of trajectory	ICB	10/42	▲	▲	Month	202302	108.8%		100.0%
S085a	Number of people with severe mental illness receiving a full annual physical health check and follow up interventions as a % of trajectory	ICB	15/42			Month	202303	99.1%	99.3%	100.0%
S086a	Inappropriate adult acute mental health placement out of area placement bed days	ICB	42/42	▲	▲	Month	Dec 22 - Feb 23	4,695		0
S110a	Number of adults and older adults with severe mental illness accessing community mental health services as a % of trajectory	ICB	13/42	▲		Month	202302	95.0%		100.0%
S125a	Adult Acute LOS over 60 days as a % of total discharges	MH Provider	16/35	▲	▲	Month	202302	24.2%	22.5%	
S125b	Older Adult Acute LOS over 90 days as a % of total discharges	MH Provider	30/35	▲		Month	202302	54.5%	38.4%	
	Outpatient transformation									
S101a	Outpatient follow up activity levels compared with 2019/20 baseline	ICB	20/42	▼		Month	202303	108.7%		75.0%
	Personalised care									
S081a	Rate of personalised care interventions	ICB	40/42	▲	▲	Quarter	22 Z3 Q4	61.90	115.14	
S082a	Personal health budgets	ICB	20/42	▲		Quarter	22 Z3 Q3	2.10	2.33	
	Primary care and community services									
S001a	Number of general practice appointments per 10,000 weighted patients	ICB	40/42	▼		Month	202302	3,887	4,432	
S106a	Available virtual ward capacity per 100k head of population	ICB	21/42			Month	202303	15.3	16.3	40.0
S107a	Proportion of urgent community response referrals reached within 2 hours	ICB	10/42	▲		Month	202302	89.8%	81.3%	70.0%
S108a	Number of completed referrals to community pharmacist consultation service from NHS 111 per 100,000 population	ICB	16/42	▼		Month	202302	70.9	86.3	
S108b	Number of completed referrals to community pharmacist consultation service from NHS 111 per 100,000 population	ICB	4/42	▼		Month	202302	120.5	88	
S109a	Units of dental activity delivered as a proportion of all units of dental activity contracted	ICB	7/42	▲	▲	Month	202303	116.4%	101.3%	100.0%
	Safe, high quality care									
S087a	Percentage of patients describing their overall experience of making a GP appointment as good	ICB	26/42	▼		Annual	2022	55.3%	56.2%	
S040a	Methicillin-resistant staphylococcus aureus (MRSA) bacteraemia infection rate	Provider	42/42	▲		Month	202303	32	295	0
S040a	Methicillin-resistant staphylococcus aureus (MRSA) bacteraemia infection rate	SUB-ICB	42/42	▲		Month	202303	57	787	0
S041a	Clostridium difficile infection rate	Provider	33/42	▼		Month	202303	135%	121.4%	100%
S041a	Clostridium difficile infection rate	SUB-ICB	28/42			Month	202303	118%	113%	100%
S042a	E.coli bloodstream infection rate	Provider	40/42	▲		Month	202303	132.9%	111.4%	100%
S042a	E.coli bloodstream infection rate	SUB-ICB	39/42	▲	▲	Month	202303	129.6%	108%	100%
S044a	Antimicrobial resistance: total prescribing of antibiotics in primary care	SUB-ICB	38/42	▲	▲	Month	Mar 22 - Feb 23	100.3%	97.2%	87.1%
S044b	Antimicrobial resistance: proportion of broad spectrum antibiotic prescribing in primary care	SUB-ICB	12/42	▼	▼	Month	Mar 22 - Feb 23	7.44%	7.81%	10%
S121a	NHS staff survey compassionate culture people promise element sub-score (out of 10)	ICB	32/42	▼		Annual	2022	6.84	6.98	
S121b	NHS staff survey raising concerns people promise element sub-score (out of 10)	ICB	28/42	▼		Annual	2022	6.40	6.43	
	Urgent and emergency care									
S123a	Adult and general acute type 1 bed occupancy (adjusted for void beds)	Provider	6/42	▲		Month	202303	93.1%	95.8%	
S124a	Percentage of beds occupied by patients who no longer meet the criteria to reside	Provider	27/42	▲		Month	202303	16.9%	14.7%	

	Highest Performing Quartile
	Interquartile Range
	Lowest Performing Quartile

NHS GM Safeguarding

NHS Greater Manchester (GM) has continued to discharge our statutory safeguarding duties throughout 2022/23 in relation to safeguarding babies, children, young people and adults at risk.

The NHS GM Chief Nurse holds the statutory accountability for safeguarding and is supported by the Deputy Chief Nurse and Associate Director of Safeguarding. Statutory safeguarding responsibilities are delegated to the Associate Director of Quality and Safety in each of the GM localities and delivery of the statutory functions are undertaken by the locality Designated Teams. The statutory safeguarding accountabilities transferred from Clinical Commissioning Groups (CCG's) to NHS GM on 01 July 2022.

NHS GM is able to demonstrate that there are appropriate safeguarding governance systems in place for discharging their statutory safeguarding duties and functions in line with the following key legislation:

- Care Act 2014
- Children Act 1989 and 2004
- Children and Social Work Act 2017
- Working together to Safeguard Children 2018

The NHSE Safeguarding and Accountability and Assurance Framework (SAAF 2022) provides the strategic framework for ensuring strategic system oversight of safeguarding priorities. Assurance and oversight of these duties is maintained via the NHS GM.

Governance

The organisational change has provided the opportunity to review and develop safeguarding governance to support a model of integrated GM safeguarding system oversight, reducing duplication, promoting effectiveness, and demonstrating improved outcomes at scale. Safeguarding remains within the overarching NHS GM quality governance structure. The NHS GM safeguarding governance structure supports an integrated model for the delivery of the safeguarding functions with the opportunity for continuing system change.

Safeguarding Delivery Functions

The delivery of statutory safeguarding functions is undertaken via an integrated system wide safeguarding model aligned to the statutory functions and priority work areas within the SAAF (2022). This promotes the opportunity for transformation across the ICS footprint providing more effective system oversight and assurance, supporting effective working, and delivering evidence of system impact with improved outcomes for the population. National, regional and local reviews and independent inquiry recommendations are incorporated within the safeguarding delivery plan and form part of our system assurance.

Engagement and Co-Production

NHS GM and wider system partners have engaged with the VCSE and Youth Focus North West to embed a consistent approach to all partnership work which will ensure that the child's voice remains the central focus of future work and the formation of the ICB Children's Voice Strategy.

Safeguarding assurance

NHS GM has a statutory responsibility for ensuring safe systems of care are delivered and to ensure that all health providers with whom they commission, discharge their functions regarding safeguarding and the promotion of welfare of children, young people and adults at risk. Effective safeguarding arrangements are in place to ensure oversight of provider safeguarding assurance via the annual Greater Manchester Safeguarding Children, Young People and Adults at Risk – Contractual Standards which provide the safeguarding audit framework used to monitor all NHS and Non-NHS providers of health care. The statutory assurance processes set out in the SAAF (2022) have been adhered too.

NHS GM Safeguarding Annual report 2022/23

The ICB Safeguarding annual report 2022/23 is currently in production and is due to progress through our internal governance structures in July 2023. The report will provide the ICB with evidence to demonstrate that the organisation has undertaken and fulfils the statutory safeguarding requirements.

Safeguarding partnerships and Boards

NHS GM has maintained the CCG statutory duties across the GM Safeguarding Children Partnerships as one of the equal and joint statutory partners (Local Authority, ICBs and Chief Officer of police) and as a statutory partner for the GM Adult Safeguarding Boards. The following locality area annual reports set out how NHS GM will work together with other agencies to safeguard and promote the welfare of children and adults in GM:

GM Safeguarding Boards annual reports – (most recent reports available at the time of writing this report)			
LOCALITY	**ADULT/CHILDREN/ JOINT**	**LINK TO REPORT**	**YEAR OF REPORT**
Bolton	Adults	https://www.bolton.gov.uk/downloads/file/4742/bolton-safeguarding-adults-board-annual-report-2022-final	2021-2022
	Children	KEEPING CHILDREN SAFE IN BOLTON Annual Report 2021/2022 (boltonsafeguardingchildren.org.uk)	2021-2022
Bury	Joint	https://burysafeguardingpartnership.bury.gov.uk/CHttpHandler.ashx?id=24170&p=0	2021-2022
HMR	Joint	annual_report_2021_22_v3.pdf (rochdalesafeguarding.com)	2021-2022
Manchester	Joint	Website under review – Annual Report 2021-22 (combined children and adults) completed and will be published here: MSP Annual Report 2020-21 : Manchester Safeguarding Boards (manchestersafeguardingpartnership.co.uk)	2021-2022
Oldham	Adult	Oldham-Safeguarding-Adults-Board-Annual-Report-2021-22.pdf (osab.org.uk)	2021-2022
	children	OSCP-annual-report-2021-22-final-.pdf	2021-2022
Salford	Adults	SSAB Annual Report 2021-24 (salford.gov.uk)	2021-2022
	Children	sscp-annual-report-2021-22-final-accessible-version.pdf (salford.gov.uk)	2021-2022
Stockport	Adults	PowerPoint Presentation (stockport.gov.uk)	2021-2022
	Children	http://www.safeguardingchildreninstockport.org.uk/about-us/	2021-2022
Tameside	Adult	https://www.tameside.gov.uk/TamesideMBC/media/adultservices/TASPB-Annual-Report-2021-22.pdf	2021-2022
	Children	TSCP-Annual-Report.pdf (tameside.gov.uk)	2021-2022
Trafford	Adult	https://www.tameside.gov.uk/TamesideMBC/media/adultservices/TASPB-Annual-Report-2021-22.pdf	2021-2022
	Children	https://www.traffordsafeguardingpartnership.org.uk/Docs/About-us/TSSP-Safeguarding-Children-Annual-Report-2021-22-v2.pdf	2021-2022
Wigan	Adult	WSAB Annual Report 2021-22 (wigansafeguardingadults.org)	2021-2022
	Children	https://www.wiganlscb.com/Docs/PDF/Professional/Annual-reports/Annual-WSCP-Report.pdf	2021-2022

Statutory Safeguarding Reviews

Safeguarding reviews are coordinated via effective statutory safeguarding partnerships and boards across GM as outlined in the links to the annual reports provided. NHS GM coordinates our statutory reviews, learning and dissemination via the safeguarding delivery group model which also supports and enhances system delivery and development.

Safeguarding System and Partnership Work

In addition to the work via the Safeguard Partnerships and Boards the ICB continues to engage with wider system partners regarding the safeguarding agenda. This is demonstrated via our NHS GM safeguarding and wider governance structures including our system boards and transformation workstreams. Integrated system safeguarding transformational workshops are planned during Q2 2023-24 to inform and agree our system priorities, principles and strategy moving froward.

Environmental matters

The inaugural Green Plan for NHS GM was endorsed in May 2022 by the NHS GM Shadow Joint Planning and Delivery Committee. The Green Plan sets out two targets.

- A Net Zero Carbon Footprint by 2038 (areas we control)
- Net Zero Carbon Footprint Plus by 2045 (areas we influence)

The focus areas included within the plan are workforce, networks and system leadership, sustainable models of care, digital transformation, travel, transport and air quality, estates and facilities, medicines, supply chain and procurement, food and nutrition, climate change adaptation, green space and biodiversity, and social value and anchors.

There has been a small interim team in place since July 2022 to lead and co-ordinate the work plan, and a full team is expected to be in place during 2023/24.

A GM Net Zero Delivery Board has been established, chaired by the Net Zero Board Lead (Deputy Chief Executive and Chief Officer for Population Health and Inequalities). The Board comprises of Senior Sponsors for the named areas of focus within the Green Plan, and meets quarterly to review progress, key risks and issues, whilst ensuring that net zero principles are strategically embedded across all aspects of the ICS's services. Several thematic working groups attended by operational leads feed into the Board.

Due to lack of availability of verified system level performance data, it is not yet possible to compare carbon footprint between 2021/22 and 2022/23, however there was an increase in the carbon footprint of 7.6% between the two preceding financial years, with a 34% increase in patient contacts. A performance dashboard to support monitoring of the Green Plan implementation is in development and will be released during 2023/24, to enable closer monitoring.

Performance highlights

- **Workforce, Networks and System Leadership -** Staff benefits linked to the Green Plan were established for NHS GM including a cycle to work scheme and a staff salary sacrifice car leasing scheme restricted to low and ultra-low emitting vehicles. Funding was secured for 70 training places with the Centre for Sustainable Healthcare, building capacity within the system. NHSE Social Value training has been rolled out across procurement teams. Close partnerships have been established with the GMCA to collaborate on shared priorities.

- **Medicines** - A communications and education campaign was launched in 2022 to encourage switching of asthma inhalers to lower emission alternatives. There has been a 2% improvement in the prescribing of lower emission inhalers between 2021/22 and 2022/23. The use of desflurane, a volatile anaesthetic gas with a high global warming potential, reduced from a high of 19% of all volatile anaesthetics in January 2022 to 1.3% in January 2023 (against the national target of 5%) following ongoing work to prioritise lower carbon alternatives. Significant focus has also been put on reducing emissions from nitrous oxide with the expected drop in emissions to occur during 23/24.
- **Supply chain and procurement** – A sustainable procurement working group leads on this area of work. As of March 2023, 98% of all white paper has recycled content and walking aid return schemes were set up both at trust level and at Greater Manchester's Household Waste Recycling Centres, in partnership with Suez.
- **Digital transformation –** As a result of the COVID-19 pandemic, there was a shift towards virtual healthcare delivery and remote or hybrid working. Hybrid working has been fully adopted by the ICB. Virtual healthcare delivery has also continued where clinically appropriate due to the benefits of saving time and transport costs for patients, in addition to the environmental benefits of reducing air pollution from transport. 2022/23 saw a drop in virtual appointments compared to 2021/22 as NHS services recovered from the COVID-19 pandemic, with 9.1% of trust out-patient appointments and 30.0% of general practice appointments being virtual, compared to 2021/22 where 11.1% of trust outpatient appointments and 37.9% of general practice appointments were virtual.
- **Travel, transport and air quality –** Travel surveys have been developed for both general practice and trusts and will be undertaken during 23/24. Trust fleets are now comprised of 61% low and zero emitting vehicles, an increase of 1% on the previous financial year. Strong partnership working with Transport for Greater Manchester (TfGM) has continued. Fully electric HGVs have been trialled at Northern Care Alliance and two trusts have e-bike hire schemes in place. We have also been participating in the NHSE 'Step up a Gear' programme, a network to accelerate modal shift.
- **Estates and facilities –** An assessment of the position of trusts in relation to estates decarbonisation has been undertaken, with the final report due early in 2023/24. Work has also been undertaken to look at financing options for large scale decarbonisation schemes.
- **Climate Change Adaptation –** Several of the GM trusts and NHS GM have been taking part in a climate change adaptation pilot, attending training sessions and workshops and trialling a risk assessment tool developed by NHSE. It is expected that adaptation plans will be developed and published during 23/24.

Improve quality

NHS GM ICB has discharged its duties to improve quality of services through the establishment of the Quality and Safety Function. A core quality team provides a pan-GM approach to improving quality of services, working with locality specific quality leads to ensure that local focus and demographic variation is central to ensuring the needs of the GM population are met. A GM-wide System Quality Group is an established part of the quality infrastructure and brings together

system wide intelligence across health and social care to gain a collective understanding of quality assurance and improvement. Moving to a GM systemwide approach to quality assurance and contract monitoring enables a more streamlined and collaborative working relationship with provider organisations. This allows less duplication and more focus on care delivery. Specific program boards such as Elective and Urgent & Emergency Care support the continuous improvement of quality and link closely with the Clinical Effectiveness Group that has been established and is chaired by the NHS GM Chief Medical Officer. Locality quality groups focusing on a system approach specific to that area, promoting full system working including VCSE groups, are central to the quality and safety approach to reduce inequality and provide both targeted and wider scale quality improvement across health and care.

The ICB have established a Quality and Performance Committee which oversees the delivery of the quality, safety & performance agenda and we have worked with region to develop a new Quality Assurance process which has been approved and is in the process of being embedded. The ICB Quality strategy is in its final stages of development and has had wide consultation across the ICB. The strategy and assurance framework are also supported by the emerging GM Quality Impact Assessment framework to ensure a clearly evidenced and robust framework for decision making which ensures that the impact on individuals and the outcomes for people in GM are central to all decision making.

There are robust reporting mechanisms in place with the GM system quality group reporting into the Quality & Performance Committee and subsequent onward reporting to the Regional System Quality Group. This provides the necessary oversight and escalation pathways to the NHSE Regional Team and enables closer working with neighbouring ICBs.

The frameworks and approach described enables the ICB to respond proportionately and in a timely manner and this has been put into practice over the last 3 months as we work with NHS England and our colleagues across our provider organisations where quality improvement plans have been put in place.

Engaging people and communities

In the first months of operation, NHS GM has continued to build on the strong legacy of ongoing engagement with local people and communities by the ten former Clinical Commissioning Groups and Greater Manchester Health and Social Care Partnership (GMHSCP).

We are fortunate in GM to have a wealth of assets to tap into to help support the delivery of engagement with our people and communities in relation to health and care. As well as the NHS GM engagement team, the Integrated Care Partnership (ICP) is fortunate in being able to tap into the engagement skills, resources and networks of GM’s VCSE sector, the ten GM local authorities, the GM Healthwatch organisations and the other providers of health and care services within the region. Between us all our ability to reach people both directly and indirectly is vast.

Why we engage

Ultimately, NHS GM has a statutory responsibility to involve the public in its work. However, the prime reason we want to involve residents in our work is the weight of evidence shows that meaningful engagement with local people - such as capturing their lived experiences, gathering and views, needs and issues will allow NHS GM to make better and more informed decisions.

NHS GM is mindful our delivery model must include ways of engaging with both those who are known and actively engaged with the health and care system; as well as those who are not routinely engaging with the health and care system. If we have a stronger understanding of those in the latter group it is likely that we will make greater progress in realising the underlying reasons for health inequality and devise more effective approaches to addressing them.

In short, we put our population's needs at the heart of all that we do because it's both the right thing to do, but also essential to achieving our objectives.

Interim People and Communities Engagement Framework

Prior to becoming a statutory body in July 2022, NHS GM was required to put together a People and Communities Engagement Framework. The decision was made by the organisation to create this document on behalf of the wider GM ICP, setting out an initial strategic approach to public engagement and involvement across our whole system. The aim of this document was to provide a blueprint for collaborative working across the partnership to ensure that how we involve people, how we respond to their views and experiences, and how we identify and share the impact of engagement activities are aligned.

The ambitions as set out in the interim framework were that we will -

- build trust
- listen
- build on what already exists
- deliver engagement at the most appropriate location
- use the most appropriate methodology
- prioritise those who need us most
- empower people and communities
- embed the value of engagement throughout everything we do
- seek to continually learn and grow
- use a strength (asset) based approach

However, NHS GM was clear that the interim framework we submitted to NHSE in May 2022 was purely regarded as an early-draft starting point for day one purposes. Partners across the system felt that more time was needed to flesh out the detail of our delivery model. The COVID-19 pandemic demonstrated the value of recognising the unique selling points of each of the ICP partners' engagement reach and working more efficiently to play to each other's strong points and reduce duplication of efforts. A great deal of focus over this first year has been on working with our ICP engagement partners to really map out each other's strengths and begin to

develop a delivery model which will ensure we can reach both the visible and less visible residents of GM with our engagement efforts.

Likewise, we recognised that it was crucial that our final framework reflected the content, aims and ambitions of the over-arching NHS GM Integrated Care Strategy, which at that point had not been published.

Healthwatch Partnership Agreement

Complementing this partnership engagement delivery modelling work, NHS GM has also formed a new Partnership Agreement with the ten Healthwatch organisations operating within our region to help us gain insight and share information about residents' needs and experiences of care. The Agreement also enables the recruitment of a Chief Co-ordinating Officer who will act as the single point of contact between the ten GM Healthwatch organisations and then link directly with the GM ICP on their behalf, providing us with a single point of contact. This effective working relationship between the ICP and Healthwatch will help the organisation to better understand the lived experiences of those receiving healthcare, be more responsive to patient's expectations and views, and add to the evidence base supporting future strategies and programmes.

Our resource

During this reporting period, the engagement staff employed by NHS GM have been in a period of organisational transition and change. Their base and focus have continued to be within the locality of the CCG that they were previously employed into, but each member of staff has also been expected to commit a portion of their working week to contribute to working on pan-GM engagement projects.

A significant amount of effort over recent months has been spent on working up a transformational, sustainable long term staffing structure which will ensure the organisation has ability to discharge its engagement duties effectively.

Engagement delivery

NHS GM delivers engagement at three different spatial levels; 1) neighbourhood, 2) place, 3) system.

Neighbourhood level engagement

Since July 2022, the NHS GM engagement team has played a key role in advising and supporting ICP partners on best practice engagement approaches for neighbourhood level activity. However, the delivery of the majority of neighbourhood engagement activity has typically been led by Primary Care Networks, locality public health teams and locality VCSE infrastructure organisations.

Place level engagement

The NHS GM engagement team have run numerous involvement projects with the public at locality level over the last financial year. A small selection of highlights include;

Trafford's Urgent Care Review

The Trafford Locality team of NHS GM has worked with their locality partners to undertake the first phase of their review of their urgent care.

This initially began with a desk-based needs assessment in partnership with Public Health and wider system colleagues to understand more about the needs of the population within the locality. The review considered services available across Trafford and experiences of urgent care, previous insight and utilisation of existing services.

A series of engagement activities were undertaken in January and February 2023 to capture the experiences and perceptions of people and communities across Trafford. This included an online survey which was hosted on NHS GM website and link promoted with partners to gain ultimate reach in communities. People were able to contact NHS GM by phone or email if they had queries about the survey or to request a printed version.

Eleven listening sessions were also held with established community groups in varying locations across Trafford, particularly targeting those areas or groups that analysis had shown may be disadvantaged in some way. Six public drop-in sessions at libraries within different neighbourhoods were also held to ensure a wide range of views and input from Trafford communities was collected.

The resulting report and the Trafford Urgent Care Review Insight Findings report by Healthwatch Trafford is currently being considered by those shaping the next phase of the review and feedback will be shared with local residents, especially those who were able to participate when it is available.

Tameside's Patient Engagement Network

The Tameside and Glossop Partnership Engagement Network (PEN) is a multi-agency approach between the NHS in Tameside and Tameside Metropolitan Borough Council to engagement. PEN provides the public and partners with a structured method to influence public services, and to proactively feed in issues and ideas.

On 28th June 2022, a PEN 'Let's Reconnect' event was held at Hyde Town Hall. It was PEN's first face-to-face event in over two years. It was a celebratory event featuring five "You Said, We Did" presentations, which illustrated how feedback from members influenced services and programmes.

Running alongside the presentations was a marketplace event with stalls featuring various statutory services and voluntary/community sector organisations, this was organised on request from PEN members themselves.

On 15 February 2023, a virtual PEN conference was held in the evening. There were two facilitated sessions, Greater Manchester's Elective Care Services, and Tameside Council's Engagement Strategy.

Wigan's children and young people's SEND project

As a result of the high levels of complaints and the informal sharing of lived experience from patients, parents caters and guardians it was recognised by the NHS GM Wigan Locality Team that there was a need for a targeted piece of formal engagement work looking into SEND services for children and young people in Wigan.

Engagement officers working in the Wigan locality team responded by creating a Typeform survey which incorporates bespoke questions designed for children and young people, parents, carers, guardians, and professionals into one platform. The children's questions are also accompanied by a video which reads the questions.

In addition to launching this innovative survey the Wigan team have set up a SEND stakeholders group and involved multiple partners including the local VCSE sector groups who it is recognised are best placed to engage their local SEND cohort.

The survey opened on 17th March 2023 and will run for 6 months. The findings will be reviewed monthly to allow the refinement of approach and to further target demographics. After the survey closes a report will be produced and shared via all partners with a view to creating a local action plan to improve health and care services for SEND. This will also be aligned to future surveys planned by the Wigan Borough Council.

Manchester and Trafford's engagement work on Long Covid

VCSE organisations in Manchester and Trafford were funded to raise awareness of Long Covid and develop peer support groups in a culturally appropriate way. The development work was aimed at the following communities facing racial inequalities and inequity - Black African and Black Caribbean, Pakistani, Bangladeshi and Disabled People.

The aim of the project was to:

Raise awareness of Long Covid – what is it, what are the symptoms and what actions people can take

Develop and deliver targeted engagement

Develop face to face peer support groups in neighbourhoods

Provide feedback from conversations with targeted communities to help us understand what is working well and what needs to be improved.

Salford Citizen Panel

Salford Locality team's Citizen Panel is made up of over 2,400 people who live and work in Salford. Members are regularly provided with information about health, care and wellbeing and are regularly involved in decision making via surveys, focus groups and invited to attend twice yearly events.

In March 2023, over 100 citizens came to an event at the Lighthouse Church, Eccles to hear more about NHS GM and the Integrated Care Partnership in Salford. Members were also able to hear the results of the Big Conversation in Salford and ask a panel of experts how they had responded to findings. Salford Care Organisation were also in attendance to update panel members on actions around patient experience and to involve members in developing their patient experience strategy.

Complaints

NHS GM has robust processes in place for complaints management. Upon establishment of the ICB, complaints were managed through two routes:

- Locality based complaints teams made up of experienced locality-based complaints staff manage complaints, informal enquiries (PALS) and MP letters. Robust policies and processes are in place with all complaints recorded and managed in line with the NHS complaints regulations. Outcomes, lessons learnt, and service improvements are reported and manged through locality governance.
- The NHSE Customer Contact Centre (CCC) and GM based complaints team receive and manage primary care complaints and MP letters. Complaints are made through the NHS Customer Contact Centre where they are triaged with general enquiries resolved by the CCC and complaints referred for investigation by the complaints team embedded in GM. Outcomes, lessons learnt, and service improvements are reported and managed through the NHS GM Nursing Directorate and through to NHSE.

NHS GM has a long-established Complaints Leads network bringing together locality and primary care teams. The network meets regularly to share information, expertise and ensures wherever possible a consistency of approach across GM and shared learning.

The future model for NHS GM is one Patient Services team for the ICB. This team will manage informal enquiries (PALS), complaints and MP letters for the ICB bringing together locality and primary care teams and functions. The team will have one front door for patients to contact NHS GM and will operate under one policy and process. Complaints outcomes will be reported through the Quality and Performance Committee.

System level engagement

The most significant piece of pan-GM engagement this year has been our GM ICP's Big Conversation on health and care. The aim of the Big Conversation was to inform the new GM ICP strategy which was under development.

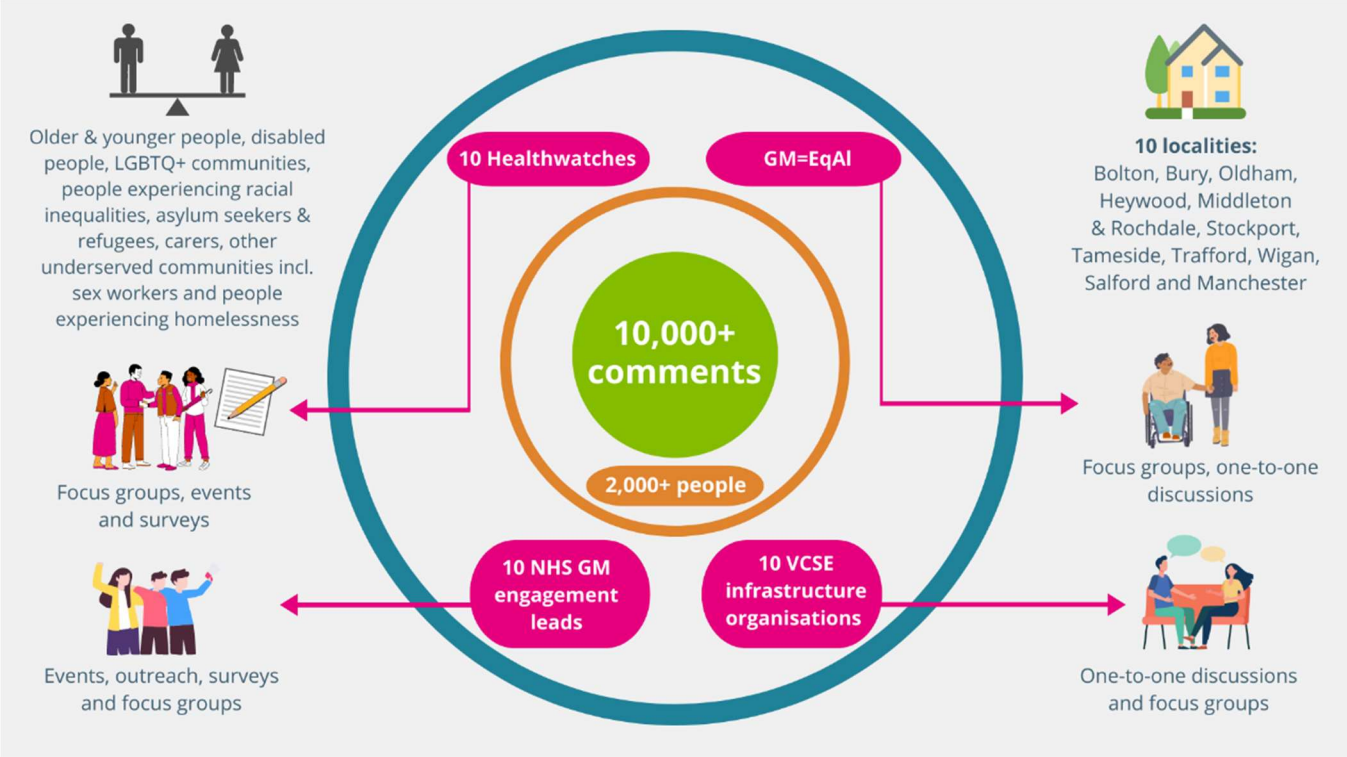
The Big Conversation rolled out in two phases. Phase one ran between March and May 2022 with the aim of consulting on the proposed vision and aims that had been suggested by the ICP leaders following a stakeholder engagement event they took part in. 1332 people gave their views and consensus was the majority of respondents agreed with the proposed aims and visions.

Phase two ran in October 2022 with the aim of ensuring the GM ICP had the insight it needed to be able to understand what matters most to communities across all ten localities - to help shape the priorities and actions for the strategy.

A 'Big Collaborative Event' took place in September to coproduce the approach to phase 2 and to establish the key lines of enquiry. These were agreed as:

1. What would make the biggest difference to your life (or the communities you service) in relation to being healthier, happier and better?
2. What's stopping this?
3. What would help this?
4. What's the most important thing health and care services need to improve?

The engagement to ask these key lines of enquiry took place in October 2022. The conversations were predominantly led by the VCSE sector (including Healthwatch, GM Equality Alliance and local infrastructure organisations) and were complimented by events and activity led by the NHS GM engagement team.



This Big Conversation approach enabled us to reach deep into communities and involve those who were typically less likely to take part in surveys or provide their views in traditional ways. We reached over 2000 people and collected over 10,000 comments.

Five main themes were identified as priorities from the engagement:

1. Better access to the NHS including GP appointments and hospital waiting lists.
2. Properly funded and resourced services.
3. Healthier lifestyles.
4. Action on the cost of living and other determinants of health.
5. Equal opportunities to be listened to and understood.

These priorities are reflected in our 5-year Strategic Plan and each place has received a locality report to help prioritise local actions within their delivery plans.

All the reports including easy read can be found at Big Conversation | Greater Manchester Integrated Care Partnership (gmintegratedcare.org.uk)

Governance and Assurance

Work has taken place this year to establish a robust governance approach for engagement, ensuring we have adequate and appropriate mechanisms in place to be able to hold ourselves and our partners to account effectively against our statutory duties.

In March 2023 the NHS GM Executive Team approved the proposal to nominate a member of the ICP board to become the board sponsor for engagement and to form an Engagement and Inclusion Assurance Group. This group will meet bi-monthly and be independently chaired and made up of engagement and inclusion professionals and representatives from across the ICP. The terms of reference for this group are currently under development.

Reducing health inequality

NHS GM with a concerted approach implemented through the NHS and wider policies to address the socio-economic causes of poor health, is already demonstrating that we can make a difference. Building on strong foundations for population health driven by our devolved arrangements we have for example demonstrated reductions in smoking prevalence a key driver of inequalities, physical inactivity, and oral health.

- Smoking at Time of Delivery is now 9.0% in GM, which is down by a quarter from 12.6% in 2018 when our Smoke Free Pregnancy Programme implementation commenced. Through this work we have closed the gap with England and ensured 3,500 more of our children have the best start in life

- The number of people completing the recommended amount of physical activity **in Greater Manchester has risen by 2.2% in the last 12 months** according to the latest Sport England data, equivalent to over 63,500 more adults with GM showing signs of a faster recovery from pandemic levels and thus starting to close the gap with England

- Smoking prevalence has continued to decline in GM with nearly 80,000 fewer smokers since inception of the Making Smoking History programme

We have continued to build on our preventative efforts with additional investment in areas such as: developing new pathways for domestic abuse and sexual violence support within sexual health and primary care settings; and implementing opt out testing for HIV and Hep C in three of our A&E Departments. Both programmes are also delivering significant improvements in access for priority inclusion groups and delivering improved health outcomes.

The ICB also approved proposals to develop a Fairer Heath for All Framework for NHS GM which outlines our priorities for coordinated action to reduce inequalities across the life course through a set of shared principles, enablers and themed priority areas that will shape the way we work, supported by a set of tools and resources to ensure that health equity and equality and sustainability are embedded systematically at the heart of NHS GM decision making, system leadership and governance. Work is underway with planned launches for a Fairer Health for All Academy and a GM health and Care Intelligence hub during 2023/24.

NHS GM has also been working with clinicians, VCSE and wider partners to deliver against the national requirements re CORE20PLUS5 (the national NHS England approach to inform action to reduce healthcare inequalities at both national and system level) for adults and children and aligning this to the One Public Service model and the strengths of integrated neighbourhood working. Integrated planning and delivery of health and care at all system levels, enabled through GM policy and partnership agreements including the Housing Tripartite agreement and VCSE Accord, is enabling public sector and VCSE partnerships to co-design and co-deliver upstream models of care that considers the wider context of people's lives and aligns clinical screening, diagnosis and treatment interventions alongside wider welfare and well-being support. Progress has been made across a number of areas including approval of a comprehensive CVD prevention plan and extensive work re children's asthma including Asthma Friendly Schools pilot and Asthma Peer Support programme increasing awareness, addressing stigma and helping children to manage their condition more effectively.

In additon our NHS GM system boards are begining to build in health inequalities elements to their plans and pathway redesign work, with progress being made re Cancer , Elective Care and Maternity in particular .

In relation to NHS GM's specific duties regarding equality and incluson

NHS GM ICB is discharging its duties to advance equality and promote inclusion through the establishment of the Strategic Equality and Inclusion function.

Following significant consultation and engagement with communities, employees and system partners, Greater Manchester Integrated Care Board has set out and agreed our high-level ambitions for addressing inequalities and advancing equality including our first four-year Equality Objectives, published in March 2023.

This year the priority has been establishing common baselines across our system from which we can measure progress in our focused areas of tackling workforce disparities, enhancing community involvement and inclusion health service improvement.

We have approved and are advancing our Women's Health Strategy, co-led between the VCSE sector and the Chief Medical Officer, are adopting the NW BAME Assembly's anti-racism framework, delivering a health equity education programme and harmonising an equality

impact assessment process across relevant governance systems. We are also establishing proportionate governance structures through an Equalities Council drawn from senior stakeholders across the system to better enable the right pace, depth and quality of interventions to advance equality systemically.

Health and wellbeing strategy

Our ten localities in Greater Manchester - Bolton, Bury, Manchester, Oldham, Rochdale, Salford, Stockport, Tameside, Trafford and Wigan - all have local authority plans (or strategies), locality plans for health and care and Health and Wellbeing plans. The Joint Strategic Needs Assessments (JSNAs) in each locality have specifically informed the Health and Wellbeing plans, as well as the other plans.

The Health and Wellbeing plans for each locality informed the development of the ICP strategy (approved in March 2023) and we have listed each plan within the strategy itself. The strategy was reviewed and commented on by Locality Boards and Health and Wellbeing Boards. The Joint Forward Plan (the delivery plan for the strategy) will be reviewed by each Health and Wellbeing Board ahead of its publication at the end of June 2023.

Financial review

The implementation of the Health and Care Act 2022 meant that NHS Greater Manchester ICB was formed on 01 July 2022, with all services and functions transferring from:

- the 10 former Greater Manchester Clinical Commissioning Groups (excluding commissioning responsibility for Glossop residents which transferred to Derby and Derbyshire ICB)
- Greater Manchester Shared Services (previously hosted by Northern Care Alliance Foundation Trust)
- GM Health and Social Care Partnership (previously hosted by Manchester CCG)

The new organisation also took on responsibility for pharmacy, dental and optometry services, under delegation from NHS England.

Please note that all the below information relates to the period 01 July 2022 to 31 March 2023, being the “financial year” for the new organisation.

Delivery of Financial Duties

The table below demonstrates that NHS Greater Manchester delivered all its statutory financial duties during the period July 2022 – March 2023.

	Duty	Target (£k)	Actual (£k)	Variance (£k)	Duty Met?
Expenditure not to exceed Revenue Resource Limit*	Statutory	5,137,655	5,137,653	(2)	Y
Expenditure not to exceed income	Statutory	5,231,377	5,231,375	(2)	Y
Expenditure not to exceed Capital Resource Limit	Statutory	355	355	0	Y
To remain within its Cash Limit	Admin	5,084,749	5,084,749	0	Y
To remain within the running cost target	Admin	48,885	48,713	(172)	Y

* This excludes historic surplus

Expenditure not to exceed revenue resource limit

Limits are set by NHS England for integrated care boards, within which they must contain net expenditure for the year. These are termed “resource limits” and there are separate limits issued for revenue and capital.

NHS GM’s in year revenue resource limit for Q2 – Q4 2022/23 was £5,137m. Against this, costs amounted to £5,137m and therefore the organisation has delivered a breakeven financial position in line with national policy and the submitted financial plan.

Expenditure not to exceed capital resource limit

NHS GM had a capital resource in 2022/23 of £0.3m, with matching expenditure. This funding related to the impact of adoption of IFRS 16 Leases across NHS GM’s headquarter estate.

To remain within cash limit

All ICBs are set a limit on the amount of cash they can spend in a financial year. The 2022/23 cash limit for NHS GM was £5,084m and the organisation fully drew down this cash from the government. From the total cash drawn down, there was £133k left as a balance in the bank at 31 March 2023 after the last payment run, which was within the 1.25% allowable limit (£6.2m).

To remain within the running costs target

The ICB receives an allocation for running costs or administrative expenditure. The target limits the amount the organisation can spend on administrative functions, such as support functions, headquarters, training. The total running cost allocation for NHS GM for 2022/23 was £48.9m. During the period, the organisation spent £48.7m on administrative expenditure, generating a small underspend against the allocation which was used on delivery of healthcare services.

Better Payment Practice Code

In addition to the financial duties, the ICB should comply with the national Better Payment Practice Code. The code is summarised as:

> **Target:** to pay all NHS and non-NHS trade creditors within 30 calendar days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed.
> **Compliance:** at least 95% of invoices paid (by the bank automated credit system or date and issue of cheque) within 30 days or within agreed contract terms.

The following table highlights the performance both in terms of the number and value for non-NHS and NHS invoices.

Measure of compliance	**2022/23**	**2022/23**
	Number	**£000**
Non-NHS Payables		
Total Non-NHS trade invoices paid in the year	96,210	1,179,001
Total Non-NHS Trade invoices paid within target	92,587	1,139,504
Percentage of Non-NHS trade invoices paid within target	96.23%	96.65%
NHS Payables		
Total NHS Trade invoices paid in the year	1,998	3,398,008
Total NHS Trade invoices paid within target	1,943	3,396,976
Percentage of NHS trade invoices paid within target	97.25%	99.97%

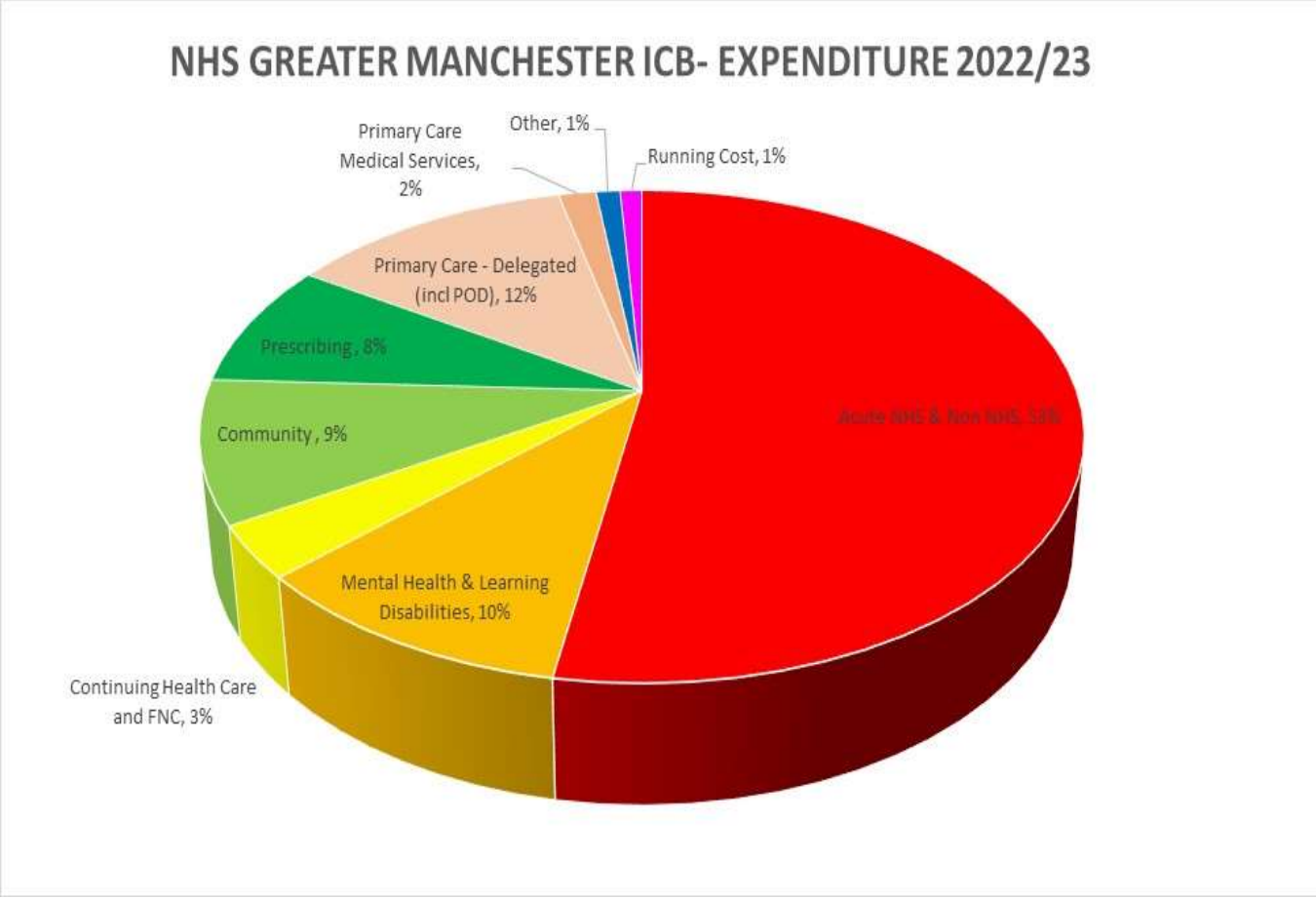
The above table shows that the performance measure has been met for both NHS and Non-NHS trade invoices.

Income

In total NHS GM received funding of £5,231m in 2022/23. The majority of this funding (£5,137m) is received directly from NHS England in the form of allocations. Other income of £93.72m has been received in the year, of which £63.4m relates to prescriptions and dental fee and charges, with the balance received from other organisations.

Expenditure

The total costs within 2022/23 are £5,231m, of which £50.1m (gross costs excluding income) relates to administrative/running costs expenditure and £5,181m to healthcare (programme) spend. The numbers quoted are gross expenditure and exclude any income.
The following chart details a breakdown of expenditure for the ICB in 2022/23.



The split of expenditure is also summarised in the table below, with the colours correlating to the chart.

	% age of Total Spend
Board Heading	
Acute NHS & Non NHS	**53%**
Mental Health & Learning Disabilities	10%
Continuing Health Care and FNC	3%
Community	9%
Prescribing	8%
Primary Care - Delegated (incl POD)	12%
Primary Care Medical Services	2%
Other	1%
Running Cost	1%
Net Expenditure Total	**100%**

Investments

The ICB has increased funding for some key services to support recovery from the pandemic and improve patient outcomes. In many cases these were based on specific additional allocations received from NHS England with specific conditions attached.

Mental health services - the ICB invested in mental health services in line with the requirements of the Mental Health Investment Standard and in line with national guidance. The main areas of spend were:

- **IAPT (Improving access to psychological therapies/talking therapies)** GM has invested in additional IAPT services so that people with anxiety and depression can access services in line with the national priorities as stated in the long-term plan target (that 25% of the population can receive services if they need them). GM has invested in additional staff for one to ones, group services and also digital/online services to meet this demand.
- **Perinatal services** GM has developed a plan to provide specialist community perinatal health services for women with moderate or severe mental health needs. This includes providing integrated maternity outreach clinics, increasing the period of specialist perinatal care to 24 months (the 1001 critical days from pregnancy to age 2), increasing the availability of evidence based psychological therapies and providing mental health assessment for partners and signposting services. It is expected that this full service will be in place by the end of the next financial year.
- **24/7 crisis helplines** This is part of a national requirement to increase access to all age crisis helplines and services and signposting, particularly in the aftermath of Covid, as the prevalence of people with anxiety and depression increased. The aim of helping those needing support when in a mental health crisis and preventing escalation. This investment aligns with the national long-term plan and the transformation of community mental health services.
- **Community mental health services** In line with government's long-term plan, GM has continued to transform and invest in community mental health teams and services with the aim to make them more resilient. The aim of such investments is to provide better access to care and support in community settings. This more timely access mean that patients can be seen quicker in the community, alongside other models like living well

schemes and within PCNs, so that their mental health condition is managed in the community rather than exacerbating and needing an inpatient stay.

- **Children and young people (CYP) -** Investment were made into the Stockport CAMHS (Child and Adolescent Mental Health Service) to expand core services to meet additional demand and to extend the service offer to children up to the age of 18 years in line with national plan. In addition, this investment also included the provision of additional parent and infant services in the Stockport locality.
- **Packages of care -** Due to additional demand and increased complexity, the GM system has experienced increased demand for mental health placements in non-NHS hospitals and residential care settings as close to home as possible.

Discharge (national funding) – Adult Discharge and Step-Down funding received to facilitate earlier discharge from hospital, particularly for those patients who were medically fit to be discharged but may have needed some support to do so. Examples of spend included purchasing additional discharge to assess beds and supporting the domiciliary care sector so more packages of care provided at home could be commissioned. Additional services were also provided within the hospital setting such as discharge lounges / additional physiotherapists and pharmacists / additional social work capacity to assess the needs of patients awaiting discharge and additional transport to aid the patient going home or to appropriate care settings.

Cancer (national funding) - Greater Manchester ICB received System Development Funding (SDF) for cancer totalling £6.883m. The funding supported the Greater Manchester Cancer Alliance delivery plan split across three workstreams:

1) Faster Diagnosis and Operational Performance

2) Early Diagnosis

3) Treatment and Personalised Care

Additional targeted funding was received to deliver various programmes as detailed below:

- Targeted lung health checks
- Lynch Syndrome – funding provided to support ImmunoHistoChemistry (IHC) testing, which is an initial tumour test recommended for the Lynch syndrome testing pathway.
- Cytosponge - funding provided to deliver the national Cytosponge pilot. The Cytosponge is a small capsule which is attached to a fine string. After swallowing, the capsule coating (vegetarian gelatin) dissolves in the stomach to release a small brush which when removed allows cell collection from the lining of the oesophagus (gullet or food-pipe). These cells are then analysed for abnormalities.
- Colon Capsule Endoscopy (CCE) – funding provided to test and develop the evidence base for this technology, and to support restoration of endoscopy services. CCE is a less invasive test that involves swallowing a camera to examine the colon without the need for hospital admission or sedation

Primary care – within primary care the key investments have been:

- **Winter Resilience Funding** – was used to support GP practices by funding additional capacity during the winter period
- **Additional Role Reimbursement** (ARRs) - was introduced in 2019 as a key part of the government's manifesto commitment to improve access to general practice by further investment in primary care services. Through the scheme, primary care networks (PCNs) can claim reimbursement for the salaries (and some on costs) of 17 new roles within the multidisciplinary team, selected to meet the needs of the local population. In expanding general practice capacity, the scheme improves access for patients, supports the delivery of new services and widens the range of offers available in primary care. The 17 ARRs roles are care coordinators, health and wellbeing coaches, social prescribing link workers, clinical pharmacists, pharmacy technicians, first contact practitioner physiotherapists, occupational therapists, paramedics, podiatrists, dietitians, advanced practitioners, nursing associates, trainee nursing associates, mental health practitioners, physician associates, general practice assistants and digital and transformation leads.

  In 2022/23, NHS GM was entitled to claim up to a maximum £54.1m of ARRs funding to support payments to Primary Care Networks (PCNs) to employ additional staff and expand the range of services they can provide to patients. GM claimed £49m of this funding to support ARRs staff in post.
- **Digital** – Investments were made in Primary Care Digital on various hardware and software items including laptops, desktops, network switches, Wi-Fi access and O365 licencing. This investment provides on-going resilience and ensures the Digital estate is up to the desired specification, helping to maintain optimum performance and compliance with cyber security policies.

- **Diagnostic hubs** - GM has a well-developed Imaging and Pathology Network which covers all aspects of joint working across these areas. This funding is the 2nd year of support for the network.

Financial Sustainability Plans

The planning guidance for 2022/23 asked organisations to look at efficiency delivery in order to deliver financial balance. NHS GM had an efficiency target of £118.8m, which was achieved in full by Month 12.

Meeting the formal efficiency target for NHS GM as an entity, contributed towards achievement of the wider system efficiency requirement of £495.3m. This included an additional £18m of system savings delivered within NHS GM through allocations and income.

Balance Sheet

NHS GM has assets and received a Capital Resource Limit in 2022/23 relating to the impact of IFRS16 Leases. The assets relate to the former CCG's headquarter premises. The ICB did not purchase any assets in the financial year.

Review of the Financial Position

NHS GM's financial health is reviewed on a monthly basis at the ICB's Board meeting. The role of detailed scrutiny is delegated to the monthly Finance Committee, which is a formal sub-committee of the Board and is chaired by the Non-Executive Director for Finance and has representation from the other non-executive and partner Members.

Independent assurance is provided to the ICB by External Audit as follows:

- An opinion on the accounts
- A "Regularity" opinion on whether the expenditure has been incurred as intended by Parliament. Failure to meet statutory financial targets automatically results in a qualified regularity assertion
- A report from the auditor that they are satisfied that the ICB has made "proper arrangements for securing economy, efficiency and effectiveness in its use of resources." This is included as a commentary within the Auditor's Annual Report

Additional independent assurance is also provided to the Board by the ICB's internal auditors, and this is covered within the Head of Internal Audit Opinion in the Corporate Governance section.

The External Audit work programme is supported by the Internal Audit work programme, both of which are monitored by the Audit Committee.

2023/24 Financial Landscape

GM System Plan

NHS GM is part of the Greater Manchester Integrated Care System (ICS), for which an annual plan is submitted to NHS England for the following financial year, covering capital, revenue, activity and workforce.

Revenue

The Greater Manchester system has submitted a balanced plan which required considerable system wide activity, collaboration across organisations and the sharing of risk to inform the plan. This covered activity, workforce and finance.

The planning guidance set out three core principles:

- **Recovering core services and improving productivity**
    - Improved ambulance response and A&E waiting times
    - Reduce elective long waits and cancer backlogs, and improve performance against the core diagnostic standard
- **Make progress in delivering the key NHS Long Term Plan Ambitions**
    - Improve Mental health services for people with learning disability and autistic people
    - Continue to support delivery of the primary and secondary prevention priorities and the effective management of long-term conditions.
- **Continue transforming the NHS for the future**

- Ensure that the workforce is put on a sustainable footing for the long term, including publication of an NHS Long Term Workforce Plan.
- Level up digital infrastructure and drive greater connectivity, including development of the NHS App to help patients to identify their needs and get the right care in the right setting.

There are a number of key operational challenges within the plan relating to performance in 2023/24:

- 65 week waits
- Mental Health Out of Area Placements
- Perinatal Mental Health

Capital

The capital plan submitted highlighted a £71m overspend based on two principles:

- **£40m Pennine Acute Transaction** – As part of this transaction, it was agreed nationally to provide capital to support the necessary developments to deliver the aims of the business case. The expectation is that the national team maintain this commitment.
- **Depreciation £31m above the current allocation of CDEL** – The system's capital allocation is not sufficient to cover the system's depreciation, this should be a minimal expectation.

There is risk as the submitted plan does not cover backlog maintenance or aged system infrastructure.

Primary care capital reflects a £0.3m capital overcommitment within the plan

NHS GM Plan

Although NHS GM has submitted a balanced financial plan, within this there is a significant amount of organisational risk, with a challenging savings plan to be delivered.

NHS GM proposes establishing a Delivery Programme, on behalf of the ICS. The programme will oversee the continued development and implementation of the operational for the year. Due to the level of risk, this will be established in the manner of a Recovery programme. This will be convened through the ICB Delivery Directorate. It will focus on:

- General oversight of delivery of the operational plan
- Rapidly developing plans to resolve planning risks (within quarter one)
- Agree and monitor plans where there are high risks to delivery.

ACCOUNTABILITY REPORT

Mark Fisher

Accountable Officer

28 June 2023

Accountability Report

The Accountability Report describes how we meet key accountability requirements and embody best practice to comply with corporate governance norms and regulations.

It comprises three sections:

The **Corporate Governance Report** sets out how we have governed the organisation during the period 1 July 2022 to 31 March 2023, including membership and organisation of our governance structures and how they supported the achievement of our objectives.

The **Remuneration and Staff Report** describes our remuneration polices for executive and non-executive directors, including salary and pension liability information. It also provides further information on our workforce, remuneration and staff policies.

The **Parliamentary Accountability and Audit Report** brings together key information to support accountability, including a summary of fees and charges, remote contingent liabilities, and an audit report and certificate.

Corporate Governance Report

Members Report

Composition of the Integrated Care Board

Members	
Sir Richard Leese	Chair, NHS GM
Shazad Sarwar	Non-Executive Director and Chair of the Remuneration Committee
Richard Paver	Non-Executive Director and Chair of Audit Committee
Dame Sue Bailey	Non-Executive Director and Chair of the Quality & Performance Committee
Kal Kay	Non-Executive Director and Chair of the Finance Committee
Dr Owen Williams	Board Member bringing the perspective of Acute Providers, Chief Executive of Northern Care Alliance (NCA) NHS Foundation Trust
Paul Dennett	Board Member bringing the perspective of Local Authorities, Salford City Mayor - ICP Chair
Dr Vish Mehra	Board Member bringing the perspective of Primary Care, General Practitioner (GP)
Leigh Vallance	Board Member bringing the perspective of the Voluntary Community and Social Enterprise (VCSE) Sector, Chief Executive of Bolton Hospice

Neil Thwaite	Board Member bringing the perspective of Mental Health, Chief Executive of Greater Manchester Mental Health (GMMH) NHS Foundation Trust
Mark Fisher	Chief Executive, NHS GM
Sam Simpson	Chief Finance Officer, NHS GM
Gill Gibson (until 31 August 2022)	Interim Chief Nursing Officer, NHS GM
Mandy Philbin (from 1 September 2022)	Chief Nursing Officer, NHS GM
Manisha Kumar	Chief Medical Officer, NHS GM
Attendees	
Geoff Little (until 28 February 2023)	Chief Executive of Bury Council, Health and Care Portfolio Lead
Alison McKenie-Folan (from 1 March 2023)	Chief Executive of Wigan Council, Health and Care Portfolio Lead
Janet Wilkinson	Chief People Officer
Warren Heppolette	Chief Officer for Strategy & Innovation
Sarah Price	Deputy Chief Executive/Chief Officer for Population Health and Inequalities
Steve Dixon (until 31 March 2023)	Chief Delivery Officer

Committee(s), including Audit Committee

All of the NHS GM ICB Committee Terms of Reference can be found in the Governance Handbook on the NHS GM Integrated Care Partnership website.

Audit Committee

The Audit Committee is accountable to the Board and provides an independent and objective view of the ICB's compliance with its statutory responsibilities. The committee is responsible for arranging appropriate internal and external audit. The Audit Committee is chaired by Richard Paver, Non-Executive Director.

During Quarter 2-4 of 2022/23, the Committee met to discharge its delegated functions in line with its Terms of Reference. Some of the key business of the Committee for the period was as follows:

- Received assurance over the handover of responsibilities following the disestablishment of CCGs, including draft accounts for the first quarter of 2022/23, Head of Internal Audit Opinions, and relevant information relating to internal audit and anti-fraud matters
- Considered the Audit Committee work plan for the year

- Received assurance on the agreement of essential Policies for the ICB on Day 1, as well as information on Policy processes for the organisation
- Received Policies for consideration, including the Conflicts of Interest Policy and Procurement Policy
- Considered risk management arrangements for the organisation, including a review of the Risk Management Framework
- Agreed the Internal Audit and Anti-Fraud Plans for 2022/23, whilst also considering plans for 2023/24
- Oversaw the External Audit procurement and appointment process
- Considered the Annual Report and Accounts process for the period
- Received a number of reports relating to corporate governance processes, including EPRR and Business Continuity, Freedom of Information (FOI) requests, Statutory Publication Requirements, Health and Safety, Information Technology, and Information Governance

Members	
Richard Paver (Chair)	Non-Executive Director / Audit Committee Chair
Shazad Sarwar	Non-Executive Director / People & Culture and Remuneration Committee Chair
Neil Thwaite	Board Member bringing the perspective of Mental Health / Chief Executive, Greater Manchester Mental Health Foundation Trust

Remuneration Committee

The Remuneration Committee is accountable to the Board for matters relating to remuneration, fees and other allowances (including pension schemes) for employees and other individuals who provide services to the ICB. The Remuneration Committee is chaired by Shazad Sawar, who is also Chair of the People and Culture Committee.

During Quarter 2-4 of 2022/23, the Committee met to discharge its delegated functions in line with its Terms of Reference. Some of the key business of the Committee for the period was as follows:

- Supported the appointment and salary awards of the Non-Executive and Executive Team members who had been appointed prior to the 01 July 2022 and subsequent Board appointments
- Supported and agreed to seek regional, and where required, national approval to serve redundancy notice for staff who were at risk of redundancy, where NHS GM had exhausted the search for alternative employment
- Supported the National Pay Deal, and approve the proposed pay award for Very Senior Managers (VSM) and Executives appointed since 01 July 2022

- Ratified and supported the appointment remuneration for all appointed VSM and Non-executive Directors (NEDs), with the exception of Manchester's Deputy Place Based Lead
- Received updates provided against the outstanding Redundancy Exit Business Cases
- Noted the Mutually Agreed Resignation Scheme (MARS) applications received for employees employed under the Agenda for Change (AfC) contracts of employment.

Members	
Shazad Sawar (Chair)	Non-Executive Director and Chair of the Remuneration Committee
Sir Richard Leese	Chair of the ICB
Dame Sue Bailey	Non-Executive Director and Chair of the Quality & Performance Committee

Finance Committee

The purpose of the Finance Committee is to contribute to the overall delivery of the ICB objectives by providing oversight and assurance to the Board in the development and delivery of a robust, viable and sustainable system financial plan. This includes:

- financial performance of the ICB.
- financial performance of NHS organisations within the ICB footprint.

The Finance Committee meets monthly.

During Quarter 2-4 of 2022/23, the Committee met to discharge its delegated functions in line with its Terms of Reference. Some of the key business of the Committee for the period was as follows:

- Considered items related to Contract Management to ensure due diligence and signatures had been obtained following the transfer of these from the disestablished CCGs
- Approved relevant allocation awards, including for the Virtual Ward, Winter Plans, Pay Awards, and allocations to providers
- Endorsed or approved relevant business cases in line with the Financial Scheme of Delegation
- Approved the release of Ockenden funding for 2022/23 based on actual forecast costs up to a maximum of the plan level, totalling £4m
- Approved recurrent Ockenden funding request of £4.3m required in 2023/24 to meet the immediate and essential actions one to seven of the Ockenden report, resulting in an increase in maternity service staffing

- Considered the Finance Committee's corporate risks as part of the Committee risk register

Members	
Kal Kay (Chair)	Non-Executive Director / Finance Committee Chair
Sam Simpson	Chief Finance Officer
Manisha Kumar	Chief Medical Officer
Paul Dennett	Board Member bringing the perspective of Local Authorities, Salford City Mayor - ICP Chair
Dr Vish Mehra	Board Member bringing the perspective of Primary Care, GP
Steve Dixon	Chief Delivery Officer (until 31 March 2023)
Mandy Philbin	Chief Nurse
Mark Fisher	Chief Executive
Dame Sue Bailey	Non-Executive Director / Quality & Performance Committee Chair

In addition, the Financial Recovery Committee has been established as a sub-Committee of the Finance Committee. The purpose of the Financial Recovery Committee is to monitor, challenge and provide assurance to the GMICB Finance Committee and NHS England on the deliverability of the Greater Manchester Integrated Care financial recovery plan. This includes assurance on both revenue and capital. Membership of the Sub Committee is drawn from a range of NHS organisations across Greater Manchester.

<u>People and Culture Committee</u>

The People and Culture Committee is established to oversee the implementation of the NHS GM's People and Culture Strategy and related workforce activity. Its purpose is to provide assurance to NHS GM Board through the robust testing of assurance provided by NHS GM management in relation to workforce matters.

The People and Culture Committee meets bi-monthly.

During Quarter 2-4 of 2022/23, the Committee met to discharge its delegated functions in line with its Terms of Reference. Some of the key business of the Committee for the period was as follows:

- Workforce reporting providing focus and assurance for our core people KPI's
- The development of the People and Culture Strategy for the system and the operating model for the NHS GM people and culture function

- Conducted discussions regarding the core offer to support our new organisation and our workforce. For example, the Health and Wellbeing offer developed for staff and the work associated to identifying an occupational health provider, mandatory training and a number of people and culture internal audits.
- Ratified a range of policies to support the establishment of the ICB
- Conducted discussions to develop NHS GM to be a leading employer within Greater Manchester committing to the Good Employment Charter, our approach to Freedom to Speak up
- Oversaw the implementation of the NHS pay award and the Mutually Agreed Resignation Scheme
- Held discussions relating to reorganising the workforce through organisational change including 4 TUPE transfers and large scale redesign of NHS GM
- Reviewed the People and Culture risk register during each meeting
- Considered system development operational planning, system and organisational industrial action, the workforce summit and the health and care awards
- Considered inclusion within the workforce and recent legal developments in relation to discrimination in with workplace
- Considered culture development of the NHS GM including the staff survey results

Members	
Shazad Sarwar (Chair)	Non Executive Director / Chair of the Remuneration Committee
Mark Fisher	Chief Executive
Jess Williams	Director of Transformation
Janet Wilkinson	Chief People Officer
Warren Heppolette	Chief Officer for Strategy & Innovation
Sarah Price	Dep Chief Executive / Chief Officer for Population Health & Inequalities NHS GM
Steve Dixon (until 31 March 2023)	Chief Delivery Officer
Kal Kay	Non Executive Director / Chair of the Finance Committee
Hannah Dobrowolska	Delivery Director for Health and Care Integration (Salford)

Quality and Performance Committee

The purpose of the Quality and Performance Committee is to:

- Using an improvement culture to support assurance of sustained quality that than one just of performance management
- Provide clear accountability and responsibility for quality
- Bring together the right people to respond together in a timely and proactive way addressing gaps in intelligence
- Develop a shared vision for quality and patient safety with oversight of the delivery of the strategy
- Use as an assurance mechanism for the progress of system wide addressing inequalities and advancing equality strategies and plans

The Quality and Performance Committee meets monthly.

During Quarter 2-4 of 2022/23, the Committee met to discharge its delegated functions in line with its Terms of Reference. Some of the key business of the Committee for the period was as follows:

- Received and approved the frameworks for assuring quality in line with NHSE and National Quality Board expectations and has been sighted on the developing plans for managing movement between the national outcomes framework segmentations and Tiers of surveillance
- Held focussed development session on constitutional standards and the role of the Quality & Performance Committee in ensuring the ICB is meeting these alongside the statutory responsibilities of the Medical, Nursing, Quality & Performance functions. This included developing a healthy and transparent approach to risk and ensuring a forward plan that enables the committee to fulfil its terms of reference under delegation from the ICB
- Had a consistent overview of the areas of accountability within the Chief Nurse portfolio, for example enabling discussion and debate regarding Continuing Health Care performance, along with assurance of improvement plans where targets for these statutory responsibilities were not being achieved
- Performance reporting on all constitutional standards has been reviewed and a comprehensive dashboard of metrics is under development which will serve to highlight areas of improvement and concern in an accessible format which will, in time, enable high level provider oversight as well as tracking individual and service outcomes
- Received updates on regulatory activity and assurance against improvement plans in both Mental Health and Maternity provisions, along with deep dives into Urgent and Emergency Care pressures, End of Life and Palliative Care with a focus on Hospice provision, Infection Prevention & Control activity and Learning Disability & Autism provision.
- Worked on developing an outcomes focused approach which provides assurance to the ICB and drives improvement across health and care delivery

Members	
Dame Sue Bailey	Non Executive Director / Quality and Performance Committee Chair
Leigh Vallance	Board Member bringing the perspective of the Voluntary Community and Social Enterprise (VCSE) Sector / Chief Executive of Bolton Hospice
Mandy Philbin	Chief Nursing Officer
Manisha Kumar	Chief Medical Officer
Owen Williams	Board Member bringing the perspective of Acute Providers, Chief Executive of Northern Care Alliance (NCA) NHS Foundation Trust
Richard Paver	Non Executive Director / Audit Committee Chair
Steve Dixon	Chief Delivery Officer (until 31 March 2023)
Tracey McErlain-Burns	Patient Representative (Healthwatch)
Dr Vish Mehra	Board Member bringing the perspective of Primary Care, General Practitioner (GP)

Primary Care Commissioning Committee

The Greater Manchester Primary Care Commissioning Committee provides the regulatory assurances as part of the matrix for primary care governance within the ICB, working alongside the Primary Care System Board and the Primary Care Provider Board to support development and delivery of primary care across Greater Manchester.

The Committee holds the responsibility for discharging the duties delegated by NHS England to NHS Greater Manchester regarding commissioning of primary care services. Explicitly this is in respect of:

- Primary Medical Services
- Primary Dental Services and Prescribed Dental Services
- Primary Ophthalmic Services
- Pharmaceutical Services and Local Pharmaceutical Services

During Quarter 2-4 of 2022/23, the Committee met to discharge its delegated functions in line with its Terms of Reference. Some of the key business of the Committee for the period was as follows:

- Maintained oversight and assurance across the 10 Greater Manchester place-based committees managing local arrangements, specifically in respect to general practice, but developing local arrangements for the rest of primary care services.
- Upholds the national regulatory frameworks and ensures that commissioning of services is in accordance with the ICB governance as well as the expectations and requirements of NHS England. This includes the local assurance of existing national contracting with primary care providers and the commissioning determination of new contracts, including determining the contracting specifications to meet population

needs and procurement of those contracts.

Members	
Sarah Price (Chair)	Chief Officer for Population Health and Inequalities and Deputy Chief Executive
Sam Simpson	Chief Finance Officer
Mandy Philbin	Chief Nurse
Rob Bellingham	Director of Primary Care and Strategic Commissioning
Will Blandemer	Deputy Place Based Lead for Health and Care - NHS GM (Bury Locality)
Martin Ashton	Associate Director of Integration & Delivery NHS GM (Tameside Locality)
Don McGrath	GM Dental Provider Board Chair
Dr Tracey Vell	GM Primary Care Provider Board Chief Officer
Dharmesh Patel	GM Optometry Provider Board Chair
Luvjit Kandula	GM Community Pharmacy Provider Board Chair
Ben Squires	Head of Primary Care
Nicola Hepburn	Director of Delivery and Transformation/Deputy Place Lead (Oldham)
Caroline Bradley	Associate Director of Primary Care (Manchester Locality)
TBC	Patient Voice (Healthwatch, Lay Member, Patient Panel) – independent member

Register of Interests

The Register of Interests for decision-making staff is available on NHS GM Integrated Care Partnership's website. This was updated in February 2023. The register will be refreshed at least annually in line with NHSE requirements, however the register is published more regularly to reflect changes in interests throughout the year. The register of interests of all staff, Board and Committee Members is updated on a regular basis as interests arose (or ceased) and when other opportunities present themselves to update.

Personal data related incidents

There were no Serious Untoward Incident relating to the data security breaches and no data security incidents have been reported to the ICO within NHS GM for between 1 July 2022 and 31 March 2023.

Modern Slavery Act

NHS GM fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the period ending 31 March 2023 will be published on our website by September 2023.

Statement of Accountable Officer's Responsibilities

Under the National Health Service Act 2006 (as amended), NHS England has directed each Integrated Care Board to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the NHS Greater Manchester Integrated Care Board (NHS GM) and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgements and estimates on a reasonable basis
- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts
- Prepare the accounts on a going concern basis
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable

The National Health Service Act 2006 (as amended) states that each Integrated Care Board shall have an Accountable Officer and that Officer shall be appointed by NHS England.

NHS England has appointed the Chief Executive to be the Accountable Officer of NHS GM. The responsibilities of an Accountable Officer, including responsibility for the propriety and regularity of the public finances for which the Accountable Officer is answerable, for keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Integrated Care Board and enable them to ensure that the accounts comply with the requirements of the Accounts Direction), and for safeguarding the NHS GM assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the Accountable Officer Appointment Letter, the National Health Service Act 2006 (as amended), and Managing Public Money published by the Treasury.

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that NHS GM's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

As the Accountable Officer, I confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and

Accounts and the judgements required for determining that it is fair, balanced and understandable.

Mark Fisher

Accountable Officer

28 June 2023

Governance Statement

Introduction and context

The NHS Greater Manchester Integrated Care Board (NHS GM ICB) is a body corporate established by NHS England on 1 July 2022 under the National Health Service Act 2006 (as amended).

NHS GM's statutory functions are set out under the National Health Service Act 2006 (as amended).

The ICB's general function is arranging the provision of services for persons for the purposes of the health service in England. The ICB is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its population.

Between 1 July 2022 and 31 March 2023, the Integrated Care Board was not subject to any directions from NHS England issued under Section 14Z61 of the of the National Health Service Act 2006 (as amended).

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of NHS GM's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in NHS GM's Accountable Officer Appointment Letter.

I am responsible for ensuring that NHS GM is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the ICB as set out in this governance statement.

Governance arrangements and effectiveness

The main function of the Integrated Care Board is to ensure that the organisation has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically, and complies with such generally accepted principles of good governance as are relevant to it.

In accordance with paragraph 3 of Schedule 1B to the 2006 Act, the membership of the ICB consists of: a Chair; a Chief Executive; and at least three Ordinary Members. In addition, NHS England Policy, requires the ICB to appoint the following additional Ordinary Members: three

executive members, namely: Director of Finance, Medical Director and Director of Nursing; and at least two Non-executive Members.

Furthermore, the ICB has four partner members and has also appointed one Ordinary Member bringing the perspective of the Voluntary, Community and Social Enterprise (VCSE) sector to the Board.

The Board is therefore composed of the following members:

a) Chair

b) Chief Executive

c) two Partner Members NHS and foundation trusts

d) one Partner Member primary medical services

e) one Partner Member local authorities

f) four Non-executive Members

g) Director of Finance

h) Medical Director

i) Director of Nursing

j) one Ordinary Member VCSE.

To add value to its work, the Board also invites specified individuals to be participants at its meetings in order to inform its decision-making and the discharge of its functions as it sees fit, namely: the Chief People Officer, Chief Officer for Strategy and Innovation, Deputy Chief Executive/Chief Officer for Population Health and Inequalities, and Chief Operating Officer.

The Board specifically invites the Health and Care Portfolio Lead as a participant at meetings.

The Board met eight times between July 2022 and March 2023. Meetings are usually held in person and are open to the public. Members of the public are able to join via a link provided or additionally in person. The quorum was achieved at each meeting.

To support the successful delivery of its functions and activities, NHS GM has several Committees, each accountable to the ICB. Committee meetings are also usually held in person and are open to the public. Comprehensive highlights of the work led by the Committees of the ICB are set out in the Members Report of this Accountability Report. All terms of reference are published in the Governance Handbook on the NHS GM Integrated Care Partnership website.
In addition, during the fourth quarter of 2022/23, 10 Locality Boards covering the 10 GM localities were formally established as committees/joint committees of the ICB. Meetings will

routinely be held in public and papers including minutes will be published on the NHS GM Integrated Care Partnership website.

In addition, there are several GM System Boards in operation, as well as the Integrated Care Partnership (ICP) Board and the Joint Planning and Delivery Committee (JPDC).

The GM ICP is a joint committee created by the 10 Greater Manchester local authorities and the Greater Manchester Integrated Care Board under s.116ZA into the Local Government and Public Involvement in Health Act 2007. Its role is to enable the discharge of the ICP's functions under the Local Government and Public Involvement in Health Act 2007 and any related guidance concerning the role of integrated care partnerships. ICPs have a statutory duty to create an integrated care strategy to address the assessed needs, such as health and care needs of the population within the ICB's area, including determinants of health and wellbeing such as employment, environment, and housing. All Health and Wellbeing Boards in Greater Manchester are involved in the preparation of the ICP Strategy.

As part of the ICB governance, the Joint Planning and Delivery Committee (JPDC) is tasked with overseeing the detailed joint planning and delivery process to ensure that locality programmes, Provider Collaborative programmes and GM enabling programmes work coherently.

Discharge of Statutory Functions

NHS GM has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislation and regulations. As a result, I can confirm that the ICB is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the ICB's statutory duties.

Risk management arrangements and effectiveness

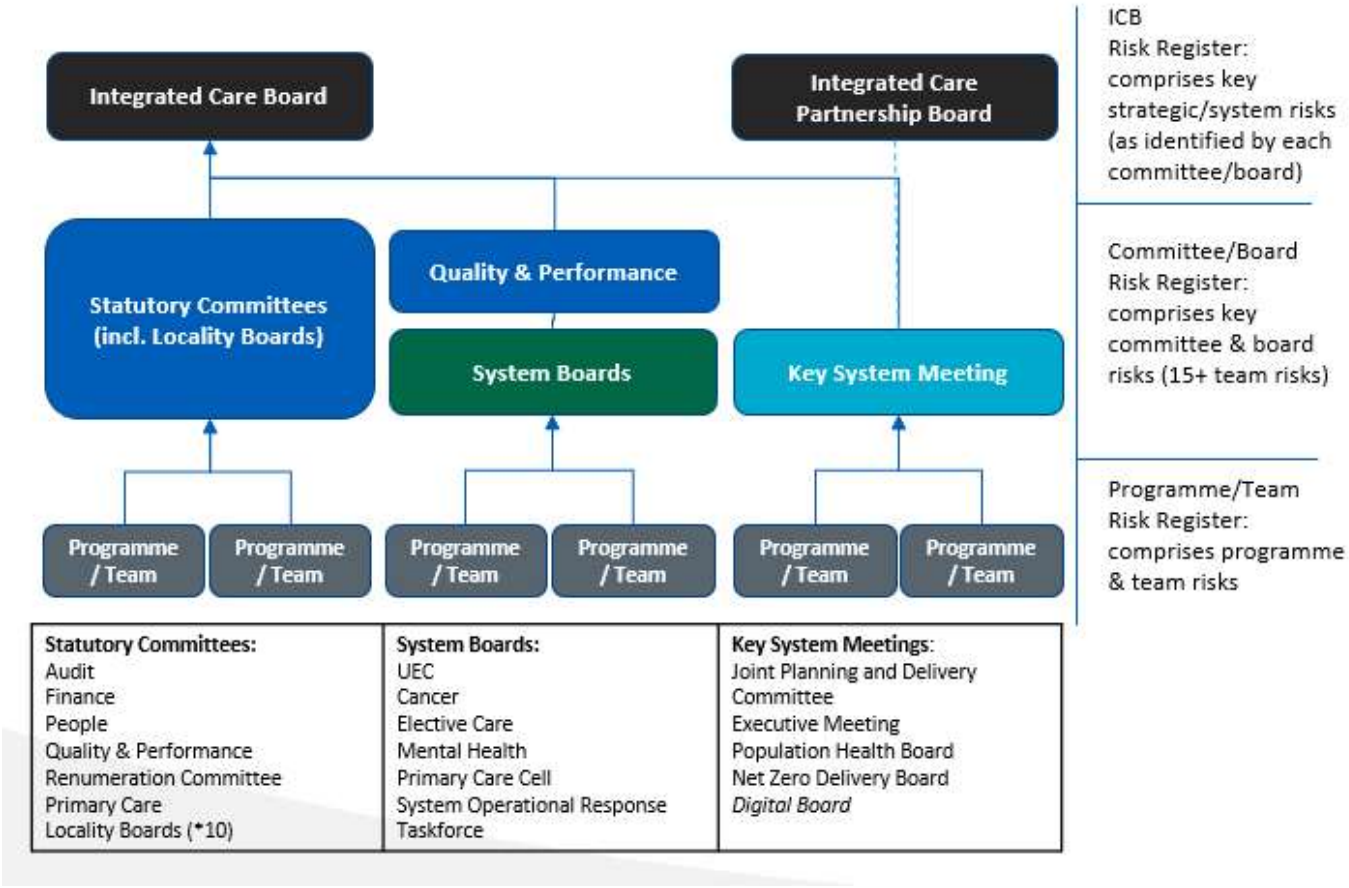
The ICB has developed a Risk Management Framework that outlines the principles to be applied across NHS GM on processes, roles, and responsibilities for dealing with risks and issues.

The Risk Management Framework is a strategic framework/approach approved by the ICB. It is a policy document that sets outs the ICB's approach to managing risk, appetite to risk, and setting out how it will get assurance. Work is ongoing to develop this framework further.

Capacity to Handle Risk

The approach to risk management is built from the governance structure identified below. This

connects to the proposed Board Assurance Framework (BAF) levels and reflects the different levels of autonomy in the system at the various committees/boards of NHS GM.



Risks are quality assured through the relevant part of sub-governance groups e.g., for quality and performance risks these would go to the Quality and Performance Committee, for mental health risks these would go to the Mental Health Board.

The overall approach to risk management remains the same, with the ICB requiring assurance that risks/issues within the GM system are managed, monitored and appropriate action is taken.

The different levels are illustrated below:

ICB Programmes/Teams	Locality Boards	System Boards
• Consistent format of reporting using templates – risks/issues will be recorded and reported in line with committee frequency • Each Programme / team manages their risk register and then further categorises (using a score threshold of 15) those risks from each programme/team that warrant escalation to the appropriate Committee/Board meeting • Committee agreement on any risks/issues that require escalation to ICB	• Localities will continue to record, manage and report risks/issues using their own agreed risk management process and framework • The threshold for reporting risks at the Locality Board will be set and managed by the locality • The central PMO will take the risks identified from each Locality Board report and use these to inform/update the Strategic Risk Register for the ICB and the BAF	• System Boards will continue to record, manage and report risks/issues using their own agreed risk management process and framework • The threshold for reporting risks at the System Board will be set and managed by the board • The central PMO will take the risks identified from each System Board report and use these to inform/update the Strategic Risk Register for the ICB and the BAF

The supporting diagram below gives a high-level summary of NHS GM's approach to risk, recognising there will be a difference in the reported information that is received. This approach will be iterative and may evolve as the risk reporting develops.

The ICB Statutory committee meetings are all meetings held in public and risk is a standing agenda item for each meeting.

The process for escalating risks is outlined below:

Programme/Team Risk Register and Issue Log
• Used to help manage all risks within a team/project/programme and helps to manage delivery • Team is responsible for all updates and management

- Each team within the directorate will need its own register with the expectation that regular review and reporting takes place within the directorate
- In addition, each team should manage and update an issue log that sits alongside the risk register

Committee/Board Risk Register & Issue Log

- Used to capture the key risks from each team register that require consideration and action at the committee/board meeting
- Not expected to consider all team risks, there will be a requirement to filer/moderate the team registers (suggested threshold 15+)
- Ownership, update, and action of the committee register will be managed within the directorate responsible for the running the relevant committee.
- The suggested threshold for risks to be considered by the committee/board is any team risk that has a score of 15 or above. For issues, this would be any issue with a score of 4 or above.
- Each committee/board is asked to agree which risks/issues require escalation to the ICB, this will then be reported on a monthly basis to the Programme Management Office (PMO) who will in turn produce the monthly risk reporting and update
- The PMO will review these risks to ensure scoring and escalation are consistent across the committees/boards

ICB Risk Register & Issue Log

- Used to capture the strategic risks from the committees/boards of the ICB – these are the risks/issues that have been agreed at the relevant committees/boards for escalation to the ICB
- The PMO will receive updates from each committee/board on a monthly basis and use these to produce ICB Strategic Risk Update
- Ownership, update, and action of the ICB Strategic Risk Register and Issue Log will be managed by the PMO
- The strategic risk and issue reports will be used to update the Board Assurance Framework Output in line with the agreed reporting schedule
- This will include any requirement for Regional/National reporting

Risk Assessment

The ICB has been reporting strategic risks to the monthly ICB meeting since November 2022 (following approval of the Risk Management Framework in October 2022). The identified risks from the March 2023 report are shown below. The management of these risks takes

place at the committee meetings of the ICB together with a strategic risk discussion at each monthly ICB Board meeting.

The risk reporting is constantly under development and future board development is planned to understand and determine risk appetite and to ensure tracking of risks over time takes place to monitor the risk severity and profile.

Risk Number	Risk	Risk Score
FIN1	Failure to meet/deliver Financial Balance both at NHS GM level and as an ICS system	16
FIN2	Inability to deliver required QIPP savings due to ongoing COVID challenges and ICS transition work, current reporting is a net open risk of circa £100m across the GM ICS	15
FIN3	Use of Non-Recurrent money used to fund recurrent costs in the 2022/23 financial position (e.g., non-recurrent money for Transformation, Service development and Covid)	20
FIN4	Decision making is slow and unclear during transition leading to financial challenges	12
FIN5	Disaggregation of Glossop Area from the former Tameside and Glossop CCG. (Glossop now transferred into Derbyshire ICB/S)	8
P&C1	There is a risk of a failure to deliver safe and effective care (social and health) to the population of Greater Manchester across the system	20
P&C2	There is a risk of industrial action from staff across the system. This is a risk to patients, service delivery and system and organisational reputation	20
P&C3	There is a risk of increase in competition for consultants across the wider system and increased costs or reduction in capacity	20
P&C4	There is a risk that staff across the system will become disengaged	16
P&C5	There is a significant risk to the Health and Wellbeing of the Workforce	16
P&C6	Lack of diversity in the workforce especially at senior levels	16
P&C7	There is a risk to the ambition for joint working across sectors and the One Workforce model with attraction to work within Social Care	16
P&C8	Higher leavers rates due to current economic climate and cultural attitudes	16

P&C9	There is a lack of capacity / funded resources within the People and Culture Function	16
P&C10	There is a significant risk that the Occupational Health provision for NHS GM as a single provision will not be in place from 1st April 2023, when current contract arrangements end	20
QUP1	Potential lack of alignment of quality and performance governance and reporting	12
QUP2	Potential lack of oversight of safeguarding during transformation	12
QUP3	Low compliance to Learning Disabilities & Autism (LDA) health agenda	12
QUP4	Failure to deliver statutory duties for CHC	8
QUP5	Delays in both ambulance response times, and ambulance handovers directly impact on patient safety and patient experience	20
QUP6	Risk to increase in clinical outcomes variation and health inequalities across our population	12
QUP7	Achievement of 78-week elective waiting time target by March 2023	20
QUP8	Cancer backlog reduction. Improving performance against the key cancer standards	16
QUP9	Urgent care system cannot deliver timely and effective care	20
QUP10	Mental health - high levels of out of area placements	20
ASC1	Demand and complexity of care requirements affects market sustainability in Adult Social Care	16
ASC2	Unable to recruit and retain existing workforce in Adult Social Care	16
PRC1	There is a risk to the stability and sustainability of the continued provision of high-quality primary care	16
PRC2	Covid-19 has negatively impacted the health, wellbeing, and resilience of the workforce. The primary care workforce has been supporting patients and worked hard in service of the public throughout the COVID19 pandemic; having to adapt to different ways of working throughout several waves of the pandemic and the following vaccination programme. Furthermore, the current economic position presents retention and recruitment challenges.	16
PRC3	The rapid expansion of additional services to be delivered under the national community pharmacy services framework presents significant challenge to capacity. Failure to implement would disadvantage the	16

	local population in accessing services, and failings in delivery present clinical safety concerns	
STR1	Failure to secure system agreement for the Integrated Care Strategy and Joint Forward Plan	12
NTZ1	Failure to deliver the objectives and commitments of the NHS GM Green Plan	12
FTR1	Failure to deliver ICB Functions Transformation programme to agreed timescales	20
VCS1	Sustainability of VCSE organisations due to changes in cost increase and funding reductions	12
EPR1	GM insufficiently prepared for emergencies	16

Other sources of assurance

Internal Control Framework

A system of internal control is the set of processes and procedures in place in the ICB to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The Committee and reporting structures of NHS GM provides the basis of the framework and process that maintains, monitors and reviews the effectiveness of the system of internal control and risk management. The ICB and Committees comprised of a mix of senior managers, clinical professionals, independent contractors and internal audit representation to provide an effective balance between the Board, executive and audit functions and furthermore to ensure that decision making is effectively triangulated.

The ICB's role is to provide active leadership of NHS GM within a framework of prudent and effective controls that enable risk to be managed. NHS GM's Risk Management Framework aims to provide the ICB with the relevant assurance of the progress of achievement of NHS GM's aims, objectives and priorities within a robust risk-based framework. Further work on risk management arrangements will take place during 2023/24 to ensure these are strengthened in line with the recommendations made by internal audit.

The ICB receives regular minutes and reports from its Committees to provide internal assurances on financial, organisational and quality performance.

The Audit Committee specifically advised the ICB on the effectiveness of the system of internal control by the review of the internal audit report, external audit report and the Risk Assurance Framework. Any significant control issues would be reported to the ICB by the Audit Committee.

Annual audit of conflicts of interest management

The revised statutory guidance on managing conflicts of interest (published June 2017) requires commissioners to undertake an annual internal audit of conflicts of interest management. To support ICBs to undertake this task, NHS England has published a template audit framework.

Whilst the formal annual internal audit has not been carried out by internal auditors in 2022/23, a checklist of Management of Conflicts of Interest and Gifts & Hospitality (Phase I &II) has been completed by the ICB. These checklist reviews identified 12 recommendations for action, which NHS GM will be working to address during the coming financial year.

Data Quality

NHS GM recognises that decision making at every level within the health and care system, whether it be for population health, commissioning or direct care purposes, needs to be based on intelligence which is of the highest quality.

As a new organisation, NHS GM is completing the migration of data and intelligence assets held in 12 legacy data warehouse environments and into one secure data environment which will represent the single source of truth for the organisation and wider system partners. This migration has presented an opportunity to use new tools to explore and assess data quality and develop systems and processes to routinely validate the completeness, accuracy, validity and timeliness of the information that that the organisation uses.

Where they exist, NHS GM uses national data standards and expects its health and care providers to do the same. Where required local standards have been agreed, these are included within schedule 6 of provider contracts and reviewed on an annual basis. We are taking the opportunity of the creation of NHS GM to review all our provider and supplier contracts and ensure that data quality is integral to these and also to ensure that data quality is built into our planned data and digital ambitions, for example in our expanded use of the Greater Manchester Care Record.

There have been a number of significant digital developments over the past year which have had the potential to impact data quality such as the implementation of a new electronic patient record within our largest trust. However, NHS GM has taken steps to acknowledge, fully understand and mitigate the adverse impact of these developments on our ICB. Having assessed the quality of data submitted to and reviewed by the Board, I am assured that the data was of sufficient quality that the ICB could carry out its duties.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the ICB, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

As NHS GM is a new organisation that was formed on 01 July 2022 and the submission of NHS GM Data Security Protection Toolkit was not until 30 June 2023, at the time of writing we were unable to provide the assessment of compliance. A baseline submission of the NHS GM Data Security Protection Toolkit was made in February 2023, with a Phase One audit to be completed by our internal auditors in April 2023.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an NHS GM Data Security Protection Framework and have developed information governance processes and procedures in line with the Data Security Protection Toolkit. We have ensured all staff undertake annual Mandatory Data Security training and are in the process of implementing a staff Data Security Handbook to ensure staff are aware of their information governance roles and responsibilities.

There are processes in place for incident reporting and investigation of serious incidents which is detailed in the NHS GM Data Security Breach and Incident Policy.

We have developed an information risk assessment and management procedure, NHS GM Information Risk Policy and a programme of work will be established to fully embed an information risk culture throughout the organisation against identified information risks.

Business Critical Models

Current organisational Information Asset Registers are being maintained which identifies business critical assets, HR assets, PCD assets and financial assets for each service within the organisation. Information Asset Owners (IAO) and Information Asset Administrators (IAA) are assigned, and all information assets are regularly reviewed. The SIRO is responsible for identifying and managing the information risks. The SIRO receives regular reports highlighting any high risks.

Current Data Flow mapping are being maintained which enables an understanding of the flows of information related to information assets within the Information Asset Registers that contain PCD or business confidential data.

During the coming year Functions Leads will be identified as IAOs and once the organisation evolves more IAOs will be identified. A new Information Asset process is being implemented

where they will be Information Assets Registers for all the Functions within NHS GM including Data Flow and Risks.

Since July 2022, the mitigation for business continuity disruptions that NHS GM may face has been to rely upon legacy arrangements established by predecessor organisations. Alongside these arrangements, the organisation implemented a new mechanism for incident notifications, both internal and external, from early December 2022. This two-tier on-call system for NHS GM provides a route of escalation from locality on-call staff to the executive level.

Third party assurances

NHS England has procured a number of Service Auditor Reports to provide third party evidence on the effectiveness of controls within the organisation providing the service to NHS GM, for which NHS GM can rely on or would need to have in place compensating controls to deal with the weakness. These are evidenced as part of the external audit process.

The organisations and status of the reports are summarised in the table below:

Service Provider	**Status of Service Auditor Report**	**ICB has compensating controls to mitigate risks?**	**ICB can place reliance on entries / processes?**
NHS Shared Business Services Ltd: Finance and Accounting Services	The 2022/23 service auditor report has not been qualified and assurance is gained from its findings	Not applicable	Yes
East Lancashire Financial Services – Payroll processing	The 2022/23 service auditor report has not been qualified and assurance is gained from its findings	Not applicable	Yes
Electronic Staff Record Programme – Payroll System	The 2022/23 service auditor report has been qualified	Yes	Yes
NHS Business Services Authority: Prescription payments	The 2022/23 service auditor report has been qualified	Yes	Yes
NHS Business Services Authority: Dental payments	The 2022/23 service auditor report has been qualified.		

Service Provider	Status of Service Auditor Report	ICB has compensating controls to mitigate risks?	ICB can place reliance on entries / processes?
		Yes	Yes
NHS Digital/NHS England GP Data Extraction	The 2022/23 service auditor report has been qualified.	Yes	Yes
CSW CSU CQRS processing	The 2022/23 service auditor report has been qualified.	Yes	Yes
Capita Primary Care Support Services	The 2022/23 service auditor report has been qualified.	Yes	Yes

Control Issues

No significant internal control issues have been identified in the reporting period.

Review of economy, efficiency & effectiveness of the use of resources

The implementation of the Health and Care Act 2022 meant that NHS Greater Manchester ICB was formed on the 1 July 2022, with all services and functions transferring from:

- the 10 former Greater Manchester Clinical Commissioning Groups (excluding commissioning responsibility for Glossop residents which transferred to Derby & Derbyshire ICB)
- Greater Manchester Shared Services (previously hosted by Northern Care Alliance Foundation Trust)
- GM Health and Social Care Partnership (previously hosted by Manchester CCG)

The new organisation also took on responsibility for pharmacy, dental and optometry services, under delegation from NHS England.

NHS GM has an obligation to use its resources efficiently, effectively and economically. In addition, it must meet financial requirements as set out by NHS England. This includes delivering a breakeven financial position.

In order to mitigate and control risks associated with NHS GM's use of resources, organisational financial health is checked and reported to the Board on a monthly basis. The Board has also delegated responsibility for some aspects of financial internal control to the Finance Committee.

The financial plan for 2022/23 was completed as part of a GM system approach, with the final submission in June 2022. The plans were constructed on an individual organisation level, and covered the full financial year, with each organisation working within an agreed system control total. The opening plan was agreed by the ICB Board in July 2022.

A number of the measures introduced during the covid pandemic have remained in place for 2022/23:

- Calculated block contracts payable to NHS bodies, adjusted for local agreements, which ceased the majority of inter-NHS invoicing
- The Greater Manchester system managed the Independent Sector directly to secure capacity and this was funded on a system agreement
- Nationally calculated LVA (Low Value Activity) for NHS providers outside of the GM system was introduced
- Contracts for 2022/23 were agreed at system level and the requirement for contracts to be signed was reintroduced, although CQUIN remained suspended
- Investments were allowable dependent on system agreement, Mental Health Investment standard delivery was fully supported

NHS England has a legal duty to annually assess the performance of each ICB. The assessment must consider the duties of ICBs to improve the quality of services; reduce health inequalities; obtain appropriate advice; involve and consult the public; and comply with financial duties. The latest available information in relation to this assessment can be found on page 29 of this report.

Delegation of functions

The ICB retains accountability for the delivery of all of NHS GM functions. On its establishment, the ICB established a number of formal Committees with delegated authority to appropriately manage some of its functions. The Committees established are:

- Audit Committee
- Remuneration Committee
- Finance Committee
- Quality and Performance Committee
- People and Culture Committee
- Primary Care Commissioning Committee

In addition, during the last quarter of 2022/23, the ICB established Locality Boards (as formal Committees of the ICB with delegated budgets and functions) for each of the 10 localities within Greater Manchester (Bolton, Bury, Heywood, Middleton and Rochdale; Manchester, Oldham, Salford, Stockport, Tameside, Trafford, and Wigan). Locality Boards bring together senior leaders for the NHS (primary, secondary, community and mental health), local authority and the VCFSE (Voluntary, Community, Faith and Social Enterprise), with their role to focus on the shared priorities within their respective Locality Plans and, by working together, improve health, wellbeing and care for the population of each locality.

The ICB's constitution and Governance Handbook sets out the arrangements under which the ICB and its Committees operate, with each of the Committees' Terms of Reference setting out their agreed delegations and responsibilities. The ICB receives the minutes and regular reports from each of its Committees detailing the delivery of work, and associated risks, within their specific remit. Risks are escalated by Committees to be included in the Board Assurance Framework if appropriate.

The internal audit process was used to provide an in-depth examination of any areas of concern, and the Audit Committee provides assurance that the statutory duties of the ICB are being managed appropriately at the different levels of the organisation.

The organisation has a Freedom to Speak Up Policy in place, and a separate Whistleblowing Policy is in development to ensure relevant information is available to both internal and external stakeholders. The Freedom to Speak Up Policy is available to all staff and confirms the organisation's Freedom to Speak Up Guardian and how they can be contacted and identifies how issues may be raised and addressed.

Counter fraud arrangements

NHS GM made the following arrangements regarding its managing of counter-fraud:

- An Accredited Counter Fraud Specialist was contracted, through Mersey Internal Audit Agency (MIAA) (NHS GM's Internal Audit service provider), to undertake counter fraud work at NHS GM proportionate to identified risks
- An annual risk-based counter fraud proactive work plan that was agreed and signed off by the Audit Committee. This was developed primarily by the Local Counter Fraud Specialist and the Chief Finance Officer, taking into consideration the Government Functional Counter Fraud Standard GovS013 (NHS Requirements), the NHS Counter Fraud Authority's National Strategic Priorities, as well as consideration of national, regional and local identified fraud risks and intelligence.
- The NHS GM Audit Committee received, through regular LCFS reporting, an indication as to the levels of compliance with the requirements set out in Government Functional Standard 013 for Counter Fraud. Work has been undertaken during the year to ensure that, an annual self-assessment against the requirements of the standard can be submitted, to the NHS Counter Fraud Authority, in May 2023. There is an ongoing commitment from NHS GM to provide appropriate executive support and direction proportionate to the identified fraud risk profile of the ICB.
- The Chief Finance Officer is the executive board member proactively and demonstrably responsible for tackling fraud, bribery and corruption. Regular liaison takes place between the LCFS, Chief Finance Officer, Counter Fraud Champion and other key stakeholders as appropriate to ensure the effective delivery and embedding of anti-fraud messaging across the organisation
- There were no NHS quality assurance recommendations issued during the year which required review and/or action. The LCFS regularly distributed NHS Counter Fraud

Authority Fraud Prevention Notices and Intelligence Bulletins to relevant staff as appropriate

Head of Internal Audit Opinion

Following completion of the planned audit work for the period 01 July 2022 to 31 March 2023 for the ICB, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the ICB's system of risk management, governance and internal control. The Head of Internal Audit concluded that:

Moderate Assurance can be given that there is an adequate system of internal control, however, in some areas weaknesses in design and/or inconsistent application of controls puts the achievement of some of the organisation's objectives at risk.

During the period, Internal Audit issued the following audit reports:

Area of Audit	**Level of Assurance Given**
Assurance Framework (AF)	The organisation's AF is partially structured to meet the NHS requirements. The organisation has not agreed its risk appetite and as such, has not been used to inform the management of the AF. There could be greater visibility of the use of the AF by the organisation. The AF generally reflects the risks discussed by the Board.
Risk Management Core Controls	NHS GM is progressing with the development and implementation of core controls.
Governance Core Controls	NHS GM has significantly progressed its development and implementation of core controls
Conflicts of Interest Core Controls	NHS GM is progressing with the development and implementation of core controls.
Quality Governance Core Controls	NHS GM is progressing with the development and implementation of core controls.
Information Governance Core Controls (ICB Integration Planning Review)	NHS GM is progressing with the development and implementation of core controls.
Financial Governance Core Controls	The ICB has significantly progressed its development and implementation of core controls

Area of Audit	Level of Assurance Given
ICB Core Controls Phase II– Follow Up	Limited progress has been made in fully implementing those actions with agreed implementation dates up to the 31st March 2023.
HfMA Improving NHS Financial Sustainability Checklist	Self-assessment was not fully complete at time of initial submission Self-assessment was appropriately approved Self-assessments against the 12 NHSE specified questions reviewed by internal audit were deemed to be reasonable apart from one area was identified as “partially compliant” (i.e., the statement holds about half of the time), but no actions for improvement were noted.
Key Financial Systems	Substantial Assurance
ESR: Payroll	Substantial Assurance
Mandatory Training	Substantial Assurance
Fit and Proper Persons	Limited Assurance
Serious Incidents	Moderate Assurance
Committee Effectiveness	Moderate Assurance
Data Security & Protection Toolkit	Feedback due to be provided to support the submission to NHS Digital in line with their timescales (30th June 2023)

Follow Up

During the course of the year, follow up reviews concluded that the organisation has made limited progress with regards to the implementation of recommendations. Internal Audit would continue to track and follow up outstanding actions.

Review of the effectiveness of governance, risk management and internal control

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the ICB who have responsibility for the development and maintenance of the internal control framework. I have

drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the ICB achieving its principles objectives have been reviewed, although acknowledge there is further work required to develop this. NHS GM will be working to address the recommendations raised as part of the period's internal audit reviews, in particular those areas identified as having either limited (Fit and Proper Persons) or moderate (Serious Incidents and Committee Effectiveness) assurance.

I have been advised on the implications of the result of this review by:

- The Board
- The Audit Committee
- The Quality and Performance Committee
- Internal audit

The role of each of these mechanisms of internal control has been described previously in this governance statement.

Conclusion

In the period 01 July 2022 to 31 March 2023 no significant internal control issues have been identified. Since its establishment, NHS GM has continued to work on strengthening its governance structures and financial controls. The Head of Internal Audit Opinion states that the CCG can take 'moderate assurance' demonstrating that there is an adequate system of internal control in place. However, it is accepted there are some areas weaknesses in design and/or inconsistent application of controls, and NHS GM will continue to develop these to ensure they are designed to meet the organisation's objectives and that controls are applied consistently.

Remuneration and Staff Report

Remuneration Report

Remuneration Committee

The Remuneration Committee is a committee of NHS Greater Manchester Integrated Care Board. It has those executive powers, delegated to it by the ICB within the NHS GM scheme of delegation contained in its terms of reference, which are reviewed on an annual basis. It does not set the remuneration, fees and other allowances for the members of the Committee. All recommendations made by the Committee are referred to the Integrated Care Board for decision.

Information on the Committee's membership can be found in the Members Report (under the heading 'Committee(s), including Audit Committee').

Only members have the right to attend Remuneration Committee meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the Remuneration Committee. Meetings may also be attended by the following individuals who are not members of the Remuneration Committee for all or part of a meeting as and when appropriate. Such attendees will not be eligible to vote:

- Chief Executive or their nominated deputy
- Chief People Officer or nominated deputy
- Other senior officer as requested by the Chair of the committee
- Board secretary

The Remuneration Committee's main purpose is to make recommendations to NHS GM on:

- Newly established or new appointments to senior NHS GM posts
- NHS GM pay policy including adoption of any pay frameworks and salaries for new director appointments (including but not limited to board members).
- NHS GM pay policy including adoption of any pay frameworks and remuneration for new nonexecutive director appointments
- The approval of any exit payments for VSM employees, including the issue of associated contractual and non-contractual payments and referral into the national approvals process.
- The approval of any non-contractual exit payments for AfC employees

The Remuneration Committee will exercise delegated authority on behalf of NHS GM to set remuneration, fees and other allowances for employees and for other people working for NHS GM who are not employed on Agenda for Change (AfC) terms and conditions of service which includes clinical leads, contracts for services or office holder arrangements.

Percentage change in remuneration of highest paid director

It is not possible for NHS Greater Manchester ICB to disclose details of the percentage change in remuneration of the ICB's highest paid Director of the average percentage change in staff. This is due to the ICB being formed on 01 July 2022, with no comparative information for the prior period. Pay ratio information is included below to provide details of the median and quartile remuneration of ICB employees and its ratio to the remuneration of the ICB's highest paid director.

Pay ratio information (subject to audit)

Reporting bodies are required to disclose the relationship between the total remuneration of the highest-paid director / member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component.

The banded remuneration of the highest paid director in NHS Greater Manchester ICB was £255,000-£260,000. This disclosure assumes that NHS GM has been an organisation for the full year as opposed to 9 months that the ICB has been established for.

The relationship to the remuneration of the organisation's workforce is disclosed in the below tables.

2022/23	25th percentile	Median pay ratio	75th percentile pay ratio
Total remuneration (£)	£35k	£47k	£59k
Salary component of total remuneration (£)	£35k	£46k	£59k
Remuneration ratio information	7.27:1	5.48:1	4.38:1
Salary ratio information	7.37:1	5.59:1	4.38:1

The table above includes the accrued costs in respect of the NHS pay award for 2022/23.

During the reporting period 2022/23, no employees received remuneration in excess of the highest-paid director. Remuneration ranged from £10,000-£257,500.

Total remuneration includes salary costs, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Policy on the remuneration of senior managers

The contract for senior managers states that:

If the employee wishes to terminate their employment, they must give the organisation an appropriate period of notice in writing – a minimum of six months. The organisation will give a period of six months' notice.

NHS GM shall be entitled to terminate the individual's employment summarily, i.e. without notice or pay in lieu of notice, without prejudice to any rights or claims it may have against them, if at any time they are guilty of gross misconduct or if they commit any serious breach of a material term of their contract of employment.

If the individual is employed on a fixed term contract, their employment will terminate on the expiry of the fixed term without the need for NHS GM to give any additional notice.
NHS GM may require an individual to take any outstanding annual leave entitlement during their notice period, whether notice to terminate is given by them or by the ICB.
NHS GM has the discretion to terminate employment lawfully without any notice by paying a payment in lieu of notice. Once notice has been given by either party the employer reserves the right to do any of all of the following:

- Exclude an employee from its premises
- Require an employee to carry out alternative duties or such specific duties as the organisation may specify or no duties
- Revoke or suspend any powers the employee may have as a Board member or require the employee to refrain from attending meetings of the Board or any of its committees
- Announce to other employees that an employee has given or received notice
- Require the employee to delivery to the Employer any of its property in your possession
- Pay the employee in lieu of notice

There are no special provisions for termination due to redundancy other than those stated for all employees in NHS GM Organisational Change Framework and legacy Organisational Change Policies.

Service Contracts of Other Board Members (non-management)

There are members of the Board whose services are via a Contract for Services. The termination arrangements for these individuals are as follows:

- Continuation of their appointment is contingent on their continued satisfactory performance and re-election/selection by the members as required by the Constitution
- The individual may resign from NHS Greater Manchester Integrated Care Board at any time by giving written notice to the Chair
- The organisation reserves the right to terminate their appointment with immediate effect and without payment of compensation by written notice
- On termination of the appointment, the individual shall only be entitled to accrued fees as at the date of termination, together with the reimbursement of any expenses properly incurred prior to that date

Due to the terms in the contract for service there is no liability to the organisation in the event of early termination.

Remuneration of Very Senior Managers

The ICB has four senior leaders who would have been paid more than £150,000 per annum had they worked on a full-time basis. All NHS GM senior leaders were appointed within the parameters of the ICB national pay framework. NHS GM has satisfied itself that the remuneration is reasonable through the application of its remuneration policy.

The CEO was appointed on a salary above £150k at the bottom of the national pay framework range for the post – this appointment was made nationally and reported to the NHS GM Remuneration Committee.

Senior manager remuneration (subject to audit)

Name and Title	1 July 2022 to 31 March 2023					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100**	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£	£000	£000	£000	£000
Executive members						
Mark Fisher (Chief Executive)	190-195	0	0	0	42.5-45	235-240
Sarah Price (Deputy Chief Executive/Chief Officer for Population Health and Inequalities)	115-120	0	0	0	5-7.5	120-125
Warren Heppolette (Chief Officer for Strategy & Innovation)	100-105	0	0	0	0	100-105
San Simpson (Chief Finance Officer)	120-125	0	0	0	102.5-105	225-230
Steve Dixon (Chief Delivery Officer)	105-110	0	0	0	15.0-17.5	120-125
Janet Wilkinson (Chief People Officer)	110-115	0	0	0	0	0
Dr Manisha Kumar (Chief Medical Officer)	130-135	0	0	0	0*	130-135
Mandy Philbin (Chief Nursing Officer)	90-95	0	0	0	180-182.5	270-275

Name and Title	1 July 2022 to 31 March 2023					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100**	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£	£000	£000	£000	£000
Gill Gibson (Interim Chief Nursing Officer)	20-25	0	0	0	0	20-25
Non-Executive Members						
Sir Richard Leese (Chair)	55-60	0	0	0	0	55-60
Richard Paver (Audit Committee)	15-20	0	0	0	0	15-20
Shazad Sarwar (Remuneration Committee)	10-15	0	0	0	0	10-15
Dame Sue Bailey (Quality Committee)	5-10	0	0	0	0	5-10
Khalida Kay (Finance Committee)	5-10	0	0	0	0	5-10
Partner Members (where remunerated)						
Dr Vishal Mehra (Partner - Primary Care)	15-20	0	0	0	0	15-20

***Note: Taxable expenses and benefits in kind are expressed to the nearest £100.*

The below notes are intended to assist the reader of the accounts in understanding the above tables.

As the ICB came into existence on 01 July 2022, all individuals joined the organisation on that date, unless separately specified below. Details are included below of the equivalent annual salary of officers:

- Mark Fisher's annual salary for his role as Chief Executive is £257,500
- Sarah Price is the Deputy Chief Executive/Chief Officer for Population Health and Inequalities from 01 July 2022 During the nine-month 6period, Sarah was paid £115,085, and the post had a full year Annual Salary equivalent of £147,544
- Warren Heppolette is the Chief Officer for Strategy and Innovation from 01 July 2022. During the nine-month period, Warren was paid £93,600, and the post had a full year Annual Salary equivalent of £122,000.
- Sam Simpson's annual salary for her role as Chief Finance Officer is £166,860.
- Steve Dixon left his role as Chief Delivery Officer on 31 March 2023, under the terms of a Mutually Agreed Resignation Scheme (MARS). As part of this MARS scheme, Mr Dixon received a payment of £80,000. The value of this payment is excluded from the table above as it does not constitute salary or other item disclosable in the table above. The MARS scheme was authorised by NHS England, and Mr Dixon's entitlement to it was calculated on the same basis as the entitlement to all other members of staff. The total

cost of the MARS scheme is disclosed within note 4 to the accounts. The post had a full year annual salary equivalent of £146,775.

- Janet Wilkinson's annual salary for her role as Chief People Officer is £146,775. Mrs Wilkinson is not a contributing member of the NHS pensions scheme, and therefore there are no pension benefits to disclose.
- Dr Manisha Kumar's annual salary for her role as Chief Medical Officer is £175,100. Prior year balances for Dr Kumar's pension entitlements are unavailable and therefore no pension benefits figures are included.
- Mandy Philbin's annual salary for her role as Chief Nursing Officer is £159,650. Mandy joined the ICB on 01 September 2022
- Gill Gibson was appointed as the ICB's Interim Chief Nursing Officer for the period 01 July 2022 to 31 August 2022 and for this period received £21,000 in salary, being an equivalent annual salary of £126,000. On the appointment of Mandy Philbin to the Chief Nursing Officer role, Gill returned to her role as Director of Quality and Nursing within the Tameside Locality. Therefore, Gill was no longer considered to meet the criteria for disclosure in the remuneration report
- Sir Richard Leese annual salary for his role as Chair of the ICB is £75,000
- Richard Paver's annual salary for his role as a Non-Executive Director is £20,000
- Shazad Sarwar's annual salary for his role as a Non-Executive Director is £16,000
- Dame Sue Bailey's annual salary for her role as a Non-Executive Director is £16,000
- Khalida Kay's annual salary for her role as a Non-Executive Director is £16,000.

The following Partner members are not remunerated by the ICB for their roles within the organisation, being paid instead by the bodies they represent as part of their role; Paul Dennett (Local Authority Partner Member), Leigh Vallance (VCSE), Dr Owen Williams (Acute Sector), Neil Thwaite (Acute Mental Health).

Dr Vishal Mehra's annual salary for his role as a Partner (Primary Care) is £21,885.
In addition to this, Dr Vishal Mehra is remunerated by the ICB for their role as Chair of the Manchester GP Board. In this role during the 9-month period they were paid £27,339.93, equating to an annual payment of £36,453.22.

Pension benefits (subject to audit)

	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31 March 2023 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2023 (bands of £5,000)	(e) Estimated Cash Equivalent Transfer Value at 1 July 2022	(f) Real Increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2023	(h) Employers Contribution to partnership pension
Name and Title	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Mark Fisher (Chief Executive)	2.5-5	0	0-5	0	0	32	58	0

Sam Simpson (Chief Finance Officer)	5-7.5	7.5-10	60-65	120-125	1,038	103	1,180	0
Steve Dixon (Chief Delivery Officer)	0-2.5	0	50-55	95-100	898	18	951	0
Mandy Philbin (Chief Nursing Officer)	7.5-10	20-22.5	55-60	135-140	979*	177	1,183	0
Dr Manisha Kumar (Chief Medical Officer)			30-35	85-90			638	0
Warren Heppolette (Chief Officer for Strategy & Innovation)	0-2.5	0	55-60	0	773	19	823	0
Sarah Price (Deputy Chief Executive/Chief Officer for Population Health and Inequalities)	0-2.5	0	60-65	125-130	1,247	16	1,307	0

- Mandy Philbin joined the ICB on 01 September 2022, the opening CETV value in the table above is estimated as at that date.
- Dr Manisha Kumar's Pension data is presented as of 31 March 2023 only. The ICB were unable to calculate the real increase in pension values and CETV values as opening balances were not available from NHS Pensions, as Dr Kumar joined the officers' element of the pension scheme on 1st August 2022.

Non-executive Directors are not permitted to become members of the NHS Pensions Scheme in respect of their roles with the ICB.

The ICB is only able to obtain confirmation of the movement in the cash equivalent transfer values for the directors' pension entitlements for the period from 1 April 2022 to 31 March 2023. As a result, the ICB has apportioned the movement on a straight-line basis to estimate the cash equivalent transfer value as at 01 July 2022. This is considered to be a reasonable approximation of the movement in the value of the entitlements during the year.

Inflation 3.1% applied to Prior year figures as per guidance provided to the ICB.

Where there has been a negative movement from last years inflated figures to closing figures for 2023 then a 'Zero' has been stated.

Cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

Compensation on early retirement of for loss of office (subject to audit)

Note 4 to the accounts discloses the Termination Benefits payable by the ICB in the 9-month period to 31 March 2023. These were payable under two separate schemes.

A compulsory redundancy scheme existed for individuals who had been displaced following transfer from their predecessor bodies on the formation of the ICB, and suitable alternative employment could not be found within the ICB. The numbers and values of payments associated with these cases are disclosed in note 4.

The Mutually Agreed Resignation Scheme (MARS) was authorised by NHS England, in line with the terms and conditions stipulated as part of Agenda for Change. The total cost of the MARS scheme is disclosed within note 4 to the accounts.

Payments to past directors (subject to audit)

The ICB has made no payments to past directors in the 9-month period to 31 March 2023.

Staff Report

Number of senior managers

The information on the number of senior managers is presented in the table below for the 9-month period to the 31 March 2023.

Pay Grade	Headcount	FTE
Band 8 - Range C	69	66.05
Band 8 - Range D	50	49.45
Band 9	17	17.40
Other	139	77.74
Grand Total	**275**	**210.64**

Staff numbers and costs (subject to audit)

The staff numbers and cost information disclosed in the following two tables (staff costs and average staff numbers) are subject to validation by external audit. These numbers relate to the nine months of the ICB only.

	Permanent £000s	Others £000s	Total £000s
Salaries & Wages	60,103	3,284	63,387
Social Security costs	6,829	2	6,831
Employer Contribution to the NHS Pension Scheme	10,430	9	10,439
Other Pension Costs	3	-	3
Apprenticeship Levy	189	-	189
Other post-employment benefits	-	-	-
Other employment benefits	-	-	-
Termination Benefits	2,086	-	2,086
Less Recoveries in respect of employee benefits	(1,270)	-	(1,270)
Staff Costs 2022/23	**78,370**	**3,272**	**81,665**

Staff composition

The numbers in the staff composition table are as of 31 March 2023.

Pay Band	Female	Male	Total
All Senior Managers	158	117	275
Comprising:			
Executive Team	6	7	13
Senior Managers	152	110	262
Other Employees	1,065	438	1,503
Total	**1,223**	**555**	**1,778**

Sickness absence data

The numbers contained in the sickness absence data have been validated by external audit and they cover 8 months of data for NHS GM.

2018-19	**Number**
Total Days lost	11,996
Total staff years	1,798.30
Average working days lost	6.70
Number of persons retiring on ill health grounds	**-**

Staff turnover percentages

The turnover figure for the ICB is 13.07% (218.46 FTE Leavers / 1672.00 FTE average staff in post over that period)

Staff engagement percentages

From November to December 2022, our people were invited to complete the NHS GM All Staff Survey. We received 764 responses which equated to a 40% response rate across the organisation.

Three key themes emerged:

1. Shared vision: Staff want to know what the short and long-term vision is for NHS GM and how their roles fit into this.
2. Leadership visibility: Staff want to see more of their Exec team and Place Based Leads, and to have more meaningful communication around key staff concerns.

3. Organisational belonging: Staff want to feel a greater sense of belonging to NHS GM, and a stronger part of the new organisation

Following receiving the results of the survey, engagement sessions were held with the workforce to start to co-design the action plan. The action plan was shared with the key individuals and groups for feedback to ensure it was reflective of what our people and staff networks and forums thought was important. We were delighted that our action plan signed off by the executive team on 27.03.23 – much of this will be used to inform our OD and Culture plan and priorities for NHS GM for 2023/24.

Staff policies

The movement of staff into NHS GM on 01 July 2022 occurred under Transfer of Undertakings Protection of Employment (TUPE) regulations which had an effect on policy status. In partnership with Staff Side representatives and incorporating due diligence in relation to Equality, Diversity and Inclusion, NHS GM developed and agreed a suite of 12 policies to operate from day 1 of the new organisation; the remainder of contractual policies from the 10 CCGs and Greater Manchester Shared Services carried forward as legacy policies, subject to their existing review dates and/or planned review work programmes for agreement with Staff Side Partnership Forum.

All policies have been publicised and are fully accessible to all employees and support is provided to Line Managers to ensure that all policies are implemented in a fair and inclusive way across the organisation.

Trade Union Facility Time Reporting Requirements

Relevant union officials The Trade Union (Facility Time Publication Requirements) Regulations 2017 requires the ICB to report on trade union facility time in their organisation. Facility time is paid time off for union representatives to carry out trade union activities.

Number of employees who were relevant union officials during the relevant period	FTE equivalent employee number
15	1599.56

Percentage of time	Number of employees
0%	0
1-50%	14
51-99%	0
100%	1

First column	Figures
Provide the total cost of facility time	£51,100
Provide the total pay bill	£82,922,000
Provide the total % of the total pay bill spent on facility time	0.0616%
Time spent of paid trade union activities as a % of total paid facility time hours	100%

Other employee matters

Learning and development

The NHS GM is committed to ensuring that all our people are developed and encouraged to meet the requirements of their job, perform to the standards expected and fulfil their potential. This involves making clear what is expected within clear timeframes, setting clear identifiable targets, monitoring performance, and providing appropriate learning and development opportunities.

NHS GM commits to providing fairness and consistency in the treatment of all employees. The ICB is committed to ensuring that all employees have equal access to opportunities to develop their full potential.

Since NHS GM came into existence in July 2022 there has been significant work to merge all mandatory training into one ICB Core Catalogue and the necessary ESR cleansing within each Locality to ensure a smooth transition of mandatory training histories.

MIAA have conducted an Audit Review of mandatory training, NHS GM have developed and agreed an action plan to achieve the following early in quarter 1 of 2023/24:

- Finalisation of the Mandatory Training Policy
- A review of the core catalogue and role specific modules to include the onset of initiatives such as the Oliver McGowan mandatory training, and Net Zero which will significantly increase the number of mandatory training modules our people need to complete
- A clear plan for mandatory training reporting and monitoring to ensure NHS GM is achieving required levels of compliance

NHS GM is committed to the safe transition of NHSE colleagues and plans have been developed to ensure that NHSE mandatory training histories are transferred successfully and that the transferring employees will adopt the NHS GM catalogue.
NHS GM is future planning around internal apprenticeships, in preparation for a single payroll levy account and to enable the management of legacy apprentices. Key priorities for 2023/24 include:

- To develop an organisational strategy and apprenticeship policy
- Scope the cost of the apprenticeship programme
- Understand the amount of money (including surplus) within the legacy levies, if it will be sufficient to cover the remainder of their programmes and whether this can be transferred to the NHS GM levy
- Establish a process for managing the centralised levy

NHS GM inherited a number of Hosted Apprentices from a legacy arrangement from Greater Manchester Shared Services. A paper was approved by NHS GM Executives recommending that NHS GM will no longer “host” apprentices placed in other organisations across the

Northwest. NHS GM will continue to manage the current “hosted” apprentices of which there are approximately thirty-two on a maximum two-year programme with the latest end date being October 2024.

NHS GM has developed an agreed process to understand the learning and development needs of our people. The Learning Needs Analysis is ready to be launched, but due to the phase 7 consultation it will now be launched across the whole organisation in autumn 2023. This will inform the priorities for utilisation of NHS GM’s Learning and Development budget for 23/24.

National Education and Training Survey (NETS)

The National Education and Training Survey (NETS) is the only national survey open to all students and doctors and dentists undertaking a practice placement or training post in healthcare services across England. The NETS offers a unique insight into the multi-professional practice learning environment and the experience of the current and future health and care workforce. The most recent NETS ran from 18 October to 30 November 2022 and a report was produced providing an overview of responses from learners based in the Northwest region.

Since the November 2022 NETS results were published HEE Northwest has undertaken many quality interventions of different types to listen to trainee experiences and to set requirements for providers where concerns are found. NETS results play a crucial role in identifying risks and external stakeholders aware of the NETS results for their learners and encourage them to engage with the concerns that learners have signposted via this route and to investigate and resolve issues.

The NHSE WTE team are undertaking a detailed analysis of the November 2022 NETS results down to the level of placement provider and programme. This will be triangulated with other evidence and intelligence sources and areas of concern will be followed up via a planned programme of quality interventions working with our stakeholders across the region to improve experiences for all our learners.

The outcomes from the NETS survey are assessable through the system education and professional governance forums across the ICS where results are discussed.

Appraisals and talent management conversations

NHS GM is currently using legacy appraisal processes, but has made available a Good Conversation Guide to support managers of newly formed teams and functions should they prefer to use a consistent approach. A new appraisal process which will embed talent management and career conversations will be scoped and launched in 2023/24.
NHS GM developed an interim process for NHS GM Executives to support the team of newly formed executives to have a consistent approach for objective setting.

Culture development

In the lead up to transition into NHS GM the OD and Culture team delivered a Cultural Audit in December 2021 – March 2022 with the aim of gaining an insight into the differing cultures of the 12 impacted organisations that formed the NHS GM (705 responses received). Several NHS GM staff have taken part in the 'Restorative Just Culture' programme – a working group has been formed and will recommend some actions to begin the journey into embedding a restorative just culture at NHS GM; using the GM ICP Strategy and People and Culture Strategy as a frame for developing our culture and ways of working.

NHS GM will utilise best practice tools and resources including Greater Manchester Good Employment Charter Leadership Development framework and NHS North West Leadership Academy system leadership behaviours to shape our culture development and the 'way we do things round here'.

NHS GM will continue the ongoing culture development work which will see the development, testing and launch of our culture, values and behaviours – our people will play a key role in helping to shape this work.

Staff Health and Wellbeing

NHS GM is focussed on a two-fold approach to the wellbeing of our workforce across the GM system:

- Design and delivery of the wellbeing activities and provision for NHS GM, to embed good wellbeing cultures into the newly established NHS Greater Manchester Integrated Care
- Support delivery of the GM system (ICS) wellbeing programme with system wide partners, and where possible, provision is extended to the wider health and care workforce across GM ICS, and will continue to build great wellbeing cultures across the Greater Manchester footprint.

The **practical, physical** and **psychological** pillars of wellbeing have a spotlight on provision and support that responds to the emerging wellbeing challenges. This includes a series of focussed approaches to improve the access and equity of health and wellbeing provision. This includes:

- **Wellbeing programme of activities and masterclasses** that support colleagues across four key areas responding to absence data and survey insights: Improving Financial Wellbeing; Mental Wellbeing, including Sleep, Suicide Prevention, Stress and Burnout; Physical activity, focussed on improving Musculoskeletal wellbeing; and Menopause
- Development and refresh of the **GM Wellbeing Toolkit and Wellbeing Engagement Quiz**, as resource for all colleagues, aligned with the recently launched GM People & Culture Strategy

- Building the network of 71 **Wellbeing Champions** across the NHS GM Integrated Care footprint, including 56 Mental Health First Aiders, 16 TRiM Practitioners, and 28 Physical Activity Champions
- Developing the **Employee Benefits** to support colleagues across NHS GM by providing products and services to improve wellbeing provision. This includes
    1. Cycle to Work scheme
    2. Car Lease provision
    3. Credit Union access via direct debit for greater equity to direct loans and savings
    4. Enhanced wellbeing provision to support Menopause CPD, and Carers UK provision.
- NHS GM has established the **Wellbeing Day** and Pay It Forward **Volunteer Days** to enhance the wellbeing provision; as well as support the set-up of peer led social networks – craft club, book club, walking groups, and various sports activities and choirs - to enhance wellbeing levels and social connection
- The **advice and guidance** across a number of workforce activities, including signposting to support provision; regular newsletters and updates through engagement networks and channels; risk assessments; support workplace cultures for good conversations; process and policy development; and flexible working approaches to create a work life balance to suit individual needs
- This is underpinned by the **Occupational Health** provision to support wellbeing and absence support in the workplace, and wider **Employee Assistance Programme** for enhanced access to services 24 hrs a day. Working with system stakeholders to explore sustainable provision, and collaborative procurement activities

Expenditure on consultancy

The expenditure on consultancy in 2022/23 for the ICB totals £314k.

Off-payroll engagements

Table 1: Length of all highly paid off-payroll engagements

For all off-payroll engagements as at 31 March 2023 for more than £245* per day:

	Number
Number of existing engagements as of 31 March 2023	34
Of which, the number that have existed:	
for less than one year at the time of reporting	34
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

*The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

Table 2: Off-payroll workers engaged at any point during the financial year

For all off-payroll engagements between 01 July 2022 and 31 March 2023, for NHS Greater Manchester Integrated Care Board of more than £245(1) per day:

	Number
No. of temporary off-payroll workers engaged between 01 July 2022 and 31 March 2023	2
Of which:	
No. not subject to off-payroll legislation	1
No. subject to off-payroll legislation and determined as in-scope of IR35	0
No. subject to off-payroll legislation and determined as out of scope of IR35	1
the number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: no. of engagements that saw a change to IR35 status following review	0

Table 3: Off-payroll engagements / senior official engagements

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 01 July 2022 and 31 March 2023:

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during reporting period	0
Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the reporting period. This figure should include both on payroll and off-payroll engagements.	9

Exit packages, including special (non-contractual) payments (subject to audit)

Table 1: Exit Packages

Exit package cost band (inc. any special payment element	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed (see Table 2 below)	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s
Less than £10,000	4	16,325	10	54,976	14	71,301	-	-
£10,000 - £25,000	2	26,667	14	221,102	16	247,769	-	-
£25,001 - £50,000	2	91,333	13	484,220	15	575,553	-	-
£50,001 - £100,000	3	186,667	8	524,507	11	711,174	-	-
£100,001 - £150,000	-	-	-	-	-	-	-	-
£150,001 – £200,000	3	480,000	-	-	3	480,000	-	-
>£200,000	-	-	-	-	-	-	-	-
TOTALS	14	800,992	45	1,284,805	59	2,085,797	-	-

No departures have occurred in the period to 31 March 2023 where special payments have been made.

Table 2: Analysis of Other Departures

	Agreements	Total Value of agreements
	Number	£000s
Voluntary redundancies including early retirement contractual costs	-	-
Mutually agreed resignations (MARS) contractual costs	**45**	**1,284.8**
Early retirements in the efficiency of the service contractual costs	-	-
Contractual payments in lieu of notice	-	-
Exit payments following Employment Tribunals or court orders	-	-
Non-contractual payments requiring HMT approval	-	-
TOTAL	**45**	**1,284.8**

All staff for whom an exit package was paid in the nine-month period to 31 March 2023 were transferred to the ICB from predecessor CCGs.

Other departure costs have been paid in accordance with the provisions of a Mutually Agreed Resignation Scheme, the terms of which were agreed with NHS England.

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the period of departure.

Parliamentary Accountability and Audit Report

NHS GM is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report. An audit certificate and report is also included in this Annual Report at page 134.

ANNUAL ACCOUNTS

Mark Fisher

Accountable Officer

28 June 2023

CONTENTS **Page Number**

The Primary Statements:

Statement of Comprehensive Net Expenditure for the nine-month period ended 31 March 2023

	Note	2022-23 £'000
Income from sale of goods and services	2	(91,550)
Other operating income	2	(2,172)
Total operating income		**(93,722)**
Staff costs	4	82,935
Purchase of goods and services	5	5,147,737
Depreciation and impairment charges	5	1,003
Provision expense	5	(3,205)
Other Operating Expenditure	5	2,833
Total operating expenditure		**5,231,304**
Net Operating Expenditure		**5,137,582**
Finance income		-
Finance expense		71
Net expenditure for the Period		**5,137,653**
Comprehensive Expenditure for the period		**5,137,653**

The ICB had no other comprehensive income or expenditure in the nine-month period ending 31st March 2023.

Statement of Financial Position as at 31 March 2023

	Note	31st March 2023 £'000	1st July 2022 £'000
Non-current assets:			
Property, plant and equipment		79	139
Right-of-use assets	8	9,982	10,571
Other financial assets	10	1,106	1,106
Total non-current assets		**11,167**	11,816
Current assets:			
Inventories		-	-
Trade and other receivables	9	62,016	32,288
Cash and cash equivalents	11	133	3,884
Total current assets		**62,149**	**36,172**
Total assets		**73,316**	47,988
Current liabilities			
Trade and other payables	12	(401,809)	(291,316)
Lease liabilities	8	(1,268)	(1,257)
Provisions	13	(1,108)	(2,930)
Total current liabilities		**(404,185)**	(295,503)
Non-Current Assets Net Current Liabilities		**(330,869)**	(247,515)
Non-current liabilities			
Lease liabilities	8	(8,766)	(9,286)
Provisions	13	(299)	(1,822)
Total non-current liabilities		**(9,065)**	**(11,108)**
Assets less Liabilities		**(339,934)**	(258,623)
Financed by Taxpayers' Equity			
General fund		(339,934)	(258,623)
Total taxpayers' equity:		**(339,934)**	(258,623)

The notes on pages 109 to 133 form part of this statement

The financial statements were approved by the Board on 21 June 2023 and signed on its behalf by:

Mark Fisher
Accountable Officer

Statement of Changes In Taxpayers Equity for the nine-month period ended 31 March 2023

		General fund £'000
Changes in taxpayers' equity for 2022-23		
Balance at 01 July 2022		-
Transfer between reserves in respect of assets transferred from closed NHS bodies	7	(258,291)
Adjusted Integrated Care Board balance at 1st July 2022		**(258,291)**
Changes in NHS Integrated Care Board taxpayers' equity for 2022-23		
Net operating expenditure for the financial period		(5,137,653)
Net gain/(loss) on revaluation of property, plant and equipment		-
Total revaluations against revaluation reserve		
Transfers by absorption to (from) other bodies	7	(331)
Net Recognised NHS Integrated Care Board Expenditure for the Financial period		**(5,137,984)**
Net funding		5,056,341
Balance at 31 March 2023		**(339,934)**

Statement of Cash Flows for the period ended 31 March 2023

	Note	2022-23 £'000
Cash Flows from Operating Activities		
Net operating expenditure for the financial period		(5,137,653)
Depreciation and amortisation		1,003
Movement due to transfer by Modified Absorption		-
Interest paid		71
(Increase)/decrease in trade & other receivables	9	(29,729)
Increase/(decrease) in trade & other payables	12	110,493
Provisions utilised	13	(139)
Increase/(decrease) in provisions	13	(3,205)
Net Cash Inflow (Outflow) from Operating Activities		**(5,059,157)**
Cash Flows from Investing Activities		
Interest received/(paid)		(71)
(Payments) for property, plant and equipment		-
(Payments) for intangible assets		-
Rental revenue		-
Net Cash Inflow (Outflow) from Investing Activities		**(71)**
Net Cash Inflow (Outflow) before Financing		**(5,059,229)**
Cash Flows from Financing Activities		
Grant in Aid Funding Received		5,056,341
Repayment of lease liabilities	8	(864)
Net Cash Inflow (Outflow) from Financing Activities		**5,055,477**
Net Increase (Decrease) in Cash & Cash Equivalents	11	**(3,751)**
Cash & Cash Equivalents at the Beginning of the Financial period		**3,884**
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		-
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Period		**133**

The notes on pages 109 to 133 form part of this statement

Notes to the financial statements

1 **Accounting Policies**

NHS England has directed that the financial statements of Integrated Care Boards (ICBs) shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2022-23 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to Integrated Care Boards, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the ICB for the purpose of giving a true and fair view has been selected. The particular policies adopted by the ICB are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 **Going Concern**

These accounts have been prepared on a going concern basis.
The Health and Care Act was given Royal Assent on 22 April 2022. The Act allowed for the establishment of Integrated Care Boards (ICB) across England and abolished Clinical Commissioning Groups (CCG). ICBs took on the commissioning functions of CCGs. The CCG functions, assets and liabilities were transferred to the ICB on 1 July 2022.
Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.
When clinical commissioning groups ceased to exist on 1 July 2022, the services continued to be provided by ICBs (using the same assets, by another public sector entity). The financial statements for ICBs are prepared on a Going Concern basis as they will continue to provide the services in the future.

1.2 **Accounting Convention**

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.3 **Movement of Assets within the Department of Health and Social Care Group**

As Public Sector Bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care Group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the Department of Health and Social Care GAM requires the application of modified absorption accounting. Modified absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector.
Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Changes in Taxpayers Equity.
Other transfers of assets and liabilities within the Department of Health and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.
As NHS Greater Manchester Integrated Care Board was formed on 1st July 2022, no revenue comparator data is included in these nine-month accounts. A Statement of Financial Position is presented at the point of transfer, being the assets and liabilities transferred from the 10 former NHS Clinical Commissioning Groups of Greater Manchester, as well as the Greater Manchester Shared Services (GMSS) function, previously hosted by the Northern Care Alliance NHS Foundation Trust. More details around the balances transferred to the ICB is provided in note 7 to these accounts.
The ICB has taken on the commissioning responsibilities of the 10 former Greater Manchester CCGs, although the commissioning responsibility related to patients registered with Glossop based GP practices has transferred instead to NHS Derby and Derbyshire Integrated Care Board. In addition, Greater Manchester ICB has taken on commissioning responsibility for Pharmacy, Optometry and Dentistry services in Greater Manchester from NHS England from 1st July 2022.

1.4 **Pooled Budgets**

The ICB has entered into pooled budget arrangement with each of the ten local authorities in Greater Manchester, in accordance with Section 75 of the NHS Act 2006. Under this arrangement, funds are pooled for the purpose of improving the commissioning of health and social care and note 16 to the accounts provides details of the income and expenditure. The operating arrangements relating to each pooled budget are specific to that agreement and are further discussed in note 16 of these accounts.

1.5 **Revenue**

The main source of funding for the ICBs is from NHS England. This is drawn down and credited to the general fund as cash is required to settle liabilities as they fall due. Funding is recognised in the period in which it is received.
Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.
Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.
Payment terms are standard reflecting cross government principles.
The value of the benefit received when the ICB accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

Notes to the financial statements

1.6 **Employee Benefits**

1.6.1 **Short-term Employee Benefits**
Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.
The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.6.2 **Retirement Benefit Costs**
Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales.
They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.
Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.
For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the ICB commits itself to the retirement, regardless of the method of payment.
The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.7 **Other Expenses**
Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.8 **Leases**
A lease is a contract, or part of a contract, that conveys the right to control the use of an asset for a period of time in exchange for consideration.
The ICB assesses whether a contract is or contains a lease, at inception of the contract.

1.8.1 **The ICB as Lessee**
A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.
The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.
The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.
The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.
The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.

1.9 **Cash & Cash Equivalents**
Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.
In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the ICB's cash management.

1.10 **Provisions**
Provisions are recognised when the ICB has a present legal or constructive obligation as a result of a past event, it is probable that the ICB will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties.

1.11 **Clinical Negligence Costs**
NHS Resolution operates a risk pooling scheme under which the ICB pays an annual contribution to NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with ICB.

Notes to the financial statements

1.12 **Contingent liabilities and contingent assets**

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the ICB, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the ICB. A contingent asset is disclosed where an inflow of economic benefits is probable.

1.13 **Financial Assets**

Financial assets are recognised when the ICB becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories:

- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income and ;
- Financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.13.1 **Financial Assets at Amortised cost**

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.13.2 **Impairment**

For all financial assets measured at amortised cost or at fair value through other comprehensive income, lease receivables and contract assets, the ICB recognises a loss allowance representing the expected credit losses on the financial asset.

The ICB adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The ICB therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the ICB does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.14 **Financial Liabilities**

Financial liabilities are recognised on the statement of financial position when the ICB becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.14.1 **Other Financial Liabilities**

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.15 **Value Added Tax**

Most of the activities of the ICB are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Notes to the financial statements

1.16 **Foreign Currencies**
The ICB's functional currency and presentational currency is pounds sterling and amounts are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions.

1.17 **Third Party Assets**
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the ICB has no beneficial interest in them.

1.18 **Losses & Special Payments**
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.
Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the ICB not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.19 **Critical accounting judgements and key sources of estimation uncertainty**
In the application of the ICB's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.19.1 **Critical accounting judgements in applying accounting policies**
The ICB has reviewed the judgements that management has made in the process of applying the ICB's accounting policies and concluded that there are no critical accounting judgements made which have a material impact on these financial statements

1.19.2 **Sources of estimation uncertainty**
The ICB has considered the areas where it makes significant estiamtes in preparing these accounts. On review of the estimates, the ICB has concluded that there are no estimates made which are subject to material estimation uncertainty.

1.20 **New and revised IFRS Standards in issue but not yet effective**

- IFRS 14 Regulatory Deferral Accounts – Not UK-endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore, not applicable to DHSC group bodies.
- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be April 2025: early adoption is not therefore permitted.

The ICB has considered the potential impact of the above new standards on its accounts, and concluded that it does not expect them to have a material impact of the ICB's financial statements.

2 Other Operating Revenue

	2022-23 Total £'000
Income from sale of goods and services (contracts)	
Education, training and research	286
Non-patient care services to other bodies	15,024
Prescription fees and charges	29,508
Dental fees and charges	33,893
Other Contract income	11,569
Recoveries in respect of employee benefits	1,270
Total Income from sale of goods and services	**91,550**
Other operating income	
Non cash apprenticeship training grants revenue	137
Other non contract revenue	2,035
Total Other operating income	**2,172**
Total Operating Income	**93,722**

3 Disaggregation of Income - Income from sale of good and services (contracts)

	Education, training and research	Non-patient care services to other bodies	Prescription fees and charges	Dental fees and charges	Other Contract income	Recoveries in respect of employee benefits
	£'000	£'000	£'000	£'000	£'000	£'000
Source of Revenue						
NHS	224	4,471	-	-	8,315	771
Non NHS	62	10,553	29,508	33,893	3,254	499
Total	**286**	**15,024**	**29,508**	**33,893**	**11,569**	**1,270**

The ICB has no contract revenue expected to be recognised in future periods related to contract performance obligations not yet completed at the reporting date.

4. Employee benefits and staff numbers

4.1.1 Employee benefits

	Total		2022-23
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	60,103	3,284	**63,387**
Social security costs	6,829	2	**6,831**
Employer Contributions to NHS Pension scheme	10,430	9	**10,439**
Other pension costs	3	-	**3**
Apprenticeship Levy	189	-	**189**
Termination benefits	2,086	-	**2,086**
Gross employee benefits expenditure	**79,640**	**3,295**	**82,935**
Less recoveries in respect of employee benefits (note 4.1.2)	(1,270)	-	**(1,270)**
Total - Net admin employee benefits including capitalised costs	**78,370**	**3,295**	**81,665**
Less: Employee costs capitalised	-	-	-
Net employee benefits excluding capitalised costs	**78,370**	**3,295**	**81,665**

4.1.2 Recoveries in respect of employee benefits

	2022-23		
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits - Revenue			
Salaries and wages	(1,145)	-	(1,145)
Social security costs	(61)	-	(61)
Employer contributions to the NHS Pension Scheme	(64)	-	(64)
Total recoveries in respect of employee benefits	**(1,270)**	**-**	**(1,270)**

4.2 Average number of people employed

	2022-23		
	Permanently employed Number	Other Number	Total Number
Total	**1,599.56**	**98.13**	**1,697.69**
Of the above:			
Number of whole time equivalent people engaged on capital projects	-	-	-

4.4 Exit packages agreed in the period

	2022-23 Compulsory redundancies		2022-23 Other agreed departures		2022-23 Total	
	Number	£	Number	£	Number	£
Less than £10,000	4	16,325	10	54,976	14	71,301
£10,001 to £25,000	2	26,667	14	221,102	16	247,769
£25,001 to £50,000	2	91,333	13	484,220	15	575,553
£50,001 to £100,000	3	186,667	8	524,507	11	711,174
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	3	480,000	-	-	3	480,000
Over £200,001	-	-	-	-	-	-
Total	**14**	**800,992**	**45**	**1,284,805**	**59**	**2,085,797**

No departures have occurred in the period to 31st March 2023 where special payments have been made.

Analysis of Other Agreed Departures

	2022-23 Other agreed departures	
	Number	£
Voluntary redundancies including early retirement contractual costs	-	-
Mutually agreed resignations (MARS) contractual costs	45	1,284,805
Early retirements in the efficiency of the service contractual costs	-	-
Contractual payments in lieu of notice	-	-
Exit payments following Employment Tribunals or court orders	-	-
Non-contractual payments requiring HMT approval	-	-
Total	**45**	**1,284,805**

All staff for whom an exit package was paid in the nine-month period to 31st March 2023 were transferred to the ICB from predecessor CCGs.

Other departure costs have been paid in accordance with the provisions of a Mutually Agreed Resignation Scheme, the terms of which were agreed with NHS England.

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the period of departure.

The Remuneration Report includes the disclosure of exit payments payable to individuals named in that Report.

4.5 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

4.5.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2023, is based on valuation data as 31 March 2022, updated to 31 March 2023 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

4.5.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

5. Operating expenses

	2022-23 Total £'000
Purchase of goods and services	
Services from other ICBs and NHS England	2,008
Services from foundation trusts	3,155,490
Services from other NHS trusts	125,678
Services from Other WGA bodies	169
Purchase of healthcare from non-NHS bodies	589,234
Purchase of social care	90,753
General Dental services and personal dental services	123,804
Prescribing costs	422,824
Pharmaceutical services	83,686
General Ophthalmic services	27,774
GPMS/APMS and PCTMS	414,153
Supplies and services – clinical	4,740
Supplies and services – general	47,484
Consultancy services	314
Establishment	21,593
Transport	374
Premises	30,519
Audit fees	276
Other non statutory audit expenditure	
· Internal audit services	-
· Other services	18
Other professional fees	4,312
Legal fees	976
Education, training and conferences	1,422
Non cash apprenticeship training grants	137
Total Purchase of goods and services	**5,147,737**
Depreciation and impairment charges	
Depreciation	1,003
Amortisation	0
Total Depreciation and impairment charges	**1,003**
Provision expense	
Provisions	(3,205)
Total Provision expense	**(3,205)**
Other Operating Expenditure	
Chair and Non Executive Members	120
Grants to Other bodies	707
Expected credit loss on receivables	387
Other expenditure	1,619
Total Other Operating Expenditure	**2,833**
Total operating expenditure	**5,148,369**

In accordance with SI 2008 no.489, The Companies (Disclosure of Auditor Remuneration and Liability Limitation Agreements) Regulations 2008, the ICB's contract with its auditors provides for the limitation of the auditor's liability to a maximum of £5m.

Audit fees include VAT that is not recoverable by the ICB.

The other non-statutory audit fees relate to certification of the ICB's Mental Health Investment Standard Compliance Statement.

Prescribing costs include £97.661m of accrued expenditure as at 31st March 2023.

6.1 Better Payment Practice Code

Measure of compliance	2022-23 Number	2022-23 £'000
Non-NHS Payables		
Total Non-NHS Trade invoices paid in the period	96,210	1,179,001
Total Non-NHS Trade Invoices paid within target	92,587	1,139,504
Percentage of Non-NHS Trade invoices paid within target	**96.23%**	**96.65%**
NHS Payables		
Total NHS Trade Invoices Paid in the period	1,998	3,398,008
Total NHS Trade Invoices Paid within target	1,943	3,396,976
Percentage of NHS Trade Invoices paid within target	**97.25%**	**99.97%**

6.2 The Late Payment of Commercial Debts (Interest) Act 1998

No claims have been made under the Later Payment of Commercial Debts (Interest) Act 1998.

7. Net gain/(loss) on transfer by absorption

Transfers as part of a reorganisation are to be accounted for by use of modified absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so the prior year transactions of the predecessor CCGs have not been restated. Modified absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Changes in Taxpayers Equity.

As explained elsewhere in these financial statements, NHS Greater Manchester Integrated Care Board was formed on 1st July 2022, taking on the assets and liabilities of the ten former Clinical Commissioning Groups (CCGs) which commissioned services for Greater Manchester. These transfers were conducted via modified absorption accounting , as described above.

In addition, NHS GM acquired the functions, assets, liabilities and staff of NHS Greater Manchester Shared Services (GMSS) from the Northern Care Alliance NHS Foundation Trust, also on 1st July 2022. Finally, NHS England transferred residual liabilities associated with the settlement of Continuing Health Care liabilities of the former Primary Care Trusts to NHS GM on 1st July 2022

	Balances transferred from closing NHS organisations										Balances transferred from continuing organisations		
	Bolton CCG £'000	Bury CCG £'000	Heywood, Middleton and Rochdale CCG £'000	Manchester CCG £'000	Oldham CCG £'000	Salford CCG £'000	Stockport CCG £'000	Tameside & Glossop CCG £'000	Trafford CCG £'000	Wigan Borough CCG £'000	Northern Care Alliance NHS Foundation Trust (GMSS) £'000	NHS England £'000	**Total £'000**
Transfer of property plant and equipment	658	2,922	745	297	-	-	883	-	877	4,328	-	-	**10,710**
Transfer of intangibles	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Transfer of other financial assets	-	-	-	-	-	1,106	-	-	-	-	-	-	**1,106**
Transfer of receivables	1,484	675	1,051	6,476	1,629	8,439	2,734	908	1,478	1,308	6,106	-	**32,288**
Transfer of cash and cash equivalents	129	12	1	58	21	2	107	259	1,142	2,153	-	-	**3,884**
Transfer of payables	(23,431)	(17,944)	(29,246)	(67,060)	(33,241)	(29,843)	(24,866)	(18,993)	(20,471)	(21,410)	(4,680)	(131)	**(291,316)**
Transfer of provisions	(731)	-	-	(512)	(228)	(681)	-	(695)	-	(278)	(1,426)	(200)	**(4,751)**
Transfer of lease liabilities	(619)	(2,925)	(746)	(297)	-	-	(884)	-	(739)	(4,333)	-	-	**(10,543)**
Net loss on transfers by absorption	**(22,510)**	**(17,260)**	**(28,195)**	**(61,038)**	**(31,819)**	**(20,977)**	**(22,026)**	**(18,521)**	**(17,713)**	**(18,232)**	**-**	**(331)**	**(258,622)**

	£'000
Balances transferred from closing NHS organisations	(258,291)
Balances transferred from continuing NHS organisations	(331)
	(258,622)

The accounts of the former 10 CCGs provide further details of these balances as at 30th June 2022, immediately prior to the transfer, and are available from the ICB website.

8 Leases

8.1 Right-of-use assets

2022-23	Land £'000	Buildings excluding dwellings £'000	Total £'000
Cost or valuation at 01 July 2022	640	10,238	10,878
IFRS 16 Transition Adjustment	-	-	-
Additions	-	355	355
Reclassifications	-	-	-
Lease remeasurement	-	-	-
Transfer (to)/from other public sector body	-	-	-
Cost/Valuation at 31 March 2023	**640**	**10,593**	**11,233**
Depreciation 01 July 2022	20	287	307
Charged during the period	60	884	944
Reclassifications	-	-	-
Transfer (to)/from other public sector body	-	-	-
Depreciation at 31 March 2023	**80**	**1,171**	**1,251**
Net Book Value at 31 March 2023	**560**	**9,422**	**9,982**

The value of leased assets represents office accommodation for the ICB's operations.

8. Leases cont'd

8.2 Lease liabilities

2022-23	**2022-23 £'000**
Lease liabilities at 01 July 2022	(10,543)
IFRS 16 Transition Adjustment	-
Additions purchased	(355)
Reclassifications	-
Interest expense relating to lease liabilities	(71)
Repayment of lease liabilities (including interest)	864
Lease remeasurement	-
Transfer (to) from other public sector body	-
Other	72
Lease liabilities at 31 March 2023	**(10,034)**

8.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	2022-23 £'000
Within one year	(1,354)
Between one and five years	(4,521)
After five years	(4,621)
Balance at 31 March 2023	**(10,496)**

9.1 Trade and other receivables

	Current 31st March 2023 £'000	Non-current 31st March 2023 £'000	Current 1st July 2022 £'000	Non-current 1st July 2022 £'000
NHS receivables: Revenue	12,542	-	2,540	-
NHS receivables: Capital	-	-	-	-
NHS prepayments	1,951	-	1,710	-
NHS accrued income	46	-	5,118	-
NHS Contract Receivable not yet invoiced/non-invoice	-	-	-	-
Non-NHS and Other WGA receivables: Revenue	13,987	-	3,294	-
Non-NHS and Other WGA receivables: Capital	-	-	-	-
Non-NHS and Other WGA prepayments	24,723	-	11,269	-
Non-NHS and Other WGA accrued income	9,195	-	8,552	-
Expected credit loss allowance-receivables	(1,305)	-	(927)	-
VAT	866	-	724	-
Other receivables and accruals	11	-	8	-
Total Trade & other receivables	**62,016**	**-**	**32,288**	**-**
Total current and non current	**62,016**		**32,288**	
Included above:				
Prepaid pensions contributions	-		-	

9.2 Receivables past their due date but not impaired

	31st March 2023 DHSC Group Bodies £'000	31st March 2023 Non DHSC Group Bodies £'000	1st July 2022 DHSC Group Bodies £'000	1st July 2022 Non DHSC Group Bodies £'000
By up to three months	6,286	-	2,062	-
By three to six months	169	-	103	-
By more than six months	371	-	3	-
Total	**6,826**	**-**	**2,168**	**-**

9.3 Loss allowance on asset classes

	Trade and other receivables - Non DHSC Group Bodies £'000
Balance at 01 July 2022	**(918)**
Lifetime expected credit loss on credit impaired financial assets	-
Lifetime expected credit losses on trade and other receivables-Stage 2	(387)
Lifetime expected credit losses on trade and other receivables-Stage 3	-
Amounts written off	-
Transfer by Absorption from other entity	-
Total	**(1,305)**

10 Other financial assets

	2022-23 £'000
Balance at 01 July 2022	1,106
Additions	-
Transfer (to) from other public sector body	-
Balance at 31 March 2023	**1,106**

The balance represents the ICB's minority shareholding in North West E-Health.

11 Cash and cash equivalents

	2022-23 £'000
Balance at 01 July 2022	3,884
Net change in period	(3,751)
Balance at 31 March 2023	**133**
Made up of:	
Cash with the Government Banking Service	133
Cash with Commercial banks	-
Cash in hand	-
Current investments	-
Cash and cash equivalents as in statement of financial position	**133**
Balance at 31 March 2023	**133**
Patients' money held by the Integrated Care Board, not included above	-

12 Trade and other payables	Current 31st March 2023 £'000	Non-current 31st March 2023 £'000	Current 1st July 2022 £'000	Non-current 1st July 2022 £'000
Interest payable	-	-	-	-
NHS payables: Revenue	9,876	-	823	-
NHS payables: Capital	-	-	-	-
NHS accruals	6,046	-	32,857	-
NHS deferred income	-	-	-	-
NHS Contract Liabilities	-	-	-	-
Non-NHS and Other WGA payables: Revenue	65,632	-	19,337	-
Non-NHS and Other WGA payables: Capital	-	-	-	-
Non-NHS and Other WGA accruals	218,645	-	168,660	-
Non-NHS and Other WGA deferred income	43	-	42	-
Non-NHS Contract Liabilities	-	-	-	-
Social security costs	1,129	-	1,227	-
VAT	-	-	-	-
Tax	1,086	-	919	-
Payments received on account	-	-	-	-
Other payables and accruals	99,352	-	67,451	-
Total Trade & Other Payables	**401,809**	**-**	**291,316**	**-**
Total current and non-current	**401,809**		**291,316**	

Other payables and accruals include payments to General Practitioners under GP contracts.
Other payables include £4.823m outstanding pension contributions at 31 March 2023.

13 Provisions

	Current 31st March 2023 £'000	Non-current 31st March 2023 £'000
Legal claims	55	-
Continuing care	200	-
Other	853	299
Total	**1,108**	**299**
Total current and non-current	**1,407**	

	Legal Claims £'000	Continuing Care £'000	Other £'000	Total £'000
Balance at 01 July 2022	**60**	**1,618**	**3,073**	**4,751**
Arising during the period	-	-	-	-
Utilised during the period	(5)	(67)	(67)	**(139)**
Reversed unused	-	(1,350)	(1,855)	**(3,205)**
Unwinding of discount	-	-	-	-
Change in discount rate	-	-	-	-
Transfer (to) from other public sector body	-	-	-	-
Transfer (to) from other public sector body under absorption	-	-	-	-
Balance at 31 March 2023	**55**	**201**	**1,151**	**1,407**
Expected timing of cash flows:				
Within one year	55	200	853	**1,108**
Between one and five years	-	-	299	**299**
After five years	-	-	-	-
Balance at 31 March 2023	**55**	**200**	**1,152**	**1,407**

Other provisions includes dilapidation costs associated within the ICB's estate.

14 Commitments

14.1 Other financial commitments

The ICB has entered into non-cancellable contracts (which are not leases, private finance initiative contracts or other service concession arrangements) which expire as follows:

	31st March 2023 £'000
In not more than one year	1,369
In more than one year but not more than five years	5,475
In more than five years	28,058
Total	**34,902**

In addition to the above, NHS Greater Manchester ICB is committed to funding the cost of the estate which NHS Property Services and Community Health Partnerships inherited from the former NHS Primary Care Trusts within Greater Manchester. The ICB works with the property companies to maximise utilisation, but where the property companies do not recover the full cost of the estate, the ICB is charged. The amount the ICB is charged varies each year dependent upon occupation and a value of the future liability cannot be reliably estimated. These assets are not considered to be leased, as the ICB does not have control of a defined space, which rests with the relevant property company.

15 Financial instruments

15.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because NHS Integrated Care Boards are financed through parliamentary funding, the ICB is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The ICB has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the ICB in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS ICB's standing financial instructions and policies agreed by the Board. Treasury activity is subject to review by the NHS ICB and internal auditors.

15.1.1 Currency risk

The NHS ICB is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The NHS ICB has no overseas operations. The NHS clinical commissioning group and therefore has low exposure to currency rate fluctuations.

15.1.2 Interest rate risk

Where the ICB is required to borrow funds, it borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The ICB had no borrowing during the period covered by these accounts. The ICB therefore has low exposure to interest rate fluctuations.

15.1.3 Credit risk

Because the majority of the NHS ICB's revenue comes parliamentary funding, the ICB has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

15.1.4 Liquidity risk

NHS Greater Manchester ICB is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The ICB draws down cash to cover expenditure, as the need arises. The ICB is not, therefore, exposed to significant liquidity risks.

15.1.5 Financial Instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

15 Financial instruments cont'd

15.2 Financial assets

	Financial Assets measured at amortised cost 31st March 2023 £'000	Equity Instruments designated at FVOCI 31st March 2023 £'000	Total 31st March 2023 £'000
Equity investment in group bodies		-	-
Equity investment in external bodies		-	-
Loans receivable with group bodies	-		-
Loans receivable with external bodies	-		-
Trade and other receivables with NHSE bodies	9,320		9,320
Trade and other receivables with other DHSC group bodies	(2,666)		(2,666)
Trade and other receivables with external bodies	29,127		29,127
Other financial assets	1,106		1,106
Cash and cash equivalents	133		133
Total at 31 March 2023	**37,020**	**-**	**37,020**

15.3 Financial liabilities

	Financial Liabilities measured at amortised cost 31st March 2023 £'000	Other 31st March 2023 £'000	Total 31st March 2023 £'000
Loans with group bodies	-		-
Loans with external bodies	-		-
Trade and other payables with NHSE bodies	2,017		**2,017**
Trade and other payables with other DHSC group bodies	17,816		**17,816**
Trade and other payables with external bodies	389,752		**389,752**
Other financial liabilities	-		-
Private Finance Initiative and finance lease obligations	-		-
Total at 31 March 2023	**409,585**	**-**	**409,585**

16 Joint arrangements - interests in joint operations

NHS Greater Manchester ICB has entered in to Pooled Budget arrangements with each of the local authorities within Greater Manchester under the provisions of section 75 of the NHS Act 2006.

A pooled budget allows the ICB and the local authority to co-ordinate expenditure to maximise the benefit of that spend to patients and residents, allowing for joined up services to be commissioned and provided.

Each of the pooled budgets are different, and this is reflected in the pooling agreement (the "Section 75 Agreement") between the ICB and each individual Local Authority.

The scope of each pooled budget is as agreed with each Local Authority, but all agreements include for the pooling of resources through the Better Care Fund as mandated by NHS England.

The common objectives of the pooled budgets are to promote joint and co-ordinated working between the ICB and the relevant Local Authority.
The ICB's share of expenditure of the pooled funds is recorded in note 5 (operational expenditure) to these financial statements.

This includes where funding is provided to a Local Authority to deliver services within a Local Authority hosted element of a pooled budget, which is also shown as expenditure in note 5.

Where the ICB administers a pooled budget on behalf of the partners, net accounting is adopted, meaning note 5 to these accounts only shows the expenditure of the ICB, and excludes expenditure formally incurred by the Local Authority, but hosted by the ICB.

More details on the Local Authority's share of expenditure from the pooled funds can be found in the annual accounts of each local authority.
The agreements with each local authority typically cover 12 months, and were novated to the ICB from the predecessor CCGs.

	Bolton MBC	Bury MBC	Rochdale MDC	Manchester City Council	Oldham MBC	Salford City Council	Stockport MBC	Tameside MBC	Trafford MBC	Wigan MBC
Host of pool	Both	Both	Both	Both	Both	ICB	Both	Both	Both	Both
Gross or Net Accounting	Net	Net	Net	Net	Net	Net	Net	Net	Net	Net
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
ICB contributions to pooled budget recorded in ICB accoun	25,291	74,100	91,700	65,712	85,800	91,937	20,387	82,471	18,033	23,710
ICB expenditure from pooled budget recorded in ICB accou	25,291	74,100	91,700	65,712	85,800	91,937	20,387	82,471	18,033	23,710
Total contributions to pooled budget	52,481	162,568	217,800	111,662	230,969	310,711	30,904	128,088	47,436	40,408
Total expenditure from pooled budget	52,481	162,568	217,800	111,662	230,969	310,711	30,904	128,088	47,436	40,408
Amounts owed to/(by) ICB in respect of pooled budget	-	-	-	-	-	4,466	-	-	-	-

The subsequent notes provide detail of expenditure of the ICB from the pooled budgets with each local authority.

16.1 Pooled Budget arrangements with Bolton Metropolitan Borough Council

A pooled budget exists between the ICB and Bolton MBC known as the Bolton Better Care Fund (BCF).

The pooled budget covers both health care spend (hosted by the ICB) and social care spend (hosted by the Council)

The fund is jointly hosted by the Council and the ICB on a lead commissioner basis.
Each organisation is responsible for over or underspends in respect of services where it is the lead commissioner.
The section 75 arrangements do not provide for risk sharing between the organisations.

As each organisation is hosting expenditure on a lead commissioner basis, there are no amounts owed to/from the pool at the balance sheet date.

During the 9-month period to 31st March 2023, NHS GM ICB incurred expenditure of £25.291m of the total value of the pool of £52.481m.

16.2 Pooled Budget arrangements with Bury Metropolitan Borough Council

A pooled budget exists between the ICB and Bury MBC known as the Bury Integrated Commissioning Fund (ICF) pooled budget.

The purpose of the pool is to support integrated health and social care.
Commissioning decisions are made by the Bury Locality Board whose voting rights on matters pertaining to the pooled budget are made up of equal numbers of NHS and Council representatives.
The pooled budget covers services under the headings of Primary Care Services, Secondary Care Services (where expenditure is incurred by the ICB) and Communities & Adult Social Care (where expenditure is incurred by the Council)

The fund is jointly hosted by the Council and the ICB on a lead commissioner basis.
Each organisation is responsible for over or underspends in respect of services where it is the lead commissioner.
The section 75 agreement does not provide for risk sharing between the organisations, without a specific variation.

As each organisation is hosting expenditure on a lead commissioner basis, there are no amounts owed to/from the pool at the balance sheet date.

During the 9-month period to 31st March 2023, NHS GM ICB incurred expenditure of £74.100m of the total value of the pool of £162.568m.

16.3 Pooled Budget arrangements with Rochdale Metropolitan Borough Council

There are two pooled budgets between the ICB and Rochdale Borough Council known as the Rochdale Health & Social Care Pooled Fund, and the Rochdale Health & Social Care Better Care Fund.
These are both governed by the Rochdale Locality Board.

Firstly, the Rochdale Health & Social Care Better Care Fund relating to the Commissioning of Integrated Health and Social Care Services.

The purpose of this arrangement is to enable joint design, development, procurement and monitoring of services for local people.
This pool contains expenditure relating to services covered by the Better Care Fund.

The fund is hosted by the Council and monitored through regular reports to the Locality Board
Each organisation is responsible for over or underspends in respect of services where it has commissioning responsibility
The section 75 agreement does not provide for risk sharing between the organisations, without a specific variation.

There are no amounts owed to/from the pool at the balance sheet date.

During the 9-month period to 31st March 2023, NHS GM ICB incurred expenditure of £19.9m of the total value of the pool of £35.2m.

Secondly, a pooled budget exists between the ICB and Rochdale MBC known as the pooled budget for the provision of All Age Health and Social Care Services.

The purpose of this arrangement is to enable joint design, development, procurement and monitoring of services for local people.
This pool contains expenditure relating to services in addition to those covered by the Better Care Fund.

The fund is jointly hosted by the Council and the ICB on a lead commissioner basis.
Each organisation is responsible for over or underspends in respect of services where it is the lead commissioner.
The section 75 agreement does not provide for risk sharing between the organisations, without a specific variation.

As each organisation is hosting expenditure on a lead commissioner basis, there are no amounts owed to/from the pool at the balance sheet date.

During the 9-month period to 31st March 2023, NHS GM ICB incurred expenditure of £71.8m of the total value of the pool of £182.6m.

16.4 Pooled Budget arrangements with Manchester City Council

A pooled budget exists between the ICB and Manchester City Council covering the Better Care Fund pooled budget for Manchester.
The Manchester Health and Wellbeing Board has strategic oversight of the pooled budget.

The aims and benefits of the partners in entering into this agreement are to:
- improve the quality and efficiency of the services in scope;
- meet the Local Objectives and the National Conditions which are as follows:
  - o deliver a jointly agreed plan between the partners, signed off by the Health and Wellbeing Board;
  - o ensure that the CCG financial contribution to adult social care is maintained in line with the uplift to the ICB minimum contribution;
  - o investing in NHS-commissioned out-of-hospital services, and
  - o delivering a plan for improving outcomes for people being discharged from hospital.
- make more effective use of resources through the establishment and maintenance of the BCF Pooled Fund for revenue expenditure on the Services.

The pooled budget covers both health care spend (commissioned by the ICB) and social care spend (commissioned by the Council)

The fund is jointly managed by the parties on a lead commissioner basis.
Each organisation is responsible for over or underspends in respect of services where it is the lead commissioner.
The section 75 agreement does not provide for risk sharing between the organisations, without a specific variation.

As each organisation is hosting expenditure on a lead commissioner basis, there are no amounts owed to/from the pool at the balance sheet date.

During the 9-month period to 31st March 2023, NHS GM ICB incurred expenditure of £65.712m of the total value of the pool of £111.662m.

16.5 Pooled Budget arrangements with Oldham Metropolitan Borough Council

Two pooled budgets exists between the ICB and Oldham MBC with the decision making body being the Commissioning Partnership Board.

The purpose of both pools is to ensure the provision of services to support reduced hospital admissions and length of stay, building on the aims and objectives of the Partners in entering the Agreement to:

- improve the quality and efficiency of service provision;
- meet the National Conditions of funding streams, such as the Better Care Fund and Local Objectives;
- make more effective use of resources through the establishment and maintenance of an aligned fund for revenue expenditure on services;
- ensure that people in Oldham will be independent, resilient and self-caring so fewer people reach crisis point, and;
- to develop an integrated health and care system, for those that need it, that enables people to proactively manage their own care with the support of their family, community and the right professionals at the right time in a joined up system.

Firstly, a pooled budget exists between the ICB and Oldham MBC known as the Oldham Integrated Community Equipment Service pooled budget
This pool is hosted by Oldham MBC for the purposes of commissioning equipment to promote independent living.

The section 75 agreement allows for the sharing of risk between the parties in proportion with their contributions to the pool, or as otherwise agreed.

During the 9-month period to 31st March 2023, NHS GM ICB incurred expenditure of £0.675m of the total value of the pool of £1.250m.
As at 31st March 2023, there was no net balance owed to the ICB from this element of the fund.

Secondly, a Pooled Aligned budget exists between the ICB and Oldham MBC supporting Other Health and Social Care services

The fund is jointly hosted by the Council and the ICB on a lead commissioner basis.
Each organisation is responsible for over or underspends in respect of services where it is the lead commissioner.
The section 75 agreement does not provide for risk sharing between the organisations, without a specific variation.

As each organisation is hosting expenditure on a lead commissioner basis, there are no amounts owed to/from the pool at the balance sheet date.

During the 9-month period to 31st March 2023, NHS GM ICB incurred expenditure of £85.125m of the total value of the pool of £229.719m.

16.6 Pooled Budget arrangements with Salford City Council

The ICB and Salford City Council have an integrated fund for health and social care services in Salford.
The ICB administers the integrated fund, which covers Adults Services, Public Health Services, Childrens Services, and Primary Care Services.
The Integrated Fund focuses on improving population health and inequalities along with improving outcomes and delivering safe, effective and efficient services for the Salford population.
The Salford Locality Board governs the use of the pooled fund.

A risk share exists between the ICB and Salford City Council which covers all expenditure within the Integrated Fund. The partners have agreed that any under or overspends of the fund are apportioned equally between them for 2022/23.

As at 31st March 2023, the net balance on the fund meant a debtor of £4.466m was recorded from Salford City Council.

During the 9-month period to 31st March 2023, NHS GM ICB incurred expenditure of £91.937m of the total value of the fund of £310.711m.

16.7 Pooled Budget arrangements with Stockport Metropolitan Borough Council

A pooled budget exists between the ICB and Stockport Metropolitan Borough Council known as the Stockport Better Care Fund.
Funds are pooled to improve partnership working between organisations and provide integrated and improved services for patients.

The Health and Care Integrated Commissioning Board (HCICB) consisting of ICB and Council representatives, governs the use of the pooled fund.

The fund is hosted by the Council. Whilst the provisions contained within the section 75 agreement indicate that joint control exists the fund operates through lead commissioner arrangements whereby the nominated lead commissioner enters into legal contract with providers and the non-lead commissioner cedes control over the end-contract. As each organisation is hosting expenditure on a lead commissioner basis, there are no amounts owed to/from the pool at the balance sheet date and each organisation is responsible for over or underspends in respect of services where it is lead commissioner.

The section 75 agreement does not provide for risk sharing between the organisations, without a specific variation.

As each organisation is hosting expenditure on a lead commissioner basis, there are no amounts owed to/from the pool at the balance sheet date.

During the 9-month period to 31st March 2023, NHS GM ICB incurred expenditure of £20.387m (Includes £13.178m contributed by the ICB to enable the Council to fulfil its lead commissioner role) of the total value of the pool of £30.904m.

16.8 Pooled Budget arrangements with Tameside Metropolitan Borough Council

Two pooled budgets exists between the ICB and Tameside MBC

Firstly, a pooled budget exists between the ICB and Tameside MBC known as the Tameside Better Care Fund
The fund is jointly hosted by the ICB and Tameside Council on a lead commissioner basis.
Each organisation is responsible for any over or under spends in respect of services where it is lead commissioner

During the 9-month period to 31st March 2023, NHS GM ICB incurred expenditure of £9.25m of the total value of the pool of £14.60m.

Secondly, a pooled budget exists between the ICB and Tameside MBC known as the Integrated Commissioning Fund

The fund is jointly hosted by the Council and the ICB on a lead commissioner basis.
Each organisation is responsible for over or underspends in respect of services where it is the lead commissioner.
The section 75 agreement provides for risk sharing between the organisations, via mutual agreement, to manage pressures in either the health or care position

As each organisation is hosting expenditure on a lead commissioner basis, there are no amounts owed to/from the pool at the balance sheet date.

During the 9-month period to 31st March 2023, NHS GM ICB incurred expenditure of £73.221m of the total value of the pool of £113.488m.

16.9 Pooled Budget arrangements with Trafford Metropolitan Borough Council

A pooled budget exists between the ICB and Trafford Metropolitan Borough Council, incorporating the Better Care Fund, the Learning Difficulties (LD) Fund and the Discharge to Assess fund.
The fund is used to commission services that support the integration of health and social care, which seeks to ensure support for people to be well and independent and in control of their own care.

As per the S75 agreement, the Trafford Health & Wellbeing Board (H&WB), made up of Council and ICB locality representatives, is the group that governs the fund.

The fund is jointly hosted by the ICB and Trafford Council on a lead commissioner basis.
Each organisation is responsible for over or underspends in respect of services where it is the lead commissioner.
The section 75 agreement does not provide for risk sharing between the organisations, without a specific variation.

As each organisation is hosting expenditure on a lead commissioner basis, there are no amounts owed to/from the pool at the balance sheet date.

During the 9-month period to 31st March 2023, NHS GM ICB incurred expenditure of £18.033m of the total value of the pool of £47.436m.

16.10 Pooled Budget arrangements with Wigan Metropolitan Borough Council

A pooled budget exists between the ICB and Wigan Metropolitan Borough Council known as the Wigan Better Care Fund pooled budget.
The fund is used to commission services that support the integration of health and social care, which seeks to ensure support for people to be well and independent and in control of their own care.

The Wigan Health and Wellbeing Board, made up of Wigan Council and ICB representatives, govern the use of the fund.

The fund is jointly hosted by the Council and the ICB on a lead commissioner basis.
Each organisation is responsible for over or underspends in respect of services where it is the lead commissioner.
The section 75 agreement does not provide for risk sharing between the organisations, without a specific variation.

As each organisation is hosting expenditure on a lead commissioner basis, there are no amounts owed to/from the pool at the balance sheet date.

During the 9-month period to 31st March 2023, NHS GM ICB incurred expenditure of £23.710m of the total value of the pool of £40.408m.

17 Related party transactions

The ICB has considered the requirements of IAS24 - Related Party Transactions, and concluded that no specific related parties are required to be disclosed.

The Department of Health and Social Care is regarded as a related party. During the period, the ICB has had a number of material transactions with entities for which the Department is regarded as the parent Department, including:

Bolton NHS Foundation Trust
Greater Manchester Mental Health NHS Foundation Trust
Manchester University NHS Foundation Trust
Northern Care Alliance NHS Foundation Trust
North West Ambulance Service NHS Trust
Pennine Care NHS Foundation Trust
Stockport NHS Foundation Trust
Tameside & Glossop Integrated Care Foundation Trust
The Christie NHS Foundation Trust
Wrightington, Wigan & Leigh NHS Foundation Trust
NHS England
NHS Pensions

18 Events after the end of the reporting period

The ICB has considered events occurring following the end of the reporting period and concluded there are no events requiring disclosure or adjustment to these financial statements.

19 Financial performance targets

NHS Integrated Care Boards have a number of financial duties under the NHS Act 2006 (as amended).
NHS Greater Manchester ICB's performance against those duties was as follows:

	2022-23 Target	2022-23 Performance	Achieved?
Expenditure not to exceed income	5,231,378	5,231,375	Yes
Capital resource use does not exceed the amount specified in Directions	355	355	Yes
Revenue resource use does not exceed the amount specified in Directions	5,137,655	5,137,653	Yes
Revenue administration resource use does not exceed the amount specified in Directions	48,885	48,713	Yes

20 Losses and Special Payments
The ICB has incurred no losses or special payments in the nine-month period to 31st March 2023.

21 Operating Segments
The ICB has reviewed its operations and concluded that it has one operating segment, for the commissioning of healthcare, therefore a segmental reporting .analysis is not provided.

Independent auditor's report to the members of the Board of NHS Greater Manchester Integrated Care Board

Report on the audit of the financial statements

Opinion on financial statements

We have audited the financial statements of NHS Greater Manchester Integrated Care Board (the 'ICB') for the period ended 31 March 2023, which comprise the Statement of Comprehensive Net Expenditure for the nine-month period ended 31 March 2023, the Statement of Financial Position at 31 March 2023, the Statement of Changes in Taxpayers Equity for the nine-month period ended 31 March 2023, the Statement of Cash Flows for the period ended 31 March 2023 and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of Schedule 1B of the National Health Service Act 2006, as amended by the Health and Care Act 2022 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23.

In our opinion, the financial statements:

give a true and fair view of the financial position of the ICB as at 31 March 2023 and of its expenditure and income for the period then ended;

have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23; and

have been prepared in accordance with the requirements of the National Health Service Act 2006, as amended by the Health and Care Act 2022.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2020) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the ICB in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accountable Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the ICB's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the ICB to cease to continue as a going concern.

In our evaluation of the Accountable Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2022-23 that the ICB's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services currently provided by the ICB. In doing so we have had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2022) on

the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the ICB and the ICB's disclosures over the going concern period.

In auditing the financial statements, we have concluded that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the ICB's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accountable Officer with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the annual report other than the financial statements and our auditor's report thereon. The Accountable Officer is responsible for the other information contained within the annual report. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Governance Statement does not comply with the guidance issued by NHS England or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2022-23; and

based on the work undertaken in the course of the audit of the financial statements, the other information published together with the financial statements in the annual report for the financial period for which the financial statements are prepared is consistent with the financial statements.

Opinion on regularity of income and expenditure required by the Code of Audit Practice

In our opinion, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions in the financial statements conform to the authorities which govern them.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

we issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or

we refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the ICB, or an officer of the ICB, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or

we make a written recommendation to the ICB under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters.

Responsibilities of the Accountable Officer

As explained more fully in the Statement of Accountable Officer's responsibilities set out on pages 64 and 65, the Accountable Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accountable Officer is responsible for assessing the ICB's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the ICB without the transfer of its services to another public sector entity.

The Accountable Officer is responsible for ensuring the regularity of expenditure and income in the financial statements.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.

We are also responsible for giving an opinion on the regularity of expenditure and income in the financial statements in accordance with the Code of Audit Practice.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the ICB and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as amended by the Health and Care Act 2022 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23).

We enquired of management and the Audit Committee, concerning the ICB's policies and procedures relating to: the identification, evaluation and compliance with laws and regulations;

the detection and response to the risks of fraud; and

the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.

- We enquired of management, internal audit and the Audit Committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.

We assessed the susceptibility of the ICB's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls. We determined that the principal risks were in relation to:

the processing of inappropriate journals, in this regard we tested journals over 20% of performance materiality, including post year end journals, journals which credited expenditure throughout the period, journals posted by senior managers, self authorised journals and a random selection of journals throughout the period; and

the prescribing accrual and the appropriateness of the estimate. We reviewed management's estimate of the prescribing accrual and challenged management on the assumptions used in its calculation.

- Our audit procedures involved:

evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;

journal entry testing, with a focus on journals over 20% of performance materiality, post year end journals, journals which credited expenditure, journals posted by senior managers, self authorised journals and a random selection of journals throughout the period;

challenging assumptions and judgements made by management in its significant accounting estimates in respect of the prescribing accrual;

assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.

These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.

The team communications in respect of potential non-compliance with relevant laws and regulations, and the significant accounting estimates related to the prescribing accrual.

Our assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:

understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation

knowledge of the health sector and economy in which the ICB operates

understanding of the legal and regulatory requirements specific to the ICB including:

the provisions of the applicable legislation

NHS England's rules and related guidance

the applicable statutory provisions.

In assessing the potential risks of material misstatement, we obtained an understanding of:

The ICB's operations, including the nature of its other operating revenue and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.

The ICB's control environment, including the policies and procedures implemented by the ICB to ensure compliance with the requirements of the financial reporting framework**.**

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities . This description forms part of our auditor's report.

Report on other legal and regulatory requirements – the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the period ended 31 March 2023.

Our work on the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources is not yet complete. The outcome of our work will be reported in our commentary on the ICB's arrangements in our Auditor's Annual Report. If we identify any significant weaknesses in these arrangements, they will be reported by exception in a further auditor's report. We are satisfied that this work does not have a material effect on our opinion on the financial statements for the period ended 31 March 2023.

Responsibilities of the Accountable Officer

As explained in the Governance Statement, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the ICB's resources.

Auditor's responsibilities for the review of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We undertake our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in January 2023. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the ICB plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the ICB ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the ICB uses information about its costs and performance to improve the way it manages and delivers its services.

We document our understanding of the arrangements the ICB has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's

Annual Report. In undertaking our work, we consider whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for NHS Greater Manchester Integrated Care Board for the period ended 31 March 2023 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until we have completed our work on the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources.

Use of our report

This report is made solely to the members of the Board of the ICB, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the members of the Board of the ICB those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the ICB and the members of the Board of the ICB as a body, for our audit work, for this report, or for the opinions we have formed.

Sarah L Ironmonger

Sarah Ironmonger, Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor

Manchester

29 June 2023