NHS
Greater Manchester

Agenda

Quality and Performance Committee

Date: 4 June 2025

Time: 14:15pm – 16:15pm

Venue: Face-to-face Ribble & Redbrook, 4th Floor, Manchester - 3PP, North West

Part A (Public)

Item No.	Time	Duration	Subject	Paper/ Verbal	Approval/ Assurance/ Discussion/ Information	By whom
1.	14:15	5 mins	Welcome, Introductions and Apologies received – Quorum, Attendance Matrix & Forward Plan	Verbal Paper	Noting Noting	Dame Sue Bailey *Chair*
2.			Declarations of Interest	Verbal	Noting	
3.			Minutes, matters arising and actions from previous meeting held on 7 May 2025	Papers	Approval	
Committee Effectiveness						
4.	14:20	10 mins	Quality Improvement	Paper	Discussion	Steven Knight *Deputy Chief Medical Officer*
Executive Portfolio Update						
5.	14:30	10 mins	Risk Report	Paper	Assurance	Ed Dyson *Director of Performance, Improvement and Assurance*
6.	14:40	25 mins	Chief Officers Report: a. CNO b. CMO c. Performance Report & Year End Review of System Oversight Framework	Paper	Assurance	Claire Smith *Associate Director Nursing & Quality Assurance* Steven Knight *Deputy Chief Medical Officer* Ed Dyson *Director of Performance, Improvement*
7.	15:05	10 mins	Healthwatch *Pain to Complain* report	Paper	Assurance	Mark Palmeria *Assistant Director Patient Services*
8.	15:15	10 mins	MIAA Audit Plan	Paper	Approval	Anita Rolfe *Deputy Chief Nurse*
9.	15:25	0 mins	Revised TOR's, timeline, and project plan for the Community Mental Health Team independent review	Paper	Noting	Steven Knight *Deputy Chief Medical Officer*
5 Minute Comfort Break						
In-depth Discussion						
10.	15:30	10 mins	Clinical Risk	Paper	Assurance	Kate Provan *Associate Director Clinical Effectiveness and Improvement*
Sub-Groups / Information						

11.	15:40	5 mins	Updates from LAMS, POMS and System Quality Group	Verbal	Information	All
Well Led Review						
12.	15:45	10 mins	Any other business Board Paper Escalations Meeting Reflection	Verbal	Discussion	All
			Date and time of next meeting **Wednesday 2 July 2025** (Development Session)			

Quality and Performance Committee Attendance Matrix from April 2025

Key:

Present	
Apologies	
No Explanation	
Attendee as per ToR	
Member as per ToR	
Not a member	

Member	*Title*	*Apr-25*	*May-25*	*Jun-25*	*Jul-25*	*Aug-25*	*Sep-25*	*Oct-25*	*Nov-25*	*Dec-25*	*Jan-26*	*Feb-26*	*Mar-26*
Dame Sue Bailey	Non Executive Director (Chair of QPC)												
Leigh Vallance	NHS GM VCSE Partner												
Luvjit Kandula	Chair of Primary Care Provider Board (Primary Care Representative)												
Mandy Philbin	Chief Nursing Officer												
Manisha Kumar	Chief Medical Officer												
Nic Firth	Chief Nurse at Stockport and Tameside (Secondary Care Representative)												
Richard Paver	Non Executive - Audit Committee Chair (Vice-Chair of QPC)												
Colin Scales	Deputy Chief Executive Officer												
Danielle Ruane	Patient Representative (Healthwatch)												
Attendee													
Alison Chilton	CQC												
Andrea Patel	Associate Director for Safeguarding												
Anita Rolfe	Deputy Chief Nursing Officer												
Dr Claire Lake	Deputy Chief Medical Officer												
Claire Smith	Associate Director for Nursing and Quality Assurance												
Ed Dyson	Director of PIA												
Jackie Driver	Strategic Lead: Equality and Inclusion												
TBC	Chief People Officer												
TBC	Place Based Lead												
Steven Knight	Deputy Chief Medical Officer												
Tracey Vell	Improvement Agency representative												
Mark Palmeria	Assistant Director for Patient Services												
Waseem Khan	Patient Safety Officer												
Officers in attendance													
Invitees/Presenters													
Samantha Hogg	Principal Consultant	Public only											
Heather Etheridge	Patient Representative (Healthwatch) - Deputising for Danielle Ruane												
Jane Seddon	Director of People Services - Deputising for Charlotte Bailey												
Gary Flanagan	Assistant Director of Mental Health Strategic Commissioning		(item 4)										
Rachel Farn	Head of Mental Health Clinical Effectiveness		(item 4)										
Melissa Maguinness	Programme Director - Commissioning Development		(item 4)										
Sandeep Ranote			(item 4)										
Gill Baker			(item 7)										
Nicola Howarth													

Development Session Minutes

Quality and Performance Committee – Private

Date: 7th May 2025

Time: 13:30pm - 15:30pm

Venue: Microsoft Teams

Present	Apologies
Members: Dame Sue Bailey (SB) – Non-Executive Director (Chair) Danielle Ruane (DR) – Patient Representative (Healthwatch Tameside) Prof. Manisha Kumar (MK) – Chief Medical Officer Mandy Philbin (MP) – Chief Nursing Officer Luvjit Kandula (LK) – Primary Care Representative Richard Paver (RP) – Non-Executive Director and Chair of Audit Committee (Vice-Chair) **In attendance:** Steven Knight (SK) – Deputy Chief Medical Officer Anita Rolfe (AR) – Deputy Chief Nursing Officer Ed Dyson (ED) – Director of Performance, Improvement and Assurance Charlotte Bailey (CB) – Chief People Officer Dr Claire Lake (CL) – Deputy Chief Medical Officer Kate Provan (KP) – Associate Director Clinical Effectiveness and Improvement Jackie Driver (JD) – Strategic Lead: Equality and Inclusion Claire Smith (CS) – Associate Director Nursing & Quality Assurance Gary Flanagan (GF) – Assistant Director of Mental Health Strategic Commissioning (for item 4) Rachel Farn (RF) – Head of Mental Heath Clinical Effectiveness (for item 4) Melissa Maguinness (MM) – Programme Director – Commissioning Development (for item 4) Professor Sandeep Ranote (SR) – Clinical Director MH (NHS GM ICB) (for item 4) Gill Baker (GB) – GM UEC Programme Director (item 7) Nicola Howarth (NH) – Quality Coordinator Faye Vaughan (FV) – Governance Advisor (Minutes)	Alison Mckenzie-Folan (AMf) – Wigan Place Lead Gill Gibson (GG) – Deputy Chief Nurse for Quality Transformation Colin Scales (CS) – Deputy Chief Executive Officer Andrea Patel (AP) – Associate Director for Safeguarding Alison Chilton (AC) – Deputy Director of Operations, CQC Leigh Vallance (LV) – VCSE Partner Member Waseem Khan (WK) – Head of Quality Oversight and Governance Arasu Kuppuswamy (AK) – Clinical Director (Programme) Claire Connor (CC) – Director Communications and Engagement Sharon Hubber – Director of Childrens Services, Rochdale Council Nicola Firth (NF) – Secondary Care Representative

Item No.	Topic	Action

1.	**Welcome, Introductions and Apologies** SB welcomed all to the meeting and the above apologies were noted.	
2.	**Declarations of Interest** SB reminded board members of their obligation to declare any interest they may have on any issues arising at the meeting which might conflict with the business of the NHS Greater Manchester. No interests were declared.	
3.	**Minutes, Actions and Matters Arising from previous meeting** The minutes were accepted as a true record of the previous meeting held on 9 April 2025. <u>Actions</u> 2024/23 – SK to bring to June meeting. 2024/24 – SK to bring to June meeting. 2024/40 – Healthwatch Network requested to be placed as an attendee on the committee membership. The committee respected their views on where best placed on the membership however, a reminder of the expectation to provide full involvement in all future meetings was raised. **ACTION:** FV to pick up with JN to update the Terms of Reference to reflect Healthwatch becoming an attendee. 2024/41 – SB confirmed Ruth Hussey had been contacted regarding specialised commissioning transition. 2024/42 – Action included within Performance report.	FV
4.	**Right Care Right Person and AFS** **Right Care Right Person (RCRP)** SB highlighted the cross-system work that had taken place to produce a detailed report and thanked the team involved. The committee were made aware that the report provided a summary of progress in delivery of Right Care, Right Person Phase 1 (concern for welfare) and Phase 2 (improved handover times for people detained under S136 MHA), following go live. Future updates on Neurodiversity and Childrens Mental Health would be provided at a later date. Gary Flanagan, Assistant Director for Mental Health Strategic Commissioning, informed the committee that it was a national approach to reduce inappropriate and avoidable involvement of the police in instances where people of all ages would be better supported in their health and/or social care needs by other agencies. The positive impact already made since RCRP, such as the increased number of people receiving the appropriate Mental Health (MH) support, with agreed pathways from Greater Manchester Police (GMP) to MH crisis teams, avoiding unnecessary police call outs was highlighted to the committee. GF also highlighted the strengthened partnership working between MH, Acute Trusts and emergency services. <u>Phase 1: Concern for Welfare and Missing Persons</u>	

	GF explained that they were in a more robust position at present, with a 24/7 crisis line in place for MH in GM. The committee were also made aware of the 2 MH vehicles in GM which they were looking to evaluate to see if the offer could be expanded to provide further support to people in MH crisis. An agreed process for people missing from a mental health setting had been developed with discussions taking place with GMP. GF assured the committee of the vast work to improve due diligence before contacting the police. The importance to not create an increased burden on community and primary care teams was also highlighted. The importance of recognising clinical risk as identified by the clinical leads within the healthcare setting was raised. <u>Phase 2: S136 Handover Times:</u> The committee were made aware that System Leads across Mental Health Trusts, Acute Trusts and ICB had confirmed that it would not be possible to deliver 1 hour handover time in all instances from April 2025. GF explained that it had derived from long standing issues of S136 MHA assessments and processes which often resulted in unacceptable long waits in ED as health-based place of safety and unreasonable length of time for GMP to stay with the individual in the department. The committee were informed of the commitment to GMP to evidence clear data every year and improve the trajectory handover times and outcomes for patients. <u>S136 Improvement Plan:</u> The committee were made aware that there was no legal basis for 1 hour handover time however, it was recognised that it was the ambition set out by GMP for RCRP to address long waits in ED and inappropriate use of police hours. GF reported the positive development that the new draft multi-agency protocol would be looking to be signed by all partners, including the police. The committee were informed of the new S136 dashboard that had been developed to collate metrics in a single, easy to navigate dashboard that would be available to all NHS GM and GMP partners. An open invite was shared to the committee to attend the monthly in person meetings that took place to discuss learning from practice groups. Challenges were raised such as the significant pressure the system were currently under. JD raised declaration of interest as the Chair of Street Health and highlighted concerns of handing women with complex needs back to the police as they did not have the capacity to manage and support them. A suggestion was raised to look at three particular communities to understand how the barriers were being met and how they could be strengthened. The importance of a review was identified; however, it was suggested that looking into particular areas where people faced challenges would be valuable. A suggestion to look at the voluntary sector to strengthen their role was also raised. A discussion took place regarding what had been commissioned from NWAS and what they were delivering. The lack of data in the report was highlighted to monitor the level of progress	

	made. GF informed the committee that they would be modelling the number of people impacted, working on a basis of an indicative number of 120 per day who call the police that would need to be supported by MH response. It was reported that having reviewed the level of calls to 111, it was identified the number of calls were not as high as 120 per day, however, there were still some sent to NWAS that would need to be worked through. Further detail on the data would be provided in future. MK explained that they were investing in upstream models to reduce crisis and different pathway approach for people who felt vulnerable. The committee were made aware that they may not see a shift, however, assurance was provided that it would be used in a better way. CS informed the committee of the Section 136 Learning Group with various elements of experience and learning from patient safety events and other reviews that had been looked into. CS offered to support the MH team to share learning from those to provide a rounded approach to use the learning to drive things forward. **ACTION:** CS to pick offline support to GF from Section 136 Learning Group to share learning. DR reminded the committee of the 360 Review Approach for people with lived in experiences and suggested looking into obtaining their views on the new approach. **ACTION:** DR to see if Healthwatch can support GF. The committee were made aware of the vast work that had taken place with VCSE partners. A suggestion to share worked examples with data and a plan on a page to be created to ensure all involved felt confident they have something in place to use was raised. Assurance was provided of the investment standard to fund the programme which was in the budget for the year. **The committee reviewed the content of the report and provided their comments, queries or concerns.** **Adult Forensic Services (AFS)** The committee were informed that the Greater Manchester Mental Health NHS Foundation Trust Adult Forensic Services (AFS) had been reopened safely. MK informed the committee that the reopening of AFS had been overseen by the System Improvement Board (SIB) with a paper being presented by GMMH in March 2025 to ensure improvement continued. It was reported that GMMH had 4 out of area placements at present which was an improvement. It was noted that AFS was part of the Spec Comm delegation to the ICB. Work was currently taking place to understand working arrangements for the ICB with region. MK informed the committee that Oliver Shanley would be coming back in July	CS DR

	2025. Within the recommendations of the Shanley review, it was explained there was a specific requirement which related to Community Mental Health Teams (CMHTs). A revised Terms of Reference would be shared with the committee virtually to review and endorse to ensure robust system oversight. **ACTION:** MK to share the Terms of Reference to FV to share with the committee for virtual sign off. A discussion took place regarding problems starting at wards which would continue to occur going forward without an operation framework in place. The staffing of the wards and capacity across GMMH footprint with issues regarding ability to recruit was identified as an issue, which had been raised at the committee previously which would need to be closely monitored. It was highlighted that the right culture and attitude in a ward would be crucial. **ACTION:** CB to bring back the Workforce Report from SIB to a future meeting. MP in the chat - *there are 100 vacancies in Pennine alone with 1000 vacancies across the northwest. GMMH try to cover with agency/bank but ongoing. Regions are accountable for staffing.* A discussion took place regarding ensuring staff felt safe to speak up safely. MK informed the committee that it was one of the areas in GMMH SIB. Assurance was provided to the committee of the cultural shift and the increase in Freedom to Speak Up. The committee also highlighted the important messages in the report regarding culture and that the key learning would need to be shared to complex key wards. **The Quality and Performance Committee noted:** **• The Governance in place to oversee all improvements at GMMH- including the safe reopening of AFS.** **• That there is a robust transition plan in place for the opening of these services which reflects a structured and collaborative approach to safely restoring services, improving care quality, and embedding sustainable operational models and that this plan has been scrutinised through the SIB.**	MK CB
5.	**Risk Report** The paper provided the committee with a monthly update on risks, including the BAF risks and the committee risks. ED informed the committee that the report showed the end of 2024/25 risk position. It was highlighted that the report showed a fair reflection of risk through the year, with an extensive range of mitigations. The committee were made aware that the next report would have a couple of changes under performance to remain to national planning guidance such as, Mental Health in-patient length of stay being included in future reporting. The areas of challenge for the next year were highlighted: • 4-hour target • LDA adult inpatient activity • Mental Health and patient length of stay	

	ED highlighted that the next year would have greater emphasis on productivity and improvement and the need to recognise it in the strategic risk. The need to recognise organisational change as a disruptive factor through the year was also raised. Failure to deliver statutory duties was highlighted as an area for concern. A query was raised whether financial constraints were having a positive, negative or neutral impact on risks. AR explained that in relation to the complaints risk, there had been concerns around roles not being filled due to the ending of the agency contracts and the ongoing recruitment freeze. AR informed the committee that they were looking at how they could support them in other ways to meet statutory obligation whilst reducing the risk. Complaints were also being closely monitored fortnightly with CS and AR involvement. A suggestion was raised to complete a Quality Impact Assessment to ensure it was measured. Concerns were raised over the financial constraints having an adverse effect on responses to complaints in a quality and timely way. A suggestion was raised to keep a register on finances effecting quality. A discussion took place regarding the grip and control on the impact of improving filling vacant jobs. It was questioned what information the panel received on recruitment of jobs and what the impact would be without the role being filled. It was also questioned whether the panel were sighted on causes to not meet statutory duties and whether those were considered. AR informed the committee of the recent delay of Dental Advisors and the impact to panel which did cause recruitment delays causing no Dental Advisors in post for 5/6 weeks. The committee were informed of the effort that goes into a full explanation to panel. A suggestion was raised to keep the national safety ambition to reduce still births and maternal death reduction by 50% by March 2025 on the risk register as it had not been achieved. KP provided assurance that the Maternity Risk was discussed at the Clinical Effectiveness Group. The committee were made aware that a new risk in relation to maternity would be placed on the risk register, however, the risk discussed was in relation to the ambition which was no longer existing in its current form. CS highlighted the huge improvement in still birth rate from the LMNs report that stated still birth rate was the lowest it had been since 2019 and the third lowest rate in the last 10 years at 4.35 per 1000 live births. Brain injury was also reported at the lowest rate in the last 10 years with a rate of 0.52 per 1000 live births. JD informed the committee of the maternity plan still in existence with staff which was missing the element of quality and inequality impact assessment to advertise posts, hold them or fill them. A suggestion was raised to work collaboratively to help evidence both those on vacant posts. **ACTION:** JD & AR to have an offline conversation to work collaboratively on a Maternity Quality & Inequality Impact Assessment to advertise posts. **The committee agreed the contents of the paper and were provided with assurance.**	JD/AR
6.	**CMO Report** The report provided an update to the committee, in relation to the statutory duties and responsibilities aligned to the Medical Directorate.	

	MK informed the committee of the advised collaborative approach with locality and system partners to develop an individual process to comply with legal obligations. The report had been brought to the committee to show how skills in providers would be looked at and to ensure clinical accountability. It was suggested that they would need to ensure the tools provided were fit for delivery. A discussion took place regarding digital funding received and whether they would be eligible for it. MK confirmed the query would be taken back to Warren Heppolette. A further discussion took place regarding the Model ICB and the areas to work through where digital may sit in the future. **ACTION:** CB to investigate equity/equality of staff recruitment with the recruitment team and EDI. A discussion took place regarding the current issue around where digital sat which needed resolving to ensure all were joined up. RP highlighted the current locality difficulties around skills in general. A suggestion was raised to advise localities to use their own resources. **ACTION:** SB & RP to raise current issues raised around where digital sits in to ensure all were joined up at NEDs on Monday. A further discussion took place regarding the differences that would have been made without the current freeze in recruitment as it was identified the external CFO role couldn't be recruited due to the current circumstances. **The Quality and Performance Committee noted the alert in relation to Clinical Digital Safety and the mitigations in place to address this, noting some assurance was provided through a best endeavours model, however, full assurance wasn't yet achieved.**	CB SB / RP
7.	**Performance Report** The committee were informed that the report was brought to the committee to keep apprised of the Greater Manchester performance against the 24/25 NHS Operational Planning trajectories. In addition, it was informed that there was an assessment of year end achievement against key metrics outlined as priorities at the start of the year. It was reported that the year end results had improved compared to March 2024 figures, with GM better relative to other ICBs. The committee were made aware of the 71.2% in 4 hours in A&E, a 5% increase than the previous year. Ambulance target had also been achieved. The committee were further made aware of the recent news of both cancer standards being achieved. It was reported 62 RTT was at 71%, with faster diagnosis standards at 80%. ED highlighted cancer alliance was a massive asset to GM in support delivering those standards. It was reported diagnostics would not be available until the end of the week; however, it was expected 12% against the 10% standard which was a much stronger position than the previous year. Looking forward, it was reported that ICB and providers would be submitting compliance plans for finance and performance.	

	The challenging assumptions in redesign, efficiency and productivity were highlighted as areas of risk to the committee. Further challenges around the conflict between financial balance and performance delivery for the year was highlighted, with money placed as a constraint to performance. The committee were informed that A&E, Elective and LDA remained alert areas. ED explained that the new provider funds assessment framework would set out the approach, however, they were still awaiting technical guidance. The committee were assured that they would continue to develop the function and would align with guidance in the future. No pausing would take during the current organisational changes; however, performance framework would be adopted within the existing arrangements. Gill Barker, UEC Programme Director was welcomed to the committee to provide an update on UEC position. GB informed the committee that the validated end of March 2025 position for the delivery of the 4-hour Standard of Care in Emergency Departments was reported at 71.2%. The committee were made aware of the GM UEC Team led “March Sprint” exercise with each of the localities and providers to maximise best possible position of 78%. It was identified that each area had different challenges. A number of data analytics were involved with detailed analysis and intense tracking of patients within the ED department for a consistent approach across GM. GB explained that tier 1 implemented a lot of work with teams, through the early part of the year, working across the whole system to share learning and identify what worked well to see if it could be implemented in other places. The committee were made aware of the vast resource and effort that had taken place for the March 2025 position which would not be sustainable every month. It was suggested that an understanding of how to get a level of sustainability in work would need to take place. <u>GM UEC Reform</u> The committee were made aware of the positive conversations with Senior Leaders in the system to understand how to support challenges such as financial deficit. Analysis on 12 hour waits in A&E were a significant measure of poor quality for patients. A drive to improve the position would need to take place, noting the cost involved supporting patients in the ED department. The committee were made aware that the Board would hold a single plan for UEC Reform, bringing together all partners and sectors work, which would all contribute to the reduction in demand on emergency services and departments, or improve patient flow. It was reported that there would be a focus on avoiding people going to hospitals in the first place. A suggestion was raised for a deep dive on performance figures such as CHC and ambulance handovers at a future meeting. GB explained that the ambulance service was a regional arrangement with NWAS 111 and 999 pts service which	

	was commissioned at a regional level with Lancashire and South Cumbria as the leads. PTS were monitored through regional groups and performance statistics which could be shared at a future meeting. **ACTION:** GB to bring back a deep dive on discharge and flow and PTS performance statistics to a future meeting. A discussion took place regarding how the committee joined work of Population Health Committee to ensure improvement and performance standards were being met through offline discussions to build connections. A suggestion was raised to move away from Acute Provider Profiles into population performance profiles. **ACTION:** CL to meet offline with ED & GB to discuss joint working across committees to ensure improvement and performance standards. GB highlighted that there was not a full view of all the work in one place at present, however, reform was suggesting a single governance structure towards reducing demand of UEC in one place. The UEC Reform Board was set up with the System Leaders Group, however, it had not been signed off yet. A discussion took place regarding the alert on paediatrics. SK informed the committee of the vast work taking place with two broad areas of work: the Operational Delivery Angle, as well as the Paediatric Hearing Services Improvement Programme which was an England wide programme. The committee were made aware that they were looking at developing a GM wide model over time. Acute aspect service challenges in Stockport were highlighted, who were no longer taking on new patients. A meeting was due to take place the following day with a private provider. Reassurance was provided to the committee of the active and live workstreams taking place and that patients were being triaged. SK further informed the committee that issues had been taken to Chief Officers with conversations also taking place at Executive Level with providers. A discussion took place regarding understanding commissioning requirements, staffing and resource. The committee were informed of the complexity of the issue with work taking place, however, it was not being adequately joined up. It was identified that the quality assurance on hearing improvement programme required a lot of work to be delivered. CS highlighted the national CSO programme was key. Complexity of staff and distances of equipment was identified, and the specific elements tied into quality oversight was raised. CS reported that once a view of GM services was pulled together over GM, it would provide a clearer picture of commissioning moving forward. **ACTION:** CS to link in with ED to support creating a briefing of a clearer picture of paediatric hearing services in Greater Manchester to be shared once received, with timelines for a more cohesive format once the commissioning landscape is understood. SB thanked all for what had been achieved so far. A suggestion was raised for the committee to link in with Population Health and People & Culture committee to create a more cohesive way of bringing information together.	GB CL CS

	ACTION: Audiology to be brought back to a future meeting. SK to confirm the risk stratification for those waiting at Stockport. **The committee noted:** **• The expected end of year position for 24/25.** **• The operational priorities for 25/26 and risks.** **• The NPAF for 25/26, published for consultation. The finalised version will replace the current NOF.** **• The work ongoing though our provider and locality oversight arrangements.**	SK
8.	**Spinal Surgery Independent Investigation** The committee were made aware of the letter that had been received from NHS England NW Regional Investigations lead regarding confirmation of the decision of NW Independent Investigation Review Group. It was reported that it would commission an initial diagnostic Patient Safety Investigation to review the lookbacks undertaken to date and determine whether any further restorative action was required. The committee were reminded of the issue reported previously to the committee. The committee were assured of the ongoing work to ensure learning was applied and practices were safe moving forward. It was highlighted that the letter focused on families and individuals effected directly by the surgeon. The committee were reminded of the Spinal Voices Group which had raised concerns to members of parliament. It was reported a two-stage approach would take place to ensure no duplication and no gaps for individuals effected by this also. It was explained that the first stage would be a desktop review of the 4 reports conducted at the time to understand fully what had been considered and whether there were any gaps in the learning. CS further reported that they would want to ensure ICB were sighted on lessons learned and minimise patient safety issues in the future. SK informed the committee that the patient and family group were not satisfied with the scope of the reviews. Addressing ongoing concerns of patient and family group were identified as crucial. The committee were made aware of the Rapid Quality Review Process with learning from the Breen report and what it meant in terms of current practice. The internal culture perspective and Freedom to Speak Up was highlighted. **The committee noted the decision making of the Independent Investigation review Group and the expected timescale of the diagnostic phase of the review.**	
9.	**NHSE Reform** The committee were made aware of the upcoming changes due to the NHSE Reform announcement. The need to understand what it meant for the committee and the NHS GM Integrated Care Board was highlighted. A high-level summary of the updates was shared.	

	It was reported that the document clearly communicated redesigning the ICB Board clinical governance and streamlining key functions at scale. It was identified that healthcare data analytics would also need to be strengthened. The committee were reminded that a lot of the key areas were not clear as the document was a guideline and not a must do. MK informed the committee of the conversations taking place regarding the key ask to make 39% cut in ICB from a funding perspective. The committee were reminded of the deadline by 30 May 2025 to provide a response with opportunities for people to feed in. A discussion took place regarding staff and workforce and ensuring they felt supported. Concerns were also raised regarding patient safety.	
10.	**Any Other Business** The committee were informed of the recent request through the governance team to move current meetings from a Wednesday to accommodate another committee meeting. The committee recognised the previous struggles to find a suitable date for all and agreed it would be best to keep the current committee dates in the diary.	
11.	**Reflections and Escalations (Well Led)** Members were asked to reflect on the meeting through Mentimeter, and the outcomes of this will be reflected on to allow tracking of the effectiveness of QPC.	
	Date and time of next meeting: Wednesday 4 June 2025, 14:15 – 16:15pm	

Actions Log: Quality & Performance Committee

No	Date	Section	Details of the issue	Details of action agreed	Action Lead	Completion Date	Status	Further Detail
2024/33	05/03/2025	6. QPC Risk Register	ED to include reputational damage, compassion & inclusion into the risks for future updates.	To feed in from May committee.	Ed Dyson	07/05/2025		
2024/39	05/03/2025	9. Performance Report	ED to look into triangulating NCA/Maternity/Nursing in the report to reduce duplication and reads as one.		Ed Dyson	30/04/2025		
2024/41	09/04/2025	6. Agree 2025/26 Committee Priorities	SB & RP to contact the Chair of the ICB Specialised Commissioning Group for a detailed handover document for Specialised Commissioning.		Sue Bailey / Richard Paver	30/04/2025		06/05: SB contacted Ruth Hussey re spec comm transition.
2024/42	09/04/2025	8. Performance Report	ED to report back on Urgent Emergency Care updates.		Ed Dyson	07/05/2025		Included within Performance report.
2024/44	07/05/2025	4. Right Care Right Person	CS to pick offline support to GF from Section 136 Learning Group to share learning.		Claire Smith	TBC		21/05: In progress - arranging discussions.
2024/45	07/05/2025	4. Right Care Right Person	DR to see if Healthwatch can support GF.		Danielle Ruane	05/06/2025		22/05: Meeting organised for 5th June.
2024/47	07/05/2025	4. Right Care Right Person and AFS	CB to bring back the Workforce Report from SIB to a future meeting.		Charlotte Bailey	TBC		
2024/49	07/05/2025	6. CMO Report	CB to investigate equity/equality of staff recruitment with the recruitment team and EDI.		Charlotte Bailey	TBC		
2024/50	07/05/2025	6. CMO Report	SB & RP to raise current issues raised around where digital sits in to ensure all were joined up at NEDs on Monday.		Sue Bailey / Richard Paver	21/05/2025		22/05: Issue raised at both the Monday NEDS and EXECS meeting and the ICB Board on the 21st of May. The Chair Sir Richard advised that this matter would be best resolved at an extended meeting of NEDS in June alongside other changes that may be needed in light of one Ned standing down and implications of changes in ICB roles and responsibilities going forward.
2024/51	07/05/2025	7. Performance Report	GB to bring back a deep dive on UEC and PTS performance statistics to the next meeting.		Gill Baker	TBC		21/05: Paper currently being written.
2024/53	07/05/2025	7. Performance Report	CS to link in with ED to support creating a briefing of a clearer picture of paediatric hearing services in Greater Manchester to be shared once received, with timelines for a more cohesive format once the commissioning landscape is understood.		Claire Smith / Ed Dyson	02/07/2025		21/05: An overview is being worked up across the different functions and will be put on the agenda for July.
2024/54	07/05/2025	7. Performance Report	Audiology to be brought back to a future meeting. SK to confirm the risk stratification for those waiting at Stockport.		Steven Knight / Claire Smith	02/07/2025		28/05: Paediatric audiology update will be coming to July's meeting.

Completed at Previous Meeting (Audit Trail)								
2024/43	07/05/2025	3. Minutes, Actions and Matters Arising from previous meeting	FV to pick up with JN to update the Terms of Reference to reflect Healthwatch becoming an attendee.		Faye Vaughan	09/05/2025	Complete	Terms of Reference has been updated to reflect Healthwatch as an attendee.
2024/48	07/05/2025	5. Risk Report	JD & AR to have an offline conversation to work collaboratively on a Maternity Quality & Inequality Impact Assessment to advertise posts.		Jackie Driver / Anita Rolfe		Complete	21/05: Meeting has taken place. JD shared useful information to support processes.
2024/52	07/05/2025	7. Performance Report	CL to meet offline with ED & GB to discuss joint working across committees to ensure improvement and performance standards.		Claire Lake / Ed Dyson / Gill Baker		Complete	21/05: Meeting arranged.
2024/46	07/05/2025	4. Right Care Right Person and AFS	MK to share the Terms of Reference to FV to share with the committee for virtual sign off.		Manisha Kumar		Complete	23/05: ToR shared with committee for virtual sign off.

NHS
Greater Manchester

Greater Manchester Integrated Care System: An Approach to Improvement

June 2025

Part of Greater Manchester Integrated Care Partnership

Quality and Performance Committee

June 2025

Required information	Details
Title of report	Greater Manchester Integrated Care System: An Approach to Improvement
Author	Dr Steve Knight, Deputy Medical Director
Presented by	Professor Manisha Kumar, Chief Medical Officer, NHS GM
Contact for further information	steven.knight6@nhs.net
Executive summary	This report provides an update to the Quality and Performance Committee on key areas progressed on developing and embedding a continuous improvement in Greater Manchester Integrated Care System
The benefits that the population of Greater Manchester will experience.	Oversight and relevant improvement work in relation to NHS GM commissioned services benefits the GM population through continuous improvement in services, targeted quality improvement where indicated, and overall improvement in experience.
How health inequalities will be reduced in Greater Manchester's communities.	The report focuses on key areas of work aligned to the statutory duties and accountabilities of the Medical Directorate and the strategy of the ICP- specifically in relation to the duty of Continuous Improvement.
The decision to be made and/or input sought	The Committee are asked to note the report
How this supports the delivery of the strategy and mitigates the BAF risks	The areas within this report and progress made to improve these relate to BAF risk SR5
Key milestones	N/A
Leadership and governance arrangements	This paper is produced for Quality and Performance Committee and has not been elsewhere but is formulated from intelligence

	and papers from NHS GM Clinical Effectiveness and Governance Groups (and related subgroups) and the NHS GM Mental Health Partnership Group
Engagement* to date ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	There has been no formal engagement on this paper as this paper is produced for Quality and Performance Committee and has not been elsewhere. The intelligence and papers used to formulate this report have come from the NHS GM Clinical Effectiveness and Governance Groups (and related subgroups) and the NHS GM Mental Health Partnership Group
Financial or Legal Implications;	There is currently work ongoing across the ICB in relation to planning for 2025/2026. The portfolio of work that sits under the Chief Medical Officer has been reviewed in relation to financial pressures, risks and opportunities and is being reported into the appropriate governance bi-weekly at present. Some of the outcomes of discussions around this may impact on programmes of work, this will be highlighted in this report as this progresses.

Public engagement	Clinical engagement	Sustainability impact	Financial advice	Legal advice	Conflicts of Interest	Report accessible
N	Y	N	N	N	N	Y

Table 1 - checklist of engagement carried out, advice sought, conflict of interest and accessiblity of report

Introduction

The need to build continuous improvement methods and approaches into workstreams across the Integrated Care Systems is articulated in the NHS Improving Patient Care Together (NHS IMPACT) framework and was strongly supported by system wide stakeholders at the NHS Greater Manchester (GM) IMPACT launch event in June 2024.

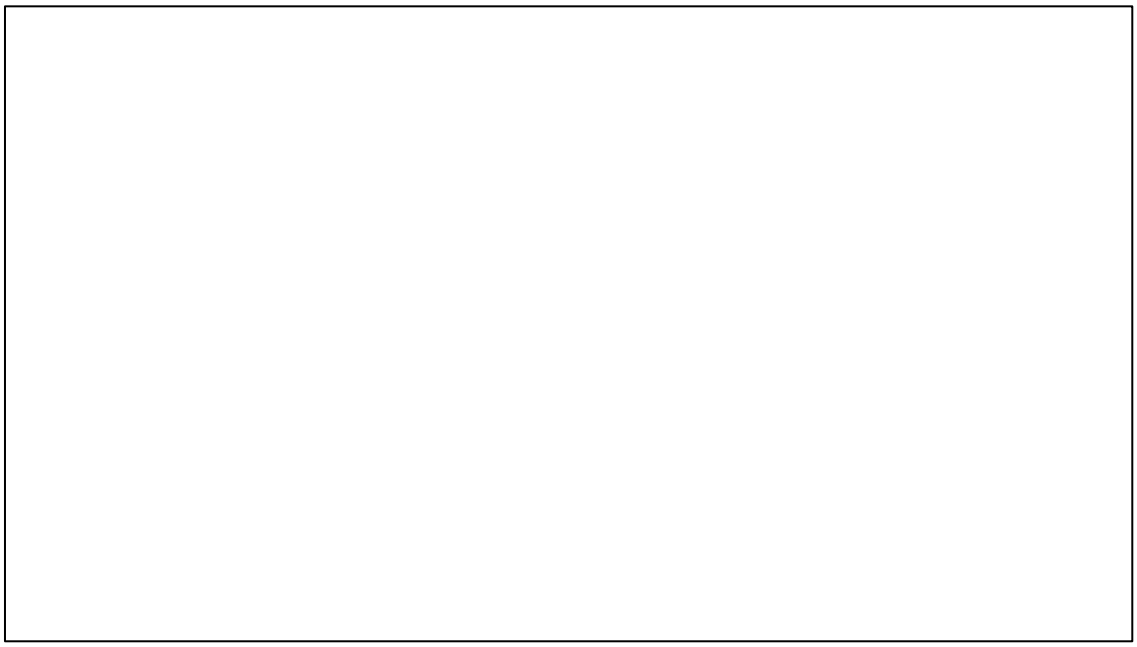
Our goal in Greater Manchester is to embed continuous improvement (CI) as core business, creating the culture, conditions and capability for improvement for all colleagues in all settings across the Integrated Care System to deliver improved outcomes and reduce unwarranted variation. Work to achieve this goal has begun and is continuing. This paper sets out the approach to continuous improvement in Greater Manchester ICS.

Building a system approach to improvement

NHS IMPACT provides a framework and a ‘common language’ for system level improvement, with five key principles:

- Building a shared purpose and vision
- Investing in people and culture
- Developing leadership behaviours
- Building improvement capability and capacity
- Embedding improvement into management systems and processes

Using these principles, and continuing work already underway in Greater Manchester, we can describe how we can achieve this goal as a driver diagram:



How we will achieve the goal of embedded continuous improvement

There are a number of key actions that will enable and support CI across the ICS. Establishing continuous improvement into reporting and governance will allow an understanding of how CI supports workstreams. Reviewing local quality indicators will inform improvement priorities. Developing a support offer for staff to lead improvement work will encourage CI approach to workstreams. Crucially, developing improvement capacity and capability into project teams will allow a sound methodological basis for workstreams. Senior leadership development in CI methods will support system groups and localities to deliver workstreams with underpinning improvement methodology.

The key enablers of this work are: application of a consistent improvement methodology across NHS Greater Manchester, coordination and curation of improvement resources and the use of data and intelligence to demonstrate the effectiveness of continuous improvement.

The System Groups provide an opportunity to support a continuous improvement approach. The shared ambition to improve patient care and reduce inequalities can build a common narrative around improvement as well as providing an environment for pooling resources and expertise, sharing successes and achievements and developing a system wide culture of improvement with Providers and Localities.

The Ambition for Greater Manchester

To develop the implementation of CI, the establishment of an NHS GM Improvement Network of colleagues from System Groups and Localities will facilitate sharing, learning and building of improvement capability, capacity and resilience, and will support assurance and operational delivery with an improvement approach.

A Community of Practice approach for wider system partners from Acute Providers and Primary Care will facilitate sharing of learning and good practice and successes. These networks will focus on improvement and not compliance or assurance

These networks will provide the ability for NHS GM and wider system workstreams to be able to demonstrate an underpinning CI framework, supported by strong governance. With a focus on improvement and not compliance or assurance, the purpose and vison articulated at the NHS GM IMPACT launch event in June 2024 can be realised.

Challenges to Delivery and Resources

There are many challenges to achieving our goals around continuous improvement. There is significant variation in continuous improvement expertise, capability and capacity across the ICS, and variation in the understanding of the utility and value of CI methods. Complexity across the ICS makes understanding the improvement landscape difficult. With much work happening in primary and secondary care, in research and innovation and in localities and system groups, joining up work in an efficient and effective way is necessary but difficult.

There are significant resources that can be used to resolve these challenges and achieve our goal: the ICS workforce with its specialist knowledge, supported by regional teams with subject matter expertise can build improvement capability and capacity. NHS IMPACT resources, and the newly established Learning and Improvement Networks (LiNs) in elective care, urgent and emergency care and mental health can also provide support. Getting It Right First Time (GiRFT) programmes provide infrastructure with pathways, standards and measurement. Academic and innovation institutions (Health Innovation Manchester and Higher Education Institutes) will have an important role supporting improvement through research and innovation.

The Role of NHS GM Quality and Performance Committee (QPC): Leadership for Improvement

QPC has a key role in the delivery of Greater Manchester's ambition for continuous improvement to ensure that effective joined up work improves patient care and reduces unwarranted variation and health inequalities both within GM and between GM and the rest of England. As a governance forum QPC must report on progress to fulfil our statutory duties and ensure that improvement work aligns with the strategic objectives of the ICB and wider ICS.

QPC can support the work described above by:

- Supporting an improvement culture
- Require visibility of an improvement approach in reporting to improve efficiency and effectiveness, and to avoid duplication and share learning
- Engage all stakeholders across the ICS to support continuous improvement
- Ensure that workstreams that fulfil the statutory duties of the ICB are conducted with an improvement approach

Summary

The approach to continuous improvement in the Greater Manchester ICS builds on work already underway and will develop the following key principles:

- Embed continuous improvement as core business
- Build improvement capability and capacity using local, regional and national resources
- Understand improvement workstreams to link teams up, avoid duplication and share learning
- Identify and adopt best practice
- Celebrate and share success

Recommendation

NHS GM QPC is asked to note the contents of the paper and support the approach described

NHS
Greater Manchester

Quality Performance Committee Risk Report

June 2025

Part of Greater Manchester Integrated Care Partnership

NHS Greater Manchester

Quality Performance Committee

June 2025

Required information.	Details.
Title of report.	Quality Performance BAF and Committee Risk Report
Author.	Jill Marston Planning and Assurance Co-Ordinator Christopher Toms, Quality Manager Alex Barke Senior Project Manager – Medical Directorate
Presented by.	Prof Colin Scales, Deputy Chief Officer, NHS GM
Contact for further information.	alexander.barke@nhs.net

Executive summary.	This paper provides a monthly update on risks – including the BAF risk/s and the committee risks. **Key updates** **Proposed reduction to BAF risk score for SR5** BAF new corporate format into landscape on a page with updates To note the decrease in risk score for COMP1 (complaints risk) Progress against both CCPL09A & CCPL09B – risk remains the same. Focus on any new clinical risks, potential areas of risk identified as part of this review & next steps for GM.
The benefits that the population of Greater Manchester will experience.	Effective risk management is essential. The NHS GM Risk Policy provides a framework to enable risk management to be embedded across all activities within the organisation
How health inequalities will be reduced in Greater Manchester's communities.	The management of strategic risks will directly contribute to the delivery of the ICP strategy.
The decision to be made and/or input sought.	The Committee is asked to agree contents of paper together with relevant mitigation is in place. And to report to board any exceptions. Agree the proposed reduction in risk score for BAF risk SR5

How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	The Quality Performance Committee is managing risk in line with the NHS GM Risk Policy. The Statutory Committees of NHS GM all have a responsibility for Risk Management. The NHS GM Risk Policy provides a framework to enable risk management to be embedded across all activities within the organisation. It also provides a method by which organisational understanding of risk in all its constituent parts; control measures, importance of actions, review and ownership of risk, is robustly assured through the committee structure.
Key milestones.	Nothing to note
Leadership and governance arrangements.	Risks discussed at the QPC risk coordination meeting
Engagement* to date. ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	Nothing to note
Financial or Legal Implications	

Table 1: Information needed about the document and its purpose.

Public engagement	Clinical engagement	Sustainability impact	Financial advice	Legal advice	Conflicts of interest	Report accessibility

No	Yes via QPC	No	No	No	No	Yes

Table 2: Assurance needed about the document.

EXECUTIVE SUMMARY INCLUDING KEY MESSAGES:

This paper provides a monthly update on the key significant risks – including the BAF and committee risks relevant to QPC. The committee is asked to consider the BAF and committee risks to ensure they are assured on the risks presented with patient safety and care at the heart of any actions & decisions made towards mitigation and reduction in both score and effect.

KEY AREAS TO BE DISCUSSED:

INTRODUCTION AND PURPOSE

1.1 This report provides an update to NHS GM Quality Performance Committee on the key risks across the organisation assigned to this committee.

1.2 The report includes the latest Board Assurance Framework (BAF) and Committee risk/s relevant to QPC.

1.3 The oversight of the risks seen by the committee will facilitate a wider appreciation of the potential impact on the ICB objectives. The committee are asked to critically challenge and note the risks presented and their impact on patient outcomes as the key focus.

1.4 The Quality Performance Committee is managing risk in line with the NHS GM Risk Policy. The Statutory Committees of NHS GM all have a responsibility for Risk Management. The NHS GM Risk Policy provides a framework to enable risk management to be embedded across all activities within the organisation. It also provides a method by which organisational understanding of risk in all its constituent parts; control measures, importance of actions, review and ownership of risk, is robustly assured through the committee structure.

BAF RISKS 2025/26

2.1 The BAF risks that are considered by this committee have been produced in the new agreed landscape format and are therefore covered at the end of the paper.

2.2 Updated review of BAF risk SR5

"There is a risk of failure to comply with our statutory duties for quality assurance in Quality and Patient Safety within the NHS GM system"

Proposed change to risk score – the Quality & Performance Committee are asked to approve a recommendation to reduce the risk score for this BAF risk from 20 (likelihood 4, impact 5) to a risk score of 15 (likelihood 3, impact 5). Significant progress has been made against the NHS GM Single Improvement Plan with NHSE with key milestones and deliverables being met. The ICB have received positive feedback and a full robust action plan is in place. The NHS GM provider oversight model is now established with regular review of providers in line with NHS England guidance outcomes of which are regularly fed into Quality and Performance Committee. Improvements have been seen within GMMH and work continues to progress against the Recovery Delivery Plan with the focus on achieving progression to Segment 3; exit criteria has now been agreed as March 2026. Patients should receive timely, compassionate, and clinically appropriate interventions, leading to better long-term health outcomes and reduced escalation of mental health crises. An internal audit (MIAA) around the Patient Safety Incident Response Framework is now complete with the final judgement noting 'There is a good system of internal control designed to meet the system objectives, and that controls are generally being applied consistently.

We are currently exploring the possibility to reduce this risk score further, however there is a possibility that the NHS Reforms may impact on the delivery of our statutory duties with unknowns around the future presence of professional voice within the ICB. In addition, we are yet to develop robust processes that include Quality Impact Assessments that need to be carried out against proposed changes in each statutory function. If Committee members approve, we will update the BAF risk with a score of 15 for Q1 of 2025-26. Committee members will be kept up to date as we progress through the impact of reforms on the delivery of statutory functions.

COMMITTEE RISKS

3.1 The Committee risk register contains the following risks that are scored with a risk rating of 15 or greater.

Risk Ref	Description	Score	Direction / Trend
Quality Risks			
Comp1	Failure to deliver statutory duties for complaints	12	↓
Operationally managed GM UEC Group			
QUP21/10/24	Achievement of 78% 4 hour wait in ED standard of care by end March 2025.	16	⇆
QUP09/01/23	If the GM UEC System is overwhelmed due to capacity constraints, then the consequence of this would be more patients attending an ED, overcrowding of EDs, less patients being seen within 4 hours, compromising patient safety and possibly leading to patient harm. Ensure that patients receive the right care in the right place.	16	⇆
Operationally managed GM Cancer			
QUP16/11/23	If the Cancer Alliance projects add operational and / or financial pressure to the GM system given the underlying operational and financial challenges, THEN the delivery of the NHS Cancer Programme priorities and targets will be affected – in turn affecting the outcomes for patients. This includes ongoing funding of projects to sustain services once the Cancer Alliance funding allocation to providers and partners in NHS GM ends	16	⇆
QUP19/03/24	If the fragility of the dermatology service is not resolved, there will be a detrimental impact on the operational performance metrics.	20	⇆
QUP22/04/24	If the improvement plans are not delivered in full, then there is a risk that the interim target of 75% for the 62-day RTT (Referral to Treatment) will not be achieved, which will lead to continual failure of the 62-day constitutional standard	16	⇆
QUP22/05/24	If investment (non-pay) is not available to deliver improvement initiatives, then there is a significant risk to the delivery of the system planning requirements for cancer performance (28 day, 62 day)	20	NEW
Operationally managed GM Elective Programme			
QUP7/01/23	GM's current RTT position as well as the ambitious targets for performance and financial control means GM has a much higher challenge than most other ICBs in the country. If the finance mechanism	16	↑

	remains constrained at either a flat or reduced level (from 24/25), there is a risk that performance targets are not achieved.		
Operationally managed GM Mental Health Partnership			
QUP10/01/23	There is a risk that the demand for MH inpatient services will outstrip capacity, leading to high levels of Out of Area Placements (OAPs)	20	⇆
QUP15/11/23	Demand for neuro-developmental services outstrips capacity leading to long waiting times	16	⇆
Operationally managed GM Clinical Effectiveness and Governance Committee			
CCPL09A	There is a risk that intense pressures on clinical care and professional leadership across the **GM system** will impact on the ability to ensure that decisions about health and social care across GM are clinically led, clinically challenged, clinically effective which will result in poorer health outcomes for our population as a whole and impact on NHS GM being able to deliver its operating model.	20	⇆
CCPL09B	There is a risk that intense pressures on clinical care and professional leadership across the **GM ICB** will impact on the ability to ensure that decisions about health and social care across GM are clinically led, clinically challenged, clinically effective which will result in poorer health outcomes for our population as a whole and impact on NHS GM being able to deliver its operating model.	20	⇆

3.2 Full details for all risks are included in Appendix 1

FOCUS ON ANY UPDATES

4.1 Comp1 - Failure to deliver statutory duties for complaints.

Risk around volume of enquiries/complaints and resource to be able to manage them - risk score was previously increased from (12 to 16) due to the ending of agency contracts and a recruitment freeze raising concerns around the subsequent effect for our populations voice being heard and responded to within expected timeframes and risk to our organisational reputation with the Greater Manchester public. Management of the cases in April has however shown that impact of removal of agency staff and consequent reduction in performance against trajectory has been less than expected. Work continues to flex resource to support timely resolution of complaints. Risk score decreased (from 16 to 12) and therefore going forward will be removed from Committee Risk Register.

QUP7/01/23 - Rationale: With flat or reduced funding, capacity within plans in 25/26 is fixed with limited scope for additionality as was heavily relied on in 24/25. Productivity and maximising efficiency remains the only viable mitigation.
This risk rating has increased to 16 again as has therefore met the threshold to be re-added to the risk report for QPC.

QUP22/05/25 - If the improvement plans are not delivered in full, then there is a risk that the interim target of 70% for the 62 day RTT (Referral to Treatment) will not be achieved, which will lead to continual failure of the 62 day constitutional standard and impact patient experience. In some cases, this may result in psychological and physical harm.

CCCPL 9a & 9b Pressure on the Clinical care and professional leadership

CCPL09A update:

Virtual and in person events scheduled in for 2025 to support development and ensure connection with NHS Reform work. These events are scheduled monthly throughout 2025.
Review of NHS Trust Provider public board papers underway to identify any risks relating to clinical leadership generally and within specific services.
To consider utilising the NHS England » Principles for assessing and managing risks across integrated care systems to strengthen the review of this risk.
Clinical risk review to incorporate a review of this risk at both ICB and system level.

Risk rating remains the same

CCPL09B update:

NHS GM Workforce Away Day held on the 2nd of April with the start of active engagement of all staff in relation to NHS Reform with specific focus on the topics of strategic commissioning, Live Well, Place, and the concept of Accountable Care Organisations. Clinical Leads encouraged to contribute into this work. Key personal from the Medical Directorate are involved in the strategic group overseeing this work.

The Workforce Away Day was also used to capture and celebrate areas of excellence across NHS GM- including achievements from clinical leads, clinical networks, medicines optimisation and the Medical Directorate as a whole.
People and Culture Action Plan to be reviewed following the publication of the staff survey.
The Clinical risk review (4.3) is to incorporate a review of this risk at both ICB and system level.

Risk rating remains the same

These risks are to remain under review given the recent announcements made nationally in respect of NHS England and the efficiencies ICBs and providers have been asked to make.

Linked to CCPL A&B there us a further risk currently under consideration by membership of Clinical Audit and Standards Sub-group and GM Clinical Effectiveness and Governance Committee.

The People & Culture Risk Owners have confirmed that they have updated their workforce risk as follows:

"We extended our impact for the risk below to cover clinical care.
Growing and developing our workforce
RISK: There is a risk that inability to recruit to key priority areas will prevent the ICB delivering on its role.
CAUSE: Financial Improvement Programme restricting recruitment/increase in headcount
IMPACT: This can lead to increased workload and stress for existing employees, reduced productivity, and inability to meet national expectations of the ICB. For example, this may impact on the ability to delivery core priorities, strategic duties and foremost – the clinical care and decision making for our population."

4.3 **Focus on any new clinical risks** – *presented at GM Clinical Effectiveness and Governance Committee on the 29th of April 2025.*

In 2025/26 a risk review is being undertaken in the context of the three shifts, NHS reform, the 25/26 Operational Planning Guidance and the six shifts to strategic commissioning. Significant financial pressures and potential capacity issues in workforce in 2025/26 mean that NHS GM will need to prioritise programmes of work potentially pausing or decommissioning services and reducing/stopping investment. Each item will need to have a quality and equality impact assessment- but where services are paused or decommissioned and where the ability to invest is reduced/stopped, we are looking at the clinical impact of this and if these need to be captured as risks and/or managed as issues. Patient impact and outcomes will be at the top of the considerations when conducting this work.

NHS Trusts and wider partners will be part of this risk review to identify any areas of collaboration/mutual aid/support. The NHS England » Principles for assessing and managing risks across integrated care systems will be used to support this risk review.

Potential areas of risk identified as part of this review already are:

- The need to strengthen the CCPL09A and B risk- potentially adding in specific speciality and service areas
- The need to incorporate specialist commissioning clinical risks within the review

- Safety within accident and emergency departments (following intelligence from ICB Nursing and Quality Directorate quality walk-rounds of the NHS Trust departments)
- Digital clinical safety (this is described as a risk within Board papers of every NHS Trust)
- Specific services where there is a rapid quality review underway that is impacting across the whole system (for example paediatric audiology)
- Out of area placements as a system, provider, and locality risk
- Enhancement of Perinatal and Parent Infant Mental Health Services to meet population needs and national targets (indicated by a cluster of serious incidents)
- Research (this is described as a risk within Board papers of every NHS Trust)
- Areas relating to LTC management (such as adequate weight management provision at all levels in line with national guidance)
- Reducing unwarranted variation (risk being developed at ICB level and also present in NHS Trust Board papers across GM)
- Maternity services risks (this is described as a risk within Board papers of every NHS Trust)

Next steps for NHS GM

- To complete the risk review- engaging with all system partners including NHS Trusts, VSCE and independent sectors to identify common areas of risk where a more coordinated approach would lead to stronger management and mitigation.
- Working with system partners use the NHS England framework to describe and mitigate common risks- that affect NHS GM, NHS Trusts, wider system partners and localities, so we can quantify the level of risk at different levels of the system and better coordinate the management response to mitigate.

The new clinical governance framework will prompt clinical leads regarding meeting attendance and risk mitigation or prompts to raise.

4.4 Committee members will be aware we have previously discussed a potential new risk in relation to GMMH service users having poorer outcomes and experience overall lower standards of care due to the current performance, finance and quality & safety challenges and subsequent level of improvement required by Greater Manchester Mental Health Trust. A new risk has been added to the corporate risk register and scored at 12 – high levels of oversight are currently in place to mitigate this risk.

RECOMMENDATIONS

The Quality Performance Committee is asked to:

Support the Committee and BAF risks as presented in the new format.

Mn,

SR4	Greater Manchester fails to deliver national operational delivery standards	
	Quality & Performance Committee	Colin Scales, Deputy Chief Executive
Risk	**Greater Manchester fails to deliver the operational delivery standards, as set out in national planning guidance**	
Cause	There are a number of operational standards NHS GM and Greater Manchester ICS risk not meeting. There are a range of root causes to this. • Backlogs of activity accumulated during Covid • Demand exceeding capacity • Financial constraints to fund activity levels and recovery initiatives • Low productivity in some areas • Workforce shortage, linked to financial challenges and hard to recruit posts	
Impact	• Long waits for residents to receive treatment, resulting in worse outcomes and experience • Regulatory risk for ICB and Providers linked to NHS performance oversight framework • Reputational risk	

Key Controls

Weekly, and daily as required, tracking of activity and performance indicators Mutual aid for elective, cancer and diagnostic care is in place. Use of independent sector support for elective care, where this is within-budget Daily monitoring of A&E activity and breaches GM system control centre meets no less than weekly to oversee operational activities and escalation. Other operational groups meeting no less than weekly to oversee activities, including patient level coordination.	The TOR for the Performance improvement assurance group (PIAG) to be refreshed and implemented to oversee implementation and impact of performance improvement plans. Performance improvement plans to be refreshed for all high-risk performance areas, including individual Trust and/or locality level where needed. (UEC, elective, cancer, mental health, diagnostics and inpatients for people with a learning disability) Provider oversight and Locality assurance meetings in place to gain assurance regarding delivery. Escalation meetings in place for Trusts which provider clearer tracking of action plans at senior level

Gaps in Control or Assurance

Limited scope for additional investment in mitigating actions.
Specific challenges within specialties/sub-specialities which have limiting factors such as available workforce. Some specialty areas where there are workforce shortages nationally.
Limited supply of materials for corneal grafts. The prioritisation of these materials is coordinated nationally and cause breaches of waiting times. These are accepted exceptions to ICB Performance management by NHSE.

Risk Scoring and Tolerance

	Inherent risk score	Q1	Q2	Q3	Q4	In year Target	Long Term Target	Long Term Target Date
Likelihood	5	4				2	2	Target – March 2028
Impact	5	5				5	5	
Risk Level	25	20				10	10	

Number of Linked Risks on Corporate Risk Register

Low (1 - 4)	Mod (5 – 12)	High (15 – 25)
0	5	4

Risk Tolerance Range	5-10

Rationale for Risk Score and Progress made in the quarter

All organisations remain committed to the plans they submitted. Areas highlighted as high risk are considered such because of the scale of the 25/26 challenge or historical non-achievement. Current plans include significant levels of mitigations and NHS GM committed to meet its planning objectives. This risk is currently outside of the risk appetite of the organisation. The target risk score moves within risk appetite by March '26. It is important to note that national guidance will require a continued incremental improvement back toward constitutional standards over several years which will mean a continued pressure against these standards. Areas of high risk are: A&E 4 hour waits; Long waits for elective care; Waiting times for Children's and adolescent mental health services including ADHD/ASD and reducing mental health inpatient LOS; Learning disability and autism inpatients; Further development of the function is required to respond to Model ICB requirements.

Defence Line	Sources of Assurance	Assurance Level
1st Line	An escalation framework is in place Weekly performance review of key metrics Executive Committee / Chief Officers review key metrics weekly 121s with programme directors (elective, cancer, urgent care, mental health, diagnostics)	Partial
2nd Line	System Group meetings to review operational performance for their respective thematic area ; Provider oversight meetings; Locality assurance meetings; GM performance improvement assurance group; Quality & Performance Committee. Monthly report and scrutiny from Committee.	Partial
3rd Line	NHS GM is part of various NHSE (regional and national) oversight relating to elective; urgent and emergency care; and cancer care. Provides access to various external support offers including GIRFT and ECIST	Partial

Actions

		Complete/BAU	On Track
		Delayed	Problematic

No	Action Required	Due Date	Progress	BRAG
1	Refresh the TOR for the Performance and Improvement Assurance Group, performance Improvement Plans (PIPs) and continue monthly meetings for high risk areas.	June 2025		
2	Refresh the TOR for Locality and Provider Oversight Meetings	June 2025		
3	Refresh assurance reports (and associated DII tools) – weekly exec report, Quality and Performance Committee, Finance Committee etc to reflect the new NHS planning objectives	June 2025		

NHS
Greater Manchester

SR5	**There is a risk of failure to comply with our statutory duties for quality assurance in Quality and Patient Safety within the NHS GM system**
	Quality & Performance Committee — Mandy Philbin, Chief Nursing Officer
Risk	**There is a risk of failure to comply with our statutory duties for quality assurance in Quality and Patient Safety within the NHS GM system**
Cause	The operational delivery of the Quality Assurance Framework and Provider Assurance Framework needs to be embedded across Greater Manchester Due to competing pressures in locality, there may be a failure to implement and prioritise the assurance process.
Impact	The ICB will be in breach of the Health and Social Care Act and be subjected to legal proceedings. Lack or delay in oversight may result in poor experience and possible harm to the population of Greater Manchester. The implementation of the "Right Care, Right Person" initiative has a profound impact on patient safety in the long term, by ensuring that patients receive the most appropriate care for their needs.

Risk Scoring and Tolerance

	Inherent risk score	Q1	Q2	Q3	Q4	In year Target	Final Year Target	Final Target date
Likelihood	4	3	4	4	4	3	2	Target – March 2028
Impact	5	5	5	5	5	5	5	
Risk Level	20	15	20	20	20	15	10	

Number of Linked Risks on Corporate Risk Register

Low (1 - 4)	Mod (5 – 12)	High (15 – 25)
0	10	0

Risk Tolerance Range	5-10

Rationale for Risk Score and Progress made in the quarter

Significant progress has been made against the NHS GM Single Improvement Plan with NHSE with key milestones and deliverables being met. The ICB have received positive feedback and a full robust action plan is in place. The NHS GM provider oversight model is now established with regular review of providers in line with NHS England guidance outcomes of which are regularly fed into Quality and Performance Committee.
Improvements have been seen within GMMH and work continues to progress against the Recovery Delivery Plan with the focus on achieving progression to Segment 3; exit criteria has now been agreed as March 2026. Patients should receive timely, compassionate, and clinically appropriate interventions, leading to better long-term health outcomes and reduced escalation of mental health crises. An internal audit (MIAA) around the Patient Safety Incident Response Framework is now complete with the final judgement noting 'There is a good system of internal control designed to meet the system objectives, and that controls are generally being applied consistently. There is a possibility that the NHS Reforms may impact on the delivery of our statutory duties with unknowns around the future presence of professional voice within the ICB. In addition, we are yet to develop robust processes that include Quality Impact Assessments that need to be carried out against proposed changes in each statutory function.

Key Controls

NHS trust provider oversight (POM) in place and well established with plans to further develop and further strengthen. Exec to exec meetings is now a regular occurrence. with Quality KLOES identified.
ICB Provider Oversight Framework established in line with National Guidance.
Locality Assurance Mechanism (LAM) is established with oversight of locality approach to the statutory quality duties.
Quality Assurance Framework established/aligned to meet the National Quality Board Standards.
Provider Oversight Sub Committee meetings (POSOM) in place to identify segmentation and KLOES for the POMs

GM System Quality Group in place supporting the good governance from place/localities to ICB to region (Terms of Reference align to assurance process).
Reporting, audits and actions in place for safeguarding assurance (aligns to Safeguarding Policy).
Quality Impact Assessment processes established – guidance approved by QPC.
Patient Safety Policy approved at QPC.
Annual reports (Quality Accounts /Safeguarding Report/Complaints annual report).
Assurance meetings with NHSE.
Submission to RSQG with escalations as part of business as usual.
GM Patient Safety Council in place
External audits.
External inspections by regulators e.g. SEND.

Defence Line	Sources of Assurance	Assurance Level
1st Line	Quality Impact Assessment Process; Reporting via appropriate governance arrangements ; Self-assessment process; Annual reports (Quality Accounts /Safeguarding Report); Statutory functions oversight group; Reporting into locality Quality meeting	Acceptable
2nd Line	Quality and Performance Committee; Greater Manchester System Quality Group Provider Oversight Sub-committee; Reporting into locality board; External assurance via statutory bodies; ICB System improvement board	Acceptable
3rd Line	Regional SQG; Single Improvement Plan responding to Enforced Undertakings Assurance meetings with NHSE; Internal Audit	Acceptable

Gaps in Control or Assurance

Gaps in control
Direct reporting of locality ADQs into non-clinical locality DPBL rather than professional nursing lead
Potential disruption of the professional line of the reporting to the CNO due to competing priorities set by the locality.
Depletion in workforce capability and capacity due to organisational changes and organisational vacancies.
Disruption to compliance to QA process to meet safeguarding, CHC, SEND and QA due to indirect reporting relationship between ADQs and CNO
Gaps in Assurance whilst organisational structures are being confirmed.
Compliance with the statutory assurance frameworks
MIAA Audit findings

Outstanding Actions

Complete/BAU	On Track
Delayed	Problematic

No	Action Required	Due Date	Progress	BRAG
1	Develop Robust structure and alignment of resources to support delivery DPBL and ADQ are required to confirm locality resource alignment to CNO.	12/25 (Extended as the implications of NHS reforms are understood)	Partially meets but there is still variation whilst the nursing and quality structure is being finalised. Good progress but slippage in final product with date for Executive Committee in February 25. The model will continue with line management of ADQ in place will be implemented through new ways of working think this can be closed	
2	Carry out Audit and peer reviews	12/25	Partially meets. Further development needed. Audit and peer review model discussed with DPBLs July 24	

NHS Greater Manchester

SR5 - completed actions

Actions		Complete/BAU	On Track
		Delayed	Problematic
No	Action Required	Progress	BRAG
1	Develop place level compliance to QA framework to meet National Quality Board. DPBL and ADQ are required to confirm locality assurance to CNO. To drive improvement and standardisation	Evidence of place enacting the QA framework which has been signed off by the Improvement Board as part of the undertakings	
2	Development of Place level compliance by DPBL and ADQ to ensure safeguarding statutory duties are in place. To drive improvement and standardisation	Business continuity plan and mutual aid agreement in place, compliance will be monitored and enacted through LAM process	
3	Embed SQG as part of NQA escalation from place to QPC. All SQG members to understand their contribution and role.	Development session has been held and the work being done through Well - Led is strengthening the SQG and coming to a close. The position of SQG is clearly articulated in the assurance & escalation framework.	
4	Develop Provider assurance framework in place for the ICB. To provide a mechanism for oversight	Framework is now well established	
5	Implement QA framework	Framework is in use and is being applied by colleagues across the organisation as per the QA model. Evidence shared as part of the undertakings which demonstrates the application and outcomes.	
6	Embed Safeguarding framework. DPBL and ADQ are required to confirm locality resource alignment to CNO.	Framework implemented. Ongoing monitoring to check embedding	
7	Clarify roles and responsibilities around CHC statutory functions. Agree TORs for new CHC assurance meeting	TORs Developed. Regular monitoring in place with direct line into QPC	
8	Establish robust governance and data processes in order to discharge SEND statutory duties and responsibilities	Governance established and escalation clarified. Quality Framework in place. Data Dashboard in Place.	
9	Develop Robust governance arrangements	QPC and SQG are established with clear lines of governance	

Q&P RISK REGISTER MAY 25 (For June 25 Q&P Paper)

Risk Number	Source	Risk Category	Risk Type	Date risk added	Risk Owner	Risk Description	Inherent Risk Score			Trend	Risk Proximity	Controls	Gaps in Controls	Current Risk Score			Actions	Action Owner	Completion Date for actions	Assurances	Gaps in Assurances	Target Risk Score (anticipated score when mitigation complete)			Functional Area (optional)	Geographical Location (optional)	Last reviewed	Risk Target Date	Open/ Closed	Date and Reasons for Closure
Number to identify risk	The source of the risk (e.g. Manager, Committee, Board meeting etc..)	Alignment to one of 13 risk categories (for GMPMO to complete)	Alignment to one of 3 risk types: 1.Organisation 2.System wide 3. Both	Date when the risk was added to the risk register	Job title of the person responsible for the management, monitoring, control and escalation	A statement describing the risk event, cause and impact	Likelihood	Impact	RAG Status	The trend indicates any change in the current risk score in the form of an arrow	Timescale as to when the risk will occur	Please describe the controls in place to manage/reduce the risk	Please describe any gaps in controls to manage/reduce the risk	Likelihood	Impact	RAG Status	The actions and activities planned to take place that will when implemented or completed reduce, eliminate or minimise the risk	Job title of the person responsible for completing the action	Each action should have a completion date set	Please describe the assurance(s) in place to manage/reduce the risk	Please describe any gaps in the assurance(s) in place to manage/reduce the risk	Likelihood	Impact	RAG Status	A functional area within a regional team or a service area within a directorate	Where the risk is attributed to	Date when the risk was last reviewed and/or updated	Date risk will be mitigated by	Select Current Status of Risk	Reasons outlining why the risk was closed
QUP19/03/24	GM Cancer Group	12.Operational Performance		31/03/2024	Colin Scales, Deputy Chief Executive Officer	If the fragility of the dermatology service is not resolved, there will be a detrimental impact on the operational performance metrics. Furthermore there will be an impact to patient expeeince and potentailly psychological impact. Skin accounts for 1/3 of the GM backlog, and c70% at the largest provider of dermatology. The volume of patients has the potential to impact the year end delivery for Greater Manchester and England	4	3	12	↔	0-3 months and ongoing	GM Cancer unable to mitigate sustainability risk of the GM dermatology service		5	4	20	GM wide work programme under sustainable services. GM lead provider proposal currently being discussed Trust Provider Collaborative / Integrated Care Board GM Cancer - tele-dermatology project, additional funded activity, operational management support to deliver year end position . Increased discussions and work to recover NCA (Northern Care Alliance) position with the Trust, including weekly oversight meetings attended by the cancer alliance Although performance at NCA has improved, this is due to unsustainable additionality. Derm programme to update GM Cancer Board. Derm programme to re-commission IS provider in Oldham following removal of cancer from commissioning specification, and no solution to capacity challenges as a result of the closure of Tameside.	Director of Performance	Cancer Alliance actions complete	Faster Diagnosis Standard, Operational Performance Programme Board, National Tiering calls		4	3	12			22/04/2025		Open	
QUP22/04/24	GM Cancer Group	12.Operational Performance		24/04/24	Colin Scales, Deputy Chief Executive Officer	If the improvement plans are not delivered in full, then there is a risk that the interim target of 70% for the 62 day RTT (Referral to Treatment) will not be achieved, which will lead to continual failure of the 62 day constitutional standard and impact patient expereince. In some cases, this may result in psychological and phyical harm.	4	4	16	↔	0-3 months and ongoing	Focussed oversight on delivery of all actions Regular meetings with Trusts Highlight report / dashboard monitoring progress to COOs (chief Operating Officres) EMDs (Exective Medical Directors), TPC (Trust Provider Collaboratives), Cancer Board		4	4	16	Delivery of the cancer alliance work plan related to FDS and Operational Performance Delivery of the three accelerated improvement initiatives through Trust Provider Collaborative; front end pathway, Single Queue Diagnostics expansion and optimisation, surgical pathway improvement Continuous monitoring of reported performance and local data to predict trends and enable corrective action to be taken National tiering calls for under performing Trusts Targeted investment to support improvement Trust level action plans for improvement and delivery to reduce variation Performance Improvement Plans in place aligned with enforced ICB (Integrated Care Board) undertakings **Risk remains elevated due to MFT(Manchester Foundation Trust), delays / inability to enact all plans and forecasted perfromance, and therefore this risks the GM overall position. Director of Performance providing dedicated support 1 day a week commencing January - extended to end March 25.** **Three times weekly meetings in place with key specialities** **Weekly forecasting in place**	Director of Performance	31/03/2025	GM Cancer SSRAG (strategy and System Risk Assurance Group and PAG (Programme Assurance Group) Faster Diagnosis Standard, Operational Performance, Treatment Variation Programme Board GM Cancer Board TPC **ICB MFT recovery meeting and regional tier 2 meeting**		2	4	8			25/02/2025		Open	
QUP7/01/23	GM Elective Care Group	12.Operational Performance	2. System wide	Jul '24	Colin Scales, Deputy Chief Executive Officer	GM's current RTT position as well as the ambitious targets for performance and financial control means GM has a much higher challenge than most other ICB's in the country. If the finance mechanism remains constrained at either a flat or reduced level (from 24/25), there is a risk that performance targets are not achieved	4	4	16	↔	3-6 months	Maximise Productivity for both Non-Admitted and Admitted pathways utilising GIRFT Further Faster and implementation of productivity initiatives via Theatre Productivity programme. Improve utilisation of Surgical Hub capacity and activity; optimisation of Surgical Hubs as GM system-assets. Ensure careful investment of Elective recovery money to target the areas highlighted in detailed modelling as having the highest impact on wait list	With flat or reduced funding, capacity within plans is fixed with limited scope for additionality as was heavily relied on in 24/25. Productivity and maximising efficiency remains the only viable mitigation	4	4	16	FEI Productivity benchmarking to help trusts define bespoke opportunities and implementation plans GM Theatre Dashboard to come online to allow bespoke, granular monitoring of theatre performance Finance and contracting teams currently working apply IS caps to activity A&G activity resulting in appropriate deflection back to PC to be claimed as equivalent to OP 1st attendance tariff	Dan Gordon, Programme Director - Elective Recovery and Reform	Dec 24 June 25 Dec 24 Dec 24	Finance and Performance monitoring		3	3	9			11/04/2025	Mar-26	Open	
QUP10/01/23	MH Partnership Group	12.Operational Performance	2. System wide	01/04/2023	Colin Scales, Deputy Chief Executive Officer	**Risk:** There is a risk that the demand for MH inpatient services will outstrip capacity, leading to high levels of Out of Area Placements (OAPs) and local spot purchases Cause: • High level of demand • High bed occupancy within acute mental health units • Discharge delays for patients who are clinically ready for discharge (CRFD) • Workforce challenges • Financial resources • Lack of understanding of costs of placements **Impact:** • Out of area care can lead to a poor experience for service users when placed away from home and family • OAPs also generate unplanned costs for the system	5	4	20	↔	0-3 months	3-tier Multi-Agency Discharge Event (MADE) structure Manchester recovery plan Locality Performance Improvement Plans (PIPs) Patient trackers for OAPs OAPs highlight report (performance and finance) taken monthly to: - Cost Improvement Programme (CIP) Delivery - PIP Oversight Group - GM MH Partnership Group Briefings sent to executives / Quality & Performance Committee (QPC) as needed and copied to GM MH Partnership Group OAPs dashboard updated daily Manchester Mobilisation Plan Inpatient Quality Transformation Plan	High level of demand High bed occupancy within acute mental health units Discharge delays for patients who are clinically ready for discharge (CRFD) Workforce challenges Financial resources Lack of understanding of costs of placements	5	4	20	1. Prioritise community service capacity growth for commissioning intentions 2. Embed the 10 High Impact Actions, including criteria-led discharge, early planning, 7-day working, and standardised use of EDD and discharge criteria. This includes eliminating variation in pathways and supporting safer, person-centred discharges. 3. Mobilise recurrent investment into discharge and flow teams (Trust and VCSE), monitor for unintended consequences (e.g. ED waits), and embed long-term change in how beds are used and admissions managed. 4. Improve escalation processes, strengthen housing and step-down options, and ensure all partners are working to unblock discharge barriers, with a focus on high-impact cases and complex needs. 5. Operationalise the Inpatient Flow Group, finalise system trajectories (LOS, CRFD, OAPs), and roll out dashboard to track flow metrics across localities, bed types, and patient groups. 6. Translate outputs from the Inpatient Quality Transformation workshop into system actions, share what works through Community of Change events, and promote co-produced care planning and post-discharge follow-up as standard practice.	Programme Manager, Mental Health (Adult Community) Programme Manager, Mental Health (Adult Crisis) Strategic Programme Manager - Mental Health	1. Apr 25 2. TBC 3. TBC 4. TBC 5. TBC 6. TBC	GM OAPs / CRFD Oversight Group GM MH OAPs/CRFD Weekly Oversight Meeting Reduction in OAPS Manchester Locality – Oversight of Action Plan Weekly Internal OAPS Meeting NW Inpatient Quality Transformation Meeting	None	3	4	12	ental Heal	GM	14/04/2025	31/03/2026	Open	
QUP15/11/23	MH Partnership Group	12.Operational Performance	2. System wide	31/08/2023	Colin Scales, Deputy Chief Executive Officer	**Risk:** Demand for neurodevelopmental (ND) services outstrips capacity leading to long waiting times **Cause:** • Adult Attention Deficit Hyperactivity Disorder (ADHD) - there is no national policy for ADHD and it is not included in the Long Term Plan (LTP). Patients can request private assessments under Right to Choose (RtC) then expect to return to the NHS for treatment. Three localities currently have no service • Children & Young People (CYP autism) - Since the pandemic, demand has increased >500% with over 80% of Child and Adolescent Mental Health Services (CAMHS) waiting lists taken up by ND patients rather than those needing core MH pathways • Autism conditions with co-morbid MH - significant gaps in adult services and links to issues within inpatient services and challenge of CRFD **Impact:** Patients will face very long waits for assessments	4	4	16	↔	0-3 months	**Adult ADHD** Adult ADHD Options Appraisal Workshop held 31/05/2024 and options for consultation agreed, with a preferred option identified Adult ADHD proposals approved at GM MH Partnership Group, Commissioning Oversight Group (COG), at Integrated Care Board (ICB) Executives Pre Consultation Business Case developed NHSE Gateway 1 and 2 process completed Letter developed and sent out to all GPs and via the Primary Care Bulletin r.e. Right to Choose Outcome from NHSE Gateway Process r.e. whether we can go to public consultation or not - supported Plan of activity for public consultation developed **CYP Autism** CYP ND proposal agreed at MH Partnership	• Adult Attention Deficit Hyperactivity Disorder (ADHD) - there is no national policy for ADHD and it is not included in the Long Term Plan (LTP). Patients can request private assessments under Right to Choose (RtC) then expect to return to the NHS for treatment. Three localities currently have no service • Children & Young People (CYP autism) Since the pandemic, demand has increased >500% with over 80% of Child and Adolescent Mental Health Services (CAMHS) waiting lists taken up by ND patients rather than those needing core MH pathways • Autism conditions with co-morbid MH significant gaps in adult services and links to issues within inpatient services and challenge of CRFD	4	4	16	**Adult ADHD** 1. Undertake Public Consultation (dependent on outcome of NHSE Gateway process) 2. Outcome of Public Consultation (dependent on outcome of NHSE Gateway process) 3. Procurement of GM Adult ADHD Triage Team 4. Pathway redesigned and implemented **CYP Autism** 1. Executive Approval 2. Pathway redesigned and implemented	**Adult ADHD** 1. ICB Comms Team 2. Strategic Lead Commissioner 3. Strategic Lead Commissioner 4. Strategic Lead Commissioner **CYP Autism** 1. Assistant Director – Mental Health 2. Assistant Director – Mental Health	**Adult ADHD** 1. Apr-25 2. Jun-25 3. TBC 4. Apr-26 **CYP Autism** 1. Feb-25 2. Apr-26	Adult ADHD Steering Group NHSE Gateway Process ND Steering Group ND Implementation Group GM ND Team Meeting COG GM MH Partnership Group ICB Executives	None	3	4	12	ental Heal	GM	09/04/2025	31/03/2026	Open	
QUP21/10/24	GM Urgent and Emergency Care (UEC) Group	12.Operational Performance	3. Both	Oct-24	Colin Scales, Deputy Chief Executive Officer	If the GM UEC system does not achieve the 78% 4 hour wait in Emergency Department (ED) standard of care by end March 2026 THEN there may be a risk to patient safety.	4	4	16	↔	12 + months	GM UEC System Programme Integrated OPEL Framework Live monitoring of system pressures - GM System Cordination Centre (SCC)	None	4	4	16	**Demand** GM UEC Reform Programme will pull together the system , with the primary goal of reducing ED demand and eradicating 12hr waits in EDs, ensuring community capacity is aligned to support flow and appropriate access in the system. The reform programme will have a single system plan, with actions from a number of system wide programmes and senior oversight. These include but are not limited to the following: -Primary care capacity increase - ensuring appropriate access for patients reducing escalation into the UEC system, enabled by the BeCCOR programme. -Urgent Treatment Centres (UTCs) improvements -Development of Single Points of Access for community care, having consistent models in each of the 10 places across GM etc, reducing variation for patients. -The GM Clinical Assessment Service (CAS) continues to support demand management of patients who are directed to the UEC system via NHS 111. This is recognised as a best practice model. -The increase in use of Same Day Emergency Care (SDEC) and direct referral is planned to have a positive impact on ED attendances. -Mental Health improvement programme, supporting the reduction in CRFD and long waits in EDs for MH patients. **Physical Capacity** There are planned improvements to estates, through the UEC Capital investment funding. These will be confirmed in Q1 of 25/26 and are expected to improve flow, patient experience, and performance. This work includes expansion of some Acute Site capacity, a focus on appropriate space for Mental Health patients in ED's and improvements to community services and investment in equipment to prevent patients escalating through the UEC pathway were possible. **Service change / Transformation** All GM localities have improvement plans, utilising best practice and specifically focussed on some of the challenges that may be unique to their population. These plans are supported day some of the improvement initiatives that are available through the national Tier 1 process. GM will continue to work with Emergency Care Improvement Support Team (ECIST) throughout 2025/6 on a care co-ordination approach to support admission avoidance, ensuring patients are directed to relevant community services as clinically appropriate. All ten GM locality systems are reviewing their community service models with a view of identifying any relevant transformation opportunities to support shifts in activity out of the acute settings. Productivity improvement, including the impact of the above ECIST are working across multiple GM providers with a particular on ward process improvements, frailty management and reducing attendances to ED with a view to reducing length of stay. All GM localities are working collaboratively to improve transfer of care hubs and to monitor length of stay on a daily basis. GM has worked with the NHSE (National) to review these systems and process ensuring learning from best practice is implemented and appropriate recording and reporting is in place. **Adult Social Care (ADSC)** Work continues (with input from independent adult social care providers) to maintain services in the short-term and on longer-term sustainable solutions. Whilst the adult social care market remains volatile, overall, it is less fragile than this time last year and challenges are being managed within localities with minimal impact on people and workforce. Currently there is good availability of social care services across GM and Operational Pressures Escalation Level (OPEL) ratings continue to be steady.	**Gill Baker, GM UEC Programme Director**	31/03/2026	**NHS GM Internal operations** GM SCC GM UEC System Programme **NHS GM Internal assurance** GM UEC System Group GM System Programme Groups GM UEC Clinical Care & Professional Leadership Group (CCPL) Group GM Ambulance Handover Group GM Discharge and Flow Group GM Operations Network GM UEC Standards of Care Oversight meetings GM Performance and Assurance Group (PIAG) GM System Improvement Board (SIB) GM Quality and Performance Committee (QPC) NHS GM Integrated Care Board (ICB) **NHS GM External assurance** NHSE(National) UEC Tier 1 meeting NHSE (Region) UEC Recovery Board NHSE (Region) and NHS GM Bi-lateral meeting	None	2	4	8	UEC	GM	29/04/2025	Open		
QUP09/01/23	GM Urgent and Emergency Care (UEC) Group	12.Operational Performance	3. Both	Oct 24	Colin Scales, Deputy Chief Executive Officer	If the GM UEC System is overwhelmed due to capacity constraint THEN the possible consequence of this would be more patients attending an ED,overcrowding of EDs,less patients being seen within 4 hours,compromising patient safety and possibly leading to patient harm.	4	4	16	↔	12 + months	GM UEC System Programme Integrated OPEL Framework Live monitoring of system pressures - GM System Cordination Centre (SCC)	None	4	4	16	**Demand** GM UEC Reform Programme will pull together the system , with the primary goal of reducing ED demand and eradicating 12hr waits in EDs, ensuring community capacity is aligned to support flow and appropriate access in the system. The reform programme will have a single system plan, with actions from a number of system wide programmes and senior oversight. These include but are not limited to the following: -Primary care capacity increase - ensuring appropriate access for patients reducing escalation into the UEC system, enabled by the BeCCOR programme. -Urgent Treatment Centres (UTCs) improvements -Development of Single Points of Access for community care, having consistent models in each of the 10 places across GM etc, reducing variation for patients. -The GM Clinical Assessment Service (CAS) continues to support demand management of patients who are directed to the UEC system via NHS 111. This is recognised as a best practice model. -The increase in use of Same Day Emergency Care (SDEC) and direct referral is planned to have a positive impact on ED attendances. -Mental Health improvement programme, supporting the reduction in CRFD and long waits in EDs for MH patients. **Physical Capacity** There are planned improvements to estates, through the UEC Capital investment funding. These will be confirmed in Q1 of 25/26 and are expected to improve flow, patient experience, and performance. This work includes expansion of some Acute Site capacity, a focus on appropriate space for Mental Health patients in ED's and improvements to community services and investment in equipment to prevent patients escalating through the UEC pathway were possible. **Service change / Transformation** All GM localities have improvement plans, utilising best practice and specifically focussed on some of the challenges that may be unique to their population. These plans are supported day some of the improvement initiatives that are available through the national Tier 1 process. GM will continue to work with Emergency Care Improvement Support Team (ECIST) throughout 2025/6 on a care co-ordination approach to support admission avoidance, ensuring patients are directed to relevant community services as clinically appropriate. All ten GM locality systems are reviewing their community service models with a view of identifying any relevant transformation opportunities to support shifts in activity out of the acute settings. Productivity improvement, including the impact of the above ECIST are working across multiple GM providers with a particular on ward process improvements, frailty management and reducing attendances to ED with a view to reducing length of stay. All GM localities are working collaboratively to improve transfer of care hubs and to monitor length of stay on a daily basis. GM has worked with the NHSE (National) to review these systems and process ensuring learning from best practice is implemented and appropriate recording and reporting is in place. **Adult Social Care (ADSC)** Work continues (with input from independent adult social care providers) to maintain services in the short-term and on longer-term sustainable solutions. Whilst the adult social care market remains volatile, overall, it is less fragile than this time last year and challenges are being managed within localities with minimal impact on people and workforce. Currently there is good availability of social care services across GM and Operational Pressures Escalation Level (OPEL) ratings continue to be steady.	**Gill Baker, GM UEC Programme Director**	31/03/2026	**NHS GM Internal operations** GM SCC GM UEC System Programme **NHS GM Internal assurance** GM UEC System Group GM System Programme Groups GM UEC Clinical Care & Professional Leadership Group (CCPL) Group GM Ambulance Handover Group GM Discharge and Flow Group GM Operations Network GM UEC Standards of Care Oversight meetings GM Performance and Assurance Group (PIAG) GM System Improvement Board (SIB) GM Quality and Performance Committee (QPC) NHS GM Integrated Care Board (ICB) **NHS GM External assurance** NHSE(National) UEC Tier 1 meeting NHSE (Region) UEC Recovery Board NHSE (Region) and NHS GM Bi-lateral meeting	None	2	4	8	UEC	GM	29/04/2025	Open		
CCPL09A	NHS GM CEG	Quality and Safety	3. Both	Jan-25	Chief Medical Officer	**Risk:** The Clinical Care and Professional Leadership across the GM system is under intense pressure, with reduced resilience; this alongside recruitment freezes will impact on retention and potentially lead to burn out. The risk is that this will impact on the ability to ensure that decisions about health and social care across GM are clinically led, clinically challenged, clinically effective which will result in poorer health outcomes for our population as whole and impact on NHS GM being able to deliver its operating model. **Cause:** The cause of the sustained, intense pressure is multifactorial: -Continued high-level demand on clinical and care leaders (CCPL) has persisted since the COVID-19 pandemic and is unabated. -A high proportion of this demand has become reactive and immediate, as opposed to proactive and planned. -A continual need to balance patient safety and quality with financial affordability and sustainability. -A culture of grip and control changing the nature of work towards increased assurance with less autonomy to define and deliver based on personal expertise. -The size and complexity of the GM system can lead to duplication and silo-ed working, across multiple spatial levels, including complexity in governance arrangements which can misalign with clinical commitments. -All of which is balanced against increasingly complex and pressured clinical duties, which makes part time working across both leadership and clinical roles less sustainable and logisticall	4	5	20	↔	6-12 months	**Preventative** •GM CCPL Framework established, which includes leadership development, mentorship, and succession planning •Governance in place to support clinical leadership in decision making including the Clinical Pathway, Audit and Standards Group and the Clinical Effectiveness and Governance Committee- reporting into the GM Quality and Performance Committee. •To continue to embed clinical and care professional leadership as a key partner in system transformation, redesign and improvement plans. •GM Clinical Governance Framework. Work is underway with the Royal College of Physicians Edinburgh to develop this. •To mature matrix working arrangements in priority areas to align a wider clinical team that is reflective of organisational and spatial levels to key GM programmes. •Bi-annual CCPL events F2F, supporting the development of teams and shared purpose •Recruitment and retention plans in every NHS Trust across GM •The Greater Manchester Primary Care Workforce Strategy **Detective** •NHS GM CEG	1. Inability to directly influence financial pressures or decisions from CCPL roles 2. This risk is a system risk. Therefore, a current gap is the lack of alignment (and therefore a lack of coordinated mitigations and controls) across the risk registers in individual organisations in GM in relation to this risk.	4	5	20	1. Strengthening the leadership potential and knowledge of CCPLs (including influencing skills at strategic levels) to support the delivery of the operating plan and ensure the clinical voice is considered when financial decisions are being taken that will impact on patient safety, experience and clinical effectiveness of care. •Delivery of CCPL Framework through the GM CCPL Programme, which includes leadership development, mentorship and succession planning 01/03/2026 •GM Clinical Governance Framework to be in place (by Q2 2025/26) to support two way communication; ensure adherence to best practice and clinical standards through system focus on clinical governance and quality improvement; enhance opportunities for shared learning; and to support clinical teams in understanding their role and responsibilities in relation to clinical governance and effectiveness. Work is underway with the Royal College of Physicians Edinburgh. 30/09/2025 •To continue to embed clinical and care professional leadership as a key partner in system transformation, redesign and improvement plans; delivered by an ongoing review of CCPL representation in key forums. 31/08/2025 •To mature matrix working arrangements in priority areas to align a wider clinical team that is reflective of organisational and spatial levels to key GM programmes by establishment of regular clinical meetings and joint clinical objectives. 01/03/2026 2. To review this risk in line with the principles for assessing and managing risks across integrated care systems published by the National Quality Board in December 2024 to support a co-ordinated approach to mitigations and controls. 30/06/2025 3. To work with the people and culture team to ensure that the refresh of the GM People and Culture Strategy incorporates and reflects issues raised in this risk. 31/05/2025	**Kate Provan, Associate Director of Clinical Effectiveness and Improvement**	Within narrative	Ownership of delivery by the CMO Senior Leadership Team and the Quality and Nursing Senior Leadership Team. Cross Directorate risk meeting supporting risks relating to quality and performance. Medical Directorate risk meeting CCPL work programme Associate Medical Director monthly meetings Associate Directors for Quality, Nursing and Safeguarding meetings Regular updates to the Quality and Performance Committee in relation to the development of CCPL through the CMO and CNO report. Clinical governance framework writing group and workshops hosted by RCP Edinburgh Priority function clinical leadership groups NHS GM Clinical Effectiveness and Governance Committee (CEG)	Full co-ordination between CCPL development and the GM People and Culture Strategy	3	5	15	CEG	GM	Apr-25	Ongoing	Open	
CCPL09B	NHS GM CEG	Quality and Safety	3. Both	Jan-25	Chief Medical Officer	The Clinical Care and Professional Leadership across the GM system is under intense pressure, with reduced resilience; this alongside recruitment freezes will impact on retention and potentially lead to burn out. The risk is that this will impact on the ability to ensure that decisions about health and social care across GM are clinically led, clinically challenged, clinically effective which will result in poorer health outcomes for our population as whole and impact on NHS GM being able to deliver its operating model. **Cause:** The cause of the sustained, intense pressure is multifactorial: -A continual need to balance patient safety and quality with financial affordability and sustainability. -An increasing pressure to make critical financial decisions at pace delaying recruitment of key CCPL posts -A culture of grip and control changing the nature of work towards increased assurance with less autonomy to define and deliver based on personal and clinical expertise. -The size and complexity of the GM system can lead to duplication and silo-ed working, across multiple spatial levels, including complexity in governance arrangements which can misalign with clinical commitments. -All of which is balanced against increasingly complex and pressured clinical duties, which makes part time working across both leadership and clinical roles less sustainable and logistically less manageable to balance competing commitments. **Impact:** This directly impacts our CCPL workforce but also impacts delivery	4	5	20	↔	6-12 months	•GM CCPL Framework established, which includes leadership development, mentorship, and succession planning •Governance in place to support clinical leadership in decision making including the Clinical Pathway, Audit and Standards Group and the Clinical Effectiveness and Governance Committee- reporting into the GM Quality and Performance Committee. •To continue to embed clinical and care professional leadership as a key partner in system transformation, redesign and improvement plans. •GM Clinical Governance Framework. Work is underway with the Royal College of Physicians Edinburgh to develop this. •To mature matrix working arrangements in priority areas to align a wider clinical team that is reflective of organisational and spatial levels to key GM programmes. •Bi-annual CCPL events F2F, supporting the development of teams and shared purpose •Recruitment and retention plans in every NHS Trust across GM •The Greater Manchester Primary Care Workforce Strategy **Detective** •NHS GM CEG	**1.** Inability to directly influence financial pressures or decisions from CCPL roles. 2.This risk is a system risk. Therefore, a current gap is the lack of alignment (and therefore a lack of coordinated mitigations and controls) across the risk registers in individual organisations in GM in relation to this risk.	4	5	20	1. Strengthening the leadership potential and knowledge of CCPLs (including influencing skills at strategic levels) to support the delivery of the operating plan and ensure the clinical voice is considered when financial decisions are being taken that will impact on patient safety, experience and clinical effectiveness of care. •Delivery of CCPL Framework through the GM CCPL Programme, which includes leadership development, mentorship and succession planning 01/03/2026 •GM Clinical Governance Framework to be in place (by Q2 2025/26) to support two way communication; ensure adherence to best practice and clinical standards through system focus on clinical governance and quality improvement; enhance opportunities for shared learning; and to support clinical teams in understanding their role and responsibilities in relation to clinical governance and effectiveness. Work is underway with the Royal College of Physicians Edinburgh. 30/09/2025 •To continue to embed clinical and care professional leadership as a key partner in system transformation, redesign and improvement plans; delivered by an ongoing review of CCPL representation in key forums. 31/08/2025 •To mature matrix working arrangements in priority areas to align a wider clinical team that is reflective of organisational and spatial levels to key GM programmes by establishment of regular clinical meetings and joint clinical objectives. 01/03/2026 2. To review this risk in line with the principles for assessing and managing risks across integrated care systems published by the National Quality Board in December 2024 to support a co-ordinated approach to mitigations and controls. 30/06/2025 3. To work with the people and culture team to ensure that the refresh of the GM People and Culture Strategy incorporates and reflects issues raised in this risk. 30/05/2025	**Kate Provan, Associate Director of Clinical Effectiveness and Improvement**	Within narrative	Ownership of delivery by the CMO Senior Leadership Team and the Quality and Nursing Senior Leadership Team. Cross Directorate risk meeting supporting risks relating to quality and performance. Medical Directorate risk meeting CCPL work programme AMD monthly meetings ADQ meetings Regular updates to the Quality and Performance Committee in relation to the development of CCPL through the CMO and CNO report. Clinical governance framework writing group and workshops hosted by RCP Edinburgh Priority function clinical leadership groups NHS GM Clinical Effectiveness and Governance Committee (CEG)	Full co-ordination between CCPL development and the GM People and Culture Strategy	3	5	15	CEG	GM	Apr-25	Ongoing	Open	

NHS
Greater Manchester

Chief Nursing Officers Report
4th June 2025

Part of Greater Manchester
Integrated Care Partnership

Quality & Performance Committee

4th June 2025

Required information.	Details.
Title of report.	Chief Nursing Officer Report
Author.	Claire Smith, Associate Director Nursing & Quality Assurance Waseem Khan, Head of Quality Oversight & Governance (Patient Safety) Andrea Patel, Associate Director of Safeguarding Mark Palmeira, Assistant Director Patient Services Louise Rule, Associate Programme Director for Transformation
Presented by.	Mandy Philbin, Chief Nursing Officer
Contact for further information.	claire.smith23@nhs.net

Executive summary.	The Chief Nursing Officer's report updates the Quality & Performance Committee on the relevant statutory duties. In relation to the Board Assurance Framework, this links primarily to strategic risk 5 - There is a risk of failure to comply with our statutory duties for quality assurance in Quality and Patient Safety within the NHS GM system – The paper highlights the highest risks, and associated mitigations, which sit with the following areas: • Greater Manchester Mental Health; Assurance mechanisms and infrastructure in place demonstrating some improvements • Stockport Audiology Service Delivery and associated risk and backlog • Continuing Healthcare backlog of reviews To note, the alerts shown in the report are ongoing risks which have been previously noted and the risk in these areas has not increased, nor decreased, in the last period of reporting. Committee is asked to consider this in terms of any further action required. In relation to both the delivery of statutory duties and the BAF strategic risk 1 - Workforce gaps limit the system's ability to plan for a future sustainable workforce – there are some assurances noted: • Tameside Re-admission rates • Pennine Care Staff Survey results ranked sixth nationally • MFT Still birth service reinstated

The benefits that the population of Greater Manchester will experience.	Oversight and relevant improvement work in relation to NHS GM commissioned services benefits the GM population through continuous improvement in services, targeted quality improvement where indicated, and overall improvement in experience.
How health inequalities will be reduced in Greater Manchester's communities.	The report covers the statutory duties of the CNO, through which runs a theme of improving standards of care and experience of care to reduce health inequalities. In particular, the committee are asked to note the information in relation to the SEND agenda and the LeDeR information included in the report.
The decision to be made and/or input sought.	Quality & Performance Committee are asked to note the contents of the report
How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	The highest impact within this report on the BAF is in relation to Strategic Risk 5 - There is a risk of failure to comply with our statutory duties for quality assurance in Quality and Patient Safety within the NHS GM system. The mitigations/actions/outcomes included in the report provide some mitigation against SR5.
Key milestones.	-
Leadership and governance arrangements.	This paper is produced for Quality & Performance Committee and has not been elsewhere but is formulated from intelligence taken from NHS GM System Quality group, Patient Safety Council and Provider Oversight Sub-Committee and Provider Oversight Meetings.

Engagement* to date. ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	N/A
Financial or Legal Implications	N/A

Table 1: Information needed about the document and its purpose.

Public engagement	Clinical engagement	Sustainability impact	Financial advice	Legal advice	Conflicts of interest	Report accessibility
No	No	No	No	No	No	Yes

Table 2: Assurance needed about the document.

Provider Oversight

Alert / Advise / Assure	Provider	CQC Rating	NOF Rating	Current Position – Quality Intelligence from System Quality Group / Provider Oversight Sub-Committee	Impact / Risk / Mitigation
Alert **BAF SR5** **BAF SR2a & SR2b**	GMMH	Inadequate	4	System Improvement Board continues aligned with NHS GM Provider Oversight Meeting with finance focus and Quality & Safety Assurance Meeting quality & safety focus.	• Overarching Contract Performance Notice remains in place • Recovery Support Programme continues with oversight from NHSE • QSAM received detailed assurance against the CQC Improvement Notices and subcontracting arrangements. • Significant work completed in relation to Safeguarding Assurance and progress acknowledged at QSAM.
Advise **BAF SR5**	Manchester FT	Good	3	• Quality & Safety Assurance Meetings (QSAM) scheduled (6 weekly) with forward plan to oversee contractual quality requirements and quality elements of exit criteria agreed through POMs. • Maternity Services continue in enhanced surveillance - Home birth service restarted after temporarily pausing across 3 sites due to staffing shortages affecting the delivery of the model of care.	• Mock CQC walk rounds in the Trust Emergency Departments have provided scrutiny, assurance and improvement focus for the organisation. Overall positive feedback by staff and programme to be further developed as part of the Clinical Leadership approach. Findings correlated with ICB walk rounds in December. • Detailed assurance given on the reinstated home birth provision with core team in place and further support outlined for transition period.
Advise **BAF SR5**					
Advise **BAF SR5**	Northern Care Alliance	Requires Improvement	3	• Quality & Safety Assurance Meeting received updates on the Clinical Leadership Model and the Freedom To Speak Up approach • Consolidated Rapid Quality Review commenced, chaired by NHS England.	• Consolidated approach for the Rapid Quality Reviews to ensure traction on the improvement journey with detailed discussion of patient recalls and look backs along with the Clinical Leadership Model and cultural improvement work. • Assurances provided to the ICB in respect of the Freedom to Speak Up and Clinical Leadership Model which is progressing as per trajectory.

Provider Oversight

Alert / Advise / Assure	Provider	CQC Rating	NOF Rating	Current Position – Quality Intelligence from System Quality Group / Provider Oversight Sub-Committee	Impact / Risk / Mitigation
Advise **BAF SR5**	Wigan Wrightington & Leigh FT	Good	2	• The ED at WWLFT remains under severe pressure, impacting patient safety and patient experience. Areas of concern include waiting room and corridor care.	• Healthwatch Wigan and Leigh are undertaking fortnightly visits to the ED waiting room to capture patient experience. NHS GM Wigan Quality Leads have met with Healthwatch to discuss their findings and have used the data to triangulate the findings with other sources of data. • The implementation of the red to green discharge process is significantly improving patient flow and early results shoe confidence in the process.
Alert **BAF SR5**	Stockport FT	Requires Improvement	3	• Paediatric Audiology continues under enhanced scrutiny both as a single site issue and part of the GM wide work in this area. • Haematology Line service raised at the Provider Oversight Meeting • Outlier in respect of AMR prescribing and the Trust working in conjunction with the Locality to improve the position. • Maternity continues under enhanced surveillance – key areas under development include triage, PWR accuracy, digital EPR strategy	• Risk of significant backlog of rehab provision due to the identified service delivery issues. Mutual aid has been identified however is minimal and has wider implications for overall GM provision. Rapid Quality Review and Commissioner Review meetings in place to find longer term solution. • Further understanding of Haematology service required to gain assurance. • A 12 month improvement programme is underway, overseen at Locality Quality Group and tied in to GM work
Advise **BAF SR5**					
Advise BAF SR5					• Maternity Oversight Group (led by LMNS) is in place. Good progress overall in year 2 of 3 year plan implementation. Ongoing oversight remains in place.
Advise **BAF SR3 & SR5**	Tameside FT	Good	2	• Bank staff usage over target • Increase in 2024/25 rates for CDiff and EColi compared with 2023/24	• Despite not reaching target, improvements seen and turnover has come down • No on-going risk associated with Cdiff outbreak - Continued focus on all aspects of Infection Prevention and Control through targeted approaches to training and monitoring of compliance • Maternity Oversight Group (led by LMNS) is in place. Support and guidance in place for implementation of 3 year plan. Retention Improvement Strategy is being refreshed,.
Advise BAF SR5				Maternity continues under enhanced surveillance – key areas under development include triage, digital EPR strategy, Audit, risk and governance processes.	
Assure **SR2 & SR5**				Re-admission rate dropped to zero in March	

Provider Oversight

Alert / Advise / Assure	Provider	CQC Rating	NOF Rating	Current Position – Quality Intelligence from System Quality Group / Provider Oversight Sub-Committee	Impact / Risk / Mitigation
Advise **BAF SR5**	Bolton FT	Good	2	• Outlier for Clostridium Difficile infection (CDIFF) – Locality led escalation continues with positive effect • Outlier for summary hospital-level mortality indicator (SHMI)	• Improvement plan in place post RQR and site assurance visit showing positive progress however yet to see sustainable improvement in relation to GM and national figures.. • Assurance received in respect of workforce measures and staff survey improved results and response rate
Advise **BAF SR3 &5**	Pennine Care FT	Requires Improvement	2	• CQC inspection in November/December across several PCFT sites & localities.	• Section 29a warning notice in place – updates shared at POM with significant progress made and on trajectory for completion by end of April • Quality Visits planned for end of March to triangulate reported improvement work.
Assure **BAF SR3**				• Trust ranked sixth nationally for staff survey results	

Provider Oversight – Independent Sector

Alert / Advise / Assure	Provider	CQC Rating	NOF Rating	Current Position – Quality Intelligence from System Quality Group / Provider Oversight Sub-Committee	Impact / Risk / Mitigation
Advise **BAF SR5**	Cygnet Lodge (Salford)	Requires Improvement	NA	• The CQC have served a Section 29A Warning Notice to Cygnet NW Limited for failing to meet the regulations to staffing and safe care and treatment.	• .A Rapid Quality Review has been initiated for Cygnet Lodge (Salford) An Action Plan is in place and is progressing well with oversight via the NHS GM Quality Team led by the Salford Associate Director of Quality. • A Quality Visit has also been completed providing early indications of positive progress. A follow-up visit is being planned and RQR meetings are taking place monthly.

Maternity & Neonatal Oversight Summary

NHS Greater Manchester

Provider	Routine Oversight	Enhanced Surveillance
Bolton	Yes	
MFT (ORC, NMGH & Wythenshawe)		Yes
Stockport		Yes
Tameside		Yes
NCA	Yes	
WWL	Yes	
Totals	**3**	**3**

3-year plan implementation (MPPOP ¼ review)

- All providers are on track to implement the 3-year plan (59 deliverables)
- Four key areas of focus in next 12 months for 3-year plan:
- Maternity Continuity of Carer (issues mainly staffing related), (only SFT declaring compliance)
- Digital; procurement of EPR system (SFT, TGH & WWL)
- MEWS and NEWTT2 tool (further work to strengthen into electronic systems and away from paper copies)
- -Personalised Care and Support Plans (revisiting local guidance and strengthening audit to match national standards)

Annual Assurance Visits

- The required level of oversight has been implemented by ICB following most recent visits
- All 3 providers in 'Enhance Surveillance' have established Maternity Oversight Groups (MOGs) in line with GM LMNS Quality and Escalation Framework (2024), with TORs agreed and chaired by their Chief Nurse.
- Exit strategies to move towards 'Routine Oversight' are being developed
- KLOE for Autumn 2025 GM LMNS annual audit of Assurance is in development with a particular focus on Homebirth provision and a KLOE on unregulated persons (such as Doulas and Traditional Birth attendants)

Patient Safety

Alert / Advise / Assure	Subject	Current position	Improvements or mitigations in place
Advise **BAF SR3 & SR5**	Prevention of Future Deaths	• There have been 5 PFDs issued to the wider GM system since the 1st April 2025. • NHS GM currently has 7 PFDs open to respond to the Coroner.	• Examples of themes through PFDs are: o Access to specialist care and advice through GP when experiencing an allergic reaction to medication o Access to mental health support & therapy (IPT) o Delay in transfer to ED o Medication issues – long term opiate prescribing • A 'Safety Scan' report has been developed and is widely shared with locality leads, providers and published on NHS Futures to encourage a proactive approach to improvements. • Monthly PFD update meetings continue with NHS GM and NHSE to improve communication, collaboratively work on responses and share learning. • PFD Annual report to follow to QPC in August 2025.
Advise **BAF SR5**	PSIRF in Independent providers	NHS Trusts in Greater Manchester have PSIRF policy and plans in place Focus remains on supporting independent sector providers	A focused piece of work to support independent sector providers to implement PSIRF is in place. A risk stratification process has been carried to ensure we target our efforts to those areas that require it the most. PSIRF Compliance and LFPSE reporting forms part of the contractual quality reporting requirements for 25/26.

Patient Safety

NHS Greater Manchester

Alert / Advise / Assure	Subject	Current position	Improvements or mitigations in place
Assure **BAF SR3 & 5**	ICB PSIRF Review (Carried out by MIAA)	Audit carried out to assess the systems and processes established by the ICB to ensure that oversight roles and responsibilities under PSIRF are discharged in line with the requirements.	The Audit concluded that there is a good system of internal control designed to meet the system objectives, and that controls are generally being applied consistently, a rating of substantial assurance was provided. An summary of the updated action is provided below All recommendations are now completed and a progress update is being shared with Audit Committee.

Update on ICB PSIRF Review Action plan

Recommendation	Update	Due Date	Status
Locality Quality and Safety Leads should be provided with clear objectives in terms of their role within GM in the oversight of the PSIRF in Providers to include training requirements and monitoring, patient safety event data collection and expectations in relation to the oversight of providers with the information currently available.	A number of priorities workshops held including Integrated Quality Sessions with ADQ's, development/ways of working sessions with Quality Managers. Task and finish groups established to map out Provider Oversight process and guidance/training documentation shared with Quality and Safety Leads.	31/03/25	Completed
The staff training monitoring arrangements under PSIRF should be reviewed with a formal record maintained to demonstrate that all staff have completed the required training (including locality leads) as per the NHSE PSIRF Standards Specification.	Training uptake record now in place, current compliance of 100% amongst quality managers. Compliance audit to be carried out on a 6-monthly basis which will include and capture any new staff.	31/03/25	Completed
The Strategic Patient Safety Council's progress reporting arrangements should be clarified including consideration of a quarterly update report to the GM Quality and Performance Committee and the GM Clinical Effectiveness Committee which sets out patient safety objectives, progress made and realised benefits/ impact.	Regular reporting on patient safety via the CNO report to QPC in place. Membership at SPSC reviewed to ensure there are members that also attend the GM Clinical Effectiveness Committee to ensure connectivity and sharing of key messages. The role of the SPSC is currently being reviewed against the NHS reform plans.	31/03/25	Completed
Progress against the planned implementation of the PSIRF for independent sector providers should be reported quarterly to QPC. The impact of the later PSIRF implementation for the GM independent sector providers on NHS contracts should be risk assessed in terms of discharging the duties of the ICB under PSIRF ensuring full implementation across these providers. The ICB should also ensure that arrangements for reporting of incidents and follow up processes at ISP's are robust until the PSIRF has been fully implemented.	Independent Sector providers contained within the CNO report of the March 25 QPC. QPC updated on patient safety on a quarterly basis. PSIRF now routinely picked up as part of contracting conversations.	31/03/25	Completed
The draft Cross System Learning Procedure should be finalised and made available to all relevant Quality and Safety Leads.	Community of practice meeting held on 5.3.25 which agreed cross system learning procedure.	30/06/25	Completed

Patient Safety

NHS Greater Manchester

Alert / Advise / Assure	Subject	Current position	Improvements or mitigations in place
Advise **BAF SR6**	Complaints	• Since 1 April 2025: o 574 cases received by Patient Services in total o 449 PALS enquiries o 81 complaints - 40 locality / 41 primary care o 42 MP enquiries - 36 locality / 6 primary care o 2 compliments • Primary care caseload of approx. 175 cases (GM BAU caseload bwtn 150 – 200 cases). • Approx. 60 cases in backlog (over 6 mnths). • Steady progress with the recovery trajectory to resolve the backlog of primary care complaints but behind trajectory.	• Patient Services model continues to work well with informal resolution provided to patients through PALS - typically 300 - 350 cases resolved per month. Early resolution prevents issues developing into complaints. • Direct telephone enquiries with primary care providers following up longstanding complaints continues to prompt responses from providers enabling Patient Services to draft responses. • Individual complaint responses and outcomes shared with locality Primary Care Leads. Dental, Pharmacy and Optometry outcomes shared with Primary Care Commissioning team. • System learning shared with NHS GM Primary Care Team for inclusion in Primary Care Newsletter to all GM practices and NHSE for qtrly national reports. • Any identified performance concerns shared with Performance Standards Group (PSG) at NHSE. • Resource flexed from wider team to cover risk of decrease in primary care complaints resolution. • Report on Healthwatch England - A Pain to Complain report – to QPC in June 2025. • Complaints Annual report to follow to QPC in August 2025.

Safeguarding

NHS Greater Manchester

Alert , / Advise / Assure	Statutory Duty	Current position	Impact and Improvements / mitigations in place
Advise BAF SR5	**Children's national reforms - safeguarding**	• The Children's Wellbeing and Schools Bill (2025) proposes that local statutory safeguarding partners will codesign and collaboratively deliver Regional Care Cooperatives (RCC) and Multi-Agency Child Protection Teams (MACPT). • Implemented from June 2025, operational by April 2027	• ICBs will need to establish a sustainable child protection health workforce for the MACPTs by 2027 as a statutory safeguarding partner via MASAs • NHS GM is required to be part of the strategic commissioning and design conversations at a GM and locality level with Local Authority – in progress. • Link The Families First Programme Guide (March 2025)
Advise BAF SR5	**Safeguarding Inspections Q4 (24-25)** (links to Safeguarding Children Partnership effectiveness –NHS GM equal lead statutory partner)	• Bolton LGA peer review (March 25) • Rochdale - LGA Peer Review of Cared for Children & Care (Feb25) experienced young people and ILAC focused visit (May 25) • Stockport – ILAC Ofsted (May 25) in progress • Tameside – ILAC monitoring visit for children's services (Feb 25). DfE Children's Commissioner working at place.	• Bolton - Co- production with service users. Strong partnership but key partners missing - others to be added. Locality work in progress. • Rochdale - health offer for care experienced young people review and Initial Health assessments completion.. ILAC focused visit feedback awaited. • Tameside - Weaknesses identified at the last inspection continue to be present in current practice. Effectiveness of Safeguarding Partnership, Locality Improvement board in place..
Assure BAF SR5	**NHSE ICB Assurance requirement Q4**	• Safeguarding commissioning and assurance submission on statutory reviews compliance –completed • Workforce audit - national NHSE submission required by ICB and Provider FTs on safeguarding workforce – completed.	• Organisational assurance provided regarding national ICB statutory review submission requirements and ICB mechanism for assuring/overseeing health provider compliance against statutory review recommendations. • A new statutory safeguarding workforce audit, outputs are aimed at supporting ICBs and providers to shape the NHS reforms agenda from June 2025.
Advise BAF SR5	**Provider safeguarding assurance**	• NHS GM Safeguarding Contractual Standards framework for 25-26 included in contracts for all commissioned providers (Foundation Trusts, Small Providers and Independent Sector) and reporting cycle agreed for contract oversight. Linked to Quality schedule. • NHSE Q1 GM provider FT submissions – partial compliance	• Safeguarding assurance framework 25-26 in place with coproduction from providers. • NHSE Safeguarding Improvement dashboard (SIDD) – statutory requirement for FT's for provider assurance, Prevent and Looked after children data sets. • Q1 5 trusts were unable to submit the NHSE submission within national timescales. Liaison with FTs to progress.
Alert BAF SR5	**Looked After Children and Care Leavers**	• NHS GM statutory requirement – commission initial and review health assessments with performance of national requirement. • Q4 continued reduction in compliance across GM to statutory timescales and NHS GM performance indicators. • Wigan FT reduced capacity to undertake health assessments on GM children placed in Wigan	• Locality improvement plans in place – impact not currently seen as reduced performance continues. • NHS GM LAC dashboard in contracts and implemented as CYPJFP delivery plan, aligns with NHSE data. • Locality oversight of current LAC risks and assurance via LAMs.

SEND

NHS Greater Manchester

Alert / Advise / Assure	Subject	Current position	Improvements or mitigations in place

BAF SR3 & 5	Area SEND inspection	• 4 local area partnerships inspected under current framework – Oldham, Bury – outcome 3, Trafford – outcome 2, Bolton – outcome 1
		• Oldham and Bury making good progress with Priority Area Action Plans following outcome 3 judgements
		• Risk of further Area SEND inspections with outcome 2 or 3 due to:
		  • Waiting times for ND assessment, SALT and mental health support.
		  • Availability of support for CYP and families while they wait for assessments.
			ICB-wide transformation programmes:
			• CYP ND transformation programme to develop an a sustainable, needs-led, long-term ND pathway that is consistent across GM. Also includes recovery work in relation to existing waiting lists.
			• Implementation of the Balanced System framework for Speech Language and Communication (SLC) support. GM transformation programme mobilised which will focus on implementing whole system approach to SLC support, deploying the skills of the SLT workforce to support the wider system across a model for place based universal, targeted and specialist support. Establishment of locality governance and action plans underway.
			• Review of CAMHS provision across GM to ensure equity of provision, including access to crisis care and early help support.
			• 'Supporting you while you wait' – scoping and mapping of the help and support available to children, young people and their families waiting for assessments and treatment.

BAF SR3 & 5	SEND workforce	Risk that SEND workforce issues impact on local area ability to provide the right support to children and young people with SEND when they need it.	• SEND Workforce Development Framework approved by People & Culture Sub-Committee. This has been rolled out and is now live. • 'Supporting you while you wait' – scoping and mapping of the help and support available to children, young people and their families waiting for assessments and treatment. • ICB-wide transformation programmes in ND and SLC will lead to earlier identification of need and wider workforce will be upskilled to improve outcomes through offering support at the right level. This will still include appropriate clinical support. • DCO vacancy in Trafford, recruitment now paused due to the reform.
BAF SR3 & 5	EHCP locality Health Advice returns (SEND dashboard)	Different or no system in place in localities to monitor number and timeliness. Some localities are counting each piece of health advice separately rather than complete when ALL health advices have been returned to LA.	• Work is ongoing to scope what the current process is in each locality in order to ensure consistency of EHCP Health Advices returns. • SOP under development. • Continued improvement of SEND data dashboard: ensuring consistent data returns from providers, unpicking legacy processes/embedding new ones, and further development of data reporting
BAF SR3 & 5	SEND assurance	ICB SEND oversight and assurance has moved into LAMS process	• SEND KLOEs have been refreshed and are in place. • New SEND strategic system group with senior SEND leads from ICB localities and LA is currently in the development phase. • GM SEND Quality Assurance Framework has been developed and rolled out to support quarterly assurance across ICB localities. First report due in July 2025.

LeDeR

NHS Greater Manchester

Alert / Advise / Assure	Subject	Current position	Improvements or mitigations in place
BAF SR3 & 5	LeDeR	• GM has had 1480 notifications since 2019 and completed 1194 reviews with a completion rate of 89%. This aligns with the regional average • There is a 3 WTE reviewer vacancy which reflects to 40% of the workforce . This has resulted in a 120 plus backlog of LeDeR reviews . National guidance regarding the future direction of LeDeR is expected	• GM has adopted a rapid review process in conjunction with agreement from NHS England. This is resulting in a more rapid completion of initial reviews in which progress towards completion will be evidenced within the next three months. • The GM Annual report has now been published. • The GM Health Workplan for 2025-2026 has been refreshed in response to the LeDeR Annual Report. The GM Good Health Group will oversee the development, delivery, and performance of the workplan • There is expected national guidance regarding the future format of LeDeR

All Age Continuing Health Care (AACC)

Alert / Advise / Assure	Current position	Issues of concern	Improvements or mitigations in place	Link to BAF risks
Assure	**Referrals completed within 28 days – target 80% or above** For Q2 2024/25 GM ICB achieved 87.5% against a target of 80%. **Referrals exceeding 28 days by 12 weeks+ - Target is 0** 2 long waits were reported for Q4.	• If vacancies cannot be filled risk of not achieving KPI • Maintaining and achieving the required KPI's due to workforce issues	• 9 out of 10 localities achieved the required KPIs (Oldham did not meet either of the KPIs) • Additional layer of scrutiny through regular monitoring of KPI via monthly assurance report • Executive meetings set up where required with Deputy Chief Nurse and locality ADQ to discuss challenges and mitigations.	Improvements in these areas significantly impact on experience of care, delivery of statutory responsibilities in respect of continuing health care, quality of service and equity of access to health and care. **BAF SR2** **BAF SR1, SR3 & SR5**
Advise	Workforce across GM CHC locality teams is stabilising and vacancies/sickness within teams are reducing	• Risk of not being able to recruit to new vacancies as they arise due to reform announcements • Still some pockets of sickness within CHC teams which is impacting on their ability to maintain business as usual. • As a result of previous low staffing levels KPI's and restitution cases have been impacted, and reviews were put on hold in some localities.	• NHS GM are currently carrying 11 clinical vacancies (10.6wte) with 2 of these posts awaiting offer letters and start dates. There is 1 admin vacancy (0.5 wte). Localities have been advised to submit vacancy requests via BCP • Vacancies and sickness within localities are reported on a monthly basis to the GM Quality team in order to monitor and provide support where required. Any identified risks are escalated to Gill Gibson as SRO and Deputy Chief Nurse for CHC. Senior leadership meetings with locality ADQ are set up where required to discuss mitigations and support.	
Alert	NHS GM have a high number of backlog reviews for FNC, PUPoC and COP/DOLs across all 10 localities	• Reviews have built up due to not being prioritised due to a number of reasons within teams such as sickness and vacancies etc. • Currently not legally complaint with the CHC Framework re; COP/DOLs due to backlog. Significant risk • Possible risk of increase in complaints and IRP's due to backlog of PUPoC reviews • Risk of Increase in finance pressures when completing PUPoC reviews due interest and long period of time	• Localities have been advised to recommence on the reviews where possible and should now be incorporated into BAU as most teams are at full complement of staff • This is an area under additional scrutiny due to the financial cost implications of the cases where there is a long period of time under review. Wider financial scrutiny has also been enacted through NHS GM's governance to monitoring CHC locality spend, as well as each CHC Team's cost improvement programme (CIP) plans for 2025/26 • Pilot is due to commence (Test of change) within Bolton and Salford localities initially to centralise PUPoC reviews. If successful will look at offering this out across the rest of GM localities.	
Alert	NHS GM have a number of localities with a high number of backlog reviews for CHC and Fast Track (Bury/Manchester/Wigan)	• Reviews have not been prioritised due to a number of reasons within teams such as sickness and vacancies etc	• Localities advised to recommence reviews as BAU • 3 x GM agency staff were in place for 3 months to help clear the backlog. Still have some pockets of high numbers	

NHS
Greater Manchester

Chief Medical Officer Report

June 2025

Part of Greater Manchester
Integrated Care Partnership

NHS Greater Manchester

Quality and Performance Committee

June 2025

Required information	Details
Title of report	Chief Medical Officer Report
Author	Dr Claire Lake, Deputy Chief Medical Officer, Kenny Li, Chief Pharmacist, Lara Shah, Deputy Chief Pharmacist, Aleksandra Houghton, Medicines Safety and Governance Portfolio Lead Pharmacist Melissa Maguinness, Programme Director Commissioning Development Gary Flannagan, Assistant Director of Mental Health Strategic Commissioning Lynzi Shepherd, Assistant Director of Strategic Mental Health Commissioning Kate Provan, Associate Director of Clinical Effectiveness, and Improvement
Presented by	Professor Manisha Kumar, Chief Medical Officer, NHS GM
Contact for further information	Kate.provan@nhs.net
Executive summary	This report provides an update to the Quality and Performance Committee in relation to the statutory duties and responsibilities aligned to the Medical Directorate.
The benefits that the population of Greater Manchester will experience.	Oversight and relevant improvement work in relation to NHS GM commissioned services benefits the GM population through continuous improvement in services, targeted quality improvement where indicated, and overall improvement in experience.
How health inequalities will be reduced in Greater Manchester's communities.	The report focuses on key areas of work aligned to the statutory duties and accountabilities of NHS GM and the strategy of the ICP.
The decision to be made and/or input sought	The Quality and Performance Committee are asked to note the alerts within the paper in relation to mental health including out of area placements, targeted locality work and community services and the mitigations in place to address this.
How this supports the delivery of the strategy and mitigates the BAF risks	The areas within this report and progress made to improve these relate to BAF risk SR5
Key milestones	These are set out within the different sections

	of the report.
Leadership and governance arrangements	This paper is produced for Quality and Performance Committee and has not been elsewhere but is formulated from intelligence and papers from NHS GM Clinical Effectiveness and Governance Groups (and related subgroups) and the NHS GM Mental Health Partnership Group
Engagement* to date ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	There has been no formal engagement on this paper as this paper is produced for Quality and Performance Committee and has not been elsewhere. The intelligence and papers used to formulate this report have come from the NHS GM Clinical Effectiveness and Governance Groups (and related subgroups) and the NHS GM Mental Health Partnership Group
Financial or Legal Implications;	There is currently work ongoing across the ICB in relation to planning for 2025/2026. The portfolio of work that sits under the Chief Medical Officer has been reviewed in relation to financial pressures, risks and opportunities and is being reported into the appropriate governance bi-weekly at present. Some of the outcomes of discussions around this may impact on programmes of work, this will be highlighted in this report as this progresses.

Public engagement	Clinical engagement	Sustainability impact	Financial advice	Legal advice	Conflicts of Interest	Report accessible
N	Y	N	N	N	N	Y

Table 1 - checklist of engagement carried out, advice sought, conflict of interest and accessiblity of report

Purpose of report/executive summary

This report provides an update to the Quality and Performance Committee on the progress made in relation to the NHS Patient Safety Strategy 2019 (responsibilities aligned to the medical directorate) and key updates in relation to Mental Health. This focus is reflective of the Chief Medical Officers statutory duties as set out in the Health and Care Act 2022:

- Duty as to improvement in quality of services
- Duties as to reducing inequalities.
- Duty to promote innovation.
- Duty in respect of research

This report takes the format of an 'Alert, Advise, Assure' rating to direct committee members to the key issues and provide an understanding of the work that is being done to address these issues. This report provides an update to the Quality and Performance Committee in relation to the statutory duties and responsibilities aligned to the Medical Directorate.

This report focuses on medicines safety, mental health and mortality.

Key issues to be discussed:

Where we have rated an item: Assure this is because there is robust governance in place to support this work, understand and mitigate the risks, and respond to new asks.

Where we have rated an item: Alert, we keep this on an issues log and will bring it back to QPC for an update every quarter or when this rating changes.

Recommendations

The Quality and Performance Committee are asked to note The Quality and Performance Committee are asked to note the alerts within the paper in relation to mental health including out of area placements, targeted locality work and community services and the mitigations in place to address this. Updates on these key areas will be provided as the work progresses.

Updates on statutory duties and responsibilities aligned to the Medical Directorate

Alert/ Advise/ Assure	Current position	Improvements or mitigations in place	Link to BAF risks
Medicines Safety			
Assure	**Integrating Pharmacy and Medicines Optimisation (IPMO) Medicines Safety Group** Medicines safety system-wide priorities for 25/26 have been agreed, these are: 1. Opioid stewardship: To reduce harm from chronic opioid use in GM 2. Teratogenic Medicines (Valproate and Topiramate): Reduction of harm to patients and their offspring relating to use of these medicines in pregnancy and conception 3. Shared Learning from Incidents: To improve our ability to learn, act and respond to medicine safety incidents as a system Key performance indicators have been agreed for medicines safety (including indicators aligned to these priorities) to ensure that work to improve safety can be monitored and the impact across the system of this work can be measured. There is now a quarterly report in relation to these key performance indicators that will be presented to the Greater Manchester Medicines Management Group and shared with locality leads for action. This report has key recommendations to be taken forward both at system and locality level. Key highlights from this report include but are not limited to: Opioids: Overall reduction in the total number of patients receiving an opioid and prescribed an opioid for more than 3 months. Data indicates that there is need for further data analysis at locality level in relation to the prescription of high	Key improvements in place to progress the safety work include: 1.Opioid stewardship: • Implementing the GM discharge communication standards including a newly developed patient information leaflet • Implementing the Safety Medication dASHboard (SMASH) indicator for patients discharged from hospital still receiving opioids 30 days post discharge • Sharing learning across the GM system from the Breakthrough Series Collaborative educational program • Creation of a GM multidisciplinary, multisector pain collaborative as a peer support, resource and shared learning forum 2. Teratogenic Medicines • The implementation of the safety improvement plan for valproate (devised in response to the National Patient Safety Alert- NPSA) • A Topiramate frequently asked questions guide has been developed. This document has been produced in response to the new safety measures published by the Medicines and Healthcare products Regulatory Agency (MHRA) where Topiramate is now contraindicated in pregnancy and in women of childbearing potential unless the conditions of a Pregnancy Prevention Programme are fulfilled. The document clarified roles and responsibilities for management of affected	**BAF SR5** **Related to Health and Social Care Act Duties:** 25: 14Z34 Duty as to improvement in quality of services

Alert/ Advise/ Assure	Current position	Improvements or mitigations in place	Link to BAF risks
	dose opioids Valproate: Over the course of several months, prescribing levels across most localities in Greater Manchester have a decrease. Report has highlighted a locality where targeted work is needed. The medicines safety team is also in the process of scoping a polypharmacy workstream, this will be discussed at the IPMO Medicines Safety meeting in July. As part of this they are also exploring how robust management of polypharmacy could contribute to delivery of cost improvement plans.	cohorts of patients and answers common queries related to the alert. 3. Shared learning • Development of a GM dashboard for medicine safety incidents • Further development of our systems and processes for the development of the 7-minute briefing tool to share learning across the system	
Mental Health: Right Care Right Person			
Advise	**Right Care, Right Person (Phase 1 – Concern for Welfare and Missing Persons)** Right Care, Right Person (RCRP) is an approach designed to ensure that people who have health and/or social care needs, are responded to by the right person, with the right skills, training, and experience to best meet their needs. At the centre of the RCRP approach is a threshold to assist police in making decisions about when it is appropriate for them to respond to incidents, including those which relate to people with mental health needs. ICB has shared positive impact across the following areas as a result of RCRP: • Increased number of people receiving the appropriate MH support, with agreed pathways from Greater Manchester Police (GMP) to Mental Health (MH) crisis teams, avoiding unnecessary police call outs. • Supported the requirement for additional investment	Maintained RCRP tactical group to ensure issues can be addressed as required. Partnership agreement to be signed by end of quater1. Agreed via QPC for dedicated session to review serious incidents where identified potential RCRP impact, by end of quarter 1. Escalation process to be maintained in quarter 1 and reviewed as required. Mobilisation of GM MH First Response Service by end of quarter 2 – 111 GM 24/7 crisis helpline, MH Urgent Triage. Develop model of community crisis response by end	**BAF SR5** **Related to Health and Social Care Act Duties:** 25: 14Z34 Duty as to improvement in quality of services

Alert/ Advise/ Assure	Current position	Improvements or mitigations in place	Link to BAF risks
	and transformation in MH crisis services, with £7m agreed to support the development of a new GM MH First Response Service, providing MH professional triage, assessment and support for people dialling 111 and 999 in self-defined MH crisis. • Strengthened partnership working – improved processes, pathways, and relationships between MH and Acute Trusts, and NHS and emergency services. • Consensus view is that RCRP phase 1 has been successfully delivered and increased activity has broadly been managed by MH teams – however recognising further reviews required and ongoing transformation work to strengthen MH crisis response. It should be highlighted that there is still risk escalation for missing persons. It may be reasonable to expect some community teams (Community Mental Health Teams (CMHT) and Home Based Treatment Teams (HBTT) for example), to respond, however this cannot be the expectation across all healthcare agencies and would require further clarity in relation to General Practice (GP), care homes etc. It is important that there is not an increased burden on community and primary care teams following 'walkout' from an acute Trust. If health teams are not able to attend to someone in the community following walkout from a healthcare setting, and they do not meet the GMP criteria for response as above (immediate risk), then they would be considered a 'concern for welfare' and ineligible for police response under RCRP.	of quarter 2 including crisis resolution 24/7, Home Treatment, and VCSE crisis spaces expansion.	

Alert/ Advise/ Assure	Current position	Improvements or mitigations in place	Link to BAF risks
	If a patient is midway through or not started an assessment (referring mainly here to MH patients in emergency departments), and leaves the department, it may not be possible for the healthcare setting to locate the person without having obtained the necessary information to undertake the checks. There would need to be a recognition of the clinical risk as identified by the clinical leads within the healthcare setting the person has left and ensure that where immediate risk of harm is identified that this ensures GMP emergency response without delay due to discussions about level of due diligence undertaken.		
Assure	**Right Care, Right Person (Phase 2 – Improved Handover Time)** GMP have set the timescale for delivery of Phase 2 of RCRP in relation to Section 136 (S136) handover times as April. Strategic planning for this is led by the RCRP Strategic Oversight Group (which includes executive/director level representation) and tactical planning by the RCRP Tactical Planning Group (includes strategic and operational leads across the health system). System leads across mental health Trusts, acute Trusts, and ICB, have confirmed that it will not be possible to deliver 1 hour handover time in all instances. The position proposed	Phase 2 implementation plan outlines several key improvements and mitigations to address current challenges. Firstly, a £1 million investment has been secured staffing, enabling 24/7 availability of two S136 suites, with further plans for a broader staffing model following the redesign of suites. Non-clinical staffing options are also being explored through a pilot Voluntary, Community and Social Enterprise (VCSE) offer, which may include advocacy, peer support, and guided self-help. A new joint protocol is being developed through intensive collaboration with GMP and healthcare stakeholders, focusing on safe detentions, medical assessments, and timely handovers.	**BAF SR5** **Related to Health and Social Care Act Duties:** 25: 14Z34 Duty as to improvement in quality of services

Alert/ Advise/ Assure	Current position	Improvements or mitigations in place	Link to BAF risks
	to GMP and system via the RCRP Strategic Oversight Group and through this report is a commitment to improved handover times for people detained under S136 of the Mental Health Act, evidenced by clear data and improved outcomes for patients. This would take into account instances where 1 hour handover would not be appropriate, such as where there is a medical need that delays Mental Health Act (MHA) assessment, or where there is risk of violence and aggression to staff or other patients. While the decision to attend an incident is determined by assessing that the incident meets the RCRP threshold, the decision to use powers under the MHA is made by an officer at the scene of an incident. S136 is one of these powers which gives the police the power to remove a person from a public place, when they appear to be suffering from a mental disorder to a place of safety. The current position regarding Phase 2 implementation for S136 MHA handover times is that GMP has set an ambitious target of achieving a 1-hour handover time by April 2025. However, system leads across mental health and acute Trusts recognise that achieving this in all instances is not feasible. The focus has shifted towards demonstrating a commitment to improved handover times through clear data and better patient outcomes, while allowing flexibility where medical needs or safety concerns arise.	Digital solutions are being explored to enhance information sharing and reduce delays. From a data perspective, the introduction of a comprehensive S136 data dashboard will support monitoring and reporting on key metrics, enabling targeted interventions and process enhancements. Additionally, work is underway to strengthen the mental health tactical service (MHTAS) and explore direct conveyance to Voluntary, Community and Social Enterprise (VCSE)-led crisis spaces as an alternative to emergency departments. While achieving full readiness by April remains challenging, the phased approach, supported by clear partnership agreements and enhanced transparency, is expected to drive tangible improvements in handover times and patient outcomes. There will be continued updates on this work as implementation of RCRP continues to provide assurance and oversight of the progression of this work.	

Alert/ Advise/ Assure	Current position	Improvements or mitigations in place	Link to BAF risks
	Agreement was reached with GMP on the following areas of focus under Phase 2: • There is a clear understanding of the NHS legal framework in relation to duties under the Mental Health Act, to be reviewed alongside a formal position from GMP on their duties in relation to S136 and how/when they can safely handover responsibility to the healthcare setting. • There is sufficient investment and workforce in place to staff the S136 suites across Greater Manchester. • Improving process issues as identified through the S136 Improvement Plan including escalation process for GMP and Emergency Department teams, with appropriate route to GM System Coordination Centre as required, and this is defined in a new joint protocol, agreed by all partners. • Improved data and reporting visibility across several key metrics relevant to track improvements in the S136 pathway for people, supporting a move to real-time monitoring and coordination, consistently across GM.		
Mental Health: Reducing Out of Area Placements			
Alert	**Independent Sector Bed Usage: Out of area placements (OAPs), Local Spot Purchase (LSPs) and North West Bed Bureau (NWBB)** While the number of OAPs has reduced significantly, this progress has largely been achieved through increased reliance on Local Spot Purchase (LSP) beds (currently 61 in use) and continued high usage of NWBB beds. These arrangements, while offering proximity to home, still pose	A clear trajectory is being developed to reduce all forms of Independent Sector bed usage. This includes aligning plans for OAPs, LSPs, NWBB beds and work around length of stay (LoS). GMMH aims for zero OAPs by quarter 3 2025/26, supported by improved oversight, community alternatives and integrated discharge planning. The Integrated Care Fund is being used to support reduction efforts.	**BAF SR5** **Related to Health and Social Care Act Duties:** 25: 14Z34 Duty as to

Alert/ Advise/ Assure	Current position	Improvements or mitigations in place	Link to BAF risks
	significant operational and financial risks.		improvement in quality of services
Advise	**Integrated Reduction Trajectory** The current position requires closer alignment across OAPs, LSPs, NWBB and LoS to ensure system-wide coordination. Hence an integrated reduction trajectory is being developed. If not tackled collectively fragmentation risks undermining the gains made in OAP reductions.	All trajectories are being integrated under a unified inpatient flow strategy, with targets and actions designed to reinforce each other. Weekly system oversight Multi-Agency Discharge Events (MADE) and collaborative working with localities are key to progressing this work. A refreshed reduction plan will be monitored through quality and safety assurance mechanisms.	
Alert	**Local Spot Purchase (LSP) Oversight and Growth** LSP bed use has increased to 61, fuelled by CRFD delays and limited internal capacity. This presents an ongoing financial risk and potential for variability in patient experience.	Gatekeeping processes have been strengthened, and a strategic oversight mechanism is in place. The arrival of new commissioned capacity in the independent sector is being monitored to ensure it offsets rather than adds to spot-purchase usage. Contractual routes are being reviewed to mitigate risk.	
Advise	**NWBB Transition Planning** The NWBB block arrangement continues to underpin a large volume of commissioned Independent Sector beds, misaligned with GM's future commissioning ambitions.	GMMH and NHS GM are jointly developing a realistic phased exit from NWBB. This includes modelling alternative capacity, strengthening community-based bed options and ensuring oversight of spot purchase flows. Alignment with national guidance on least restrictive care and local discharge routes is being embedded.	
Mental Health: Targeted Locality Work			
Alert	**Manchester Locality – Pressures in Clinically Ready for Discharge (CRFD), OAPs and Community Integration** Manchester accounts for 55% of the CRFD burden within Greater Manchester Mental Health NHS Foundation Trust (GMMH), with mobilisation delays for key schemes impacting reduction trajectories for both OAPs and LSPs. Community infrastructure requires strengthening to support	A refreshed Manchester Action Plan has been established, including enhanced MADE oversight, prioritised mobilisation of 2025/26 schemes, and renewed alignment of Living Well teams to the broader Live Well model. Early Intervention Psychosis service (EIP) improvements and Community Mental Health Teams (CMHT)	**BAF SR5** **Related to Health and Social Care Act Duties:** 25: 14Z34

Alert/ Advise/ Assure	Current position	Improvements or mitigations in place	Link to BAF risks
	recovery closer to home.	operational reviews are also in progress.	Duty as to improvement in quality of services
Advise	**Manchester Locality Disaggregation of Section 75 and Community Alignment** The disaggregation of the Section 75 agreement has presented both operational risks and opportunities for redesign. The need for improved locality-wide coordination remains urgent.	Enhanced local governance is in place, and Manchester leadership is working to ensure stronger connections between shared care, Intensive Alternatives to Admission Teams (IAOT) implementation, and VCSE partnerships. Continued support from GMMH's Medical Director through locality forums is reinforcing engagement.	
Advise	**CRFD Discharge Focus and Flow** CRFD delays remain the biggest constraint on inpatient flow in Manchester, contributing to LSP reliance and capacity blockage. In 2024/25, 33,394 GMMH bed days were lost to CRFD, with Manchester responsible for more than half.	Implementation of the 10 High Impact Discharge Challenges is a priority. A quarter 1 audit will be undertaken and tracked through the Strategic Improvement Board. The establishment of dedicated discharge facilitators and strengthened brokerage escalation are part of the response.	
Mental Health- Community Services			
Advise	**Rehabilitation Pathways and Bed-Based Overreliance** There is an ongoing over-reliance on inpatient and spot-purchased beds for patients requiring step-down or rehabilitation. Community rehabilitation options remain inconsistent and underdeveloped across some localities.	The capital Programme of Works to repurpose Park House and Wentworth House aims to create step-down community hubs. Plans are underway to close existing rehab wards and reinvest in community provision. GMMH has committed to aligning this with CRFD and LoS reduction.	**BAF SR5** **Related to Health and Social Care Act Duties:** 25: 14Z34 Duty as to improvement in quality of services
Assure	**Community First Principles and Discharge Planning** GMMH has adopted a Home First approach with the aim of embedding least restrictive care pathways for complex cohorts. Progress has been made in introducing integrated gatekeeping and discharge roles.	Community pathway strengthening is being prioritised through the IAOT action plan, locality assurance forums, and VCSE partnerships. MADE meetings now review rehab and Learning Disability and Autism cohorts, and new capacity is being developed through both capital investment and partnership redesign.	
Alert	**Workforce Capability and Package Delays** Delays in assembling individual community packages remain a constraint, particularly for patients with complex needs or	GMMH is reviewing workforce training and development to ensure confidence and competence in community-based roles. A shared care framework	

Alert/ Advise/ Assure	Current position	Improvements or mitigations in place	Link to BAF risks
	transitions from rehab. The workforce's ability to manage complexity in the community varies across the footprint.	is also being refreshed to support continuity of medical oversight post-discharge. Integration with VCSE crisis and step-down offers continues to evolve.	
NHS GM Mortality System Group			
Assure	**GM Mortality System Group** Mortality Surveillance groups feeding into an NHS GM Mortality System Group are now well established in NHS GM. This structure supports monthly surveillance of mortality metrics and has seen the development of several reporting tools/dashboards and models to support overall surveillance, learning and improvement. The System group brings together partners across the system with representation from the NW Chief Medical Examiner, NHS Trusts, NWAS, subject matter experts and wider partners to look at information in relation to excess mortality, hospital mortality metrics, learning from medical examiners and prevention of future deaths and focused areas such as suicide, palliative care and bereavement (among others.)	The meeting in May focused on excess mortality data, palliative care, including the development of palliative care dashboards, suicide and an overview of the NHS GM Bereavement Service In exploring the palliative care dashboard, it was apparent that there are still a lot of situations where people at end of life with clear plans in place to support them are presenting multiple times into acute services. In response to this it was agreed that we would explore partnerships with Health Watch to gather soft intelligence on why people present to acute services at the end of life and also consider a deep dive into the number of investigations and inappropriate use of resources for patients on the palliative care register.	**BAF SR5** **Related to Health and Social Care Act Duties:** 25: 14Z34 Duty as to improvement in quality of services
Advise	**Excess Mortality** Currently NHS GM does not have any excess mortality overall- which is in line with the North West. There has been some anomalies in some localities- which on further data interrogation has been found to be normal variation. The current publication shows no excess mortality for any locality in GM.	Further work is essential to replicate the national excess mortality model across all indicators at both GM and locality levels. This will allow us to connect the data to see how different areas of deprivation and ethnicities are affected by mortality. This understanding will enable us to undertake more targeted interventions and assess whether our efforts in long-term condition management, suicide	

Alert/ Advise/ Assure	Current position	Improvements or mitigations in place	Link to BAF risks
	There are two cause of death areas where a deep dive will be undertaken and these are dementia and influenza/pneumonia, these are flagging as excess mortality at North West level and further analysis is being undertaken to establish if this data can be broken down to GM and locality level to interrogate. Discussions will be held with Dementia United and our Vaccination and Immunisations Teams to progress these deep dives.	prevention, etc., are positively impacting mortality metrics.	

Glossary:

MEDICINES TERMS:

LFPSE (Learn from Patient Safety Events)
A national NHS service that replaced the NRLS. It allows healthcare staff to:

- Report patient safety events
- Learn from incidents to improve care
- Share insights across the NHS to reduce harm.

Opioid Stewardship
A coordinated approach to ensure the safe, appropriate, and effective use of opioids. It aims to minimise harm from opioid prescribing by:

- Promoting non-opioid alternatives where appropriate
- Using the lowest effective dose for the shortest duration
- Monitoring for signs of misuse or dependence.

Pert (Pancreatic Enzyme Replacement Therapy)
A treatment for people with exocrine pancreatic insufficiency, often due to pancreatic cancer or chronic pancreatitis. It involves taking capsules containing digestive enzymes to help absorb nutrients from food.

SMASH (Safety Medication Dashboard)
A digital tool used in primary care across Greater Manchester to:

- Identify patients at risk from potentially hazardous prescribing
- Support safer prescribing practices
- Enable real-time monitoring and intervention by clinicians.

Teratogenic Medicines (Valproate and Topiramate)
These are medications known to cause birth defects or developmental disorders if taken during pregnancy:

- Valproate: Used for epilepsy and bipolar disorder; associated with a high risk of birth defects and developmental disorders.
- Topiramate: Also used for epilepsy and migraines; linked to increased risk of cleft lip/palate and neurodevelopmental issues.

Prescribing guidance includes strict pregnancy prevention programmes and informed consent.

MENTAL HEALTH TERMS

Clinically Ready for Discharge
A patient is considered clinically ready for discharge when they no longer require acute hospital care and can be safely transferred to another setting (e.g., home, community care, or rehabilitation), even if social or logistical arrangements are still pending.

Community Mental Health Teams (CMHTs)
Multidisciplinary teams that provide specialist mental health support in the community. They typically include psychiatrists, nurses, social workers, and therapists, and support people with complex or severe mental health needs outside of hospital settings.

Early Intervention Psychosis Services
Specialist services designed to identify and treat psychosis early, particularly in young people. These services aim to reduce the long-term impact of psychotic disorders by providing rapid access to treatment and support.

Home Based Treatment Teams (HBTTs)
These are specialist mental health teams that provide intensive, short-term support to individuals experiencing a mental health crisis, in their own homes rather than in hospital.

IAOT Implementation (Intensive Alternatives to Admission Teams)
Refers to the rollout of community-based crisis services that offer intensive support to individuals at risk of hospital admission. These teams aim to manage mental health crises in the community, reducing the need for inpatient care.

Local Spot Placements
A spot placement is a one-off, unplanned care arrangement made outside of existing provider frameworks. It is used when an individual's needs are too complex or urgent to be met by standard services.

Multi-Agency Discharge Events (MADE)
Regular meetings involving health and social care partners to review and unblock delays in hospital discharges. The MADE process helps ensure timely, coordinated discharge planning for patients who are medically fit to leave hospital.

North West Bed Bureau (NWBB)
A regional coordination service that helps manage mental health bed availability across the North West of England. It supports patient flow by identifying available inpatient beds, including in the independent sector, to reduce delays and inappropriate out-of-area placements.

Out of Area Placements (OAPs)
These occur when a person with acute mental health needs is admitted to an inpatient unit outside their local area, often due to a lack of local bed availability. OAPs can disrupt continuity of care and are considered inappropriate unless clinically justified.

Right Care, Right Person (RCRP)
Right Care, Right Person is an approach designed to ensure that people of all ages, who have health and/or social care needs, are responded to by the right person, with the right skills, training, and experience to best meet their needs.

At the centre of the RCRP approach is a threshold to assist police in making decisions about when it is appropriate for them to respond to incidents, including those which relate to people with mental health needs. The threshold for a police response to a mental health-related incident is:

- To investigate a crime that has occurred or is occurring; or
- To protect people, when there is a real and immediate risk to the life of a person, or of a person being subject to or at risk of serious harm.

Right to Choose – ADHD

People based in England under the NHS have a legal right to choose their mental healthcare provider and their choice of mental healthcare team. This important right means that, for instance, should they decide the waiting time for an ADHD assessment is too long, then they can choose alternative providers. The provider must supply the service to the NHS somewhere in England.

Section 75 Agreement
A Section 75 agreement refers to a legal arrangement under Section 75 of the National Health Service Act 2006, which allows NHS bodies and local authorities to pool budgets and jointly commission services. These agreements are designed to support integrated care delivery, particularly in areas like mental health, social care, and community services.
Purpose:

- Enable joint planning, funding, and delivery of health and social care services.
- Improve coordination and outcomes for people with complex needs.
- Support the development of integrated care systems (ICSs) and place-based partnerships.

Examples of Use:

- Joint commissioning of mental health services
- Shared funding for intermediate care or reablement services
- Integrated discharge planning and support

Section 136
Section 136 allows the police to take you to (or keep you at) a place of safety. They can do this without a warrant if all of these apply:

- The person appears to have a mental disorder.
- The person is in in a public place. The law defines this as any place other than a house, flat or room where a person is living, or garden or garage that only one household has access to.
- The person is 'in need of immediate care or control'. This means the police think it's necessary to keep the person or others safe.

Voluntary, Community and Social Enterprise (VSCE)
Collaborations between the NHS and third-sector organisations to deliver health and wellbeing services. VCSE partners often provide culturally appropriate, community-based support that complements statutory services.

NHS
Greater Manchester

Performance Report

2025-2026

Part of Greater Manchester
Integrated Care Partnership

NHS Greater Manchester

Quality and Performance Committee

June 2025

Required information	Details
Title of report	Performance Report
Author	Zoe Mellon, Associate Director of Performance
Presented by	Colin Scales – Deputy Chief Executive Ed Dyson – Director of Performance, Improvement & Assurance
Contact for further information	Zoe Mellon Zoe.mellon@nhs.net
Executive summary	This paper provides an update on Greater Manchester's year-end delivery against the 2024/25 NHS operational planning objectives. It includes a brief update on the national objectives for 2025/26, a summary of our current position against plans finalised in April, and an outline of the NHS Performance Assessment Framework (NPAF) for 2025/26. Additionally, it assesses our providers against the NHS Oversight Framework (NOF) and highlights key themes from Locality Assurance Meetings (LAMs).
The benefits that the population of Greater Manchester will experience.	Achievement of performance objectives will improve access to services and drive up standards of care for the Greater Manchester population.
How health inequalities will be reduced in Greater Manchester's communities.	Ensuring delivery of standards across Greater Manchester Trusts will equalise geographical variation.
The decision to be made and/or input sought	This paper is for assurance and discussion allowing the committee to agree levels of assurance and identify any further actions.
How this supports the delivery of the strategy and mitigates the BAF risks	This supports delivery of operational planning and constitutional standards.
Key milestones	Monthly and quarterly milestones are in

	place.
Leadership and governance arrangements	This paper is for Performance and Quality Committee only.
Engagement* to date ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	Engagement is undertaken within various programmes contributing to performance delivery.

Public engagement	Clinical engagement	Sustainability impact	Financial advice	Legal advice	Conflicts of Interest	Report accessible
N	N	N	N	N	N	Y

NHS
Greater Manchester

Quality and Performance Committee: Operational Delivery Report June 2025

Part of Greater Manchester Integrated Care Partnership

Presented by: Professor Colin Scales
Date: 4th June 2025

Introduction and Key Messages

NHS Greater Manchester

Introduction

1. This paper provides an update on Greater Manchester's year-end delivery against the 2024/25 NHS operational planning objectives. It includes a brief update on the national objectives for 2025/26, a summary of our current position against plans finalised in April, and an outline of the NHS Performance Assessment Framework (NPAF) for 2025/26. Additionally, it assesses our providers against the NHS Oversight Framework (NOF) and highlights key themes from Locality Assurance Meetings (LAMs).

Operational Planning Objectives 2024/25 – year end position

2. For 2024/25, GM improved across 15 objectives, with 1 remaining static. Benchmarking against other ICBs shows improvement or stability in all but three metrics. Despite these three areas showing a decline in benchmark position, the system met its operational planning ambitions.

Operational Planning Objectives 2025/26

3. For 2025/26, GM's provider and system operational plans, submitted to NHS England in April, comply with national objectives but face risks in elective and urgent care, mental health inpatient services, and care for people with autism and learning disabilities. We continue to work with leads and partners to address these challenges through our improvement and assurance structures.

4. Early data for 2025/26 metrics are included in our charts, with full reporting expected in mid June. Key risks include elective care, cancer care, mental health, urgent & emergency care, and reducing reliance on inpatient care for adults with learning disabilities and/or autism. We summarise key issues and action plans and are establishing operational delivery meetings (ODM) for high-risk areas to oversee improvement plans and more robust monitoring of improvement actions and demonstrable impacts.

Introduction and Key Messages

NHS Performance Assessment Framework (NPAF) for 2025/26 NHS England » The NHS Performance Assessment Framework for 2025/26

5. An overview of the proposed NHS Performance Framework (NPAF) was presented at the last meeting. A further update to this document in the form of a consultation response request was published on the 12th May 2025.

6. The framework document was not amended but the consultation request outlined some changes to the original. These were;

   - Reduction of the set of metrics to be used in the assessment process from 77 to 42, spreads across 4 organisation types - ICB = 19 / Acute = 19 / MH+ Community = 15 / Ambulance = 10. Data is not reported at locality (sub ICB) level as it stands.
   - Proposal to assess capability separately, rather than making the capability rating a component of the segment score. This ensures that segmentation is based exclusively on delivery, making it more objective, transparent and providing for greater public accountability.
   - Removal of the system adjustment from provider scoring - Providers will not have their scores adjusted to reflect wider system performance.
   - Introduction of a segment limit on organisations in financial deficit - such that any provider or ICB reporting a financial deficit cannot be allocated to a segment above 3.
   - The approach to identifying organisations with the most intense support needs and their entry into segment 5 remains under consideration.

7. The framework being proposed is just for 25/26. Longer-term transformation measures that align to the NHS 10 Year Plan and the redefined roles of ICBs and the centre will be introduced from 2026/27.

8. This consultation is now live and will run from 12 May to 30 May 2025.

9. Full data against the proposed metrics will not be available until mid-June, after the consultation has closed.

10. Once the metrics and data are finalised the region will run 3 sessions, one for each ICB and providers, where they will be take colleagues through the data, including showing where we would expect each organisation to be initially segmented.

Recommendation

11. Committee is asked to note

- the end of year position for 24/25
- operational priorities for 25/26 and risks
- the NPAF for 25/26, published for consultation. The finalised version will replace the current NOF
- the work ongoing though our provider and locality oversight arrangements

Summary of Key Metrics 2024/25

NHS Greater Manchester

Area	KPI	Performance			Movement between March 24 and March 25			ICB Benchmarking			Comments
		ICB or GM providers	Mar-25 actual	Mar-25 plan	Mar-24	Variance	Movement	Mar-24	Mar-25	Movement	
Elective	Referral to Treatment 78 weeks +	GM Providers	9	0	92	-83	↓	15/42	10/42	↑	% of total Waiting List used for referral to treatment benchmarking data
	Referral to Treatment 65 weeks +	GM Providers	195	0	2,834	-2,639	↓	18/42	6/42	↑	
	Referral to Treatment 52 weeks +	GM Providers	18,008		29,955	-11,947	↓	38/42	38/42	↔	
Urgent and Emergency Care	4 hours in A&E ALL	GM Providers	71.2%	78.0%	66.2%	5.0%	↑	40/42	32/42	↑	
	Cat 2 Ambulance Response	NWAS	00:23:57	00:30:00	00:23:53	00:00:04	↔				Full YTD - Category 2 ambulance responses remain well under the 30 minute standard.
	G&A Bed Occupancy	GM Providers	91.2%	91.8%	91.5%	-0.3%	↓	4/42	6/42	↓	
	12 hour decision to admit	GM Providers	2,592	0	2,849	-257	↓	25/42	22/42	↑	12 hour DTAs accounted for 8.8% of the total emergency admissions in March 25
	14+ Length of Stay	GM Providers	1,742		1,802	-60	↓	33/42	31/42	↑	Benchmarking based on '% occupied G&A beds occupied by patients with a length of stay of 14 or more days' rather than absolute
	21+ Length of Stay	GM Providers	1,218	1,055	1,258	-40	↓	36/42	35/42	↑	Benchmarking based on '% occupied G&A beds occupied by patients with a length of stay of 21 or more days' rather than absolute
Cancer	28 day Faster Diagnosis Standard	GM Providers	80.3%	77.0%	77.3%	0.03	↑	17/42	18/42	↓	
	62 day Referral to Treatment	GM Providers	71.6%	70.2%	69.0%	2.6%	↑	17/42	22/42	↓	
Diagnostics	6 week % (ICB)	GM ICB	10.5%	10.0%	20.7%	-10.2%	↓	20/42	7/42	↑	GM Provider performance 11.1%.
Mental Health	Mental Health: OAPs placements	GM ICB	18	51	124	-106	↓	41/42	39/42 (Feb)	↑	National feed not in line, figures rounded up. Measured on absolute values so GM figures are disadvantaged
	Access to Perinatal services (12m rolling)	GM ICB	2,780	2,985	2,525	255	↑	4/42	3/42 (Feb)	↑	Measured on absolute values so GM figures are advantaged Latest ranking available Feb 25
Learning Disabilities and Autism	Children inpatients with a learning disability and/or Autism	GM ICB	11.02	14.17	14.17	-3.15	↓				Rate per million. March = 7 inpatients
	Adult inpatients with a learning disability and/or Autism	GM ICB	49	35.58	51	-2.00	↓	38/42	37/42	↑	Rate per million. March = 107 inpatients

Notes:
all benchmarking is in relation to ICB performance

NHS
Greater Manchester

Delivery challenges, actions and risks:
Focus on Urgent and Emergency Care, Elective, Mental Health, Cancer, Diagnostics, Learning Disabilities and Primary Care.
Update on new community services measure.

2025/26 National Priority Metrics Alert/Advise/Assure summary

NHS Greater Manchester

Area	Metric	Alert	Advise	Assure
Urgent and Emergency Care (UEC)	A&E % of patients managed within 4 hours (GM Providers)			
	A&E (type 1) % waits over 12 hours (GM providers)			
	CAT 2 response times			
Elective	% of incomplete RTT pathways of 52 weeks or more			
	% of incomplete RTT pathways of 18 weeks or less			
	% of pathways waiting no longer than 18 weeks for a first appointment			
Diagnostics	6 week diagnostic performance (not a planning metric but key enabler for elective and cancer delivery)			
Cancer	% of patients receiving communication of diagnosis within 28 days (GM providers			
	% of patient with cancer receiving treatment within 62 days			
Mental Health	Access to CYP MH services			
	Average Length of Stay in Adult Acute Mental Health Beds			
Learning Disabilities	Inpatient care for Adults with LD			
	Inpatient care for Autistic Adults			
Primary Care	Appointments in General Practice			
	% of resident population seen by an NHS dentist	New measure and month 1 data not available		
Prevention	% of patients with hypertension treated according to NICE guidance	Annual data only – sourcing more local data		
	% of patients with GP recorded CVD, who have their cholesterol levels managed to NICE guidelines	Metric in development		
Total		2	7	5

Urgent and Emergency Care (UEC)

Alert/ Advise/ Assure	Current position / performance	Issues of concern	Key actions taken/improvement programmes	Links to BAF risks
Alert	**A&E 4 hour** - Between the 1st and 20th May, the 4-hour standard was at 67.6%, which is below plan (70.6%) and a deterioration from April (68.9%).	Delivering the 4hr target in March 2026 comes with a high degree of risk.	For 2025/6 the focus remains on reducing demand on the UEC system and improving patient flow and hospital discharge. To enable progress, a key deliverables for quarter 1 is implementing a Single Point of Access (SPA) for Urgent Community Care. A SPA will be a service in each of the 10 localities to manage urgent patient referrals from health care professionals. For example, referrals from 999 prior to ambulance dispatch, from on scene paramedics where a conveyance to emergency department could be avoided or from other community professionals such as GP, social care. The healthcare professional can contact the SPA for a remote clinical assessment by a multidisciplinary (MTD) team. The MDT are community, ambulance, primary care, acute and social care staff working together to ensure patient is directed to the most suitable service quickly and safely. For example, the patient could be referred to urgent community response, hospital at home, urgent treatment centre, same day emergency care unit, or general practice. This help prevent unnecessary ambulance dispatches and reduces attendances to emergency departments. There are some existing SPA models in place across GM currently, however they vary in the pathways that they manage and the access to services that they have. To gain the full benefit of opportunity and to ensure equity for patients, it is essential that all localities deliver the same standard of SPA, with sufficient capacity to avoid a patient escalating into acute hospital services There is also continued effort to reduce 12 hour waits. Overcrowding in emergency department (ED) leads to longer ambulance handover times. For example, GM ICB will provide additional clinical support with 12hr waits at Northern Care Alliance's Salford site, along with some focussed work to understand the profile of patients and some of the root causes.	SR4
Assure	**Category 2** – Since January, Category 2 ambulance response time have consistently been within the 30-min target and have fallen to an average of 20 minutes and 45 seconds in May (1st to 20th).			SR4
Assure	**A&E (type 1) 12 hr waits** – In April 7.8% of patients attending type 1 A&E departments spent more than 12 hours in the ED, against a 10.7% plan. The combined provider target for March 2026 is <7.5%.	If patients are waiting over 12 hours in an Emergency Department, then there is a potential impact on patient safety, possibly leading to patient harm.		SR4

Elective Care

NHS Greater Manchester

Alert/ Advise/ Assure	Current position / performance	Issues of concern	Key actions taken/improvement programmes	Links to BAF risks
Advise	% of incomplete RTT pathways of 52 weeks or more **3.8% (March 25)**	The 25/26 planning metrics across elective and outpatient programmes will be a challenge for the GM system to achieve by March 2026.	In 2025/26 the elective system group working with providers will focus on: • Development of care navigation centre across GM to support new pathways and patient choice • Implementation of a GM wide pre-referral specialist advice service • Pilot of diagnostic enhanced Advice and Guidance (A&G) services in key specialties • Addressing referral variation • Elective capacity right-sizing • Elective recovery against target waiting list size and long-wait position • Waiting list validation • Outpatient productivity • Theatre estate utilisation and surgical hub strategy • System mapping - referrals flows, demand and capacity	SR4
	% of incomplete RTT pathways of 18 weeks or less **54.1% (March 25)**			
	% of pathways waiting no longer than 18 weeks for a first appointment **58% (March 25)**			
Metrics not in planning 25/26 but included for completeness to close 24/25	Patients over **78 weeks** was 9 in March which is a reduction from 20 in February. This is anticipated to increase to 62 in April and 53 in May (51 corneal grafts).	Ability to ensure there are zero patients over 78 weeks and sustain this position Patients waiting over 78 weeks in coming months are forecast to be corneal graft patients only. Corneal graft availability remains a concern.		
	Patients over **65 weeks** was 195 in March which is a significant reduction from 415 in February . This is anticipated to reduce to 180 in April and then 139 in May.			

Cancer

Alert/ Advise/ Assure	Current position / performance	Issues of concern	Key actions taken/improvement programmes	Links to BAF risks
Assure	The **62 day** cancer standard for patients waiting no more than 62 days from urgent GP referral to first cancer treatment has improved from 67.6% in February to 71.6% in March 25 against the 70% standard and was better than the national average	Meeting plan and then continuing to improve by March 26 to meet the 75% standard *The 63 day backlog is not within 25/26 planning metrics.* However there is concern due to the growth from 787 in March 24 to the current forecast of 864 in May 25 as this could impact on the above metrics	Significant work has been underway across providers in quarter 4 alongside intense supports with the Cancer Alliance for some providers. In 2025/26 the focus is now on: • sustainable changes to pathways • increased grip and control generally across the system and robust tracking of patients • additional weekend and in week theatre lists to maximise as much capacity as possible • Early Diagnosis & Primary Care • Addressing treatment variation • Implementing personalised care • Workforce & Education • Post-primary treatment pathway management	SR4
Assure	The **28 day Faster Diagnosis Standard (FDS)** whereby a cancer or non-cancer diagnosis is given within 28 days has slightly declined from 80.4% in February to 80.3% in March 25 which is 3.3% above the 77% standard and better than the national average	Only 1 provider did not meet their plan in March 25. The system will need to retain performance to meet the 80% standard by March 26		

Diagnostics

(Metrics not in planning 25/26 but included for completeness to close 24/25 and due to impact on elective and cancer pathways)

NHS Greater Manchester

Alert/ Advise/ Assure	Current position / performance	Issues of concern	Key actions taken/improvement programmes	Links to BAF risks
Advise	The March 2025, **6 week wait diagnostic performance** across all 15 DM01 tests was 11.1% for GM Acute providers which was a 1.2% improvement from 12.2% in February. From February to March, the number of pathways over 6 weeks has reduced from 9,067 in February to 8,244 in March. ICB performance for March 2025 was 10.5%, ranking the ICB 7th out of 42 nationally.	Continuing to reduce long waiting patients across Greater Manchester (GM). Continuing decline in Paediatric Audiology performance at one provider within GM.	Following the decline in the January position at 18.9% significant improvements have been made during the reminder of quarter four to reach 11.1% in March 25. There has been increased utilisation of the private sector along with the use of locums and agency in quarter 4 to support driving improvements. Although diagnostic performance is not a planning metric for 25/26 it is recognised as a key contributor to patient pathways across both cancer and non cancer cohorts. A diagnostic workplan has been devised for 2025/26 with overarching strategic objectives to reduce overall wait time, support cancer and elective pathways, optimise system capacity, contribution to the financial position, reduce health inequalities and provide workforce sustainability. Audiology - A decision was made in February 2025 to close referrals one of our Paediatric Audiology Service providers. The impact of this, going into 2025/26 means that further decline in performance is being forecast as mitigations are not yet sufficient to deliver the improvements required.	SR4

Mental Health

NHS Greater Manchester

Alert/ Advise/ Assure	Current position / performance	Issues of concern	Key actions taken/improvement programmes	Links to BAF risks
Assure	March 25, the number of children and young people receiving at least one contact was 55,785 meeting the end of year target of 54,310.	Sustaining level of access remains a challenge. Workforce pressures, inability to recruit and retain staff. Sustaining access level will require resources.	• A review of the CYP crisis pathways and implementation of the new service specification commenced in quarter 4. • Focus on increasing access amongst CYP & families from disadvantages groups is a priority during 25/26. • MH support team (MHST), trainee workers have been enrolled on the university courses and will begin to support young people alongside qualified staff. Further trainees to be sourced as part of 25/26 allocation to help bring the service up to capacity. This is a key priority for NHSE. Plans are in development for annual expansion to 100% coverage up to 2029/30.	SR4
Alert	Average length of stay in MH acute (adult acute, older adult and PICU) bed is a new measure for 25/26. The average LOS of stay in the three months to February 25 for ICB is 70 days. End of year 25/26 target is to reduce to 57 days.	CRFD will have direct impact on LOS, increasing and not meeting target. Potential for organisations not discharging Lack of resources within CMHTs	• LOS of stay to be monitored directly alongside patients CRFD, with super week planned end of May • An increase in length of stay currently demonstrates that people with a long length of stay have been discharged. At GMMH, 3 patients with a length of stay of over a 1000 days discharged during February and March. We will see an increase in LOS. However, this should be deemed as positive as we begin to see patients being discharged. • Senior gatekeep in post at GMMH from February 25. In their first few weeks they directly supported 11 service users with alternatives to admission. Using average LOS of 48 days at a conservative average cost of £750 per bed night this potentially creates a saving of £36,000 per service user or £396,000 • Review of resources ongoing to focus on discharge pathways, rather than admission pathways.	SR4

Learning Disability and Autism - inpatients

Alert/ Advise/ Assure	Current position / performance	Issues of concern	Key actions taken/improvement programmes	Links to BAF risks
Advise	Adult inpatients with a learning disability – April 25, GM reported 56 inpatients with a learning disability in line with Q1 plan of 56	Manchester outlier with 23 LD inpatients. Service development funding reduced	• A revised budget demonstrating reduced investment has been developed and opportunities for further savings to be achieved throughout the year have been identified. • Split for LD and Autism patients has been developed and locality targets in place with oversight via LAMs. • Challenges with recruitment of community support staff are ongoing, particularly to support people being discharged. • GM complex needs project to support discharge from hospital to continue. • LDA Multi agency discharge events to remain in place.	SR4
Advise	Adult inpatients with autism – April 25, GM reported 56 inpatients with autism just below Q1 plan of 55	Manchester outlier with 22 autism patients, patients have increased in 24/25		SR4

Primary Care

Alert/ Advise/ Assure	Current position / performance	Issues of concern	Key actions taken/improvement programmes	Links to BAF risks
Advise	GM ICB has set a target of 1,449,589 GP appointments per month throughout 25/26. In March 25, 1,436,233 appointments were delivered. Compared to pre-pandemic levels, GP appointment activity in Greater Manchester has increased by 13%, outperforming the national increase of 9% (based on February 2025 data). There is also a continued upward trend in same-day appointments, along with strong performance in appointments booked within 2–7 days and 8–14 days. In March 2025, 83.6% of routine appointments were delivered within 14 days, falling short of the 87.3% target.	Following the publication of the 2025/26 GP contract, the national GP Collective Action has now been formally stood down. This period of collective action has prompted a shift in how GP practices approach the delivery of uncommissioned services, particularly those that span the primary and secondary care interface, however the underlying principles established during this period are expected to remain embedded in practice, supporting the development of safer and more sustainable ways of working.	• The delivery of the Greater Manchester (GM) Primary Care Access Improvement Plan continues as a key component of the GM Primary Care Blueprint. Ongoing efforts are being led through the GM Primary Care Pressures Working Group and the GM Primary/Secondary Care Interface Working Group to address persistent pressures and capacity challenges within general practice. These collaborative structures represent an established and sustained approach to system-wide problem-solving. • To support system-level mitigations in response to the impacts of collective action, we are actively monitoring a range of impact indicators, including GP appointment volumes, referral patterns, NHS 111 activity, and A&E attendances.	SR4
New measure and Month 1 data not available	For 25/26 the % of patients seen by an NHS dentist will be monitored quarterly. For Adults the target will be 43% 24m rolling and for Children 65% 12m rolling by end of Q1. Greater Manchester's NHS dental contracts are projected to achieve 98% of their annual activity targets—well above the national forecast of 88%. However, due to an 8-week delay in data submissions, the most recent national performance data (as of December 2024) may not fully reflect actual year-end performance.	Significant demand for access to NHS dental services may result in overperformance in-year for some primary dental care contracts which may result in reduced access towards the end of the year, and/or impact on the dental commissioning budget.	• There are a number of contracts which were forecast to meet their contracted activity before the end of the contract year, and agreement was made to allow them to sustain access for patients and delivery up to 110% of their contract. This means that actual end of year performance is expected to be better than the position indicated from December 2024 data • Continuous assessment of performance and budget in relation to contracted dental activity levels, with ongoing engagement and collaboration with the GM Dental Provider Board and GM Local Dental Committees.	SR4

Community Services – New measure for 2025/26

Alert/ Advise/ Assure	Current position / performance	Issues of concern	Key actions taken/improvement programmes	Links to BAF risks
New measure for 2025/26.	In the most recent planning round GM was asked to submit a plan showing the number of patients expected to wait in excess of 52 weeks each month. All our Trusts are planning to eliminate over 52 week waits across the year with the exception of NCA who plan a significant reduction **Provider Plans** **NCA** – Planned reduction from 1138 – 691 (April 25 – March 26)@ approx. 40 / month. March 25 figure = 1,330 **Bolton** – Planned reduction from 17 – 0 (April 25 – Jan 26) @ approx. 2 / month March 25 figure = 1 **MFT, Stockport, TGI and WWL** – forecasting 0 all year. March 25 figures – Stockport / MFT / WWL = 1 TGI = 0	**NCA** – 52-week waiters are primarily in Speech and Language Therapy (CYP), Podiatry (Adults) and Dietetics	The ICB has established a community services programme group which is progressing 5 workstreams. These are: • Finance and Contracting • Data • Intermediate Care • Community Nursing • Workforce Oversight of long waits at our providers will be via provider contract meetings in the first instance. In addition, understanding the joint work in our localities will be channelled through the LAM structure.	SR4

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Systematic review of providers and localities against the NHS Oversight Framework and operational planning trajectories

NHS Oversight Framework, Greater Manchester Providers

Trust	Current SOF rating	Last review	Notes	Next review
Bolton NHS Trust	SOF 2	22.01.25	Challenges with finance, elective and UEC. ICB fortnightly assurance meetings (UEC and elective). Quality focus on HCAI.	18.07.25
Christie NHS Trust	SOF 2 Exit criteria agreed	14.05.25	Moved from segment 1 to 2 in August 2023. Movement back to segment one declined by NHSE on the basis of a more comprehensive Well Led review needed to evidence movement. NPAF will supercede NOF scoring.	12.08.25
Greater Manchester Mental Health NHS Trust	SOF 4	14.04.25	Nationally led oversight, quality, performance and workforce. Improvement plan focus of GMMH POM.	11.07.25
Manchester University NHS Trust	SOF3 Exit criteria agreed	12.12.24	Performance risks include UEC, elective, cancer and diagnostics. In year finance risk. Quality focus on HCAI and maternity. Tier 2 cancer and diagnostics.	03.06.25
Northern Care Alliance	SOF3 Exit criteria agreed	17.12.24	Performance risk: UEC, cancer and diagnostics. Significant finance risk, quality focus on maternity. ICB fortnightly assurance meetings (elective, diagnostic and cancer)	18.06.25
Pennine Care NHS Trust	SOF2	28.04.25	Relatively low risk, performance challenges being dealt with through routine engagement.	23.07.25
Tameside NHS Trust	SOF2	04.12.24	Finance and UEC major risk.	11.06.25
Stockport NHS Trust	SOF3 Exit criteria agreed	07.05.25	Significant financial challenge, main performance risk is paediatric audiology, service closed and no robust plan in place. Quality risks identified and positively responded to. Quality focus on maternity. Moved out of tiering.	06.08.25
Wrightington Wigan and Leigh	SOF2	27.02.25	Elective assurance meetings in place. Focus within GM tier one UEC programme. Placed into tier 2 elective.	22.05.25

Locality Assurance Meetings

Locality	Last review date	Next review date
Bolton	08/04/25	03/07/25
Bury	28/11/24	05/06/25
Manchester	22/04/25	15/07/25
Oldham	11/11/24	04/06/25
Rochdale	06/05/25	29/07/25
Salford	26/11/24	29/05/25
Stockport	01/11/24	28/05/25
Tameside	29/04/25	25/07/25
Trafford	17/04/24	10/07/25
Wigan	09/05/25	01/08/25

Highlights

- Routine LAMs have restarted following and end of year focus on those localities requiring additional support.
- Focus for the first quarter is on financial planning 25/26 including developing and implementing robust cost improvement plans (CIP) plans, reducing the amount of time people with mental health condition spend in a hospital setting, reducing the number of people with LD and/or autism in a hospital setting, improving services for children with special educational needs and disabilities (SEND), appropriate access and quality of continuing healthcare and progress against locality and neighbourhood plans.

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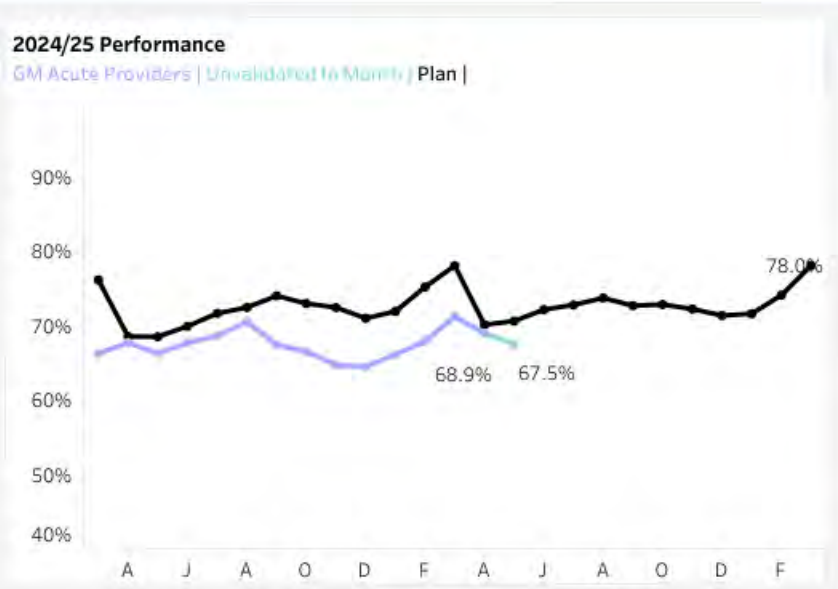
Operational delivery graphs: Key Metrics

Full suite of graphs for 2025/26 objectives will be available when month 1 validated data has been published (expected mid June)

A&E - percentage of patients managed within 4 hours (All types)



Regional Benchmarking

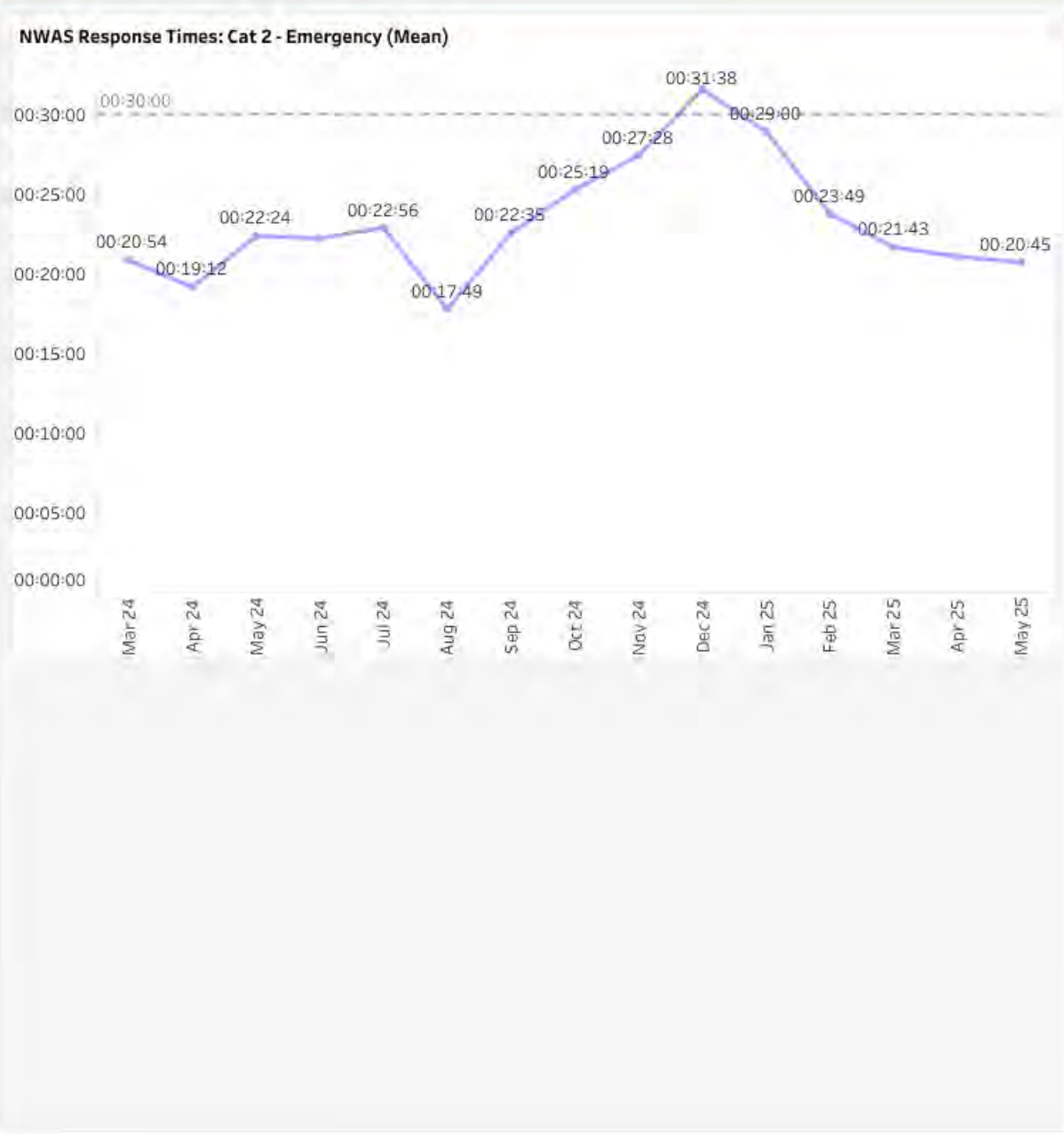
	Jan 25	Feb 25	Mar 25	Apr 25
Greater Manchester	66.1%	67.8%	71.2%	68.9%
North West	70.4%	71.7%	72.9%	72.2%
England	72.7%	73.1%	74.7%	74.5%

A&E 4hr waits standard of care performance fell to 68.9% in April. May in month (1st – 21st) shows a decrease to 67.5%. In March, NHS Greater Manchester Integrated Care Board (GM ICB) was ranked 37th out of 42 nationally. The objective is to deliver 78% in March 2026.

		Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	21 May	Jun 25
Bolton FT	Actual	60.4%	61.2%	61.8%	66.6%	69.6%	66.0%	62.3%	62.5%	61.5%	66.0%	63.7%	71.8%	66.3%	68.1%	
	Plan	65.0%	67.0%	68.0%	69.0%	70.0%	71.0%	68.0%	70.0%	73.0%	75.0%	77.0%	78.0%	72.0%	72.0%	75.0%
MFT	Actual	68.9%	67.4%	69.9%	71.9%	73.7%	69.7%	68.2%	64.0%	64.8%	67.3%	69.5%	73.9%	70.5%	71.1%	
	Plan	68.9%	67.4%	69.3%	72.1%	74.0%	77.3%	75.0%	72.7%	70.5%	70.2%	74.8%	78.0%	72.0%	72.2%	73.9%
NCA	Actual	68.7%	66.1%	66.6%	66.4%	67.0%	65.8%	66.0%	64.2%	64.6%	66.1%	67.0%	68.8%	67.9%	65.7%	
	Plan	66.8%	68.0%	70.1%	71.5%	71.4%	72.9%	74.4%	74.9%	72.4%	73.6%	76.5%	78.0%	68.2%	69.5%	70.9%
Stockport FT	Actual	63.2%	61.9%	65.6%	62.0%	65.4%	60.0%	62.0%	62.7%	63.0%	60.6%	69.5%	69.0%	68.3%	60.5%	
	Plan	63.4%	66.0%	67.2%	67.6%	67.8%	67.4%	65.5%	66.4%	64.8%	68.1%	72.7%	78.0%	66.1%	64.8%	68.5%
T&G ICO FT	Actual	66.3%	63.9%	62.7%	64.6%	71.1%	66.0%	65.2%	67.6%	62.6%	66.8%	67.1%	68.9%	66.2%	60.1%	
	Plan	71.0%	69.5%	69.3%	71.4%	71.0%	70.6%	68.2%	67.5%	65.6%	67.5%	71.0%	78.0%	69.2%	69.5%	69.3%
WWL FT	Actual	71.4%	72.0%	74.0%	73.3%	72.9%	71.6%	69.8%	68.6%	68.3%	65.3%	67.8%	71.7%	71.4%	71.4%	
	Plan	76.0%	76.1%	76.0%	76.2%	76.3%	76.4%	76.5%	76.6%	76.7%	76.8%	77.1%	78.0%	70.6%	71.4%	72.0%
GM Acute Providers	Actual	67.7%	66.2%	67.6%	68.6%	70.5%	67.4%	66.5%	64.6%	64.4%	66.1%	67.8%	71.2%	68.9%	67.5%	
	Plan	68.5%	68.5%	69.9%	71.6%	72.4%	74.0%	72.9%	72.4%	70.9%	71.9%	75.2%	78.0%	70.1%	70.6%	72.1%
GM Registered	Actual	66.7%	65.1%	66.7%	67.6%	69.5%	66.4%	65.5%	63.7%	63.4%	65.3%	66.9%	70.1%	67.9%	67.4%	
	Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Data up to 1st Mar24 is published and validated, data onwards is unvalidated.

Cat 2 Ambulance Response Times



In April, Category 2 ambulance response times were on average 21 minutes and 8 seconds across GM. This has reduced from 31 minutes and 38 seconds in December and is within the 30-minute threshold. May in month (1st - 20th) shows a further decrease to 20 minutes and 45 seconds.

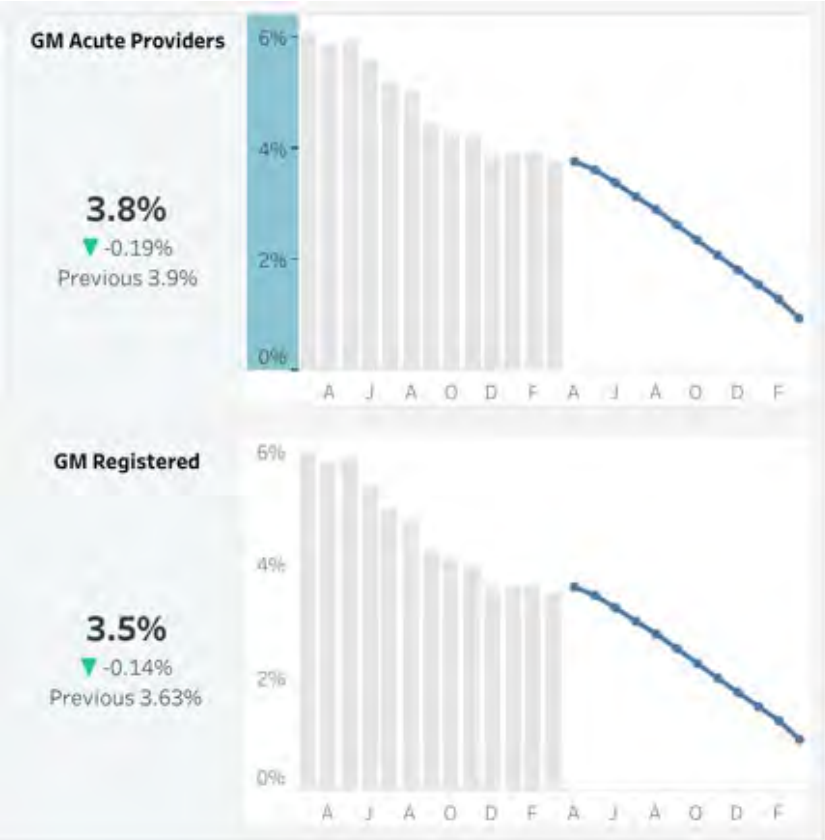
Proportion of patients spending 12+ hours in an emergency department

In April, 7.8% of patients attending type 1 A&E departments spent more than 12 hours in the ED. The latest unvalidated data for May (1st – 21st) shows a decrease to 7.1%

The combined provider target for March 2026 is <7.5%.

		Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	21 May	Jun 25
Bolton FT	Actual	12.1%	11.4%	11.1%	9.9%	8.4%	9.9%	11.7%	10.7%	11.8%	9.3%	10.3%	5.4%	8.4%	5.4%	
	Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	17.0%	16.7%	16.2%
MFT	Actual	6.3%	6.7%	5.8%	5.5%	3.6%	5.3%	5.2%	5.9%	7.4%	7.4%	5.3%	3.1%	4.2%	2.9%	
	Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	6.6%	6.2%	5.6%
NCA	Actual	9.5%	9.2%	10.4%	9.3%	9.0%	9.6%	11.9%	11.6%	11.0%	12.0%	11.0%	10.7%	10.3%	9.0%	
	Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	12.1%	12.5%	11.2%
Stockport FT	Actual	10.7%	11.6%	8.9%	11.2%	6.0%	10.5%	11.9%	12.0%	12.6%	13.8%	8.7%	10.3%	10.7%	12.4%	
	Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	11.0%	10.5%	9.0%
T&G ICO FT	Actual	5.5%	5.8%	5.0%	7.8%	5.6%	8.2%	8.8%	8.2%	10.9%	10.9%	7.8%	5.4%	7.3%	11.5%	
	Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	5.8%	6.5%	5.3%
WWL FT	Actual	11.4%	11.4%	10.4%	10.2%	10.8%	12.0%	11.8%	12.3%	11.7%	13.5%	11.7%	11.2%	11.8%	10.8%	
	Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	19.6%	19.2%	18.8%
GM Acute Providers	Actual	8.5%	8.6%	8.2%	8.1%	6.7%	8.3%	9.1%	9.2%	10.0%	10.2%	8.4%	6.9%	7.8%	7.1%	
	Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	10.7%	10.5%	9.7%
GM Registered	Actual	8.4%	8.5%	8.1%	7.9%	6.6%	8.2%	9.1%	9.1%	9.8%	10.0%	8.4%	6.9%	7.7%	7.0%	
	Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	

% of RTT waits over 52 weeks for incomplete pathways



Data in the purple box is weekly and unvalidated

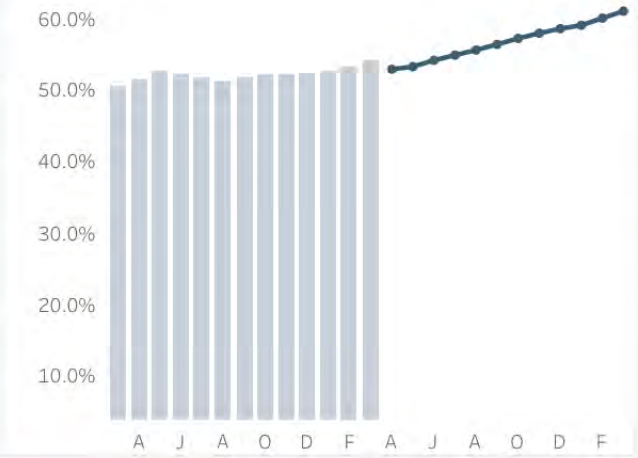
		Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	18 May	Jun 25
Bolton FT	Actual	7.4%	7.6%	8.0%	8.1%	7.3%	6.4%	5.4%	5.2%	4.6%	3.9%	3.5%	3.3%	3.1%	3.8%	
	Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	3.1%	2.9%
MFT	Actual	7.1%	6.7%	6.8%	6.0%	5.6%	5.5%	5.0%	4.8%	5.0%	4.6%	4.5%	4.6%	4.4%	4.6%	
	Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	4.1%	3.9%
NCA	Actual	5.3%	5.1%	5.2%	5.1%	4.7%	4.9%	4.0%	3.9%	3.5%	3.0%	3.4%	3.6%	3.5%	3.8%	
	Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	3.5%	3.2%
Stockport FT	Actual	7.8%	6.8%	6.5%	5.8%	5.5%	5.2%	4.4%	4.2%	4.5%	4.4%	4.7%	4.6%	4.6%	4.2%	
	Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	4.5%	4.1%
T&G ICO FT	Actual	2.1%	2.3%	2.5%	2.0%	1.6%	1.3%	0.9%	0.4%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	
	Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0.0%	0.0%
WWL FT	Actual	4.7%	4.7%	4.7%	4.8%	4.9%	4.4%	4.2%	4.6%	4.8%	4.6%	4.3%	4.2%	3.8%	3.9%	
	Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	3.6%	3.4%
Christie	Actual	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
	Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		0.0%
GM Acute Providers	Actual	6.1%	5.9%	6.0%	5.6%	5.2%	5.0%	4.5%	4.3%	4.2%	3.8%	3.9%	3.9%	3.8%	4.0%	
	Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	3.6%	3.4%
GM Registered	Actual	6.0%	5.8%	5.9%	5.4%	5.0%	4.8%	4.2%	4.1%	4.0%	3.6%	3.6%	3.6%	3.5%		
	Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		3.2%

Within the 2025/26 national planning guidance, one of the priorities is to reduce the proportion of people waiting over 52 weeks, the GM plan is no more than 1% by March 2026. As of the 11th of May, 4.0% of pathways were waiting over 52 weeks.

Elective – RTT Incomplete: % within 18 weeks

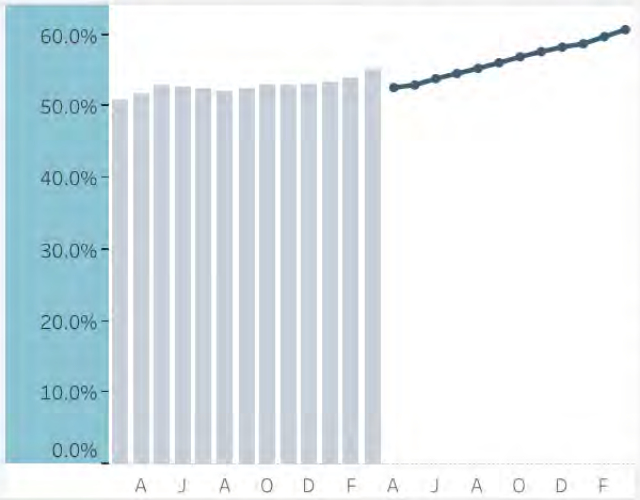
GM Acute Providers

54.1%
▲ 0.94%
Previous 53.2%



GM Registered

55.2%
▲ 1.0%
Previous 54.2%



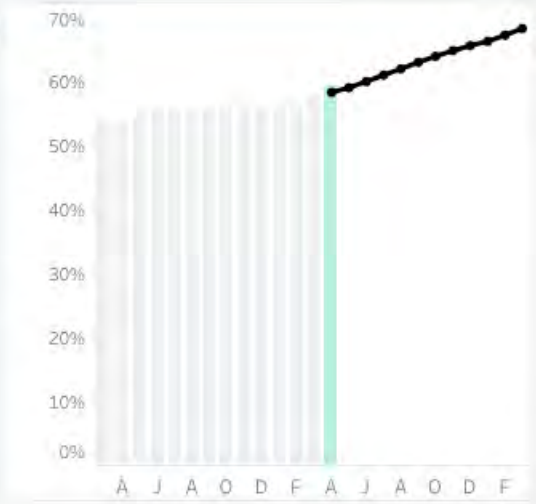
		Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25
Bolton FT	Actual	48.9%	49.6%	51.2%	50.3%	50.4%	50.1%	52.3%	53.0%	54.2%	54.7%	54.5%	54.8%	55.4%	
	Plan														55.8%
MFT	Actual	47.4%	48.0%	48.5%	48.3%	48.3%	48.0%	48.3%	48.3%	48.2%	48.3%	49.6%	50.4%	51.4%	
	Plan														50.3%
NCA	Actual	50.9%	52.4%	54.1%	52.7%	52.4%	51.3%	52.2%	52.9%	52.8%	52.8%	51.8%	52.0%	52.6%	
	Plan														52.6%
Stockport FT	Actual	49.8%	50.8%	52.6%	52.5%	52.4%	51.2%	52.5%	53.7%	53.7%	54.2%	54.1%	54.3%	55.2%	
	Plan														54.2%
T&G ICO FT	Actual	59.2%	60.3%	61.5%	61.8%	61.9%	62.4%	63.1%	65.8%	68.3%	69.0%	69.5%	71.1%	70.3%	
	Plan														68.5%
WWL FT	Actual	54.2%	56.1%	57.6%	58.1%	56.6%	56.7%	54.7%	53.7%	54.0%	53.2%	53.6%	54.6%	56.0%	
	Plan														53.0%
Christie	Actual	98.3%	97.0%	97.7%	97.2%	97.3%	97.2%	96.8%	98.2%	97.4%	97.7%	98.1%	98.0%	97.7%	
	Plan														97.2%
GM Acute Providers	Actual	50.5%	51.3%	52.5%	52.0%	51.7%	51.2%	51.6%	52.1%	52.2%	52.2%	52.5%	53.2%	54.1%	
	Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	52.9%
GM Registered	Actual	50.9%	51.8%	53.0%	52.8%	52.6%	52.1%	52.5%	52.9%	53.0%	53.1%	53.4%	54.2%	55.2%	
	Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	52.9%

At the end of March, the % of referral to treatment pathways seen within 18 weeks was 54.1% (GM Acute Providers).
One of the 2025/26 national priorities is to reduce the time people wait for elective care, improving the percentage of patients waiting no longer than 18 weeks for elective treatment to 61% across our GM providers.

Elective – RTT Incomplete: % first appointment within 18 weeks

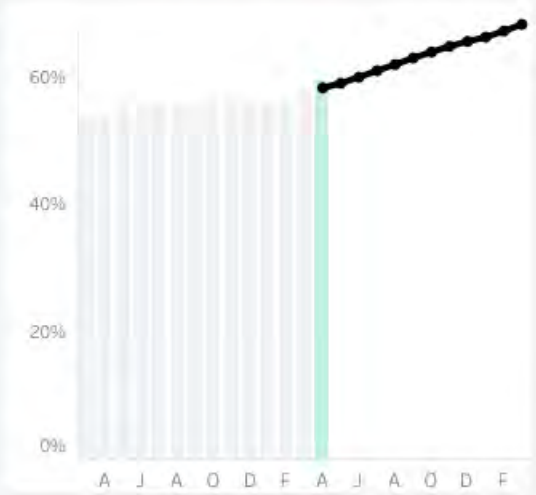
GM Acute Providers

59.2%
▲ 1.2%
Previous 58.0%



GM Registered

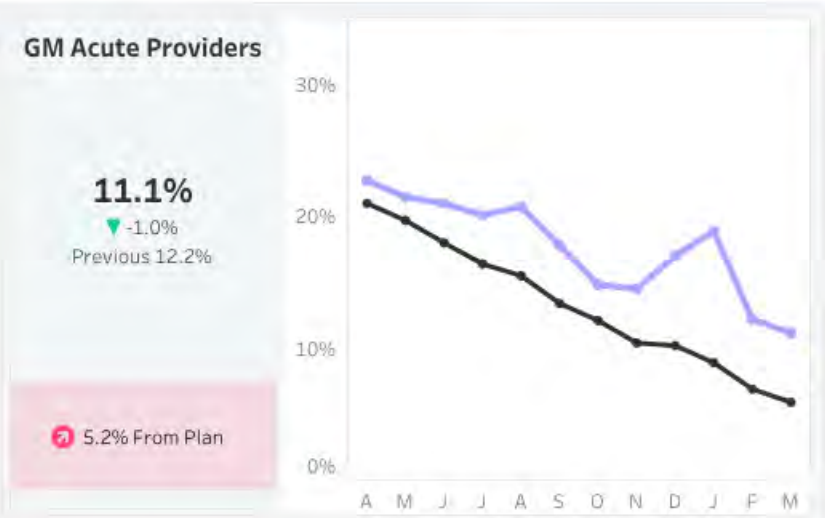
59.1%
▲ 1.2%
Previous 57.9%



		Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25
Bolton FT	Actual	54.1%	53.3%	55.0%	54.1%	54.0%	54.7%	56.8%	58.7%	61.0%	60.4%	60.7%	60.9%	61.1%	61.8%	
	Plan														61.9%	62.6%
MFT	Actual	49.6%	49.8%	50.9%	51.5%	51.5%	51.3%	51.6%	51.6%	52.2%	51.0%	51.2%	52.0%	53.6%	55.1%	
	Plan														53.6%	54.8%
NCA	Actual	54.6%	54.9%	56.6%	56.9%	56.3%	55.2%	56.2%	56.8%	56.9%	55.7%	55.7%	56.0%	57.5%	58.1%	
	Plan														57.5%	57.2%
Stockport FT	Actual	55.3%	56.2%	58.0%	57.3%	57.1%	56.3%	57.1%	59.6%	59.6%	59.7%	60.9%	61.7%	61.5%	63.5%	
	Plan														62.5%	63.0%
T&G ICO FT	Actual	66.3%	65.5%	67.2%	66.1%	67.8%	69.0%	71.7%	75.9%	77.5%	80.0%	81.9%	82.8%	81.1%	81.6%	
	Plan														81.2%	82.2%
WWL FT	Actual	57.5%	58.9%	61.4%	62.1%	60.8%	59.6%	58.0%	59.3%	59.0%	57.8%	58.4%	60.0%	61.9%	63.6%	
	Plan														60.2%	60.8%
Christie	Actual	99.7%	99.3%	99.6%	99.6%	99.7%	99.8%	99.8%	99.8%	99.4%	99.7%	99.8%	99.6%	99.5%	99.1%	
	Plan														99.7%	99.7%
GM Acute Providers	Actual	53.7%	54.0%	55.5%	55.7%	55.4%	55.0%	55.4%	56.2%	56.6%	55.7%	56.1%	56.8%	58.0%	59.2%	
	Plan														58.2%	59.0%
GM Registered	Actual	53.6%	53.9%	55.4%	55.7%	55.5%	54.6%	55.3%	56.1%	56.5%	55.6%	55.9%	56.7%	57.9%	59.1%	
	Plan														58.1%	58.8%

Within the 25/26 national planning guidance, one of the priorities is to reduce the proportion of people waiting over 18 weeks for their first appointment. In April 59.2% of pathways were seen within 18 weeks. The 25/26 aim is to reduce the time people wait for elective care, improving the percentage of patients waiting no longer than 18 weeks for their first appointment. The GM plan is to deliver 68% within 18 weeks by March 2026 across all GM providers.

Diagnostics: % waiting 6 weeks+



In March, the GM Acute Providers' 6-week wait (6ww) performance across all DM01 tests was 11.1%, a decrease of 1.1 % points from the previous month.

GM Registered performance stood at 10.5%, ranking GM 7th out of 42 nationally, just above the 10% end of year target.

	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Bolton FT	7.7%	9.6%	13.3%	15.5%	17.1%	12.9%	12.5%	14.3%	18.4%	15.8%	12.2%	3.7%
	5.1%	5.1%	5.1%	5.1%	11.6%	11.9%	11.4%	5.4%	11.5%	10.7%	5.0%	5.0%
MFT	31.8%	29.2%	27.0%	25.3%	26.1%	22.1%	18.5%	17.8%	22.2%	25.5%	14.2%	11.7%
	32.3%	30.0%	28.0%	25.3%	23.0%	20.9%	19.4%	17.9%	16.5%	14.5%	12.1%	10.0%
NCA	14.3%	13.7%	14.8%	14.4%	15.9%	14.0%	10.7%	10.9%	11.8%	13.2%	9.1%	9.3%
	11.5%	11.4%	11.2%	11.0%	10.8%	10.2%	9.4%	8.7%	7.7%	6.9%	5.7%	4.9%
Stockport FT	21.1%	20.5%	19.3%	20.5%	22.4%	17.3%	14.5%	15.9%	18.2%	23.0%	21.2%	23.3%
	15.9%	14.6%	13.6%	12.0%	6.7%	1.4%	0.4%	0.7%	1.0%	0.4%	0.2%	0.3%
T&G ICO FT	12.8%	9.6%	13.0%	7.4%	6.5%	7.2%	7.9%	4.3%	4.9%	0.8%	0.3%	0.4%
	2.4%	2.4%	2.4%	2.1%	2.2%	2.4%	2.2%	2.3%	2.2%	2.5%	2.0%	2.1%
WWL FT	22.2%	23.2%	23.7%	23.1%	22.9%	21.7%	18.5%	17.0%	16.7%	17.1%	10.0%	10.1%
	24.9%	26.7%	21.0%	19.8%	17.2%	11.3%	9.1%	7.9%	6.8%	5.7%	5.2%	4.9%
Christie	0.8%	1.0%	0.6%	1.9%	1.1%	1.2%	0.9%	1.0%	0.9%	0.8%	0.5%	0.8%
GM Acute Providers	22.7%	21.5%	21.0%	20.1%	20.7%	17.8%	14.8%	14.5%	17.0%	18.9%	12.2%	11.1%
	21.0%	19.7%	18.0%	16.4%	15.5%	13.4%	12.1%	10.4%	10.2%	8.9%	6.9%	5.9%
GM Registered	21.1%	19.9%	20.0%	19.4%	20.1%	16.9%	14.5%	14.0%	16.2%	17.9%	11.6%	10.5%

28 Day Wait from Referral to Faster Diagnosis: All Patients

The end of year target for 28 day FDS was to achieve 77.0%. In March performance was delivered at 80.3%.

The NHS Greater Manchester Integrated Care Board (GM ICB) ranked 18th out of 42 nationally.

The GM plan is to deliver 80% by March 2026.

		Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25
Bolton FT	Actual	85.8%	81.5%	83.7%	80.5%	83.7%	86.3%	88.1%	89.6%	89.6%	90.9%	86.7%	90.2%	90.5%	
	Plan		83.4%	84.0%	84.4%	84.2%	84.3%	84.1%	84.2%	83.8%	83.8%	83.7%	83.7%	77.0%	80.0%
MFT	Actual	73.8%	72.7%	75.1%	76.3%	77.3%	76.3%	76.0%	76.2%	77.8%	74.7%	70.2%	76.2%	76.0%	
	Plan		70.0%	70.0%	70.0%	73.0%	73.0%	73.0%	74.0%	74.0%	72.0%	75.0%	76.0%	77.0%	76.3%
NCA	Actual	75.3%	73.1%	75.6%	75.5%	69.7%	61.4%	57.7%	68.2%	75.5%	78.2%	72.6%	79.6%	77.3%	
	Plan		75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	72.0%	76.0%	77.0%	75.8%
Stockport FT	Actual	82.6%	79.7%	80.4%	82.9%	79.4%	75.4%	76.0%	80.5%	76.2%	79.8%	75.2%	80.7%	82.1%	
	Plan		72.2%	72.9%	70.5%	73.2%	72.9%	73.9%	74.8%	75.4%	74.1%	74.2%	76.2%	77.1%	77.0%
T&G ICO FT	Actual	76.3%	68.8%	73.3%	75.3%	75.9%	77.0%	77.0%	78.8%	77.9%	83.4%	81.3%	83.9%	86.2%	
	Plan		73.2%	74.6%	76.0%	75.4%	75.0%	73.0%	75.7%	77.2%	71.4%	73.5%	76.0%	77.0%	79.1%
WWL FT	Actual	82.8%	78.9%	81.4%	79.7%	78.2%	79.7%	81.3%	84.8%	83.6%	81.5%	78.7%	82.3%	85.5%	
	Plan		77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	78.8%
Christie	Actual	55.0%	81.3%	75.0%	100.0%	91.7%	86.4%	90.0%	81.3%	89.5%	88.9%	83.3%	87.5%	87.0%	
	Plan		78.6%	78.6%	78.6%	78.6%	78.6%	78.6%	78.6%	78.6%	78.6%	78.6%	78.6%	78.6%	80.0%
GM Acute Providers	Actual	77.5%	74.7%	77.2%	77.3%	76.2%	74.1%	73.2%	76.9%	79.1%	79.4%	74.9%	80.4%	80.3%	
	Plan		74.1%	74.5%	74.6%	75.6%	75.7%	75.5%	76.0%	76.2%	75.0%	75.2%	77.1%	77.0%	77.2%
GM Registered	Actual	77.6%	74.7%	76.9%	76.8%	75.8%	74.1%	73.2%	76.8%	79.3%	79.5%	74.9%	80.2%	80.1%	
	Plan		74.3%	74.7%	74.8%	75.7%	75.8%	75.7%	76.2%	76.4%	75.3%	75.4%	77.2%	77.2%	77.2%

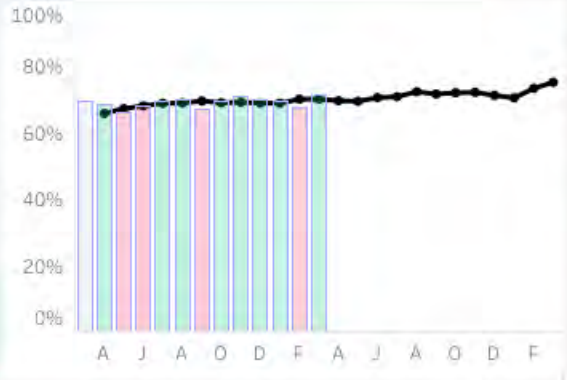
62 Day Wait from Referral to First Treatment: All Patients

GM Acute Providers

71.6%

▲ 4.1% Previous 67.6%

1.4% From Plan

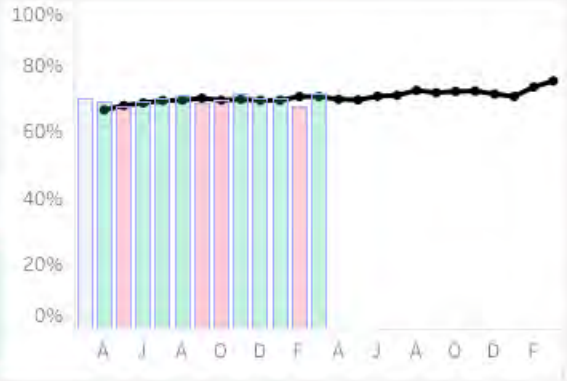


GM Registered

71.4%

▲ 3.8% Previous 67.6%

0.9% From Plan



The national target for 62-day referral to treatment was to achieve 70.0% by end of year (24/25). In March performance for All GM NHS Acute Providers was 71.6%.

The NHS Greater Manchester Integrated Care Board (GM ICB) ranked 22nd out of 42 nationally

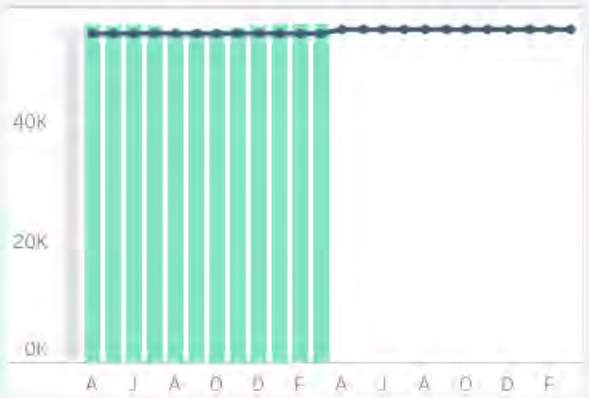
The GM plan is to deliver 75% by March 2026.

		Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25
Bolton FT	Actual	85.3%	77.5%	78.2%	80.8%	85.5%	87.4%	86.6%	86.2%	85.2%	89.0%	86.3%	81.5%	80.4%	
	Plan		80.4%	81.3%	82.0%	82.2%	82.8%	82.4%	83.0%	84.4%	84.6%	85.1%	85.7%	70.6%	75.4%
MFT	Actual	59.5%	57.1%	58.3%	59.1%	60.0%	57.2%	53.5%	58.2%	62.2%	59.1%	60.1%	58.6%	63.3%	
	Plan		61.9%	64.9%	66.9%	67.9%	67.9%	68.0%	65.1%	64.1%	63.1%	65.0%	67.1%	70.0%	62.4%
NCA	Actual	67.7%	70.0%	63.7%	68.5%	69.8%	66.9%	63.7%	65.6%	71.3%	67.0%	69.3%	64.8%	70.7%	
	Plan		60.3%	61.0%	61.9%	62.7%	63.7%	64.7%	65.5%	66.4%	69.1%	66.9%	68.0%	70.0%	69.0%
Stockport FT	Actual	64.4%	76.6%	67.3%	65.3%	74.9%	77.3%	71.3%	73.8%	74.4%	70.5%	67.6%	72.6%	74.2%	
	Plan		67.3%	67.2%	65.1%	70.6%	64.5%	70.4%	71.9%	72.4%	70.2%	66.0%	71.1%	70.2%	70.0%
T&G ICO FT	Actual	81.4%	71.5%	77.3%	77.2%	78.5%	79.8%	76.3%	77.5%	70.0%	77.4%	83.3%	74.6%	81.5%	
	Plan		68.7%	70.8%	70.2%	71.4%	73.3%	71.2%	70.8%	70.2%	69.3%	70.0%	69.4%	71.1%	75.0%
WWL FT	Actual	78.6%	77.4%	75.3%	72.1%	64.8%	76.8%	81.5%	82.8%	78.8%	81.7%	76.6%	73.4%	78.2%	
	Plan		70.3%	70.3%	70.6%	70.3%	70.3%	70.6%	70.3%	70.6%	70.5%	70.5%	70.6%	70.5%	80.3%
Christie	Actual	75.1%	71.3%	72.4%	73.1%	76.7%	80.1%	75.1%	81.6%	76.9%	76.4%	71.3%	73.3%	75.6%	
	Plan		70.4%	70.4%	70.4%	70.4%	70.4%	70.4%	70.4%	70.4%	70.4%	70.4%	70.4%	70.4%	75.2%
GM Acute Providers	Actual	69.6%	68.5%	66.4%	67.9%	69.7%	70.2%	67.3%	69.7%	71.1%	70.2%	69.6%	67.6%	71.6%	
	Plan		65.9%	67.4%	68.2%	69.0%	69.1%	69.7%	69.1%	69.3%	69.0%	69.0%	70.2%	70.2%	69.8%
GM Registered	Actual	70.1%	68.9%	67.3%	68.8%	69.8%	70.7%	68.5%	69.4%	71.4%	70.1%	70.0%	67.6%	71.4%	
	Plan		66.6%	67.9%	68.6%	69.4%	69.5%	70.1%	69.5%	69.8%	69.5%	69.5%	70.6%	70.6%	69.8%

Access to Children and Young People Mental Health Services

55,785

▼-0.1% Previous 55,855



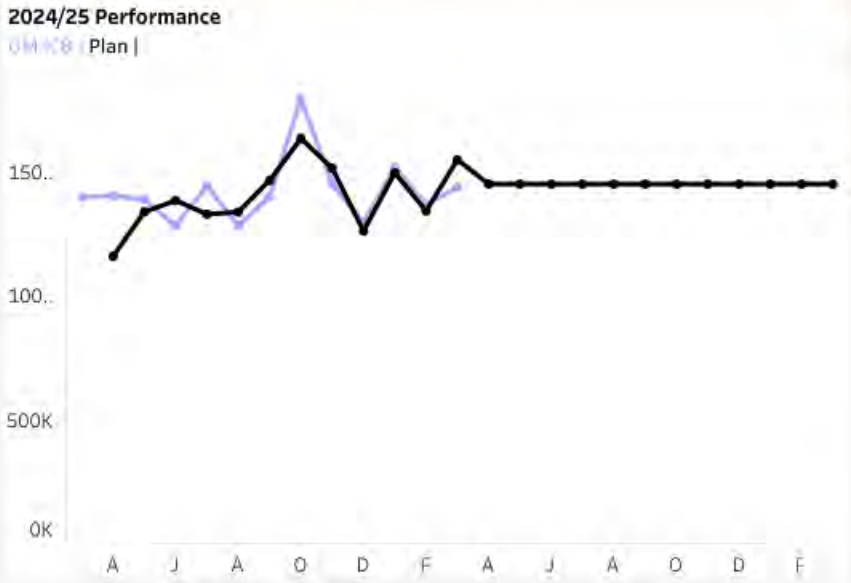
2.7% From Plan

		Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25
GM Registered	Actual	55,095	55,685	55,605	55,615	55,430	54,810	54,555	54,655	55,270	55,555	55,825	55,855	55,785	
	Plan		54,310	54,310	54,310	54,310	54,310	54,310	54,310	54,310	54,310	54,310	54,310	54,310	55,000

Latest data March 25, the number of CYP receiving at least one contact was 55,785 meeting the end of year target of 54,310.

The GM plan is 55,000 across 25/26.

Appointments in General Practice



		Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25
GM Registered	Actual	1,396,964	1,402,490	1,387,406	1,282,093	1,442,564	1,281,626	1,398,340	1,792,766	1,450,952	1,294,668	1,517,955	1,368,309	1,436,233	
	Plan		1,158,659	1,337,352	1,383,099	1,328,038	1,336,624	1,464,465	1,632,954	1,514,007	1,260,316	1,495,110	1,341,169	1,547,826	1,449,589

GM ICB has set a target of 1,449,589 GP appointments per month throughout 25/26. In March 25, 1,436,233 appointments were delivered.

NHS
Greater Manchester

A Pain to Complain – Healthwatch report into the NHS complaints process

2024-2025

Part of Greater Manchester Integrated Care Partnership

NHS Greater Manchester

Quality and Performance Committee

May 2025

Required information.	Details.
Title of report.	*A Pain to Complain* – Healthwatch report into the NHS complaints process
Author.	Mark Palmeria, NHS GM
Presented by.	Mark Palmeria, NHS GM
Contact for further information.	mark.palmeria@nhs.net
Executive summary.	This report introduces and outlines research and a report produced by Healthwatch England into the patient experience of making an NHS complaint.
The benefits that the population of Greater Manchester will experience.	Listening to patients, the public and our communities is a statutory duty and will improve services.
How health inequalities will be reduced in Greater Manchester's communities.	Learning from patient experience promotes equality of access and services that meet the needs of our communities.
The decision to be made and/or input sought.	QPC is asked to: • Note the contents of this update report. • Recognise the effort, actions and good practice within NHS GM to manage complaints efficiently and effectively and share learning from complaints to improve health and care for the people of Greater Manchester. • Note that the Complaints annual report will be presented at the August 2025 Committee

How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	This mitigates the following BAF risk: • SR6 Statutory Duties Compliance
Key milestones.	-
Leadership and governance arrangements.	The paper has been approved by Nursing and Quality senior leadership.
Engagement* to date. ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	*A Pain to Complain* has been circulated to all ICBs and presented through the national complaints forum.
Financial or Legal Implications	-

Table 1: Information needed about the document and its purpose.

Public engagement	Clinical engagement	Sustainability impact	Financial advice	Legal advice	Conflicts of interest	Report accessibility
No	No	No	No	No	No	Yes

Table 2: Assurance needed about the document.

Introduction and context

1. This report introduces and outlines research and a report produced by Healthwatch England into the patient experience of making an NHS complaint.

A Pain to Complain – details of the report

2. In response to record numbers of complaints about health services, the Darzi view that patient satisfaction is at a low and the independent Dash review considering complaints as part of its wider look at patient safety, quality and patient experience, the Healthwatch England report – *A Pain to Complain* – recognises that written complaints in the NHS reached a record high in 2024. With public satisfaction with the NHS at record low levels, the way the NHS handles, responds and learns from complaints is vital.

3. A high quality, responsive NHS complaints process not only provides a key way for services to learn and improve care, it also shows patients that the NHS values their feedback. The report by Healthwatch found low public confidence is preventing people from taking any action after experiencing poor care, meaning that current complaints numbers could just be the tip of the iceberg. The report also noted that is little evidence that complaints are being systematically used to improve care.

4. The report can be found on the Healthwatch England website www.healthwatch.co.uk.

The methodology and basis of the report

5. The report was carried out using a mixed-method approach, consisting of:

   Polling - YouGov conducted polling for in two parts. **Part one was a nationally representative sample of 2,042 adults** living in England, between 17-22 October 2024. This asked people if they'd experienced poor NHS care since October 2023 and their general confidence in making complaints. **Part two was a boosted sample, made up of 2,650 adults who had experienced poor NHS care since October 2023**, polled 17–29 October 2024, about whether they took any action and experience of the complaints process.

   Freedom of Information requests - data was sought from health and care organisations, but which was not in the public domain via Freedom of Information requests sent in September 2024 to:

   - 206 NHS hospital, mental health or community trusts, asking about their budget for Patient Advice and Liaison Services (PALS) and total staff in PALS and complaints teams. 166 responses were received.
   - All 42 integrated care boards (ICBs), asking about resourcing of complaints handling, response times and if they delegated the remit to another ICB. All but one responded.
   - 151 upper-tier local authorities, about how much they spent on statutory NHS complaint advocacy services. 114 responses were received.

   Roundtables with Healthwatch - In November 2024, two roundtables with more than 20 staff from approximately 17 local Healthwatch services took place. These focused on patient feedback on complaints, local complaints processes, and their role in providing NHS complaints advocacy if their organisation also delivered this service. To note, Healthwatch from the Greater Manchester localities were not represented at the round table discussions.

   An analysis of Healthwatch feedback on complaints - In October 2024, over 200 pieces of

feedback on people's experiences of the NHS complaints process shared by local Healthwatch services were analysed. Some of the stories appear in the report.

The key findings of the report

6. The Healthwatch report identified several key findings:

   - **Very few patients complain**. Almost a quarter (24%) said they had experienced poor NHS care in the past year. Yet more than half (56%) of people who experienced poor care took no action, and fewer than one in 10 (9%) made a formal complaint.

   - **Low confidence stops people acting**. Of those who didn't make a complaint after poor care, 34% believed that the NHS wouldn't use their complaint to improve services, 33% thought organisations wouldn't respond effectively, and 30% felt the NHS wouldn't see their concern as 'serious enough'.

   - **A poor complaints experience is common**. Over half (56%) of people who made a formal complaint were dissatisfied with both the process and the outcome of their complaint.

   - **Falling investment in support to help people complain**. The budget allocated to councils to arrange statutory NHS complaints advocacy for local people has declined by more than 20% over the last decade.

   - **People experience long waits for responses**. On average, integrated care boards (ICBs) took 54 working days to respond to complaints they handled as commissioners of NHS services. Response times ranged from between 18 and 114 working days.

   - **The NHS is not effectively learning lessons**. NHS organisations do not effectively capture the right data about who makes complaints, do not welcome complaints or fail to fully demonstrate learning from complaints. There is little national oversight and accountability over the complaints process.

Key recommendations of the Healthwatch report

7. Healthwatch states that their findings show the NHS does not consistently welcome, handle, respond or learn from complaints in a patient-centered manner.

8. They recommend action is needed to:

   Make the complaints process easier for patients and their families to navigate:
   - NHS England (NHSE) should require NHS bodies to collect wider data about complainants, such as gender, ethnicity and disability.
   - The Department of Health and Social Care (DHSC) should set detailed and mandatory standards on NHS 'front-door' information - including on the NHS App - about how people can navigate the complaints process.
   - DHSC should commission a comprehensive review of statutory NHS complaints advocacy services.

   Monitor and improve the performance of organisations that handle complaints:
   - DHSC should set mandatory response times for complaints following a baseline exercise on current average response times at all providers and ICBs

- NHS organisations should survey patients after complaint cases are closed to monitor their satisfaction with the process and outcomes.
- NHSE should require all NHS bodies to report on new performance indicators of complaint handling, including the number of re-opened complaints, and the number of complaints referred to the Parliamentary and Health Services Ombudsman (PHSO).
- NHSE should carry out a performance audit on ICB compliance with the 2009 complaints handling regulations.

Develop a culture of listening to and learning from complaints:

- DHSC should strengthen regulations to require NHS bodies to publish their annual complaints reports, rather than 'on request' as currently required.
- DHSC should require providers to better demonstrate learning from complaints through more detailed annual complaints reports.
- DHSC should make the PHSO's NHS Complaints Standards mandatory and clarify which body should lead in monitoring and enforcing them.
- NHSE should assess ICBs' complaints handling in ICB annual assessments.
- The Care Quality Commission (CQC) should improve the regulation of providers' complaints' handling responsibilities by checking this at every new and full assessment.

Reflections and opportunities

9. Accepting that the scale of polling represents a small sample (compared to the total numbers who do complain and the total number of patient interactions with NHS services in the given timeframe) and the fact that no NHS GM Healthwatch were involved in the round table discussions, there are nevertheless some important reflections on the recommendations in the report for NHS GM.

10. It is noted that several of the recommendations point to NHSE as the responsible body for action. In light of recent NHS Reform, it is assumed that these will be picked up by successor structures or organisations.

- **Collect wider data about complainants**, such as gender, ethnicity and disability.

  Collecting data when managing complaints has proven a challenge. Whilst some data is available through the complaint and associated documentation (e.g. patient records), it is recognised that making a complaint can be challenging for some so requesting wider data from complainants in an already difficult and emotional charged time is difficult. NHS GM Patient Services team does not have access to patient records so opportunities to access data are also limited for this route. We are considering a data collection form at the start of the process when we ask for consent.

- **Mandatory standards on NHS 'front-door' information** - including on the NHS App - about how people can navigate the complaints process.

  Good quality information on how to navigate the complaints process will help. The Patient Services team with the support of the communications team have in April / May 2025 reviewed the content of the ICB web page and improved information on how to make a complaint for patients. Improvements on how to navigate to the page have also been made.

- **Comprehensive review of statutory NHS complaints advocacy services**

NHS GM receives complaints from advocates on behalf of complainants and from complainants who have been empowered through advocacy to make their complaint themselves. The impression, however, is that the levels of support are low when compared with the need.

The Patient Services team promote advocacy at every opportunity – when taking calls, when dealing with complaints via email and through a dedicated space on the Patient Services webpage.

- **Mandatory response times** for complaints following a baseline exercise on current average response times at all providers and ICBs.

  The current NHS complaints regulations introduced individual timescales that are agreed with complainants. This recognises differences in the complexity of complaints and was a departure from a fixed investigation timeframe in previous versions of the regulations. The regulations call for complaints to be dealt with *speedily and efficiently* and do have a 'failsafe' endpoint built in at 6 months requiring NHS bodies to either notify the complainant in writing and explain the delay with their complaint response as soon as reasonably practicable. Any change will need a review and update of the regulations.

  The complaints regulations do allow for issues to be speedily resolved (verbal complaints that are resolved by the next working day), and these cases are dealt with through the PALS part of Patient Services. This accounts for the majority of issues resolved for patients by NHS GM.

  It is acknowledged however that NHS GM does have some complaints that have taken well over the recommended timeframes to resolve. In all of these cases, complainants are updated, and every effort is made to provide a response as soon as is practically possible. QPC have been expressly appraised of the challenges with some primary care complaint responses and the recovery trajectory in place. The recovery trajectory is being reviewed as is the approach to improve the timeliness of the response.

- **Survey patients after complaint cases are closed** to monitor their satisfaction with the process and outcomes.

  NHS GM Patient Services team has worked with colleagues in Cheshire and Mersey and Lancs and South Cumbria ICBs to develop a post complaints experience survey and we intend to pilot a survey in NHS GM.

- All NHS bodies to report on **new performance indicators of complaint handling**, including the number of re-opened complaints, and the number of complaints referred to the Parliamentary and Health Services Ombudsman (PHSO).

  Patient Services reports on a six-monthly basis to QPC and, in line with the complaints regulations, also produces an annual complaints report. National reporting is already in place in the form of the annual KO41 complaints submission. This includes metrics on complaints, themes, trends and data on cases referred to and investigated by the PHSO.

- **Performance audit on ICB compliance with the 2009 complaints handling regulations.**

  NHS GM will be open to comply with an audit of compliance against the regulations.

- **Strengthen regulations to require NHS bodies to publish their annual complaints reports**, rather than 'on request' as currently required.

  Our experience is that NHS organisations across the GM system adhere to the request to produce and publish an annual complaints report in line with the requirement under the regulations. NHS GM reports complaints through QPC and these are published with the committee papers on the website. The complaints annual report is due at QPC in August 2025.

- **Make the PHSO NHS Complaints Standards mandatory** and clarify which body should lead in monitoring and enforcing them.

  Our experience is that NHS organisations take the PHSO NHS Complaints Standards very seriously and follow them in policy and practice. NHS GM Patient Services policy is based on and underpinned by the standards.

- **Assess ICBs' complaints handling in ICB annual assessments.**

  ICBs produce an Annual Report as per the regulations and submit an annual complaint submission (the KO41) to NHSE. NHS GM will be open to comply with any assessment of complaints compliance.

A note on *Lost in the System – The Need for Better NHS Admin*

11. For information and noting, another report was published around the same time as the Healthwatch *A Pain to Complain* report. This report, by the Kings Fund, titled Lost in the System: The Need for Better NHS Admin looked at patient experience of NHS admin and its effect on care. It is noted within that report that patients and their families' experience of NHS admin is often poor, the basics around organisation and support of NHS care are missed, people with additional needs can bear the burden of poor admin and there is a direct link with the increase in complaints including administration of care, breakdown in communication around appointments and delays in getting information and test results. These themes have featured in complaints received in NHS GM.

Ask of QPC

12. QPC is asked to:
    - Note the contents of this update report.
    - Recognise the effort, actions and good practice within NHS GM to manage complaints efficiently and effectively and share learning from complaints to improve health and care for the people of Greater Manchester.
    - Note that the Complaints annual report will be presented at the August 2025 Committee

NHS
Greater Manchester

Quality and Performance Committee MIAA Audit Plan 2025-2026

NHS Greater Manchester

Quality and Performance Committee

June 2025

Required information.	Details.
Title of report.	MIAA Audit Plan
Author.	Chris Gaffey Associate Director Corporate Services
Presented by.	Anita Rolfe Deputy Chief Nurse
Contact for further information.	Faye Vaughan Committee Secretary
Executive summary.	The Quality and Performance Committee (QPC) sets the strategic direction of quality and performance governance and oversight for the organisation. This audit plan provides structure for the committee to receive audit opinion and holds the system to account in relation to quality improvement, system learning and the reduction of inequalities.
The benefits that the population of Greater Manchester will experience.	Continuous improvement of safe health care in line with the Living Well strategy.
How health inequalities will be reduced in Greater Manchester's communities.	This audit plan provides structure for the committee to receive audit opinion and holds the system to account in relation to quality improvement, system learning and the reduction of inequalities.
The decision to be made and/or input sought.	QPC to note the agreed plan.

How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	QPC will regularly review the BAF and risks pertinent to the committee.
Key milestones.	Annual review of effectiveness.
Leadership and governance arrangements.	The forward plan has been developed as part of the organisational audit plan process and has been considered at audit committee.
Engagement* to date. ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	
Financial or Legal Implications	

Table 1: Information needed about the document and its purpose.

Public engagement	Clinical engagement	Sustainability impact	Financial advice	Legal advice	Conflicts of interest	Report accessibility
No	No	No	No	No	No	Yes

Table 2: Assurance needed about the document.

NHS Greater Manchester Integrated Care Board (NHS GM)- DRAFT

Internal Audit Plan 2025/2026 (Extract)

5 Operational Internal Audit Plan 25/26

Review & Scope	Rationale	Planned Delivery	Indicative Days	Executive Lead	Committee
Governance & Leadership					
Assurance Framework: To evaluate the effectiveness of the Board's Assurance Framework	**HOIA Opinion Requirement/ PSIAS requirement**	Q4	12	Colin Scales, Deputy Chief Executive	Audit Committee
Risk Management (Core Controls): To provide assurance that core risk management controls have established and maintained.	**HOIA Opinion Requirement/ PSIAS requirement**	Q4	12	Colin Scales, Deputy Chief Executive	Audit Committee
Primary Care Commissioning Assurance Framework (POD Delegation): To review the ICB's self-declaration against the Primary Care Commissioning Assurance Framework.	**Risk Assessment/NHSE requirement**	Q1	12	Katherine Sheerin, Chief Commissioning Officer	Primary Care Commissioning Committee
Conflicts of Interest: To provide assurance on the systems and processes in place to ensure key decisions are taken following the application of declaration and management of conflicts of interest guidance	**NHS Requirement**	Q4	15	Colin Scales, Deputy Chief Executive	Audit Committee
Finance, Performance & Sustainability					
Key Financial Transactional Processing Controls: To provide assurance that the most significant key controls are appropriately designed and operating effectively in practice.	**Core Assurance**	Q3	15	Kathy Roe, Interim Chief Finance Officer	Finance Committee
Financial Recovery Programme: To provide an overview of how the ICB is managing the programme through the POMs and LAMs and ICB oversight meetings, as well as the FROG which reports into the Finance Committee. It is proposed to consider the levels of assurance around financial recovery governance and how the CIP and PID flow through this structure. The review will include providing assurance around overall financial grip and control across the organisation and, the robustness of its governance processes.	**BAF SR2a & 2b**	Q1	20	Katherine Sheerin, Chief Commissioning Officer Colin Scales Deputy Chief Executive	Finance Committee
Supplier Due Diligence: The overall objective of the review is to provide assurance that the financial position of the organisation is being reported appropriately during the financial year which should thereby minimise the risk of any surprises arising at the financial year end.	**BAF SR4/ Management Request**	Q4	18	Kathy Roe, Interim Chief Finance Officer	Finance Committee

Review & Scope	Rationale	Planned Delivery	Indicative Days	Executive Lead	Committee
Finance, Performance & Sustainability					
Financial Reporting: The overall objective of the review is to provide assurance that the financial position of the organisation is being reported appropriately..	**BAF SR 2a & 2B**	Q3	12	Kathy Roe, Interim Chief Finance Officer	Finance Committee
Mental Health: The review will seek to provide assurance over Mental Health expenditure and controls for commissioning and delivering savings. The proportion of Mental Health expenditure is increasing year on year and was £677m in 2023/24 and the ICB has continued to invest in services in line with the Mental Health Investment Standard. 2024/25 in year accounts continue to flag this area as a risk.	**BAF SR 2a & 2B**	Q2	12	Katherine Sheerin, Chief Commissioning Officer Manisha Kumar, Chief Medical Officer	
Quality					
Community Pharmacy - Additional Services: To ensure that NHS GM has robust management systems in place for the provision of additional services by community pharmacies.	**BAF SR3/ SR4**	Q2	13	Katherine Sheerin, Chief Commissioning Officer	
Continuing Healthcare (CHC): The overall objective of the review is to provide assurance over the arrangements in place at a high level over CHC, including governance and performance reporting arrangements, compliance with legislative requirements, expenditure and delivering savings, as well as performance management over service providers.	**BAF SR3/ SR4**	Q3	30	Mandy Philbin, Chief Nursing Officer	
People					
Training and Development: The review will provide assurance over the ICB's approach to staff training and development, including completion of mandatory training and the controls and processes to monitor and report on this, as well as the organisation's approach to staff development.	**BAF SR1**	Q3	15	Janet Wilkinson, Chief People Officer	
ESR: To provide an assessment of the effectiveness of the systems of control operating at the ICB to ensure that only employees are paid, and only for work that they perform on behalf of the ICB.	**Core Assurance**	Q3	12	Janet Wilkinson, Chief People Officer	
Information & Technology					
Data Security and Protection Toolkit: To review the governance process, policies and systems in place, the validity of the assertions of the DSPT submission and any wider risk exposures	**Mandated Requirement**	Q1 & Q4	17	Warren Heppolette, Chief Officer Strategy & Innovation	Audit Committee

Review & Scope	Rationale	Planned Delivery	Indicative Days	Executive Lead	Committee
Information and Technology					
Additional IT System Wide Assurance: The objective of the review is to provide additional assurance for the areas that are not covered by the mandatory annual DSPT review. The DSPT objectives cover the following areas: A - Managing risk B - Protecting against cyber-attack and data breaches C - Detecting cyber security events D - Minimising the impact of incidents E - Using and sharing information appropriately Therefore, the additional review will cover areas that complement these objectives in order to provide further system wide assurance.	**BAF SR 7/ Audit Committee Request**	Q3	15 (TBC)	Warren Heppolette, Chief Officer Strategy & Innovation	Audit Committee
Planning & Reporting, Follow Up and Contingency					
Planning, Management, Reporting & Meetings	**GIAS requirement**	Q1 – Q4	25	Kathy Roe, Interim Chief Finance Officer	Audit Committee
Follow up	**GIAS requirement**	Q1 – Q4	22	Kathy Roe, Interim Chief Finance Officer	Audit Committee
Contingency	**GIAS requirement**	Q1- Q4	15	Kathy Roe, Interim Chief Finance Officer	Audit Committee
25-26 Total Plan Days			292	***58 days remaining based on a 350 day annual plan***	
23-24 Deferred Days					
Specialised Commissioning: To assess the arrangements put in place by NHS GM to ensure the effective handover of specialist commissioning services from NHSE.	**Management/Audit Committee Request**	Q4 TBC	11	Katherine Sheerin Chief Commissioning Officer	NW Specialised Commissioning Joint Committee
Grand Total Plan Days			303		

The planned review days are indicative and are mainly used for internal monitoring, focus is placed on the delivery of sufficient outputs for inclusion in the Head of Internal Audit Opinion The Internal Audit Risk assessment and plan will be reviewed on an ongoing basis throughout the year and any requests for change discussed and approved via the Audit Committee. A formal 6-month review of the plan will also take place.

The following risk areas were identified as part of the annual risk assessment (refer above) but, are not currently prioritised within the Internal Audit Plan coverage.

Risk Area	Review Origin	Rationale
Health & Wellbeing	Risk Assessment / BAF	Considered for 25-26 but not included in draft, included in future strategic internal audit plan
Recruitment	Risk Assessment / BAF	Considered for 25-26 but not included in draft, included in future strategic internal audit plan
Equality, Diversity and Inclusion	Risk Assessment / BAF	Considered for 25-26 but not included in draft, included in future strategic internal audit plan
Implementation of new ways of working	Risk Assessment / BAF	Considered for 25-26 but not included in draft
Shanley Report Progress	Risk Assessment / BAF	Considered for 25-26 but not included in draft
Prescribing	Risk Assessment / BAF	Considered for 25-26 but not included in draft, included in future strategic internal audit plan
Persona Health Budgets	Risk Assessment / BAF	Considered for 25-26 but not included in draft, included in future strategic internal audit plan
IT Supplier Management	Risk Assessment / BAF	Considered for 25-26 but not included in draft
Critical Application Review (Incident Management Product)	Risk Assessment / BAF	Considered for 25-26 but not included in draft
Digital and Data Strategy Review	Risk Assessment / BAF	Considered for 25-26 but not included in draft, included in future strategic internal audit plan
Remote Access Review	Risk Assessment / BAF	Considered for 25-26 but not included in draft, included in future strategic internal audit plan
Data Centres Review	Risk Assessment / BAF	Considered for 25-26 but not included in draft, included in future strategic internal audit plan
Facilitate a BCP Exercise for Digital	Risk Assessment / BAF	Considered for 25-26 but not included in draft, included in future strategic internal audit plan
Sickness Absence	Risk Assessment / BAF	Considered for 25-26 but not included in draft, included in future strategic internal audit plan

3 Year Strategic Internal Audit Plan

We have mapped your strategic risks to the 3 Year Strategic Internal Audit Plan. This will be reviewed as part of the risk assessment process to ensure that it remains focused on the ICB's key risks and challenges and adds value.

BAF REF	Strategic Risk	Risk Score	2025/26	2026/27	2027/28
Principal Objective: SR1 Workforce gaps limit the system's ability to plan for a future sustainable workforce					
SR1	Workforce gaps (including resource, capacity, capability & leadership) limit the system's ability to plan for a future sustainable workforce.	20	Training and Development ESR	Health and Wellbeing EDI	Recruitment Sickness Absence ESR
Principal Objective: SR2a GM ICS fails to deliver in line with the agreed financial plan in the current financial year 2024/25.					
SR2a	GM ICS fails to deliver in line with the agreed 24/25 financial plan (revenue and capital).	20	Financial Recovery Programme Mental Health Financial Reporting	Financial Governance	Financial Governance CIP
Principal Objective: SR2b GMICS fail to deliver financial balance by 2026/27					
SR2b	GMICS fail to deliver financial balance by 2006/27	15		System Savings Plans (system piece of work or IBC focused- TBC)	
Principal Objective: SR3 Widening health inequalities and continued poor health outcomes due to a reduced focus on prevention for the GM population					
SR3	Widening health inequalities and continued poor health outcomes due to a reduced focus on population health and prevention	25	Specialised Commissioning	Population Health GM Prevention Plan	Patient & Public Engagement
Principal Objective: SR4 Greater Manchester fails to deliver national operational delivery standards					
SR4	Greater Manchester fails to deliver the operational delivery standards, as set out in national planning guidance	20		Provider Performance Plan monitoring arrangements	Dentistry

BAF REF	Strategic Risk	Risk Score	2025/26	2026/27	2027/28
Principal Objective: SR5 There is a risk of failure to comply with our statutory duties for quality assurance in Quality and Patient Safety within the NHS GM system					
SR5	There is a risk of failure to comply with our statutory duties for quality assurance in Quality and Patient Safety within the NHS GM system	20	Community Pharmacy CHC	GM provider oversight model GM Single Improvement Plan	Complaints Quality Assurance Framework
Principal Objective: SR6 An emergency could overwhelm NHS GM's ability to respond effectively.					
SR6	An emergency could overwhelm NHS GM's ability to respond effectively.	16			EPRR
Principal Objective: SR 7Significant systemic service disruption occurs as a result of Cyber-attack, on NHS GM or cyber-attack on key suppliers moving quickly across the GM health and care IT estate					
SR7	Significant systemic service disruption occurs as a result of cyber-attack moving quickly across the GM health and care IT estate	16	DSPT Additional IT System Wide Assurance:	DSPT Facilitate a BCP Exercise for Digital Data Centres Review	DSPT Remote Access Review Digital and Data Strategy Review
Principal Objective: SR8 Failure of NHS GM to deliver the Green Plan and consider and prepare for the impacts of climate change.					
SR8	Failure of NHS GM to maintain and deliver the Green Plan including the required carbon emissions reductions and failure to prepare for the impacts of climate change.	20		Delivery of the Green Plan	

NHS
Greater Manchester

Community Mental Health Teams, Independent review (Shanley)

May 2025

Part of Greater Manchester Integrated Care Partnership

Quality and Performance Committee

June 2025

Report information.

Required information.	Details.
Title of report.	Community Mental Health Teams Independent Review (Shanley)
Author.	Prof Sandeep Ranote, Clinical Director Mental Health, NHS GM Melissa Maguiness, Programme Director – Commissioning Development, NHS GM Rachel Farn, Head of Mental Health Clinical Effectiveness, NHS Gm
Presented by.	Prof Sandeep Ranote, Clinical Director, Mental Health, NHS GM
Contact for further information.	Rachel Farn, Head of Mental Health Clinicial Effectiveness, NHS GM

Executive summary.	In January 2024 the "*Independent Review of Greater Manchester Mental Health NHS Foundation Trust Final Report, January 2024 authored by Professor Oliver Shanley OBE"* [1]was published. Within the recommendations of the Shanley review there was a specific requirement which related to Community Mental health teams (CMHTs) *'As a second stage review, the Trust and its partners should identify together where and in which services further independent assurance is needed. We recommend that Community Mental Health Services are independently reviewed.'* In order to meet this recommendation NHS Greater Manchester (NHS GM) must commission an independent review which assesses the provision of CMHTs across Greater Manchester Mental Health Trust (GMMH), although it isn't specified to do this for the entire population it is recommended that we include CMHTs provided by Pennine Care Foundation Trust (PCFT) so that we learn from good practice, reduce unwarranted variation and strengthen the offer. The review of these services will be in line with themes identified in the Shanley Review. A service specification was previously presented to QPC which outlined the ask to independent providers. However, once this was considered by Niche (independent consultant for NHS organisations) it was apparent the proposal carried significant cost implications, and the suggested timelines were not conducive to the overarching Shanley action plan. In addition Niche that have since been selected to work with NHSE on a Mental Health system review and would be a conflict of interest. A revised terms of reference are presented for review by QPC. These are more specific

	to the Shanley report, with complete focus on Community Mental Health teams and key lines of inquiry have been set under five key themes aligned to Shanley. A desk top review methodology is suggested, alongside patient feedback focus groups and a staff survey. The review will be led by the Clinical Director, Mental Health as the senior responsible officer and a steering group has been set up for regular oversight. It is expected that the final report will be completed by 31st Aug 2025. QPC is asked to review and endorse the revised terms of reference.
The benefits that the population of Greater Manchester will experience.	Better quality and consistency of care through alignment with best practice More person-centred and responsive services shaped by patient and staff feedback. Improved equity and access by identifying and addressing local differences in service provision. Increased public confidence and accountability through independent oversight. learning from good practice and improving service design.
How health inequalities will be reduced in Greater Manchester's communities.	Reviewing consistency and reduce variation to address health inequalities. Reviewing the CMHT's ability to make adjustments for different groups.

[1] NHS England — Northwest » Independent review – Greater Manchester Mental Health NHS Foundation Trust

The decision to be made and/or input sought.	The Board / Committee is asked to: 1. Review the revised terms of reference 2. Approve the terms of reference
How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	Meeting the requirements of the Shanley Review.
Key milestones.	May 2025– Planning and procurement June – July 2025 – Gathering Data Aug 2025 – Evaluation and writing report Sep – Dec 2025 – Implementing actions from recommendations Jan – Mar 2026 – embedding and evaluating actions, shared learning
Leadership and governance arrangements.	SRO: Professor Sandeep Ranote Working group: CMHT independent review steering group Oversight: Mental Health Clinical Effectiveness Group, as a sub-group of GM Clinical effectiveness group Approval: Quality and Performance Committee
Engagement* to date. ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	Shanley report has wide ranging engagement CMHT review discussed at QPC and GM MHPG previously and wide engagement on the findings and the action plan will take place

Financial or Legal Implications	financial engagement and STAR process completed and approved.

Table 1: Information needed about the document and its purpose.

Public engagement	Clinical engagement	Sustainability impact	Financial advice	Legal advice	Conflicts of interest	Report accessibility
No	Yes	No	Yes	No	No	Yes

Table 2: Assurance needed about the document.

NHS
Greater Manchester

Terms of Reference
Independent Review of the Greater Manchester Community Mental Health Teams
May 2025 – draft

1. Introduction

In January 2024 the "*Independent Review of Greater Manchester Mental Health NHS Foundation Trust Final Report, January 2024 authored by Professor Oliver Shanley OBE"* [1]was published. This report will be referred to as the "Shanley review" throughout this document. Within the recommendations of the Shanley review there was a specific requirement which related to Community Mental health.

"Recommendation 9: We identified some common concerns across services we visited at the Trust, which were also prevalent within Edenfield. The Trust and the wider system must consider how they understand issues identified in these services (and others) in more detail, including through the actions described below

Bullet 4 under this recommendation is:

- *As a second stage review, the Trust and its partners should identify together where and in which services further independent assurance is needed. We recommend that Community Mental Health Services are independently reviewed."*

A decision to focus this recommendation on Community Mental Health Teams (CMHT's) has been made.

NHS Greater Manchester (NHS GM) will commission an independent review which assesses the provision of CMHTs, the review of these services will be in line with themes identified in the Shanley Review and measure the safety and effectiveness of the services against what is commissioned.

2. Purpose

- To conduct an independent review of CMHTs in in line with the themes identified in the Shanley review.
- To evaluate the quality and safety within these services, the experience of patients and staff and the effectiveness of care, particularly focused on the clinical voice and leadership.

[1] NHS England — Northwest » Independent review – Greater Manchester Mental Health NHS Foundation Trust

- To compare the service delivery of CMHTs against what is commissioned
- To develop and share with NHS GM the tool used for the review in Manchester so this can later be applied to review other CMHTs across GM for the purpose of quality improvement.

The Shanley review identified a number of key themes.

Six of these themes align with the operational and clinical practice of CMHTs and so will be in scope for review.

Table 1 below shows a summarised description of these themes.

Theme	**Summarised description from the Shanley Review**
The voice of patients, families, and carers.	There was a failure to listen to patients and families. The report highlights that patients lacked a meaningful voice in their care and in service transformation, families raising concerns about care and safety were often dismissed and there was no consistent mechanism for engaging families or carers in care or complaints processes.
Leadership	Shanley highlights failings in both clinical and operational leadership. Particularly that senior leaders failed to act on concerns or investigate further, that there was a lack of clinical oversight during decision making and the clinical voice was not always included in service improvement and quality improvement.
Culture	The Shanley review outline's themes relating to the culture of organisation. It describes a culture of prioritising its external reputation at the detriment to patient safety and a defensive attitude in response to concerns with little appetite for learning or reflection. Shanley describes this culture impacting on staff, making them afraid to raise concerns and

	in some cases when issues were raised being ignored for long periods of time. Staff described whistle blowing as career-limiting. Shanley also outlines a number of issues relating to discrimination in minority groups and a culture of bullying and exclusion toward these groups.
Workforce	Shanley describes chronic staffing shortages impacting on the ability to deliver safe care. The review particularly highlights a heavy reliance on agency staff, inadequate supervision and high vacancy and sickness rates creating an unmanageable workload.
Governance and Organisational Learning and responsiveness	Board-level governance lacked effective challenge and scrutiny. It is described that data on safety and incidents was not adequately scrutinised which led to a gap in oversight at board level, the absence of this data being used for improvement and leaders not being held accountable for failings over several years. In addition, the systems, and processes for learning from incidents and complaints were weak and the outputs from them not used to drive improvement.
Oversight	Shanley found that the organisations with responsibility for regulation, oversight and support to GMMH were not effective in identifying the issues found at Edenfield and makes recommendations to strengthen oversight and assurance processes.

3. Objectives

This review will evaluate the extent to which CMHTs are delivering effective care and supporting meaningful recovery and in line with what is commissioned by:

- Reviewing and identifying any gaps in service delivery compared to what is commissioned by NHS GM.
- Examining the patient and carer involvement and experience, in both care delivery and service design.
- Assessing the quality of leadership and governance structures.
- Exploring the current culture within the CMHT team, including equality and the processes for raising concerns.
- Reviewing current workforce capacity, skills, supervision, and support structures.
- Evaluating how reporting and investigation of incidents impacts on learning and quality improvement and how the governance serves the CMHT to ensure this remains at the forefront.

The review will

- Identify areas of good practice, gaps or areas requiring improvement.
- Provide clear, actionable recommendations to improve the effectiveness and impact of community mental health services for Greater Manchester service users, patients, and their families.
- Support a commissioner-led review of CMHT services across GM to inform a revised service specification with clear, measurable outcomes

In order to meet the objectives outlined above a desk top review approach will be utilised alongside patient and staff feedback. The review will focus solely on the outlined themes by reviewing services through set Key lines of Enquiry (KLOEs)

Note: More information re methods and a summary of the KLOEs is included in section 4 – Methodology

Note: The independent review will incur a financial cost in the region of £50K and the cost envelope will determine how many CMHT's can be independently reviewed:

Option 1 – One CMHT in Manchester locality and One CMHT in Oldham locality
Option 2 – One CMHT in Manchester locality
Option 3 – One CMHT in each of the ten localities

4. Methodology

The review will adopt mixed methods which will be primarily focussed on a desk top review approach, including:

- Document review (policies, audits, performance and quality reports, board reports, data) to include
    - Data analysis on a suite of metrics including number of referrals received, time to assessment, percentage accepted/rejected, re-referrals, subsequent deterioration (referral to HBTT/admission) and others in line with the service specification
- An audit of a sample of care notes from the electronic patient record
- A focus group for patients and carers in each CMHT and provide a thematic analysis of the feedback.
- Distribute an electronic survey to staff and produce an analysis of the responses.
- Distribute an electronic survey to stakeholders such as primary care and social care and produce an analysis of the responses

The CMHTs will be reviewed using the KLOEs set out in ***Table 2*** below.

Note: Some of the KLOEs link to more than one theme. Where this occurs, they're shown in each relevant section. The workplan in Appendix 4 brings these together and sets out the actions needed.

Theme	Key line of Enquiry	Method(s)
The voice of patients, families, and carers Key Focus: Patients have a meaningful voice in their care. Patients and carers feel able to feedback concerns and can expect this is acted upon.	Patients have a meaningful voice in their care	
	Are the voices of patients and carers heard, in care planning?	Document review – Care planning.
		Audit of care record – in line with the GMMH service user and engagement strategy

Patients and carers are treated with dignity and respect. The patient voice should be used to shape service improvement.		Patient / Carer Focus Group
	Are patients well informed about their medications, side effects, dose and monitoring and what to do if they have concerns?	Patient / Carer Focus Group
		Audit of care record
		Stakeholder survey
	Patients and Carers are able to feedback concerns	
	Do patients know how to raise concerns, and do they feel they will be listened too when they do? Are concerns recorded in the care record? Are staff aware of the complaints procedure and can they direct patients to use this when required?	Document review – complaints policy.
		Patient / Carer Focus Group
		Audit of care record
		Staff survey
	Patients are treated with dignity and respect	
	Do patients have access to an independent advocacy service if they are on a CTO?	Audit of Care record
		Document review – CTO processes
	Do patients and carers feel they are treated with dignity and respect?	Patient / Carer Focus Group
	Do staff adjust for people with communication, cultural, or learning needs?	Patient / Carer Focus Group
		Staff survey
		Audit of Care record

	Carers are treated with dignity and respect	
	Are carers offered assessments and signposted to support when required? Is this recorded in the care record?	Document review – Carers assessment performance and audit.
	Do carers assessments meet the criteria as per NICE guideline Supporting Adult carers [2]	Patient / Carer Focus Group
		Audit of care record
	Is patient and stakeholder feedback used to shape service and quality improvement? Can staff describe these mechanisms?	Patient / Carer Focus Group
		Staff survey
		Stakeholder survey
Leadership Key Focus: Clinical Leaders should play a leading role in oversight and decision making relating to care and risk. The MDT approach must include senior clinical voices and system wide working should be evident. The clinical voice should be integral to quality and service improvement	Clinical Leadership in Care	
	Is there a responsible clinician and care co-ordinator allocated?	Document review – CMHT process.
		Audit of care record
		Staff survey
	Are clinical leaders visible in the MDT and care planning processes?	Audit of Care record
	Do risk and escalation processes include adequate pathways for senior clinical oversight and is this effective?	Document review – Risk management policy, Audits.

[2] Overview | Supporting adult carers | Guidance | NICE

		Audit of Care record
		Staff survey
	Clinical Leadership and quality improvement	
	Is clinical leadership visible and respected within teams?	Staff survey
	Are there mechanisms for clinical leaders to influence service and quality improvement?	Document review – Governance.
		Staff survey
Culture Key Focus: Staff feel safe at work. Staff can speak up. All staff are treated fairly and equitably. Patients feel safe in the environment and their care.	Staff feel safe	
	Do staff feel safe at work?	Responses from staff survey
	Staff can speak up	
	Is the freedom to speak up policy accessible and well socialised with staff? Do staff feel safe to use it? Is feedback provided to staff relating to any concerns? Are staff aware of themes from staff feedback?	Document review – whistleblowing and freedom to speak up. Responses from staff survey
	Staff are treated equitably and fairly	
	Are team meetings in place and communication methods accessible to all staff?	Document review – team meeting minutes or evidence.
		Staff Survey
	Is there evidence of bullying, discrimination, or inequity in staff experience?	Document review – most recent national staff survey results.

	Have staff received any support or training relating to discrimination and inequity?	Staff survey
	Patients feel safe	
	Do patients feel safe?	Feedback from patients / carers
	Do staff have a good understanding of safeguarding procedures?	Document review – Safeguarding procedures and SG1 incident records.
		Staff survey
Workforce Key Focus: Staff have workloads they can manage. Staff are adequately trained and given opportunities for development. The organisation supports staff to manage their wellbeing.	Staff have manageable workloads	
	Does the CMHT have adequate staff skills that include community psychiatric nurses, social workers, occupational therapists, clinical psychologists, medical staff (including a consultant psychiatrist),mental health support workers and administrative staff plus Peer Mentors? Is data on staffing levels and staff skill mix monitored and acted upon?	Document review – staff lists and structures in line with the community mental health framework NHS England » The community mental health framework for adults and older adults Document review - Safe staffing data and reports. Document review – Current caseload data to include demographics and reasons for movements
	Do patients think there are enough staff to meet the needs? Are caseloads manageable?	Staff Survey
	Are caseloads adjusted based upon complexity and factors such as local demographics and availability of other functional teams to support patients?	Patient / Carer Focus Group

	Is the caseload managed as a team caseload and are systems in place to ensure adequate throughput, with cover provided for staff for time off work?	Audit of care records
	Staff are adequately trained, and supervision is in place	
	Do staff have protected time to meet training requirements?	Document review – mandatory training logs. Responses from staff survey
	Are appraisals up to date and regular supervision provided?	Document review – Appraisal completion data. Responses from staff survey
	Staff wellbeing	
	How is staff wellbeing addressed?	Document review – policies to address staff wellbeing and available resources. Responses from staff survey
Governance and Organisational Learning and responsiveness Key Focus: Incident processes and learning are effective and embedded in culture. Governance and visible oversight are in place and staff	Incident reporting	
	Are incidents recorded and investigated in line with the policy? [3]	Document review – incident data and improvement plans. Responses from staff survey
	Can staff describe the themes from incidents and complaints relating to their service as well as the patient safety priorities	Document review – PSIRF plan and governance.

[3] NHS England » Patient safety incident response framework and supporting guidance

and patients are aware of it.	outlined in the PSIRF plan? Are they aware of how these themes are being addressed? How do they feel about the priority of improvements?	 Responses from staff survey
	Are patients and carers aware of safety themes from incidents? Do they know what improvements are being made?	Patient / Carer Focus Group
	How are lessons learned from previous incidents applied?	Document review – Audit schedule and reports
	Governance	
	Is there effective oversight of oversight of safety, quality, and workforce culture? Do staff feel governance and oversight is pro-active or reactive?	Document review – board reports and minutes. Responses from staff survey
Oversight of service delivery Key Focus: Does the service deliver in line with the service specification commissioned?	Oversight of Assessment processes	
	Are service users assessed for a severe mental health need that prioritises vulnerability, distress and risk and does the assessment process have robust arrangements for acceptance into service?	Document review – Referral and triage procedures Assessment tool

Are assessment processes, care delivery and discharge / transition processes in line with best practice? Is there evidence of clinical leadership and oversight in care? Is there evidence of patient and carer engagement within care?	Is there evidence of flexibility to make positive risk decisions with the safety of employees, service users and carers at the centre in assessment?	Audit of Care Record
	Oversight of Care delivery	

	Is there a responsible clinician and care co-ordinator allocated? Is there evidence of effective co -ordination of care including regular review in line with the community mental health framework? Are patients clustered based on their risk and is this reviewed using an MDT approach with senior clinical oversight? Is there evidence of (bio-psychosocial) interventions including psychological therapies, physical health care, medication management, activities of daily living assessment, access to employment and education preparation and provision, family and carer help, support and specific family-based interventions [4]treatment of substance misuse, relapse prevention and interventions to improve concordance with treatment plans, and crisis management planning? Is the service competent in interventions that are sensitive to ethnicity, culture, gender, religion, age and sexuality? Is the Mental Health Act being used appropriately?	Document review - Clustering Tool / Zoning Process MHA Training records and policy Care planning policy CMHT processes / service spec IT Access reports for care record

[4] Quality statement 3: Family intervention | Psychosis and schizophrenia in adults | Quality standards | NICE

	When patients are admitted to inpatient care do care coordinators maintain active involvement in care? When patients are being discharged from inpatient settings back into the community is their evidence that the CMHT, and patients / Carers are involved in the discharge planning process as per the *Parliamentary and Health Service Ombudsman report "Discharge from mental health care: making it safe and patient-centred"*.[5] Is there visible evidence of sharing information and Joint working with primary care, social care, and other services? Including providing advice and guidance where required? Do staff use the GM shared care record to inform clinical care planning? Are the voices of patients and carers heard, in care planning? Are patients well informed about their medications, side effects, dose and monitoring and what to do if they have concerns?	Audit of Care records Staff survey Patient / Carer Focus Group Stakeholder Survey
	Oversight of discharge processes	

[5] Discharge from mental health care making it safe and patient-centred_10.pdf (ombudsman.org.uk)

	Is there robust evidence of discharge planning with engagement with primary care, social care and VCSE and the service user and their carers ? Is there evidence that transition is managed in line with NICE guidance [6]	Document review – discharge processes.
		Audit of Care records
		Stakeholder Survey
	Service performance	
	Is the service meeting its performance targets as per the NHS standard contract? (in line with the data analysis as presented in the methodology and scope) Is there an audit cycle in place and is it adhered to?	Document review – Current Performance and trends over the past 3 years (pre Shanley, during post) Audit cycle and evidence of audit
	Oversight	
	Is the information relating to performance regularly shared with commissioners and what are the mechanisms?	Document review – Reports, meeting minutes
		Stakeholder survey

[6] Overview | Transition from children's to adults' services for young people using health or social care services | Guidance | NICE

A draft work plan outlining the requirements to meet this KLOEs can be found at Appendix 1.

5. Scope

- The review will focus on Adult Community Mental Health Teams and should consider core services, their patients, and staff including.
    - Core contracted and commissioned Community Mental Health teams.
    - Over 18 services (including older peoples)
    - S75 arrangements in place
    - Dual Diagnosis pathways in and out of CMHT
    - Secondary psychological
    - Assertive outreach
    - EIT pathways in and out of CMHT
    - Complex Emotional Relation Need Pathways in CMHT

- The independent review will incur a financial cost in the region of £50K and the cost envelope will determine how many CMHT's can be independently reviewed:

    - Option 1 – One CMHT in Manchester locality and One CMHT in Oldham locality
    - Option 2 – One CMHT in Manchester locality
    - Option 3 – One CMHT in each of the ten localities

- The final review tool and methodology will be shared with NHS GM so it can be replicated afterwards as a self-assessment tool in all 10 localities to support quality improvement and peer collaboration and learning.

- Six methods of review will take place for each CMHT.
    - 1 patient and carer focus group and evaluation of the responses.
    - A review of documents and policies relating to the themes
    - 1 staff survey sent to all staff and evaluation of the responses.
    - 1 stakeholder survey and evaluation of the responses.
    - An evaluation and audit of care records randomly selected.
    - Data analysis on a suite of metrics including number of referrals received, time to assessment, percentage accepted/rejected, re-referrals, subsequent deterioration (referral to HBTT/admission) and others in line with the service specification.

- Areas of enquiry will be in line with the KLOEs outlined in *section 4 -methodology*.

6. Governance, Reporting and Output

The review will be tracked and managed through its stages using a comprehensive project plan, held by a dedicated task and finish group to include representation from:

- Clinical Director, Mental Health (SRO, Chair)
- Programme Director
- Head of Mental Health Clinical Effectiveness
- Assistant Director, Adult Community
- Programme Manager, Adult Community
- Clinical Care Professional lead (CCPL) Adult Community
- Deputy Chief Nursing Officer, NHS GM
- Contracts / Procurement representation
- Lived experience, service user / carer representation.
- Provider (Greater Manchester Mental health and Pennine Care) representation (as required)
- Independent review provider representation (as required)

- The review will be part of the Mental Health Programme team workplan within the remit of Clinical Effectiveness and Governance and in collaboration with the Community Mental Health transformation plan.
- The Senior responsible officer (SRO) for the review is : Prof Sandeep Ranote, Clinical Director, Mental Health, NHS GM
- Support from the Senior Mental Health Team will be provided by: Melissa Maguiness, Programme Director – Commissioning Development, NHS GM
- Interim findings and progress throughout the review should be shared at agreed touch points with the SRO at the task and finish group. This is essential to ensure that the interim findings from the review are shared to inform the community transformation framework and development of the GM CMHT service specification which is being developed in parallel.
- A final report will include findings, thematic analysis, and evidence-based recommendations aligned with the KLOEs and Shanley review themes.
    - Recommendations should be made at all three spatial levels of the system, Provider, Place and System and displayed as such in the final report.
- The final report will be presented at the following NHS GM meetings.

- Mental Health Clinical Effectiveness Group (with an update to GM Clinical Effectiveness Group as required)
- Adult Community Group
- Mental Health Partnership Group
- Quality & Performance Committee

- Touch points updates and the final report will be shared with both PCFT and GMMH and must be presented through the internal trust governance as part of their response to the Shanley Review.

7. Timeline

The timeline specified below provides a high-level estimate, a detailed timeline will be included in the project plan.

- Preparation : Friday 2nd May 2025 – 26th May 2025
- Planning: Monday 26th May – 13th June 2025
- Review Commences w/c 20th June 2025
- Draft findings / touch point with review team: W/c 14th Jul 2025 (*note: further reviews may be requested)*
- Review Concludes W/c 25th Aug 2025
- Final report and recommendations: w/c 29th Sep 2025
- Socialisation and Governance: Oct 2025

8. Appendices

Appendix 1 – Draft workplan for the CMHT review:

Action	**Purpose of reviewing**	**Information Required**
Document Review	To ensure documents are fit for purpose and in line with national best practice and guidelines. To review if documents are	Data analysis on a suite of metrics including number of referrals received, time to assessment, percentage accepted/rejected, re-referrals, subsequent deterioration (referral to HBTT/admission) and

	accessible and used by staff. To evidence performance	others in line with the service specification.
		Audit Schedule for CMHT (team specific)
		Care Planning Policy
		GMMH Service user and engagement strategy
		Complaints and feedback policy
		Core CMHT Spec and policy.
		Community treatment order policy
		Carers Assessments / Audits
		Risk Management and Escalation policy.
		Governance structure
		Freedom to speak up / Whistle blowing policy.
		Safeguarding policy
		CMHT team meeting agenda and minutes
		PSIRF plan and governance
		National staff survey results (team specific)
		Caseload Data
		Mandatory Training data
		Safe staffing / Skill Mix data
		Incident data and themes
		Appraisal completion data.
		board reports and minutes.
		Referral and triage procedures

		Assessment tool
		Clustering Tool / Zoning Process
		MHA Training records and policy
		IT Access reports for GM shared care record
		discharge processes
		Document review – Current Performance and trends over the past 3 years
Care Plan review	To review individual care record to establish evidence of factors relating to the KLOES	Is there evidence within the record of: Patient and Carer voice engagement in the care plan Carers assessments considered / offered. A responsible clinician and / or Care -coordinator allocated. Evidence of a risk plan with senior clinical oversight Evidence of escalation to a senior clinician should it be required. Evidence of a senior clinician in the MDT process Evidence of liaison with primary care, social care, or other agencies
Staff survey	An electronic survey is sent to staff and responses analysed	The survey should cover: Staff understanding of **(note: suggested questions provided)** • Complaints procedure • Incident procedure • Safeguarding procedure • GM Shared Care record and working with other agencies. • How themes are addressed • How patient feedback is used to make improvements. The way staff feel about.

		• If senior clinical input is visible and respected • If escalation pathways are in place and if they get the right level of senior clinician support • If the clinical voice influences improvements • If they are equipped to adjust meet the needs of people with cultural, learning, or additional needs. • The trust governance and if it is pro-active or reactive. Are staff receiving. • Regular team meetings • Appraisals • Mandatory training • Additional training particularly relating to equality and discrimination. In relation to their wellbeing. • Do they feel safe at work. • Do they feel safe to speak up. • Can they access the trust resources relating to wellbeing? • Can they manage their workload / case load? • Are they happy with the work -life balance?
Patient focus group	A focus group is held, and responses analysed	Patients and carers should feedback on: **(note: suggested questions provided)** • Involvement in care planning • Their Understanding of Medications and how to raise concerns. • How they raise concerns

		• If they feel valued and listened to • If they are treated with dignity and respect • If adjustments were made for them as required • Were carers assessments offered / carers supported? • How they feel about staffing levels • If they are aware of any improvements that have been made relating to feedback
Stakeholder Survey	An electronic survey is sent to stakeholder and responses analysed	Stakeholders should feedback on: • Medicines management • Quality improvement outputs • Engagement MDT

Appendix 2 – Full List of Greater Manchester CMHT's, Manchester and Oldham CMHT's are highlighted in red.

Locality / Provider	**Team name**
Bury / PCFT	Bury community mental health service
HMR / PCFT	Hanson Corner - Heywood and Middleton community mental health team
Oldham / PCFT	Oldham Community Mental Health Team – East
Rochdale / PCFT	Rochdale East Community Mental Health team
Rochdale / PCFT	Rochdale West Community Mental Health team
Stockport / PCFT	Stockport West community mental health team / Councillor Lane Resource Centre

Stockport / PCFT	Stockport community mental health team east - Baker Street
Tameside and Glossop / PCFT	North community mental health team – covers Ashton and Stalybridge
Tameside and Glossop / PCFT	South community mental health team – covers Hyde and Glossop
Tameside and Glossop / PCFT	West community mental health team – covers Denton, Dukinfield and Audenshaw.
Bolton / GMMH	Bolton South functional team
Bolton / GMMH	Bolton North functional team
Bolton / GMMH	Bolton assessment team
Manchester / GMMH	Central West CMHT
Manchester / GMMH	Mersey South CMHT
Manchester / GMMH	Mersey North CMHT
Manchester / GMMH	Central East CMHT
Manchester / GMMH	North East CMHT

Manchester / GMMH	North West CMHT
Salford / GMMH	Prescott House CMHT
Salford / GMMH	Cromwell House CMHT
Salford / GMMH	Ramsgate House CMHT
Trafford / GMMH	North CMHT
Trafford / GMMH	West CMHT
Trafford / GMMH	South CMHT
Trafford / GMMH	Central CMHT

NHS
Greater Manchester

Clinical Risk Review

Part of Greater Manchester Integrated Care Partnership

Kate Provan

30 April 2025

Quality and Performance Committee

June 2025

Required information	Details
Title of report	Chief Medical Officer Report
Author	Kate Provan, Associate Director of Clinical Effectiveness, and Improvement
Presented by	Professor Manisha Kumar, Chief Medical Officer, NHS GM
Contact for further information	Kate.provan@nhs.net
Executive Summary	This report resents a desktop review of emerging clinical risks and sets out a proposal for undertaking a system risk review following the principles for system risk assessment withing the National Quality Board Guidance NHS England » Principles for assessing and managing risks across integrated care systems
The benefits that the population of Greater Manchester will experience.	Oversight and relevant improvement work in relation to NHS GM commissioned services benefits the GM population through continuous improvement in services, targeted quality improvement where indicated, and overall improvement in experience.
How health inequalities will be reduced in Greater Manchester's communities.	The report focuses on key areas of work aligned to the statutory duties and accountabilities of NHS GM and the strategy of the ICP.
The decision to be made and/or input sought	The Quality and Performance Committee are asked to note the desktop clinical risk review and support the proposed desktop review of 1-2 areas of clinical risk at system level.
How this supports the delivery of the strategy and mitigates the BAF risks	The areas within this report and progress made to improve these relate to BAF risk SR5

Required information	Details
Key milestones	These are set out within the different sections of the report.
Leadership and governance arrangements	This paper is produced for Quality and Performance Committee and has not been elsewhere but is formulated from intelligence and papers from NHS GM Clinical Effectiveness and Governance Groups (and related subgroups) and the NHS GM Mental Health Partnership Group
Engagement* to date ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	There has been no formal engagement on this paper as this paper is produced for Quality and Performance Committee and has not been elsewhere. The intelligence and papers used to formulate this report have come from the NHS GM Clinical Effectiveness and Governance Groups (and related subgroups) and the NHS GM Mental Health Partnership Group
Financial or Legal Implications;	There is currently work ongoing across the ICB in relation to planning for 2025/2026. The portfolio of work that sits under the Chief Medical Officer has been reviewed in relation to financial pressures, risks and opportunities and is being reported into the appropriate governance bi-weekly at present. Some of the outcomes of discussions around this may impact on programmes of work, this will be highlighted in this report as this progresses.

Public engagement	Clinical engagement	Sustainability impact	Financial advice	Legal advice	Conflicts of Interest	Report accessible
N	Y	N	N	N	N	Y

Table 2 - checklist of engagement carried out, advice sought, conflict of interest and accessibility of report

Background

In 2025/26 a risk review of clinical risks is being undertaken in the context of the three shifts, NHS reform, the 25/26 Operational Planning Guidance and the six shifts to strategic commissioning. NHS Reform brings with it significant financial pressures and potential capacity issues in workforce in 2025/26 - this means that at all levels of the system we will need to prioritise programmes of work potentially pausing or decommissioning services and potentially reducing/stopping investment. This is alongside making reductions in our running costs. We have a responsibility throughout this to keep our patients safe and continue to improve clinical outcomes.

We are undertaking this because we know that when we have significant change in the NHS either at provider, locality or system level this comes with risks to patient safety and clinical outcomes.

To kick this off we have started with a desktop review of NHS Trust and ICB Board papers, looking at risk in general and a BAF risk review. We are bringing this here today as the start of an engagement process with the ambition creating better connectively to enable us to identify, mitigate and mange clinical risks that impact on patient safety and clinical outcomes as we move through this period of change.

What we have in place already:

1. The development of a framework of Clinical Governance for complex systems (currently in final draft stages). This is a joint piece of work with the Royal College of Physicians Edinburgh. The framework will support the clinical voice , risk identification and provide tools to improve confidence, training and education in clinical risk.
2. A robust EQIA approach is in place within NHS GM with clinical oversight
3. Close working with trust Exec MDs and assurance on Trust Provider Clinical risk.
4. The TOR and remit of Primary Care Secondary Care GM interface forum has been widened to include clinical areas where we require a cross-system view. Membership includes representation from all Trust providers , Locality Commissioning Lead clinicians , Pan GM Clinical leads and Primary Care provider leads including the LMC. Early identification of impact across borders is encouraged
5. Quarterly System Mortality group in place and is well attended

Initial desktop review

NHS Greater Manchester

Emerging areas of clinical risk:

- The need to strengthen the Clinical Leadership risks on the risk register- potentially adding in specific speciality and service areas
- The need to incorporate specialist commissioning clinical risks within the review
- As a result of the NHSE DHSC integration programme and financial efficiencies national and in GM there is a risk that capacity of staff may be impacted along with financial support to implement quality improvement work at system and provider level across portfolios of work led by the Strategic Clinical Networks. Further work is needed to quantify this risk.
- Safety within accident and emergency departments (following intelligence from ICB Nursing and Quality Directorate quality walk-rounds of the NHS Trust departments)
- Digital clinical safety (this is described as a risk within Board papers of every NHS Trust)
- Specific services where there is a rapid quality review underway that is impacting across the whole system (for example paediatric audiology)
- Out of area placements as a system, provider and locality risk
- Enhancement of Perinatal and Parent Infant Mental Health Services to meet population needs and national targets (indicated by a cluster of serious incidents)
- Research (this is described as a risk within Board papers and of every NHS Trust and is also described within board assurance frameworks)
- Areas relating to LTC management (such as adequate weight management provision at all levels in line with national guidance)
- Reducing unwarranted variation (risk being developed at ICB level and present in NHS Trust Board papers across GM)
- Maternity services risks (this is described as a risk within Board papers of every NHS Trust)
- Oversight and grip of quality and safety in relation to NHS Reform, the model ICB and the three shifts

Board Assurance Framework Review

General:
Publication date varies with oldest published in July 2024, and the most recent in April 2025 (8 out of 10 published in 2025). The language/terms used differs widely across the BAFs, as does format.

With the wider Board paper review- 4 out of 7 Trusts used the alert, advise, assure format

Groupings of strategic objectives and principal risks were done under the following categories:

- Quality
- Workforce
- Performance
- Finance
- Partnerships
- Sustainability
- Research and Innovation

Appendix 1 and 2 sets out the strategic objectives and principal risks grouped under these categories.

National Quality Board Principles for assessing and managing risks across integrated care systems

NHS Greater Manchester

This guidance has been put in place to answer these questions:

- do we have a sufficiently good understanding of the risk profile and mitigating actions within and across our organisations, pathways, services and places or are there emerging risks that are not being addressed?
- are all staff clear and sighted on the organisation and local system approach to risk sharing and what that means for individual staff and staff groups?
- how do we best work together as organisations across a place, integrated care system and Partnership to manage risks?
- how do risks across the pathway/organisations in our system aggregate and interrelate to impact on the overall summarised risk profile presented?

It is important to consider risks from the perspective of different organisational/outcome lenses to understand connectivity and where resources should best be applied, and to support decision-making in rapidly changing and multi-factorial situations where collaborative solutions may be required to achieve a risk reduction across the system.

If a risk meets the criteria as set out in the right-hand side of the table opposite, then use of the NQB guidance should be considered.

Although the guidance has principles to work to and examples- it does not have a guide on how you would go about undertaking a system risk assessment which could be seen as a barrier or an opportunity for us to develop a methodology that works for us.

Standard risk	**Risk in multi-factorial, fast changing environments**
Usually simple risks based on linear cause and effect	Reflective of a changeable set of internal/environmental states – often speculative
More easily predictable and therefore assessable	Less easily predictable and more complicated to assess
Tends to support risk trajectory from high towards low	When viewed from different perspectives; concludes a least worse/best possible option, which may not reduce all risks
A single risk, within the remit of a single team, department or organisation	Risk within a system or network, with recognised connectivity and contagion
Based on historical knowledge/patterns	Can be unpredictable and often unknown/novel conditions
Commonly the factors used in corporate risk assessments	Commonly associated with unknown situations or emerging information
Assessment requires a variation from a set of known baseline conditions.	Requires assessment of a number of interconnecting factors (e.g. pathways, organisations, time). Determines the reasonably practicable measures to be taken.

Examples of the NQB risk assessment

NHS Greater Manchester

Improving Ambulance Handover

The Risk	Setting	Safety	Experience	Workforce	Regulation
Primary care team with patient awaiting ambulance	Primary care	2x3=6	2x3=6	3x5=15	
Ambulance response time – 999	Pre-hospital	5x5=25			
Ambulance to hospital – queuing and handover		5x5=25			
Trust – queuing and decision to admit delays	ED	4x4=16	4x5=20	3x5=15	4x3=12
Boarding to wards	Wards	3x3=9	3x4=12	4x3=12	3x3=9
Single room 'doubling up'		2x3=6	3x4=12	4x3=12	4x3=12
Escalation areas		2x3=6	3x4=12	4x3=12	3x3=9
Infection control (outbreak)	Inpatient outcomes	4x2=8	3x3=9	3x3=9	3x3=9
No Criteria to Reside		4x4=16	2x5=10	3x4=12	1x3=3
Elective Care Backlog	Responsive patient outcomes	3x3=9	3x5=15	2x4=8	3x4=12
Cancer Backlog		3x4=12	4x4=16	2x4=8	3x4=12

Known risk factors for closed cultures in mental health hospitals, which can lead to breaches of people's human rights, including patient abuse.

The Risk	Setting	Safety	Experience	Workforce	Regulation
High number of people involved with limited quality oversight	Hospital	3 x 4 =12	3 x 4 =12	2 x 5 =10	3 x 4 =12
A provider left without a CQC registration		2 x 5=10	2 x 5=10	2 x 5 =10	2 x 5 =10
Placement in another hospital setting with the same risk factors, without considering more therapeutic alternatives	Hospital	4 x 5=20	4 x 4=16	4 x 4=16	4 x 3 =12
Lack of community providers to support discharge, resulting in people being overly restricted		4 x5=20	4 x 5=20	4 x 4=16	
Discharge plans impacted by sudden closure	Person	4 x 4=16	4 x 4=16	4 x 3=12	4 x 3=12
Increase in use of inappropriate hospital areas (such as A&E/MH acute wards) as a knock-on impact	Hospital	4 x 3=12	4 x 3=12	4 x 3=12	
Increase in levels of patient distress due to lack of psychological safety around quick move	Next setting	4 x 4=16	4 x 5=20	4 x 4=16	4 x 3 =12

Next steps

As we move into a time of significant change it is important we have a close grip on clinical risks from a system perspective, in terms of the emerging areas of clinical risk we need to challenge ourselves as to if we can answer the following questions:

- do we have a sufficiently good understanding of the risk profile and mitigating actions within and across our organisations, pathways, services and places or are there emerging risks that are not being addressed?
- are all staff clear and sighted on the organisation and local system approach to risk sharing and what that means for individual staff and staff groups?
- how do we best work together as organisations across a place, integrated care system and Partnership to manage risks?
- how do risks across the pathway/organisations in our system aggregate and interrelate to impact on the overall summarised risk profile presented?

It is proposed we establish a small task and finish group and potentially look at 1-2 areas of clinical risk and approach this utilising the NQB principles, with the aim of addressing the four questions above. We would propose that we start with clinical leadership capacity and capability in relation to NHS Reform, the model ICB and the three shifts.

In addition to this the NQB principles could also be used where we identify a new area of clinical risk to support assessment and management or to support programmes of work to help target areas of highest risk. This could be an area for further development and consideration.

NHS England » Principles for assessing and managing risks across integrated care systems

The Committee are asked to note the desktop review of areas of emerging clinical risk (including the BAF review) and support a small, time limited task and finish group to look at 2 key areas through using the NQB principles.

Appendix 1-Strategic objectives-1

	GMICB	Bolton FT	Christies	MFT	NCA	Stockport FT	Tameside FT	WWL	GMMH	PCFT
Quality	4. Help people to stay well and detect illness earlier	Improving care, transforming lives	To demonstrate excellent and equitable clinical outcomes and patient safety, patient experience and clinical effectiveness for those patients living with and beyond cancer	2. Provide high quality, safe care with excellent outcomes and experience	Ambition: Improving Quality – safety, experience, and outcomes	1. Deliver personalised, safe and caring services	1. Deliver personalised, safe and caring services	Patients: To be widely recognised for delivering safe, personalised and compassionate care, leading to excellent outcomes and patient experience	1.Work with service users and carers to achieve their goals by delivering high quality care	1. Outstanding Care
Workforce	5. Supporting our workforce and carers	A great place to work		3. Be the place where people enjoy working, learning and building a career	Ambition: Caring for and Inspiring Our People	4.Develop a diverse, talented and motivated workforce to meet future service and user needs	4.Develop a diverse, talented and motivated workforce to meet future service and user needs	People: To ensure wellbeing and motivation at work and to minimise workplace stress	2. Create an outstanding place to work, ensuring staff feel valued and are supported to reach their potential	2. Great place to work

Appendix 1-Strategic objectives-2

	GMICB	Bolton	Christies	MFT	NAC	Stockport	Tameside	WWL	GMMH	PCFT
Performance	2. Recover core health and care services 7. Meet our statutory obligations	A high performing productive organisation	To maintain excellent operational, quality and financial performance		Ambition: Improving Performance – meeting and exceeding standards			Performance: To consistently deliver efficient, effective and equitable patient care		
Finance	5. Achieve Financial sustainability				Ambition: Financial Sustainability of NCA and our Places	6. Use our resources efficiently and effectively	6. Use our resources efficiently and effectively		5. Be a sustainable, well-led organisation that delivers social value	
Sustainability		An organisation that's fit for the future	To promote equality, diversity & sustainability through our system leadership for cancer care	4. Ensure value for our patients and communities by making the best use of resources	Ambition: Supporting Social and Economic Development in all our Places	7. Develop our estate and digital infrastructure to meet service and user needs	7. Develop our estate and digital infrastructure to meet service and user needs			

Appendix 1-Strategic objectives-3

	GMICB	Bolton	Christies	MFT	NCA	Stockport	Tameside	WWL	GMMH	PCFT
Partnerships	1. Strengthen our communities 3. Help people get into, and stay in, good work	A positive partner		1. Work with partners to help people live longer, healthier lives	Ambition: Improving Population Health in all our places, working with partners	2. Support the health and wellbeing needs of our community and colleagues 3. Develop effective partnerships to address health and wellbeing inequalities	2. Support the health and wellbeing needs of our community and colleagues 3. Develop effective partnerships to address health and wellbeing inequalities	Partnerships: To improve the lives of our community, working with our partners across the Wigan Borough and Greater Manchester	4.Work in partnership with others to improve wellbeing and challenge stigma	3. Listening to improve
Research and Innovation			To be an international leader in research and innovation which leads to direct patient benefits at all stages of the cancer journey. To be an international leader in professional and public cancer education	5. Deliver world-class research and innovation that improves people's lives		5. Drive service improvement through high quality research, innovation and transformation	5. Drive service improvement through high quality research, innovation and transformation		3. Continuously improve services for users through research, innovation and digital technology	

Appendix 2 BAF Risks- Quality

ICB	There is a risk of failure to comply with our statutory duties for quality assurance in Quality and Patient Safety within the NHS GM system
Bolton	If the Trust does not provide safe, high-quality, and effective patient care, then overall experience of care may be adversely affected resulting in poor clinical outcomes, an inability to meet patients' evolving needs, increased health inequalities, and unsustainable services
	If the trust does not deliver high quality, safe and effective care to patients then everyone will not have a positive experience of our care resulting in an inability to learn from experience, poor clinical outcomes and unsustainable services
Christies	If we do not maintain an awareness of and respond to changing statutory and legal requirements there is a risk that we will fail to comply leading to being sanctioned for being in regulatory or statutory breach.
	f the CQC or other regulatory body changes their approach to regulation there is a risk that we will not be able to demonstrate compliance leading to us being assessed as not meeting the fundamental care standards
	If we are unable to fully implement the new Patient Safety Incident Response Framework (PSIRF) there is a risk that we will miss opportunities to learn lessons and improve patient safety leading to preventable patient harm.
	If there are changes to NICE guidance or other advances in practice that we have not anticipated (diagnostic, therapeutic, care) there is a risk that there will be a delay in their introduction leading to a delay in patients obtaining the benefits of new treatments.
MFT	Failure to maintain essential standards of quality, safety, and patient experience
NCA	IF we fail to identify, act and respond to quality standard and quality system failures THEN we will not achieve CQC and national best practice outcomes and deliver on our Vision of Saving and Improving Lives
	IF our maternity services do not meet safety standards and outcomes for mothers and babies THEN avoidable harm will occur and colleague satisfaction adversely impacted
Stockport	There is a risk that the Trust does not deliver high quality of care to service users, which may lead to suboptimal patient safety, effectiveness and/or experience and failure to meet regulatory standards
Tameside	Failure to maintain standards of quality and safety and to assess and monitor the quality-of-service provision and evidence the quality of services
	Failure to ensure personalised care, patient experience, patient/user involvement and provide appropriate structures for communication between service users and Board
	Failure to safeguard people who use services from abuse - Adults & Children, New-born and Unborn
WWL	Sepsis Recognition, Screening and Management: There is a risk of the under diagnosing of patients with Sepsis, due to Health Care Professionals failing to recognise Sepsis in the deteriorating patient, which may result in patients not receiving Sepsis 6 treatment within one hour of triggering for Sepsis.
	Harm Free Care - Avoidable Pressure ulcers: There is a risk that our systems and processes, coupled with challenged staffing, may not facilitate the swift identification of potentially avoidable pressure ulcers resulting in harm to our patients.
	Complaint response rates: There is a risk that complaints received may not be responded to and acted upon within our agreed timeframes, due to operational pressures, resulting in missed targets, unresolved complaints and adverse publicity.
GMMH	If we fail to deliver high quality, safe and effective care, then we could have incidents of avoidable patient harm, poor clinical outcomes, poor patient experience and risk further reputational harm or regulatory oversight.
PCFT	Failure to provide safe healthcare

Appendix 2 BAF Risks- Workforce

ICB	Workforce gaps (including resource, capacity, capability & leadership) limit the system's ability to plan for a future sustainable workforce.
Bolton	If the Trust does not invest in its staff or support them to develop their skills, then it will be unable to recruit, retain and support staff to maximise their potential
Christies	If we are unable to maintain current levels of skilled staff there is a risk that they will not have the time or expertise required for excellent care and communication leading to a reduction in the standards of patient safety and experience.
	If our response to the cultural audit is insufficient there is a risk that a negative culture will persist in some specific parts of our organisation leading to an increase in the number of staff reporting a poor experience
MFT	Failure to effectively address issues affecting staff experience
	Failure to effectively plan for, recruit, and retain a diverse workforce with the right skills
NCA	IF all of our people and our leaders do not continuously invest in and demonstrate our values of care, inspire and appreciate THEN we will not create an inclusive and equitable culture for colleagues and patients
	IF all of our leaders are not trained and developed in line with their roles and accountabilities THEN we will fail to deliver on the changes needed to achieve our all of our Board objectives
Stockport	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing, leading to low morale, higher turnover & sickness absence and gaps in the workforce that may impact on delivery of high-quality care
	There is a risk that the Trust's workforce is not reflective of the communities served and staff with a protected characteristic having a suboptimal staff experience (career progression, turnover) which may lead to a poorer patient experience.
	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit & retain the optimal number of staff, with appropriate skills and values, which may lead to suboptimal staff and patient experience.
Tameside	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing, leading to low morale, higher turnover and sickness absence and gaps in the workforce that may impact on the delivery of high-quality care
	There is a risk that the Trust's workforce is not reflective of the communities served and staff with a protected characteristic having a sub optimal staff experience (career progression, turnover) which may lead to a poorer patient experience.
	There is a risk of not delivering an educational programme, that makes sure we have people who are adequately trained, with mandatory and essential skills, and receiving a good standard of educational/experience for trainees.
WWL	There is a risk that we may not deliver the workforce sustainability agenda objective, due to issues with staff retention and keeping colleagues well in work, that may result in an increase in sickness absence, vacancies, time to hire challenges and an increase in employee relations cases.
	There is a risk that we may not deliver the cultural development agenda objective, due to a lack of staff engagement and low morale.
	The Trust has taken significant steps to fill ongoing qualified nursing gaps through the recruitment of over 405 internationally educated nurses. There is a risk that we will not retain this valued workforce. Feedback received highlights that colleagues who have been educated internationally have a negative work experience. The Trust also reports less positively with our Disabled workforce
GMMH	If we fail to recruit and retain a sufficient, appropriately skilled and diverse workforce, then this will impact negatively on patient safety, care and experience and staff safety, wellbeing and morale
PCFT	Competition for staff

Appendix 2 BAF Risks- Performance

ICB	Greater Manchester fails to deliver the operational delivery standards, as set out in national planning guidance
Bolton	If the Trust does not optimise processes or adhere to standards then this may harm service productivity and efficiency, leading to regulatory action and financial instability.
	If the Trust does not deliver reliable compliance of the operational standards, then this may result in regulatory action
	If the Trust does not optimise its processes, this could negatively impact productivity and efficiency, resulting in unsustainable services
Christies	If diagnostic, MDT and referral processes at local hospitals across the GM system are not efficient there is a risk that we receive patients on 62-day pathways late leading to them not being treated within 62 days.
MFT	Failure to improve operational performance
	Failure to meet regulatory expectations, and comply with laws, regulations and standards
NCA	IF we do not close current service capacity and demand gaps through greater productivity, efficiency and developing new pathways/systems of care delivery THEN we will not achieve the nationally mandated access standards for cancer, planned and urgent care
Stockport	There is a risk that patient flow across the locality is not effective which may lead to patient harm, suboptimal user experience, and inability to achieve national access standards for urgent & emergency care
	There is a risk that the Trust does not have capacity to deliver elective, diagnostic and cancer care, including the clearance of surgical backlog caused by the Covid19 pandemic, which may lead to suboptimal patient safety, outcomes and experience and inability to achieve national access standards for elective care.
Tameside	Failure to achieve mandatory access standards (cancer, elective, non-elective)
WWL	There is a risk that demand for elective care may increase beyond the Trust's capacity to treat patients in a timely manner, due to demand management schemes not resulting in a reduction in demand and insufficient diagnostic capacity to deliver elective waiting times, resulting in potentially poor patient experience, deteriorating health, more severe illness and late cancer diagnosis.
	There is a risk to urgent and emergency care delivery as we are consistently operating above 92% occupancy levels, due to insufficient capacity and bed base in comparison to Acute Trust's across GM and nationally, resulting in longer waits, delayed ambulance handovers, reduced patient flow and more scrutiny through NHS England.
GMMH	If we do not have sufficient capacity and effective plans to meet demand for services, then we will negatively impact care and the experience of users and staff and fail to maintain operational performance.
PCFT	Overwhelming Demand

Appendix 2 BAF Risks- Finance

ICB	GM ICS fails to deliver in line with the agreed 24/25 financial plan (revenue and capital)
	GMICS fail to deliver financial balance by 2026/27
Bolton	If the Trust does not deliver its Financial Plan, then it will fail to meet its financial objectives, which could negatively affect the Trust's long-term financial sustainability
Christies	If the GM system does not continue to support local provision of cancer care with contractual and funding flow changes there is a risk that we are unable to devolve more systemic therapy, clinical trials and radiotherapy treatments to local communities leading to persistence or increases in inequalities in provision to economically deprived and ethnically diverse communities.
	If we do not achieve the planned activity levels and our target efficiency savings there is a risk that we won't achieve financial balance leading to us having to repay the difference to our agreed plan in the following year
MFT	Failure to embed the Trust's approach to value and financial sustainability
NCA	IF we don't develop robust multi-year cost saving plans, including identification and delivery of safe and sustainable cost improvements THEN we will not deliver our agreed financial plan.
Stockport	There is a risk that the Trust does not deliver the 2024/25 financial plan leading to increased regulatory intervention
	There is a risk that the Trust does not develop and agree with partners a Trust (3 year recovery plan) and GM Sustainability Plan, optimising opportunities for financial recovery through system working, leading to lack of financial sustainability.
Tameside	Failure to deliver revenue (including cash) and capital financial plans in line with Provider Licence compliance framework
WWL	There is a risk that the Trust may fail to fully mitigate in year pressures to deliver key finance statutory duties. This includes ERF, CIP (see PR8), further impact of industrial action, inflationary pressures and any other unforeseen pressures arising in the year
	There is a risk that the CIP plan will not be achieved and/or will not be cash releasing, resulting in a significant overspend.
	There is a risk a that the Trust may have insufficient cash balance to meet normal business activities on a day-to-day basis, due to cash balances potentially becoming too low, resulting in the need to request additional support, financial obligations not being met, or the capital programme being restricted.
GMMH	If we do not deliver the Trust's annual financial plan and longer-term financial strategy, then we will fail to meet our statutory duties and be unable to deliver improvements and sustainable services.
PCFT	Lack of financial sustainability

Appendix 2 BAF Risks- Sustainability-1

ICB	An emergency could overwhelm NHS GM's ability to respond effectively.
	Significant systemic service disruption occurs as a result of cyber-attack moving quickly across the GM health and care IT estate
	Failure of NHS GM to deliver the Green Plan and consider and prepare for the impacts of climate change
Bolton	If the Trust does not proactively plan for the future, then it will face significant challenges with its estate and digital infrastructure. This could lead to barriers to services, missed opportunities, and potential legal and regulatory breaches
	If the Trust does not establish partnerships that align with its Ambitions, then this could negatively affect the services on offer, infrastructure, and financial stability.
	If the Trust is not digitally enabled and inclusive, then it can face significant challenges, including barriers to essential services, widening health inequalities, missed economic and educational opportunities.
	If the Trust does not provide compliant and reliable premises and supporting infrastructure then personal safety and business effectiveness will be compromised resulting in potential harm, service disruption and potential statutory breach.
	If the Trust fails to proactively plan for the future, it will negatively affect service provision and hinder the overall achievement of the Strategy
Christies	If we or our suppliers are subjected to a cyber-attack there is a risk of loss of data and operational disruption leading to patient care being delayed or cancelled
	If we can't maintain supply of essential products for the treatment and care of our patients there is a risk that their treatment and care will be adversely impacted or delayed
	If there is an extreme weather event (heat wave, freeze, floods etc) due to climate change there is a risk of business disruption (increased staff absence, increased patient non-attendance and equipment malfunction) leading to delayed or cancelled care.
	There is a risk that adverse events will attract media coverage resulting in a decrease in public confidence in our services
	If the capital planning and allocation system does not enable full use of our charitable and commercial reserves there is a risk that we may not be able to fund our capital and asset replacement programmes leading to delays, cancellations or reprioritising of planned projects and equipment not being replaced when needed.
MFT	Failure to implement and embed infrastructure plans including digital and estates
NCA	IF we fail to operate, design, deliver and implement an appropriate digital environment that is stable, resilient and responsive to current and future priorities THEN delivery of safe and effective services, our ability to beneficially impact population health, patient care and colleague experience could be adversely compromised.
	IF we do not ensure robust security measures and governance across our digital systems along with comprehensive emergency planning, resilience, and readiness to respond to Major Incidents, THEN we will be unable to maintain, recover, and operate safe digital services for our patients and communities in the event of a cyber attack
	IF capital investment is not prioritised effectively to safely maintain and develop our estate and digital infrastructure THEN we will be unable to meet statutory requirements and transform services for the future
	IF we do not have a comprehensive, well led change portfolio programme that supports both our clinical quality ambitions and our financial sustainability plans, in the context of system working, THEN we will fail to be a safe and sustainable organisation and be subject to regulatory oversight

Appendix 2 BAF Risks- Sustainability-2

Stockport	There is a risk that the Trust does not deliver the Green Plan / Net zero targets and that the Trust fails to prepare for the impacts of climate change
	There is a risk that the Trust does not implement the Digital Strategy designed to ensure a resilient and responsive digital infrastructure which may lead to inability to support improvements in quality of care and compromise of data/information.
	There is a risk that the estate is not fit for purpose and does not meet national/regulatory standards, partly due to increasing maintenance requirements, which may lead to: - Inefficient utilisation of the estate to support high quality of care. - Significant disruption to clinical activity. - Poor patient/staff experience - Increased requirement to undertake contingency works with increased revenue expenditure. - Increased health & safety incidents and litigation/claims. - Breach of NHS standards/statutory regulations/ resulting in statutory /regulatory intervention - Loss of Trust reputation
	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus which may lead to an adverse long-term impact on the Trust's capability to deliver modern and effective care.
Tameside	Failure to deliver the Green Plan / Net Zero targets and prepare for the impacts of climate change
	Failure to maintain the suitability of the ICFT- wide IT infrastructure
	Failure to maintain suitability of premises and environments due to the age and condition of the Trust wide infrastructure and lack of funding and capital investment available
WWL	There is a risk that the Trust will not meet its net zero commitments and Climate Change will have an impact on the Trust delivering services, that cannot be mitigated.
	There is a risk that there is inadequate capital funding to enable priority schemes to progress. Due to uncertainties around capital funding arrangements the strategy may assume that more investment can be made than is available.
GMMH	If we fail to maintain adequate business continuity and emergency planning arrangements in order to sustain core functions, then we risk harm to patients, pressure on staff, reputational damage or regulatory intervention.
PCFT	Major Incident

Appendix 2 BAF Principal Risks- Partnerships

ICB	Nil
Bolton	If the Trust fails to integrate care, opportunities to improve the health and wellbeing of the population of Bolton will be missed
	If the Trust does not play its part in improving health and preventing illness, then the Trust will be unable to plan and respond to the needs of its community leading to an increase in health inequalities, unsustainable services and poor clinical outcomes.
	If the Trust fails to integrate care, opportunities to improve the health and wellbeing of the population of Bolton will be missed
	If the Trust does not promote a collaborative environment, it could result in fragmented efforts, misaligned objectives, and inefficiencies.
Christies	If we are unable to capture data on the protected characteristics of our patients there is a risk we will be unable to assess any inequalities in access, experience or outcomes leading to lack of focus in addressing health inequalities
MFT	Failure to work with system partners to address health inequalities, and deliver social value and sustainability
	Failure to deliver the required transformation and integration of services
NCA	Nil
Stockport	There is a risk that the Trust does not actively participate in and progress local collaborative programmes and neighbourhood working leading to suboptimal improvement in primary and secondary health and well-being outcomes.
	There is a risk the Trust does not contribute to effective place-based partnership arrangements that support delivery of priorities/objectives of the Stockport's ONE Health & Care (Locality) Board, leading to a delay in the delivery of models of care, which support improvements in health inequalities in the local population.
	There is a risk that the Trust does not deliver on the collaborative working opportunities that exist with Tameside and Glossop Integrated Care Trust (TGICT) leading to suboptimal pathways of care for the populations served and/or limited-service resilience across the footprint of both Trusts
	There is a risk that the Trust does not contribute to, and as part of the Greater Manchester Integrated Care System (GM ICS) collectively deliver on the collaborative working opportunities that exist within GM leading to limited-service resilience, unwarranted variation of services and inequality in health outcomes for the populations served
Tameside	Failure of effective partnership working at either ICS/ICB or locality provider level and impact of third parties - GM structural changes on the ICFT.
	Lack of capacity and resilience to respond effectively to multiple and sustained incidents
	Failure to recognise and manage the impacts of health inequalities on service provision
WWL	There is a risk that staff with local knowledge and understanding may be lost due to the changes within CCGs, resulting in uncertainty regarding partnership working.
	There is a risk that access to funding for support initiatives which support widening access to employment for local residents is less certain, due to pressures on the Trust's financial position, which may impact on delivery of the objective.
GMMH	If we do not engage with our service users, carers, system partners and wider community stakeholders to form effective partnerships then we will be unable to transform care and address health inequalities.
PCFT	Lack of stakeholder support

Appendix 2 BAF Principal Risks- Research and Innovation

ICB	Nil
Bolton	If the Trust does not create a culture where staff can innovate and collaborate to improve care, then it will be unable to support or take an innovative approach to healthcare research to adapt to the changing needs of our patients resulting in sub-optimal response to the needs of its patients and staff.
Christies	Nil
MFT	Failure to expand MFT's research and innovation capacity and capability
NCA	Nil
Stockport	There is a risk that the Trust does not implement high quality service improvement programmes, as identified through Trust and locality prioritisation, which may lead to suboptimal improvements in quality of care for patients and staff.
	There is a risk that the Trust does not implement high quality research & development programmes which may lead to suboptimal service improvements.
Tameside	Failure to meet information governance requirements.
	Failure to ensure clinical effectiveness and outcomes.
WWL	There is a risk that all the criteria that the University Hospital Association have specified may not be met, due to uncertainty regarding achieving the required core number of university Principal Investigators, resulting in a potential obstacle towards our ambition to be a University Teaching Hospital.
GMMH	Nil
PCFT	Nil