NHS Greater Manchester

Agenda

Greater Manchester Integrated Care Board (Public)

Date: 18th March 2026

Time: 2.00pm to 4.15pm

Venue: Boardroom, Tootal Buildings

Item No.	Time	Duration	Subject	Paper/ Verbal	For Approval/ Discussion/ Information	By Whom
1.	2.00	5 mins	Welcome, Introductions and Apologies: Anthony Hassall	Verbal	-	Sir Richard Leese, Chair
2.	2.00		Declarations of Interest	Verbal	-	Sir Richard Leese, Chair
3.	2.05	5 mins	Minutes of previous meetings and matters arising	Paper	Approval	Sir Richard Leese, Chair
Actions: Log attached						
Leadership Reports						
4.	2.10	5 mins	Chair's Briefing	Verbal	Information	Sir Richard Leese, Chair
5.	2.15	10 mins	Acting Chief Executive's Update including Reform	Paper	Discussion	Colin Scales, Acting Chief Executive
Strategic Updates						
6.	2.25	10 mins	Governance and SORD update including new committee structures	Paper	Decision	Charlotte Bailey, Chief Strategy, People and Partnerships Officer
7.	2.35	10 mins	Board Assurance Framework	Paper	Discussion / Approval	Nicola Hepburn, Acting Chief Reform & Improvement Officer
8.	2.45	20 mins	GM MH & Wellbeing Strategy Update	Paper	Discussion	Manisha Kumar, Chief Clinical Officer
9.	3.05	10 mins	Clinical Strategy	Paper	Decision	Manisha Kumar, Chief Clinical Officer
10.	3.15	10 mins	VCFSE Accord Refresh	Paper	Decision	Paul Lynch, Director of Strategy
10 MIN BREAK **Assurance Reports and Updates**						

11.	3.25	10 mins	Finance: • Finance Sub-Committee Report • Finance Report	Paper Paper	Information Discussion	Kal Kay, Non-Executive Director / Chair of the Finance Sub-Committee Kathy Roe, Chief Finance Officer
12.	3.35	10 mins	Quality and Performance: • Quality & Performance Report	Paper	Approval / Discussion / Information	Manisha Kumar, Chief Clinical Officer
13.	3.45	5 mins	Audit Committee: Audit Committee Report	Verbal	Information	Richard Paver, Non-Executive Director / Chair of Audit Committee
14.	3.50	5 mins	Remuneration Committee	Verbal	Information	Rachel Egan, Non-Executive Director / Chair of the Remuneration Committee
15.	3.55	5 mins	Primary Care Commissioning Committee	Paper	Information	Katherine Sheerin, Chief Commissioning Officer
16.	4.00	5 mins	Specialised Commissioning Committee	Paper	Information	Katherine Sheerin, Chief Commissioning Officer
17.	4.05	5 mins	Transition Committee	Paper	Information	Rachel Egan/Sue Bailey, Non-Executive Directors / Co-Chairs of the Transition Committee
For Information						
18.	4.10	5 mins	Approved minutes of Committees: • Transition Committee	Paper	Information	-
19.			Any other business	Verbal	-	Sir Richard Leese, Chair
20.			Date and time of next meeting: 20th May 2026, 2-4pm	Verbal	Information	

Please note that due to the limited time we have we cannot respond to public questions within the Board meeting. We will acknowledge all the questions we get and will respond to them formally within 20 days. The questions and answers will also be published on our website.

Leese, Sir Richard Charles	Y	Finanical Interests	Outside employment	Board Member, West Coast Development Partnership Independent Advisory Board		30/03/2025	31/10/2026
Leese, Sir Richard Charles	Y	Indirect interests	Outside employment	Daughter works for a training company that provides training inter alia to NHS organisations		01/11/2011	
Leese, Sir Richard Charles	Y	Non-financial personal interest	Loyalty interests	Honorary President, Manchester City Football Club		01/12/2021	
Leese, Sir Richard Charles	Y	Non-financial professional interest	Outside employment	Honorary Professor, Chair in Integrated Care and Population Health, University of Manchester		01/08/2022	31/07/2025
Employee Name	**Interest Declared**	**Interest Category**	**Interest Situation**	**Interest Description**	**Comments**	**CoI Date From**	**CoI Date To**
Bailey, Ms. Charlotte Elizabeth	Y			Nil			
Kumar, Dr Manisha	Y	Financial Interest	Outside employment	Salaried GP at the Robert Darbishire Practice - 1 session per week		2004	Ongoing
Kumar, Dr Manisha	Y	Non-financial professional interest	Loyalty interests	Honorary Professor University of Salford		01/05/2023	Ongoing
Kumar, Dr Manisha	Y	Non-financial personal interest	Loyalty interests	Husband has the following roles: • Operations Director - Primary Eye Care Services LTD • Case Examiner – General Optical Council		2021 2019	Ongoing
Njoroge, Jackie	Y	Financial professional interest	Outside employment	Chief Strategy & Data Officer University of Salford		2016	
Njoroge, Jackie	Y	Financial professional interest	Outside employment	First Choice Homes Oldham (FCHO) Independent Non Exec		2025	
Njoroge, Jackie	Y	Financial professional interest	Outside employment	GMCA Independent Audit Committee member		2025	
Njoroge, Jackie	Y	Non-financial professional interest	Outside employment	Transforming Access & Student Outcome (TASO) Trustee		2025	
Njoroge, Jackie	Y	Non-financial professional interest	Outside employment	Deputy Chair Higher Education Strategic Planning Association (HESPA)		2015	
Roe, Mrs. Kathryn Anne	Y	Non-financial personal interest	Loyalty interests	My son works in the finance department at Tameside and Glossop NHS Foundation Trust.		14/10/2024	Ongoing
Scales, Mr. Colin	Y	Non-financial professional interest	Loyalty interests	Honorary Professor of UCLan		2024	
Scales, Mr. Colin	Y	Indirect interests	Outside employment	Wife works at NCA as a nurse		19/09/2024	Ongoing
Sheerin, Mrs. Katherine Mary (Katherine)	Y	Non-financial professional interest	Loyalty interests	Trustee and Deputy Chair of the Board of the The Whitechapel Centre, a charity which works to prevent homelessness and support people who are homeless, operating across the Liverpool City Region.	This is a voluntary role with no remuneration or expenses paid.	01/01/2025	Ongoing
Non-Executive Directors	**Interest Declared**	**Interest Category**	**Interest Situation**	**Interest Description**	**Comments**	**CoI Date From**	**CoI Date To**
Bailey, Dr Susan Mary	Y	Financial Interest	Outside employment	Independent NED on the board of KOOTH PLC, a mental health online digital platform. I am remunerated for this work. Neither any members of my family or I hold shares in this PLC		2022	Ongoing
Bailey, Dr Susan Mary	Y	Non-financial professional interest	Loyalty Interests	Chair of Centre for Mental Health. The centre and myself advocate for better mental health outcomes for all through the delivery of evidenced based policy briefings and lobbying at a national and Regional level		2018	Ongoing

Bailey, Dr Susan Mary	Y	Non-financial professional interest	Outside employment	Council member university of Salford		2016	
Bailey, Dr Susan Mary	Y	Non-financial professional interest	Loyalty Interests	BEVAN commissioner - Bevan through evidence base support improved health and social care outcomes For the population of Wales.		2014	Ongoing
Egan, Rachel Mrs	Y			Nil			
Kay, Mrs. Khalida (Kal)	Y	Financial interests	Outside employment	Interim FD Derian House Childrens Hospice		06/10/2025	
Kay, Mrs. Khalida (Kal)	Y	Financial interests	Shareholdings and other ownership interests	Director and Shareholder of GSD Financial Consulting Ltd	Set up my own consultancy firm	01/04/2025	
Kay, Mrs. Khalida (Kal)	Y	Non-financial personal interests	Outside employment	Great Academies Education Trust	Trustee (non remunerated)	20/04/2020	
Kay, Mrs. Khalida (Kal)	Y	Non-financial professional interest	Shareholdings and other ownership interests	Association of Camerados	Non Exec, non remunerated director	22/10/2018	
Paver, Mr. Richard	Y			Nil			

Partner Members	Interest Declared	Interest Category	Interest Situation	Interest Description	Comments	CoI Date From	CoI Date To
Mehra, Dr Vishal	Y	Financial interest	Outside employment	Chief Medical Officer for Health Innovation Manchester		Dec-25	Ongoing
Mehra, Dr Vishal	Y	Financial interest	Outside employment	Clinical Director, Gorton and Levenshulme Primary Care Network		Apr-19	Ongoing
Mehra, Dr Vishal	Y	Financial interest	Outside employment	Executive Committee Member, Manchester Local medical Committee		Jan-26	Ongoing
Mehra, Dr Vishal	Y	Financial interest	Outside employment	Salaried GP, West Point Medical Centre		Apr-23	Ongoing
Hassall, Anthony	Y	Financial interest	Outside employment	Chief Executive, Pennine Care NHS Foundation Trust		2022	Ongoing
Vallance, Leigh	Y	Financial interest	Outside employment	CEO of Bolton Hospice which is part funded by an NHS Grant		2023	Ongoing
Vallance, Leigh	Y	Financial interest	Outside employment	As Chair of Bolton CVS, (a voluntary sector infrastructure body) who are in receipt of NHS funding		Ongoing	
Williams, Dr Owen	Y	Non-financial professional interest	Outside employment	Co-Chair of the Chairs and CEO Ethnic Minority Network		2021	Ongoing
Williams, Dr Owen	Y	Non-financial professional interest	Outside employment	Acute Partner Member of the NHS Greater Manchester Integrated Care Board (ICB)		2022	Ongoing
Williams, Dr Owen	Y	Non-financial professional interest	Outside employment	Chair - Yorkshire and Humber PSRC Strategic Advisory Board		Jan-24	Ongoing
Williams, Dr Owen	Y	Financial interest	Loyalty Interests	Chief Executive Officer – Northern Care Alliance NHS Foundation Trust		Nov-21	Ongoing
McKenzie Folan, Alison	Y	Financial interest	Outside employment	Chief Executive at Wigan Council		2019	Ongoing

Actions Log: ICB Board								
No	**Date**	**Item**	**Details of action agreed**	**Action Lead**	**Deadline**	**Status**	**Further Detail**	
19	19/11/2026	10. Major Trauma	Assurance on compliance, clinical safety and long-term sustainability including timescales for the NHS GM Major Trauma model to be provided to QPC.	KS	15/07/2026		Proposal to update the new Committee in June then back to Board in July as part of our undertakings.	
Completed at Previous Meeting (Audit Trail)								
1	17/07/2024	4. Chair's Briefing	WH to meet with members of the KONP group to discuss the petition and agree next steps	WH	18/09/2024		The meeting went ahead on the 20th August, and the group submitted questions back to WH which the Communication Team are collating the answers.	
2	17/07/2024	6. Single Improvement Plan	Single Improvement Plan should be shared with members of the board as soon as it is available showing progress against the plan.	MF	18/09/2024		The plan was shared with members at the Board strategy session on 21st August and updates will be provided.	
3	18/09/2024	3. Matters arising	The Chair to meet with MP and team regarding the data in the performance report following concerns raised at the previous meeting	MP/CS	20/11/2024		The performance matrix is still under review and discussed at QPC. Meeting with the Chair has taken place.	
4	18/09/2024	4. CEO Report	RB to provide update on Health and Care Review at next meeting in November.	RB	20/11/2024		On agenda for November meeting	
8	19/02/2025	4. 2025/26 operational plan	Board meeting to be reconvened prior to final submission of the draft plan on 27th February which would be held in public.	JN	27/02/2025		Meeting reconvened on 26th February	
9	26/02/2025	4. Annual plan 25/26 update	Board seminar to be arranged prior to formal meeting.	JN	26/03/2025		Seminar held on 19th March and formal meeting moved to the 26th	
6	15/01/2025	7. Board Assurance Framework	Risk appetite to be discussed as part of operational planning at February Board.	CS	05/02/2025		Deferred to June Board development session. Complete	
7	15/01/2025	13. Quality and Performance	MP and JW to meet with SMc and SB to discuss maternity workforce issues.	MP/JW	05/02/2025		Meeting took place on 7th April	
10	26/03/2025	7. Baord Assurance Framework	CS to meet with Committee Chairs in April prior to Board Seminar.	CS	16/04/2025		Meeting took place on 14th April	
11	21/05/2025	7. Committee ToR	JN to amend the Quality and Performance TOR after the meeting.	JN	16/07/2025		Complete	
14	16/07/2025	6. NHS Reform	MP to meet with RE to discuss the process and decision behind the safeguarding as part of the reform agenda	MP/RE	17/09/2025		Complete	
15	16/07/2025	6. VR Scheme	CB to share the EIA that had been to the T&F Group.	CB	17/09/2025		Complete	
16	16/07/2025	16. GM Alcohol Harm Strategy	WH to share map of drug and alcohol services in GM.	WH	19/08/2025		Info can be found here: https://gmintegratedcare.org.uk/find-a-service/type/alcohol-and-drug-support/	
5	17/07/2024	12. Primary Care Blueprint Delivery Update	RB to work with John Herring and his team to provide a briefing to the People and Culture Committee and bring a position statement back to Board at a future meeting.	RB	20/11/2024		A paper has been prepared and presented to the PC Blueprint Group. This is in respect to FTSU for Primary Care. We have a proposed model , with delivery through PCB but delivery resource dependent. Update on Primary Care Blueprint provided in Sep 25	
13	21/05/2025	10. Assertive outreach	To share report with AMK and other place leads via the Exec Committee	MK	TBC		Complete	
17	17/09/2025	3. Matters arising	MK to provide update on the ADHD consultation after the meeting	MK	ASAP		Update provided and paper on agenda for November meeting	
12	21/05/2025	9. Federated Data Platform (FDP)	To bring FDP back to Board at later date.	WH	19/11/2025		Paper to come back to the board 6 months following the last meeting. Update provided in CEO report	
18	19/11/2026	8. Draft Clinical Strategy	Commissioning intentions including plan to be presented to Board at strategy session in December.	KS	17/12/2025		Presented at December meeting	
20	19/11/2026	15 People and Culture Report	Freedom to Speak Up report to be shared with RP.	CB	21/01/2026		Sent to RP on the 21/11/25	
21	17/12/2026	3. Approval of 2026/7 planning submission	JN to reschedule February Board meeting from the 18th to the 11th and arrange seminar in January.	JN	11/02/2026		Complete	

NHS Greater Manchester

Minutes

Greater Manchester Integrated Care Board (Public)

Date: Wednesday 11th February 2026

Time: 2.00pm to 3.00pm

Venue: John Tocher Room, Mechanics Centre

Present		
Members:		
Sir Richard Leese	RL	Chair, NHS Greater Manchester
Richard Paver	RP	Non-Executive Director and Chair of Audit Committee, NHS GM
Dame Sue Bailey	SB	Non-Executive Director and Chair of the Performance & Quality Committee, NHS GM
Kal Kay	KK	Non-Executive Director and Chair of the Finance Committee, NHS GM
Jackie Njoroge	JNj	Deputy Chair/Senior Independent Director, NHS GM
Leigh Vallance	LV	Board Member bringing the perspective of the Voluntary Community, Faith and Social Enterprise (VCFSE) Sector, Chief Executive of Bolton Hospice
Anthony Hassall	AH	Board Member bringing the perspective of Mental Health, Chief Executive of Pennine Care NHS Foundation Trust
Colin Scales	CS	Acting CEO, NHS GM
Kathy Roe	KR	Chief Finance Officer, NHS GM
Professor Manisha Kumar	MK	Chief Clinical Officer, NHS GM
Charlotte Bailey	CB	Chief Strategy, People and Partnerships Officer, NHS GM
Katherine Sheerin	KS	Chief Commissioning Officer, NHS GM
Executives:		
Gareth Robinson	GR	Acting Chief Officer for System Reform, NHS GM
Attendees / Participants:		
Jenny Noble	JN	Board Secretary, NHS GM
Lucy Cunliffe	LC	Governance Manager, NHS GM
Claire Connor	CC	Director of Communications and Engagement, NHS GM
Ed Dyson	ED	Director of performance, Improvement & Assurance, NHS GM

Jo Street	JS	Programme Director- Transition, NHS GM (Items 5 and 6 only)
Apologies:		
Rachel Egan	RE	Non-Executive Director and Chair of the Remuneration and Population Health Committees, NHS GM
Dr Owen Williams	OW	Board Member bringing the perspective of Acute Providers, Chief Executive of Northern Care Alliance (NCA) NHS Foundation Trust
Dr Vish Mehra	VM	Board Member bringing the perspective of Primary Care, General Practitioner
Alison McKenzie-Folan	AMK	Chief Executive Wigan Council, Place Based Lead Health & Care for Integrated Care Partnership
Cllr Sean Fielding	SF	Board Member bringing the perspective of Local Authorities, Bolton Council

	Topic	**Action**
1.	<u>Welcome, Introductions and Apologies</u> RL welcomed attendees and members of the public to the Board meeting. Apologies were noted.	
2.	<u>Declarations of Interest (DOI)</u> RL reminded board members of their obligation to declare any interest relating to items on the public part of the agenda.	
3.	<u>Minutes of previous meetings</u> The minutes of the public Board meeting on Wednesday 21 January were approved. <u>Matters Arising</u> The Chair updated Board that the constitution had been approved by NHSE and would be published on the website shortly.	
4.	<u>Medium-Term Planning including ICB Board Assurance 2026-27</u> KK noted that the Finance Committee had met prior to this meeting to review the financial plan and provide assurance to Board regarding the numbers. She noted thanks to finance colleagues for providing the detail. CS introduced the item and sought approval of the NHS GM ICB medium term plan and associated documents noting that provider submissions were separate this time. ED provided a summary of the plan which was compliant to all performance and finance expectations highlighting the risk in the delivery of these standards which was reflected in the Board Assurance statements. He confirmed that the equality and quality impact assessment had now been signed off. He highlighted that the Board is asked to approve the plan including Board Assurance statements. GR	

	added that the plans would be developed further to focus on delivery. KR was pleased to present a compliant financial plan despite the low growth level received and cost pressures which had been mitigated. She reiterated that the key focus was now on delivery of the plans. AH thanked everyone who had worked so hard on the plan and agreed with the level of risk within the Board Assurance Statements but felt the plan on a page (within the Strategic Commissioning Plan) should reference LD as well and Mental Health and Well-Being. The Chair queried why specialised commissioning was £8m less (page 40 of the pack) and KR confirmed funding had moved to population basis not host ICB, meaning Trusts recover income for other ICBs. She also confirmed that elective activity was an issue due to over performance in 25/26 that needed to be funded first. The Chair commented on the workforce plans noting that Trusts took on extra staff during covid and continued to recruit but activity was lower. He also queried urgent GP appointments (page 63 of the pack) noting that as a metric it didn't relate to demand, and it would be more useful to look at how many people who needed an emergency appointment couldn't get one. KS highlighted that the draft Strategic Commissioning Plan was still work in progress but would be submitted at the same time tomorrow, with the integrated needs assessment to be completed by the 31st March. This described what and how we would commission over the next five years to ensure high-quality service provision and sustained improvement in the health of our population through Live Well. Members welcomed the strategy noting the following comments: • Investment in mental health • Population health metrics were physical health focussed and should include mental health • References development of neighbourhoods but should include importance of mental health in this model • Reference to involving providers but could include provider led commissioning which couldn't be ruled out • Need to look at reference to LD as mentioned above • Need to invest in VCFSE sector to improve efficiency • Reference to co-commissioning as well as co-production MK noted that the Clinical Strategy had been developed alongside the Commissioning Strategy and the full version would be presented to Board in March. The Chair reflected that the document was still draft echoing the comments above which KS would take away. He thanked all involved in the planning submission which was approved by Board. **The Board:**	

	• **Acknowledged report and appendices**
	• **Noted the associated risks set out**
	• **Agreed submission of:**
	  o **3-year finance plans (4 year for capital)**
	  o **3-year workforce plans**
	  o **3-year activity and performance plans**
	  o **Integrated medium term planning template giving commentary to non-compliance and board assurance statements**
	  o **5-year strategic commissioning plans**
	• **Agreed further work to mitigate system risk**	

5.	<u>Sign off of the final operating model</u> CB introduced JS to the meeting to present the final version for Integrated Care Board sign off noting that a period of structured engagement was conducted on the 'Draft for engagement' version of the operating model during Nov 2025. JS welcomed questions on the final version today. AH acknowledged the work in the context of reform but queried next steps and CB confirmed that a 3-year OD plan had been drafted to sit alongside this. CS agreed this was a comprehensive piece of work and reassured Board that engagement had taken place with partner organisations to be implemented in Q1 recognising the importance of co-production to be able to do this. The Chair commented on the role of acute providers and left shift, moving resources from acute into community which was linked to Darzi. This wasn't simply about moving resources and need to do things differently to deliver this. **The Board approved the final version of the NHS GM Operating Model.**	
6.	<u>Model ICB Blueprint Assurance Statement</u> NHS England requested assurance that all ICBs understand and could deliver their statutory, delegated and Blueprint-specified functions. This paper and accompanying appendices set out our proposed response, including; NHS GM's Operating Model, which JS confirmed provides the best opportunity to safely and efficiently deliver functions, however risk to delivery was noted given the scale of reductions required. The retention of more functions than was originally indicated in the Model ICB Blueprint increases pressure within the cost envelope. NHS GM has reviewed all 18 "Review for Transfer" functions with a draft response provided which would be an appendix to the response letter. Cell leads had confirmed that the five Good Practice Guides (CHC, IPC, Medicines Optimisation, SEND, Safeguarding) had been reviewed and that any risks were adequately reflected in the organisational risk registers. The Chair thanked JS for drafting the response and requested a line to say that the retention of additional functions ought to be supported by transfer of equivalent funding. CS thanked the Chair for his comments and JS for a drafting a carefully worded	

	response. **The Board reviewed and approved the assurance statement (letter) and accompanying appendices (NHS GM response to update to ICB Model Blueprint review for transfer functions and NHS GM Operating Model- Final) subject to the additional line above.**	
7.	<u>Finance Report</u> KR updated the Board on the overall Month 9 ICS financial position for Greater Manchester as at 31st December 2025 noting the discussion at Transition Committee last week. She noted that CIP delivery was £23.8m ahead of target as a system but there continued to be a risk to delivery. DSF had been received up to and including Q4 but again there remained a risk that this was subject to clawback. **For the System Financial position, the Board:** • **Noted the Month 9 year to date reported financial position for GM ICS of £76.0m deficit, against a planned deficit of £66.0m, resulting in a variance against plan of a £10.0m deficit.** • **Noted the in-month improvement in the deficit position, a reduction in the extrapolated run rate for the GM providers of £18.6m (excluding IA costs), a reduction in reported gross risk of £0.4m, a further reduction in net risk of £4.2m for NHS GM as a result of the on-going delivery of recovery plans, and a £6.6m improvement against the recovery plan forecast trajectory for providers.** • **Noted the breakeven forecast outturn position in line with NHSE reporting requirements.** • **Noted the year-to-date delivery of CIP as at Month 9 of £445.8m against a plan of £422.1m, an over delivery of £23.8m.** • **Noted the forecast capital position is expected to be brought back into a balanced position.** • **Noted the risk to the system wide cash position which continues to be closely monitored.** • **Noted that full DSF has been received, but there remains a risk that this is subject to clawback if a balanced position for the system is not delivered.** • **Noted the on-going system meetings to provide assurance on the delivery of the overall system financial plan, and to address the current shortfall in CIP delivery and monitor delivery of recovery plans to mitigate reported pressures.**	
8.	<u>Performance Report</u> On behalf of CS, GR advised the Board on the levels of assurance regarding performance following the verbal update at Transition Committee. GR highlighted that UEC performance was 2.2% behind plan, with pressures from OPEL 4 incidents and IT failures. The Board was made aware of the improvements compared to previous years and ongoing oversight. Elective care was reported slightly behind plan, with a Q4 sprint and close monitoring taking place. **The Board agreed the levels of assurance for performance provided in the**	

	report.	
9.	Any Other Business including reflections of the meeting None this time.	
10.	Date and time of next meeting: Wednesday 18th March 2026, 2pm – 4.30pm, Tootal Buildings.	

NHS
Greater Manchester

Acting CEO's Report to the Board 2025-2026

Part of Greater Manchester
Integrated Care Partnership

Board

18 March 2026

Report for Information

Required information.	Details.
Title of report.	Acting CEO's Report to the Board
Author.	Professor Colin Scales
Presented by.	Professor Colin Scales
Contact for further information.	gmhscp.gmicb.corporate@nhs.net
Executive summary.	The paper details updates from the Acting CEO with reference to the national, regional and local system positions.
The benefits that the population of Greater Manchester will experience.	The NHS Greater Manchester (GM) response to NHS Reform. Consideration being made, through the necessary due diligence. Proactively responding to Jess's Rule and mobilising the NHS GM vaccination campaigns.
How health inequalities will be reduced in Greater Manchester's communities.	Proactively responding to Jess's Rule and mobilising the NHS GM vaccination campaigns.
The decision to be made and/or input sought.	The Board is asked to note the contents of the CEO's Report to the Board. Also, disseminate and cascade the necessary key messages and information as appropriate.

How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	Delivering key messages in the context of NHS Reform and specifically SR3 in response to Jess's Rule.
Key milestones.	Key messages in the context of NHS Reform.
Leadership and governance arrangements.	For consideration and dissemination by the Board.
Engagement* to date. ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	Engagement has already commenced with the GM system's key stakeholders and NHS GM staff. Also, any formal decisions to be taken, will proceed through the necessary governance arrangements.
Financial or Legal Implications	NHS GM proceeding with the organisational change programme in response to NHS Reform.

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

Introduction

1.1. The paper details updates from the Acting CEO with reference to the national, regional and local system positions.

National and Regional Updates

1.2. This section of my report is aimed to update the Board on the key areas of development from a national and regional position, since the last CEO's Report to the Board in January.

1.3. The Board will be aware from previous CEO Reports, that reference has been made to the System Improvement Board (SIB) with NHS England to address our undertakings, as detailed within our Single Improvement Plan (SIP). This was explained in detail to the Board in March 2025 and May 2025. As of May 2025, significant elements of reporting on undertakings had transferred into NHS GM's structural governance, which was reflected in the embedded changes resulting from the SIP. NHS GM has now reached a significant milestone in its improvement journey, with the organisation successfully strengthening its leadership and governance, and improving performance and quality across the Integrated Care System (ICS).

1.4. Following a formal review, NHS England has now discontinued the 'enforcement undertakings' it set out in 2024' relating to governance arrangements, performance, quality of care and outcomes, leadership capability, and programme management. The decision reflects the considerable progress made by NHS GM and its partners across the NHS, local authorities, primary care, and the voluntary, community, social enterprise and faith sector (VCSFE) over the past year to stabilise and strengthen the foundations of the GM Integrated Care Partnership (ICP). At the end of January 2026, NHS England issued NHS GM with the compliance certificate, confirming that the undertakings were to be discontinued. For completeness, I have appended the compliance certificate, as Appendix A, within my CEO's Report. I would like to highlight that areas of financial oversight remain. However, subject to NHS England's consideration at the end of the 2025/26 financial year, I am hopeful that the remaining areas of financial oversight will be removed.

1.5. Board members will be aware of the organisational change process currently underway across all Integrated Care Boards (ICBs) since the respective announcements made by the Prime Minister and Secretary of State for Health and Social Care in 2025. NHS GM launched the staff consultation and shared the proposed new structures with staff, as planned at the end of January. Running concurrently with this, NHS GM opened a second window for voluntary redundancy (VR). At the point of writing my CEO's Report to the Board, we are still progressing the formalities of the consultation process. Where possible, and if necessary, I can verbally update the Board during the meeting itself.

1.6. In respect of the outcome of round one of VR, I held sessions with colleagues who had chosen to apply and were successful in their applications to leave at the end of January. I would like it to be noted that many of these colleagues had carried out years of dedicated service to the NHS, and the wider health and social care system across GM, the North West of England and in some cases nationally. I felt it was important to take this opportunity to recognise their respective contributions and say goodbye. I trust that Board members will also echo this sentiment and once again in the coming weeks for those who exit the organisation as part of the second round of VR.

Greater Manchester (GM) System Updates

2.0 This section of my CEO Report is specifically focussed on what is happening here within the GM system.

The NHS GM Board and Revised Operating Model

2.1. Within January's CEO Report to the Board, I spoke about the new Chief Officer structure, which came into effective from 1st January 2026, which was an important step as we progress the consultation with the whole workforce on new structures for the rest of the organisation, as detailed in Section 1.5 above. Sir Richard has spoken to the senior leaders from across the GM ICS to announce the formal advertisement of the substantive CEO role with our recruitment partner Alumni Global. The application process for the CEO role will remain open until 27th March.

2.2. Given my own interim arrangements as Acting CEO, Gareth Robinson acted up to cover the Chief System Reform and Improvement Officer duties of my substantive role, until his planned departure from NHS GM earlier this month. I know Board members have spoken to Gareth both prior to, and after his departure to wish him the very best in his new leadership role with the Wirral University Teaching Hospital NHS Foundation Trust (WUTH).

2.3. As a result of Gareth's planned departure, an internal secondment opportunity was advertised for the role of Interim Chief System Reform and Improvement Officer. I am delighted to announce that Nicola Hepburn – Recovery and Improvement Programme Director was successfully appointed to fulfil the secondment opportunity. Board members will be able to formally meet Nicola at the meeting itself on 18th March.

The NHS GM Primary Care Portal

2.4. Board members will be aware from recent communications both internally and externally to wider stakeholders, that the NHS GM Primary Care Portal has been launched and is now live. The portal will be rolled out to partners mid-year. Since the introduction of ICBs, reaching all Primary Care Teams consistently has become more complex. With around 22,000 staff across 1,800 GM primary care services, NHS GM recognises that communication must be clear, coordinated and aligned with system priorities. Currently, updates come from multiple routes including Locality Teams, the NHS GM Primary Care Team, newsletters, the Medicines Optimisation Team, IT Services and the Primary Care Provider Board, creating duplication and missed messages. A primary care survey confirmed strong support for a single platform tailored to individual roles, topics and localities.

2.5. It is expected that the portal will bring all communication channels together, as well as reducing duplication through a clear process for contributors. It will also deliver fewer but

more relevant messages. Users can personalise their account and will receive a fortnightly summary by email based on their preferences. It is also planned for more urgent issues being highlighted on the homepage and via email when needed.

Pennine Care NHS Foundation Trust (PCFT) and the NHS App

2.6. Staying on the topic of digital, I wanted to share the news about PCFT being the first mental health provider in England to offer appointment notifications through the NHS App. This has been possible through partnering with DrDoctor, who are the UK's leading patient engagement platform. This partnership supports the NHS 10-Year Health Plan's goal of bringing care closer to home and ensuring mental health services have access to the same digital tools as physical health services. As the Mental Health Partner Member of the Board and being the Chief Executive of PCFT, Anthony Hassall will happily share more information at March's Board meeting itself. I have also provided the link to the PCFT website for Board members to review: First mental health provider to offer appointment notifications through the NHS App :: Pennine Care NHS Foundation Trust

Jess's Rule

2.7. Over recent months there has been both national and local media attention associated with Jess's Rule. Jess's Rule is a safety initiative launched by NHS England in September 2025, promoting a "three strikes and you rethink" approach. It urges GPs to review, reconsider, and potentially refer patients for further testing if they present with the same, persisting, or worsening symptoms three times, aiming to speed up diagnoses of serious conditions like cancer or sepsis.

2.8. Jess Brady was a 27 year old woman who, in the 5 months before her death from cancer, had 20 consultations with her GP practice for the same symptoms which became progressively worse without her being referred. Recent research demonstrates bias and disparities experienced by young people in accessing healthcare and diagnostics, particularly within the NHS and primary care settings. As a result, NHS England, the Royal College of General Physicians and Jess's family have collaborated to design Jess's Rule. The aim of the rule will help to catch serious conditions earlier and support GPs with guidelines that bolster their clinical judgement, while encouraging them to reflect, review and rethink if they are uncertain about a patient's condition.

2.9. This rule aligns with GM's commitment to proactive, equitable, and patient-centred healthcare. Jess's Rule also emphasises the need to remain alert to symptoms that might suggest serious conditions, regardless of a patient's age or ethnicity, thereby reducing health inequalities. The implementation of Jess's Rule also supports NHS GM to address the BAF Risk SR3. SR3 is a risk that the quality of care, patient safety and care experience will decline if the ICB fails to comply with our statutory duties for quality assurance, in quality and patient safety within the NHS GM system. This may lead to poorer health outcomes for the GM population. GPs across England will receive a

physical copy of the *Jess's Rule: Three Strikes and we Rethink* poster for displaying in their consultation rooms. For completeness, I have also provided the following link to the NHS England's Campaign Resource Centre.

Vaccination Campaigns

2.10. In July 2025 NHS GM commissioned a media and creative agency to support on three vaccination campaigns, being winter vaccinations, 0-5 vaccinations and school-aged vaccinations. All campaigns fall under a campaign umbrella called 'Keep Protected'. The winter vaccination campaign ran from August 2025 until February 2026. Formats for the campaign included radio, advertising across the Transport for Greater Manchester (TfGM) network and paid social media advertising.

2.11. Reaching ethnic minority communities with traditionally low vaccine uptake was a focus for both the winter vaccination and childhood vaccination campaigns. NHS GM produced videos and leaflets in multiple languages, produced a radio advert in Urdu and used digital platforms which translated our messaging to a language relevant to the user. NHS GM also had a focus on accessibility, producing a British Sign Language (BSL) video and easy read documents so that messaging could be shared with as many people across GM as possible.

2.12. The winter vaccination campaign is currently at evaluation stage. However, performance was monitored on a regular basis which showed that the media formats exceeded forecasts across several channels, including strong listen-through rates for digital audio and high click-through rates on Meta activity. Our childhood vaccination campaigns began in December 2025 and will run until August 2026. Formats for the childhood vaccination campaigns include radio, YouTube and Disney+ adverts and play centre advertising such as digital screens and table-talkers.

Health and Safety Oversight

2.13. I have previously committed to update the Board on all matters relating to health and safety, with a standing item within the CEO's Report to the Board. As part of the response to NHS Reform and the associated organisational change pressures, I have stood down the formal meetings of the Health and Safety Oversight Group. Due to the impact of NHS Reform and the number of colleagues who left NHS GM as part of the first round of VR, I have also stepped down the Health and Safety Champions Meetings. However, it is anticipated that both meetings this will formally relaunch in Quarter 1 (Q1) of 2026/27.

2.14. The oversight arrangements for health and safety, as well as security are being reviewed as part of the organisational change programme. This encompasses the reporting of accidents and incidents. I am aware that NHS GM will need to provide additional Health and Safety Management Training to all managers across the organisation. Moreover,

there will also be Leading for Safety Training for Executives of the organisation. It is my intention to update the Board on this in more detail in May 2026.

2.15. As reported to the Board in September 2025, in respect of the Mersey Internal Audit Agency (MIAA) Health and Safety Audit, the latest audit produced four key recommendations, which are now being addressed. Members of the Board who attend the Audit Committee, will be aware of the recommendations and their respective progress. Again, I will appraise the Board at the next meeting in May, against progress made against the four key recommendations for 2025/26.

Recommendations

3.0 The NHS GM Board is asked to:

3.1. Note the contents of the Acting CEO's Report to the Board.

3.2. Disseminate and cascade the necessary key messages and information as appropriate.

Appendix:

A) Compliance Certificate from NHS England, 23rd January 2026

APPENDIX A

COMPLIANCE CERTIFICATE

INTEGRATED CARE BOARD:
NHS Greater Manchester Integrated Care Board
4th Floor
3 Piccadilly Place
Manchester
M1 3BN

BACKGROUND

NHS England accepted enforcement undertakings in connection with NHS England's functions under the National Health Service Act 2006, as amended (the NHS Act 2006) from NHS Greater Manchester Integrated Care Board (''the ICB'') on 23 July 2024 ("the Undertakings").

UNDERTAKINGS TO BE DISCONTINUED

NHS England hereby certifies that it is satisfied that NHS Greater Manchester Integrated Care Board (''the ICB'') has complied with: Paragraph 1 (Future Operating Model and Governance Arrangements); Paragraph 3 (Performance); Paragraph 4 (Quality of Care, Access and Outcomes and Leadership and Capability); Paragraph 5 (Programme Management) of the section titled ''Undertakings'' in the Enforcement Undertakings of 23 July 2024.

NHS England and the ICB agree to discontinue all of: Paragraph 1 (Future Operating Model and Governance Arrangements); Paragraph 3 (Performance); Paragraph 4 (Quality of Care, Access and Outcomes and Leadership and Capability); Paragraph 5 (Programme Management) of the section titled ''Undertakings'' in the Enforcement Undertakings of 23 July 2024.

Signed: Professor Colin Scales 

Position: Acting Chief Executive of the Integrated Care Board

Date: 23 January 2026

Signed:  Louise Shepherd

Position: North West Regional Director and Chair of the North West Regional Support Group

Date: 26 January 2026

NHS
Greater Manchester

Implementation of New NHS GM Committee Structure and Updated Scheme of Reservation and Delegations (SORD)

Part of Greater Manchester
Integrated Care Partnership

NHS GM Board

18 March 2026

Report information.

Required information.	Details.
Title of report.	Implementation of New NHS GM Committee Structure and Updated Scheme of Reservation and Delegation (SORD)
Author.	Chris Gaffey, Associate Director of Corporate Services
Presented by.	Charlotte Bailey, Chief Strategy, People and Partnerships Officer
Contact for further information.	Chris Gaffey, Associate Director of Corporate Services chris.gaffey@nhs.net
Executive summary.	This report provides the Board with proposals on the new NHS GM Committee structure, and revised Scheme of Reservation and Delegation (SORD) and for approval. Further actions and next steps are also provide on how arrangements will continue to be reviewed and developed during 2026/27.
The benefits that the population of Greater Manchester will experience.	Ensuring good governance arrangements are in place will ensure NHS GM is a well-led organisation, which will benefit the population of Greater Manchester.

How health inequalities will be reduced in Greater Manchester's communities.	Ensuring good governance arrangements are in place will ensure NHS GM is a well-led organisation, which will support the delivery of the ICP Strategy, and in turn, reduce health inequalities in GM communities.
The decision to be made and/or input sought.	The Board are asked to: 1. Consider and approve the Committee Terms of Reference (Appendices One and Two) and the Scheme of Reservation and Delegation (Appendix Three) presented with this report to enable the establishment of the new Committees from 1 April 2026. 2. Note the next steps and actions required to further develop and embed these new arrangements, as set out in paragraph 1.14 onwards.
How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	Ensuring good governance arrangements are in place will ensure NHS GM is a well-led organisation, and one of the objectives of moving to a new Committee structure is to ensure that the Board and its Committees have the required strategic focus. This will support the delivery of the ICP Strategy, as well as ensure focus on the Board Assurance Framework.
Key milestones.	17 December 2025 – Agreement of Transition Arrangements by Board 4 March 20026 – Consideration of proposals by Transition Committee 11 March 2026 – Further consideration and refinement by NEDs / Execs. 18 March 2026 – Board consideration 1 April 2026 – Implementation

Leadership and governance arrangements.	The Chief Strategy, People and Partnerships Officer is responsible for Corporate Governance arrangements, supported by the Associate Director of Corporate Services. The proposed Strategic Commissioning Committee will be chaired by Sue Baily, Non-Executive Director, and the People and Resources Committee will be chaired by Kal Kay, Non-Executive Director.
Engagement* to date. ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	Proposals have been drafted via working group meetings including officers from across functions, which were followed by working group meetings between NEDs and lead Chief Officers. Further discussions then took place at NEDs / Execs meeting on 11th March 2026, before final comments and views were incorporated into the proposals.
Financial or Legal Implications	No formal legal or financial implications as part of this report, however the new arrangements do propose that the Strategic Commissioning Committee will have financial approval limits in line with the financial scheme of delegation (however further engagement in this area is required before limits are confirmed).

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.

Introduction

1.1. NHS GM has been in a transition period whilst the organisation focuses on key priorities and required transitional arrangements to free up capacity during this period of significant change.

1.2. This report sets out the further work that has been conducted to review some of the key NHS GM governance arrangements and associated documents following the paper that was presented to Board in December 2025, to ensure governance arrangement align to the ICB Model Blueprint and the new NHS GM Operating Model.

1.3. It should be noted that the scope and remit of the Audit Committee and Remuneration Committee are not affected by these proposals.

1.4. In addition, Place Based Partnership Committees (as set out in the Scheme of Reservation and Delegation (SORD)) will continue in their current constituted form whilst work on establishing the new locality operating model takes place during 2026/27 – once implemented, further amendments will be required to the SORD, which will be presented for approval by the Board at the appropriate time.

Proposed Committees and Scheme of Reservation and Delegation

1.5. The new Committee structure will see two new Committees established – the Strategic Commissioning Committee, and the People and Resources Committee.

1.6. Together, the Strategic Commissioning Committee and the People and Resources Committee will provide end-to-end oversight of the strategic commissioning cycle on behalf of the Board, ensuring that population needs and outcomes drive commissioning priorities, and that those priorities are deliverable, affordable and sustainable.

1.7. The Strategic Commissioning Committee leads on what the system commissions — setting strategic direction, outcomes, service models and priorities, and assuring quality, performance, population health impact and statutory delivery.

1.8. The People and Resources Committee leads on how those priorities are enabled — ensuring that workforce, finance, estates, data and infrastructure are aligned to commissioning intent and deliver value for money.

1.9. Working together, the Committees will provide integrated assurance on deliverability, value and impact, with clear escalation to the Board where trade-offs or misalignment cannot be resolved.

1.10. For the ToRs, input was initially provided by key lead officers on the remit of the new Committees and their interactions to ensure that the Committee structure will be appropriate for transacting the business of, and providing the relevant assurance to, the Board

1.11. Following this, engagement has taken place via working group meetings between NEDs and Lead COs, as well as discussion at the March Transition Committee meeting, with further discussion taking place at the March NEDs / Execs meeting.

1.12. As a result of this engagement, the proposed Committee Terms of References (ToR) are appended to this report (see Appendices One and Two), along with the Scheme of Reservation and Delegation (Appendix Three).

1.13. The following sets out at a high level the responsibilities of each of the Committees in relation to the strategic commissioning cycle.

Next Steps and Further Actions

1.14. As we enter this period of implementation, flexibility will be required to allow arrangements to be shaped in action and respond to emerging issues. To support this, the following will take place:

- The established working groups between Committee Chairs, NEDs and the Lead COs will be maintained throughout Q1 to support development.

- A rapid review of the learning from the Transition Committee, also considering feedback from the Good Governance Institute's (GGI) Well- Led Review conducted during the year, to ensure best practice is carried forward into the new arrangements.

- A three-month post-implementation review of the two Committees will be conducted to further identify areas of potential improvement and amendment to the arrangements, which may include further changes to the SORD to enable more flexible decision-making arrangements.

- Rapid development of the sub-group structure that will support the work of the newly established Committees.

- Reaffirm governance hygiene processes and principles (building on GGI Well-Led Review), whilst also conducting a review of report standards to ensure timely and strategically focused reports to the Board and Committees.

- Strengthen processes and governance of management oversight and sign off of Committee reports ahead of their presentation to the Committees and the Board.

1.15. In addition to the above, the following areas will also be addressed during the coming period:

- Financial Scheme of Delegation – to be reviewed to ensure alignment with the new Committee structure, and to enable more flexible decision making across the organisation (expected to be presented to the Board in May 2026).

- Confirm locality governance arrangements to support the delivery of the NHS GM Operating Model (changes required to the SORD as a result, which will be presented to the Board).

- A review of System Groups to ensure these are aligned to the NHS GM Operating Model and linked into the governance structure appropriately.

- Review management forums, including Chief Officers, the Operational Leadership Group, and Executive Committee to ensure these are structured in the best way possible to support the delivery of the Operating Model and support the Board and its Committee structure.

- Development of more comprehensive decision logs to ensure decisions are accurately captured and communicated.

Recommendations

1.16. The Board are asked to:

1. Consider and approve the Committee Terms of Reference (Appendices One and Two) and the Scheme of Reservation and Delegation (Appendix Three) presented with this

report to enable the establishment of the new Committees from 1 April 2026.

2. Note the next steps and actions required to further develop and embed these new arrangements, as set out from paragraph 1.14 onwards.

NHS Greater Manchester

Strategic Commissioning Committee (Draft for Approval)

Terms of Reference

Purpose	The purpose of the Strategic Commissioning Committee ('the Committee') is to obtain assurance, on behalf of the Board, that the ICB has the right commissioning strategy and approach, supported by intelligence, which is delivering its quality, performance, population health, and oversight functions in a way that secures continuous improvement, whilst ensuring that the ICB operates as a strategic commissioner. The Committee will have a strong focus on improvement, prevention, population health and the left-shift as set out in the 10-Year Health Plan. The Committee will operate within an agreed shared governance model with the People and Resources Committee to ensure clarity of decision flow, avoid duplication, and prevent delays in financial approvals. The Strategic Commissioning and People and Resources Committees collectively provide Board assurance across the end-to-end strategic commissioning cycle, from assessment of population need and outcomes, through prioritisation and design, to resource enablement, implementation, performance, value and learning. The Strategic Commissioning Committee leads on commissioning intent, outcomes, service models and priorities, and provides assurance that these are clinically, population and evidence-led. The Committees will share information, risks, and escalations in a systematic and timely way to support effective Board oversight.
Duties	The Committee will: **Strategic Commissioning** - Apply constructive challenge to the strategic commissioning arrangements, and make recommendations to the Board or People and Resources Committee regarding procurement, and evaluation of contractual delivery. - Oversight of development and implementation of the Commissioning Strategy, ensuring this is developed within the resources available. - Ensure that opportunities for service redesign in line with the Commissioning Strategy are optimised. - Where proposals fall within approved budgets and the financial scheme of delegation, the Strategic Commissioning Committee will retain decision making responsibility. Where proposals exceed budget or require material financial variation (as set out in the financial scheme of delegation), the

People and Resources Committee will scrutinise financial implications and make relevant decisions, or where appropriate, escalate recommendations to the Board."

- Receive assurance on the commissioning processes and decisions across all commissioned services, including:-
    - Primary Care
    - Hospital and Community Health Services
    - Specialised Services
    - Services commissioned from VSCFE providers
    - NHS GM Place Based Partnerships

Clinical strategy

- Provide assurance to the Board that the ICB is compliant with the National Quality Board (NQB) requirements.
- Apply constructive challenge to the clinical strategy (including system clinical governance, patient safety and continuous improvement arrangements), make recommendations to the Board and monitor their implementation.
- Apply constructive challenge regarding the effectiveness of the arrangements in place to support quality planning, management, control and improvement across the system.

Performance and Planning

- Oversight of the development of annual and medium-term plan as required by NHSE and in line with the ICP Strategy.
- Receive assurance on the delivery of the constitutional standards as core deliverables for the organisation.

System oversight

- Obtain assurance that effective mechanisms (including System Oversight Framework mechanisms) are in place to review and monitor the quality of care delivered by providers and localities and are working effectively. This is mainly done by applying constructive challenge to the Integrated Performance Report.

Continuous improvement

- Apply constructive challenge to learning from patient safety, clinical effectiveness and patient experience activity.

Digital Strategy

- Apply constructive challenge to the strategic role of digital and IT in transforming commissioning, care delivery, system performance and outcomes.

- Oversee and obtain assurance on the development, implementation, and embedding of strategic digital priorities within the ICB's Commissioning Strategy, Population Health functions, and Integrated Care Partnership Strategy.

- Provide strategic oversight of alignment with the GM Health and Care Digital Transformation Strategy 2023-2027 and national digital infrastructure.

Population Health

- Take comprehensive action and exert influence across the organisation to ensure the delivery of the core aims of the ICB as they relate to improving health, reducing inequalities, retaining people in good health for longer, and driving whole system left shift.

- Provide assurance to the ICB that NHS GM is meeting is statutory responsibilities in relation to population health (including those responsibilities discharged through localities).

- Provide assurance that population health intelligence and analytical capabilities are robust in generating insight on population needs and inequalities, and that these insights are utilised to drive improvement action through a population health management approach.

- Ensure that the opportunities for the ICB to work with partners to improve the health of the population are maximised

Data and Intelligence

- Provide oversight and assurance that high quality intelligence, analytical insight and modelling are embedded across commissioning, performance, and population health activity. This includes ensuring that insight informs prioritisation, strategy development, service redesign and decision-making.

Delegated NHS England Responsibilities

Ensure that NHS GM fulfils its delegated statutory Public Health requirements as set out in the annual S7A Public Health Functions Agreement and collaborates with regional and national colleagues through the emerging Office for Pan-ICB Commissioning (OPIC) arrangements. Ensure that NHS GM fulfils its delegated responsibilities for Primary Care Commissioning under the NHS England delegation agreement, providing system-level assurance, oversight and strategic direction across primary medical, dental, ophthalmic and pharmaceutical services. Oversight

	of this area will be provided by the Primary Care Commissioning Group. **Strategic risks** - Monitor and provide assurance to the Board on BAF risks assigned to the committee, as well as relevant Corporate Risks. **Statutory Functions** - Apply constructive challenge to the delivery of the ICB key statutory and policy requirements, including All Age Continuing Healthcare (AACHC), complaints, mortality and learning from deaths, safeguarding adults and children, SEND, infection prevention and control, equality and diversity in relation to service delivery, patient safety incident response, medicines optimisation and safety and citizen involvement. **Other duties** - Apply constructive challenge to the ICB's response to all relevant (as applicable to quality) Directives, Regulations, national standard, policies, reports, reviews and best practice as issued by the DHSC, NHSE and other regulatory bodies / external agencies (e.g. CQC, NICE) to gain assurance that they are appropriately reviewed and actions are being undertaken, embedded and sustained. - Apply constructive challenge to the oversight of EPRR arrangements.
Membership	The membership of the committee shall comprise of the following members: • Non-executive Director (Chair) • Non-executive Director (Deputy Chair) • Non-executive Director • NHS GM Partner Member • NHS GM Partner Member • Chief Clinical Officer • Chief Commissioning Officer • Chief Reform and Improvement Officer • Chief Strategy, People and Partnerships Officer Only members of the Committee have the right to attend Committee meetings.
Attendees	Where any conflicts arise, the Chair may ask any or all of those who may be conflicted, including members, to withdraw from the meeting. Other individuals or partners will be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter including representatives from the Health and Wellbeing Board(s), Secondary and Community Providers. The Chief Executive should be invited to attend the meeting at least annually.

	The Chair of NHS GM may also be invited to attend one meeting each year in order to gain an understanding of the Committee's operations.
Delegated authority	The Committee is established by the Board as a Committee of the Board in accordance with its constitution. The Committee has delegated responsibility by the Board to: • Investigate any activity within its terms of reference • Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these terms of reference • Commission any reports it deems necessary to help fulfil its obligations • Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice. • The Committee may establish a sub-committee and arrange for the functions exercisable by the Committee to be exercised by the sub-committee. For the avoidance of doubt, the Committee will comply with the ICB Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation. Members will be expected to conduct business in line with NHS GM values and behaviours, including demonstrably considering the equality and diversity implications of decisions they make.
Meeting management	**Frequency** The Committee shall meet monthly a minimum of 10 times per year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required. Meetings will be held in public, however there may be occasions where items will need to be considered in private. And decisions to consider items in private will be evidenced, and be by agreement with the Chair. **Agenda and papers** The agenda and papers for meetings will be distributed five working days in advance of the meeting. **Attendance and Quorum** A quorum shall consist of 3 committee members, including The Chair or Vice Chair, and the Chief Clinical Officer or Chief Commissioning Officer (or nominated Clinical

	Deputy as agreed by the Chair). Members should attend at least 75% of meetings within any calendar year. Members are expected to nominate a deputy to attend in their absence. Attendance will be monitored and addressed by the Chair, who will be responsible for discussing regular non-attendance with the relevant member. The Chair of the Committee will also be required to bring to the attention of the Chair of NHS GM if they feel that lack of attendance has not enabled adequate discussion or decision making. **Support** The Corporate Governance team will support the committee. **Conflict of interest** Conflicts of interest should be disclosed and managed in line with the NHS GM Conflict of Interest Policy. The chair is responsible for the management of all conflict of interest matters. **Reporting** The Committee Chair shall report to the Board on the Committee's activities by: • Providing a written update report following each meeting • The presentation of an annual report • The minutes of the Committee's meetings shall be formally recorded by the Secretary and submitted to the Board. The Chairperson of the Committee shall draw to the attention of the Board of any issues that require disclosure to the full Board of Directors, or require action. **Annual self-assessment** The Committee shall undertake an annual self-assessment. It will report thereon to the Board. These terms of reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board.

Date agreed by the Strategic Commissioning Committee:	
Date approved by the Board:	
Review date:	

Appendix: Constructive challenge

In the context of this committee, constructive challenge typically involves prompts in one or more of the following areas:

Area:	Prompt:
Strategic alignment	Does the proposal support us to achieve our aims and objectives?
Deliverability	Do we have the capacity and capability to deliver?
Engagement	Do we understand the perspective of our stakeholders?
Learning and innovation	Is there evidence of learning shared across the system? Does the proposal harness innovation and best practice?
Evidence-base	How robust is the evidence that supports out approach?
Integration	Does the proposal leverage the opportunities for integration?
Value	Does the proposal create value, including social and economic value?
Measures	How are we measuring success?
Risks	What are the risks and how are we addressing them?

NHS Greater Manchester

People and Resources Committee (Draft for Approval)

Terms of Reference

Purpose	The purpose of the People and Resources Committee ('the Committee') is to obtain assurance, on behalf of the Board, that the ICB will achieve its statutory financial duties, and that the system is financially sustainable, by having the right financial strategy that results in the ICB meeting its financial targets and sustainability. The Committee will also provide strategic oversight, assurance, and guidance on behalf of the Board on all matters relating to workforce, organisational culture, and staff experience across NHS GM. The Committee will ensure that through the delivery of our organisation's People Plan, NHS GM fosters an inclusive, compassionate, and high-performing culture that supports the recruitment, retention, wellbeing, and development of its people. The Committee will also provide strategic oversight and assurance on matters relating to estates and environmental sustainability across NHS GM, as well as receiving assurance and constructively challenging the operational resourcing and delivery in the areas of digital and IT infrastructure, and data and intelligence. The Committee will operate within an agreed shared governance model with the Strategic Commissioning Committee to ensure clarity of decision flow, avoid duplication, and prevent delays in financial approvals and ensure delivery of investment standards. The People and Resources and Strategic Commissioning Committees will collectively provide Board assurance across the end-to-end strategic commissioning cycle, from assessment of population need and outcomes, through prioritisation and design, to resource enablement, implementation, performance, value and learning. Specifically, the People and Resources Committee leads on enabling delivery of agreed commissioning intent through workforce, finance, estates, IT, data and infrastructure, ensuring affordability, sustainability and value. The Committees will share information, risks, and escalations in a systematic and timely way to support effective Board oversight.
Duties	The Committee will: <u>Finance</u> **Financial strategy and planning** - Ensure delivery of the ICB financial plan / strategy and make recommendations to the Board

- Have oversight of the ICS financial position
- Where delivery of the financial plan is not assured, ensure the necessary actions are being taken to recover the position wherever possible
- Apply constructive challenge to medium and long-term ICB financial plans and monitor their implementation.

Resource allocation

- Apply constructive challenge to proposals in line with Financial Scheme of Delegation.
- Apply constructive challenge to business cases for major investments / disinvestments for material service change or efficiency schemes.
- Where proposals fall within approved budgets and the financial scheme of delegation, the Strategic Commissioning Committee will retain decision making responsibility. Where proposals exceed budget or require material financial variation (as set out in the financial scheme of delegation), the People and Resources Committee will scrutinise financial implications and make relevant decisions, or where appropriate, escalate recommendations to the Board."

Financial performance

- Provide assurance in relation to the ICB achieving its statutory duties.

People

Strategy and planning

- Review the NHS GM People, Culture and Organisational Development Plan and monitor progress with its implementation, through regular highlight reports.
- Review delivery of the ICB workforce elements of the 10 Year Health Plan, with a focus on sustainability and effectiveness.
- Oversee workforce planning, transformation and change programmes on behalf of the organisation.
- Oversee our performance against CQC standards, with a focus on the 'well led' measure.

Statutory duties

- The approval of disciplinary process and arrangements for employees, including the accountable officer (where he/she is an employee of NHS GM)

and for other persons working on behalf of NHS GM.

- Making recommendations regarding the approval of arrangements for discharging NHS GM's statutory duties as an Employer and for staff appointments.
- Making recommendations to the Remuneration Committee on items relating to the terms and conditions, remuneration and allowances for AfC employees
- Reviewing national policy and implementing accordingly, to ensure the organisation follows core employment legislation changes etc.
- Provide system oversight of workforce efficiencies.

Workforce performance and experience

- To monitor and review workforce key performance indicators for the organisation, including sickness absence, training, appraisal, bank and agency usage and escalate any issues to the NHS GM Board.
- Review the results of the annual staff survey and any other staff surveys and proposed organisation action plans.
- Review reports from the Freedom to Speak Up Guardian regarding activity within the organisation, reflecting the updated national and regional models.
- Review and approve partnership agreements with staff side.

Equality, diversity and inclusion

- Review workforce elements of the organisation's Equality, Diversity and Inclusion Implementation Plan prior to its submission to the Board, and monitor progress with delivery, including review of WRES, WDES, PSED, Gender, Disability and Ethnicity Pay Gap reports.
- Oversee progress to act on the Anti-Racism Framework and the Sexual Safety Charter.

Estates

Strategy

- To monitor implementation of the Infrastructure Strategy ensuring outcomes are achieved in line with required timescales
- Apply constructive challenge whilst working collaboratively with Strategic Partners and Stakeholders to drive the development of a flexible, greener and cost-efficient estate, aligned with service transformation priorities

Utilisation

- Provide strategic direction and support in achieving realistic cost efficiencies

and effective use of accommodation whilst ensuring optimum utilisation of retained estate

- Ensure DH Property Companies work in partnership with NHS GM to increase levels of utilisation; reduce void and subsidy costs; increase capital investment in the retained estate and to consider options at the end of the LIFT lease concessionary periods

Primary Care

- Review GP non mandatory occupational subsidies to reduce reimbursement costs and achieve an equitable outcome for all NHS GM practices
- Ensure adherence to statutory requirements under the provisions of the Premises Cost Directions in relation to GP Practice new leases and lease renewals in order to achieve value for money in terms of rent reimbursement
- Provide strategic advice and support to ensure primary care capital and revenue business case governance and approvals processes are followed

Corporate

- Review the corporate estate to establish strategic need and drive best practice in terms of provision and utilisation
- Promote flexible access to accommodation throughout the corporate estate
- Promote a robust Health & Safety culture ensuring compliance with statutory regulations and business policies

<u>Environmental Sustainability</u>

- Assurance of appropriate oversight for the implementation of the NHS Greater Manchester Green Plan
- Assurance of appropriate oversight for NHS Greater Manchester's statutory responsibilities on environmental sustainability

<u>IT and Digital</u>

- Apply constructive challenge to the operational resourcing and delivery of digital and IT infrastructure.
- Oversee and obtain assurance on resource planning and allocation for digital/IT.
- Manage corporate risks related to digital/IT (e.g., system downtime, cyber incidents, resource constraints, supplier performance), contributing to strategic

	risk oversight and the Board Assurance Framework where thresholds are met. - Apply constructive challenge to evidence of deliverability, value creation integration with estates/workforce functions. <u>Data</u> - Manage corporate risks in relation to the maintenance and development of the ICB's data assets. This will involve recognising the centrality of the asset to the wider system, including the provision of a secure data environment to support Research and innovation. - Oversee and obtain assurance on data assets in respect of data governance, infrastructure investment, recognising that data costs are naturally inflationary and that the commercial value of data is being realised through partnership reimbursement (data is not a free good) - Oversee and obtain assurance that data and analytical skills are being developed and supported in accordance with professionalisation and the future requirements of the organisation and it's role in the system **Enabling strategies** - Provide assurance around any enabling strategies, e.g. capital, and monitor their implementation. **Strategic risks** - Monitor and provide assurance to the Board on <u>BAF risks</u> assigned to the committee, as well as relevant Corporate Risks. **Other Duties** - Review and recommend the ICB's Standing Financial Instructions to the ICB Board. - Apply constructive challenge to action taken in response to changes in relevant national policy. - Approve any business cases, procurements, non-healthcare contracts and expenditure and also be notified of any Individualised Commissioning healthcare placements or packages in line with the financial scheme of delegation.
Membership	The membership of the committee shall comprise of the following members: • Non-executive director (Chair) • Non-executive director (Deputy Chair) • Non-executive director

	• NHS GM Partner Member • NHS GM Partner Member • Chief Executive Officer • Chief Finance Officer • Chief Strategy, People and Partnerships Officer • Chief Reform and Improvement Officer
Attendees	Where any conflicts of interest arise, the Chair may ask any or all of those who may be conflicted, including members, to withdraw from the meeting. Other individuals or partners will be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter. The Chair of NHS GM may also be invited to attend one meeting each year in order to gain an understanding of the Committee's operations.
Delegated authority	The Committee is established by the Board as a Committee of the Board in accordance with its constitution. The Committee has delegated responsibility by the Board to: • Investigate any activity within its terms of reference • Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these terms of reference • Commission any reports it deems necessary to help fulfil its obligations • Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice. • The Committee may establish a sub-committee and arrange for the functions exercisable by the Committee to be exercised by the sub-committee. For the avoidance of doubt, the Committee will comply with the ICB Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation. Members will be expected to conduct business in line with NHS GM values and behaviours, including demonstrably considering the equality and diversity implications of decisions they make.
Meeting management	**Frequency** The Committee shall meet monthly a minimum of 10 times per year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

Meetings will be held in public, however there may be occasions where items will need to be considered in private. And decisions to consider items in private will be evidenced, and be by agreement with the Chair.

Agenda and papers

The agenda and papers for meetings will be distributed five working days in advance of the meeting.

Attendance and Quorum

A quorum shall consist of 3 Committee members, including the Chair or Vice Chair, one other Non-Executive Director and the Chief Finance Officer (or Deputy Chief Finance Officer).

Members should attend at least 75% of meetings within any calendar year. Members are expected to nominate a deputy to attend in their absence. Attendance will be monitored and addressed by the Chair, who will be responsible for discussing regular non-attendance with the relevant member. The Chair of the Committee will also be required to bring to the attention of the Chair of NHS GM if they feel that lack of attendance has not enabled adequate discussion or decision making.

Support

The Corporate Governance team will support the committee.

Conflict of interest

Conflicts of interest should be disclosed and managed in line with the NHS GM Conflict of Interest Policy. The chair is responsible for the management of all conflict of interest matters.

Reporting

The Committee Chair shall report to the Board on the Committee's activities by:

- Providing a written update report following each meeting
- The presentation of an annual report
- The minutes of the Committee's meetings shall be formally recorded by the Secretary and submitted to the Board. The Chair of the Committee shall draw to the attention of the Board of any issues that require disclosure to the full Board of Directors, or require action.

Annual self-assessment

The Committee shall undertake an annual self-assessment. It will report thereon to the Board. These terms of reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board.

Date agreed by the People and Resources Committee:	
Date approved by the Board:	
Review date:	

Appendix: Constructive challenge

In the context of this committee, constructive challenge typically involves prompts in one or more of the following areas:

Area:	Prompt:
Strategic alignment	Does the proposal support us to achieve our aims and objectives?
Deliverability	Do we have the capacity and capability to deliver?
Engagement	Do we understand the perspective of our stakeholders?
Learning and innovation	Is there evidence of learning shared across the system? Does the proposal harness innovation and best practice?
Evidence-base	How robust is the evidence that supports out approach?
Integration	Does the proposal leverage the opportunities for integration?
Value	Does the proposal create value, including social and economic value?
Measures	How are we measuring success?
Risks	What are the risks and how are we addressing them?

NHS Greater Manchester Integrated Care Board –Scheme of Reservation and Delegation (SoRD) March 2026

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility	Supporting Notes
1.	**Regulation, control, constitution & governance**						
1.1	Determine the arrangements by which the ICB approves those decisions that are reserved for the Board where they have not been delegated	Board				Chief Strategy, People and Partnerships Officer	
1.2	Consider and approve applications to NHS England on changes to the Constitution	Board				Chief Strategy, People and Partnerships Officer	
1.3	Exercise or delegation of those functions of the ICB which have not been retained as reserved by or delegated to the Board or to a committee or sub-committee of the group or to one of its	Board				Chief Strategy, People and Partnerships Officer	

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility	Supporting Notes
	employees.						
1.4	Prepare the ICB scheme of reservation and delegation (SORD), which sets out those decisions that are in statute the responsibility of the ICB are reserved to the ICB and those delegated to • committees and sub-committees, • employees			Chief Strategy, People and Partnerships Officer		Chief Strategy, People and Partnerships Officer	
1.5	Approval of the ICB scheme of reservation and delegation, which sets out those decisions that are statutory responsibility and that are reserved and those delegated to the • Board • committees, sub-committees, or advisory panels	Board			Audit Committee	Chief Strategy, People and Partnerships Officer	

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility	Supporting Notes
	of the group or • employees						
1.6	Promote the governance arrangements of the ICB to employees and to people working on behalf of the ICB			Chief Executive		Chief Strategy, People and Partnerships Officer (Corporate) Chief Finance Officer (Financial)	
1.7	Disclosure of non-compliance with the group's constitution (incorporating its standing orders, prime financial policies and scheme of reservation and delegation)	Board			Audit Committee	Chief Strategy, People and Partnerships Officer (Corporate) Chief Finance Officer (Financial)	Any incidents of non-compliance relating to financial governance should also be reported to the People and Resources Committee.
1.8	Review of suspension of standing orders		Audit Committee			Chief Strategy, People and Partnerships Officer	

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility	Supporting Notes
1.9	Suspension of standing orders	Board				Chief Strategy, People and Partnerships Officer	
1.10	Preparation of the operational scheme of delegation (incl. financial limits) that underpins the group's overarching scheme of reservation and delegation			Chief Strategy, People and Partnerships Officer (Corporate) Chief Finance Officer (Financial)		Chief Strategy, People and Partnerships Officer (Corporate) Chief Finance Officer (Financial)	
1.11	Approval of the operational scheme of delegation (incl. financial limits) that underpins the group's overarching scheme of reservation and delegation	Board			Audit Committee	Chief Strategy, People and Partnerships Officer (Corporate) Chief Finance Officer (Financial)	

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility	Supporting Notes
1.12	Approve the group's prime financial policies on financial governance	Board			People and Resources Committee	Chief Finance Officer	
1.13	Set out who can execute a document by signature/ use of the seal	Board				Chief Finance Officer	
1.14	Approve the arrangements for discharging the ICB's statutory duties and functions	Board				Chief Strategy, People and Partnerships Officer (Corporate) Chief Finance Officer (Financial)	

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility	Supporting Notes
1.15	Establish governance arrangements to support collective accountability between partner organisations for whole system delivery and performance, underpinned by the statutory and contractual accountabilities of individual organisations	Board				Deputy CEO (Chief System Reform and Improvement Officer)	Any quality, performance and financial implications should be considered and reviewed by the relevant NHS GM directorates before recommending a course of action.
1.16	Establish governance arrangements to support collective accountability between partner organisations for place- based system delivery and performance, underpinned by the statutory and contractual accountabilities of individual organisations.	Board			Locality Place Based Committees	Locality Place Based Leads Chief Strategy, People and Partnerships Officer (Corporate) Deputy CEO (Chief System Reform and Improvement Officer)	Any quality, performance and financial implications should be considered and reviewed by the relevant NHS GM directorates before recommending a course of action.

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility	Supporting Notes
1.17	Establish governance arrangements to ensure the continuation of joint commissioning and partnership working at locality level of those functions that are apt for inclusion in a s.75 agreement between the ICB and local authority.	Board			Locality Place Based Committees	Locality Place Based Leads	Any quality, performance and financial implications should be considered and reviewed by the relevant NHS GM directorates before recommending a course of action.
1.18	To exercise any function at locality level which has not been reserved to the Board or delegated to Locality Place Based Committees or any other committee or board or sub-committee or joint committee or board, or any other officer.			Locality Place Based Leads		Locality Place Based Leads	
2. Strategy & Planning							
2.1	Approve the values and planning in accordance with strategic direction of the ICP	Board			People & Resources Committee Strategic	Chief Finance Officer Chief Strategy, People & Partnerships Officer	

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility	Supporting Notes
					Commissioning Committee		
2.2	Approve the ICB operating structure	Board			Chief Executive	Chief Executive	
2.3	Approve the ICB strategic plan	Board			Chief Executive	Chief Strategy, People & Partnerships Officer	
2.4	Approve the ICB arrangements for engaging the public and key stakeholders in the group's planning and commissioning arrangements	Board			Strategic Commissioning Committee	Chief Strategy, People & Partnerships Officer Chief Commissioning Officer	The Assurance and Involvement Group (AIG) will consider all proposals for public engagement or consultation before referring to the Board for agreement.
2.5	Approve the ICB budgets that meet the financial duties of the ICB	Board			People and Resources Committee	Chief Finance Officer	
2.6	Agree a plan to meet the health and healthcare needs of the Greater Manchester population, within the context of national strategy, the Partnership integrated care strategy and place	Board			Strategic Commissioning Committee	Chief Healthcare Commissioning Officer Chief Strategy, People & Partnerships Officer	

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility	Supporting Notes
	health and wellbeing strategies						
2.7	Agree a plan to meet the health and healthcare needs of the population within each place, within the context of national strategy, the Partnership integrated care strategy and place health and wellbeing strategies		Locality Place Based Committees			Locality Place Based Leads	Strategic direction set by the Board, supported by the Strategic Commissioning Committee
2.8	Allocate resources to deliver the plan across the system, determining what resources should be available to meet population need across GM and in each place and setting principles for how they should be allocated across services and providers (both revenue and capital)	Board			People and Resources Committee Strategic Commissioning Committee	Chief Finance Officer	
2.9	Allocate resources to deliver the plan at place, determining what		Locality Place Based Committees			Chief Finance Officer Locality Place Based	Resource allocation plans for NHS GM will be agreed by the Board. Localities will determine

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility	Supporting Notes
	resources as delegated by the Board should be available to meet population need in place and setting principles for how they should be allocated across services and providers (both revenue and capital)					Leads	how delegated resources will be used to deliver the plans in place (operating in line with the Financial Scheme of Delegation)
2.10	Approve decisions on the review, planning and procurement of primary medical care services (to reflect the terms of the delegation agreement with NHS England)		Primary Care Commissioning Group			Chief Commissioning Officer	Any quality, performance and financial implications should be considered and reviewed by the relevant NHS GM directorates before recommending a course of action. Any financial implications of a decision will need to be agreed in line with the NHS GM Financial Scheme of Delegation.
2.11	Approve decisions on the review, planning and procurement of Specialised	Board			People and Resources Committee	Chief Commissioning Officer	Any financial implications of a decision will need to be agreed in line with the NHS GM

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility	Supporting Notes
	Commissioning services for the Greater Manchester population (to reflect the terms of the delegation agreement between NHS England and NHS Greater Manchester ICB)				Strategic Commissioning Committee		Financial Scheme of Delegation Any quality, performance and financial implications should be considered before recommending a course of action.
2.12	Approve decisions on the review, planning and procurement of Specialised Commissioning services for the North West of England population made at the North West Specialised Commissioning Services Joint Committee			Chief Healthcare Commissioning Officer Non-Executive Director	People and Resources Committee Strategic Commissioning Committee	Chief Commissioning Officer	Any financial implications of a decision will need to be agreed in line with the NHS GM Financial Scheme of Delegation. Any quality, performance and financial implications should be considered before recommending a course of action.
2.13	Approve the operating structure in each place			Chief Executive	Locality Place Based Committees	Locality Place Based Leads	The operating structure for each service area will be agreed by the relevant Executive Director or Chief Officer
2.14	Agree system-wide action on data and digital:	Board				Deputy CEO (Chief Reform and	

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility	Supporting Notes
	working with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services to put the citizen at the centre of their care					Improvement Officer)	
2.15	Agree place action on data and digital: working with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services to put the citizen at the centre of their care		Locality Place Based Committees			Deputy CEO (Chief Reform and Improvement Officer) Locality Place Based Leads	
2.16	Agree GM joint work on estates, procurement, supply chain and commercial strategies to maximise value for money across the system and support wider goals of development and		People and Resources Committee			Chief Finance Officer	

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility	Supporting Notes
	sustainability						
2.17	Agree place action on estates, procurement, supply chain and commercial strategies to maximise value for money across the system and support wider goals of development and sustainability		Locality Place Based Committees		People & Resources Committee	Chief Finance Officer Locality Place Based Leads	
2.18	Agree arrangements for planning responding to and leading recovery from incidents (EPRR), to ensure NHS and partner organisations are joined up at times of greatest need, including taking on incident coordination responsibilities as delegated by NHSE/I	Board			Deputy CEO (Chief Reform and Improvement Officer)	Deputy CEO (Chief Reform and Improvement Officer)	
3. Annual Reports and Accounts							

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility	Supporting Notes
3.1	Approval of the ICB annual report and annual accounts		Audit Committee			Chief Strategy, People and Partnerships Officer Chief Finance Officer	
3.2	Approval of the arrangements for discharging the group's statutory financial duties	Board			Audit Committee	Chief Finance Officer	
4. Partnership Working							
4.1	Agree joint working arrangements with partners that embed collaboration as the basis for delivery within the ICB plan	Board				All Chief Officers and Place Based Locality Leads	
4.2	Develop joint working arrangements with partners in place that embed collaboration as the basis for delivery within the ICB plan		Locality Place Based Committees			All Chief Officers and Place Based Locality Leads	

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility	Supporting Notes
4.3	Approve arrangements for coordinating the commissioning of services with other ICBs or with local authorities, where appropriate	Board			Chief Executive	Chief Healthcare Commissioning Officer Chief Finance Officer	
4.4	Approve arrangements for risk sharing and /or risk pooling with other organisations (for example arrangements for pooled funds with other ICBs or pooled budget arrangements under section 75 of the NHS Act 2006)	Board			People & Resources Committee	Chief Finance Officer	
5. Employment, Remuneration, Workforce & OD							

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility	Supporting Notes
5.1	Agree implementation of the ICB's People, Culture and Organisational Development Plans.		People and Resources Committee		Chief Strategy, People and Partnerships Officer	Chief Strategy, People and Partnerships Officer	
5.2	Agree implementation of the ICB's People, Culture and Organisational Development Plans in Locality		Locality Place Based Committee		People and Resources Committee	Chief Strategy, People and Partnerships Officer	
5.3	Accountability for the ICB's responsibilities as an employer including adopting a Code of Conduct for staff	Board			People and Resources Sub-Committee	Chief Strategy, People and Partnerships Officer	

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility	Supporting Notes
5.4	Approve the terms and conditions, remuneration and travelling or other allowances for Board members, including pensions and gratuities		Remuneration Committee		Chief Strategy, People and Partnerships Officer	Chief Strategy, People and Partnerships Officer	Relevant financial implications must be considered with the NHS GM Finance Team before recommending a course of action.
5.5	Approve the terms and conditions of employment for non-AFC employees including pensions, remuneration, fees and travelling or other allowances for employees of the ICB and to other persons providing services to the ICB		Remuneration Committee		Chief Strategy, People and Partnerships Officer	Chief Strategy, People and Partnerships Officer	Relevant financial implications must be considered with the NHS GM Finance Team before recommending a course of action.
5.6	Approve any other terms and conditions of services for the ICB's AFC employees		People Resources Committee		Chief Strategy, People and Partnerships Officer	Chief Strategy, People and Partnerships Officer	Relevant financial implications must be considered with the NHS GM Finance Team before recommending a course of action.
5.7	Approve disciplinary arrangements for employees, including the accountable officer (where he/she is an		People and Resources Committee			Chief Strategy, People and Partnerships Officer	

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility	Supporting Notes
	employee of the ICB) and for other persons working on behalf of the ICB						
5.8	Approve disciplinary arrangements where the ICB has joint appointments with another group and the individuals are employees of that group		People and Resources Committee			Chief Strategy, People and Partnerships Officer	
5.9	Approval of the arrangements for discharging the ICB's statutory duties as an employer	Board			People and Resources Committee	Chief Strategy, People and Partnerships Officer	
5.10	Approve human resources policies for ICB employees and for other persons working on behalf of the ICB		People and Resources Committee			Chief Strategy, People and Partnerships Officer	All policies must be considered by the NHS GM Policy Review Groups before a course of action is recommended
5.11	Approve arrangements for staff appointments	Board			People and Resources Committee	Chief Strategy, People and Partnerships Officer	
5.11a	Appointment of ICB Chief Exec			NHS GM Chair		Chief Strategy, People and Partnerships Officer	As per the NHS GM Constitution, the appointment will be

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility	Supporting Notes
							subject to the approval of NHS England in accordance with any procedure published by NHS England The Remuneration Committee, in consultation with Finance, should consider financial implications of the proposed appointment.
5.11b	Appointment of all other roles			Chief Executive	People and Resources Committee	Chief Strategy, People and Partnerships Officer	
5.12	Approve the ICB organisational development plans		People and Resources Committee		Chief Executive and Chief People Officer	Chief Strategy, People and Partnerships Officer	
6. Quality and Safety							
6.1	Establish clinical governance arrangements to support collective accountability between partner organisations		Strategic Commissioning Committee		Quality Group	Chief Clinical Officer Chief Commissioning Officer	

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility	Supporting Notes
6.2	Approve arrangements to ensure duties are discharged effectively and foster the development of policies, processes and initiatives to minimise clinical risk, maximise patient safety, and promote equality to secure the continuous improvement in quality and patient outcomes		Strategic Commissioning Committee		Clinical Effectiveness Group Quality Group	Chief Clinical Officer Chief Commissioning Officer	All policies must be considered by the NHS GM Policy Review Groups before a course of action is recommended
6.3	Approve the ICB arrangements for handling complaints		Strategic Commissioning Committee		Quality Group	Chief Strategy, People and Partnerships Officer	
6.4	Approve the ICB arrangements for safeguarding children and vulnerable adults		Strategic Commissioning Committee		Quality Sub-Group Safeguarding Group	Chief Clinical Officer Chief Commissioning Officer	
6.5	Approve the ICB arrangements for engaging patients and their carers in decisions concerning their healthcare		Strategic Commissioning Committee		Quality Group	Chief Clinical Officer Chief Commissioning Officer	

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility	Supporting Notes
6.6	Approve arrangements for supporting the NHS in discharging its responsibilities in relation to securing continuous improvement in the quality of general medical services		Strategic Commissioning Committee		Quality Group	Chief Clinical Officer Chief Commissioning Officer	
6.7	Approve the arrangements for the quality oversight, assurance and improvement systems within the ICS.		Strategic Commissioning Committee		Quality Group	Chief Clinical Officer Chief Commissioning Officer	
6.8	Approve the arrangements for delivering the NHS Patient Safety Strategy to achieve its vision to continuously improve patient safety and to develop and implement the patient safety initiatives that the strategy introduced.		Strategic Commissioning Committee		Quality Group	Chief Clinical Officer Chief Commissioning Officer	

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility	Supporting Notes
6.9	Agree the Strategy for Quality and Patient Safety inclusive of the aligned quality priorities for the system		Strategic Commissioning Committee		Quality Group	Chief Clinical Officer Chief Commissioning Officer	
6.10	Agree the ICB arrangements for responding to and learning from patient safety events		Strategic Commissioning Committee		Quality Group	Chief Clinical Officer Chief Commissioning Officer	
6.11	Approve the operating structure for the monitoring, oversight and reporting on Quality and Safety in each place		Strategic Commissioning Committee		Quality Group	Chief Clinical Officer Chief Commissioning Officer	
7. Business operation and Risk Management							
7.1	Approve the ICB counter fraud and security management arrangements		Audit Committee			Chief Finance Officer	
7.2	Approval of the ICB risk management arrangements	Board			Audit Committee	Chief Strategy, People and Partnerships Officer	

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility	Supporting Notes
7.3	Approve ICB operational policies (i.e. excluding those defined as clinical or finance)		Audit Committee			Relevant Chief Officer Dependent on Policy Area Chief Finance Officer (any financial implications)	All policies must be considered by the NHS GM Policy Review Groups before a course of action is recommended
7.4	Approve ICB corporate and financial policies		Audit Committee		Finance Committee (for financial policies)	Chief Strategy, People and Partnerships Officer Chief Finance Officer	All policies must be considered by the NHS GM Policy Review Groups before a course of action is recommended
7.5	Approve ICB clinical and medical policies and clinical pathways		Strategic Commissioning Committee		Clinical Effectiveness Group (CEG)	Chief Clinical Officer	
7.6	Approve system-level arrangements to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes	Board			Strategic Commissioning Committee	Chief Clinical Officer	

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility	Supporting Notes
7.7	Approve arrangements for managing conflicts of interest	Board			Audit Committee	Chief Strategy, People and Partnerships Officer	
7.8	Approve arrangements for complying with the NHS Provider Selection Regime	Board			People and Resources Committee	Chief Finance Officer	
7.9	Report and provide assurance to the Board on the effectiveness of ICB governance arrangements		Audit Committee			Chief Strategy, People and Partnerships Officer (Corporate) Chief Finance Officer (Financial)	
7.10	Receive the annual governance letter from the External Auditor and advise the Board of proposed action		Audit Committee			Chief Strategy, People and Partnerships Officer Chief Finance Officer	
7.11	Approve the internal audit, external audit and counter-fraud plans and any changes to the provision or delivery of related services (other than the appointment or		Audit Committee			Chief Strategy, People and Partnerships Officer (Corporate) Chief Finance Officer (Financial)	

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility	Supporting Notes
	removal of the external auditor where authority is reserved to the Board)						
8.	**Information Governance**						
8.1	Approve the arrangements for ensuring appropriate and safekeeping and confidentiality of records and for the storage, management and transfer of information and data			Chief Executive	Information Governance Operational Group	Senior Information Risk Officer (SIRO) Caldicott Guardian	Assurance to be provided to the Audit Committee via the SIRO
8.2	Approve information sharing protocols with other organisations			Chief Executive	Information Governance Operational Group	Senior Information Risk Officer (SIRO)	Assurance to be provided to the Audit Committee via the SIRO
8.3	Approve arrangements for handling Freedom of Information and Subject Access requests			Chief Executive	Information Governance Operational Group	Executive Director Responsible for Governance	Assurance to be provided to the Audit Committee via the SIRO
9.	**Partnership, joint or collaborative working**						

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility	Supporting Notes
9.1	Approve the arrangements governing joint or collaborative arrangements between the ICB and another statutory body(ies), where those arrangements incorporate decision making responsibilities	Board		Chief Executive		Chief Strategy, People and Partnerships Officer (Corporate) Chief Finance Officer (Financial)	Discussion at Chief Officers as required
9.2	Approve the delegated decision-making responsibilities of individual employees of the ICB who represent the ICB in joint or collaborative arrangements with another statutory body(ies)	Board			NHS GM Chair	Chief Strategy, People and Partnerships Officer (Corporate) Chief Finance Officer (Financial)	

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility	Supporting Notes
9.3	Receive the minutes of meetings of, or reports from, joint or collaborative arrangements between the ICB and another statutory body(ies)	Board				Chief Strategy, People and Partnerships Officer	
10. Communications							
10.1	Approval of ICB communications plan	Board			Chief Executive	Chief Strategy, People and Partnerships Officer	
11. Arrangements for Patient & Public Involvement							
11.1	Approve arrangements for the involvement of and consultation with patients and the public in ICB decision making	Board			Strategic Commissioning Committee	Chief Strategy, People and Partnerships Officer	

NHS
Greater Manchester

Board Assurance Framework Report

18th March 2026

Part of Greater Manchester
Integrated Care Partnership

NHS Greater Manchester

Integrated Care Board

18th March 2026

Required information	Details
Title of report	Board Assurance Framework Report
Author	Chris Gaffey, Associate Director of Corporate Services
Presented by	Nicola Hepburn, Interim Chief Reform and Improvement Officer Chris Gaffey, Associate Director of Corporate Services
Contact for further information	Rick Thompstone, Assistant Director Risk & PMO – rick.thompstone@nhs.net
Executive summary	This report provides an update to the Integrated Care Board on the updated strategic risks for the organisation (the BAF is set out in Appendix One).
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 Integrated Care Board is asked to: • Consider and approve the updated strategic risk descriptions and scores • Confirm the assignment of BAF risks to the relevant Committees (if approved and established) from April 2026, as set out in section three of the report.
How this supports the delivery of the strategy and mitigates the BAF risks	This report is directly focused on Risk Management which includes the BAF risks.
Key milestones	Transition Committee – 4 March 2026 Formal Board consideration – 18 March 2026
Leadership and governance arrangements	Each strategic risk has an assigned risk owner, who is a Chief Officer of NHS GM. The BAF is reported to and considered by the Board at each of its meetings, with the strategic

	risks also considered at the Transition Committee. The NHS GM Risk Policy provides a framework to enable risk management to be embedded across all activities within the organisation
Engagement* to date ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	The BAF and Corporate Risks are considered by the relevant Committee, as well as the NHS GM Chief Officers for management oversight.
Financial or Legal Implications	None.

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

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

1.0 Introduction

1.1 This report provides the update on the Strategic Risks following review during February 2026.

2.0 Strategic Risks

2.1 Since the January Board meeting, the strategic risks have been considered by the Executive Lead in partnership with their Non-Executive Director to finalise the risk descriptions and provide an update on the current risk positions.

2.2 Table 1 below shows the agreed strategic risks, aligned to the strategic objectives as well as the current risk score (some risk leads have provided provisional Q4 scores, these will be confirmed in the May 2026 update). Appendix One contains the details for each of the risks but headline messages are identified below:

- BAF Risk SR6 (Workforce) is reporting an increased risk score for this return, with a current score of 16 - this is above the year-end target.
- Risks SR4 (Good Employment), SR7 (Finance) and SR9 (Emergency Incident) are reporting a reduced risk score for this quarter. Additional information has been provided below to fully explain the rationale for these reductions.
- All remaining risks are reporting a static risk score this quarter
- Risks SR1 (Population Health), SR5 (Health Inequalities), SR6 (Workforce), SR7 (Finance) and SR10 (NHS Reform are all showing a variation between current score and year-end target score. A full analysis of the variation between final year-end scores and the target scores will be provided in the May report and risk leads will be asked to provide an explanation of any variations. This analysis will also include an analysis of the position between the year end score and the agreed risk appetite.

2.3 The Board Assurance Framework risks were considered at the Transition Committee. There was discussion around the four risks (SR1, SR4, SR7 and SR9) that had reduced scores and a request for these scores to be reconsidered in light of the increased uncertainty in relation to the ongoing NHS Reform Programme. The risk owners and leads were asked to review the scores and provide a further rationale on any proposed reductions.

2.4 The rationales are set out below:

SR1 Population Health

2.5 The rationale for reducing this was that the mitigation and controls related to the development of the GMS and its delivery plan, both of which are now in place. For this reason, the likelihood score was reduced from 3 (Possible) to 2 (Unlikely).

2.6 However, there is a very recent counterbalance to this which is the likely impact of the Iran conflict on the cost of living and the economy. As such, whilst this unfolds the likelihood score has been increased back up to 3 (Possible).

SR4 Good Employment

2.7 The rationale for reducing this risk score was that the mitigation and controls related to the development of the GMS and its delivery plan, the agreement to an Integrated Settlement, creation of a Get GM Working Plan and delivery of various work programmes, all of which are now in place. This to some extent reduces the likelihood which is what is reflected in the reduction of the score from 4 (Likely) to 3 (Possible). It does not remove the risk which is why there is still a score of 3 (Possible).

SR7 Financial sustainability

2.8 The risk score reduced from 20 to 16 on the basis of the “likelihood” of missing the year-end position reduced from 5 to 4. This is because, based on the M10 position, NHS GM is on target to deliver the plan.

SR9 Emergency Incident

2.9 The score has reduced risk due to the recruitment in Q3 and the return of a member of staff from long term sick, improving the staffing position.

2.10 The team now includes a band 8C, 2 x Band 7’s and a full time Band 6, along with a secondee providing some leadership and expertise. There is increased resilience and once a band 8B is in post the team will have a full complement.

NHS GM Board Assurance Framework
March 2026

Strategic Objectives

Strengthen our Communities	Recover core health and care services	Help people get into, and stay in, good work	Help people to stay well and detect illness earlier	Support our workforce and carers	Achieve financial sustainability	Meet our statutory obligations

Strategic Risks

SR1	SR2	SR3	SR4	SR5	SR6	SR7	SR8	SR9	SR10
Health of the Population	**Health Outcomes**	**Quality of Care**	**Good Employment**	**Health Inequalities**	**Workforce**	**Financial Sustainability**	**Cyber Security**	**Emergency Incident**	**NHS Reform**
Current Score 2 (L) x 5 (I) = **15**	Current Score 4 (L) x 5 (I) = **20**	Current Score 3 (L) x 5 (I) = **15**	Current Score 3 (L) x 4 (I) = **12**	Current Score 4 (L) x 4 (I) = **16**	Current Score 4 (L) x 4 (I) = **16**	Current Score 4 (L) x 4 (I) = **16**	Current Score 3 (L) x 4 (I) = **12**	Current Score 4 (L) x 4 (I) = 9	Current Score 4 (L) x 4 (I) = 16
Trend: ⇔	Trend: ⇔	Trend: ⇔	Trend: ⇩	Trend: ⇔	Trend: ⇧	Trend: ⇩	Trend: ⇔	Trend: ⇩	Trend: ⇔
Year End Target 2 (L) x 5 (I) = 10	Year End Target 4 (L) x 5 (I) = 20	Year End Target 3 (L) x 5 (I) = 15	Year End Target 3 (L) x 4 (I) = 12	Year End Target 3 (L) x 4 (I) = 12	Year End Target 3 (L) x 3 (I) = 9	Year End Target 4 (L) x 3 (I) = 12	Year End Target 3 (L) x 4 (I) = 12	Year End Target 3 (L) x 3 (I) = 9	Year End Target 3 (L) x 3 (I) = 9
Final Target Score **5** (2028)	Final Target Score **10** (2028)	Final Target Score **10** (2028)	Final Target Score **8** (2029)	Final Target Score **4** (2028)	Final Target Score **9** (2028)	Final Target Score **12** (2025)	Final Target Score **8** (2028)	Final Target Score **6** (2028)	Final Target Score **4** (2026)
Risk Appetite: Open	Risk Appetite: Cautious to Open	Risk Appetite: Cautious to Open	Risk Appetite: Open	Risk Appetite: Open	Risk Appetite: Open	Risk Appetite: Open	Risk Appetite: Cautious	Risk Appetite: Cautious to Open	Risk Appetite: Cautious to Open
10 - 20	**5 - 15**	**5 - 15**	**10 - 20**	**10 - 20**	**10 - 20**	**10 - 20**	**5 -10**	**5 - 15**	**5 - 15**

3.0 Proposed BAF Risk Reporting Arrangements for New Committee Structure (pending approval)

3.1 As the Board will be aware, BAF risks are considered by the relevant supporting Committees to ensure robust discussion and assurance at Committee level ahead of reporting to the Board.

3.2 If agreed, the two new Committees of the Board will be as follows:

- Strategic Commissioning Committee
- People & Resources Committee

3.3 Following discussion at the Transition Committee, it is proposed that the BAF risks will be considered by the new Committees (if approved) as follows:.

3.4 The People and Resources Committee will consider the following BAF risks:

SR6	SR7	SR8
Workforce	**Financial Sustainability**	**Cyber Security**

3.5 The Strategic Commissioning Committee will consider the following BAF risks:

SR1	SR2	SR3	SR4	SR5	SR9
Health of the Population	**Health Outcomes**	**Quality of Care**	**Good Employment**	**Health Inequalities**	**Emergency Incident**

3.6 Due to its cross-cutting nature, it was proposed and agreed that the SR10 (NHS Reform) would be considered by both Committees.

4.0 Recommendations

4.1 The Board is asked to:

- Consider and approve the updated strategic risk descriptions and scores.
- Confirm the assignment of BAF risks to the relevant Committees (if approved and established) from April 2026, as set out in section three of the report.

Strategic Risk **SR1**	There is a risk that the health of the population will worsen due to wider economic and social conditions deteriorating. This could include societal challenges and structural inequalities that relate to poverty / socio-economic disadvantage, housing and local infrastructure, early years experiences and educational attainment, access to good employment, crime and safety, air quality and transport. This will result in poorer health, unsustainable demand on health and care services and will impede economic growth.			
Strategic Objective	Strengthen our communities			
Chief Officer / Committee	Charlotte Bailey	Transition Committee (formerly Population Health Committee)		
Risk Appetite Level	3 - Open	Risk Tolerance Range (e.g. 5 to 10)	10 - 20	

Rationale for Risk Score and Progress made in the quarter

The health of the population is primarily determined by the wider, social and commercial determinants of health ("building blocks of health") and structural inequalities / discrimination. This includes determinants such as housing, poverty, educational attainment, air quality, good employment, transport. Building upon significant progress over recent years in areas such as growth, early years and transport, the ambitions set out within the new Greater Manchester Strategy 2025-35 provide the framework upon which the system will take action to influence these risk factors and improve health outcomes, including through Live Well.

Key Controls

The Greater Manchester Strategy is the main control measure and the deliverability of the strategy including the extent to which the ICB can act as a system influencer and strategic investor is key to mitigating this risk. In the current landscape of NHS reform, it is crucial that the ICB retains the capacity, expertise and ability to act as a collaborative system influencer and co-investor in relation to the building blocks of health which the strategy covers.

Alongside the GMS, another key control is the development of a comprehensive strategic approach to NHS 'left shift' which builds upon our GM Population Health Model and comprehensive Prevention and Early Intervention Framework and underpins ICB reform and future transformational operating model.

An evidence-based, co-produced and fully costed NHS GM Annual Plan for 2025/26 includes a series of actions relating to reducing the prevalence of poor health and scaling up proactive care.

A Fairer Health for All Framework has been agreed by the Integrated Care Board and there are significant implementation plans in place for 2025/26 which will seek to embed tacking inequalities as a focus of the system. The GM Housing Tripartite Agreement ensures a collaborative approach to healthy homes across NHS GM, GMCA and Housing Providers.

Gaps in Control or Assurance

Current reforms have and likely will continue to significantly impact any proactive NHS system involvement in delivery of the various strategic ambitions. Continuation of this will mean programmes develop without relevant health system influence and opportunities are missed to improve the health of the population.

The NHS Reform could impact on the capability of the ICB to provide the resource, skills, expert knowledge and capacity to effectively work across multiple systems in order to fulfil our role in driving the delivery of the GMS. A significant reduction in ICB headcount due to VR and restructuring will mean capacity and expertise gaps will appear. The total impact of the reform is still to be fully understood, however direct impact on Population Health capacity is already apparent with some key programmes of work losing key personnel.

The delay in organisational 'left shift' activity and investment will impact progress of prevention and early intervention opportunities and transformation propositions.

Risk Scoring and Tolerance

	Inherent risk score	Q1	Q2	Q3	Q4	Year-end Target	Long Term Target	Long Term Target Date
Likelihood	3	3	3	3	3	2	1	2028
Impact	5	5	5	5	5	5	5	
Risk Level	15	15	15	15	15	10	5	

Number of Linked Risks on Corporate Risk Register

Low (1 - 4)	Mod (6 – 12)	High (15 – 25)
0	0	6

Lines of Defence	Sources of Assurance	Assurance Level
1st Line	ICB twice weekly Chief Officers meetings; Strategy People & Partnership directorate SLT meetings; Weekly Population Health function SMT; SPP Chief Officer is a member of NHS GM Chief Officers Group; GM Tripartite Agreement Core Group; GM Housing First Board	Acceptable
2nd Line	Population Health Committee governance processes followed. PHC Chair sits on ICB and regularly reports from PH Committee and PH function to ICB and ICP Board. Maintenance of Strategic Risk Register and collation of the strategic risks into the Board Assurance Framework.	Acceptable
3rd Line	GM Public Health Leadership Group which consists of 10xLocal Authority Directors of Public Health, NHS GM, OHID, UKHSA and NHSE NW; NW Population Health Board; GMCA and Health Scrutiny - includes an articulation of key risks and issues.	Acceptable

Action		
	Complete/BAU	On Track
	Delayed	Problematic

No	Action Required	Due Date	Progress	BRAG
1	Delivery of GMS under a new delivery framework	Ongoing	The delivery plans and associated governance are now well advanced and provide confidence around delivery of the strategy	
2	Development of refreshed Tripartite Agreement document (completed in October) and delivery plan to continue best practice work across NHS GM and GMCA re: housing	March 2026	Tripartite Agreement signed off by GMCA on 28th Nov 2025. And ICB in Jan 2026 Action to be replaced in Q1 2026/27.	
3	Ensure the NHS Reform programme maintains the "left shift" priority and can provide the capability required from NHS GM to continue as a system influencer and strategic investor across the GMS building blocks for health, including through greater collaboration with key partners such as the GM Directors of Public Health and the GMCA.	March 2026	Programme of ICB Reform is ongoing and the draft Strategic Commissioning Plan has a strong focus on Population Health and Prevention	
4	Development and design of an integrated GM Public Health Network which consists of 10xLocal Authority Directors of Public Health, NHS GM Pop Hlth, OHID, UKHSA and NHSE NW	June 2026	On track for the implementation of Phase 1 of the transformation during Q1 2026/27.	

Strategic Risk **SR2**	There is a risk that key health and care services become unsafe and unstable due to growing and changing demand, pressures faced by other sectors and workforce, estates and technology gaps. This will result in poorer health outcomes for the GM population and a reduction in quality of care and patient safety and an inability to deliver operational delivery standards.
Strategic Objective	Recover core health and care services
Chief Officer / Committee	Gareth Robinson Transition Committee (formerly Quality and Performance Committee)

Risk Appetite Level	Cautious to Open	Risk Tolerance Range (e.g. 5 to 10)	5 – 15

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 is 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 '28. 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. High risk areas continue to be 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. Further development of the function is required to respond to the ICB reform requirements including oversight arrangements. Financial constraints is a contributory factor.

Key Controls

Weekly, and daily as required, tracking of activity and operational planning objectives and/or constitutional standards. 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 oversees operational activities and escalation of UEC.
Improvement plans refreshed for all high-risk 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 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, such as investing to support additional activity.
Locality assurance meetings stepped down until the end of the year when new arrangements will be put in place, Quality and Performance Committee not currently meeting with new arrangements to be put in place from April 2026.
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	Year-end Target	Long Term Target	Long Term Target Date
Likelihood	5	4	4	4		4	2	March 2028
Impact	5	5	5	5		5	5	
Risk Level	25	20	20	20		20	10	

Number of Linked Risks on Corporate Risk Register

Low (1 - 4)	Mod (6 – 12)	High (15 – 25)
2	25	19

Lines of Defence	Sources of Assurance	Assurance Level
1st Line	Weekly 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 contract meetings; provider oversight meetings;	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	Acceptable

Action		
	Complete/BAU	On Track
	Delayed	Problematic

No	Action Required	Due Date	Progress	BRAG
1	Refresh the TOR for Locality and Provider Oversight arrangements in line with the new operating model and implementation thereafter	Sept 2025	Teams across the organisation are working on new oversight arrangements in line with the refreshed operation model. As the timelines for implementation of the model have been delayed it is recommended the due date is changed to April 2026.	
2	Trusts behind plan to submit revised plans and trajectories for Q3 (elective and UEC) and implement monitoring in line with these.	December 2025	In place and monitoring against these	
3	Full implementation of the elective care transformation fund.	March 2026	Additional activity in place to deliver improvements against waiting time standards	
4	Q3 and Q4 LAM agendas have ceased and replaced by targeted meetings addressing the most significant challenges.	March 2026	New arrangements to be developed and in place for 2026/27	

Strategic Risk **SR3**	There is a risk that the quality of care, patient safety and care experience will decline if the ICB fail to comply with our statutory duties for quality assurance in Quality and Patient Safety within the NHS GM system. This may lead to poorer health outcomes for the GM population.
Strategic Objective	Recover core health and care services
Chief Officer / Committee	Manisha Kumar Transition Committee (formerly Quality and Performance Committee)

Risk Appetite Level	Cautious to Open	Risk Tolerance Range (e.g. 5 to 10)	5 – 15

Rationale for Risk Score and Progress made in the quarter

The NHS GM provider oversight model is now well embedded with regular review of providers in line with NHS England guidance which provides significant mitigation, however some quality oversight processes are currently paused whilst current models and mechanisms for escalation are being reviewed in light of model ICB and model region guidance. Following the system wide recommendations from the Independent Assurance Review into GMMH (The Shanley Review), the ICB has responded to NICHE with evidence of its progress in the identified areas and is awaiting the publication of the final report. Whilst delayed from the original timescale due to data sharing issues, an independent review into community mental health has now been undertaken, with the findings and actions are being finalised.

NHS Reforms have impacted on the delivery of our statutory duties following a reduction in resource and loss of organisational memory, however transition of quality functions to a single clinical portfolio and a matrix-working approach alongside performance and contract colleagues has partly mitigated this. Risk stratification methodology is in place to focus a more limited resource in the most appropriate way to mitigate risk whilst still providing early warning of lapses in quality & safety. Work is ongoing to undertake Quality Impact Assessments against proposed changes in each statutory function. Engagement work has been undertaken to develop the new organisational/operating model for the ICB which includes review of oversight of quality and patient safety as a Strategic Commissioner. Development of new ways of working to strengthen contractual oversight is ongoing.

Key Controls

• NHS trust provider oversight (POM) in place and well established with plans to further develop and further strengthen. • Exec to exec meetings now a regular occurrence, with Quality KLOES identified. • ICB Provider Oversight Framework established in line with National Guidance. • Quality Assurance Framework established/aligned to meet the National Quality Board Standards. • Work underway to strengthen quality in contractual mechanisms to align with the strategic commissioner aim.	• Quality Impact Assessment processes established – • GM System Quality Group currently being reviewed in line with wider governance work underway at the ICB). • Reporting, audits and actions in place for safeguarding assurance (aligns to Safeguarding Policy). • MIAA Audit findings/actions • Annual reports (Quality Accounts / Safeguarding Report). • Assurance meetings with NHSE. • Submission to RSQG with escalations as part of business as usual. • External audits. • External inspections by regulators

Gaps in Control or Assurance

Gaps in Assurance whilst organisational structures are being confirmed.
Compliance with the statutory assurance frameworks.

Risk Scoring and Tolerance

	Inherent risk score	Q1	Q2	Q3	Q4*	Year-end Target	Long Term Target	Long Term Target Date
Likelihood	4	3	3	3	3	3	2	March 2028
Impact	5	5	5	5	5	5	5	
Risk Level	20	15	15	15	15	15	10	

Number of Linked Risks on Corporate Risk Register

Low (1 - 4)	Mod (6 – 12)	High (15 – 25)
0	9	0

Lines of Defence	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	Transition 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

Action		
	Complete/BAU	On Track
	Delayed	Problematic

No	Action Required	Due Date	Progress	BRAG
1	Co-Design of a future Clinical Leadership Model and Strategy across GM	March 2026	Underway with a series of codesign workshops in place	
2	Development of the new operating model to clearly define roles and responsibilities for oversight of quality and patient safety within the context of the ICB as a Strategic Commissioner. This should also consider the role of place vs centralised work.	March 2026	Engagement work undertaken to identify high-level structures. Further development work required to establish clear roles and responsibilities and governance arrangements.	
3	Development of new ways of working within the new operating model to strengthen contractual oversight of providers.	June 2026	Ongoing engagement work to define how quality assurance/oversight will feed into contractual oversight	

Strategic Risk **SR4**	There is a risk that the GM position on good employment will deteriorate without an increased emphasis on tackling the health barriers to employment and improving the quality of employment that is available. This will lead to an increase in poor health attributable to economic inactivity or poor-quality employment (driving up health service utilization and cost), have an adverse impact on the NHS as a major employer in GM, and inhibit city-regional growth and productivity.		
Strategic Objective	Help people get into, and stay in, good work		
Chief Officer / Committee	Charlotte Bailey Transition Committee (formerly Population Health Committee)		
Risk Appetite Level	3 – Open	Risk Tolerance Range (e.g. 5 to 10)	10 – 20

Rationale for Risk Score and Progress made in the quarter

The health impact of economic inactivity or poor quality of employment is widely recognised and as such is one of the key building blocks of health which is outlined as a priority in the GM strategy (Greater Manchester Strategy). Reciprocally, poor health is a contributor to economic inactivity and low productivity. There are several opportunities across the ICB and partners to positively address good employment and increase economic activity, primarily driven through the Get GM Working Plan, Working Well and as part of Live Well. Effective collaboration and integration are key to the delivery of the Get GM Working Plan with a strong connectivity and joint working between several NHS GM's partners, notably GMCA, DWP, LA's and VCSFE sector. The scale up of Health and Growth Accelerators has been included in the 10 Year Plan and GM could be a health and growth accelerator site Phase 2 (April 2026), as well as further extension for the successful WorkWell partnership Vanguard which is currently being jointly led by NHS GM and GMCA.

Key Controls

There are key drivers within the Get GM Working Strategy which will have a significant impact on employment as a determinant of health and poor health as a contributor to economic inactivity. During the NHS Reform process, NHS GM will need to ensure that the ICB can continue to be a strategic investor and system influencer to reduce economic inactivity and improve health outcomes by supporting people in work and to be in good employment. The Get GM Working Collaborative has oversight of Get GM working Plan which is nationally required and signed off by DWP. Examples of these key activities where the ICB has a specific involvement are:

- WorkWell Partnership
- Additional funding for Primary Care innovation funding – sick note reform
- Adults Skills and Employment thematic panel – examine themes, share good practice
- Collaborative Work ongoing between NHS GM & GMCA, DWB to integrate and share work, health and skills data

GM has an existing and mature Good Employment Charter to drive up employment standards in GM and ensure that employment is conducive to good health.

Gaps in Control or Assurance

The ICB transformation and response to the NHS reform needs to ensure NHS GM has the capacity, expertise and ability to influence the wider determinants of health and create opportunities to improve the building blocks of health in partnership with other key partners. The new Operating Model will need to ensure that this is possible.

The NHS reform could also have a potential negative impact on NHSE colleagues to shape the GM approach to the Health and Growth accelerator site Phase 2. Delays in future funding could cause financial difficulties for VCSFE partners and other short term staffing groups within the programme. Trailblazer funding is required to be utilized and evaluations by April 2026.

A significant reduction in ICB headcount due to VR and restructuring will mean capacity and expertise gaps will appear. The total impact of the reform is still to be fully understood, however direct impact on Population Health capacity is already apparent with some key programmes of work losing key personnel.

Risk Scoring and Tolerance

	Inherent risk score	Q1	Q2	Q3	Q4	Year-end Target	Long Term Target	Long Term Target Date
Likelihood	4	4	4	4	3	3	2	March 2029
Impact	4	4	4	4	4	4	4	
Risk Level	16	16	16	16	12	12	8	

Number of Linked Risks on Corporate Risk Register

Low (1 - 4)	Mod (6 – 12)	High (15 – 25)
0	0	3

Lines of Defence	Sources of Assurance	Assurance Level
1st Line	Employment, Work and Skills Executive Group with LA CX leadership; Workwell steering group, Get GM Working Collaborative Weekly; ICB twice weekly Chief Officers meetings; Strategy People and Partnership directorate SLT meetings; Weekly Population Health function SMT; People Communities and Partnership Chief Officer is a member of NHS GM Chief Officers Group.	Acceptable
2nd Line	Population Health Committee governance processes followed. PH Advisory Group that supports the PH Committee and contains representation from each of the 10 Locality Committees. PHC Chair sits on ICB and regularly reports from PH Committee and PH function to ICB and ICP Board. Maintenance of Strategic Risk Register and collation of the strategic risks into the Board Assurance Framework.	Acceptable
3rd Line	GM Public Health Leadership Group which consists of 10xLocal Authority Directors of Public Health, NHS GM, OHID, UKHSA and NHSE NW; NW Population Health Board; GMCA and Health Scrutiny	Acceptable

Action		
	Complete/BAU	On Track
	Delayed	Problematic

No	Action Required	Due Date	Progress	BRAG
1	Completion and launch of Get GM Working Plan with accompanying implementation plan.	February 2026	Get GM Working Plan formally approved by the CA in December 2025 and agreement to a GM Integrated Settlement with a strong focus on work and health. Delay to Implementation plan due to staff shortages – now expected June 2026.	
2	Confirmation of future funding for WWP, Primary Care Innovation Fund and Health and Growth Accelerator	March 2026	Funding confirmed. From 2026/7 they will form part of the GM Integrated Settlement provided greater GM-level flexibility and accountability for delivery and improved outcomes	
3	Delivery of GMS under a new delivery framework	Ongoing throughout 26/27	the delivery plans and associated governance are now well advanced and provide confidence around delivery of the strategy	
4	ICB reform and transition process to ensure new Operating Model is capable of mitigating BAF risk	March 2026	Structures and capacity/capability to deliver controls still being established	

Strategic Risk **SR5**	There is a risk that health inequalities are widened, and health outcomes are reduced to due to a lack of sustained investment in preventive, proactive and evidence-based services. This will result in increased demand and cost of health and care services and impede economic growth.
Strategic Objective	Help people to stay well and detect illness earlier
Chief Officer / Committee	Charlotte Bailey — Transition Committee (formerly Population Health Committee)

Risk Appetite Level	3 - Open	Risk Tolerance Range (e.g. 5 to 10)	10 – 20

Rationale for Risk Score and Progress made in the quarter

The GM system has a strong track record of building upon existing strengths to expand on relationships between partners such as GMCA, DPH's, other system infrastructure. Integration and collaboration will be key to driving forwards prevention and early intervention work in order to effectively address health inequalities across the GM footprint. Whilst there are several key controls in place to mitigate this risk, there remains a high degree of uncertainty about the extent to which these controls can be fully realised and of the impact this will have. There are challenges at present in relation to: translating planned investment into actual expenditure against agreed priorities in the context of the sustained financial challenges facing the system; agreeing an overarching and comprehensive left shift strategy; the impact of NHS reform (including the model ICB blueprint).

Key Controls

Development of a comprehensive strategic approach to NHS 'left shift' which underpins ICB reform and future operating model. Inclusion of 'left shift' investments in the annual plan and budget for 2025/26.
Strong oversight of the risk and mitigations through the Population Health Committee (chaired by an NHS GM NED) which has a risk register in place which is reviewed as a standing item at every committee meeting. An evidence-based, co-produced and fully costed NHS GM Annual Plan for 2025/26 includes a series of actions relating to reducing the prevalence of poor health and scaling up proactive care.
A Fairer Health for All Framework has been agreed by the Integrated Care Board and there are significant implementation plans in place for 2025/26 which will seek to embed tacking inequalities as a focus of the system. The ICP Strategy and NHS GM Sustainability Plan both have a strong emphasis on improving health and reducing inequalities through prevention. NHS GM has agreed a comprehensive, whole system model for improving health and reducing inequalities in the form of the GM Prevention and Early Intervention Framework and co-produced GM Population Health Model. Refresh of the GM Strategy which has a significant impact on the wider determinants of health.

Gaps in Control or Assurance

Whilst the organisation has committed to a "left-shift" approach, the exact detail of the approach and how it will strategically develop and lead on a more preventative and early intervention approach across NHS GM is still under development.
The pausing of funding for 2025/26 due to the potential for further financial challenges in future years, prevents the delivery of flagship programmes of work included in the Annual Plan which in turn diminishes the likely impact of activity and creates uncertainty amongst providers (particularly those within the VCFSE sector).
The NHS reform could have a significant impact on the resource, capacity, expertise and knowledge across the building blocks of health programme areas which may impact the delivery of the organisational left shift. A significant reduction in ICB headcount due to VR and restructuring will mean capacity and expertise gaps will appear. The total impact of the reform is still to be fully understood, however direct impact on Population Health capacity is already apparent with some key programmes of work losing key personnel.

Risk Scoring and Tolerance

	Inherent risk score	Q1	Q2	Q3	Q4	Year-end Target	Long Term Target	Long Term Target Date
Likelihood	4	4	4	4	3	3	2	March 2029
Impact	4	4	4	4	4	4	4	
Risk Level	16	16	16	16	12	12	8	

Number of Linked Risks on Corporate Risk Register

Low (1 - 4)	Mod (6 – 12)	High (15 – 25)
0	0	3

Lines of Defence	Sources of Assurance	Assurance Level
1st Line	Employment, Work and Skills Executive Group with LA CX leadership; Workwell steering group, Get GM Working Collaborative Weekly; ICB twice weekly Chief Officers meetings; Strategy People and Partnership directorate SLT meetings; Weekly Population Health function SMT; People Communities and Partnership Chief Officer is a member of NHS GM Chief Officers Group.	Acceptable
2nd Line	Population Health Committee governance processes followed. PH Advisory Group that supports the PH Committee and contains representation from each of the 10 Locality Committees. PHC Chair sits on ICB and regularly reports from PH Committee and PH function to ICB and ICP Board. Maintenance of Strategic Risk Register and collation of the strategic risks into the Board Assurance Framework.	Acceptable
3rd Line	GM Public Health Leadership Group which consists of 10xLocal Authority Directors of Public Health, NHS GM, OHID, UKHSA and NHSE NW; NW Population Health Board; GMCA and Health Scrutiny	Acceptable

Action		
	Complete/BAU	On Track
	Delayed	Problematic

No	Action Required	Due Date	Progress	BRAG
1	Completion and launch of Get GM Working Plan with accompanying implementation plan.	February 2026	Get GM Working Plan formally approved by the CA in December 2025 and agreement to a GM Integrated Settlement with a strong focus on work and health. Delay to Implementation plan due to staff shortages – now expected June 2026.	
2	Confirmation of future funding for WWP, Primary Care Innovation Fund and Health and Growth Accelerator	March 2026	Funding confirmed. From 2026/7 they will form part of the GM Integrated Settlement provided greater GM-level flexibility and accountability for delivery and improved outcomes	
3	Delivery of GMS under a new delivery framework	Ongoing throughout 26/27	the delivery plans and associated governance are now well advanced and provide confidence around delivery of the strategy	
4	ICB reform and transition process to ensure new Operating Model is capable of mitigating BAF risk	March 2026	Structures and capacity/capability to deliver controls still being established	

Strategic Risk **SR6**	There is a risk that existing workforce challenges are exacerbated due to the requirement for financial savings and the impact of NHS reforms. This will result in recruitment challenges to key areas, reduced staff wellbeing, lower morale and inequality of opportunity. This will further impact on service delivery and leadership capacity to manage change.		
Strategic Objective	Support our workforce and carers		
Chief Officer / Committee	Charlotte Bailey	Transition Committee (formerly Population Health Committee)	
Risk Appetite Level	Open	Risk Tolerance Range (e.g. 5 to 10)	10 to 20

Rationale for Risk Score and Progress made in the quarter

The current risk score has increased from 12 to 16 to reflect the cumulative impact of several escalating and interrelated pressures:

- Workforce cost pressures, with Trusts exceeding workforce cost plans by £51.3m at Month 6 and projections indicating a potential £100.3m year-end variance, despite progress in reducing bank and agency spend in line with national targets.
- Industrial action, including ongoing and planned doctor strikes, which continue to disrupt service delivery, increase pressure on remaining staff, and impact morale.
- Persistent workforce gaps, many of which are influenced by national supply issues and outside of local control.
- Increased reliance on migrant workers, combined with rising visa costs, tighter settlement and sponsorship rules, ethical recruitment requirements, and strong international competition, heightens recruitment and retention risks and may exacerbate workforce shortages. These pressures also carry delivery, skills dilution, and workforce wellbeing risks, particularly affecting a predominantly female and migrant workforce amid growing anti-migrant sentiment.
- Organisational change and turnover, particular within NHS GM following national VR announcement, resulting in loss of organisational memory, reduced continuity, and increased reliance on interim and agency staff.
- Financial constraints, including the requirement to reduce pay bills to achieve long-term sustainability, limiting flexibility to invest in workforce growth and development.
- Rising winter sickness absence, further constraining workforce capacity

Key Controls

- Direct reporting to NHS GM Board while Committee is stood down.
- P&C Governance and supporting TORs
- Committee working groups, focus on workforce efficiency, Transforming People Services, Leadership Culture & EDI
- Monthly workforce reports
- Operational planning rounds and provider oversight meetings, supporting pay bill reduction to support long term financial sustainability.
- Regular review of the P&C risk register
- Leadership, Culture and EDI; System-level equality impact assessment (EIA) risks noted at P&C; mitigation through electronic systems to increase visibility and assurance

Gaps in Control or Assurance

Some of the causes of this risks are outside of the control of our ICB e.g. national workforce shortages, training, social care rates of pay etc but mitigating actions put in place will help reduce the risk score.
No P&C Committee in January – stood down to support NHS GM to focus on business continuity. Mitigated by direct reporting to Board as necessary.
Increased requirements for the ICB to focus resources and capacity on statutory duties and leading NHS Provider and lack of full data sets for the entire health and care system is also a current gap that limits the ability to fully understand the position and impact of actions we are taking
Lack of additional funding such as HEE workforce development funding which previously supported transformation projects.

	Risk Scoring and Tolerance							
	Inherent risk score	Q1	Q2	Q3	Q4	Year-end Target	Long Term Target	Long Term Target Date
Likelihood	4	4	4	4		3	3	March 2028
Impact	4	3	3	4		3	3	
Risk Level	16	12	12	16		9	9	

Number of Linked Risks on Corporate Risk Register		
Low (1 - 4)	**Mod (6 – 12)**	**High (15 – 25)**
0	1	5

Lines of Defence	Sources of Assurance	Assurance Level
1st Line	Bi-monthly workplan completed which aligns to priorities for the remainder of the financial year reported to SLT.	Partial
2nd Line	Regular reports provided to the; GM People & Culture Committee and ensuring oversight of progress against workforce priorities & delivery of agreed objectives. Contributions also feed into the ICB assurance process to demonstrate compliance & effective governance	Partial
3rd Line	Internal Audit Plans developed and delivered to provide evaluation of control effectiveness and management across key workforce areas	Partial

Action					Complete/BAU	On Track
					Delayed	Problematic
No	Action Required			Due Date	Progress	BRAG
1	Development of a Leadership Development approach including Board development and 360 feedback			Dec 2025	Board Development remains paused due to upcoming leadership changes	
2	Refresh of the P&C Strategy for 25-28 to support the 10 year plan for health and associated people plan - and extension of current strategy, with refined priority actions for the rest of 25/26.			March 2026	Development delayed due to NHS Reform.	
3	Implementation of digital EIA approach to increase system visibility.			Nov 2025	Proposed amended due date to Feb 2026. The platform is in it's final stages prior to testing. Implementation expected Early 2026.	
4	Enhance individual and collective focus on workforce efficiency; reporting at POMs and HRDs, sharing good practice, improving quality of workforce data.			March 2026	NHS GM has introduced a more robust process of individualised provider workforce deep dives, enabling direct assurance-level discussions and promoting best practice sharing, with meeting frequency increasing in response to monthly performance trends and escalation needs. Working towards greater workforce focus through	

			Provider Oversight Meetings in January. Increased scrutiny around annual planning round – and workforce affordability in preparation for restrictions on temporary staffing usage.	
5	Support all system boards to adopt and implement workforce delivery plans	Oct 2025	Collaborate with system programme leads to identify workforce challenges and develop responsive action plans, offering expert guidance, sharing best practice, and fostering peer support. Some plans are developed - some still emerging and meet quarterly to ensure progress.	
6	To widen the scope of Transforming people services beyond occupational health and policy, with an initial focus on recruitment	March 2026	Highlight reports to Committee	
7.	Deliver Careers Event, alongside other planned staff support offers, to support staff through organisational change by providing clear career pathways, retention support, skills development opportunities, and targeted guidance for affected and at-risk groups.	Early 2026	In Progress	
8.	Migrant Workers - joint working and sharing best practice		NHS trusts collaborating to understand scale of the issue and sharing best practice. NHS GM is also supporting the issue in primary care and social care.	

Strategic Risk **SR7**	There is a risk that the ICS does not achieve in-year and medium-term financial sustainability due to continued growth in demand, inflationary and cost pressures, inability to deliver CIPs in full and other identified causes such that the financial resources do not meet system needs. This will result in the inability to deliver on the ICP Strategy, reducing our ability to invest in preventative care which will drive demand, and continued inequalities and variation in health and care.		
Strategic Objective	Achieve financial sustainability		
Chief Officer / Committee	Kathy Roe		Transition Committee
Risk Appetite Level	Level 3 - Open	Risk Tolerance Range (e.g. 5 to 10)	10 - 20

Rationale for Risk Score and Progress made in the quarter

The risk score is based on the financial plan submitted to NHSE for 2025/26, taking on board the financial grip and control measures currently in place and the financial risk associated with delivering financial balance over the medium term (2 to 5 years) which is rated as high, as there is a significant amount of work to do as an organisation and system to develop robust savings plans that deliver savings on a recurrent basis. A considerable amount of work has already been undertaken, savings plans are being further developed across the whole GM ICS over a medium-term basis to help ensure the ICS can move to an affordable and sustainable financial position within the overall financial resources available to it.

The sustainability plan is developed upon 5 pillars (cost improvement, system productivity, reducing prevalence, proactive care, and optimising care). The financials were developed through a review of all organisations financial sustainability plans to ensure consistency of assumptions and a system approach.

The risk score has decreased from 20 to 16 to reflect the reduced likelihood in not achieving the desired target, this is based on the current financial position and the remainder of the time left in the finical year to meet the required target.

Key Controls

- The enhanced levels of grip and control and financial assurance established during 2024/25 continue across the GM system, including CIP Governance, Provider Oversight.
- NHSE has undertaken a review of both ICB and Provider Trusts exit run rate modelling to ensure consistency and robustness as part of planning. ICB plans submitted to NHSE 12/2/26 showing achievement of plan in 2026/7,2027/8 and 2028/29.
- The medium-term financial plan and financial strategy will be further developed to identify key principles and robust CIPs to support financial sustainability.
- ICB has revised the reporting pack with a focus on run rate to allow identification of potential issues and mitigation plans have been implemented to address the risks on in year delivery. Run rates became a focus within the finance item of LAMs from July and are a key item within monthly monitoring for all ICB areas of expenditure.
- Recovery plans have been developed for the 4 key areas of overspend:
  - CIP
  - Independent Sector
  - IPoC
  - ADHD/Autism

Each recovery plan has SMART actions in place which will be monitored through the Financial Recovery Group with Committee and Board scrutiny.

The ICB Recovery plan is now being accelerated to evaluate and approve new options to mitigate the current risk level with appropriate Board governance. Further schemes were developed including:

  - Meds Optimisation stretch target
  - Additional IS contracts activity plans
  - Primary Care
  - Non Pay and Workforce

- All CIPs are subject to a quarterly deep dive to ensure they remain on track and determine if there is any opportunity for stretch.
- Productivity pack - GM to continue with the system developed productivity pack that is now used across the NW. This helps to inform opportunities for improved performance and will become part of POMs.
- Red lines - GM has developed trigger points that will require corrective actions. There will be clear agreement and a 'Golden thread' through POMs/LAMs, SIB and sub committees of Boards.

Medium- and long-term financial plans were approved by the Board on 11/2/26. Localities and system Boards were engaged in the process of developing commissioning intentions.

Gaps in Control or Assurance

- Areas of overspend/performance may not be picked up in a timely manner due to a time lag in information.
- Time lag in financial / performance (Acute activity and prescribing) information may lead to ineffective or delayed decision making.
- Savings plans are not fully developed in a timely manner or do not realise the necessary savings or on a recurrent basis.
- Planning does not adequately reflect growth and/or impact of strategic decisions, and prevention investments on all parts of the system or budgets.
- Impact of NHS Reforms may delay development of new control measures.
- Recovery plans once agreed take time to implement and provide evidence of success

	Risk Scoring and Tolerance							
	Inherent risk score	Q1	Q2	Q3	Q4	Year-end Target	Long Term Target	Long Term Target Date
Likelihood	5	5	5	5	4	4	4	31/03/26
Impact	4	4	4	4	4	3	3	
Risk Level	20	20	20	20	16	12	12	

Number of Linked Risks on Corporate Risk Register		
Low (1 - 4)	Mod (6 – 12)	High (15 – 25)
0	3	

Lines of Defence	Sources of Assurance	Assurance Level
1st Line	Contract meeting (Monthly) Executive Management Team (Weekly) Internal Finance and Governance meetings (Weekly)	Acceptable
2nd Line	Finance Committee (Monthly) Executive CIP Group (Weekly) NHS GM Board (Bi-Monthly) Audit Committee (Quarterly) Locality Assurance meetings (Quarterly) these move to monthly for those localities which are challenged. Provider Oversight Meetings (Monthly)	Acceptable
3rd Line	External Audit Reports Internal Audit Reports NHSE (Monthly)	Acceptable

Action		
	Complete/BAU	On Track
	Delayed	Problematic

No	Action Required	Due Date	Progress	BRAG
1	Recovery plans have been developed for the 4 key areas of overspend: CIP Independent Sector IPoC ADHD/Autism Each recovery plan has SMART actions in place which will be monitored through the Financial Recovery Group with Committee and	31/03/26	Regular updates will be provided to Finance Sub Committee	

	Board scrutiny. The ICB Recovery plan is now being accelerated to evaluate and approve new options to mitigate the current risk level with appropriate Board governance. Further schemes have been developed including Meds Optimisation stretch target Additional IS contracts activity plans Primary Care Non Pay and Workforce Finance Recovery Group meets on a weekly basis to review progress and identify barriers to progress in delivery of all schemes. Additional resource has been identified and redirected from other areas to work on these priority areas.			
2	CIP plans are further being developed for 2026/27 and implemented to realise efficiencies along with commissioning intentions that will deliver efficiencies while improving services. Work ongoing through PMO. CIPs are being identified for 2026/27. All are subject to a quarterly deep dive to ensure they remain on track and determine if there is any opportunity for stretch.	31/03/26	Regular updates provided to Finance Sub Committee. As a consequence of continuous challenge and risk to full delivery some schemes may require a review of their original target. The schemes on the opportunities and difficult decisions list also need progressing at pace.	
3	Those localities who are forecasting a deficit are being offered additional support to identify and deliver further recovery plan schemes. Recovery plans must deliver sufficient opportunities to optimise 2025/26 financial plan delivery and retention of DSF.	31/03/26	Updates will be provided to Finance Sub Committee	

Strategic Risk **SR8**	Significant systemic service disruption occurs as a result of cyber-attack moving quickly across the GM health and care IT estate
Strategic Objective	Meet our statutory obligations
Chief Officer / Committee	Gareth Robinson — Executive / Audit Committee

Risk Appetite Level	Cautious	Risk Tolerance Range (e.g. 5 to 10)	5 – 10

Rationale for Risk Score and Progress made in the quarter

NHS GM do not have a defined approach to dealing with a significant cross-system cyber incident – though there is a Cyber Special Interest Group - but no defined path to identify the impact of a cyber incident and act as a system to report and manage the incident through initial containment and eventual resolution.
Every NHS organisation has its own business continuity plan. As these are not consistent across the system, this leads to variation and inhibits swift movement to enable continuity of operation as a system.
An NHS GM ICS cyber incident exercise was performed on the 9th of January with representative from the ICS member organisations, the exercise went well and identified a need to develop a high-level response plan. The aim of the plan will be to coordinate activities across the system to ensure a swift region wide response to a cyber incident. Work has started to develop the plan but is not in place currently.

Key Controls

Each part of the system (ICS) has their own security and protection measures in place.
There is a GM NHS Cyber Security Special Interest Group in place.
The results of the cyber maturity assessment conducted across all NHS GM ICS member organisations highlighted areas for improvement within each organisation. NHS England risk reduction funds are being utilised to address improvements including business continuity arrangements, system vulnerability management, Privileged access management, supply chain risk assessment and management
NHS GM Cyber Security Strategy has been developed with an associated improvement plan and is progressing through the appropriate governance.

Gaps in Control or Assurance

Commitment to creating a single ICS oversight group for cyber security controls and management which can be linked to the EPRR process in the event of an incident with well-defined management and escalation processes in place – and a Business Continuity Plan that is regularly tested.

Risk Scoring and Tolerance

	Inherent risk score	Q1	Q2	Q3	Q4*	Year-end Target	Long Term Target	Long Term Target Date
Likelihood	4	4	3	3	3	3	2	March 2028
Impact	4	4	4	4	4	4	4	
Risk Level	16	16	12	12	12	12	8	

Number of Linked Risks on Corporate Risk Register

Low (1 - 4)	Mod (6 – 12)	High (15 – 25)
0	0	1

Lines of Defence	Sources of Assurance	Assurance Level
#1st Line	Monthly digital IT assurance group for ICB	Partial
2nd Line	Cyber security maturity assessments considered at monthly Special Interest Group attended by all heads of security across the ICS Trust CIO's weekly meeting (includes CIO for NHS GM and NHS E) GM ICS secure GM communication group that is not reliant on NHS Mail or Microsoft Teams which shares risks and issues across trusts, NHS E and GMCA and LA's and CIOs.	Acceptable
3rd Line	Regular Regional and National communication with NHSE and other NHS organisations. Annual Data Security Protection Toolkit (DSPT) carried out by each care setting, which is reviewed by NHS E. DSPT is carried out annually between January and June. Will more stringently review in 2025, based on national cyber security centre cyber assessment	Partial

Action		
	Complete/BAU	On Track
	Delayed	Problematic

No	Action Required	Due Date	Progress	BRAG
1	To develop the Cyber Security Strategy and implementation plan	Dec 2025 (Delayed)	The approval of the strategy and implementation plan is delayed until the new structure of the NHS GM ICB is published and the implications of the changes are understood and fed into the strategy	
2	An ICS system wide cyber incident response plan is being produced.	March 2026	Working group has been setup representing ICS member organisation to produce a coordinated response plan	
3	Utilise NHS England risk reduction funds to address areas for improvement identified during the cyber maturity assessment	March 2026	NHS England funds have been applied for addressing areas for improvement in NHS GM ICS member organisations. Currently waiting for funds to be approved by NHS E	
4	Implement system to address identified arras of weakness utilising approved NHSE funding.	March 2026	NHSE funds have been approved waiting for the transfer of funds to NHS GM ICS organisation.	
5	Implement solutions to remediate identified areas of weakness, utilising approved NHSE funding.	March 2026	NHS England Funding has now been received by NHS GM ICS member organisations. and work has started to procure and implement cyber security improvements across the ICS.	

Strategic Risk **SR9**	There is a risk that the ICS system is significantly disrupted due to an emergency e.g. pandemic, major incident, etc. This could result in health services becoming overwhelmed.
Strategic Objective	Meet our statutory obligations
Chief Officer / Committee	Gareth Robinson Transition Committee (formerly Quality & Performance Committee)
Risk Appetite Level	Cautious to Open

Risk Appetite Level Rationale for Risk Score and Progress made in the quarter	Cautious to Open	Risk Tolerance Range (e.g. 5 to 10)	5 – 15

Rationale for Risk Score and Progress made in the quarter

The risk score for Q4 25/26 reflects a Likelihood of 3 that is related to the EPRR team staffing position. The team had longstanding gaps in its structure and has recently recruited to two full time posts.
There will be a period of transition as the two individuals settle into their new roles.
The team will ensure that the delivery of training and exercising for NHS GM staff with a potential incident response role continues.
The consultation announcement has provided an opportunity to review the on-call arrangements for NHS GM, to ensure adequate tactical and strategic cover is in place to respond to incidents and emergencies.
NHS GM and partner agencies continue to plan, train and exercise for emergencies, which provides a level of mitigation for the risk to the GM system of disruption due to an incident.
In Q2 of 25/26 a major incident did occur in Greater Manchester that required a response from NHS GM as a Category 1 responder. Although NHS GM were able to fulfil their duties with regard to the incident, learning has been identified and a detailed recovery process is underway.

Key Controls

- In light of the EPRR team's staffing position, support for NHS GM's EPRR work has been sought from Lancashire and South Cumbria ICB EPRR team. A 2 day a week secondment is currently in place.
- In addition to the above, recruitment has taken place to 2 posts for the team, providing sufficient capacity in the team to carry out the statutory duties of the organisation.
- Existing training delivery and ongoing exercise participation for NHS GM staff with an incident response role.
- Ongoing liaison with key stakeholders and partners to ensure NHS GM is linked in with multi-agency planning for major incidents, including liaison with GM NHS providers, GM Category 1 responders, other ICBs in the Northwest and NHS England Northwest EPRR team.

Regular updates are provided to Chief Officers on the progress of the recruitment and the risks in the workload.

Gaps in Control or Assurance

Reporting on progress with delivery of EPRR training and exercising. This will be monitored going forward as part of the EPRR core standards process.

	Inherent risk score	Q1	Q2	Q3	Q4	Year-end Target	Long Term Target	Long Term Target Date
Likelihood	4	3	3	4	3	3	2	TBC
Impact	4	4	4	4	3	3	3	
Risk Level	16	12	12	16	9	9	6	

Number of Linked Risks on Corporate Risk Register		
Low (1 - 4)	**Mod (6 – 12)**	**High (15 – 25)**
0	0	1

Lines of Defence	Sources of Assurance	Assurance Level
1st Line	Meetings within the EPRR team and with the NHS GM Accountable Emergency Officer.	Partial
2nd Line	Meetings and workshops with NHS GM staff with a potential incident response role.	Partial
3rd Line	Meetings and collaboration with NHS EPRR colleagues across GM and from neighbouring ICBs as well as NHS England North West	Partial

Action			
		Complete/BAU	On Track
		Delayed	Problematic

No	Action Required	Due Date	Progress	BRAG
1	Ongoing review of team staffing and workload to ensure optimal use of team capacity for mitigation of identified risk	December 2025	Successfully recruited	
2	Delivery of EPRR training and exercising for NHS GM staff with a potential incident response role (more trained staff provides increased organisation resilience in the face of intense and/or prolonged emergencies requiring GM heath system incident coordination)	March 2026	Progress is delayed due to the staffing gaps in the team	
3	Maintain oversight of the ICB transition process so that impacts for EPRR are assessed and factored into team activities	December 2025	Work being led by L&SC ICB through the "Do it Once Group" – Gill Baker engaged as GM interim lead. Progress delayed due to organisational restructure	

Strategic Risk **SR10**	There is a risk that the NHS Reform Programme could disrupt delivery of core ICB business due to restructure and staffing reductions. This will result in core ICB business being disrupted during the transition.
Strategic Objective	Meet our statutory obligations
Chief Officer / Committee	Charlotte Bailey — Chief Officers meeting

Risk Appetite Level	Cautious to Open	Risk Tolerance Range (e.g. 5 to 10)	5 to 15

Rationale for Risk Score and Progress made in the quarter

The risk score remains at 16 following a recommendation to reduce the score to 12 as new instructions have been received from NHS which has confirmed the reduction target of £19 p/h as described in the model ICB blueprint to be achieved from April 26. This has also resulted in Voluntary Redundancy being approved for implementation by the ICBs. This means the pace of the reform work will now increase at pace in order to achieve the targets set with high likelihood and impact to the disruption of core ICB business.

Key progress made this quarter:

- As a result of the Government announcement that all ICBs are expected to achieve their £19 per head target from April 2026, we have re-designed the Reform programme outcomes with the need to implement the organisational restructure now the key priority.
- Formal consultation on the structures was launched on 28th January and will run till the 27th February. We will utilise the feedback from staff to finalise the organisational structures with the aim of publishing the final structures on 11th March.
- VR Scheme (Phase 1) was successfully delivered with a number of staff opting for VR exiting the organisation on 31st January. VR Scheme (Phase 2) launched on 2nd February – staff opting for VR are due to exit the organisation by no later than 31st March.
- Regional Do Once programme is being progressed with formal governance now being stood up for OPIC and IFR. We are also progressing work on Pop Health and GP IT with the aim of transferring these services from April 2027.
- Continuing to work with Place stakeholders – through the Place mobilisation working group to progress work on key areas such as funding and options for transfer.

Key Controls

- The development of a business continuity framework to ensure work is managed through core organisational priorities.
- Programme dedicated resource in place (with additional resource recently agreed) in order to minimise capacity issues within current BAU programmes.
- Transition Risk Group established with key system stakeholders to ensure we have captured and mitigated against high-risk areas.
- These risks are also being escalated to Transition Operational Delivery Group from potential areas which the highest likelihood of impact to resource reductions with scenarios to be tested to ensure the programme is considering how to manage and mitigate the reductions.

Risk Scoring and Tolerance

	Inherent risk score	Q1	Q2	Q3	Q4	In year Target	Long Term Target	Long Term Target Date
Likelihood	4	N/A	4	4		3	2	
Impact	4	N/A	4	4		3	2	April 2026
Risk Level	16	N/A	16	16		9	4	

Number of Linked Risks on Corporate Risk Register

Low (1 - 4) | **Mod (6 – 12)** | **High (15 – 25)**

Lines of Defence	Sources of Assurance	Assurance Level
1st Line	Transition Programme Team- The team oversees management and updates of the risks for all component programme areas. Transition Operational Delivery Group - This group holds oversight on all the risks within the transition programme and component workstreams. Transition Risk Group – New group creates within the transition programme governance to have a grip and oversight over all programme risks. This group will monitor controls, actions and ensure that all work is being done to lower the risk	
2nd Line	**Chief Officers** - Exec level assurance and approval of BAF risks and other high-level risks within the transition needed to be escalated. They will be provided periodic updates to ensure progress on mitigations. **ICB Board** - Exec level assurance and approval of BAF risks and other high-level risks within the transition needed to be escalated. They will be provided periodic updates to ensure progress on mitigations. **Executive Committee** - Exec level assurance and approval of BAF risks and other high-level risks within the transition needed to be escalated. They will be provided periodic updates to ensure progress on mitigations. **NEDs/Execs** – Assurance of the high-level risks within the transition programme with monitoring to ensure the risks are correctly being mitigated periodically.	
3rd Line	NHSE Oversight Meetings – Reporting on progress of the reform and any risks that need to be escalated.	

Action — Complete/BAU — Delayed — On Track — Problematic

No	Action Required	Due Date	Progress	BRAG
1	Organisational restructure implementation to ensure the organisation is meeting its £19ph obligations from April 2026.	June 2026	In the process of engaging with staff on new organisational structure - concurrently we are running Phase 2 VR scheme. We will then look to undertake filling of posts exercise (including any necessary compulsory redundancies) with the aim to complete by end of May 2026.	
2	Assurance Statement for Model Integrated Care Board	February 2026	GM ICB provided NHSE confirmation (through official correspondence) that we are developing our future operating structure in line with the £19 running cost allowance and the Model Integrated Care Board (ICB) Blueprint.	

NHS
Greater Manchester

Greater Manchester (GM) Mental Health (MH) and Wellbeing Strategy – 2 years on

2026

Part of Greater Manchester Integrated Care Partnership

NHS GM Integrated Care Board (ICB)

March 2026

Report information.

Required information.	Details.
Title of report.	**GM MH and Wellbeing Strategy – 2 years on**
Author.	**Professor Sandeep Ranote** – Clinical Director, Mental Health, NHS GM **Melissa Maguinness -** Programme Director – Commissioning Development, NHS GM **Charlene Mulhern** – Assistant Director of Mental Health, NHS GM **Dashrena Kaur** – Lead Analyst (Mental Health) – Public Service Reform, GMCA **Phoebe Willis** – Strategic Programme Manager, Mental Health, NHS GM **Chloe Lindley** – Mental Health Business Manager, NHS GM
Presented by.	**Professor Manisha Kumar** – Chief Clinical Officer, NHS GM **Professor Sandeep Ranote** – Clinical Director, Mental Health, NHS GM **Dashrena Kaur** – Lead Analyst (Mental Health) – Public Service Reform
Contact for further information.	**Professor Sandeep Ranote FRCPsych** – Clinical Director, Mental Health, NHS GM

Executive summary.	The GM MH and Wellbeing Strategy " Doing Mental Health Differently" 2024–2029 sets out a five-year, all-age, city-region approach to improving mental health, supporting people with mental ill health, and reducing inequalities. It aligns with the Integrated Care Partnership (ICP) Strategy and Joint Forward Plan (JFP), recognising that good mental health underpins all six ICP missions. Developed through extensive engagement across GM, the strategy is built around five shared missions and a clear vision: that GM will be a mentally healthy city-region where every child, adult and place matter. The strategy is founded on strong partnership working. It recognises that no single organisation can address the complex drivers of mental health, which span services, communities, and wider social and economic conditions. Since the launch of the strategy, the national NHS landscape has changed, as have the roles and responsibilities of NHS GM in line with the Model Blueprint. Despite these changes, we have re-committed to the importance of MH and Wellbeing in our Clinical Strategy and in the Five Year Commissioning Plan. ***This report provides a progress update two years on, highlighting what has been achieved, where challenges remain, and what is needed next in GM***.
The benefits that the population of Greater Manchester will experience.	The GM MH and Wellbeing Strategy addresses health inequalities by focusing on all-age, system wide

How health inequalities will be reduced in Greater Manchester's communities.	The GM MH and Wellbeing Strategy reduces health inequalities by: • Rebalancing investment into neighbourhood mental health services • Designing inclusive services that tackle discrimination and reflect community need • Embedding prevention and early help in everyday settings • Monitoring equity through a system-wide outcomes framework • Partnering across sectors to address the wider determinants of mental health Together, these shifts create a mental health system where every child, adult and place matters, a core ambition stated in the strategy itself.
The decision to be made and/or input sought.	The NHS GM ICB Board is asked to: • Endorse the pace and direction of travel, recognising both progress and complexity. • Support the system to unblock cross-cutting issues (workforce, digital, finance, estates). • Back a whole system approach that enables GM to improve outcomes, deliver equity, and maximise the impact of mental health investment for our population.
How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	The delivery of the GM MH and Wellbeing Strategy supports the mitigation of SR1-SR7 of the BAF risks.

Key milestones.	• **Year one** (24/25) focused on building shared governance, establishing new cross sector groups, and embedding links across neighbourhood, place and GM level programmes. • **Year two** (25/26) marks the start of measurable progress against our five strategic missions, supported by the first baseline metrics for GM Our focus remains on building a mental health system that enables people to thrive where they live, work, study and connect. Our commissioning intentions set out a clear shift into neighbourhood mental health and core community services, while ensuring inpatient care remains high quality NHS provision delivered close to home. This means reducing routine Independent Sector reliance and reinvesting those funds into local support, preventing escalation and long waits for treatment.
Leadership and governance arrangements.	Professor Sandeep Ranote is the Senior Responsible Officer (SRO) for the GM MH and Wellbeing Strategy. The GM MH and Wellbeing Strategy Oversight group is responsible for overseeing the delivery of the GM MH & Wellbeing Strategy, with the support of 5 key delivery groups to help drive forward delivery plans. The Mental Health Partnership Group is our system group bringing together partners around shared priorities, with reporting previously through QPC. In future arrangements, this will report through the Strategic Commissioning Committee to the ICB Board
Engagement* to date. ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	GM MH and Wellbeing Strategy progress updates, alongside demonstrations of the strategy dashboard have been presented to the GM Mental Health Partnership Group (MHPG), GM MH and Wellbeing Strategy Oversight Group, and other key mental health governance meetings, throughout 2025/26.
Financial or Legal Implications	N/A

1.0 Introduction

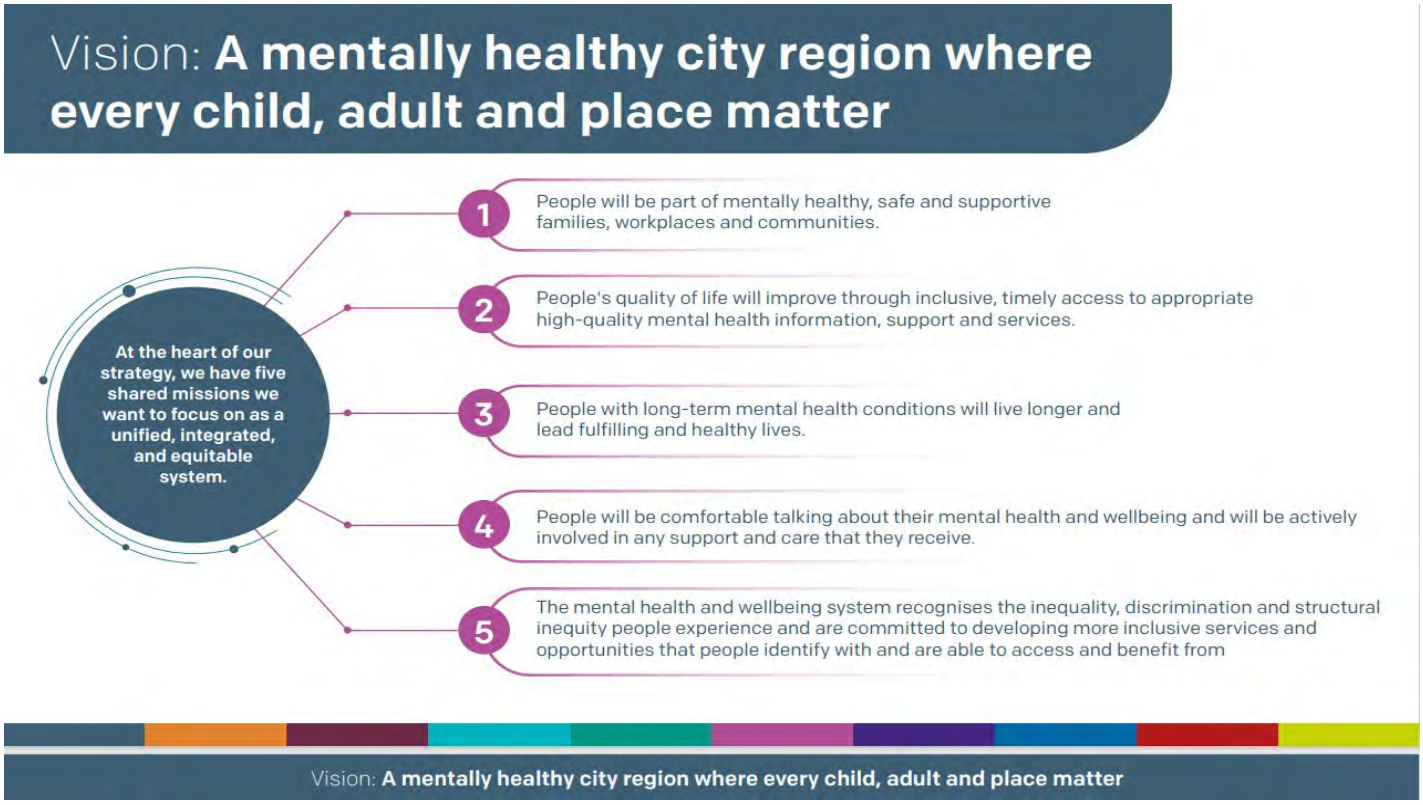
1.1 The GM MH and Wellbeing Strategy “Doing Mental Health Differently” 2024–2029 sets out a five-year, all-age, city-region approach to improving mental health, supporting people with mental ill health, and reducing inequalities. It aligns with the ICP and JFP, recognising that good mental health underpins all six ICP missions. Developed through extensive engagement across GM, the strategy is built around five shared missions and a clear vision: that GM will be a mentally healthy city-region where every child, adult and place matter.

1.2 The strategy is founded on strong partnership working across health, local government, the voluntary and community sector, other public services, and—critically—people with lived experience. It recognises that no single organisation can address the complex drivers of mental health, which span services, communities, and wider social and economic conditions. Delivery of each mission is supported by a system-owned action plan with clear outcomes, focused on tackling inequalities and ensuring services work with people on their terms.

1.3 This report provides a progress update two years on, highlighting what has been achieved, where challenges remain, and what is needed next in GM.

The strategy has a clear vision, underpinned by 5 missions as shown in *figure 1 below*

figure 1



2.0 Background and Context

2.1 The NHS ten-year plan for England "fit for the future" [1] places the left shift ambition prominently at its core. The aim is to move care out of hospitals into community, prevention of illness rather than cure and to ensure early help to prevent crisis response.

2.2 The Mental Health Integrated Fund is a key enabler to achieving the left shift ambition. It is a dedicated fund to join up services across the system, and it provides the resources to deliver care focussed on our priorities including the shift to community. The focus of services funded through this mechanism is to improve outcomes, prevention and recovery leading to less waits and improved quality in patient services. Delivery of this ambition is to ensure sustainable services in GM for now and in the future.

2.3 There are a number of measurable outcomes that left shift will deliver including less attendances at Accident & Emergency (A&E) departments and less inpatients admissions, improved offering of care in the community, better engagement and experience and faster access to care and support.

2.4 The GM MH and Wellbeing strategy aligns to the purpose of both the left shift ambition and the principles of the Mental Health Integrated Fund as an enabler, providing a useful vision and vehicle to support the achievement of these goals, ultimately improving Mental Health and Wellbeing for the GM population.

2.5 National policy direction is increasingly clear in its expectation that Integrated Care Systems act as strategic commissioners, responsible for shaping services and investment to improve population outcomes. In GM, the MH and Wellbeing Strategy provides the framework through which national ambitions are translated into local delivery. It supports NHS GM in aligning commissioning intentions, investment and system partnerships across health, local government and the VCFSE sector to strengthen prevention, neighbourhood-based support and improved mental health outcomes for the GM population.

3.0 The Strategy - 2 Years on

3.1 Two years into delivery of the strategy, the system has moved from design and governance to visible transformation.

- **Year one** (24/25) focused on building shared governance, establishing new cross sector groups, and embedding links across neighbourhood, place and GM level programmes.

- **Year two** (25/26) marks the start of measurable progress against our five strategic missions, supported by the first baseline metrics for GM.

3.2 Our focus remains on building a mental health system that enables people to thrive

[1] 10 Year Health Plan for England: fit for the future - GOV.UK

where they live, work, study and connect. Our commissioning intentions set out a clear shift into neighbourhood mental health and core community services, while ensuring inpatient care remains high quality NHS provision delivered close to home. This includes reducing routine Independent Sector reliance and reinvesting those funds into local support, helping to prevent escalation and long waits for treatment.

3.3 Delivering this shift requires strong system partnerships and is increasingly being realised through place-based working, bringing together NHS organisations, local authorities and the VCFSE sector to design support around the needs of local populations.

3.4 The development of the Live Well approach and the Prevention Demonstrator provides a key opportunity to accelerate delivery of the Strategy's ambitions by strengthening prevention and neighbourhood based support. Through mission 1, partners are shaping the development of a Live Well mental health offer to better connect statutory services with community assets and support earlier intervention. The Mission 1 group has also initiated development of a GM Mental Health JSNA, starting with Chapter 1, to support Live Well and locality planning across GM, with further chapters in development (see Appendix 2).

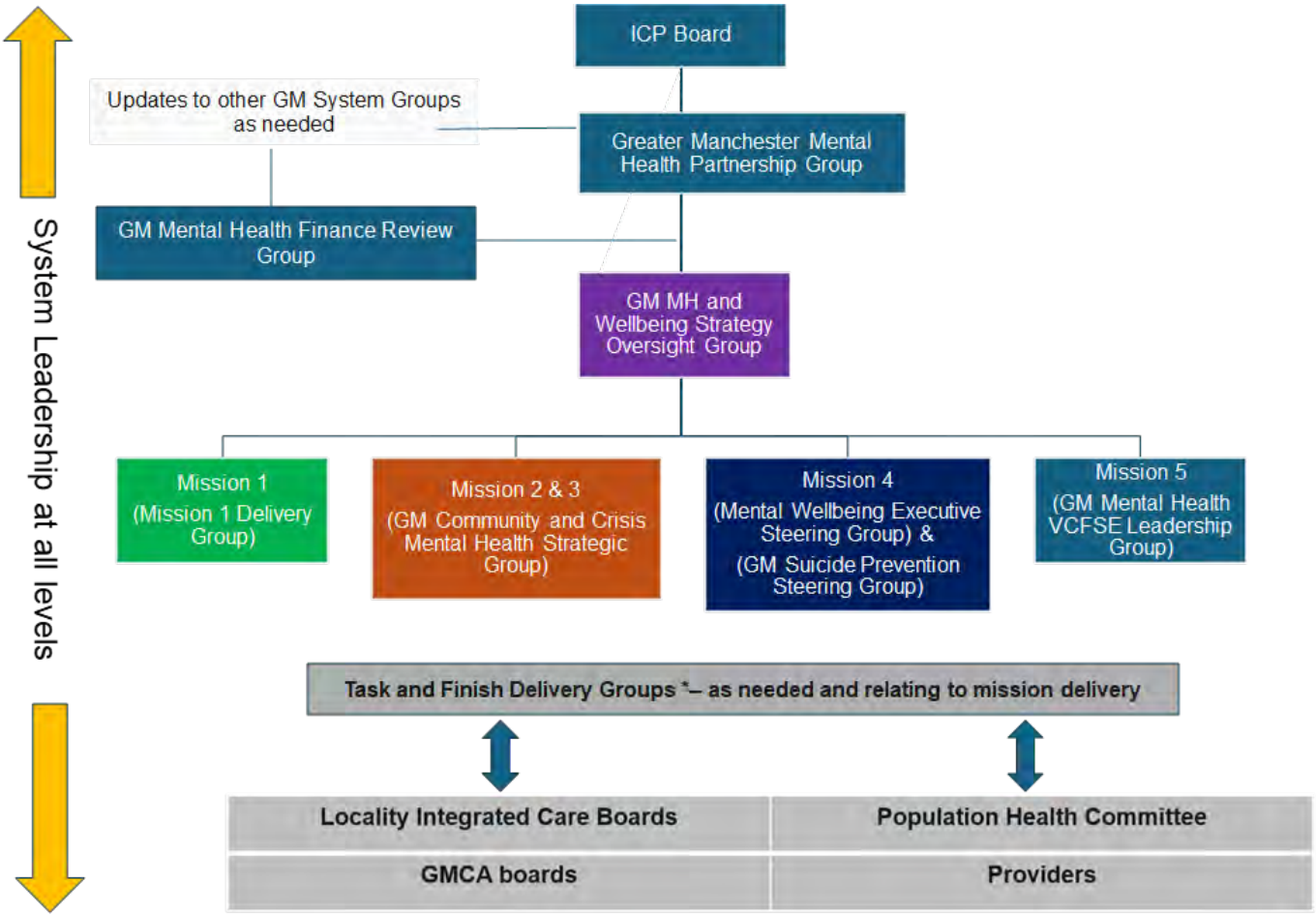
3.5 Together, these developments support GM's ambition to deliver a meaningful left shift, moving support upstream towards prevention and community based care, improving outcomes, while reducing avoidable demand on crisis and inpatient services.

4.0 Governance

4.1 The GM MH and Wellbeing Strategy Oversight group brings together senior executive sponsors and Mental Health expertise to provide a high-level strategic oversight for the delivery of the GM MH and Wellbeing Strategy. This executive level group is accountable for championing the strategy, challenging systems to ensure accountability and fostering high-profile and political connections to align priorities and maximise impact. The group will steer progress aligned with the five missions of the strategy, assess impact using metrics dashboards, manage risks, and report to key GM Boards and Committees to ensure transparency and alignment.

4.2 The delivery groups operate underneath the oversight group and are accountable for driving forward the delivery plans for each mission and providing updates through the designated senior exec sponsor through a highlight report process.

Figure 2: Governance Structure



4.3 To support delivery across the five missions, a Senior Executive Sponsor has been nominated for each mission. Executive Sponsors provide critical system leadership by championing the strategy's ambitions, aligning partners across the system, removing barriers to delivery and maintaining momentum to achieve improved outcomes. Each mission is also supported by a designated delivery lead responsible for coordinating programme activity and reporting progress through the governance structure outlined above.

GM Mental Health and Wellbeing Strategy Mission	Executive Sponsors Nominated	Driving delivery leads
Mission 1	**Neil Evans – Director of police, crime, fire and criminal justice (GMCA)**	Charlene Mulhern, AD mental Health Programme
Mission 2	**Gaynor Mullins- Director of Strategy, PCFT**	Gary Flanagan, AD mental Health Programme
Mission 3	**Tim McDougall , Executive Director of Quality, Nursing and Healthcare Professionals, PCFT**	Lynzi, Shepherd, AD mental Health Programme
Mission 4	**Director of Public Health representative; Claire Robson – Public Health Consultant, Trafford Council**	Charlene Mulhern, AD mental Health Programme
Mission 5	**Simone Spray, VCSE MH leadership group chair**	Kris Wraxall, Mental Health VCSE Integration Lead

5.0 Performance & Outcomes and Baseline Metrics

5.1 A GM MH and Wellbeing Strategy Performance and Outcomes Framework (the Framework) has been developed to underpin the Strategy. The Framework consists of indicators selected to monitor the progress towards achieving the overall vision for the GM MH and Wellbeing Strategy. The Framework is intended to be used by partners as a progress monitoring tool as well as supporting with strategic level monitoring updates to the GM MH and Wellbeing Strategy Oversight Group on a quarterly basis.

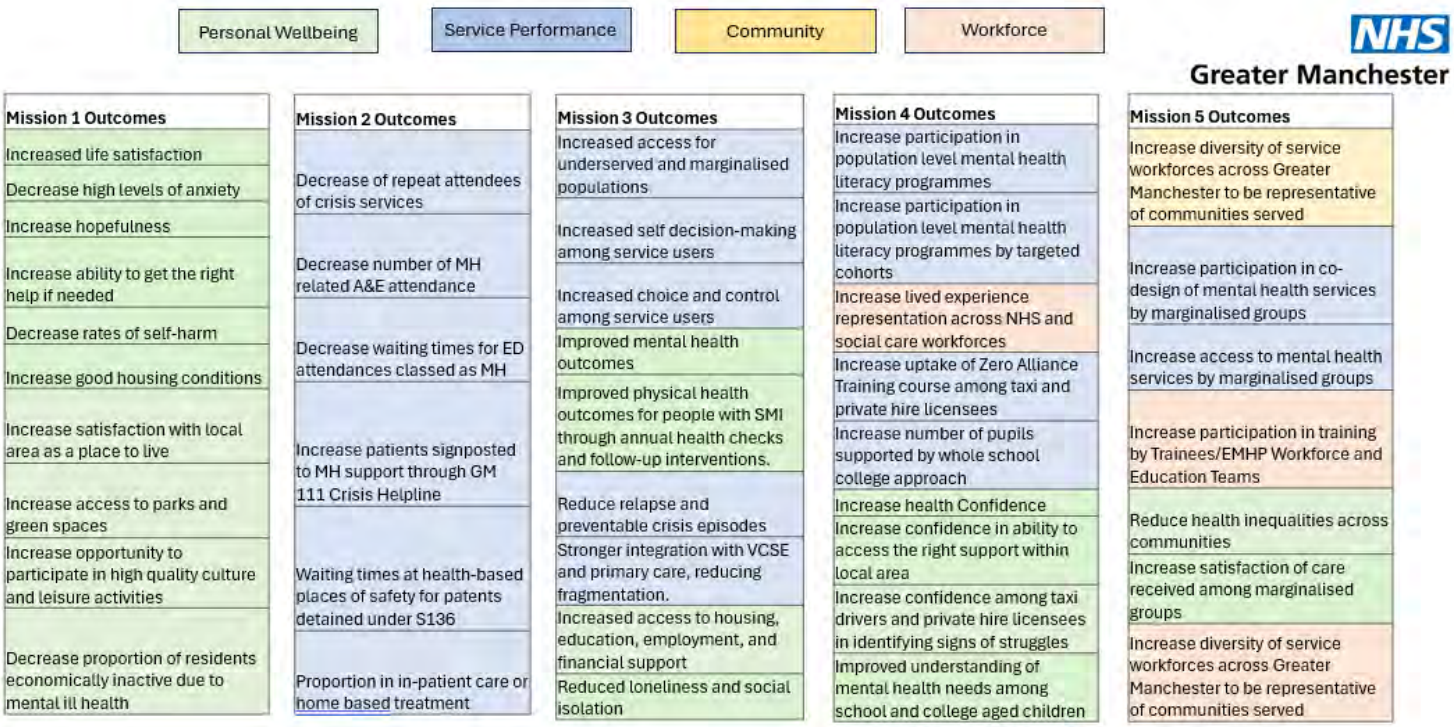
5.2 Extensive stakeholder engagement has occurred to ensure the selected indicators reflect current programmes of work across the GM Mental Health Programmes whilst also aligning to the wider strategies and initiatives including the Greater Manchester Strategy (GMS), the NHS 10-year plan, and Live Well/Prevention Demonstrator.

5.3 The Framework covers all five missions of the Strategy and will include indicators that

measure progress against each mission.

5.4 The selected outcomes and metrics are shown in *figure 3* below;

Figure 3



5.5 The monitoring tool for the outcomes framework is a dashboard on the GM Intelligence Hub - GM MH & Wellbeing Strategy Dashboard. Development of the dashboard commenced in early November 2025 and will be rolled out in phases:

- *Phase 1:* November 2025 [Status – Complete] – establishing a dashboard and including those set indicators that already exist across the system.
- Phase 2: Ongoing. Phase 2 will consist of further refinement to dashboard functionality and setting up data flows for those indicators that are currently not flowed through the NHS system (e.g. various training provider data and Voluntary Care Faith and Social Enterprise (VCFSE) data).
- Phase 3: Mid-2026. Finalisation of dashboard

5.6 The Dashboard will be open to all system partners to support with monitoring progress against the identified set of indicators.

5.7 During Year 1 of the strategy a set of baseline metrics were selected, these metrics are process based measures specifically to drive rapid change in some key areas. They are set in line with national and local priorities and there is one aligned to each mission. To ensure wide stakeholder buy-in to the approach, the metrics included measures from beyond statutory requirements (what we have to measure) to bring into consideration a different approach to understanding impact and outcomes and drive change from

different perspectives and sectors.

The baseline metrics for year one and the achievement against them is outlined in *figure 4* below.

Figure 4: Baseline Data (Year 1 Strategy metrics)

Mission	Headline Metric (24/25)	National Target	Direction of Travel	Baseline (23/24 position)
1. People will be part of mentally healthy, safe and supportive families, workplaces and communities.	A reduction in inappropriate mental health related calls to GMP	N/A	Fewer	With Right Care, Right Person (RCRP) coming into effect, there has been an update to codes applied by GMP to classify MH related calls. From September 2024, a new code came into effect and will be used to monitor MH related calls to GMP, therefore a baseline figure for 23/4 has not been provided.
2. People's quality of life will improve through inclusive, timely access to appropriate high-quality mental health information, support and services.	Eliminate acute out of area placements	0	Fewer	**119** weekly average of Out of Area Placements (OAPS) across GM
3. People with long-term mental health conditions will live longer and lead fulfilling and healthy lives	Increase in Severe Mental Illness Physical Health checks	**70%**	More	**68%** of patients on severe mental illness register received all 6 physical health checks
4. People will be comfortable talking about their mental health and wellbeing and will be actively involved in any support and care that they receive	Increase in Mental Health and Wellbeing training (Connect 5, Mental Health First Aid and Suicide Awareness) across the Greater Manchester system	N/A	More	**1294** people trained in Connect 5 - a training programme that gives participants the skills and confidence to have enabling conversations with people in their work and lives
5. The mental health and wellbeing system recognises the inequality, discrimination and structural inequity people experience and are committed to developing more inclusive services and opportunities that people identify with and are able to access and benefit from	Increase coverage across GM of pupils and settings covered by Mental Health Support Teams*	**50%**	More	**43%** of pupils covered by a mental health support team in Greater Manchester

5.8 The performance against the baseline metrics is outlined in figures 5 and 6 below. (This is also shown as an example of the dashboard)

Figure 5 – Year end performance, 24/25 Mission 1, 2 and 3

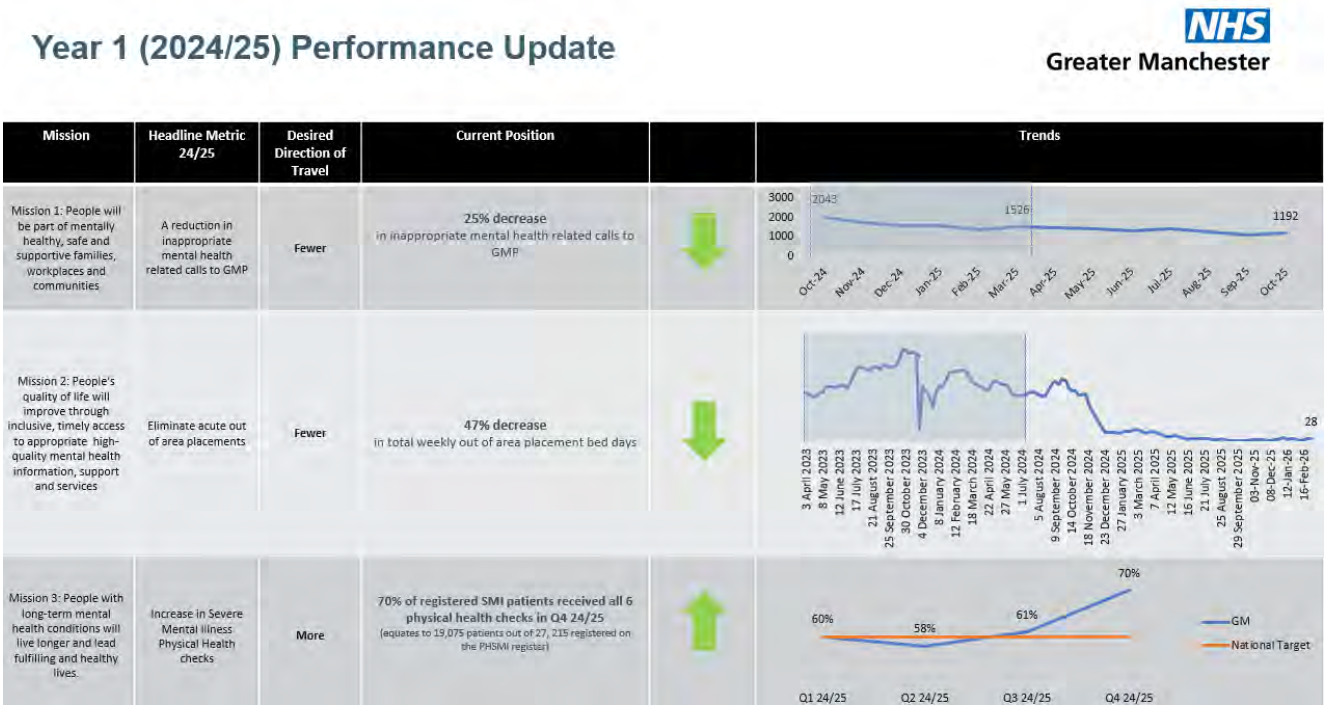
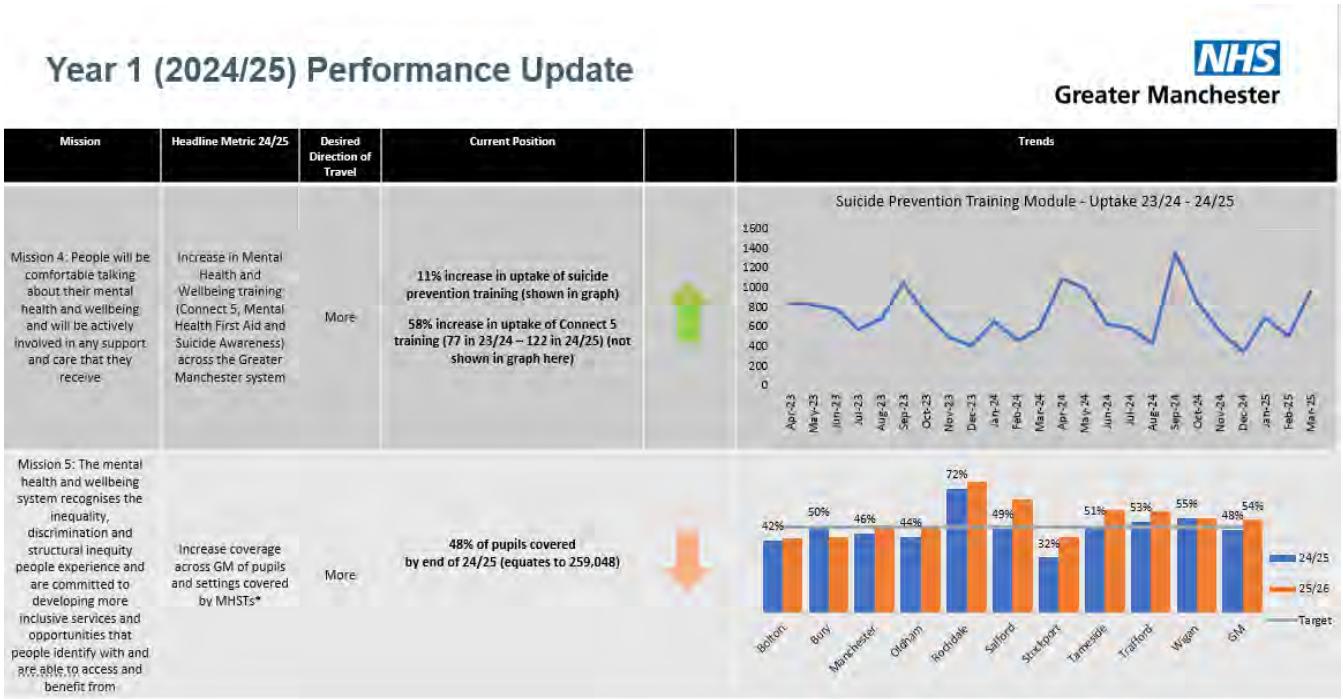


Figure 6 - Year end performance, 24/25 Mission 4 and 5



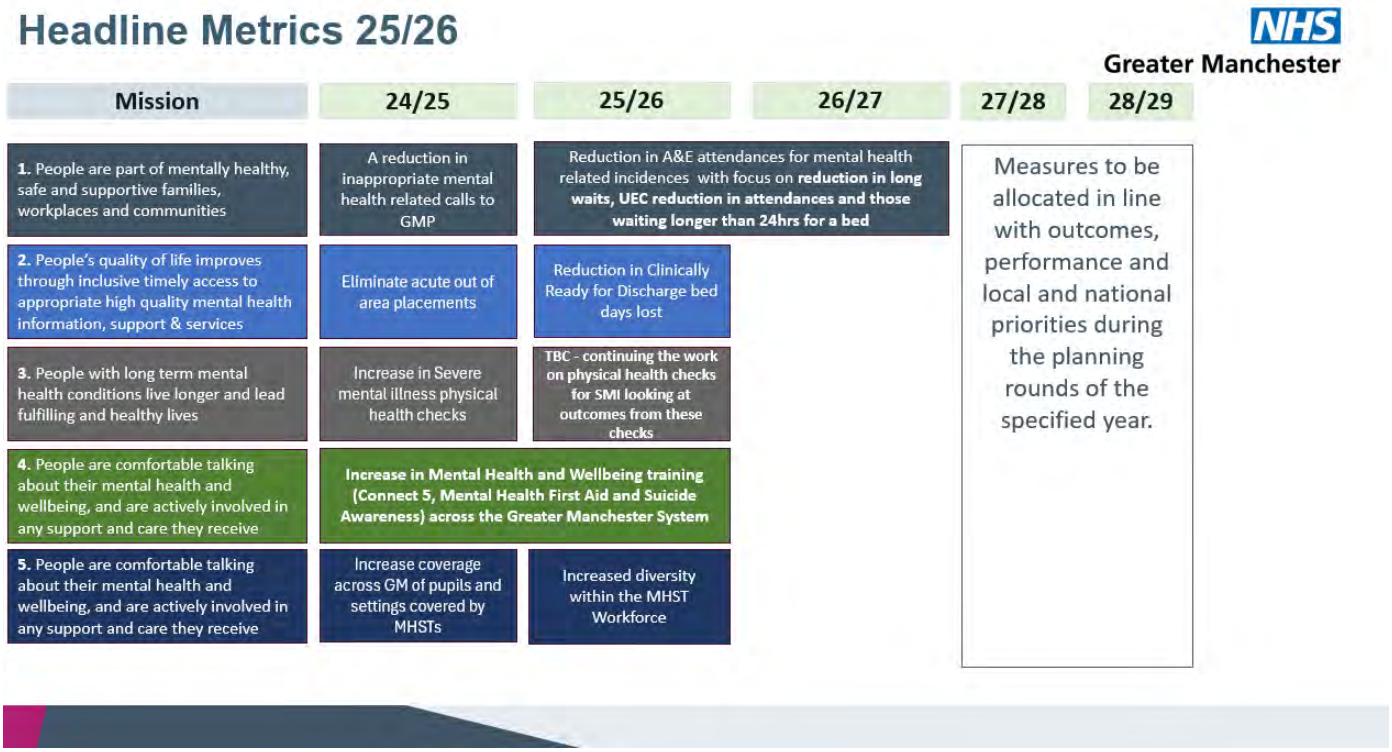
5.7 Year end performance for 24/25 is positive with 4 of the 5 missions meeting their desired target:

- 25% decrease in inappropriate MH related calls to Greater Manchester Police (GMP)
- 47% decrease in total weekly MH Out of area placement (OAP) bed days
- 10% increase (to 70%) of registered Severe Mental Illness (SMI) patients received all 6 physical health checks Q4 24/25 (19,075 patients out of 27, 215 registered on the Physical Health Severe Mental Illness (PHSMI) register)
- 11% increase in uptake of suicide prevention training and 58% increase in uptake of Connect 5 training
- Whilst coverage for Mental Health Support Teams (MHSTs) increased from 43% to 48%, it didn't quite meet the nationally set target of 50% and so is marked as Amber. **

*** Despite the year end position being just below the 50% target, the current position is 56% which is above the national target of 52%.*

5.8 In order to ensure focused analysis across a suite of metrics, the baseline metrics will be reviewed each year. The review for year 2 (25/26) resulted in some changes to the baseline metrics, these are displayed in *figure 7* below.

Figure 7 – Baseline Metrics 25/26



5.9 Whilst year end performance position will not be available until April 2026, the Performance and Outcomes Framework and associated baseline metrics are live tools, with implementation continuing in phases. As this outcomes-based monitoring approach is relatively new, some data gaps remain; however, where data is available, year to date performance indicates positive progress. For example:

- 3% decrease in number of A&E attendances for mental health related incidences between April and December 25/26
- 17% decrease in bed days lost between April and November 2025. In addition to the performance shown above, the current data is showing a favourable position. February 2026 OAP have decreased by 88.2% since April 2025, Local Spot Purchase placements have decreased by 73.45% over the same period.
- The Department of Education publishes official pupil and setting coverage for Mental Health Support Teams annually in May. Indicative data, however, estimates approximately 56% coverage of pupils, a positive direction of travel towards achieving the new national target of 77% of pupils coverage.

6.0 Translating the Missions into Improved Mental Health and Wellbeing.

6.1 Mental health needs span a broad spectrum across GM, and the GM MH and Wellbeing Strategy sets out a vision to improve care for everyone, wherever they sit on that spectrum. A substantial programme of work aligns with the strategy's missions, delivering meaningful improvements and significant benefits for the population.

6.2 *Figure 8* below outlines some of the programmes of work which are contributing to the achievement of the missions.

Figure 8 – Examples of programmes contributing to the MH and Wellbeing strategy missions

6.3 Further information relating to these programmes and a progress update is provided in *Appendix 1.*

6.4 The delivery of the GM MH and Wellbeing Strategy is closely aligned with the NHS Greater Manchester Medium-Term Plan for 2026–2029. The Medium-Term Plan sets out the operational priorities, performance standards and financial trajectory required to meet national planning requirements. The Strategy provides the broader system vision for improving mental health and wellbeing across Greater Manchester and supports partners in aligning delivery around shared priorities.

6.5 Delivery across the strategies missions therefore plays an important role in focusing system action on the areas that will support achievement of the Medium-Term Plan commitments, particularly in relation to prevention, neighbourhood mental health services and reducing avoidable demand on crisis and inpatient care.

6.6 The following case study examples (one for each mission) illustrate examples of delivery contributing to the strategy's missions. While not all align directly with the headline metrics, they demonstrate the breath of programmes supporting delivery, as reflected within the wider outcomes framework (Figure 3) and programme overview (Figure 8).

6.7 Case Study 1

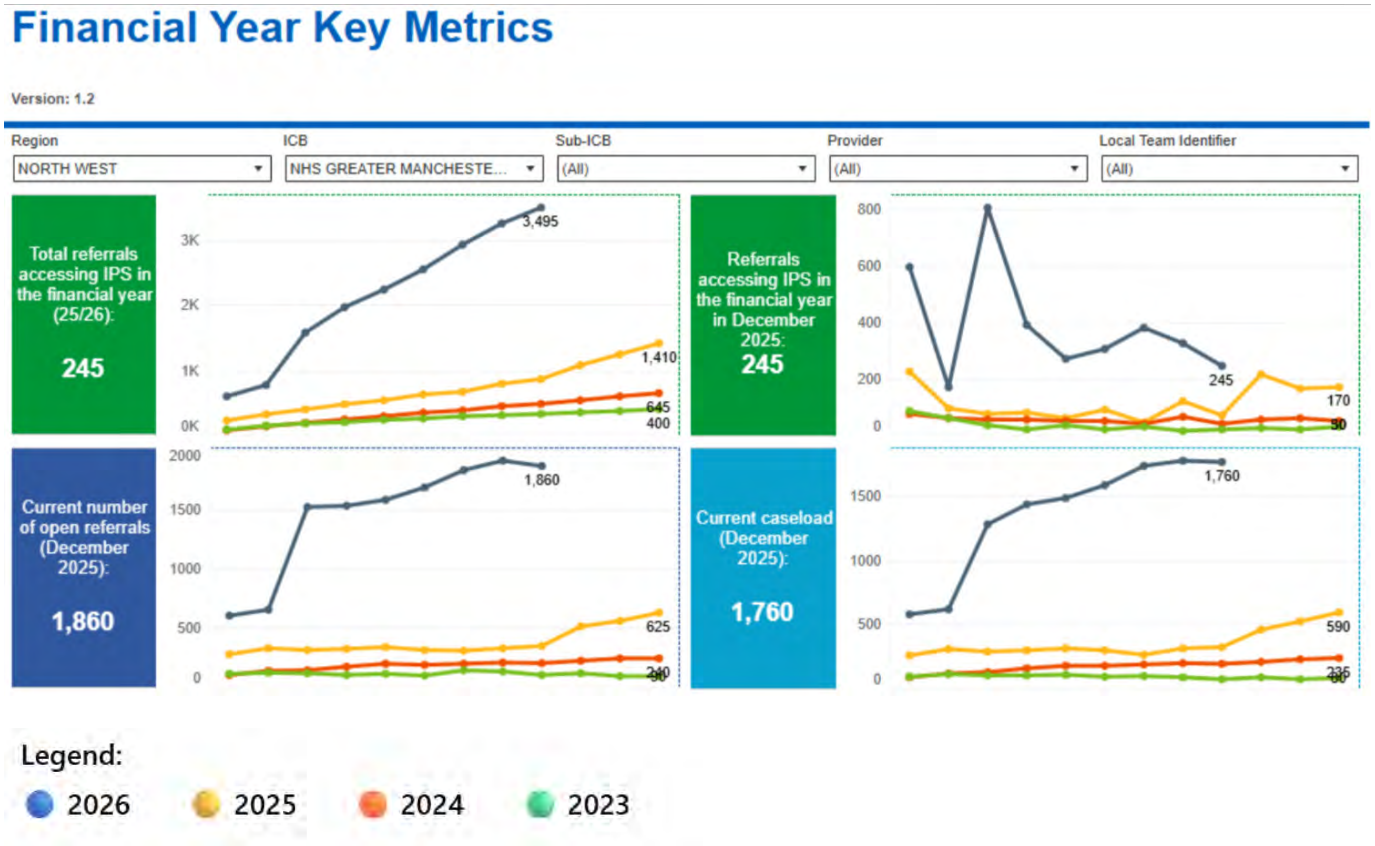
Mission 1: *People are part of mentally healthy, safe and supportive families, workplaces and communities.*

Case Example: Individual Placement Support (IPS)	
Description:	GM is one of twelve areas selected to pilot the Individual Placement and Support in Primary Care (IPSPC) programme, which is a 'first step' in the delivery of the Department for Work and Pension's (DWPs) Universal Support programme. It is funded by both the DWP and Department for Health and Social Care (DHSC), and is administered through DWP. IPS is a model of supported employment found to be effective in assisting people with SMI to find and sustain employment. The model is based around 8 principles: • Focus on competitive employment • Open to all those who want to work (no exclusion on the basis of readiness, disability/health conditions or benefits claim) • Integration with clinical health teams • Rapid job search • Focus on jobs consistent with the participant's preferences (enabled by a focus on vocational profiling) • Relationships are built with employers who are targeted based on participant preferences • Ongoing, time-unlimited and individualised support for the person and their employer • Benefits counselling is included
Progress Update	
• GM is now exceeding the NHSE target. Across GM 3,745 individuals have accessed IPS against an annual target of 3,109 (data to end December). This is the first year that GM has achieved the target. • The IPS SMI, Wellness in Work programme is overachieving against all contractual outcomes and KPIs. With 1,810 individuals accessing the service against an annual target of 1,420 (data to end December). Against KPI targets they are achieving 159% of target for out of work gaining employment targets, 292% of Job retention targets and 119% of the 13-week Job sustainment targets. • The IPS in Primary Care programme is also overachieving against all contractual outcomes and KPIs, with 1,700 individuals with SMI accessing the service (data to end	

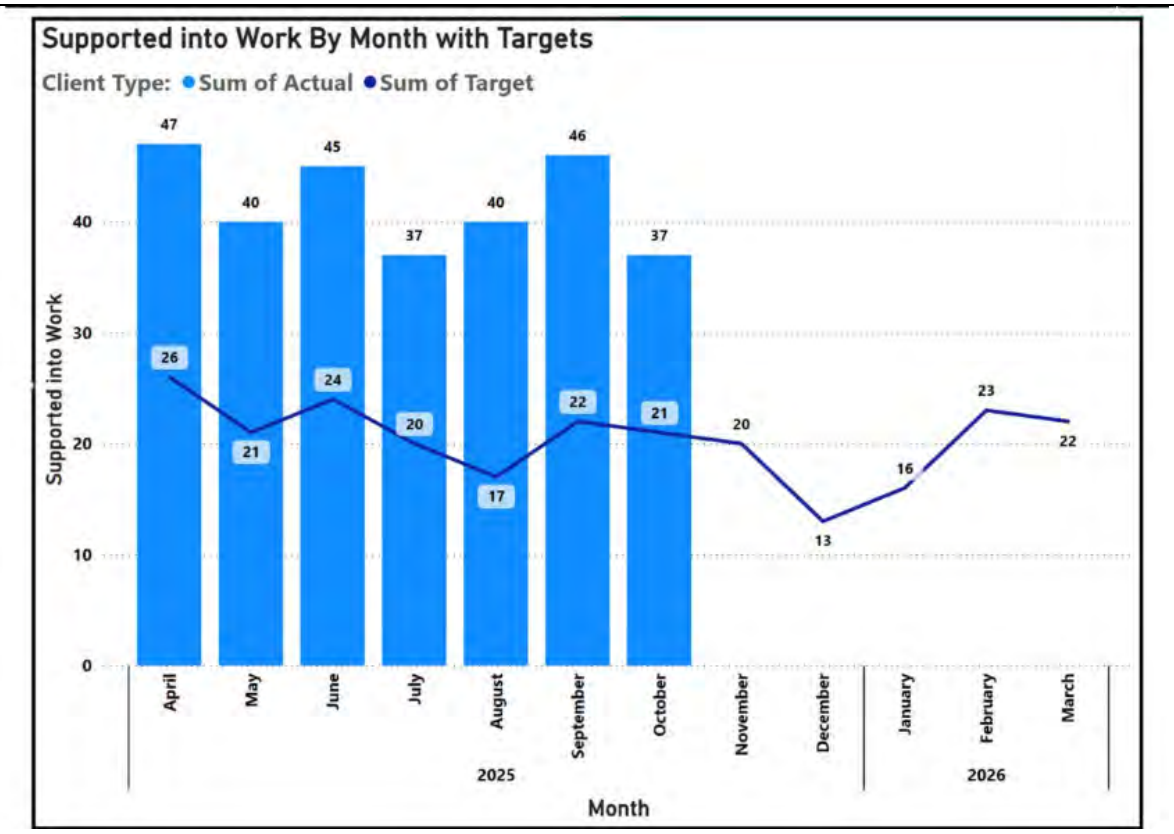
December) Against targets they are achieving 104% of out of work starts, 101% of in work starts, 104% of OOW job starts, 482% of OOW lower threshold outcome and 94% of in work higher threshold outcome

- In July 2024 following an external audit of the IPS service received a score of 105 and a Good Fidelity rating.
- Currently the service is oversubscribed across GM with waiting lists for the service in Tameside, Salford and Stockport.
- The ICB have now agreed additional funding to expand the service; allowing for the recruitment of additional staff to meet demand, reducing unwarranted variation of access to treatment and quality of provision.

Outcomes / Performance:



*Each data point on the x-axis represents one month within the financial year (starting April–March).



Impact on patients and community :

Patient Case Study: *Mental health support helps Callum press start on gaming career :: Pennine Care NHS Foundation Trust*

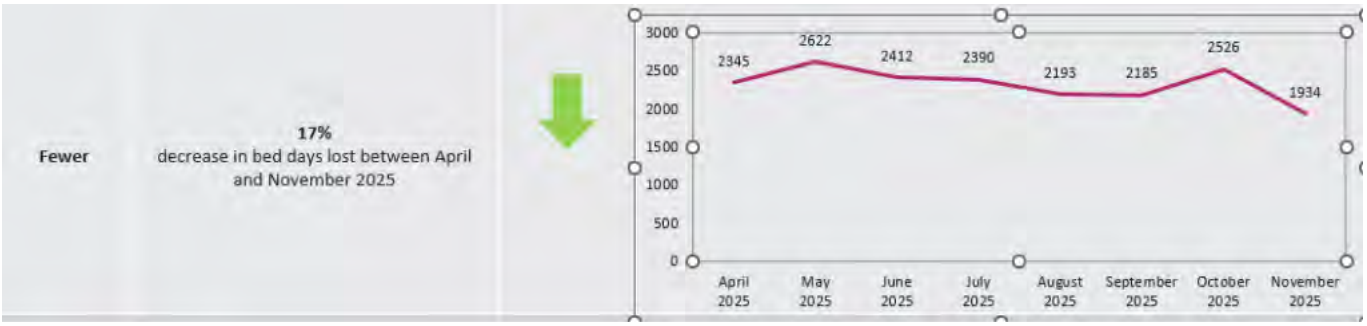
Service Information Video: *Wellness In Work: IPS at Pure Innovations*

6.8 Case Study 2

Mission 2: *People's quality of life improves through inclusive timely access to appropriate high quality mental health information, support & services*

	Case Example: VCFSE Crisis Spaces
Description:	VCFSE Crisis Spaces provide inclusive, rapid-access, community-based mental health support. By offering timely, high-quality information and community crisis support, they de-escalate distress and reduce reliance on acute services, preventing unnecessary admissions. The Recovery Lounge in the Manchester locality provides a non-clinical, city-centre safe space for people experiencing a mental health crisis, offering a person-centred approach through self-referral and access to trained, experienced workers who listen and provide supportive, compassionate care.
Progress Update	
A GM wide review of VCFSE crisis space provision has been completed, highlighting strengths in personalised, community-based support but also variation in access, hours, and integration. Key developments: • A new draft service specification has been issued, with local feedback being collated. • Proposals include establishing two overnight VCFSE led crisis spaces (one per Trust footprint) offering access to support overnight. The North West (NW) Regional Transformation Fund bid to fund this was successful, this will enable work to begin at pace to deliver this offer. • Review of Older People's Home Treatment/Community Crisis Offer taking place in Q4 25/26. • Review of Mental Health Liaison offer will also take place in Q4 25/26.	
Outcomes:	
Year End Position 24/25 - *Eliminate acute out of area placements*	

November 2025 – reduction in CRFD bed days lost



As a GM system we have committed to reducing the total number of OAPs to 2 by end March 2026 and reducing the number of Local Spot Purchase (LSP) beds to 14 by end March 2026. Regarding OAPs, this has been achieved, with a slight exception in January (4) OAPs targets have been achieved since September 2025. LSP targets have been achieved since December 2025. A comprehensive overarching CRFD improvement plan is in place.

The CRFD Mental Health individual escalation process has been drafted to support the system to resolve the most complex cases in the GM system. The process has been piloted over the summer and is due to be implemented in Q1 26/27.

Rehab focus has been on implementing a new service specification for GM. A single outcome framework for inpatient and community pathways is being developed. A deep dive into understanding the needs of our rehab inpatient population has taken place. There has been a 14% decrease in the number of Independent Sector rehab beds used, and a 14.8% reduction in rehab OAPs, which is without specific targets being in place for this reduction – targets are in planning for 26/27.

Impact on patients and community :

People say:

"They were very supportive; they helped me constructively come up with proactive plans to feel better and also validated me in a compassionate way"

"Space was cosy. I felt listened to. It felt like workers were genuinely just trying to help me with no judgment. It is great."

Source: *Manchester | Recovery Lounge | Mental Health Crisis | Turning Point*

6.9 Case Study 3

Mission 3: *People with long term mental health conditions live longer and lead fulfilling and healthy lives*

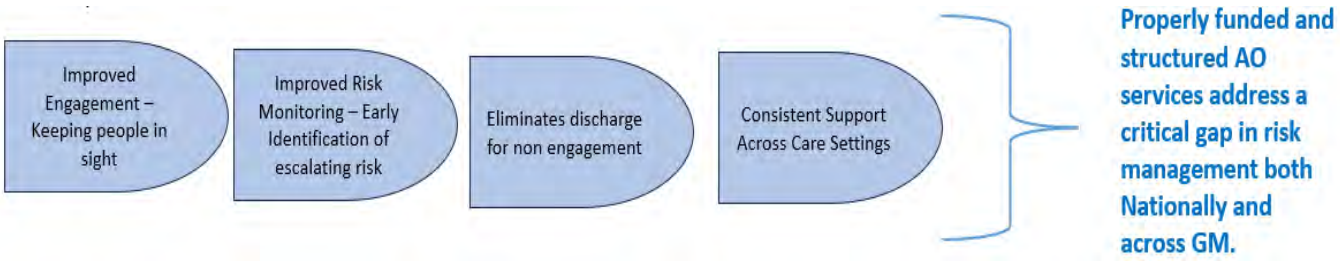
Case Example: GM Assertive Outreach (AO)	
Description:	Assertive Outreach pathways are central to delivering the mission that people with long-term mental health conditions live longer and lead fulfilling, healthy lives by proactively engaging those at highest risk of poor outcomes who are least likely to access routine services. Through persistent, relationship-based engagement, outreach teams reach people who are disengaged, socially excluded, or experiencing multiple barriers to care, ensuring their physical health needs are not overlooked.

Progress Update

- Cohorts for AO have been systematically identified by care coordinators, with several Community Mental Health Teams (CMHTs) now using PARIS pathways to streamline identification and case management.
- Triangle of Care principles have been embedded, supported by the establishment of a Carer Council, ensuring carers are active partners in care planning and decision-making.
- Blanket Did Not Attend (DNA) discharge policies have been removed, supporting a more personalised and recovery-oriented approach to engagement and discharge
- Future service model: A business case for a dedicated Assertive Outreach Team (AOT) model is in development, aligned to NICE and national policy, to ensure a sustainable, high-quality offer for individuals with complex needs who are at risk of disengagement.

Outcomes:

Year End achievement – 24/25

Impact on patients and community :
The NHS England » Independent mental health homicide report into the treatment of Valdo Calocane highlights the importance of dedicated provision for AO. 

6.10 Case Study 4

Mission 4: *People are comfortable talking about their mental health and wellbeing and are actively involved in any support and care they receive*

	Case Example: Headstart
Description:	Headstart is as an innovative early help programme supporting Year 6 pupils in their transition from primary to secondary school. This transition has been largely overlooked; however, it can have a long-term effect on emotional wellbeing, mental health and a range of social outcomes (education and employment) for young people. Further that there are distinct health and social benefits to framing this transition as part of a positive discourse (Garner and Bagnall, 2024). Headstart aims to identify and work with young people, who are at risk of needing referrals to other services including Child & Adolescent Mental Health Services (CAMHS). In the first two years of the programme, we have demonstrated improvement in individual wellbeing outcomes as well as modelled reductions in uptake of services and cost benefit for health system as well as longer term wider benefits, largely driven by outcomes in terms of educational and employment. In 25-26, our intervention group have been compared to non-intervention peers using comparative NHS data.

Progress Update

A rigorous economic evaluation was carried out using pre and post Strength & Difficulties Questionnaire (SDQ) data for 109 young people. Findings included:

- There is a high level of need amongst those supported
- The number of children with "high" or "very high" needs declined from 53% to 43%
- There was an average reduction in total difficulties score of 1.3 points
- This change now meets standard academic tests for "statistical significance" but would be considered a "small" effect size
- We saw a 1.3 point improvement in SDQ for young people supported by Headstart (reduction in total difficulties score)
- But the matched comparison group from the NHS survey data also typically saw an improvement of around 0.9 points meaning that around 0.4 points of improvement can be attributed to the Headstart programme
- This was associated with a reduction in the demand for NHS services:

Short-term demand for CAMHS

- Based on SDQ scores at the start of the programme we would have expected 79 of the 247 children supported to have been referred to CAMHS in a given year
- We estimate that the improvements in SDQ are associated with a reduction in expected referrals of around 5 referrals to around 74
- If this improvement in SDQ persists across secondary school then could be **equivalent to an economic benefit of around £20K**

Long term demand for adult mental health services

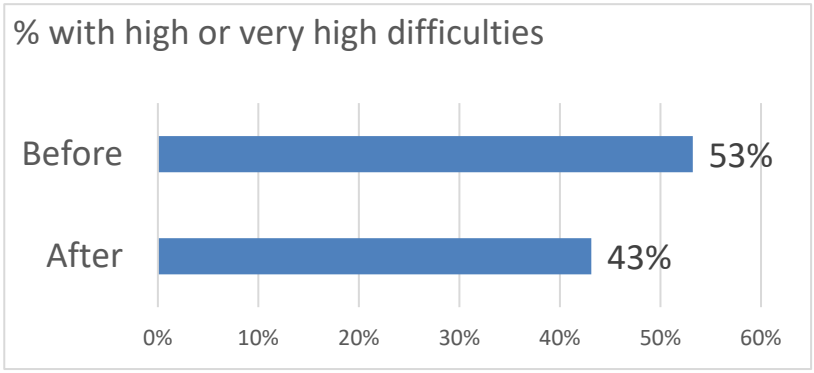
- The improvement in SDQ has been associated with a reduction in the likelihood of being treated for depression as an adult
- This is a potential cost saving of £60 per young person
- If the improvement in SDQ persists the it could be **equivalent to savings across the whole programme of around £13K**

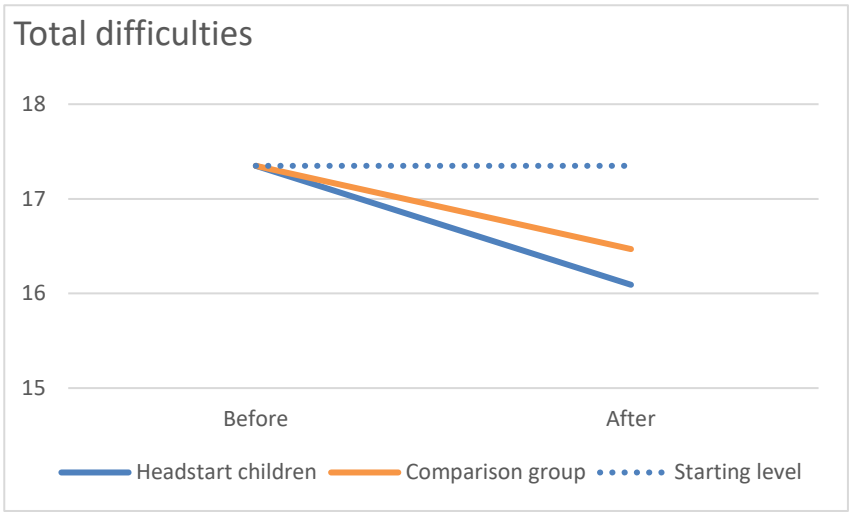
Importantly, if these improvements in mental health persist, they could be associated with potential lifetime economic benefits of around **£680,000** to the system. This is largely driven by improvements in educational and employment outcomes as well as reductions in costs associated with criminal justice.

Headline messages:

- Participants see a small but meaningful improvement in mental health
- We are adopting/presenting very transparent and rigorous method/results since we are able to model the improvements attributable to the programme and what improvement is likely to have happened in the absence of the programme
- We estimate that the first three years of the programme will deliver around £680,000 of economic benefits to the system.
- Return on Investment is somewhere in range depending on attribution of benefits modelled. It could be as high as £6.50 for every £1 spent but modelling suggests it will be in the medium range equivalent to £2.50 for every £1 spent.

Outcomes:





Impact on patients and community :

A young person described their experience:

"The sessions are good because we can just be ourselves, we have someone who can listen to us and the group sessions are fun because we can all be together in one safe space," "My anxiety is 100% better than it was."

Source: Headstart programme helping young lives make a positive school transition - EFL in the Community

6.11 Case Study 5

Mission 5: *The mental health and wellbeing system recognises the inequality, discrimination and structural inequity of people's experience, and is developing more inclusive services and opportunities that people identify with and are able to access and benefit from*

	Case Example: Reducing Racial Inequalities (RRI)
Description:	The RRI Mental Health Service Fund led by the NHS GM, aims to address the mental health inequalities that exist in the black and minority ethnic communities in GM. It is reported that people in Black or Black British ethnic groups were around 27% more likely to be in contact with mental health services than those in White ethnic groups in 2021/22 [1]. In relation to serious mental health illness: • 3.5% of people identifying as Black or Black British screened positive for bipolar disorder compared with 2.0% of White people and 1.4% of people Asian or Asian British. • 1.4% of people identifying as Black or Black British screened positive for psychotic disorders compared with 0.9% of Asian or Asian British and 0.5% of White people. Evidence also suggests there are clear barriers to seeking help for mental health problems in the black and minority ethnic communities. This is rooted in a distrust of both primary care and mental health care providers, as well as a fear of being discriminated against in healthcare[2]. The RRI Fund aims to breakdown these barriers and improve access to community mental health services. [1] Mental health statistics: prevalence, services and funding in England – March 2023 [2] Kapadia et al (2022) 'Ethnic Inequalities in Healthcare: A Rapid Evidence Review conducted on behalf of the NHS Race Obse…
Progress Update	
• The programme continues to support efforts to reduce racial disparities in access to community mental health services across GM. For 2025/26, the fund has been allocated to 24 VCFSE	

providers delivering services specifically focused on individuals with SMI from Black, African, Afro-Caribbean, and South Asian communities.

- The service specification has been refined to ensure alignment with these priorities, and 4 providers falling outside the scope have been decommissioned following a full equality impact assessment. They stopped service provision on 30th September 2025.
- Although 32% of people supported have a SMI, this figure rises to 37% without the providers who have been decommissioned as they supported wellbeing rather than SMI
- This is the final year of the fund in its current format, with plans to refresh the approach moving forward. Following the insolvency of Greater Manchester Centre for Voluntary Organisation (GMCVO), administration of the fund has transitioned to GADDUM, which now also hosts the RRI Coordinator post.
- Communities of Practice (CoP) meeting for the 24 providers continue to be held every 6-8 weeks with a key focus on the RRI measuring tool, mental health services data set (MHSDS) submissions and Patient and Carer Race Equality Framework (PCREF). RRI providers were invited to Greater Manchester Mental Health NHS Foundation Trust (GMMH) and Pennine Care NHS Foundation Trust (PCFT) PCREF Community Leadership Voice event in October 2025.
- RRI Coordinator has also spoken at events about RRI programme and monitoring data has been used at NHS England PCREF meetings. The RRI Coordinator has also linked up with the Recovery in Community project in Manchester co-delivered by Manchester Mind and Gaddum, easy referral process to RRI projects for those with delayed discharge if appropriate.

Outcomes:

Q1 monitoring data has been received.~1,200 people supported across 3,700 sessions. 33% with SMI

Main types of support; counselling 28.5%, Group Work Therapy 28%, Children & Young People (CYP) 16%, Group work activities 22%, bi-lingua counselling 12%, domestic abuse 10%

Additional support most popular– peer support 33%, befriending 9%, no recourse to public funding 8%

29 types of support available, including trafficking, drugs and alcohol, modern slavery, honour based abuse

Impact on patients and community :

GM detains black people at 3 times the rate of white people

24% of GM population is from an ethnic minority yet only 15% of people accessing talking therapy & 12% of referrals to secondary MH services are from an ethnic minority.

People from ethnic minorities have worse talking therapies outcomes than white people.

Source: Integrating health and care in Greater Manchester

7.0 Strategic Priorities and Delivery Focus (2026/27)

GM remains committed to delivering the vision of *Doing Mental Health Differently* and to sustaining the momentum achieved in the first two years of the strategy. However, the current ICB blueprint and associated organisational restructuring is creating a period of uncertainty and reduced system capacity. This is being felt across commissioning, programme management and transformation delivery functions. In this context, our approach for 2026/27 is to be clear about delivery constraints, protect what matters most, and ensure we continue to make progress against our highest impact local priorities and our national operational planning requirements.

This next phase of focused delivery will therefore be characterised by disciplined capacity prioritisation, strengthened system leadership and a refresh of governance to ensure it remains proportionate, efficient and fit for the operating environment. We will review current Mental Health Strategy governance arrangements to ensure decision making is streamlined, responsibilities are clear across neighbourhood, place and GM and that delivery groups are aligned to the priorities and “must-do” requirements for 2026/27.

Delivery of the next phase of the GM Mental Health Strategy will remain closely aligned with the ICB’s commissioning intentions, the GM Clinical Strategy, the GM Medium-Term Planning submission and our Joint Forward Plan. Together these provide the strategic framework for improving mental health outcomes across GM while ensuring services remain high quality, equitable and sustainable. The priorities outlined below therefore support both the delivery of our long-term strategic ambitions and the achievement of national operational planning and performance requirements.

7.1 Strategic Priorities for the Next Phase

To provide assurance to the Board, we are clear that we will continue to drive forward the strategy’s ambitions, with an initial focus on three system critical priorities that align with the NHS 10-year health plan direction of travel (improved access and quality of services for children and young people, community-based support and urgent and emergency care pathways):

1. **CYP access and continued support**
   We will prioritise protecting and improving CYP access (including mental health support teams across all schools and colleges), reducing unwarranted variation, and ensuring timely quality support is sustained once accessed. This includes maintaining required national focus on better productivity from individual practitioners and services as well as increased capacity within CYP community mental health services, strengthening targeted support pathways for vulnerable children and their families, and ensuring access routes are clear for families, schools and partners. Alongside this, we will continue to prioritise system-wide improvement to neurodevelopmental pathways, including implementation of the new needs-led early help model, strengthened waiting list management and clinical prioritisation approaches and the refreshed CAMHS core community specification to support more timely and equitable access to assessment and support for children and young people.

2. **Community Mental Health and neighbourhood teams**
   We will prioritise the continued development and sustainability of neighbourhood integrated community mental health models, ensuring adequate community support upstream and specialist teams are in place to prevent escalation to care breakdowns to further reduce reliance on inappropriate acute, rehab and high-cost care packages (especially those Out of Area provision). This includes tackling known fragilities from historical under-investment in community services (including skilled workforce and funding risks through changes to s75 joint funding arrangements), strengthening VCFSE integration offers, and supporting delivery of the core GM-wide Community Mental Health specification and associated data and digital alternative enablers.
3. **A clear urgent and emergency care (UEC) mental health crisis pathway**
   We will prioritise a consistent, safe and effective crisis pathway across GM, ensuring people can access timely support in crisis, that escalation routes are clear, and that flow is improved across the system. This includes strengthening community crisis alternatives, supporting improvements in clinically ready for discharge processes, and ensuring acute interfaces are robust as part of our wider Quality Inpatient Improvement and Assertive Outreach development programmes.

7.2 2026/27 NHSE "Must Do" Requirements

In addition to the three locally agreed strategic priorities outlined above, the GM MH programme is required to deliver on the defined set of national operational planning commitments in 2026/27.

Helpfully, these national "must do" requirements both reinforce our local priorities (particularly in terms of enhanced children and young people's access, better community-based provision and developed UEC pathways) and align with other requirements for further productivity, inpatient transformation, workforce capability and quality improvement.

Collectively, this context provides for a clear delivery framework of *Doing Mental Health Differently* across GM in the coming year.

This should ensure that despite significant changing environment including ongoing system pressures and reduced leadership capacity, our focus can remain aligned to national policy, statutory expectations and measurable improvements in outcomes, access and safety.

The particular required commitments for the ICB in 2026/27 are:

- Reduce longest waits for CYP community mental health services by improving productivity, reducing local inequalities and unwarranted variation in access
- In children and young people's community mental health services, increasing the number of direct and indirect contacts per whole time equivalent hours worked
- Significant expansion and coverage of MHSTs in schools and colleges (inc. new teams in training) with all working to national evidenced-based practice guidance

- Meeting the existing commitments to expand NHS Talking Therapies and IPS to ensure more people with mental health difficulties are able to remain in and gain employment
- Eliminating the continued inappropriate over-reliance on hospital inpatient care admissions and use of high-cost restrictive packages of care or out of area placements as well as reducing length of stay for particularly vulnerable patient groups (e.g. autistic individuals, women with traumatic/PD histories, dual alcohol/ substance misuse, homeless and complex dementia)
- Eliminate locked rehabilitation inpatient services
- Establish mental health emergency departments co-located with or close to at least half of Type 1 emergency departments by 2029/30 as alternative options to inappropriate Acute Hospital presentations
- Reduce the average length of stay in adult acute mental health beds
- Mental health practitioners across all providers to undertake training and deliver care in line with the Staying safe from suicide guidance

7.3 How We Will Deliver in a Reduced Capacity Environment

In light of the NHS Reform Blueprint transition for ICBs and associated reduced system capacity, we will take a disciplined and prioritised approach to delivery that focuses on highest impact activity (7.1), statutory and national requirements (7.2) and areas of greatest system risk.

A refreshed delivery plan will align priorities to available capacity, consolidate programmes where appropriate and maximise place-based leadership, VCFSE partnership and integration with Live Well and neighbourhood models.

So while our commitment to the strategy's vision remains unchanged, the immediate focus must now be on sustaining momentum on the highlighted local priority areas and national minimum requirements - while ensuring refreshed governance and delivery arrangements that are resilient through a period of significant organisational change.

We would be happy to return to the ICB Board later in the year with an update on revised ways of working, governance refinements and progress against agreed priorities.

8.0 Recommendations

The NHS GM ICB Board is asked to:

- Endorse the pace and direction of travel, recognising both progress and complexity.
- Note the strategic priorities going forward and support the system to unblock cross-cutting issues (workforce, digital, finance, estates).
- Back a whole system approach that enables GM to improve outcomes, deliver equity, and maximise the impact of mental health investment for our population.

Appendix 1 : Two year strategy progress update

Type	Programme of Work	Progress
Mission 1: People are part of mentally healthy, safe and supportive families, workplaces and communities.		
All Age	**Mental Health Live Well**	Mission 1 Delivery Group established with partners from GMCA, Housing, ICB and Local authorities. Strategic vision for Mental Health Live Well agreed with ICB Chief Officers with a focus to align mental health programmes across the lifespan. Mental Health Trust Chief Executive Officers (CEOs) have endorsed the strategic MH Live Well vision, with a coordinated plan now being developed with MH Trusts, VCFSE and partners to drive delivery forward.
	Mental Health Needs Assessment	Work is underway on an initial GM wide Mental Health Joint Strategic Needs Assessment (JSNA). Chapter 1 has now been completed and has been added *as Appendix 2*.
	Parent Infant Mental Health (PIMH) Services Model	Specialist PIMH teams are now present in each of the ten GM localities, though they vary significantly in size and capacity. By aligning with Best Start for Life (BSFL) funding, PIMH services have been able to maintain, and in some areas expand its focus on early years, provide more responsive and universal support and keep the 1001 critical days as a central priority Work has begun on rethinking and redesigning the GM PIMH services model
	Individual (employment) Placement Support (IPS)	The IPS SMI, Wellness in Work programme is overachieving against all contractual outcomes and KPIs. With 1,810 individuals accessing the service against an annual target of 1,420 (data to end December). Against KPI targets they are achieving 159% of target for out of work gaining employment targets, 292% of Job retention targets and 119% of the 13-week Job sustainment targets. Currently the service is oversubscribed across GM with waiting lists for the service in Tameside, Salford and Stockport. Funding for expansion has been allocated by NHS GM, with the proposal awaiting approval from the PCFT Board. The IPS in Primary Care programme is also overachieving against all contractual outcomes and KPIs, with 1,700 individuals with SMI accessing the service (data to end December) Against targets they are achieving 104% of out of work starts, 101% of in work starts, 104% of OOW job starts, 482% of OOW lower threshold outcome and 94% of in work

		higher threshold outcome (this will increase, current data lag validating through HMRC) Between the two services, Greater Manchester is now exceeding the NHSE target. Across GM 3,745 individuals have accessed IPS against an annual target of 3,109 (data to end December). This is the first year that GM has achieved this target.
Mission 2: People's quality of life improves through inclusive timely access to appropriate high quality mental health information, support & services		
CYP	**Specialist Perinatal Mental Health Services: Perinatal Trauma and Loss Service (PETALS)**	PETALS has remained highly responsive to growing demand, achieving significant impact with referrals increasing to 481 in 2024 (up from 228 in 2023) and consistently high acceptance rates. The team has worked to maintain a 93% referral acceptance rate.
	Specialist Core Community CAMHS Specification Refresh	The refreshed specification incorporates recommendations from the North West CAMHS Review and CYP engagement (Bee Heard/Bee Counted), strengthens priorities such as extending the model to 18-year-olds and improving waiting time management, and prepares GM for upcoming NHSE waiting time standards while acknowledging financial, resource and workforce pressures.
	New Neurodevelopmental (ND) Early Help Model of Care	NHS GM have co-produced a new needs-led model of care, to create a more sustainable system that supports CYP and their families without requiring a formal diagnosis A universal GM offer is being developed including a new website, sensory toolkit, chat messaging service, peer support and a neuro profiling toolkit
	ND Waiting Lists Initiative	Clinical prioritisation criteria agreed by the GM Clinical Effectiveness Group (CEG) will guide safe and equitable decision making. Implementation of clinical prioritisation criteria which will be introduced in January 2026 to support a consistent, fair and person-centred approach to prioritising assessment for CYP based on their holistic needs
	Children's Eating Disorder Service (CEDS)	GM wide review is underway to refresh the service specification, including establishing a clear understanding of Avoidant Restrictive Food Intake Disorder (ARFID) provision and intensive Treatment pathways. Teams are supporting the implementation of the Medical Emergencies in Eating Disorders (MEED) guidelines across GM A GM-wide performance dashboard has also been developed

	Looked After Children (LAC) / Cared For, Care Leavers (CFCL)	All three CAMHS providers have developed strengthened offers, with two trusts fully staffed (Manchester Foundation Trust (MFT) and GMMH) and the third mobilising and recruiting to posts (PCFT).
	CYP Crisis	A review of the GM CYP crisis services and new specification was undertaken in April 2025, setting out several recommendations for further improvements to CYP crisis pathways. These recommendations will inform 2026/2027 planning.
Adults	**NHS Talking Therapies**	NHS Talking Therapies nationally is moving from an access-focused model to delivering episodes of care that prioritise completed courses of treatment. In Greater Manchester, Talking Therapies reliable recovery has been below the national target, around 47–49% in 2024/25, despite efforts to increase completion and outcomes. Split commissioning between Step 2 and Step 3 services complicates recovery reporting, with local work underway to unify systems for clearer performance data. Workforce development and integrated care pathways are supporting GM's shift to a more outcome-focused approach while driving performance improvements
	IAPT-SMHP workforce capacity	Benchmarking and mapping of secondary care psychological therapies in Greater Manchester shows services currently reach only 10% of adult need across the two main providers. This underlines gaps in access, and there is a clear commitment to expand provision and improve coverage and outcomes in the future.
	MEN-Sat developments	The MENSat workstream has progressed across multiple areas, including the development of a mental health crisis and emergency care dashboard, which is due to launch shortly, and strengthening governance across the workstream. Planned work for Q4 includes a systemic review of all-age allied services to identify gaps and opportunities for improvement. These initiatives aim to provide better oversight, coordination, and strategic development across Greater Manchester's mental health services.
	Adult ADHD	Greater Manchester recently ran a public consultation on adult ADHD services to inform a new model aimed at reducing waiting times and improving consistent access. Over 2,500 people contributed, emphasizing faster triage, fairer pathways, and broader support options. Feedback will shape a needs-led, equitable ADHD service across the city region. This marks a key step in transforming adult ADHD care to better meet demand and improve outcomes.
	Early Intervention in Psychosis	Early Intervention in Psychosis (EIP) services in Greater Manchester have been strengthened through national collaboration with GMMH to improve access and care quality. A comprehensive mapping and options appraisal has guided

		future service development. In the latest NCAP review, *Pennine Care NHSFT* EIP teams were ranked *top performing* across key standards. Work continues to embed audit-driven improvements and enhance outcomes for people with first-episode psychosis.
	GM NHS 111 Mental Health	The GMMH and PCFT Crisis Helplines ceased in November 2025, and this function has transferred across to 111. The staff from the Crisis Helplines were consulted with and have either moved across to 111, Mental Health Urgent Triage Service (MHUT), or elsewhere. Recruitment remains ongoing for any outstanding vacancies
	Mental Health Urgent Triage (MHUT)	MHUT is now fully operational across GM as a 24/7 multi-agency urgent triage hub. During the pilot, over 1,400 people (57% of calls handled) avoided a blue light response, easing pressure on emergency services and improving patient outcomes
	Crisis Resolution Home Treatment Team (CRHTT)	Implementation of the enhanced CRHTT model has been agreed, following detailed scoping and provider engagement. A phased approach is in place, with future work to move towards Core Fidelity
	VCFSE Crisis Spaces	A GM wide review of VCFSE crisis space provision has led to a new draft service specification has been issued, including proposals for two overnight VCFSE-led crisis spaces across GM.
	Section 136 (S136):	Partners committed to achieving 6-hour police handovers by December 2025 and a 4-hour standard by April 2026. Additional staffing for S136 suites confirmed, including PCFT operating two suites 24/7 from Oct 2025 with recruitment underway for dedicated Advanced Mental Health Practitioners (AMHPs) and VCFSE capacity. Phase 1 of Right Care, Right Person is live and increased activity has been successfully absorbed
	Inpatient Quality Transformation	NHS GM has reduced OAPs from c.180 people at any one time to ~1. LSPs have also reduced from 69 (April 2025) to 60 (Oct 2025) and Average Length of Stay (Los) has reduced from 77 days (April 2025) to 64 days (Oct 2025) Gatekeeping roles have seen conversion rates (of Mental Health Liaison assessments leading to mental health admissions) at their lowest rates in 2 years (5.9%). An NHSE Capital Bid was successful and is delivering capital works on rehab and acute pathways to reduce OAPs and CRFD, projects being implemented by both GMMH and PCFT. GMMH have successfully recruited to the Integrated Discharge Team which bolsters patient flow and VCFSE capacity has been increased in localities with greatest need via innovative Recovery in Community Team which supports

		timely discharge, reduces CRFD and prevents readmission.
Mission 3: People with long term mental health conditions live longer and lead fulfilling and healthy lives		
Adults	**Physical Health checks for People with SMI**	GM has achieved significant progress in improving physical health outcomes for people with SMI. In 2024/25, GM surpassed the national target for annual General Practitioner (GP) physical health checks, delivering 19,075 checks out of 27,215 registered individuals, equating to 70% coverage, well above the national ambition of 60%. Every locality across GM met or exceeded the 60% standard
	Workforce Strategy	Supply plans were implemented, including: • Peer Support: 600 trained (Adult Crisis, global majority, suicide prevention). • Talking Therapies: Autumn funding expansion of 20 HITs and a further 8 HITs and 35 Psychological Wellbeing Practitioners (PWPs) as replacement posts • Employment Advisors: Employment Advisors: 11 Senior, 55 Advisors. Inclusion was promoted through paid clinical experience for aspiring psychologists (4 placements) and leadership mentoring for ethnic minority professionals (20 participants).
	GM Assertive Outreach (AO)	Cohorts for AO have been systematically identified by care coordinators, with several Community Mental Health Teams (CMHTs) now using PARIS pathways to streamline identification and case management. Enhanced family and carer involvement: Triangle of Care principles have been embedded, supported by the establishment of a Carer Council, ensuring carers are active partners in care planning and decision-making. Improved equity in care: Blanket DNA discharge policies have been removed, supporting a more personalised and recovery-oriented approach to engagement and discharge
	Neighbourhood Mental Health Teams (NHMTs)	NMHT model across GM has reduced waiting times for community mental health (CMH) services, enabling quicker access to care. Improved access pathways have supported early intervention, ensuring individuals receive help before reaching crisis point.
	Independent Community Mental Health Team (CMHT) Review	In response to Recommendation 9 and 10 of the Oliver Shanley Review (January 2024), NHS GM has commissioned an independent review of CMHTs

Mission 4: People are comfortable talking about their mental health and wellbeing and are actively involved in any support and care they receive		
CYP	**Headstart Programme**	Commissioned English Football League to deliver low intensity intervention (group and individual) at transition between primary and secondary: Helps schools meet their whole school approach to mental wellbeing. Engagement with 40 schools, 266 sessions delivered, 716 hours of 121 support and 799 delivery hours overall. 44% of participants are from most deprived deciles. Improved Mental Wellbeing shown via Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS) pre v post. Programme reaching and seeing improvement in children with high need. Hypothesised 2-3 fewer referrals to CAMHS (saving £34K). Potential savings to the system = £435K largely driven by improvements in educational and employment. In 26-27 map to MHST pathway.
	Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and other sexual orientations (LGBTQ+) Pilot	Proud Trust, LGBT Foundation and 42nd Street delivered LGBTQ+ youth-led pilot to develop and test resources/training/tools for education setting to drive improved understanding and reduce stigma. Young people drove project from commissioning. 12 young people received training, coaching. They co-produced resource packs, toolkits tested and shared in youth settings and events including GM Youth Summit. Submitted findings to NHSE LGBTQ+ evidence review.
Adults	**Zero Suicide Alliance (ZSA)**	A GM Taxi & Private Hire initiative was launched in May 2025 to encourage drivers to complete ZSA bespoke suicide prevention training. GM have also commissioned ZSA to produce new suicide awareness training focused on older people. This is funded by GM and other Northwest suicide prevention leads and NHS Wales
	Shinning a Light on Suicide	The Shining a Light on Suicide Campaign returned to Parklife again this year (2025) to reach. younger people. The League Managers Association (LMA) and Andy Burnham showed support again for the Shining a Light on Suicide Campaign in a second film with male and female football managers across the country encouraging people to complete ZSA suicide awareness training. The Shining a Light on Suicide Campaign now has over 1000 followers on Instagram
	Month of Hope	ICB MH representative appeared on BBC Breakfast to discuss the Shinning a Light on Suicide campaign and the LMA shared posts each day through our GM Month of Hope with many football managers sharing on their personal social media accounts too reaching millions of people.

	Self-Harm	GM have developed two Older People & Self Harm resources in co-production with Mature Minds Matter & the Older People's Mental Health Network. They were launched on the 1st October 2025 – International Day for Older Persons
	Domestic Abuse and Suicide Prevention training	Training has been rolled out across GM for the second time to reach those working day to day with those who are or have experienced domestic abuse (September/October 2025)
	GM Suicide Prevention	The new GM Suicide Prevention Strategy and Action Plan was launched in time for World Suicide Prevention Day (10th September 2025). In GM, we have seen a decline in suspected suicides each year since 2022
All Age	**All Age MH Lived Experience**	GM is developing a consistent, system wide approach to lived experience across all ages. For adults, workshops with ICB, VCFSE and Mental Health Trust partners have shaped a proposed model for Mental Health Lived Experience GM has also delivered a multi-phase young adults project using peer researchers to generate insights from over 150 young adults, resulting in practical recommendations, further investment proposals and a new service specification emphasising the role of the VCFSE sector. Over the past year, youth-led groups like Bee Heard and Bee Counted have helped design, inspect and improve CYP mental health services, leading to service improvements, greater accountability, and national recognition for youth participation
	Bereavement Support and Lived Experience Leadership	GM's creative and community led initiatives continue to gain national recognition, including the Sing Their Name Choir becoming a CIC and a finalist in the 2025 Manchester Culture Awards, and the Speak Their Name Memorial Quilts exhibition being showcased at the House of Commons. The Time Together Service of Reflection was held at Manchester Cathedral, and GM launched its first CYP suicide bereavement peer support group, Alfie's Squad- in Oct 2025. Based in Bolton it is open to children aged 6-18years of age across GM
Mission 5: The mental health and wellbeing system recognises the inequality, discrimination and structural inequity of people's experience, and is developing more inclusive services and opportunities that people identify with and are able to access and benefit from		
CYP	**MHSTs:**	GM is continuing to expand MHSTs to improve early access to support in education settings, with teams now operating in all ten localities and reaching 433 schools, more than half of

		all pupils across the city region. NHS England has approved three further teams from January 2026, supporting GM's trajectory toward full school and pupil coverage by December 2030. GM has strengthened collaboration with borough Educational Psychology teams to build system wide capacity and deepen the embedding of Whole School and College Approaches (WSCA). Workforce supply has also improved, with increased numbers of Education Mental Health Practitioners and supervisors.
Adults	**Reducing Racial Inequalities (RRI):**	Black, African, Afro-Caribbean, and South Asian communities living with SMI across GM. Key achievements include targeted investment: Funding allocated to 24 VCFSE providers delivering culturally responsive mental health support, with provision now fully aligned to the SMI focus of the programme In quarter one, more than 1,200 people were supported through over 3,700 sessions, with 37% of individuals living with SMI and delivery spanned 29 culturally appropriate interventions including counselling (28.5%), group therapy (28%), peer support (33%), bilingual counselling (12%), and targeted work around domestic abuse, trafficking, and modern slavery.

Appendix 2: Mental Health JSNA Chapter 1 included as PowerPoint slides

NHS Greater Manchester

Mental Health and Wellbeing Needs Assessment 2025 – Chapter 1: Overview

December 2025

Part of Greater Manchester Integrated Care Partnership

Contents

About this Joint Strategic Needs Assessment

NHS Greater Manchester

This Joint Strategic Needs Assessments (JSNA) was developed to support strategic commissioning decisions of mental health and wellbeing services across Greater Manchester. It is intended to support the already existing mental health and wellbeing programmes of work to improve the mental health and wellbeing of Greater Manchester residents and reduce inequalities.

This JSNA provides evidence and analysis of needs to help share local priorities and identify evidence-based priorities for action. It seeks to provide an assessment of mental health and wellbeing in Greater Manchester.

Given the broad scope of mental health and wellbeing and the factors that can influence them, as well as the breadth of programmes in Greater Manchester, this JSNA presents a selection of items have been provided here as an initial assessment and foundation for potential future work.

This JSNA draws upon quantitative data from a range of sources to examine levels of mental health and wellbeing across Greater Manchester.

Mental Health and Wellbeing Definitions

Wellbeing

"… is a positive state experienced by individuals and societies. Similar to health, it is a resource for daily life and is determined by social, economic and environmental conditions. Wellbeing encompasses quality of life and the ability of people and societies to contribute to the world with a sense of meaning and purpose"
– WHO, 2025

Mental Health

"State of mental wellbeing that enables people to cope with stresses of life, realise their abilities, learn well and work well and contribute to their community. Mental health is more than the absence of mental disorders. It exists on a complex continuum, which is experienced differently from one person to the next, with varying degrees of difficulty and distress and potentially very different social and clinical outcome"
– WHO, 2025

Mental Health conditions

"..include mental disorders and psychological disabilities as well as other mental states associated with significant distress, impairment in function, or risk of self-harm"

National and Local Policy Context

NHS Greater Manchester

Current national and local policy highlights mental health and wellbeing as a priority and focusing on early intervention and prevention, as well as mental health inequalities.

NHS 10 Year Plan

Sets out the need for significant change to the way services are organised, delivered and funded. For Mental Health, the ambition is everyone gets access to rapid high-quality support. The focus is on prevention, digital transformation, workforce and neighbourhood models.

Live Well/Prevention Demonstrator

Aim is to ensure people in every neighbourhood can access the right support, at the right time, in the right place. This includes integrated access to financial, employment, wellbeing, health & social support through Live Well centres, spaces & offers, backed by a connected & proactive workforce.

Mental Health and Wellbeing Strategy

A shared vision to tackle inequalities and improve mental health outcomes through early intervention, prevention, and timely support across the life course - including crisis care. Aligned with the national ambition and Live Well, it champions lived experience, with co-produced delivery plans and measurable outcomes in development to drive systemwide, lasting change.

Shared ambition to deliver person-centred, preventative and place-based care

- Invest up to £120 million more to develop more dedicated mental health emergency departments, to ensure patients get fast, same –day access to specialist support in an appropriate setting
- Neighbourhood mental health mode, integrating health, social carer and voluntary services locally
- Expand mental health support teams in schools and colleges and provide additional support for children and young people's mental health through Young Future Hubs

- Live Well provides the delivery mechanism to bring organisational delivery and strategies to life.
- GM is partnering with Government to become the UK's 'Prevention Demonstrator', using Live Well to lead public service reform. This opportunity enables greater freedoms, collective investment, and integrated delivery focused on prevention, reducing demand, and improving outcomes- anchored in neighbourhood models and aligned budgets to drive better health and economic participation.

- Aims to support the vision of a mentally healthy city region where every child, adult and place matter.
- Underpinned by five missions to focus on as a unified, integrated and equitable system.

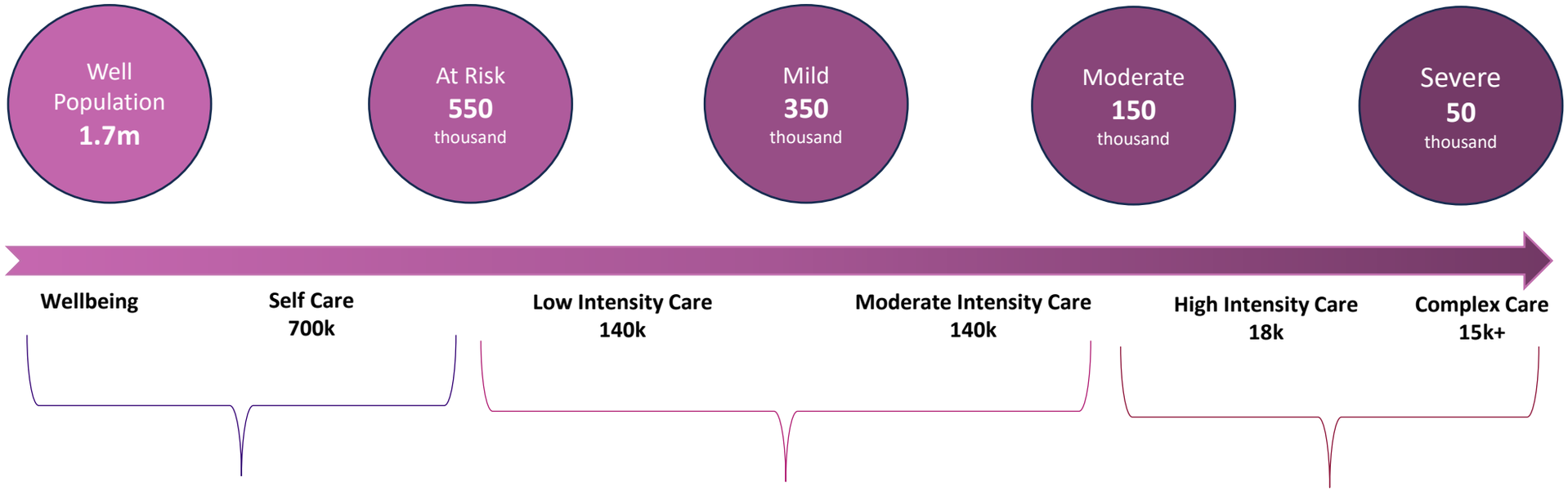
Structure of this Joint Strategic Needs Assessment

This JSNA is designed to demonstrate the current baseline of need across Greater Manchester . It is not a complete JSNA and should be considered as a foundation for future evidence base building. It has therefore been structured to look at a selected number of variables across three areas of care; **pre-need**, **existing need**, and **unmet need.**

NHS Greater Manchester

Estimated spectrum of mental health need across Greater Manchester population

(Based on GM MH & Wellbeing Strategy)



Structure of this JSNA Report

Cohorts

Age
Gender
Ethnicity
Deprivation

Pre-need

General population wellbeing

- Deprivation and Life Expectancy
- Severe Mental Illness
- Loneliness
- Anxiety

Existing Need

Population with an existing mental health need already receiving support

- Neurodivergence
- Fit notes
- Referrals
- Attrition and Do not Attends
- Prescriptions

Unmet Need

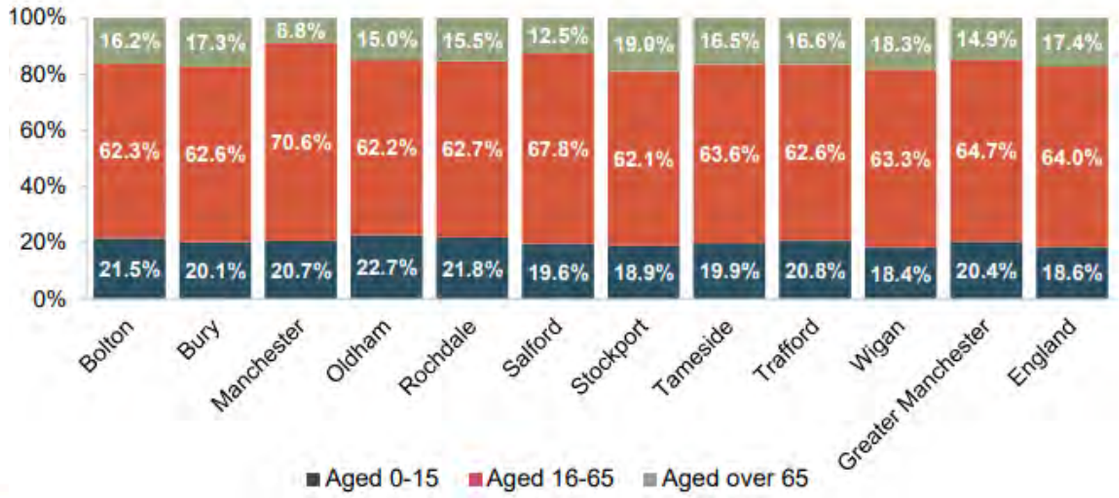
Population requiring crisis support

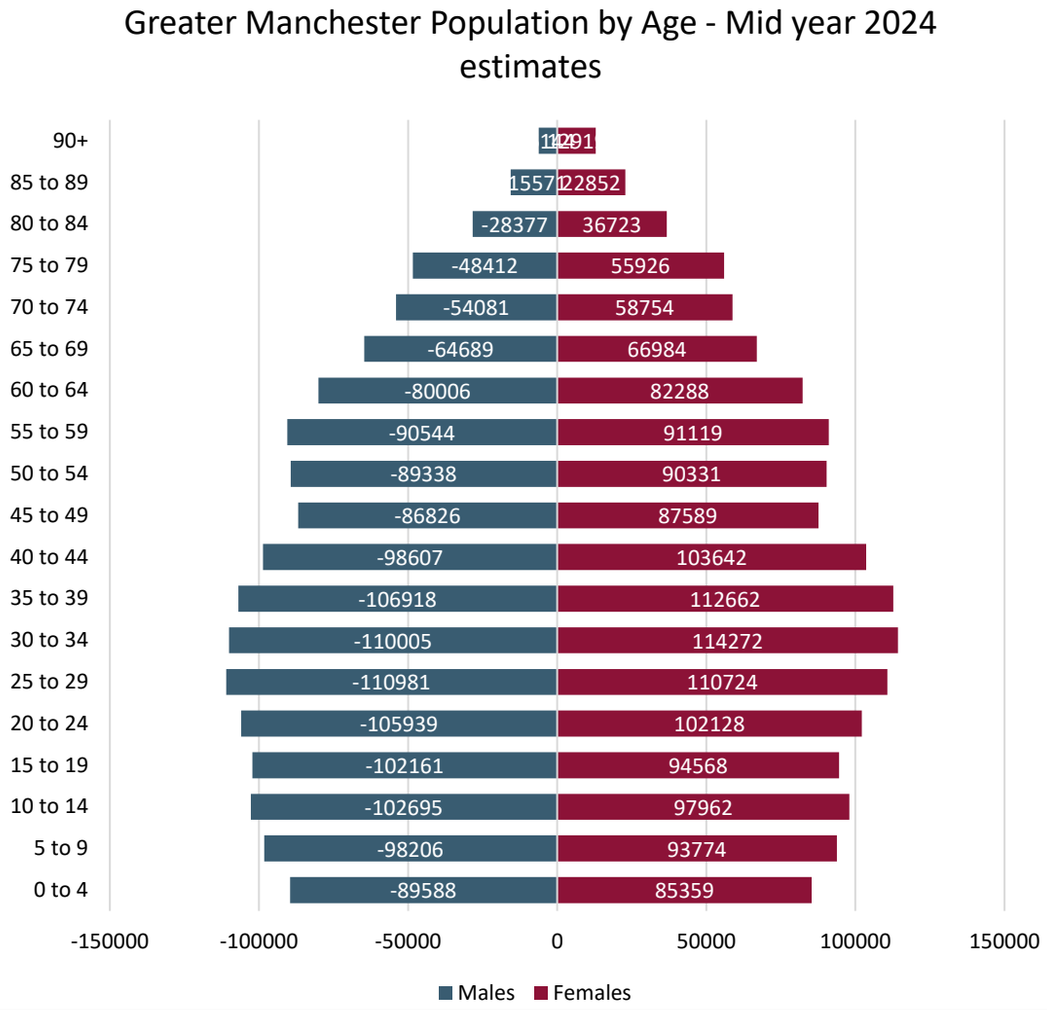
- Self-harm and Suicides
- Wait times
- A&E Attendance and Admissions
- Ambulance
- Length of Stay (Bed days)

The mid-year census estimates indicate a population of approximately 3,009,664 people living in Greater Manchester

NHS Greater Manchester

- Greater Manchester has a younger population when compared to GM nationally. According to the 2021 census, 20.4% of the population was aged 0-15 (18.6% for England), and 14.9% was aged over 65 (17.4% nationally).
- Manchester has a considerably young population with 9 in 10 residents aged 65 and below and older populations across Stockport and Wigan.





Greater Manchester is seeing an ethnic minority growth

NHS Greater Manchester

Ethnic Diversity

Residents from Asian, Black, Mixed and 'Other' populations accounted for 28.7% of the Greater Manchester population in 2021. Making Greater Manchester slightly more ethnically diverse than England as a whole (26.5%).

The increasing ethnic diversity of Greater Manchester is demonstrated in its growing cultural diversity, with numerous ethnic sub-groups becoming increasingly established in the city-region. The ethnic minority growth seen between 2011 and 2021 is likely to continue over time, given the population is relatively young. The ongoing demographic change confirms the requirement for public services to respond to the needs of a diverse range of ethnic groups – for example through the provision of translation services and language courses.

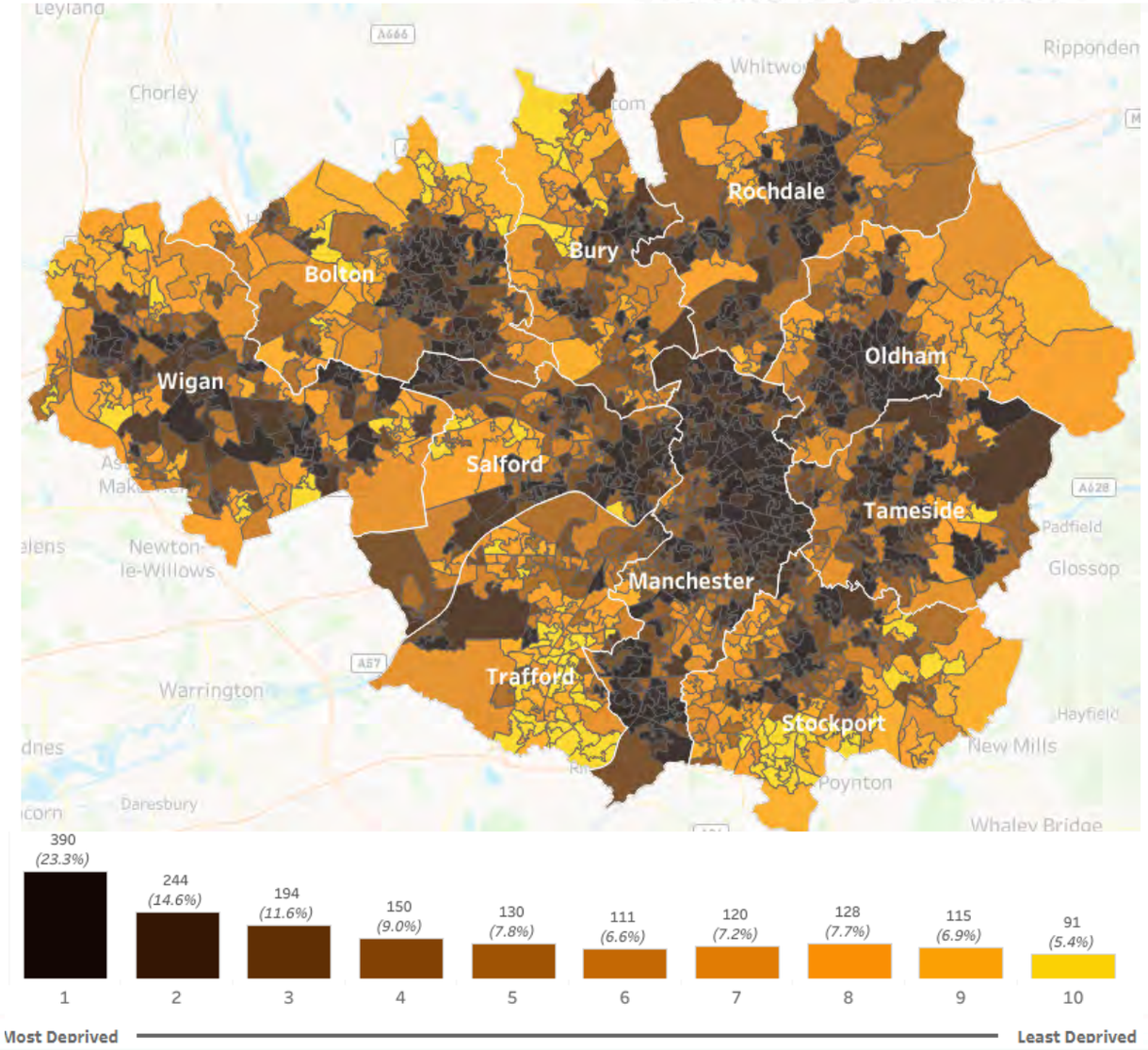
Close to a quarter of GM are living in the most deprived areas of the city-region

NHS Greater Manchester

Deprivation

The Index of Multiple Deprivation combines data about levels of income, employment, education attainment, health outcomes, crime, housing and environment. This information is used to rank small areas in England on a combined measure of deprivation.

23.3% of Greater Manchester areas are ranked in the most deprived national quintile.



Indices of Deprivation | GM ADSP

NHS
Greater Manchester

Pre-need

This section explores general population wellbeing and covers the following:

Snapshot of mental wellbeing (select metrics only)
Anxiety
Loneliness
Life Expectancy/Healthy Life Expectancy
SMI Prevalence

Mental Wellbeing Snapshot by Local Authorities in GM

NHS Greater Manchester

This table uses most recently available public data on a number of wellbeing metrics to present an overall mental wellbeing picture across the 10 local authorities in GM. The colour grading shows lower scores across each of the localities (i.e. poorer scores or higher prevalence). They are indicative only and should not be used as RAG ratings.

Sub-ICB	Estimated Prevalence of Common Mental Health Disorder (2017)	Low Life Satisfaction (2022/23)	Low worthwhileness (2022/23)	Low Happiness (2022/23)	High Anxiety (2022/23)	Severe Mental Illness Prevalence (2025)	Open Referrals into adult mental health services (July 2025 only)
Bolton	18.90%	6.00%	2.90%	6.70%	25.40%	3629	5253
Bury	17.50%	4.90%	2.70%	7.10%	25.50%	2499	7692
Manchester	22.20%	7.20%	6.20%	9.80%	24.00%	9462	26438
Oldham	19.20%	9.60%	6.40%	12.50%	24.80%	2290	8826
Rochdale	19.90%	9.40%	5.50%	7.60%	25.20%	3115	7006
Salford	20.40%	4.90%	4.10%	11.90%	23.30%	3664	9877
Stockport	15.80%	3.90%	3.40%	9.90%	28.50%	3341	9318
Tameside	19.50%	6.30%	5.20%	10.00%	22.70%	2272	6899
Trafford	15.40%	5.30%	4.90%	7.90%	25.90%	2677	7499
Wigan	18.00%	4.10%	4.30%	8.40%	22.10%	3602	11160

Pre-Need

Approaching 4 in 10 report ‘high’ levels of anxiety across Greater Manchester. Younger people and those from the most deprived areas on GM tend are more likely to report ‘high’ anxiety

Note: Insights presented here are from the GM Residents’ Survey (Jan - July 2025) to provide a more recent picture of anxiety trends and to allow further breakdowns by demographics and characteristics.

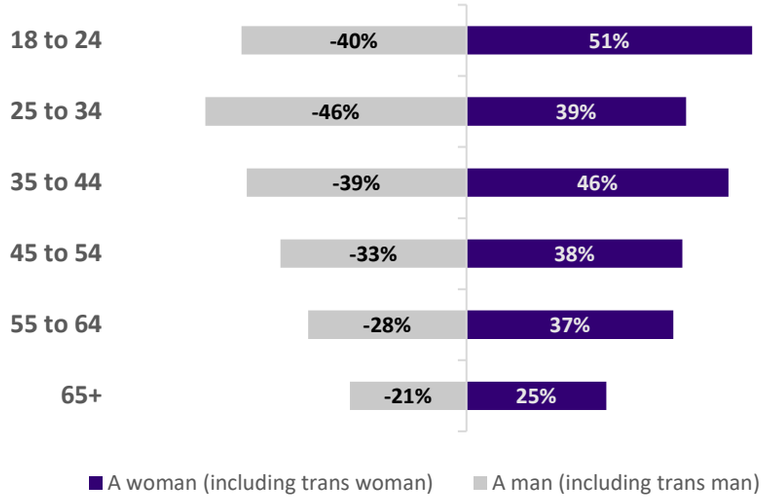
NHS Greater Manchester

Gender and Age

Women are slightly more likely than men to report high levels of anxiety. This is true across all age groups.

However, women aged between 18-24 years of age are much more likely to report high levels of anxiety.

High levels of anxiety by gender and age



Deprivation

Experience of high levels of anxiety seem to increase in line with deprivation.

Those living in the more deprived areas of GM tend to report higher levels of anxiety with over 4 in 10 (44%) of those in the most deprived areas of GM reporting high anxiety.

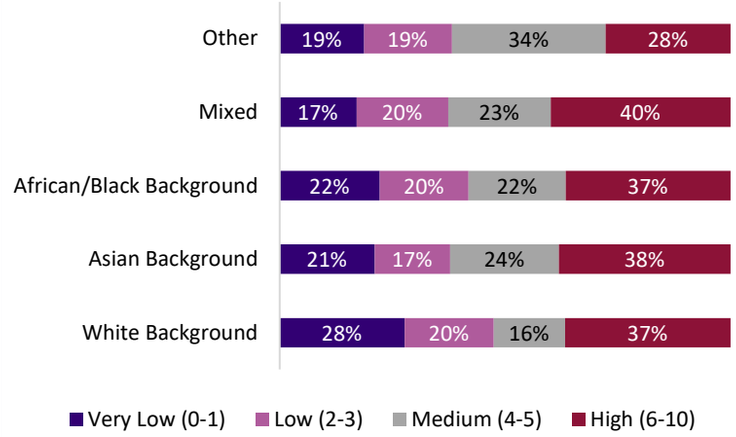
High levels of anxiety by deprivation

Ethnicity

Levels of ‘high’ anxiety are similar regardless of ethnic background.

However, ethnic minority groups are more likely to report levels higher levels of ‘medium’ anxiety than those from a white background.

Levels of anxiety by broad ethnicity groups



Pre-Need

Approaching 3 in 10 (29%) report feeling lonely at least some of the time

Latest figures from the GM Residents' survey indicate the GM tracks higher than the GB average for loneliness. In May 2025, 29% of respondents to the GM Residents' Survey reported feeling lonely at least some of the time (9% often/always) compared with 24% for GB. This has remained fairly consistent over the yearly period.

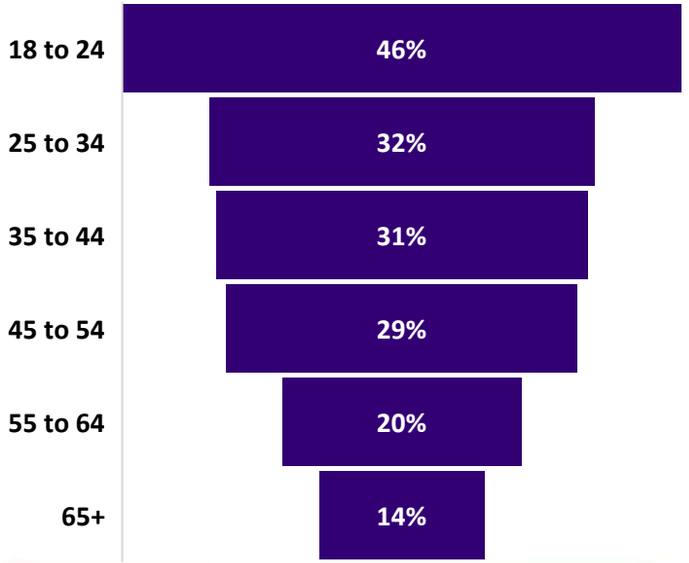
NHS Greater Manchester

Gender and Age

Women tend to report feeling lonely more often than men. About 3 in 10 women report feeling lonely at least some of the time at compared to a 1 in 4 men.

Reporting of loneliness appears to decrease by age with the 18-24 year-old cohort more likely to report feeling lonely. Almost 50% of 18–24-year-olds reported feeling lonely at least some of the time compared to just 14% of those aged 65+.

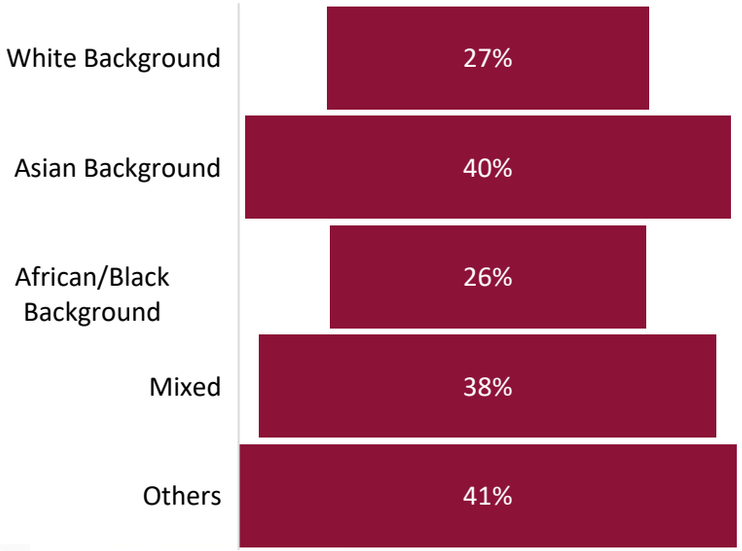
Percentage feeling lonely at least some of the time by age



Ethnicity

Those from an Other, Asian or Mixed background are more likely to report feeling lonely at least some of the time compared to other ethnic groups and the overall GM average (29%).

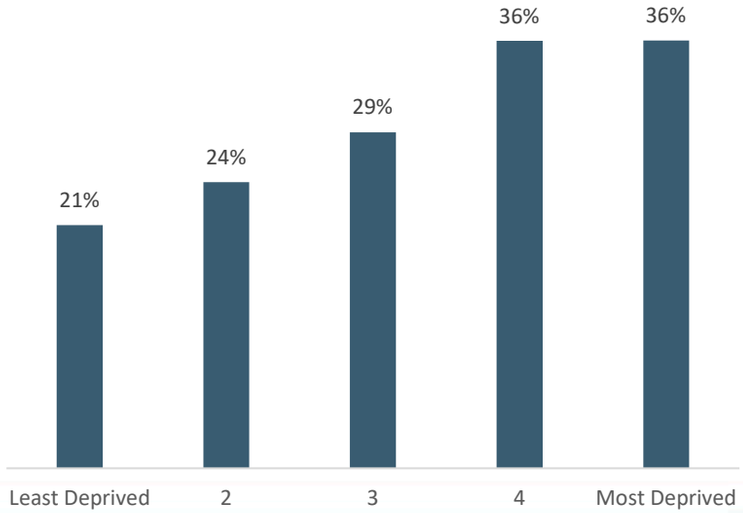
Percentage feeling lonely at least some of the time by ethnicity



Deprivation

Feelings of loneliness appear to increase in line with deprivation. Over one-third of those living in the most deprived areas were lonely at least some of the time.

Proportion feeling lonely at least some of the time by deprivation



Notes: Loneliness measure obtained from the GM Residents' Survey. A5. How often do you feel lonely? Base: Dec'24 (S16) 1523, Feb'25 (S17) 1515. GB benchmarking taken from UK measures of wellbeing (fieldwork period 2 to 27 April 2025).

Pre-Need

Life Expectancy and Healthy Life Expectancy in Greater Manchester

NHS Greater Manchester

Healthy Life Expectancy

The Healthy Life expectancy for males and females in Greater Manchester is similar, with the average healthy life expectancy for males 58.19, compared to 59 for females. However, there are notable differences among local authorities in Greater Manchester. **The Healthy Life expectancy is lowest for both male and females in Rochdale and highest in Trafford.**

Life Expectancy at birth

Females in Greater Manchester have a longer life expectancy at birth compared to males, with the life expectancy of females being approximately 4 years longer. The Life Expectancy for females is 81.3 years compared to 77.3 years for males.

Both males and females in Manchester have the lowest life expectancy at birth compared to other local authorities with Stockport and Trafford having the longest life expectancy.

	Healthy Life Expectancy		Life Expectancy at birth	
	Males	Females	Males	Females
Bolton	57.3	58.4	76.7	81.3
Bury	59.3	60.1	77.5	81.3
Manchester	57.6	58.5	75.2	79.6
Oldham	57.6	58.1	76.6	80.5
Rochdale	54.3	54.7	76.5	80.9
Salford	56.4	57.4	76.3	80.9
Stockport	62.0	63.1	79.3	83.4
Tameside	55.6	56.2	76.5	80.6
Trafford	63.9	65.0	79.4	83.5
Wigan	57.9	58.5	77.3	80.9

Data available at: Public Health Outcomes Framework - Data | Fingertips | Department of Health and Social Care

Severe Mental Illness (SMI) Prevalence

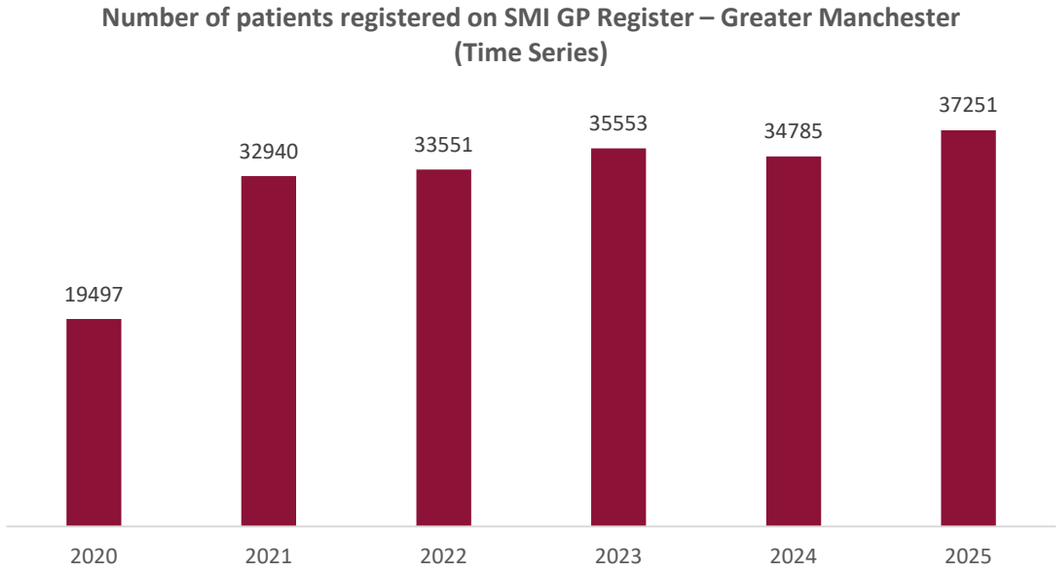
NHS Greater Manchester

There is no standardised measure of prevalence of Severe Mental Illness (SMI) across Greater Manchester. However, we can use the number of patients registered with GPs with an SMI as an estimate (though this is likely to be an underestimation).

Pre-Need

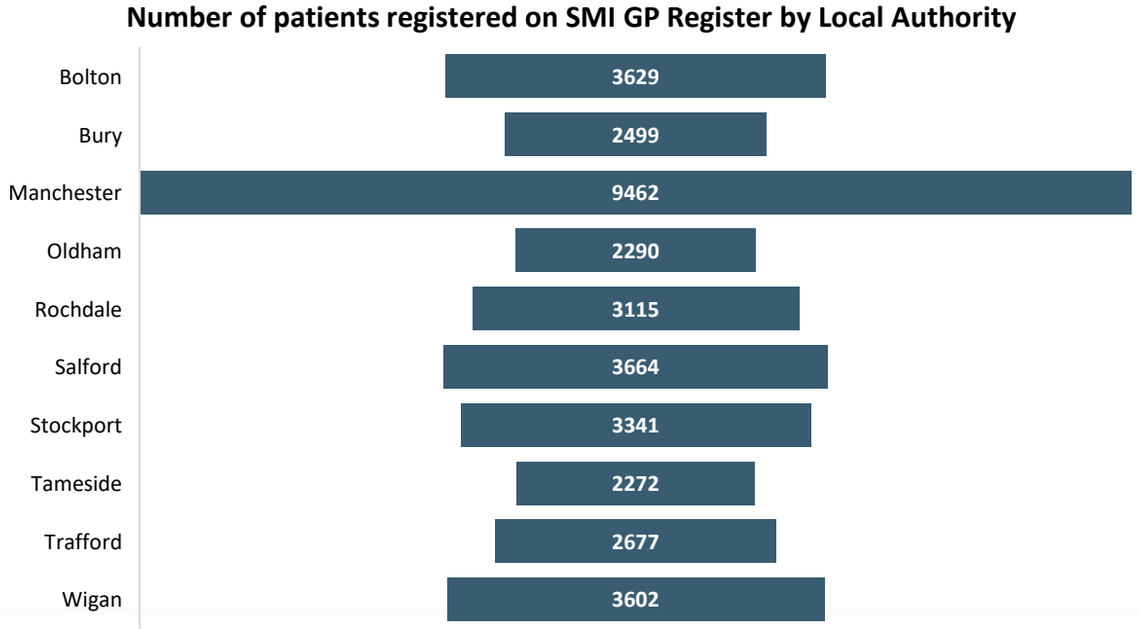
Patients registered with an SMI over time

The number of patients registered with GPs who have an SMI is showing a steady increase across Greater Manchester. As on mid-2025, there were about 37,000 patients with an SMI registered with a GP.



Patients registered with an SMI by local authority

As would be expected in line with general population density, a larger portion of these patients with an SMI are registered with GPs in central parts of Greater Manchester, in particular, Manchester.



NHS
Greater Manchester

Needs – Those in Services

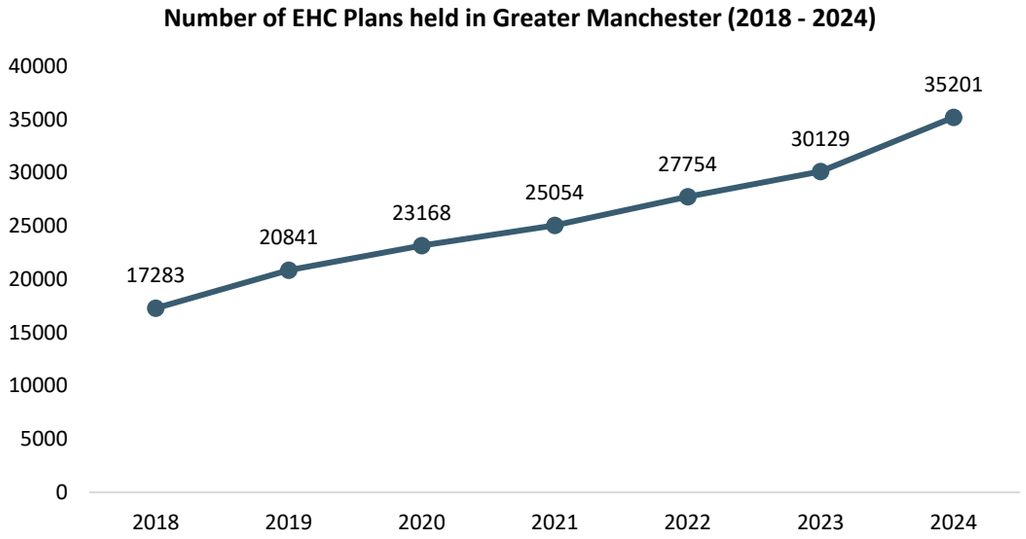
Neurodivergence – Prevalence among CYP
Fit Notes
Prescriptions

Neurodivergence - The number of Children and Young People (CYP) with an Education Health Care Plan (EHCP) has been increasing year-year from 2018, supporting the narrative of growing SEN need across GM

NHS Greater Manchester

EHC Plans over time

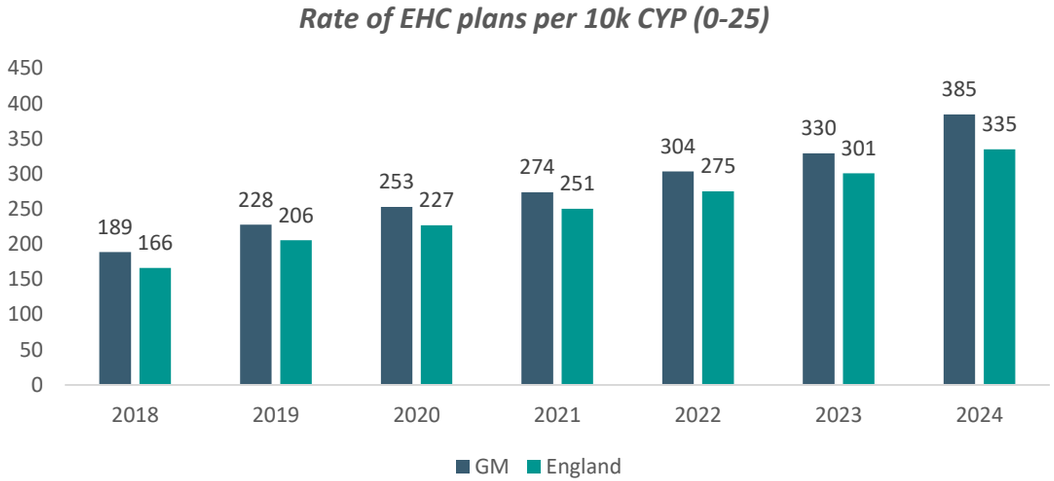
As of January 2024, there were 35,201 EHC plans held in Greater Manchester. This represents a 16.8% increase from 2023 (cf. 11.4% for England) and a 103.6% increase compared to 2018 (cf. 101.6% for England).



Rate of EHC Plans

The average percentage increase year-on-year for number of EHC Plans across the city-region is 19.8%, similar to the England average of 19.1%.

However, the rate of EHC Plans for children and young people aged 0-25 is higher across the city-region that for England. In 2024, there were 385 EHC Plans for every 10,000 CYP, higher than the national rate of 335 per 10,000.



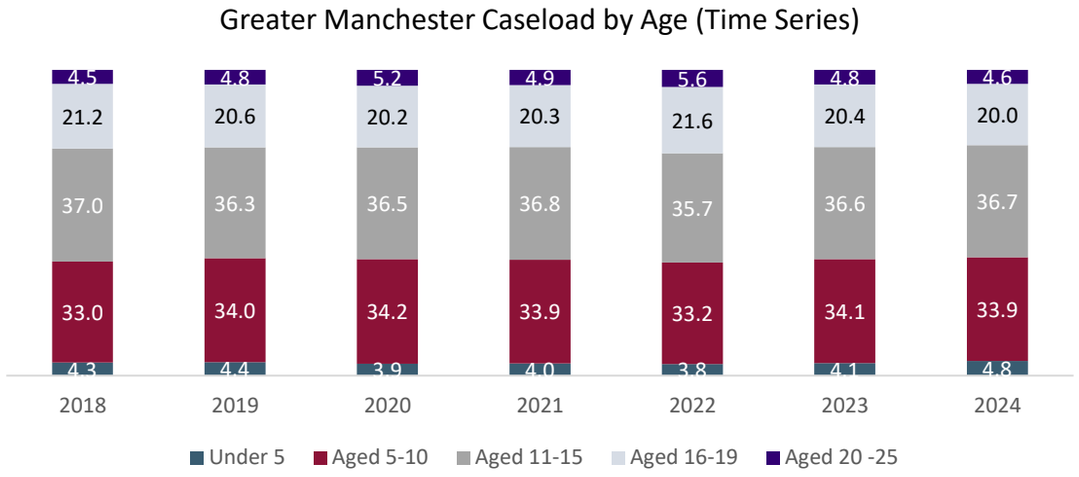
The majority of EHC Plans cohort continues to be aged 5-15 years of age with growth occurring relatively evenly among all age groups. However, those aged under 5 saw a greater increase in 2024 compared to other age groups.

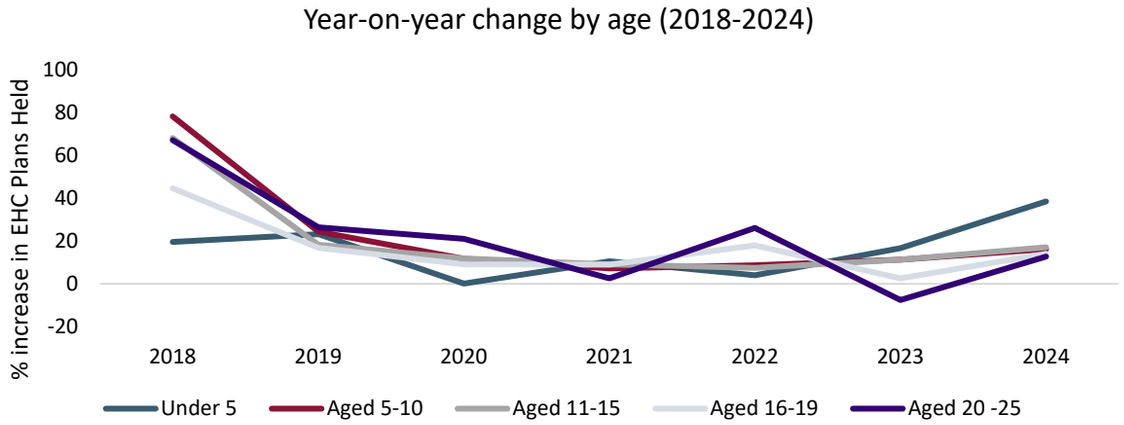
NHS Greater Manchester

As of January 2024, of the 35,201 EHC plans held in Greater Manchester, 70% were held by children and young people of school age (between 5-19 years old). This has largely been the case since 2018.

Growth among the five age sub-groups has remained relatively even, with some fluctuations observed for those aged under 5 and those aged 20-25 over the years since 2018 (likely due to a smaller sample size).

However, 2023, and 2024 saw a growth in under 5s with an EHC Plan. In 2023, those under 5 saw a 16.7% (cf. 4.1% for England) yearly increase in EHC Plans, and this was even higher for 2024 at 38.5% (cf. 4.6% for England).



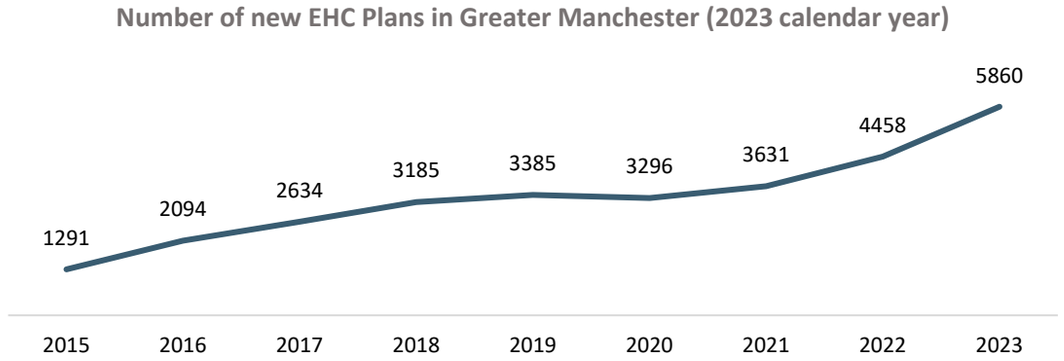


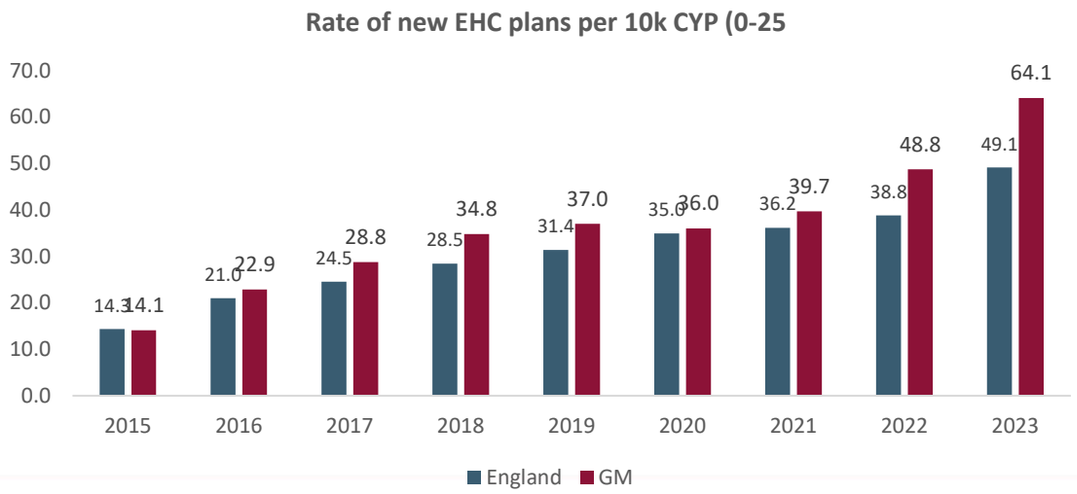
The number of *new* cases saw the highest yearly increase in 2023 with the rate of CYP with a new EHC Plan in GM at 31.4 per 10,000

NHS Greater Manchester

In the 2023 **calendar** year, 5860 children and young people were put on a EHC Plan. This represents a year-on-year increase of 31.4% across GM (cf. 26.6% across England). This is the highest year on year increase observed since 2016.

The rate of new EHC Plans for children and young people aged 0-25 has also grown, with a rate of 64.1 new EHC Plans for CYP per 10,000 higher than the rate of 49.1 new cases per 10,000 CYP for England.

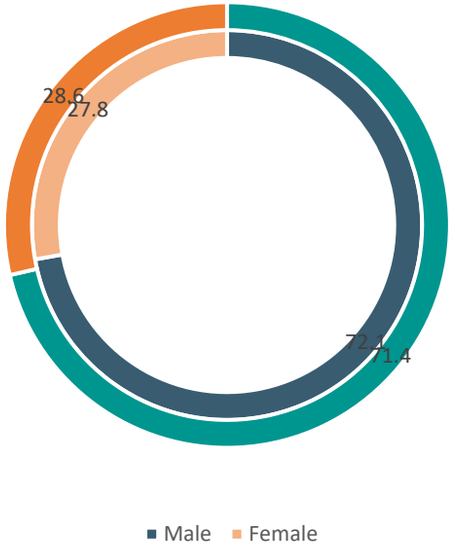




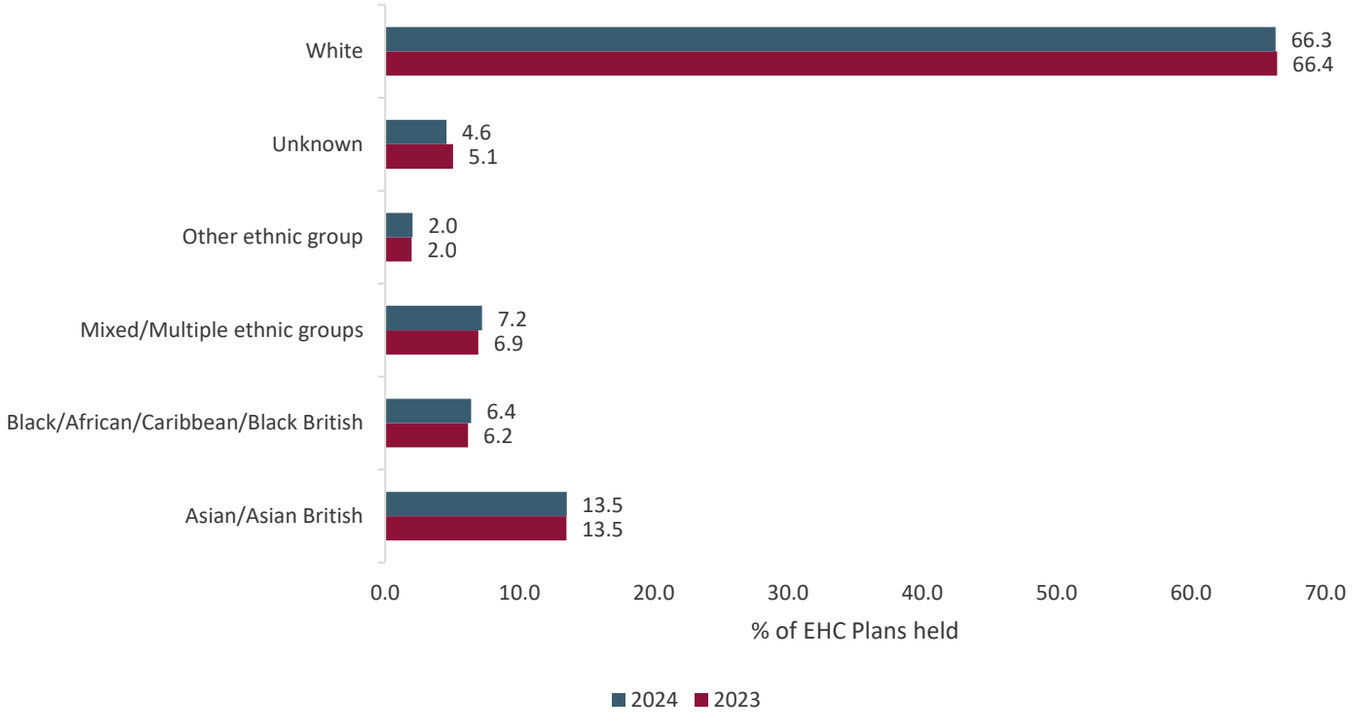
Since 2023, gender and ethnicity details have become available for the cohort of CYP with EHC Plans. The majority of EHC Plans are held by males and CYP with a white background. Tracking is limited for gender and ethnicity, with both gender and ethnicity cohorts observed in 2024, to those seen in 2023

NHS Greater Manchester

EHC Plans held by Gender (2023-24)



EHC Plans held by Ethnicity (2023-24)



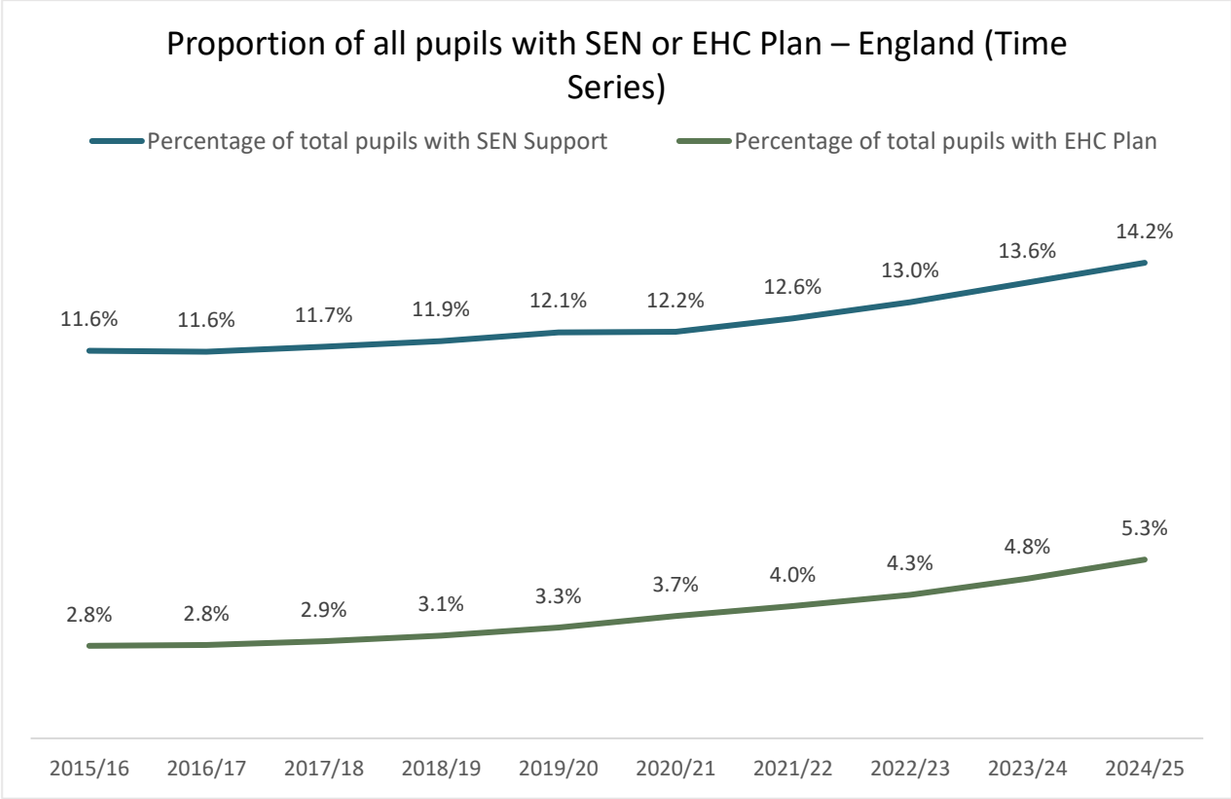
NEW Data

NHS Greater Manchester

- Over 1.7 million pupils in England were identified as having special educational needs (SEN) in January 2025. This consists of:
  - **1,284,284 pupils with SEN support** (without an EHC Plan) up by 3.7% from 2024.
  - **482,640 pupils with an Education Health Care(EHC) Plan.** This is an increase of 11.1% from 2024

The percentage of all pupils with SEN or EHC Plan have been rising. In January 2025:

- **14.2% of pupils of all pupils had SEN**
- **5.3% of all pupils had an EHC Plan**



NEW Data

Latest insights indicate that for every 10,000 children and young people in GM, 563 hold an EHC Plan, higher than the England rate of 493

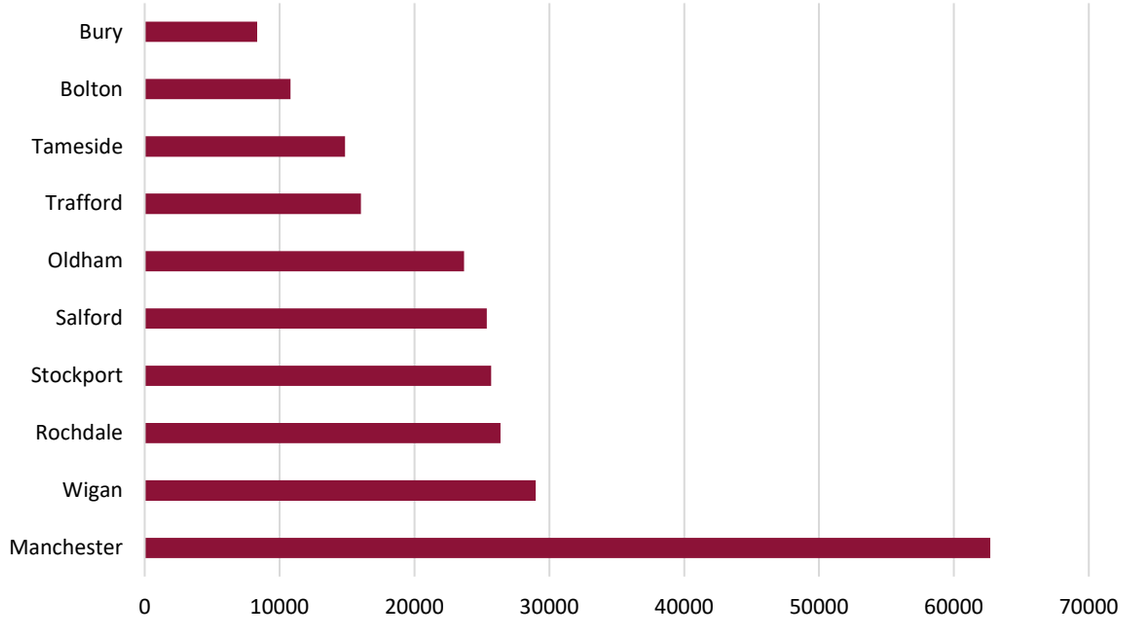
NHS Greater Manchester

	Number of pupils with EHCP	Total pupil headcount	Percentage of pupils with EHCP	Rate per 10,000 CYP (5-18 years of age)
England	**482,640**	**9,032,426**	**5.3**	**493**
GM	**30,840**	**499,895**	**6.2**	**563**
Bolton	3063	57,557	5.3	
Bury	1975	30,988	6.4	
Manchester	7027	99,873	7.0	
Oldham	3323	47,772	7.0	
Rochdale	2222	38,719	5.7	
Salford	2624	44,930	5.8	
Stockport	2925	47,999	6.1	
Tameside	2473	37,606	6.6	
Trafford	2411	45,585	5.3	
Wigan	2797	48,866	5.7	

Fit Notes

Fit notes are issued to patients by healthcare professionals following an assessment of their fitness for work. A fit note is issues after the first seven days of sickness absence (when patients can self-certify) if the healthcare professional assesses that the patient's health affects their fitness to work.
Important to note that this data does not cover all GP practices and with data coverage considered, caution must be exercises when making comparisons at the Sub ICB level. Fit notes data also provides information on the patters of certification of fitness for work, rather than the patterns of long-term sickness and absence from employment. Therefore, the data does not provide a reliable picture of working days lost to illness.

Number of Fit Notes for mental or behaviour disorder 24/25 by LA



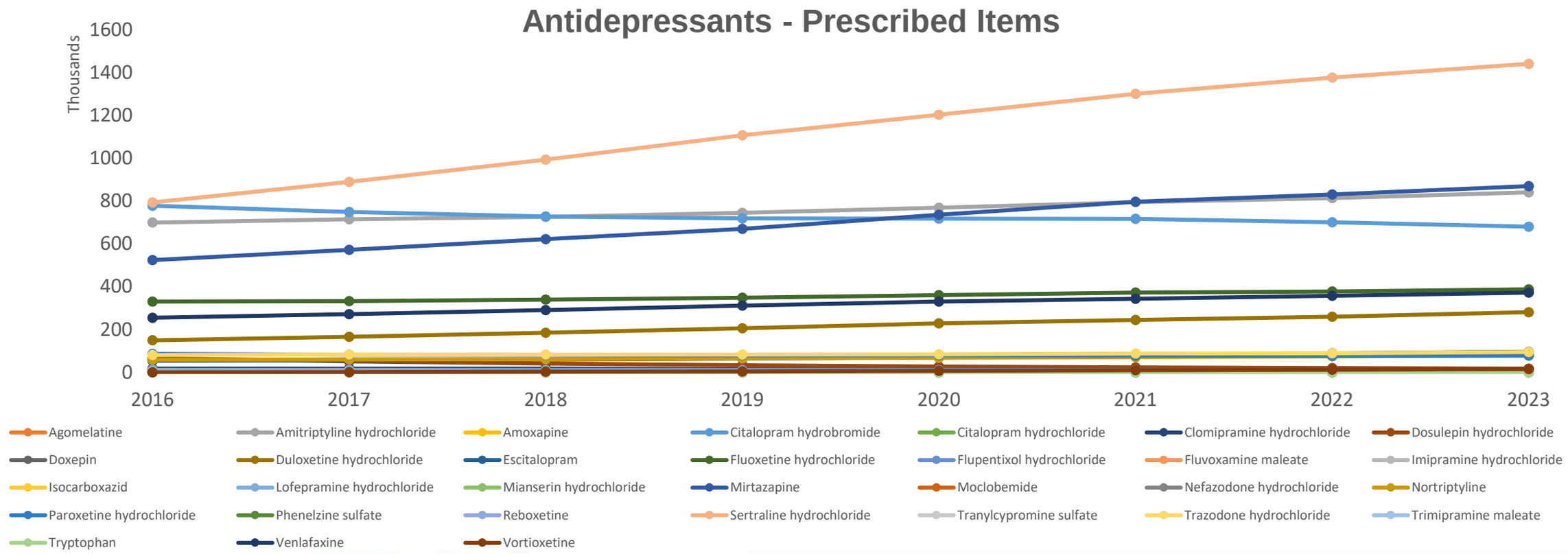
% of all fit notes that were issued for mental or behaviour disorder related concerns

Unmet Need

Antidepressant prescriptions are increasing since 2016

NHS Greater Manchester

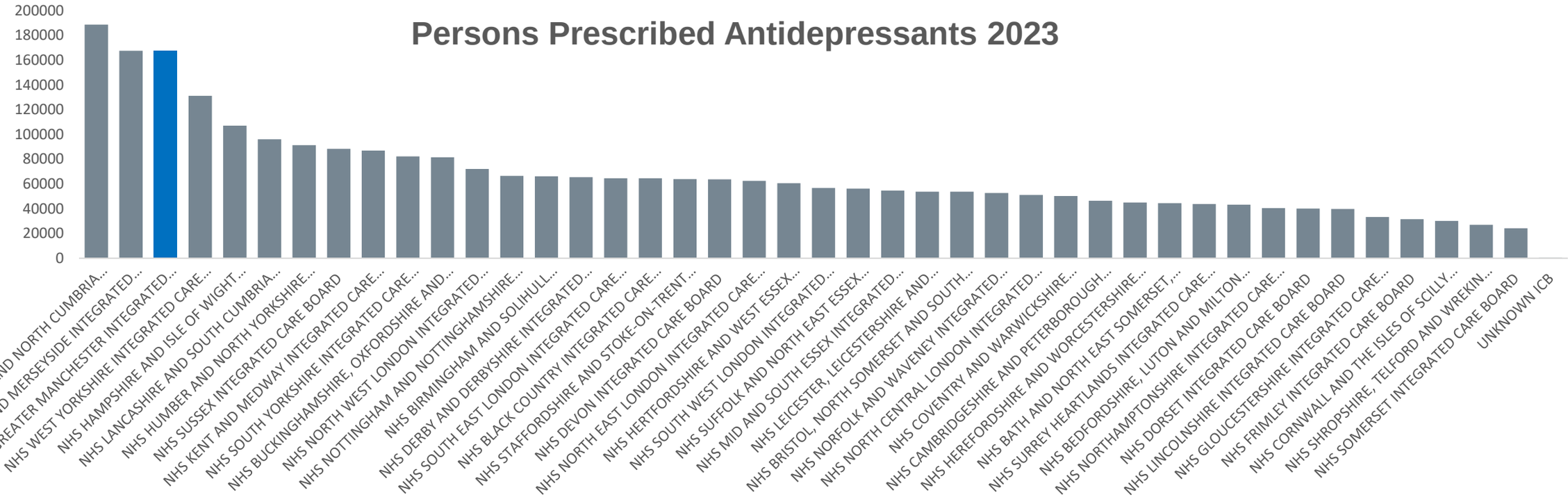
*Increase in Sertraline Hydrochloride due to changes in NICE guidance around anti-depressant recommendations



Unmet Need

Looking across ICBs, GM ICB has the 3rd highest number of people who have been prescribed anti-depressants at 167,660

NHS Greater Manchester



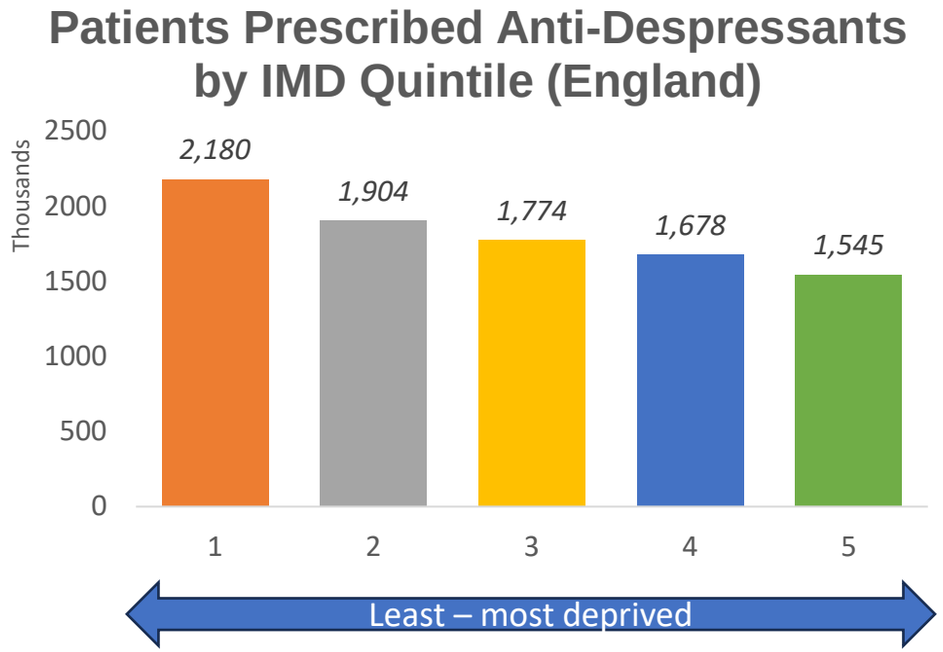
Unmet Need

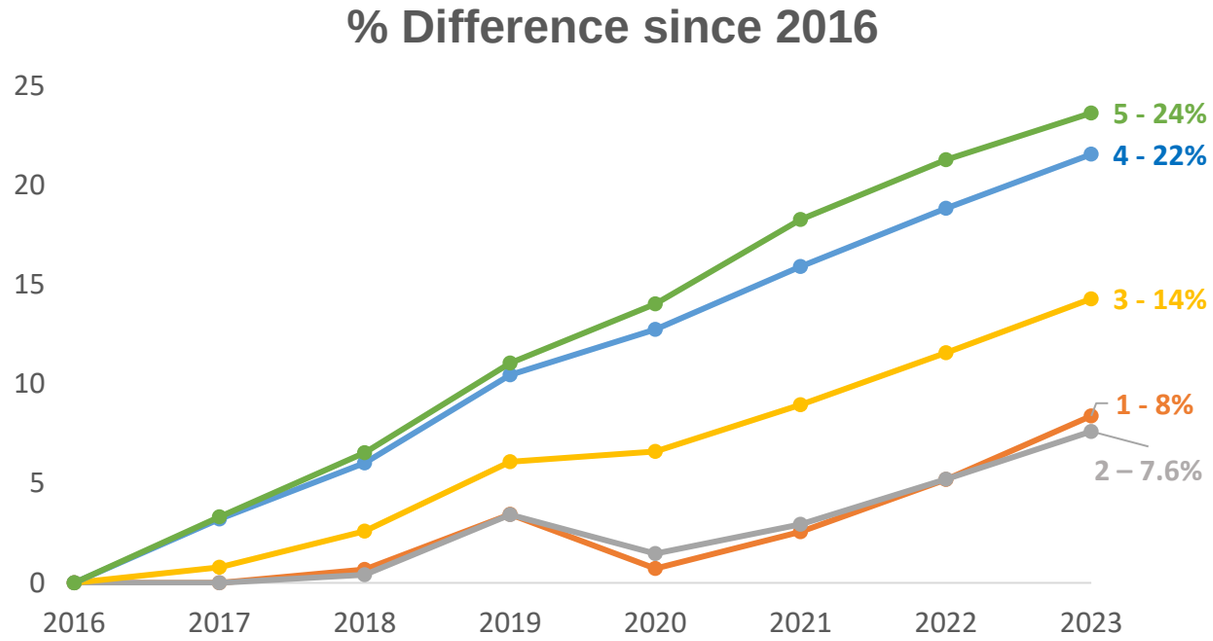
Patients living in the some of the most deprived areas of Greater Manchester have recorded an increase in anti-depressant prescriptions.

NHS Greater Manchester

Data insights show a notable link between deprivation and patients prescribed anti-depressants.

IMD quintiles 4 and 5 (i.e. those patients living in deprived areas) have seen a much higher percentage increase since 2016 (22% and 24% difference respectively) in anti-depressant prescriptions





NHS
Greater Manchester

Unmet Need – Crisis Care

Suicides
MH A&E Attendances
Ambulance Data
Inpatient wards – length of stays (bed days)

Unmet Need

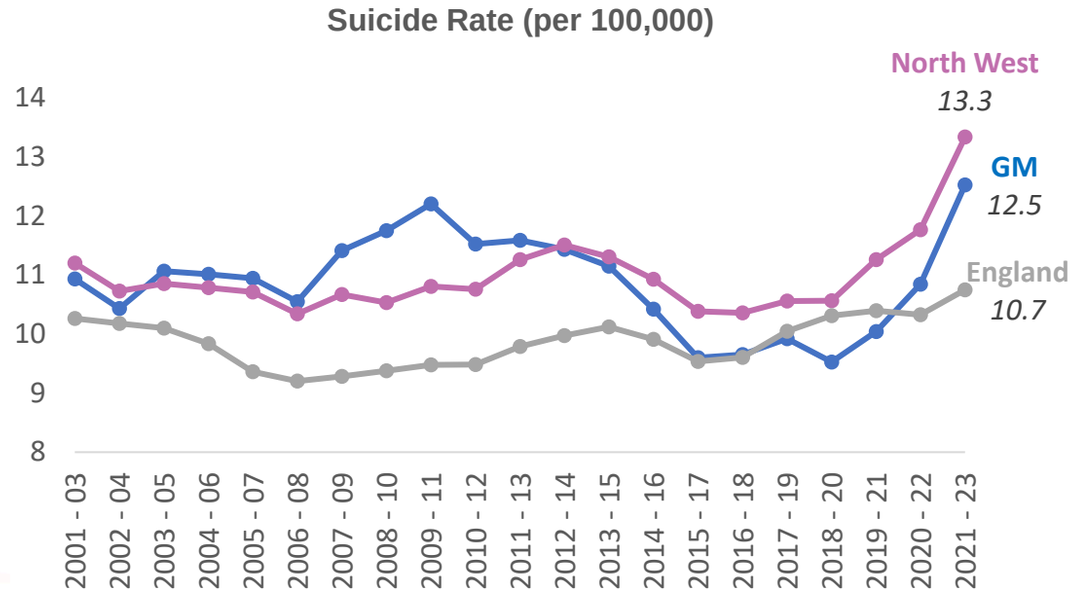
Suicides across Greater Manchester have been increasing. In 2021-23, GM recorded the highest rate of suicide, at 12.5 per 100,000 people, since 2001-03

NHS Greater Manchester

Suicide Rate

958 people in GM died by suicide during the 3-year rolling period of 2021-23.

Most recent available data shows that the suicide rate for GM is above the England rate (10.7) but lower than the North-West rate (13.3.). On average, GM has tended to record a higher rate of suicides that seen nationally.



Suicide rates by local authority

Manchester records the highest number of suicides of all the 10 localities. Manchester accounted for around 1 in 5 (20%) of all suicides across the city-region in the 2021-23 period.

Taking into account total population however, the areas with the highest suicide rates were:

- *Wigan (15.7 per 100,000 people)*
- *Salford (14.6 per 100,000 people)*
- *Manchester (14.2 per 100,000 people)*

	Number of Suicides 2021 - 23	Suicide Rate 2021 - 23
Wigan	138	15.7
Salford	109	14.6
Manchester	205	14.2
Rochdale	79	13.8
Bury	68	13.6
Bolton	101	13.2
Trafford	62	10.3
Oldham	61	10.0
Tameside	59	9.7
Stockport	76	9.7

Unmet Need

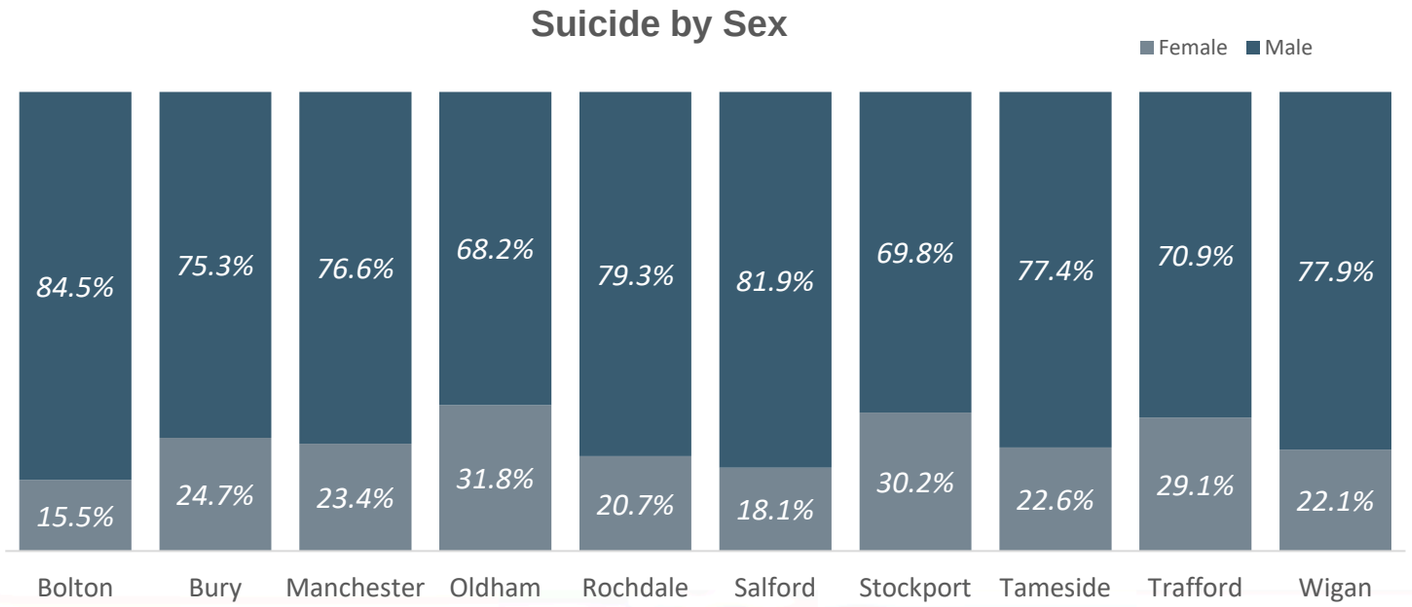
Across Greater Manchester, 60-80% of suicides are by men

NHS Greater Manchester

Distribution by Sex

Across all localities, men make up the majority of deaths by suicide. Bolton had the highest proportion of men whose death was recorded as suicide.

For females, Oldham, Stockport and Trafford recorded the highest proportions who died by suicide. In Oldham, approaching 1 in 3 deaths by suicide were female.



Suicide rate by locality and sex

In Bolton, the suicide rate for men is approx. 5 times higher than for women.

Looking across all localities, suicide rates for men is highest in Wigan (24.6 per 100,000 men) and lowest in Stockport (13.7 per 100,000 men). Similarly, the suicide rate for women is highest in Wigan (7.0 per 100,000 women). However, for females, it was Bolton that recorded the lowest rate for females (4.2 per 100,000).

Suicide Rate by Locality and Sex

	Female	Male
Bolton	4.2	22.7
Bury	6.7	20.6
Manchester	6.7	21.9
Oldham	6.4	13.8
Rochdale	5.8	22.2
Salford	5.3	23.8
Stockport	5.9	13.7
Tameside	4.5	15.5
Trafford	6.1	14.8
Wigan	7.0	24.6

Greater Manchester records are higher number of calls to NWAS than the regional average. When taking population into count, Wigan records the highest rate of MH incidents

Unmet Need

Demand

Mental Health calls make up around 7.8% of all emergency calls to NWAS, in GM this is slightly higher at 8.6% (this equates to around 3,000 calls per month)

Majority of Mental Health Related Incidents come from:

- Emergency Calls - 71%
- Police - approx. 20%
- other Health Services (e.g. 111 calls, Health Care Professionals, Hospital) - approx. 10%

- The number of incidents is highest in Manchester, due to increased population in this area – around 20% of incidents
- When population is taken in to account the areas with the highest rate of MH incidents are:
  - Wigan (40.5)
  - Tameside (30)
  - Trafford (29.1)

	Number of Emergency Incidents	Rate of Emergency Incidents
Wigan Borough	7,261	40.5
Tameside	5,072	30.0
Trafford	3,944	29.1
Stockport	4,877	20.2
Bury	4,243	19.9
Oldham	4,668	18.8
Heywood Middleton and Rochdale	5,217	18.4
Salford	6,873	16.1
Bolton	6,674	11.8
Manchester	14,299	6.5

Unmet Need

Most incidents for Mental Health are from non-life-threatening incidents

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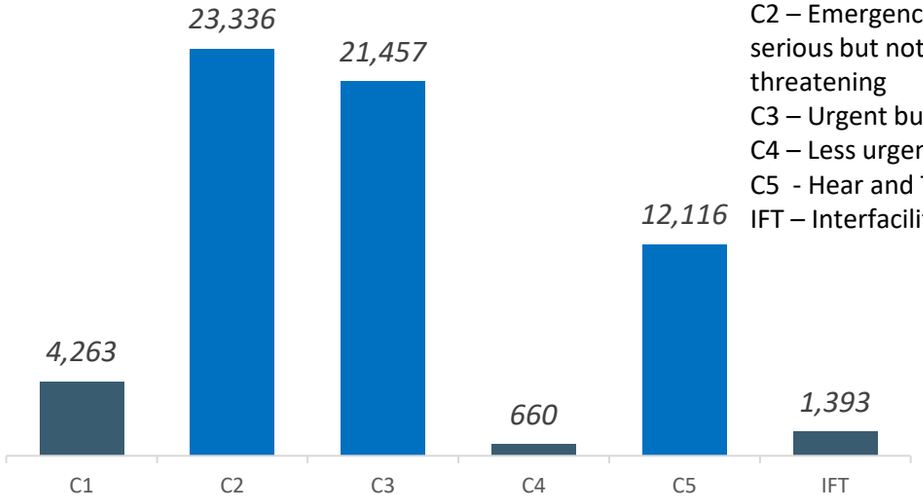
Nature of calls

Incidents are categorised based on the severity of the call, which in turn informs resource allocation

The majority of incidents recorded in 2024/25 were emergency incidents that were non-life threatening (23,336) followed by urgent but non-life threatening calls (21,457)

Mental Health Incidents by Category ('24 to '25)



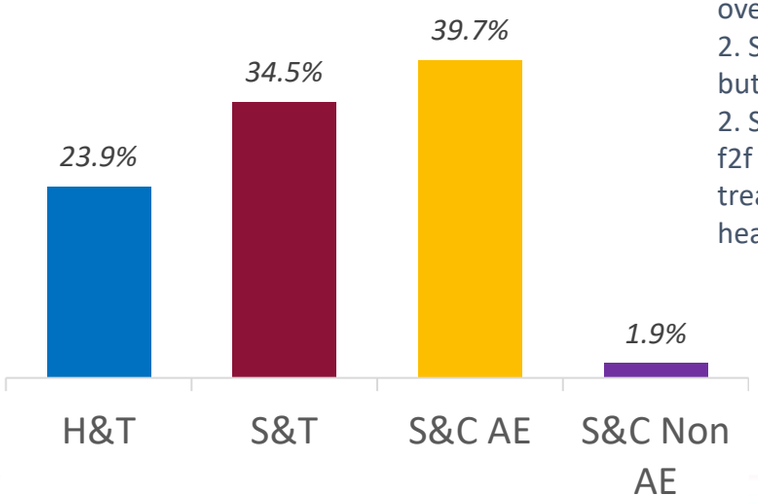
Key
C1 – Life threatening incidents
C2 – Emergency incidents that are serious but not immediately life threatening
C3 – Urgent but not life threatening
C4 – Less urgent calls
C5 - Hear and Treat
IFT – Interfacility Transfers

Patient Outcomes

When it comes to patient 'outcomes', about 40% of MH incidents result in the patient being transported to A&E.

About a third of MH Incidents are treated 'at scene' and without further intervention from NWAS

Mental Health Patient Outcomes as % of whole ('24 to '25)



Key
1. Hear & Treat – the patient is advised over the phone
2. See & Treat – The patient is seen f2f but is not transported anywhere
2. See & Convey – The patient is seen f2f and transported for further treatment, either to A&E or other healthcare services

Unmet Need

Higher numbers of MH Incidents in teenage years to middle age

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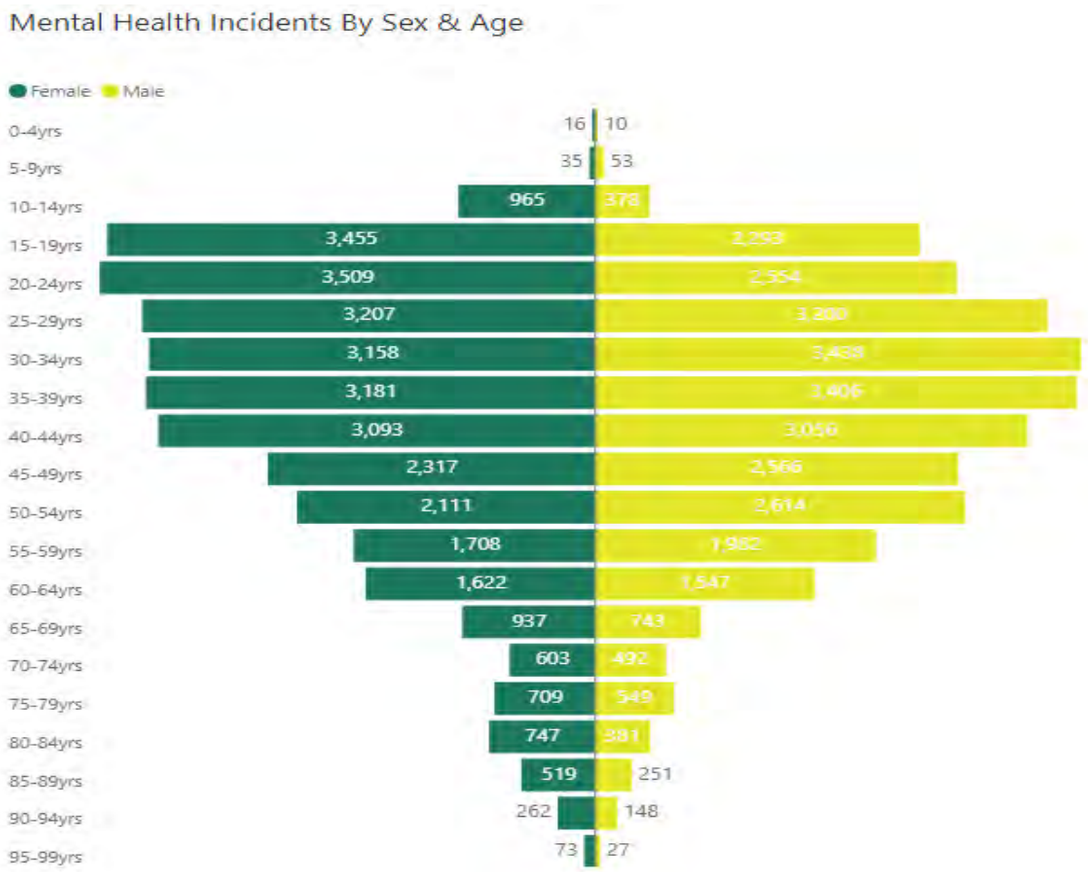
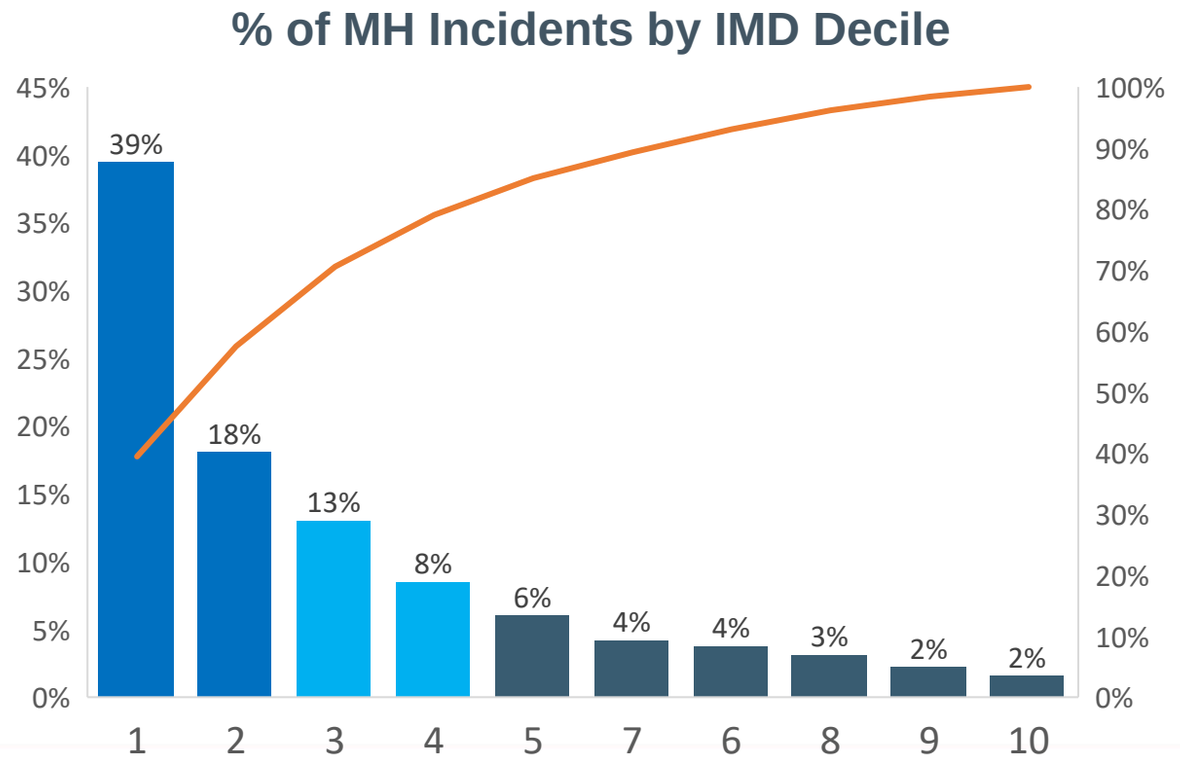
Age

Incidents for female sex are disproportionately higher in adolescence and later life. More than double the number of incidents for Under 18s



Deprivation

Clear link between Deprivation and number of MH Incidents. 58% of all MH Incidents happen in the 20% most deprived parts of GM and 80% of all MH incidents happen in the 40% most deprived parts of GM



*Nb – data is not age standardised

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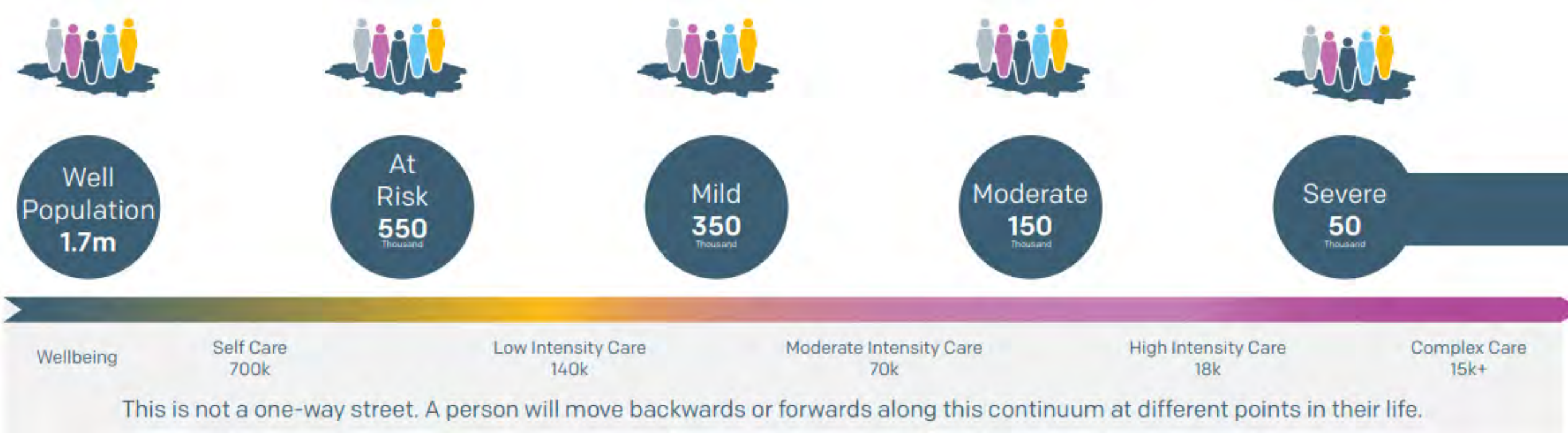
GM Mental Health & Wellbeing Strategy – Performance and Outcomes Framework Update

Part of Greater Manchester Integrated Care Partnership

Estimated spectrum of mental health need across Greater Manchester population



£14,700,000	**£33,600,000**	**£161,600,000**	**£182,700,000**	**£545,300,000**

NB; Spend covers estimated spend across both MH and LDA for 2024/25

Vision: **A mentally healthy city region where every child, adult and place matter**

At the heart of our strategy, we have five shared missions we want to focus on as a unified, integrated, and equitable system.

1. People will be part of mentally healthy, safe and supportive families, workplaces and communities.
2. People's quality of life will improve through inclusive, timely access to appropriate high-quality mental health information, support and services.
3. People with long-term mental health conditions will live longer and lead fulfilling and healthy lives.
4. People will be comfortable talking about their mental health and wellbeing and will be actively involved in any support and care that they receive.
5. The mental health and wellbeing system recognises the inequality, discrimination and structural inequity people experience and are committed to developing more inclusive services and opportunities that people identify with and are able to access and benefit from

Executive Summary

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The GM Mental Health & Wellbeing Strategy 2024–2029 ***" Doing Mental Health Differently"*** is two years into delivery.

Its Vision : ***A mentally healthy city region where every child, adult and place matter.***

Focus

- The system has moved from design and governance to **visible transformation.**
- Focus remains on building a mental health system that enables **people to thrive where they live, work, study and connect.**
- The commissioning intentions set out a **clear shift into neighbourhood mental health** and core community services, ensuring inpatient care remains high quality NHS provision delivered close to home.

Performance

- Driving **visible transformation** across multiple missions, pathways and population groups.
- **Performance and Outcomes Framework has been developed** to underpin the Strategy. The indicators monitor the progress of achieving the vision
- **The outcomes framework dashboard** will be open to all system partners to support with monitoring progress against the identified set of indicators

Future Direction

- **Progress is being made, but it is uneven**, change requires sustained, coordinated action across the system.
- **Risks remain** across capacity, flow, workforce, financial sustainability, neurodevelopmental pathways and crisis response. System fragility persists in areas where demand is rising faster than capacity can safely expand.
- **Continued transformation requires stronger collective ownership**, clear prioritisation and alignment across the system. GM will need to strengthen delivery and ensure accountability for outcomes as well as invest in preventative, neighbourhood-based support.

Left Shift, Mental Health Integrated Fund and Outcomes

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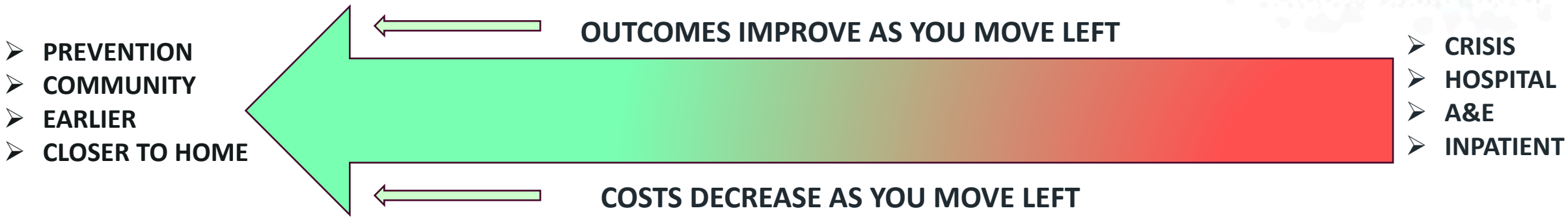

Enabler: Mental Health Integrated Fund

- A dedicated fund to join up services across the system
- Provides the resources to deliver care in the community
- Enables earlier support and Co-ordinated Care
- Focus on prevention, Recovery and Better Outcomes
- Less waits and improved quality in inpatient services
- Sustainable services for GM now and in the future

Outcomes: Improved Mental Health and Wellbeing

- ✓ Less A&E Attendances
- ✓ Less Inpatient Admissions
- ✓ Lower Length of stay
- ✓ Eliminate out of Area Placements
- ✓ Care in the community
- ✓ Faster Access to support and Care
- ✓ Better Engagement and Experience
- ✓ Better Management of LTC's
- ✓ Less Health Inequalities
- ✓ Improved Staff Wellbeing

5 STRATEGY MISSIONS

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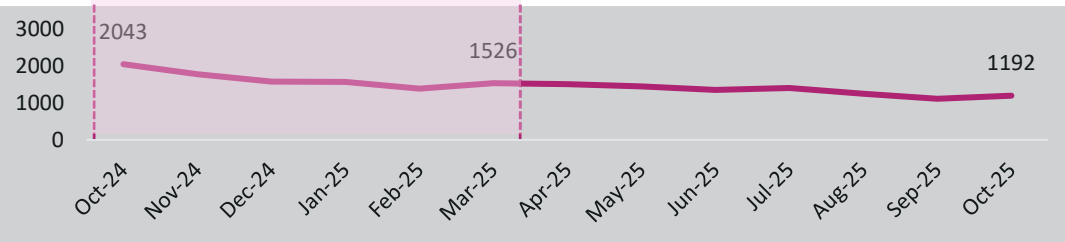
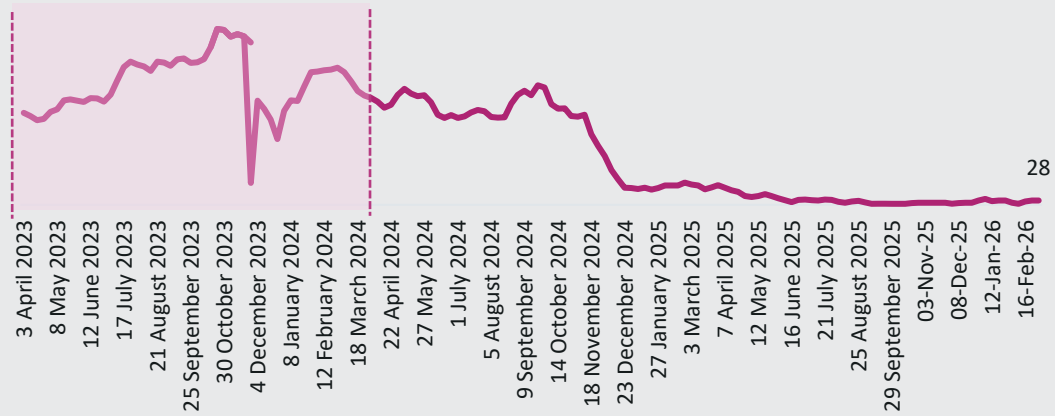
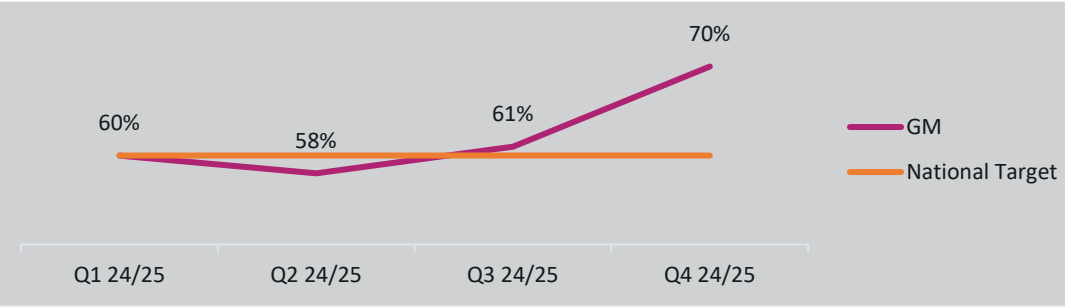
GM Mental Health & Wellbeing Strategy- Performance and Outcomes Frameworks

Year 1 (2024/25) Performance Update

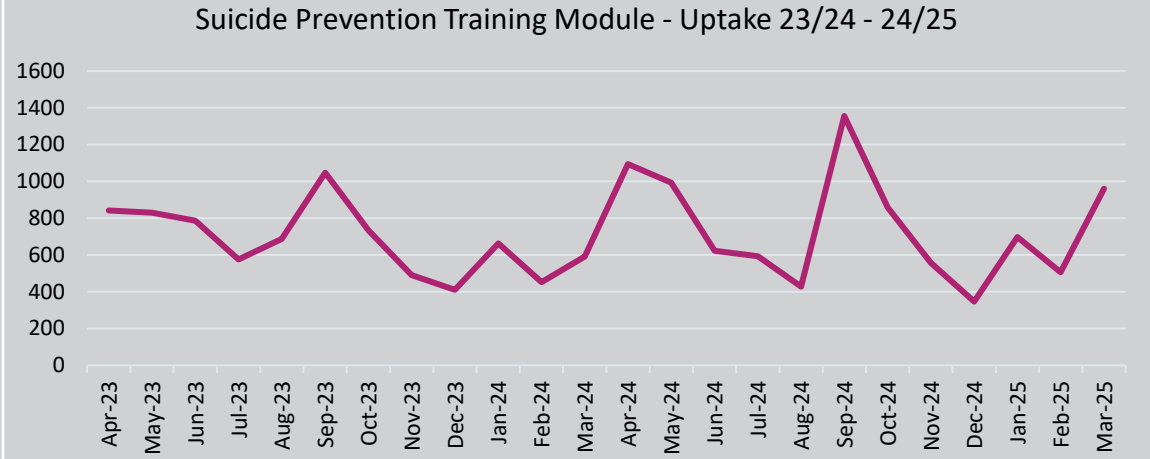
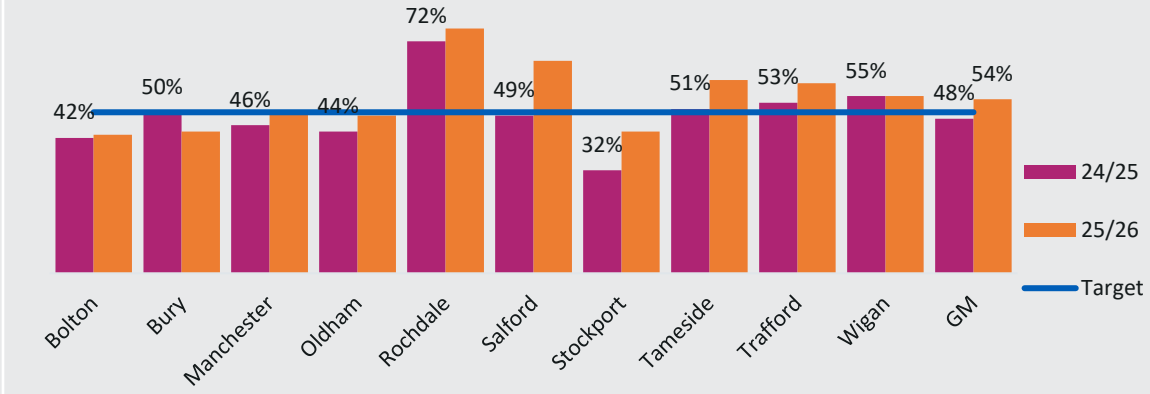
NHS Greater Manchester

The GM MH & Wellbeing Strategy set out 5 headline metrics – one of each mission - in the first year of the strategy. These metrics looked at process-based measures specifically to drive rapid change in some key areas. To ensure wide stakeholder buy-in to the approach, the metrics included measures from beyond statutory requirements (what we have to measure) to bring into consideration a different approach to understanding impact and change from different perspectives and sectors.

Mission	Headline Metric 24/25	Desired Direction of Travel	Current Position		Trends
Mission 1: People will be part of mentally healthy, safe and supportive families, workplaces and communities	A reduction in inappropriate mental health related calls to GMP	**Fewer**	**25% decrease** in inappropriate mental health related calls to GMP		
Mission 2: People's quality of life will improve through inclusive, timely access to appropriate high-quality mental health information, support and services	Eliminate acute out of area placements	**Fewer**	**47% decrease** in total weekly out of area placement bed days *to enable us to baseline the 23/24 position effectively we used this metric taken from safety sirens dashboard as we have a complete year's data reported as a weekly average. Since Dec 23 the OAPs/CRFD dashboard has been in place which has tracked 'total OAP placements' this is the data we are now more used to seeing.		
Mission 3: People with long-term mental health conditions will live longer and lead fulfilling and healthy lives.	Increase in Severe Mental Illness Physical Health checks	**More**	**70% of registered SMI patients received all 6 physical health checks in Q4 24/25** (equates to 19,075 patients out of 27, 215 registered on the PHSMI register)		

Year 1 (2024/25) Performance Update

NHS Greater Manchester

Mission	Headline Metric 24/25	Desired Direction of Travel			Trends
Mission 4: People will be comfortable talking about their mental health and wellbeing and will be actively involved in any support and care that they receive	Increase in Mental Health and Wellbeing training (Connect 5, Mental Health First Aid and Suicide Awareness) across the Greater Manchester system	More	**11% increase in uptake of suicide prevention training (shown in graph)** **Expanded Connect 5 delivery from 6 to 7 GM localities. Expected to be delivered in 9 to 10 from 26-27** **(1,294 trained in 23/24 – 950 in 24/25)** **(not shown in graph here)**		
Mission 5: The mental health and wellbeing system recognises the inequality, discrimination and structural inequity people experience and are committed to developing more inclusive services and opportunities that people identify with and are able to access and benefit from	Increase coverage across GM of pupils and settings covered by MHSTs*	More	**48% of pupils covered by end of 24/25 (equates to 259,048)**		

Performance and Outcomes Framework

NHS Greater Manchester

The Strategy made a commitment to revisit the metrics and to evolve to capture long-term system change. This was to support with tracking the impact of the strategy on the demand for and cost of NHS services, as well as tracking wider impact for the GM region, such as increased productivity. Work has been progressing in this space over the past 8-9 months. The missions cover outcomes across key 4 domains – personal wellbeing, community, service performance and workforce

1

Outcomes
Increased life satisfaction
Decrease high levels of anxiety
Increase hopefulness
Increase ability to get the right help if needed
Decrease rates of self-harm
Increase good housing conditions
Increase satisfaction with local area as a place to live
Increase access to parks and green spaces
Increase opportunity to participate in high quality culture and leisure activities
Decrease proportion of residents economically inactive due to mental ill health

2

Outcomes
Decrease of repeat attendees of crisis services
Decrease number of MH related A&E attendance
Decrease waiting times for ED attendances classed as MH
Increase patients signposted to MH support through GM 111 Crisis Helpline
Waiting times at health-based places of safety for patents detained under S136
Proportion in in-patient care or home based treatment

3

Outcomes
Increased access for underserved and marginalised populations
Increased self decision-making among service users
Increased choice and control among service users
Improved mental health outcomes
Improved physical health outcomes for people with SMI through annual health checks and follow-up interventions.
Reduce relapse and preventable crisis episodes
Stronger integration with VCSE and primary care, reducing fragmentation.
Increased access to housing, education, employment, and financial support
Reduced loneliness and social isolation

4

Outcomes
Increase participation in population level mental health literacy programmes
Increase participation in population level mental health literacy programmes by targeted cohorts
Increase lived experience representation across NHS and social care workforces
Increase uptake of Zero Alliance Training course among taxi and private hire licensees
Increase number of pupils supported by whole school college approach
Increase health Confidence
Increase confidence in ability to access the right support within local area
Increase confidence among taxi drivers and private hire licensees in identifying signs of struggles
Improved understanding of mental health needs among school and college aged children

5

Outcomes
Increase diversity of service workforces across Greater Manchester to be representative of communities served
Increase participation in co-design of mental health services by marginalised groups
Increase access to mental health services by marginalised groups
Increase participation in training by Trainees/EMHP Workforce and Education Teams
Reduce health inequalities across communities
Increase satisfaction of care received among marginalised groups
Increase diversity of service workforces across Greater Manchester to be representative of communities served

Headline Metrics

NHS Greater Manchester

	24/25	25/26	26/27	27/28	28/29
1. People are part of mentally healthy, safe and supportive families, workplaces and communities	A reduction in inappropriate mental health related calls to GMP	Reduction in A&E attendances for mental health related incidences with focus on **reduction in long waits, UEC reduction in attendances and those waiting longer than 24hrs for a bed**			
2. People's quality of life improves through inclusive timely access to appropriate high quality mental health information, support & services	Eliminate acute out of area placements	Reduction in Clinically Ready for Discharge bed days lost			
3. People with long term mental health conditions live longer and lead fulfilling and healthy lives	Increase in Severe mental illness physical health checks	**Continuing the work on physical health checks for SMI looking at outcomes from these checks**			
4. People are comfortable talking about their mental health and wellbeing, and are actively involved in any support and care they receive	**Increase in Mental Health and Wellbeing training (Connect 5, Mental Health First Aid and Suicide Awareness) across the Greater Manchester System**				
5. People are comfortable talking about their mental health and wellbeing, and are actively involved in any support and care they receive	Increase coverage across GM of pupils and settings covered by MHSTs	Increased diversity within the MHST Workforce			

Measures to be allocated in line with outcomes, performance and local and national priorities during the planning rounds of the specified year.

Monitoring of the Performance and Outcomes Framework

NHS Greater Manchester

- The outcomes framework will be monitored using a dashboard on the GM Intelligence Hub - GM Mental Health & Wellbeing Strategy | GM ADSP
- This current version of the dashboard is not the final version, with further work to be completed for the dashboard to be fully functional by mid-2026.
- The primary function of the dashboard will be to monitor headline and supporting metrics, acknowledging, however, that there are various dashboards that already exist across the MH work programmes. A mental health ‘landing page’ has been developed to signpost users to the wider suite of MH dashboards that exist on the GM Intelligence Hub.
- The dashboard will be open to all system partners to support with monitoring progress against the identified set of indicators.

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GM Mental Health & Wellbeing Strategy- Next Steps and Forward Plan (2026/27)

Strategic Priorities and Delivery Focus (2026/27)

- GM remains committed to delivering the *Doing Mental Health Differently* vision and building on progress from the first two years.
- ICB blueprint and system restructuring are creating reduced capacity across commissioning, programme and transformation functions.
- **Approach for 2026/27:** disciplined prioritisation of highest impact work, national operational requirements and areas of greatest system risk.
- Delivery will remain aligned with the GM Clinical Strategy, commissioning intentions, Medium-Term Plan and Joint Forward Plan, ensuring progress against both local ambitions and national planning requirements.
- **Governance refresh** to streamline decision-making, clarify accountability across neighbourhood, place and GM, and align delivery to national “must-dos”.
- **Immediate System Priorities (aligned to the NHS 10-Year Health Plan):**
  - **Children & Young People:** improve access and sustain support, including expansion of Mental Health Support Teams and system action on neurodevelopmental pathways and waiting lists
  - **Community Mental Health:** strengthen neighbourhood teams and community support to prevent escalation to crisis.
  - **Crisis & Urgent Care:** deliver a clear GM-wide mental health crisis pathway and improve system flow.

Our ask of the ICB Board

- Endorse the pace and direction of travel, recognising both progress and complexity.

- Note the strategic priorities going forward and support the system to unblock cross-cutting issues (workforce, digital, finance, estates).

- Back a whole system approach that enables GM to improve outcomes, deliver equity, and maximise the impact of mental health investment for our population.

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NHS GM Clinical Strategy

Part of Greater Manchester
Integrated Care Partnership

NHS GM Board

March 2026

NHS GM Clinical Strategy

Required information.	Details.
Title of report.	NHS GM Clinical Strategy
Authors	Prof. Manisha Kumar, Chief Clinical Officer Dr Claire Lake, Deputy Chief Medical Officer Dr Jim Ritchie, Deputy Chief Medical Officer
Presented by.	Prof. Manisha Kumar, Chief Clinical Officer
Contact for further information.	Claire.lake@nhs.net

Executive summary.	This report presents the Greater Manchester Clinical Strategy, developed through extensive engagement with clinical leaders, stakeholders, and partners. The Greater Manchester Clinical Strategy has been developed in response key strategic drivers – The 10 year Health Plan and GM Strategy 2025-2035 – and in response to the evolving needs of our population and the challenges facing health and care systems. It reflects a shared ambition to deliver high-quality, equitable, and sustainable care across all localities, ensuring that clinical leadership is embedded at every level of planning and delivery. The strategy sets out a clear framework for embedding clinical leadership at all levels; for optimising the delivery of clinical care through every care interaction and through clinical service delivery; strengthening prevention and proactive care; optimising patient centred pathways; and driving transformation through integrated governance, digital infrastructure, and workforce development. The clinical strategy outlines immediate priorities and approaches as well as longer-term priorities (such as embedding of innovation and new technologies) to deliver improved outcomes, reduce health inequalities, and ensure sustainable, high-quality care across GM. The GM Clinical Strategy has been used to support the development of, and will continue to underpin, the GM 5 year strategic commissioning plan and be used to guide strategic and commissioning decisions. Extensive engagement has taken place to develop the strategy. A review of the Clinical Strategy of each Acute Provider organisation has also been undertaken. The strategy presented brings together the many clinical strategies and clinical plans that are already in place within GM and builds on these to provide a strategic clinical approach for the next 5 years. The detail – therefore – sits within existing delivery and plans. This document aims to focus the delivery of these in a strategic, data-led/evidenced based and prioritised way. In terms of next steps, ongoing work is underway to develop: - A full Clinical Strategy document to accompany this overview document - A set of metrics to measure delivery, outcomes and impacts

	- A prioritisation matrix to identify core areas for year 1 delivery (guided by population health analysis) and an implementation roadmap - A Board assurance Framework to link delivery of the strategy with the Clinical Governance Framework
The benefits that the population of Greater Manchester will experience.	• Improved health outcomes through prevention and early intervention. • Enhanced patient experience via integrated, person-centred care models. • Reduced hospital admissions and length of stay through proactive care and community-based services. • Greater equity in access and outcomes across all localities.
How health inequalities will be reduced in Greater Manchester's communities.	• Targeted interventions for CORE20PLUS groups and underserved communities. • Embedding health creation and Making Every Contact Count (MECC) principle. • Co-design with VCFSE partners and community representatives to ensure culturally competent care. • Use of GM Care Record and real-time data/ADSP to identify and address gaps. *Full EHIA undertaken and available on request
The decision to be made and/or input sought.	The Board is asked to: 1. Approve the Clinical Strategy
How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	Aligns with NHS GM strategic intents: prevention, proactive care, optimising care, transformation and sustainability. Strengthens governance and leadership capacity, mitigating risks related to quality, workforce, and system integration and contributes to mitigating key risks in the Board Assurance Framework. Enhances digital and data capabilities to support assurance and decision-making.

Key milestones.	Engagement completed – Feb 2026 Next Steps: 1. A workshop is being held on 2nd April to engage with clinical leaders on a Clinical Strategy Outcomes Framework to measure delivery, progress and impact of clinical strategy (approach is laid out in accompanying slide deck) 2. Implementation and delivery of the clinical strategy – aligned to new Operating Model
Leadership and governance arrangements.	Senior Responsible Officer: Prof. Manisha Kumar, Chief Clinical Officer Governance: was via NHS GM Quality and Performance Committee and will continue via GM Strategic Commissioning Committee
Engagement* to date. ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	Public consultation has taken place through the NHS 10-Year Plan and the Greater Manchester Conversation work conducted last year. The outputs from this have been used to inform the development of the clinical strategy. The document presented has been through extensive engagements with Greater Manchester clinicians and clinically facing teams to contribute their insights and help shape the development of the strategy. Engagement to date 1. Clinical Leadership Workshop held on the 14th of October 2025 (80 participants from across the NHS GM system) 2. Online feedback form launched 1st October 2025- 30th November 2025 3. Further engagement sessions scheduled in with key system partners and clinical leaders throughout October, November and December 2025 4. Extended Leadership Team 21st October – Senior leads from across GM 5. Executive Committee 22nd October – Place Based Leads and Chief Officers 6. TPC engagement via Exec MDs and Chief Nurses

Financial or Legal Implications	Financial: Initial implementation within existing resource envelope. Legal: No immediate legal implications; compliance with NHS governance and equality duties confirmed.

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	Yes	No	No	No	Yes

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Greater Manchester Clinical Strategy 2025-2030

Overview

Part of Greater Manchester Integrated Care Partnership

February 2026
Final post feedback

Greater Manchester – Strategy and Plan Alignment. Proposed Update for 2026/27 for New National Guidance

Greater Manchester Strategy – 2025 to 2035

10 Year Health Plan 2025-2035

GM's Health and Care plans are connected and build on each other to ensure the delivery of GM and national strategy and objectives

NHSE Plan Returns

DHSC/NHSE will engage with ICBs and providers on the specific requirements

Five-year organisational plans will be expected to fully align with and support numerical returns.

There will be separate returns from ICBs and trusts. ICBs and providers will need to work together to ensure that these are fully aligned.

Five-Year Integrated Delivery Plans (GM NHS provider trusts)

Demonstrates how the organisation will deliver national and local priorities and secure financial sustainability. Specific guidance to follow.

Providers will be expected to refresh these plans annually as part of establishing a rolling five-year planning horizon for the NHS

Neighbourhood Health Plans (Localityx10)

These will be drawn up by local government, the NHS and its partners at single or upper tier authority level under the leadership of the Health and Wellbeing Board, incorporating public health, social care, and the Better Care Fund.

The plan should set out how the NHS, local authority and other organisations, including social care providers and VCFSE, will work together to design and deliver neighbourhood health services.

5 Year Clinical Strategy (GM Level)

Reviewing and refreshing the organisation's clinical strategy to ensure it is up to date and aligned to the 10YHP.

Perform a refresh of the clinical / organisational strategy as required to ensure they are updated to reflect changes in national policy (e.g. the 10YHP) or local context.

5 Year Strategic Commissioning Plans (GM Level)

Describes how, as a strategic commissioner, the ICB will improve population health and access to consistently high –quality services across its footprint.

ICBs will be expected to refresh these plans annually as part of establishing a rolling five-year planning horizon for the NHS.

It is proposed that this Plan incorporates a refresh of our ICP Strategy and Sustainability Plan

Introduction

Strategic Vision: To create a healthier and fairer Greater Manchester by delivering high quality, integrated, person-centred care that tackles inequalities and empowers communities; supported through a culture of prevention and improvement, alongside clinical priorities to improve the access to and experience of health care as well as the health outcomes of our population

The following slides outline this **strategic clinical approach** for our Greater Manchester System:

- This clinical strategy is intended to be used across all ages and for GM population; by all providers and partners across the GM system to guide commissioning decisions and service development and delivery.
- This clinical strategy will inform the **GM 5-year Strategic Commissioning Plan**
- Public engagement '**Fit for the Future**' has informed the development of the clinical strategy
- Prioritisation for delivery will be informed by the needs of our population – both current and future needs – and **a prioritisation matrix** will guide implementation
- **Implementation** will be overseen and reported via **clinical governance assurance framework** aligned to BAF.

Greater Manchester Clinical Strategy 2025-2030:

Harnessing intelligence and clinical evidence to deliver high quality, integrated, person-centred care that tackles inequalities and empowers communities; supported through a culture of improvement and clinical priorities to improve access to and experience of health care and improve the health outcomes of our population

NHS Greater Manchester

Strategic Intent

Drivers

- 10 Year Health Plan 2025-2035
- GM Strategy 2025-2035
- GM Population Health Needs Analysis

Optimising preventative clinical care to improve health outcomes	Supporting good health through a comprehensive approach to prevention, early intervention and health creation to deliver the best start in life for children and young people and to enable healthy lives through adulthood
Proactive care; prioritised for those with most unmet need	A consistent offer of proactive care delivered through neighbourhood and population health management approaches, with a prioritised focus on those with the most unmet clinical and care needs; and in partnerships between NHS, wider public sector and VCFSE.
The Delivery of Clinical Care; and Clinical Service Design and Delivery	Optimisation of each healthcare interaction to deliver best practice care in the most efficient and effective way, with the patient at the centre of the interaction
	A clinical service offer to deliver a culture of 'home first'; with core standards for clinical service design, delivery and outcomes, and consistency of access, aligned across all services, including specialist services
System Transformation and Scaling	A commitment to transform, scale and pipeline, through research and evaluation; system improvement coordination; and digital transformation and AI

Built on a foundation of a shared, system focus on:

- **Clinical Leadership**
- **Clinical Governance**
- **Quality, Safety and Patient Experience**
- **Partnerships**

as core drivers for a culture of continuous improvement, learning and adaptation across the system to improve health outcomes for all

Enabled by **data capabilities, a unified medicines strategy, workforce planning, value based procurement and clinical integration**

Enabling **optimisation of clinical care; proactive quality management and robust clinical assurance**

To inform the GM Strategic Commissioning Plan 2025-2030

Greater Manchester Clinical Strategy 2025-2030: Cross Cutters, Enablers and Delivery

Greater Manchester Clinical Strategy 2025-2030: Harnessing intelligence and clinical evidence to deliver high quality, integrated, person-centred care that tackles inequalities and empowers communities; supported through a culture of improvement and clinical priorities to improve access to and experience of health care and improve the health outcomes of our population

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GM Clinical Strategy 2025-2030

Cross-cutters, Enablers and Delivery

Cross Cutting Themes

- An ambition to achieve a consistent delivery of high-quality, evidence-based, preventative care across all ages, in all settings and across mental and physical health
- Built on a foundation of improvement and a culture of shared learning
- With, improved experience of care and reduced health inequalities at the heart of this GM Clinical Strategy

Core Enablers

- Multi-professional clinical leadership across all provider settings
- Co-development, partnership working and local relationships across the NHS and public sector including VCFSE
- Data, Insight and Intelligence
- Digital Capabilities, GMCR and ADSP
- Quality Improvement capacity and capability
- Clinical workforce modelling and development
- Strategic Financial Modelling that incorporates value-based procurement, Health Economics and Analysis of Cost-Effective delivery models

Delivered Through

The GM Model for Health

- **Acute, community and mental health provider clinical strategies and delivery plans**
- **Integrated neighbourhood plans x 10 and LiveWell**
- **GM Primary Care Blueprint**

GM 5 Year Strategic Commissioning Plan 2025-2030

Greater Manchester Clinical Strategy 2025-2030

Strategic Intent 1: Prevention, Early Intervention and Optimisation. Supporting health creation through preventative care, optimisation of long-term conditions and adoption of a strategic, person-centred approach to multiple long-term conditions, frailty and end of life care

NHS Greater Manchester

GM Clinical Strategy 2025-2030

Strategic Intent 1

Optimising preventative clinical care to improve health outcomes

Sickness to Prevention

Hospital to Home

Key inputs / underpinning strategies and plans

- Children and Young People's Delivery Plan
- Population Health: Making Smoking History, Alcohol Harm Strategy, GM HIV and Fast Track Cities Plan
- Prevention: GM Screening and Immunisation Plans; GM CVD Prevention Strategy
- Mental Health: GM Mental Health Strategy
- Maternity and CYP Strategies including CYP Asthma and Epilepsy
- GM LTC Strategies: Cardiac, Diabetes, Stroke, Respiratory (draft), Cancer, GM Dementia and Brain Health; Weight Management and Palliative and End of Life Care;
- GM Medicines Strategy (draft)

Developing and implementing

- **A Strategic GM Approach to:**
  - Children and Young People: Supporting Good Health through Prevention
  - A GM Preventative Approach to Multiple Longterm Conditions
  - A comprehensive GM Approach to Frailty and End of Life Care
- **Population health needs analysis applied to this clinical strategy to produce to enable the prioritisation of areas of clinical focus to support:**
  - Provider clinical delivery plans
  - Commissioning Intentions
  - Neighbourhood delivery priorities

Delivering for GM

- Early diagnosis and early intervention
- Increase proportion of population in good health
- Increased healthy life expectancy and increased life expectancy
- Reduction in inequalities gap for life expectancy and for onset of multiple long-term conditions
- Reduce avoidable admissions
- Financial sustainability through health creation

Greater Manchester Clinical Strategy 2025-2030

Strategic Intent 2: Proactive Care and Population Health Management approaches to prioritise those with greatest need. Bringing clinical care and LiveWell approaches together within GM Neighbourhoods

NHS Greater Manchester

GM Clinical Strategy 2025-2030

Strategic Intent 2

Proactive care delivered through neighbourhoods; prioritised for those with most unmet need

Sickness to Prevention

Hospital to Home

Key inputs / underpinning strategies and plans

- GM Livewell
- GM Prevention Demonstrator
- GM Neighbourhood Plans
- LA Health and Wellbeing Strategies
- GM Population Health Management Roadmap
- GM Primary Care Blueprint
- GM Fairer Health for All
- Making Every Contact Count

Focusing on those with most unmet need

Starting in 2025-2027 with 4 key groups:

- Those with multiple disadvantage (including severe mental illness, homelessness, substance misuse and asylum seekers)
- Those with long-term conditions with high and very high unmet clinical need (focusing on CVD/Diabetes, Respiratory and Older Adults for 2025-2027)
- CYP on waiting lists for assessment or treatment which impacts on health, development and education
- Those with health conditions leading to time out of work or education (e.g. Musculoskeletal Conditions and Anxiety and Depression)

Developing and maintaining

- The digital capabilities to identify prioritised groups across care settings
- A framework to commission for care pathways to address unmet need, focusing on care delivery within primary care, neighbourhood and community settlings and adapting services to meet the needs of people
- Strategic and local partnerships with NHS providers, social care, VCSFE, local authorities and wide public sector

Delivering for GM

- Measurable reduction in unmet need (clinical parameters and socioeconomic measures)
- Achievement of Prevention Demonstrator metrics for identified cohorts
- Demonstrable reduction in inequalities in health outcomes across these domains
- Reduced unplanned service utilisation
- Improved experience of health care

Greater Manchester Clinical Strategy 2025-2030

Strategic Intent 3a: Optimise each healthcare interaction to deliver best practice, evidence-based care in the most efficient and effective way and with the patient at the centre of the interaction

NHS Greater Manchester

GM Clinical Strategy 2025-2030

Strategic Intent 3

3a) The Delivery of Clinical Care

Analogue to Digital

Hospital to Home

Creating the culture and conditions for all clinicians to deliver best practice care

- A culture of shared learning and improvement, underpinned by improvement capacity, skills and networks
- Programme of clinical effectiveness - using tools such as National Clinical Audit and GIRFT - to drive consistency and systematic improvement across the whole system
- Embedding NHSE Modern Service Frameworks from 2026
- Supporting professional development and maintaining professional standards
- Producing and maintaining accessible clinical guidelines and pathways to support best practice, especially for medicines
- Horizon scanning to anticipate and plan for future

Optimising Clinical Resources

- Promoting clinical stewardship – especially diagnostic stewardship – to use our clinical resources most effectively; supported through the use of clinical decision aid tools
- Adopting innovation and digital tools to maximise clinical efficiency and productivity – e.g. ambient scribe technology and theatre optimisation tools
- Reducing waiting lists for elective care through optimising use of A+G and referral support tools and systems
- Compliance with Effective Use of Resources Clinical Policies

Improving Interfaces of Care

- Reducing handovers of care by redesigning care around a patient rather than a service
- Aligning clinical skills and resources to patients – e.g. implementing models where specialist care is delivered in community settings
- Building clinical leadership and relationships – to mature our understanding of different clinical settings
- Reducing bureaucracy via the Red Tape Challenge
- Clinical integration to embed innovation and new ways of working to overcome interface barriers

Greater Manchester Clinical Strategy 2025-2030

Strategic Intent 3b: A clinical service offer to deliver a culture of 'home first'; with core standards for clinical service design, delivery and outcomes, and with consistency of access, aligned across all services, including specialist services.

NHS Greater Manchester

GM Clinical Strategy 2025-2030

Strategic Intent 3

3b) Clinical Service Design and Delivery

Hospital to Home

Access to Clinical Services

- Define a GM population offer for core services to drive consistency in modes of access, clinical triage and waiting times – to apply to General Practice, Community Services, Emergency and Elective Care
- Adopting a 'home first' culture, grow our GM Primary Care and Community Service offer to deliver more care closer to home and thereby reduce unplanned admissions to Emergency Departments and improve services to support timely discharge from hospital
- Continue to prioritise recovery of Elective Care waiting lists – and deliver Outpatient Transformation over the next 5years

Consistent Service Standards

- **Set GM Standards for Clinical Service Design, Delivery and Outcomes** :
  - Consistent standards for service design and delivery: with patient centred, end to end clinical pathways at the heart to unlock redesign across a care pathway and a shift from hospital to home
  - Consistent outcomes delivered and measured across clinical services, to reduce unwarranted variation
  - Clinical services prioritised for redesign/recommissioning based on a) quality and safety outcome data b) population health needs (including deprivation related needs), as well as c) service needs
  - Proactive identification of fragile services and specialist clinical workforce gaps to inform a multiyear commissioning cycle for service sustainability

Specialist Services

- Clinical strategy development for specialised commissioning to ensure integration and alignment with GM clinical strategy e.g. major trauma and vascular reorganisation as priority examples
- Clinical leadership and oversight of specialist clinical programmes – e.g. Maternity, Children's, Mental Health and Cancer services – to ensure high quality outcomes are achieved
- Future planning for specialist care to meet the changing needs of the population – planning to include longitudinal service modelling and clinical workforce modelling

Greater Manchester Clinical Strategy 2025-2030

Strategic Intent 4: System transformation and scaling of change. Delivering an equitable, consistent approach to evaluating, promoting and scaling change in GM to more rapidly bring appropriate new processes, solutions and technologies into routine clinical practice

NHS Greater Manchester

GM Clinical Strategy 2025-2030

Strategic Intent 4

System transformation and scaling of change

- Sickness to Prevention
- Hospital to Home
- Analogue to Digital

Key inputs / underpinning plans

- GM Digital and AI strategy / policy
- GM Research strategy
- Innovation and Life Sciences Strategy
- NICE HealthTech EVA framework
- NIHR MedTech research centre
- GMCR and ADSP

Working with partners

- HEI and NIHR partners including the ARC and knowledge mobilisation teams
- NHSE – region and centre
- Health Innovation Manchester
- NICE
- Local Authority and GMCA
- CQC
- Clinical networks
- NHS IMPACT

Developing and maintaining

- Triangulation of evidence and evaluation with demand management, quality and safety outcomes and system stability
- Transparent evaluation criteria for adopt / adapt / abort decision making
- GM model of change / system improvement framework providing a delivery framework at system scale
- Activity list for pilot work and horizon opportunities (including interdependency mapping)
- NICE EVA HealthTech adoption process
- Agreed metrics and data to track delivery and long-term value
- Stakeholder maps and relationship management

Delivering for GM

- Accelerated pathways to change
- Productivity and efficiency focus
- Fairness and transparency in decision making
- Alignment of change with clinical pathway and service design
- Support process efficiency and productivity improvements at a system level

Greater Manchester Clinical Strategy 2025-2030

Underpinned by a shared, system focus on Clinical Leadership, Clinical Governance and Quality, Safety and Patient Experience as core drivers for a culture of continuous improvement, learning and adaptation across the system to improve health outcomes

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GM Clinical Strategy 2025-2030

Built on a Foundation of Clinical Governance and Quality

GM Strategy & Frameworks

- GM Clinical Governance Framework
- GM Clinical Leadership Framework
- GM Quality Strategy
- GM Patient Safety Strategy
- GM Safeguarding Strategy
- GM Equalities Framework

System arrangements

- System-wide arrangements for clinical and quality governance which clearly sets out how the ICB works and interacts with Providers and Partners including Local Authorities, VCFSE and Regulators.
- Use of evidence-based guidelines, NICE standards, and best practice pathways to underpin objectives and shape intentions
- Clinical Leadership Framework to embed a just and learning culture, with continuous improvement and learning from harm
- Triangulation of clinical governance and quality intelligence to drive system improvement and inform commissioning decisions

Developing & Maintaining

- NHS GM commitment to strategic commissioning of care that is safe, effective, person-centred, timely, equitable and efficient.
- Multi-professional approach to a robust, valued clinical leadership model
- Creating an environment where staff have the right skills, support and environment- to deliver safe care to a high standard.
- Leadership development to empower system clinical leaders and promote compassionate and accountable leadership
- Outline accountability through use of a RASCI model to provide clarity and reduce duplication/bureaucracy
- Alignment with the National Quality Board and the NHS Patient Safety Strategy including systematic planning for embedding a system wide approach to reducing avoidable harm

Delivering for GM

- Monitoring of clinical outcomes and benchmarking against peers; reducing unwarranted variation and promoting equity of access, experience and outcomes
- Demonstrable system learning from patient safety incidents leading to evidence of reduced avoidable harm
- A culture of shared learning and continuous improvement, with capacity and capability for quality improvement across staff groups with a consistent QI methodology to support achievement of shared improvement priorities

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Prioritisation Framework

Part of Greater Manchester
Integrated Care Partnership

	0-12 months	12-36 months	36+ months
Digital Transformation & the 5 Big Bets	1. Adopting **AI and Digital tools** to increase clinical efficiency and productivity e.g., Ambient Scribe, Theatre Optimisation Tools 2. Roll out **Pharmacogenomics** for Stroke	1. Develop **GM model of change for system improvement** providing an at-scale delivery framework for implementation 2. Coordinated activity list for innovations, pilots and projects to plan **scale and adopt**	
Care Closer to Home	1. **Community Mental Health Transformation** 2. Continued progress on **Elective Recovery** – maximizing A+G, PIFU, alternatives to referral and Diagnostics 3. A coordinated system response to anticipated **Modern Service Frameworks*** and the **Red Tape Challenge** 4. Develop **GM strategic plan for MSK** conditions and services	1. **Outpatient Transformation at scale** – to reduce OP followup by 50% and to shift specialist care into community settings 2. **A Consistent offer of preventative community services** across GM that **reduces demand on Urgent Emergency Care** – e.g., Fracture Liaison Service, Acute Frailty and Falls Offers, MSK services 3. Embed **behavioural change** into new models of care 4. **Clinical workforce** planning	1. Embed evidence based **multiple long-term condition pathways** within neighbourhoods and places
Prevention and Proactive Care	1. Adopt a **Population Health Management** (PHM) Approach within GM Neighbourhoods for Frailty, LTCs (CVD/Diabetes/Respiratory), Early Years, Multiple Disadvantage and Immunisations 2. **Obesity** – prevention and management (Including Tirzepatide NICE TA) 3. Increased **cancer detection** at earlier stage through screening, case finding and symptomatic presentation 4. Implement a medicines strategy to improve clinical and population outcomes, improve safety reduce inequalities and deliver better value for the NHS	1. A Strategic GM Approach for **Children and Young People: Supporting Good Health through Prevention** 2. Expand whole system approach to **prevention to include Respiratory and full CVRM pathway** 3. Further expand **Population Health Management (PHM) Approach** to preventative and proactive care within GM Neighbourhoods according to needs of local population and to support those whose are not able to be in education or work due to health concerns	

OUTCOMES

1. Increased in Healthy Life Expectancy
2. Improved access to and experience of healthcare; and reduced inequality gaps in health outcomes
3. System sustainability achieved through demand management, efficiency, productivity and health creation

* MSF - Frailty and Dementia, SMI, Sepsis , CVD Prevention and PEOLC

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Clinical Strategy Outcomes Framework

Part of Greater Manchester
Integrated Care Partnership

An accompanying Clinical Strategy Outcomes Framework is in development

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Purpose:

The Clinical Strategy Outcomes Framework will measure the impact of the GM Clinical Strategy in a way that supports service transformation, enables timely course-correction, and demonstrates improvement in equity, access, experience and outcomes. It reframes metrics from topic lists into a time-sequenced model so the system can see what should change first, why, and how that cascades to population outcomes.
Note: the Clinical Strategy Outcomes Framework is fully aligned with the outcomes work of the GM 5 year Strategic Commissioning Plan.

Health Equity:

- The framework operationalises our Public Sector Equality Duty by tracking inequality gaps alongside headline values for every priority metric. It addresses known evidence and inequalities gaps within our population by applying an inequalities lens to data (e.g. deprivation, ethnicity, disability, frailty, carers).
- Enabler metrics explicitly include equity of scaling, learning from patient safety events, and reduction in unwarranted variation, ensuring transformation is both safe and fair.
- Ongoing engagement with seldom-heard groups and lived experience is built into the experience measures and evaluation cycle.

Data Principles

1. Equity by default: Disaggregate by IMD, ethnicity, age, sex, disability, carer status—and where feasible digital access—so we track gaps, not just averages.
2. Feasibility first: Start with metrics available now; define a clear data-development path for new items with owners and timelines.
3. Leading + lagging indicators: Balance process/clinical change with utilisation and population outcomes to tell a coherent cause-effect story.
4. Single data dictionary: One GM definition per metric to reduce variation and debate.
5. No duplication with performance targets: This set complements (not repeats) constitutional or operational targets.

A time sequenced approach to the Outcomes Framework

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A time sequenced model has been developed to support system transformation and at scale change:

- **A suite of clinical indicators will respond first (6–18 months)** to demonstrate early improvement as new pathways are adopted (e.g., vaccination rates, stage 1–2 cancer diagnosis, CVD risk-factor optimisation, diabetes care processes). *These are the first indicators that the intervention will lead to the desired system impact.*
- **Optimised care measures will then demonstrate impact of changes to clinical practice/pathways (1–2 years),** such as adherence to GM or national standards of clinical care, reduction in high/very-high unmet need, reduction in acute exacerbations of illness (e.g. asthma), reduction in falls, reduction in polypharmacy, reduction in heart attacks/strokes/limb amputations and end-of-life care preferences. *These demonstrate to the system an evidencable change in health outcomes across care pathways.*
- **These drive system utilisation measures (1–3 years) as demand profiles change:** reduced avoidable admissions, readmissions, non-elective bed days for frailty/care-home cohorts, shifts from urgent and emergency to planned utilisation of specialist care, and care shifted into community settings. *Workforce measures need to be captured alongside these and these measure need to dovetail these measures into annual operational planning assumptions to drive the evidence for left shift*.
- **A change in Population outcomes (3–5 years):** improvements in Healthy Life Expectancy, reduced avoidable mortality for major conditions (e.g. for CVD, respiratory disease, cancer), reduced inequality gaps (e.g. reduction in the 15yr inequality gap in multiple long-term conditions between those living in highest and lowest IMDs) and a shift in population health segmentation analysis. *These measures start to demonstrate achievement of strategic intent and a shift in the health of our population.*
- Throughout, **patient experience and process measures of core enablers** (research/adoption, safety/quality, governance, QI capability, standardised pathways, and a single outcomes dashboard) will evidence learning, quality improvement and scaled spread. *These measures evidence safe, high quality and improvement driven change.*

4 Phases of Work

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1. **Design phase – Nov 25-Feb 2026**
   - Joint work and logic modelling with 5-year strategic commissioning plan and GM population health needs analysis
   - Scoping with DII regarding data availability and development
   - Developing the sequenced approach to the outcomes framework
   - An extensive literature review of currently used measurables and data frameworks
   - Compiling a long list of measurables for consideration
2. **Development phase – due to complete 19th March 2026**
   - Contribution by leads of all the clinical strategies and plans within the GM Clinical Strategy of 3 headline metrics for each area
   - Working group populating outcomes framework
3. **Engagement phase – starts 2nd April 2026 (workshop)**
   - Engagement on proposed metrics to be included in Clinical Strategy Outcomes Framework
   - Further development work based on feedback
4. **Implementation – May 2026**
   - Working with DII team to collate and present information in a way that is useable
   - Communicate, demo and share the outcomes framework to ensure wide adoption and utilisation

Glossary of Terms

NHS Greater Manchester

Acronym / Term	Definition
5 Big Bets	Referred to in the NHS 10-Year Plan (2025); includes AI tools, genomics, wearables and predictive analytics, robotics, and joined-up data quality and interoperability for innovation
A+G	Advice and Guidance
ADSP	Greater Manchester Analytics and Data Science Platform
AI	Artificial Intelligence
CQC	Care Quality Commission
CYP	Children and Young People
CVD	Cardiovascular Disease
GIRFT	Getting It Right First Time National Programme
GM	Greater Manchester
GMCR	Greater Manchester Care Record
HEI	Higher Education Institution
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
VCFSE	Voluntary, Community, Faith and Social Enterprise Sector

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VCFSE Accord Agreement 2026-35

Part of Greater Manchester
Integrated Care Partnership

NHS GM ICB Board

March 2026

Report information.

Required information.	Details.
Title of report.	GM VCFSE Accord Agreement 2026-35 – Final Draft
Author	Sarah Harris, GM Strategy & Partnerships Lead, NHS GM sarah.harris10@nhs.net
Agreement co-authored by	Anna Cooper, GM Programme Manager, VSNW Jennifer Rouse, VCFSE Accord Principal, GMCA Sarah Harris, GM Strategy & Partnerships Lead, NHS GM
Presented by.	Paul Lynch, Director of Strategy, NHS GM paul.lynch@nhs.net
Additional Contacts for further information	Warren Escadale, Chair of the GM VCFSE Leadership Group, VSNW warren.escadale@vsnw.org.uk Sara Roscoe, Associate Director – Commissioning Transformation sara.roscoe@nhs.net
Executive summary.	This paper presents the final draft of the **Greater Manchester VCFSE Accord Agreement 2026–2035** for Board Approval, following which the Agreement will proceed to formal signing. The refreshed Accord sets out a shared framework for partnership working between NHS Greater Manchester, Greater Manchester Combined Authority, local authorities and the voluntary, community, faith and social enterprise (VCFSE) sector. It replaces the current Accord (2021–26), which concludes on 31 March 2026. The Agreement has been co-authored in partnership and reflects extensive engagement and co-development with system partners and the VCFSE sector during 2025. It builds on the strengths of the existing Accord and aligns with the refreshed Greater Manchester Strategy, with a renewed focus on prevention, neighbourhood working and addressing health inequalities.

	Subject to ICB Board approval, the final Accord will be presented for formal signing on 27th March, with a system-wide launch planned for June 2026.
The benefits that the population of Greater Manchester will experience.	Through implementation of the Accord Agreement, Greater Manchester communities will benefit from: • A stronger, more consistent framework for partnership working with the VCFSE sector • Improved alignment of community-based activity with GM priorities, including prevention and neighbourhood health • A strengthened role for the VCFSE sector as a system partner, particularly in underserved communities • Earlier, community-led intervention that supports wellbeing and helps reduce demand on statutory services
How health inequalities will be reduced in Greater Manchester's communities.	The VCFSE sector plays a critical role in reaching communities that experience the poorest health outcomes and greatest barriers to access. The Accord Agreement provides a shared framework that will: • Strengthen inclusive partnership working with organisations rooted in communities most affected by inequality • Support neighbourhood-level approaches to prevention and early intervention • Contribute to Greater Manchester's wider approach to reducing health inequalities through coordinated system action
The decision to be made and/or input sought.	Board Members are asked to: • Review and approve the final draft of the GM VCFSE Accord Agreement 2026–2035 • Note that associated funding arrangements are presented in a separate paper
How this supports the delivery of the strategy and mitigates the Board Assurance	The Accord Agreement supports delivery of the NHS GM 5yr Strategic Commissioning Plan and Greater Manchester Strategy by: • Strengthening partnership working with the VCFSE sector as a core system partner

Framework (BAF) risks.	• Supporting prevention, community resilience and neighbourhood models of care • Contributing to mitigation of BAF risks relating to health inequalities, system sustainability and demand management
Key milestones.	☑Agreement of VCFSE Accord principles and delivery approach ☐ Board Approval (18 March 2026) ☐ Formal Signing (27 March 2026) ☐ System-wide Launch (June 2026)
Leadership and governance arrangements.	Overall accountability for the VCFSE Accord sits jointly with Greater Manchester Combined Authority and NHS Greater Manchester, working in partnership with Voluntary Sector North West (VSNW) as the grant-holding body. Operational oversight of grant funding and delivery is currently provided through established VCFSE governance arrangements, with monitoring and assurance through relevant GM partnership forums. A full review and redesign of arrangements is planned in the first six months of the new agreement. Any proposed changes to governance arising from this review will be brought back through the appropriate governance routes for approval. The Senior Responsible Officer on behalf of NHS Greater Manchester is Charlotte Bailey, Chief Strategy, People and Partnerships Officer.
Engagement to date.	Engagement has taken place through the GM VCFSE Leadership Group and Accord governance arrangements, including co-development of the refreshed Accord commitments and implementation approach. Key stakeholder engagement between April and July 2025, followed by a 3-month open consultation with VCFSE and public sector colleagues that closed at the end of October 2025
Financial or Legal Implications	Finance advice has been provided by the NHS Greater Manchester ICB Finance Team. Associated funding arrangements are presented in a separate paper

Introduction

1.1. The Accord is an agreement between Greater Manchester's ten local authorities, GMCA, NHSGM, and the Greater Manchester voluntary, community, faith, and social enterprise sector (VCFSE) represented by the GM VCFSE Leadership Group aimed at enhancing working relationships and serving as a key mechanism for delivering the refreshed Greater Manchester Strategy. The agreement outlines a set of principles and commitments on how partnership working should be conducted and specifies which projects or activities should be advanced on a GM footprint.

1.2. There have been notable successes of the first Accord, including:

- Elevating the profile of the VCFSE sector amongst public sector leaders thus enabling its voice to shape strategic discussions.
- Flagship initiatives to strengthen VCFSE organisations, such as the GMCA and VCFSE Fair Funding Protocol.
- The Greater Manchester VCFSE Accord was also a significant influence on the national Civil Society Covenant, and was named as a case study in the Covenant.

1.3. The final draft of the GM VCFSE Accord Agreement 2026-35 replaces the current Accord Agreement 2021-26 ending on 31st March, 2026.

1.4. A refresh process was initiated, including key stakeholder engagement between April and July 2025, followed by a 3-month open consultation with VCFSE and public sector colleagues that closed at the end of October 2025. NHS Commissioning Principles that are part of the GM Accord, were signed off at the July 2025 NHS GM ICB meeting.

1.5. Board Members are asked to approve the final draft prior to formal signing on 27th March and launch planned for June 2026.

The final draft reflects a series of engagement conversations, including with:

- Deputy Placed Leads
- GMCA Oversight & Scrutiny Committee
- GM VCFSE Accord Refresh Steering Group
- GM VCFSE Leadership Group
- Accord Commitment Delivery Group

Local authorities and the VCFSE sector are taking the Accord through their own parallel approval processes. Other organisations are invited to join as additional signatories from April 2026 onwards.

1.6. A VCFSE Accord introduction session has been scheduled for NHS GM Extended Leadership Team on Tuesday 17th March.

Recommendations

Board Members are asked to:

- Review and approve the final draft of the GM VCFSE Accord Agreement 2026–2035
- Note that associated funding arrangements are presented in a separate paper

The Greater Manchester Voluntary, Community, Faith and Social Enterprise (VCFSE) Accord

2026 - 2035

GMCA Greater Manchester Combined Authority | Greater Manchester VCFSE Leadership Group | NHS Greater Manchester | Transport for Greater Manchester | Greater Manchester Fire and Rescue Service

Bolton Council | Bury Council | Manchester City Council | Oldham Council | Rochdale Borough Council

Salford City Council | Stockport Metropolitan Borough Council | Tameside Metropolitan Borough | Trafford Council | Wigan Council

Contents

The Greater Manchester VCFSE Accord is a commitment to put in place working relationships between the public sector and voluntary, community, faith and social enterprise (VCFSE) sector that will improve outcomes for Greater Manchester's communities, residents and places. It is based on a relationship of mutual trust, honesty, ambition and accountability and is jointly owned by the public and VCFSE sectors in Greater Manchester – including NHS GM, the Greater Manchester Combined Authority (GMCA), Transport for Greater Manchester, Greater Manchester Fire and Rescue Service, 10 local authorities, and the Greater Manchester VCFSE sector (represented by the GM VCFSE Leadership Group).

This agreement seeks to align with and strengthen related place-specific agreements, strategies, and shared objectives for collaboration. It also runs alongside the Greater Manchester Strategy, and is our Greater Manchester version of the national Civil Society Covenant. The Accord outlines how signatories will work together to redress power and resource imbalances so that partnership working is as effective as possible.

The Accord seeks to work in conjunction with existing and new equivalents to the Accord that are locally developed and owned. The Accord commitments will be enacted in addition to these local agreements.

From this point on, the words "we", "our" or "us" refer to all signatories to this Accord - acting with a single voice and shared purpose.

1. Introduction

We all exist to serve all of Greater Manchester's residents in their rich diversity; the places we all live; and the climate and environment on which all our lives depend. Each of the signatories to this agreement – VCFSE organisations across Greater Manchester, and the public sector - has a role in making our city region a sustainable place where everyone can live a good life: a place of equity, opportunity, and belonging. We can achieve this by working together, collectively, for the benefit of the communities we are all part of.

The VCFSE sector holds a unique power: the trust, relationships, credibility, and insight that come from being rooted in communities. By ensuring the sector can lead boldly, increase its own capacity, and work on an equal footing alongside public sector partners, we will unlock the potential of community-led change.

The Accord sets out the shared values that guide collaboration of Greater Manchester's VCFSE and public sectors, and the commitments we make to one another as partners. The Accord should be used as a common reference point and guiding tool owned across sectors that helps us stay aligned in purpose, valued in our roles, and be accountable to each other and the communities we serve.

2. Our Shared Vision, Mission & Beliefs

Our Vision

A thriving Greater Manchester where everyone can live a good life: a place of equity, opportunity, belonging, and environmental stewardship.

Our Mission

A thriving, connected, and resilient Greater Manchester VCFSE ecosystem that fully contributes to driving change for Greater Manchester's people, communities, places, and environment, working in trusting collaboration with public sector partners.

Our Shared Beliefs

Underpinning our shared vision and mission are our shared beliefs:

1. **We achieve more together than alone**. The combined size, roles, and approaches of the Greater Manchester VCFSE sector and public sector together bring depth, resilience, and innovation to our shared work, adding a value which is more than the sum of its parts.
2. **An integrated, connected, and well-resourced Greater Manchester VCFSE ecosystem benefits everyone.** When the VCFSE sector can lead alongside public partners with equality of voice and status, we move closer to our shared vision of a city region where everyone can live a good life.
3. **The rich diversity of our local communities is where we will find the expertise to drive change and justice in society.** The VCFSE sector is a key route to do this. Greater Manchester's residents must have power, spaces, and opportunity to participate in decisions that affect them.
4. **Decision-making in partnership enables outcomes to be more inclusive and effective.**
5. **By sharing power, we build the trust needed to achieve real and lasting change.**
6. **Values must be lived, not just stated.** Transforming our shared values into everyday practice is how change happens.

3. Our Shared Values & Behaviours

Over several decades we have learnt that strong relationships are the foundation for us to collaborate effectively in the interests of the common good. We commit to ensuring that our core value of trust, and underpinning values of honesty, ambition and accountability, guide all our work together:

Our Core Value: Trust

We commit to create conditions of mutual trust and understanding.

Building trust must be the foundation of everything we do. Trust is not automatic; it grows over time as our actions make clear our commitments to each other, and the people of Greater Manchester. We know that without trust, we cannot have authentic conversations, take bold steps, or hold each other to account. We recognise that building trust can take time and we should be realistic about the complexities of building trusting relationships. Through consistent action in line with our shared values, understanding, and empathy about the contexts we each work in, we can create the trust across our diverse organisations and communities.

Honesty

We commit to creating spaces where honesty is encouraged alongside reciprocal care and respect.

Trust between partners fosters our ability to speak openly and honestly, share challenges, and offer constructive feedback without fear of negative consequences, both ways. We will identify and address barriers to trust and honesty, such as power imbalances. We will remain transparent about decisions, whilst also respecting that sometimes respect for confidentiality, legislation, and formal responsibilities must be prioritised.

Ambition

We commit to continuously strive for better outcomes, resilient through our shared purpose and ambition.

We know that being bold and ambitious is only possible when we trust that we have the support from each other we need to shift practice or challenge the way things are. As the world changes rapidly, we must evolve and adapt so that we can respond to, anticipate and act on the future priorities and experiences of the people of Greater Manchester. This will require us to build strong resilient relationships and act boldly and with integrity to challenge our mindsets, structures, and systems and step into new ways of working.

Accountability

We commit to accountability founded on transparency, integrity and positive impact.

We define accountability as listening to others' priorities and perspectives, acting when we have committed to act, and being transparent about progress, challenges, and why something has not worked out as planned. We see accountability as essential for trust to thrive between us. We believe that good relationships depend on action, not just words and see accountability as essential to achieving real change. This is particularly important where power imbalances exist, as decisions made by some partners can have a greater impact on others. Accountability is not about control or blame; it is about all working to the same standards and behaviours in order to achieve greater clarity and impact.

Ultimately, we recognise that we are all accountable to the people of Greater Manchester, and this framing will guide all our work.

4. Accord Commitments

We recognise the areas of change outlined below as our three key priorities for the next 9 years.

Each area includes a full list of commitments to be progressed over this timeframe, building on the headline commitments.

4.1 Involve & Devolve

We are committed to building a future where significant power and wealth are in the hands of our communities. Achieving this requires a community-centred model - one that is rooted in the people, knowledge and relationships that already exist within our neighbourhoods. This is important for all our communities, but most important where power and wealth is the least accessible. VCFSE groups and organisations are integral in this model, as they are usually the first to understand community strengths and needs. They achieve this through their deep local insight, trusted connections, and work delivering social and climate justice. We commit to building this VCFSE model, and, from the earliest possible point, involving people in the decisions that affect them. We believe that lasting change will depend on trusted VCFSE approaches that elevate community voice, challenge inequality, and strengthen the leadership, participation and infrastructure that enable people to shape their own futures.

We commit to deepening collaboration across sectors by systematically involving the VCFSE sector and working together to devolve more power to communities.

Headline commitments:

i. **Devolve to communities through building stronger participatory approaches (including co-production, co-design, co-commissioning, co-delivery and co-evaluation)** where this is essential to community outcomes. Where we agree that co-production will add value, we will ensure that local people are active participants in shaping their futures, not passive recipients of services. We will enact these approaches to involve local people, and the VCFSE groups and organisations that represent them, at the earliest point of our work, and consider developing and adopting a charter to assist in embedding this in practice.

ii. **Involve the VCFSE sector in more decision making, steering group, programme and formal governance** such as public sector boards as standard. Partners should ensure representatives feel supported in these roles and connected with VCFSE networks.

We will:

a. **Put people and communities first**, **working from an approach that recognises strengths,** resilience and potential, rather than problems, deficits or need

b. **Ensure visible and active leadership that challenges structures and behaviours that perpetuate inequalities**. Leadership should be diverse and reflective of local populations to strengthen representation and trust. Leadership that is visible and courageous sets the tone for change, confronting the systems and barriers that sustain inequality and driving progress toward equity.

c. **Ensure that people with direct experience of issues and intersectional perspectives** influence governance, policy, commissioning and delivery at every level. We will always ask whether the right people are in the right rooms and challenge ourselves and each other on whether we are reaching all communities, particularly the disenfranchised.

d. **Reduce barriers to participation in our structures -** avoiding models that solely favour specific organisational forms over others. For example, where smaller VCFSE organisations and community groups may face capacity challenges.

e. **Build forms of collective leadership** that facilitate significant power and wealth moving to our communities, tackling inequalities in the most disadvantaged and discriminated communities.

f. **Take action to support community asset acquisition or development.**

4.2 Resource & Enable

For the VCFSE sector to fulfil its potential in supporting communities, we recognise that it needs long-term funding as standard and flexibility so that funding worries do not get in the way of its work. We recognise that any financial resources that either VCFSE organisations or Greater Manchester public sector organisations hold ultimately belong to the people of Greater Manchester, and we are its custodians. The public sector signatories commit to increasing the overall proportion of their budgets to Greater Manchester VCFSE organisations as this keeps public value working locally - increasing the wealth retained by our communities and long-term benefit. All signatories recognise that financial resourcing must sit alongside other forms of capacity such as digital and workforce capacity and spaces to meet. We all commit to building this capacity and supporting each other to do so.

We commit to increasing the proportion of fair, transparent, and sustainable funding that public sector signatories invest in VCFSE organisations, working in a spirit of honesty and openness regarding the challenges of resourcing decisions.

Headline commitments:

i. **Resource the VCFSE sector through increasing the proportion of public sector funding invested in VCFSE groups and organisations**, as this is a direct investment in the people and places of Greater Manchester. By directing public funds through locally rooted, community-led organisations, we keep public money working locally - increasing the wealth retained by our communities and committing to working together to end extraction by external profit driven models.

ii. **Enable the sector by fully implementing the Greater Manchester Fair Funding Protocol[1] or equivalent agreement such as the NHS GM Commissioning Principles[2]**. Where no such protocol exists, commit to the development and adoption of a locally or organisationally tailored version that upholds principles of financial fairness, transparency, and shared accountability.

We will:

a. **Ensure that partners are adequately resourced to act - through funding and other capacity - by working collectively to advocate for sufficient, long-term, and flexible investment in the VCFSE sector at both regional and national levels,** with a shared commitment to long-term funding and responsibility for delivery, recognising that sustainable investment is essential to lasting change.

b. **Shift to greater community control of funding and participation in decision-making around how public money is spent** with appropriate processes and a clear framework to implement this shift.

c. Develop robust and transparent mechanisms for the **VCFSE sector to manage more funding, influence commissioning processes focused on shared responsibility and partnership, and to co-design and co-deliver solutions** alongside statutory partners, ensuring that that the driver is community outcomes, rather than shifting the burden of risk from public sector to VCFSE organisations.

d. **Jointly identify where new or enhanced skills and capacity are needed**. This might include skills such a facilitation, participatory budgeting, conflict resolution, or work to support embracing of new technologies/ways of working e.g. digital. We will work together to ensure that this is put in place.

[1] GMCA Fair Funding Protocol
[2] NHS GM Commissioning Principles

e. **Ensure public sector officers with responsibility for budgets and financial strategy within public sector organisations,** (e.g. directors of finance, commissioners, and those with day-to-day budget decision-making powers), **understand the values and commitments in this Accord, and that VCFSE colleagues understand the pressures and responsibilities of these staff**.

4.3 Recognise & Value

We value the commitment of those who work for the common good across Greater Manchester and recognise the wide range of roles played by both the VCFSE and public sectors. Some responsibilities sit firmly with public bodies, and others rely on the independence of the VCFSE sector - including its ability to advocate, organise, and challenge. Sometimes we will need to switch from or blend the roles we traditionally hold to be effective as a partnership. We will honour this balance of collaboration and independence as we work to improve outcomes for our communities. We also recognise the need to 'rebalance' across our sectors, with a specific priority to recognise and value the role of the VCFSE sector and ensure that action taken in line with this Accord emphasises this priority.

We commit to recognising and valuing the roles of all those who work for the common good, with specific emphasis the contribution of VCFSE organisations through efforts to improve understanding, transparency, involvement, practical support and investment.

Headline commitments:

i. **Recognise the impact of the sector and the breadth of roles VCFSE organisations play**[3], as set out in 'The role of the VCFSE Sector in Greater Manchester'. This includes recognition of the VCFSE sector contribution to economic, social and environmental change; the inherent social value they generate; and their ability to build cohesive, inclusive communities. Roles include campaigning, innovation, community organising, leadership, expert advice, and supporting prevention and early intervention.

ii. **Value the unique insight, evidence and community-generated data held by VCFSE organisations** by drawing on this intelligence to inform policy, strategy and service design, alongside other forms of insight.

We will:

a. **Acknowledge that generating 'social value' is inherent to the purpose, work and organisational structure of VCFSE organisations,** by working together to ensure public sector funding decisions are reflective of this.

b. **Support responsible, proportionate, and ethical sharing of data and insight** between sectors while meeting all legal and safeguarding duties and work together support the development of further data and insight.

c. **Value the VCFSE sector and public sector workforce, including volunteers and unpaid carers** as "one workforce". We will support VCFSE staff development programmes, broaden access staff support programmes and, where possible, create cross-sector coaching/mentoring opportunities aligned to the standards set out by the Good Employment Charter.

d. **Acknowledge our shared responsibility to act in ways that protect and restore the environment**. We will embed environmental sustainability into decision-making, resource allocation, and programme delivery.

e. **Recognise the VCFSE sector's potential to take on new roles, including in areas where it has not traditionally operated.** We will not only increase the amount of delivery the VCFSE sector leads, but its

[3] Appendix 1 – The Role of the VCFSE sector in Greater Manchester (2025)

breadth of involvement. We will generate innovative solutions by working together to scope opportunities that offer clear added value for our people, places, communities and environment.

f. **Support leadership development across the VCFSE sector** and ensure VCFSE voices shape policy, service design, practice, and resource allocation.

g. **Acknowledge that certain statutory, legal and decision-making functions sit with public bodies.** We commit to widening participation within the existing framework and challenging where this would lead to better outcomes but is not currently possible. We will also recognise that some public sector responsibilities should always remain distinct and will be exercised transparently in the public interest. We commit to both increased openness and understanding of public sector constraints and statutory responsibilities that impact on the VCFSE sector.

h. **Ensure VCFSE groups and organisations, as well as public sector staff across Greater Manchester are aware of the Accord,** understand the values and commitments it contains and how they can use it within their own context.

5. Accord Implementation: demonstrating action

Through a shared commitment to transforming values into visible and practical actions, the Accord will become a lived reality and deliver meaningful change.

Each signatory will take responsibility for embedding its values, behaviours and commitments through the following actions:

1. **Identify named individuals with clear responsibility** for driving change, and be specific about the roles, responsibilities and decision-making powers of those involved in change. This is essential to ensuring commitments are delivered and in making progress visible.
2. Signatories will **set and integrate clear formal governance process and structures** accountable for Accord delivery within our organisations. We recognise that there are a large number of commitments and signatories will work through a process of prioritisation to define **specific, actionable initiatives**.
3. We will **create spaces defined by the right people being in the right rooms** to share learning, address challenges collectively, and work with accountability, honesty, and ambition.
4. We will make **decision-making processes open and clear**, including where decisions are made and who is making them.
5. Partners will **agree meaningful measures of success**, recognising that progress may look different across sectors and localities. Regular reflection and reporting will show how actions contribute to the Accord's goals and/or local strategies and priorities and improve outcomes for communities.
6. **We will outline accountability and escalation protocols,** to define the mechanisms to support accountability in case partnership working doesn't go to plan.
7. Partners will actively **share what works, through structured feedback loops** and support its adoption across the system to accelerate improvement.
8. We will ensure the Accord complements other strategies across Greater Manchester and localities, **embedding structured accountability through mechanisms such as job descriptions, governance arrangements, and evidence-based practice.**

6. Deliverables

The below table shows the deliverables that result from our commitments to action. These will be assessed as part of a regular implementation review.

Phase 1 – Established at the point of signing
Phase 2 – By the end of the first year, supporting documentation to be approved and shared with relevant audiences.
Phase 3 - Deliverables to be continuous throughout the course of the agreement.

Phase 1 - Share and keep informed on:
a. Named individuals with clear responsibilities for Accord* - *see appendix* 3
b. Formal governance processes and structures
c. Decision-making processes and timelines (e.g. commissioning intentions)
d. Routes of escalation and emergency response protocols
Phase 2 - Co-Design and Develop:
a. Effective methods and spaces to develop understanding and sharing learning
b. Mechanisms for continuous improvement and system learning
c. Key delivery metrics for monitoring and reporting
d. Prioritisation and process to enact commitments (e.g. Fair Funding Protocol, Commissioning Principles)
e. Accord Delivery Plan
Phase 3 - Integrate and Embed:
a. Staff awareness and understanding of the Accord Agreement
b. Alignment and integration with wider strategies and plans
c. Evidence through tangible improvements in research findings

**With recognition that each partner will demonstrate the commitments of the Accord in ways that reflect their own context, stage of development, capacity and priorities.*

A list of examples of how partners might demonstrate action through working towards specific outcomes is included in appendix 2.

7. Duration

The duration of this Accord will be nine years, 2026-2035, to align with the Greater Manchester Strategy and the 10-year Health Plan for England.

This will be supported by implementation review and planning every three years to assess our collective progress and set our upcoming priorities.

Signed Date:
Agreement Renewal Due Date: April 2035

- **Implementation Review:** Every three years.
  - **Next review:** Winter 2028, to enact from April 2029
- **Delivery Reporting:** Annual

8. Signatories

This document has been formally signed and endorsed by:

The Greater Manchester VCFSE Leadership Group, on behalf of Greater Manchester's 17,400+ Voluntary, Community, Faith and Social Enterprise Sector*****.

Key public sector organisations that serve the people of Greater Manchester, including the ten Local Authorities (Bolton, Bury, Manchester, Oldham, Rochdale, Salford, Stockport, Tameside, Trafford, Wigan), Greater Manchester Combined Authority, NHS Greater Manchester, Transport for Greater Manchester, and Greater Manchester Fire and Rescue Service.

***'VCFSE sector' (Voluntary, Community, Faith and Social Enterprise sector)** is an umbrella term, which includes, but is not limited to:*

- *Charities and voluntary organisations*
- *Community, grassroots and informal groups (which make up the largest proportion of 'VCFSE')*
- *Community organising coalitions*
- *Campaign organisations*
- *Faith centres and organisations*
- *Social enterprises, social businesses, co-operatives and* other models that aim to reinvest profits for social purpose and/or democratise ownership.

Additional signatories

Grounded in shared values and principles, this Accord is open to welcoming additional signatories whose work aligns with these commitments.

Organisations that embrace the expectations of this Accord agreement are encouraged to sign and support its ongoing development and delivery.

Amendments

The Accord commits signatories to act in a way that is aligned with the beliefs, values, and behaviours and commitments it contains and to ensure the ongoing viability of the integrated Greater Manchester system in a changing environment. The Accord will ONLY be amended in the instance that all signatories agree an amendment to be beneficial to the people, communities, places and environment of Greater Manchester.

Signatures:

9. List of Appendices

Appendix 1 – The Role of the VCFSE sector in Greater Manchester (2025)

Appendix 2 – Demonstrating Action – examples of Accord implementation

Phase 1 Deliverables

Appendix 3 – Named accountability leads table - Phase 1(a) deliverable

To be added to this document from 1st April 2026:

Appendix 4 – Formal governance processes and structures – Phase 1(b) deliverable

Appendix 5 – Decision-making processes and timelines (e.g. commissioning intentions) – Phase 1(c) deliverable

Appendix 6 - Routes of escalation and emergency response protocols - Phase 1(d) deliverable

Implementation planning toolkit

To be added to this document by the end of the first year:

Appendix 7 – Accord Commitment Maturity Self-Assessment Checklist

Appendix 8 – Template Accord Delivery Plan – Phase 2(e) deliverable

10. Appendices

Appendix 1 – The Role of the VCFSE Sector in Greater Manchester paper

The Role of the VCFSE sector in Greater Manchester (2025)

Appendix 2 – Demonstrating Action – examples of Accord implementation

The following outlines a series of **suggested changes**, developed with broad support from both VCFSE and public sector partners in consultation in 2025.

These illustrate the kinds of actions and shifts that can bring the Accord's values to life, while allowing flexibility for each signatory to determine how best to implement and measure them. In many cases these changes will need to be made in steps, as underpinned by the broader culture shift that the Accord agreement will drive.

We recognise that each partner will demonstrate the principles and values of the Accord in ways that reflect their own context, maturity, and capacity.

1. Involve & Devolve

1. **Devolution of power, equity and involvement –** measurable shift of decision-making and resources
2. **More assets in community ownership**
3. **Shared participatory approaches systematically included**. These include co-design, co-production and co-delivery. The voice of lived experience in policy making principles created by GM=EqAl used as a best practice benchmark.
4. **Increased VCFSE involvement in decision making, steering group, programme and formal governance spaces** such as public sector boards with additional support via VCFSE networks.

2. Resource & Enable

1. **The Fair Funding Protocol or equivalent** implemented across whole of GM
2. Increasing the funding of VCFSE services through also broadening the diversity of activities VCFSE organisations are trusted and funded to undertake.

3. **1% community levy** for large public sector contracts
3. Shift of **resources to follow Live Well principles** – e.g. number of Live Well Centres owned by VCFSE sector as a metric
4. **Improved procurement processes** such as improved **Social Value** that gives weight and recognition to inherent social value of VCFSE and a **better use of Provider Selection Regime**
5. More **investment in VCFSE control, with a clear framework** to implement the shift

3. Value & Recognition

1. Improved **measurement and increased use of VCFSE impact data** within the system
2. Recognition of **VCFSE expertise**
3. **Challenging outdated systems together,** whilst addressing power imbalances – e.g., commissioning reform
4. **Increased co-commissioning, grants** and equal commissioning voice for VCFSE organisations
5. **Adoption of 'keep it local' principles,** prioritising local partnerships and investment
6. Enhanced **embedding of co-ops and inclusive economy** into strategy
7. **Public sector staff induction module** about Accord and VCFSE sector, Accord ways of working embedded in job descriptions

Appendix 3 – Named accountability leads table - Phase 1(a) deliverable – as at 1st April 2026

The below should be maintained on a regular **basis** by the officer lead for each signatory*.

Accord Signatory	**Exec Lead** (current post holder)	**Strategic Lead** (current post holder)	**Officer Lead** (current post holder) **Responsible for keeping other names up to date*
NHS GM	**Chief Strategy, People, & Partnerships Officer (CSPPO)** (Charlotte Bailey)	**Director of Strategy** (Paul Lynch)	GM Strategy & Partnerships Lead (Sarah Harris)
GMCA	**Portfolio Holder for Communities. Deputy Chief Executive** (Andrew Lightfoot)	**Head of Policy & Implementation** (Eve Holt)	VCFSE Lead (Jenny Rouse)
VCFSE	**Chair of the GM VCFSE Leadership Group** (Warren Escadale)	**N/A**	GM Programme Manager, GM VCFSE Leadership Group (Anna Cooper)
TfGM			
GM Fire and Rescue Service			
Bolton *Local Authority* *NHS* *LIO*			
Bury *Local Authority* *NHS* *LIO*			
Manchester *Local Authority* *NHS*			

LIO			
Oldham *Local Authority* *NHS* *LIO*			
Rochdale *Local Authority* *NHS* *LIO*			
Tameside *Local Authority* *NHS* *LIO*			
Trafford *Local Authority* *NHS* *LIO*			
Salford *Local Authority* *NHS* *LIO*			
Stockport *Local Authority* *NHS* *LIO*			
Wigan *Local Authority* *NHS* *LIO*			
Accord Signatory			
Accord Signatory			
Accord Signatory			
Accord Signatory			

NHS
Greater Manchester

Report from:	**Finance Committee**
Date of Meeting:	February 2026
Chair:	Kal Kay
Quoracy Achieved:	Yes

Key escalations and discussion points from the meeting:

Alert
GM Month 10 Financial Position - The committee's discussion of the Greater Manchester (GM) Month 10 Financial Position addressed the current deficit, underlying trends, and key risks. The paper reported a system-wide deficit of £24.8 million against plan, with NHS GM itself in line with its planned deficit of £6.3 million, but providers showing a larger variance. Although the provider deficit had worsened since Month 9, it was noted that the run rate had improved, and gross and net risks had reduced due to focused recovery efforts and slippage in some spending areas. The risk of DSF clawback was considered low, given strong assurance that the system would deliver a balanced or better position by year-end.
Advise
IT Update Report Rationalisation of Software – The Finance Sub-Committee had requested assurance on different software systems currently in operation and how these would be rationalised/streamlined, if they are fit for purpose and whether they represent value for money. This report provided an update on the work to date and ongoing across three work streams: 1. GM ICS-wide systems. 2. GM ICB discretional locality systems. 3. NHS GM IT review of toolsets.
Assure
Finance Recovery Plan Update – Month 10 - The committee's discussion of the Month 10 Financial Recovery Plan Update focused on the progress and challenges in mitigating the system's financial risks. Figures were presented showing mitigations of £27.2 million year-to-date and £47.4 million in the forecast, both reduced from the previous month, indicating some improvement but not full recovery.

ICB Financial Planning - The discussion centred on the submission of a compliant ICB break-even plan for the coming year, supported by £17.7 million in deficit support funding, which was a reduction from the previous year's £42.5 million. The plan's high-risk nature was outlined, with a £150 million CIP target, only £90 million of which was identified at the time, and £129 million in cost pressures, some of which may not be fully spent due to delays or business case requirements. NHS England had flagged the plan as high risk, prompting a scheduled follow-up meeting.
Risks discussed and new risks identified
This paper provided a monthly update on the BAF and the strategic committee risks as identified by the Finance Committee. Amendments made to the context of the risks were highlighted, and it was confirmed that there were no changes to the number or rating of the BAF risks.
Learning for sharing
There were no specific points of learning from the February 2026 meeting.

NHS
Greater Manchester

Finance Sub-Committee Report

18 March 2026

Part of Greater Manchester Integrated Care Partnership

NHS Greater Manchester

Integrated Care Board

18 March 2026

Required information	Details
Title of report	Transition Committee Report
Author	Ross Baxter, Governance Advisor
Presented by	Kal Kay, Non-Executive Director/ Chair of Finance Sub-Committee
Contact for further information	Ross Baxter
Executive summary	To highlight key issues and provide assurance to the Board.
The benefits that the population of Greater Manchester will experience.	N/A
How health inequalities will be reduced in Greater Manchester's communities.	N/A
The decision to be made and/or input sought	The Board is asked to: • Note the contents of the report and provide feedback to the Committee Chair.
How this supports the delivery of the strategy and mitigates the BAF risks	N/A
Key milestones	N/A
Leadership and governance arrangements	Overview of discussions at the Finance Sub-Committee
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 - core information relating to the content and creation of paper

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

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

NHS
Greater Manchester

Month 10 Finance Report

2025-2026

Part of Greater Manchester
Integrated Care Partnership

NHS Greater Manchester

NHS GM Integrated Care Board

18th March 2026

Required information	Details
Title of report	Month 10 Finance Report
Author	Jackie Gardiner – Corporate Director of Operational Finance – Financial Management Sandra Davies – Interim Associate Director of Finance - Corporate & Reporting
Presented by	Kathy Roe – Chief Finance Officer
Contact for further information	Jackie Gardiner – Corporate Director of Operational Finance – Financial Management
Executive summary	The purpose of the report is to update the Board on the overall Month 10 ICS financial position for Greater Manchester as at 31st January 2026.
The benefits that the population of Greater Manchester will experience.	Effective financial management will contribute to the delivery of the ICP strategy and delivery of health and social care services to the population of Greater Manchester.
How health inequalities will be reduced in Greater Manchester's communities.	Effective financial management will support the delivery of the ICP strategy and the focus on commissioning decisions to reduce health inequalities.
The decision to be made and/or input sought	For the System Financial position, the Board is asked to: 1. Note the Month 10 year to date reported financial position for GM ICS of £75.7m deficit, against a planned deficit of £50.9m, resulting in a variance against plan of a £24.8m deficit. 2. Note the in-month improvement in the deficit position, a reduction in the extrapolated run rate for the GM providers of £9.7m (excluding IA costs), a reduction in reported gross risk of £18.4m, a further reduction in net risk of £8.4m for NHS GM as a result of the on-going delivery of recovery plans. 3. Note that whilst there has been adverse performance against the in-month recovery plan for providers, all trusts have confirmed with NHSE that they will deliver plan and manage any remaining financial risk. 4. Note the breakeven forecast outturn position in

	line with NHSE reporting requirements. 5. Note the year-to-date delivery of CIP as at Month 10 of £500.8m against a plan of £496.6m, an over delivery of £4.1m. 6. Note the forecast capital position is expected to deliver in line with allocation. 7. Note the risk to the system wide cash position which continues to be closely monitored. 8. Note that full DSF has been received, and whilst there remains a risk that this is subject to clawback if a balanced position for the system is not delivered, this is low as the system has confirmed that it will deliver the recovery plans and an overall balanced system position. 9. Note the on-going system meetings to provide assurance on the delivery of the overall system financial plan, and to address the current shortfall in CIP delivery and monitor delivery of recovery plans to mitigate reported pressures.
How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks	The report provides an update aligned to the strategic risk to ensure financial balance for GM ICS for 2025/26.
Key milestones	Monthly reporting within 2025/26 Financial Year.
Leadership and governance arrangements	Shared with Chief Officers on 20th February 2026. Presented to Finance Sub Committee on 25th February 2026. Presented to Transition Committee on 4th March 2026. Will be presented to the NHS GM Integrated Care Board on 18th March 2026.
Engagement* to date ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	N/A, part of on-going monthly reporting.
Financial or Legal Implications	N/A as this is the monthly Finance Report.

Table 1 – core information relating to the content or creation of paper

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

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

1. Introduction

1.1 The purpose of the report is to update the Board on the financial position for Greater Manchester as at 31st January 2026.

2. Key Messages

2.1 Plan

The 2025/26 Greater Manchester ICS final plan following the receipt of Deficit Support Funding (DSF) is breakeven, and as previously reported is split £7.5m deficit for NHS GM and a £7.5m surplus for GM providers.

2.2 Month 10 reported position

As at Month 10 the ICS deficit plan is £50.9m, with an actual deficit of £75.7m, which equates to a £24.8m adverse variance to plan, a deterioration of £14.8m compared to last month.

M10 2025/26 ICS Surplus/(Deficit) £m	In Month Plan	In Month Actual	In Month Variance	YTD Plan	YTD Actual	YTD Variance	Full Year Plan	Full Year Forecast	Full Year Variance
GM NHS Providers	£15.7	£0.9	-£14.8	-£44.6	-£69.5	-£24.8	£7.5	£7.5	£0.0
NHS GM	-£0.6	-£0.6	-£0.0	-£6.3	-£6.3	£0.0	-£7.5	-£7.5	£0.0
ICS Total	**£15.1**	**£0.3**	**-£14.8**	**-£50.9**	**-£75.7**	**-£24.8**	**£0.0**	**-£0.0**	**-£0.0**

Key messages of the overall position are:

- Whilst an overall deficit continues to be reported, there has been:
  - a reduction in the extrapolated run rate for the GM providers of £9.7m (excluding IA costs)
  - a reduction in system reported gross risk of £18.4m
  - a further reduction in net risk of £8.4m for NHS GM this month as a result of the on-going delivery of recovery plans
- The YTD provider position is now £24.8m behind plan, a deterioration of £14.8m in month, with the remaining reported pressures mainly relating to the delay in CIP delivery. Whilst there has been a £16.1m adverse performance against the in-month recovery plan forecast trajectory for providers (£13.2m attributed to MFT, £1.6m to NCA), all trusts have confirmed directly with NHSE they will deliver the plan and manage any remaining financial risk.
- NHS GM is reporting a £6.3m YTD deficit this month, which remains in line with the plan. Pressures continue to be reported relating to ADHD, Autism and s117 within Mental Health, due to the continuing issue of backdated invoices being submitted by new providers under Right to Choose. All Age Continuing Care has deteriorated this month, due to new backdated high-cost complex cases, and pressures associated with Independent Sector elective activity and delays in delivery of savings also continue to be reported. Finance Recovery Plans continue to be monitored, and updates indicate that whilst the recovery actions have reduced the level of spend compared to earlier in the year, they haven't delivered the original planned reductions.
- On a YTD basis, CIP delivery is £4.1m ahead of target as a system (£0.2m behind plan by NHS GM, offset by a favourable provider variance of £4.3m). Whilst it is forecast that CIP targets will be met in full, there continues to be a risk to delivery reported by a number of organisations.
- Deficit Support Funding (DSF) has been received up to and including Q4, and whilst there remains a risk that this is subject to clawback if a balanced position for the system is not delivered, this is low as the system has confirmed that it will deliver the recovery plans and an overall balanced system position.
- An increased financial control framework of enhanced grip and control still remains in place to ensure only essential additional expenditure is committed, and on-going scrutiny of the financial

position and delivery of CIP through the System Improvement process continues.

2.3 Efficiencies / CIP

The overall efficiency target for Greater Manchester ICS for 2025/26 is £656.0m, split £175.0m NHS GM and £481.0m GM providers. As at Month 10 providers are £4.3m ahead of the YTD plan. NHS GM is £0.2m behind the YTD plan. Weekly monitoring has now been paused by NHSE NW but there continues to be on-going review to identify efficiency schemes to fully deliver against the £656.0m plan and to provide assurance that schemes are moving into developed and implemented schemes.

2.4 Risk and Mitigations

At Month 10 the ICS gross risk is estimated at £87.6m. £31.0m relates to GM providers and the remaining £56.6m related to the NHS GM financial position. The majority of this relates to risk associated with the delivery of efficiency targets. This is a reduction of £18.4m in the ICS gross risk from Month 9. The GM system is currently assuming that all risk will be fully mitigated, resulting in zero net risk.

2.5 Recovery Plans

At Month 10 the following is noted in terms of progress being made against the individual Finance Recovery Plans:

- AACC is reporting further increased spend in M10 against the trajectory and overall is reporting a deterioration of £1.3m in the forecast position.
- ADHD is reporting an improvement against the trajectory in M10, and the FOT position has remained consistent with M9 at £10.7m.
- Whilst M9 flex data indicates a reduction in activity levels, Independent Sector activity is still estimated as being slightly behind the recovery plan, with the FOT increased to £15.0m this month.
- CIP is reporting as being behind the M10 trajectory, but risk to delivery continues to reduce, and this now also reflects a reduction of net risk to £8.5m reflecting the impact of the VR1 scheme.

Further workforce capacity is still in place to continue to increase the pace of delivery against the recovery plans wherever possible.

2.6 Capital

Overall, YTD spend for provider capital is £220.7m, compared to a plan of £277.9m. Within this total, a system allocation is issued to GM on both internally generated and IFRS 16 capital expenditure, which is currently £200.9m. At this stage, a balanced forecast outturn position is still assumed.

The NHS GM annual capital plan is now £11.2m, £6.6m 'business as usual' capital, £3.8m of Modernisation and Utilisation fund and £0.8m GPIT for ARRS roles. It is expected that all of this will be fully utilised in year.

2.7 Cash

At Month 10 NHS GM had drawn down cash largely in line with the expected straight-line rate of 83.3%. This is mainly due to internal processes to ensure that the ICB meets the cast limit at year end. The allowable cash balance at the end on Month 10 equated to £8.5m with an actual closing balance of £0.5m.

GM providers are £68.9m below the planned cash balance (plan £402.5m), which has decreased since M9. There are continuing concerns with future cash flow for some providers.

The cash position remains challenging for the remainder of the financial year, and NHS GM will continue to actively manage the working capital position, promoting prompt invoicing and collection of debtors, and utilisation of payment terms with creditors to manage the position.

3. Recommendations

3.1 For the System Financial position, the Board is asked to:

- Note the Month 10 year to date reported financial position for GM ICS of £75.7m deficit, against a planned deficit of £50.9m, resulting in a variance against plan of a £24.8m deficit.
- Note the in-month deterioration in the deficit position, however a reduction in the extrapolated run rate for the GM providers of £9.7m (excluding IA costs), a reduction in reported gross risk of £18.4m, a further reduction in net risk of £8.4m for NHS GM as a result of the on-going delivery of recovery plans continue to be reported.
- Note that whilst there has been an adverse performance against the in-month recovery plan for providers, all trusts have confirmed directly with NHSE they will deliver the plan and manage any remaining financial risk.
- Note the breakeven forecast outturn position in line with NHSE reporting requirements.
- Note the year-to-date delivery of CIP as at Month 10 of £500.8m against a plan of £496.6m, an over delivery of £4.1m.
- Note the forecast capital position is expected to deliver in line with allocation.
- Note the risk to the system wide cash position which continues to be closely monitored.
- Note that full DSF has been received, and whilst there remains a risk that this is subject to clawback if a balanced position for the system is not delivered, this is low as the system has confirmed that it will deliver the recovery plans and an overall balanced system position.
- Note the on-going system meetings to provide assurance on the delivery of the overall system financial plan, and to address the current shortfall in CIP delivery and monitor delivery of recovery plans to mitigate reported pressures.

NHS
Greater Manchester

NHS Greater Manchester Finance Slide Pack Month 10 – January 2025

Part of Greater Manchester Integrated Care Partnership

Presented by: Kathy Roe
Date: 18th March 2026

System Financial Position Overview

NHS Greater Manchester

At Month 10 the total ICS year to date deficit is £75.7m, a £24.8m variance behind plan (Month 9: variance of £10.0m), which is a deterioration of £14.8m compared to last month.

M10 2025/26 ICS Surplus/(Deficit) £m	In Month Plan	In Month Actual	In Month Variance	YTD Plan	YTD Actual	YTD Variance	Full Year Plan	Full Year Forecast	Full Year Variance
GM NHS Providers	£15.7	£0.9	-£14.8	-£44.6	-£69.5	-£24.8	£7.5	£7.5	£0.0
NHS GM	-£0.6	-£0.6	-£0.0	-£6.3	-£6.3	£0.0	-£7.5	-£7.5	£0.0
ICS Total	**£15.1**	**£0.3**	**-£14.8**	**-£50.9**	**-£75.7**	**-£24.8**	**£0.0**	**-£0.0**	**-£0.0**

Key points of note for Month 10 are:

- Whilst an overall deficit continues to be reported, there has been:
  - a reduction in the extrapolated run rate for the GM providers of £9.7m (excluding IA costs)
  - a reduction in system reported gross risk of £18.4m
  - and a further reduction in net risk of £8.4m for NHS GM this month as a result of the on-going delivery of recovery plans
- The YTD provider position is now £24.8m behind plan, a deterioration of £14.8m in month, with the remaining reported pressures still mainly relating to the delay in CIP delivery. Whilst there has been a £16.1m adverse performance against the in-month recovery plan forecast trajectory for providers (£13.2m attributed to MFT, £1.6m to NCA), all trusts have confirmed directly with NHSE they will deliver the plan and manage any remaining financial risk.
- NHS GM is reporting a £6.3m YTD deficit this month, which remains in line with the plan. Pressures continue relating to ADHD, Autism and s117 within Mental Health, due to the continuing issue of backdated invoices being submitted by new providers under Right to Choose. All Age Continuing Care has deteriorated this month, due to new backdated high-cost complex cases, and pressures associated with Independent Sector elective activity and delays in delivery of savings also continue to be reported. Finance Recovery Plans continue to be monitored, and updates indicate that whilst the recovery actions have reduced the level of spend compared to earlier in the year, they haven't delivered the original planned reductions.
- On a YTD basis, CIP delivery is £4.1m ahead of target as a system (£0.2m behind plan by NHS GM, offset by a favourable provider variance of £4.3m). Whilst it is forecast that there will be over-delivery against CIP targets, there continues to be a risk to delivery reported by a number of organisations.
- Deficit Support Funding (DSF) has been received up to and including Q4, and whilst there remains a risk that this is subject to clawback if a balanced position for the system is not delivered, this is low as the system has confirmed that it will deliver the recovery plans and an overall balanced system position.
- An increased financial control framework of enhanced grip and control still remains in place to ensure only essential additional expenditure is committed, and on-going scrutiny of the financial position and delivery of CIP through the System Improvement process continues.

Note: *all numbers are rounded to nearest £0.1m. This may result in small discrepancies when adding together columns/rows or reviewing variances in the table. But all values presented are* calculated using precise values, before rounding is applied.

Key Metrics Dashboard

NHS Greater Manchester

2025/26 ICS Key metrics £m	YTD Budget M10	YTD Actual M10	YTD Variance M10	Full Year Budget/ Allocation	Full Year Forecast	Full Year Variance	RAG
Financial position - NHS GM	-£6.3	-£6.3	£0.0	-£7.5	-£7.5	£0.0	G
Financial position - Provider	-£44.6	-£69.5	-£24.8	£7.5	£7.5	£0.0	A
Financial position - ICS	**-£50.9**	**-£75.7**	**-£24.8**	**£0.0**	**£0.0**	**£0.0**	G
CIP	£496.6	£500.8	£4.1	£656.0	£656.9	£0.9	G
Agency (provider) *	£47.6	£53.6	-£6.0	£55.7	£62.5	-£6.8	G*
Capital - NHS GM	£6.2	£6.2	£0.0	£11.2	£11.2	£0.0	G
Capital - Provider (CDEL)	£277.9	£220.7	£57.2	£396.0	£393.5	£2.5	G
Capital - ICS	**£284.1**	**£226.9**	**£57.2**	**£407.2**	**£404.7**	**£2.5**	G
Cash (provider)	£402.5	£333.5	-£69.0	£427.9	£289.7	-£138.2	A
Key metrics - ICB only							
MHIS (excluding LD & Dementia)	£690.9	£690.9	£0.0	£829.1	£829.1	£0.0	G
Delegated Specialised Commissioning MHIS **	£99.5	£99.5	£0.0	£119.1	£119.1	£0.0	G
Running costs	£45.9	£45.9	£0.0	£74.0	£74.0	£0.0	G

	NHS	Non NHS
BPPC Target Achieved (out of 10 ICS organisations)	6	7

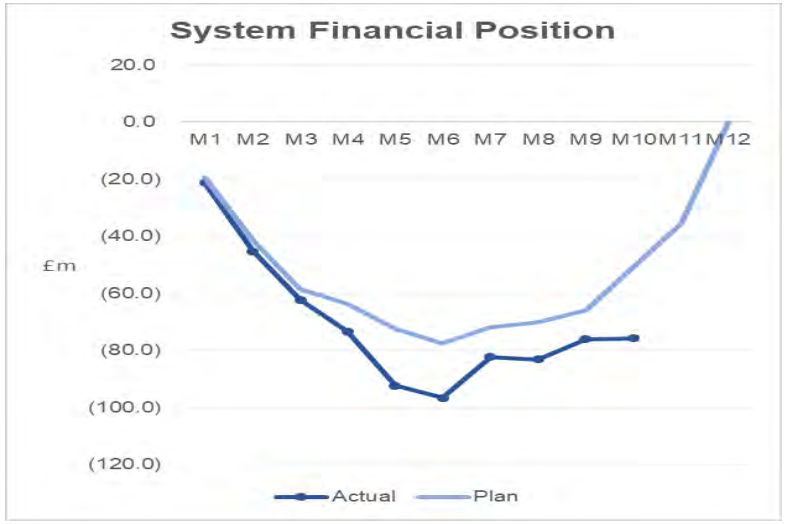
*Whilst agency (provider) spend is above plan, this is currently within the Agency Ceiling Cap
**NHSE have not yet updated the SCMHIS target from £109.4m to £119.1m which reflects the additional allocations in year, the table above is reflective of the allocations received and forecast spend.

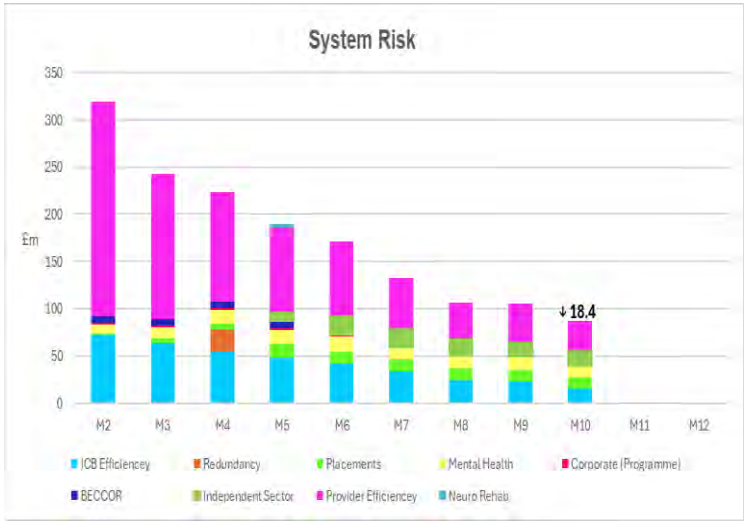
Note: *all numbers are rounded to nearest £0.1m. This may result in small discrepancies when adding together columns/rows or reviewing variances in the table. But all values presented are* calculated using precise values, before rounding is applied.

Key Metrics

Analysis

NHS Greater Manchester





System Financial Position

- The M10 YTD position for the GM NHS System is a £24.8m deficit against plan and is split as follows:
  - £0.0m NHS GM (Month 9: £0.0m)
  - £24.8m GM Providers (Month 9: £10.0m)
- The GM system continues to report a forecast breakeven position as per the 2025/26 plan and in line with NHSE reporting requirements, although risks to delivery are noted.
- There continues to be an improvement in the extrapolated run rate compared to M9.

System Risk

- The total gross risk has been estimated at £87.6m at M10. This is a further decrease of £18.4m from M8. Of the total:
  - £31.0m relates to providers.
  - £56.6m relates to NHS GM.
- The majority of this relates to risk associated with the delivery of efficiency targets.
- The GM system is currently reporting that all risk will be fully mitigated, resulting in zero net risk.

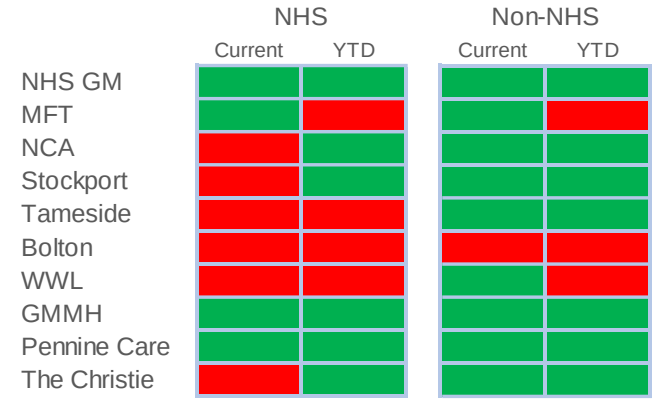
System Efficiency

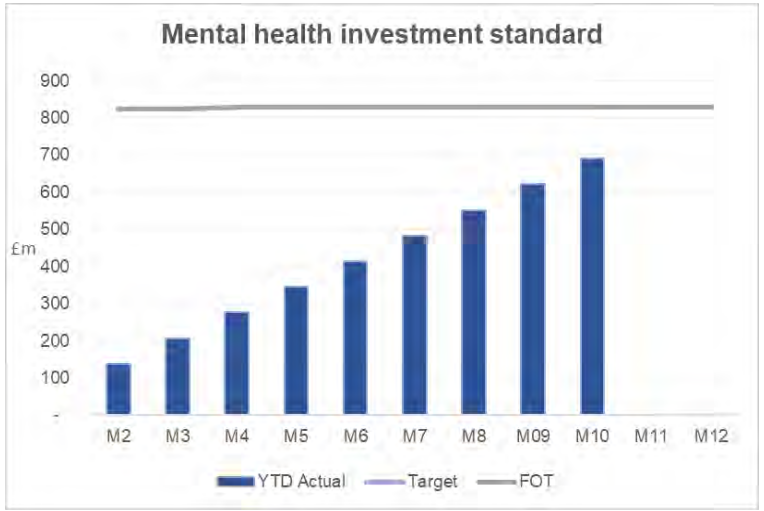
- The chart above details the savings delivered against an overall system savings target of £656.0m
- YTD savings of £500.8m have been delivered against a target of £496.6m, of which 58.4% has been delivered recurrently. Delivery is currently £4.1m ahead of plan YTD.
- The full year target of £656.0m is forecast to be exceeded by £0.9m, albeit with risks still being reported.

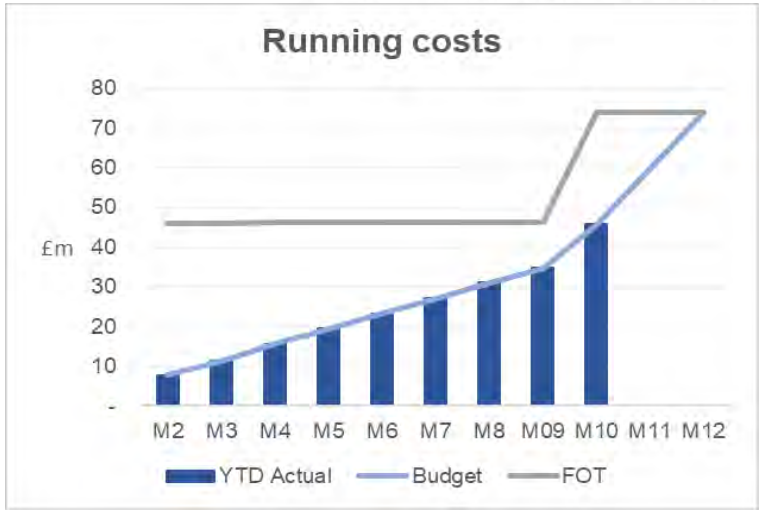
Key Metrics

Analysis

NHS Greater Manchester







System Better Payment Practice Code

- BPPC is monitored on the YTD performance, and currently 6 organisations are meeting the target relating to NHS organisations.
- Out of the 4 of the organisations not meeting the NHS targets in M9, 1 (Bolton) has worsened their performance from the previous month, a worsening of 1.7%. MFT has improved their performance by 2.5% from the previous month
- 7 organisations are meeting the target for YTD achievement for Non-NHS organisations.
- For the remaining 3 organisations not achieving the Non-NHS target, both Bolton, 0.9% and MFT, 0.8%, are reporting a deterioration since M9.

Mental Health Investment Standard

- There are 2 targets relating to the Mental Health Investment Standard (MHIS) which are reported and monitored separately and not combined.
- The core MHIS target requires NHS GM to spend £829.1m on mental health provision in 2025/26.
- In addition, there is a Specialised Commissioning MHIS (SCMHIS) target of £109.4m. This target has not been updated to reflect the additional allocations received in-year, which now totals £119.1m.
- At Month 10 NHS GM is reporting expenditure in line with both plans.

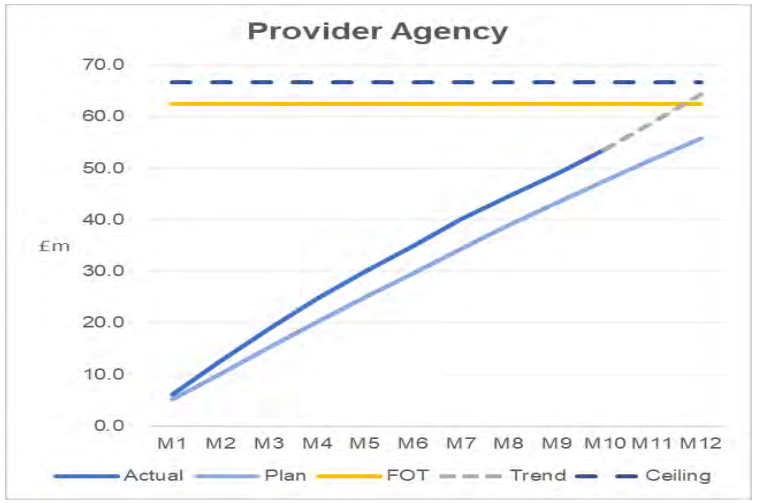
NHS GM Running costs

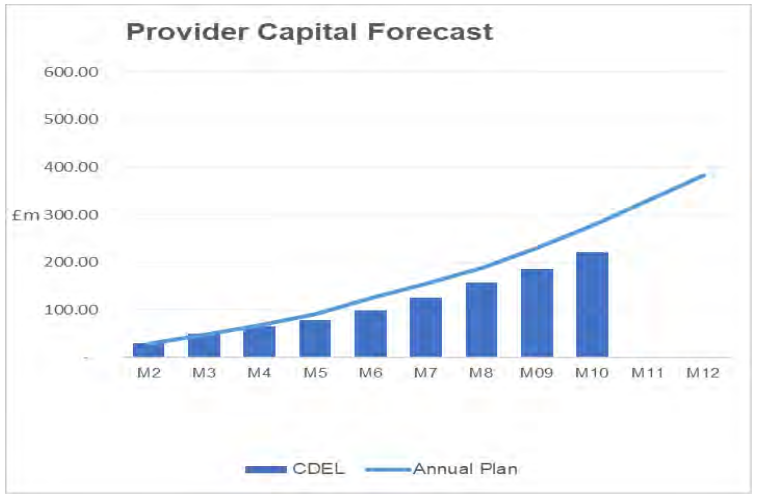
- The YTD running cost allowance for NHS GM at M10 is £45.9m and spend is being reported in line with the plan.
- It is expected that NHS GM will achieve the running cost target and is currently reporting a balanced position in the forecast.
- Whilst plans have now commenced again regarding the NHS Reforms, estimated costs of redundancy and savings which will be delivered this financial year have now been factored into the financial position.

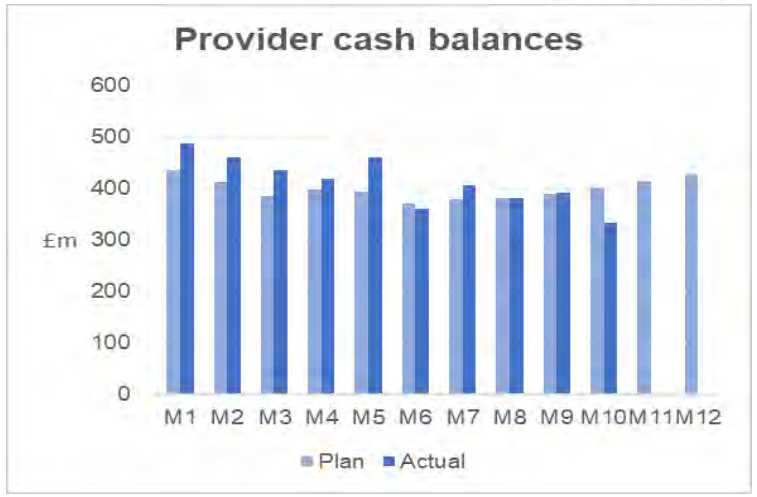
Key Metrics

Analysis

NHS Greater Manchester







Provider Agency

- The M10 YTD agency spend for GM providers is £53.6m which is £6.0m above the plan of £47.6m.
- At present a forecast of £62.5m is expected, which is higher than the plan of £55.7m, but this remains under the 2025/26 agency ceiling set at £66.7m.

Capital

- The chart above shows the entirety of the provider plan for the Capital Departmental Expenditure Limit (CDEL) including internally generated, IFRS 16 (leases) and PDC which totals £396.0m. Forecast capital expenditure is £393.5m. YTD spend for provider capital is £220.7m, which is below the plan of £277.9m.
- Within this total there is a system allocation of £200.9m issued to GM providers for both internally generated and IFRS 16 capital expenditure. Actual spend of £200.5m is forecast, an underspend of £0.4m against allocation, which will be managed as part of the Q4 process.
- The NHS GM annual capital allocation remains at £11.2m, with the expectation that all of this will be fully utilised in year.

Cash

- GM providers (as shown in the chart above) are £68.9m below the planned cash balance (plan: £402.5m, actual: £333.5m).
- At M10 NHS GM had drawn down cash largely in line with the expected straight-line profile (83.3%), which is due to internal processes to ensure that the ICB meets the cash limit at year end. The allowable cash balance at the end of M10 equated to £8.5m, with an actual closing balance of £0.5m.
- The cash position remains challenging for the rest of the year, and NHS GM will continue to actively manage the system working capital position, promoting prompt invoicing and collection of debtors, and utilisation of payment terms with creditors.

System Financial Position

System Efficiencies

NHS Greater Manchester

2025/26 System CIP Savings January 2026 £m	Forecast Outturn Recurrent/Non Recurrent Split		M10 YTD Plan	M10 YTD Actual	M10 YTD Variance	Full Year Plan	Full Year Forecast	Full Year Variance
	Recurrent	Non Recurrent						
ICB Savings	65%	35%	£142.7	£142.5	-£0.2	£175.0	£175.0	£0.0
Breakdown by Provider								
Manchester University NHS Foundation Trust	54%	46%	£115.5	£123.6	£8.1	£165.8	£165.8	£0.0
Northern Care Alliance NHS Foundation Trust	54%	46%	£76.1	£85.4	£9.3	£110.0	£110.9	£0.9
Stockport NHS Foundation Trust	79%	21%	£23.7	£25.0	£1.3	£29.2	£29.2	£0.0
Tameside and Glossop Integrated Care NHS Foundation Trust	65%	35%	£20.4	£20.9	£0.6	£25.3	£25.3	£0.0
Bolton NHS Foundation Trust	66%	34%	£25.6	£13.2	-£12.3	£36.9	£36.9	£0.0
Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust	48%	52%	£31.6	£27.8	-£3.8	£38.4	£38.4	£0.0
Greater Manchester Mental Health NHS Foundation Trust	87%	13%	£25.6	£25.7	£0.1	£32.5	£32.5	£0.0
Pennine Care NHS Foundation Trust	46%	54%	£14.6	£15.7	£1.1	£17.5	£17.5	£0.0
The Christie NHS Foundation Trust	45%	55%	£21.0	£21.0	£0.0	£25.3	£25.3	£0.0
GM Provider Savings	58%	42%	£354.0	£358.3	£4.3	£481.0	£481.9	£0.9
Total Efficiencies	60%	40%	£496.6	£500.8	£4.1	£656.0	£656.9	£0.9

- On a YTD basis, delivery is £4.1m ahead of target as a system:
  - £0.2m adverse NHS GM variance, offset by
  - £4.3m favourable GM provider variance
- As a system it is forecast that CIP targets are expected to be exceeded by £0.9m by the end of the year, albeit with remaining associated risk.

Note: *all numbers are rounded to nearest £0.1m. This may result in small discrepancies when adding together columns/rows or reviewing variances in the table. But all values presented are calculated using precise values, before rounding is applied.*

System Financial Position

Cash Position

NHS Greater Manchester

The latest cash position for the ICS as at M10 is shown in the following table:

M10 2025/26 ICS Cash Position £m and Operating Cash Days	M10 Actual	M11 Forecast	M12 Forecast	M10 Operating Cash Days Forecast	M11 Operating Cash Days Forecast	M12 Operating Cash Days Forecast
Manchester University NHS Foundation Trust	£7.0	£18.1	£9.5	0	2	1
Northern Care Alliance NHS Foundation Trust	£29.8	£33.8	£10.2	5	6	2
Stockport NHS Foundation Trust	£32.9	£41.1	£29.5	24	29	23
Tameside And Glossop Integrated Care NHS Foundation Trust	£9.7	£8.3	£6.0	10	8	6
Bolton NHS Foundation Trust	£6.0	£4.7	£2.6	4	3	2
Wrightington, Wigan and Leigh NHS Foundation Trust	£7.0	£15.0	£9.2	4	9	6
Greater Manchester Mental Health NHS Foundation Trust	£67.6	£72.9	£61.1	47	47	44
Pennine Care NHS Foundation Trust	£55.3	£53.7	£52.2	60	55	59
The Christie NHS Foundation Trust	£118.4	£115.9	£109.3	78	75	78
Total GM NHS Provider Total*	**£333.5**	**£363.4**	**£289.7**			
NHS GM*	£0.5					
Total GM ICS	**£334.0**					

* For NHS GM, the ICB work to an allowable cash balance set by NHSE which was £8.5m (1.25%) for M10, with an actual closing balance of £0.5m

Recommendations

Month 10

NHS Greater Manchester

For the System Financial position, the Board is asked to:

- Note the Month 10 year to date reported financial position for GM ICS of £75.7m deficit, against a planned deficit of £50.9m, resulting in a variance against plan of a £24.8m deficit.
- Note the in-month deterioration in the deficit position, however a reduction in the extrapolated run rate for the GM providers of £9.7m (excluding IA costs), a reduction in reported gross risk of £18.4m, a further reduction in net risk of £8.4m for NHS GM as a result of the on-going delivery of recovery plans continue to be reported.
- Note that whilst there has been adverse performance against the in-month recovery plan for providers, all trusts have confirmed with NHSE that they will deliver plan and manage any remaining financial risk.
- Note the breakeven forecast outturn position in line with NHSE reporting requirements.
- Note the year-to-date delivery of CIP as at Month 10 of £500.8m against a plan of £496.6m, an over delivery of £4.1m.
- Note the forecast capital position is expected to deliver in line with the allocation.
- Note the risk to the system wide cash position which continues to be closely monitored.
- Note that full DSF has been received, and whilst there remains a risk that this is subject to clawback if a balanced position for the system is not delivered, this is low as the system has confirmed that it will deliver the recovery plans and an overall balanced system position.
- Note the on-going system meetings to provide assurance on the delivery of the overall system financial plan, and to address the current shortfall in CIP delivery and monitor delivery of recovery plans to mitigate reported pressures.

NHS
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Appendix - Individual Organisation Reported Positions

NHS GM Financial Position

Month 10

NHS Greater Manchester

The financial summary for NHS GM by expenditure type as at Month 10 is shown in the table below:

NHS GM Financial Position £m	In Month Plan	In Month Actual	In Month Variance	In Month Variance %	YTD Plan	YTD Actual	YTD Variance	YTD Variance %	Full Year Plan	Full Year Forecast	Full Year Variance	Full Year Variance %	M09 Full Year Variance	Change in Forecast M09 to M10
Allocations	£787.9	£787.9	£0.0	0.0%	£7,702.9	£7,702.9	£0.0	0.0%	£9,346.9	£9,346.9	£0.0	0.0%	£0.0	£0.0
Admin														
Running Costs	£11.0	£11.0	£0.0	0.0%	£45.9	£45.9	£0.0	0.0%	£74.0	£74.0	£0.0	0.0%	£0.0	£0.0
Total Admin	£11.0	£11.0	£0.0	0.0%	£45.9	£45.9	£0.0	0.0%	£74.0	£74.0	£0.0	0.0%	£0.0	£0.0
Programme														
Mental Health	£81.4	£80.0	£1.4	1.7%	£818.5	£826.9	-£8.3	-1.0%	£983.1	£989.5	-£6.4	-0.7%	-£7.6	£1.2
Acute	£364.3	£366.2	-£1.9	-0.5%	£3,523.1	£3,541.2	-£18.1	-0.5%	£4,246.6	£4,264.5	-£17.9	-0.4%	-£16.5	-£1.4
Specialised Commissioning	£82.7	£82.8	£0.0	0.0%	£831.0	£831.1	£0.0	0.0%	£997.8	£997.9	£0.0	0.0%	£0.0	£0.0
Primary Care	£9.0	£8.9	£0.1	1.5%	£85.9	£83.6	£2.3	2.7%	£104.2	£101.0	£3.2	3.1%	£3.2	-£0.0
GP Medical, Pharmacy, Dental and Optometry	£92.5	£93.3	-£0.9	-0.9%	£893.1	£892.6	£0.5	0.1%	£1,077.3	£1,076.8	£0.5	0.0%	£0.4	£0.1
Prescribing	£52.8	£51.2	£1.6	3.0%	£503.3	£501.5	£1.8	0.4%	£599.4	£596.4	£3.0	0.5%	£2.7	£0.3
All Age Continuing Healthcare	£23.4	£24.1	-£0.7	-3.0%	£241.4	£248.9	-£7.5	-3.1%	£287.4	£296.3	-£8.9	-3.1%	-£7.6	-£1.3
Community Health Services	£65.8	£66.2	-£0.3	-0.5%	£661.7	£663.3	-£1.6	-0.2%	£793.0	£792.9	£0.1	0.0%	£0.2	-£0.1
Programme Operating Costs	£5.6	£5.1	£0.6	10.5%	£81.4	£79.1	£2.2	2.7%	£97.0	£95.2	£1.8	1.8%	£0.7	£1.1
Other expenditure	£0.0	£0.1	-£0.1	-524.4%	-£2.1	-£1.9	-£0.2	9.7%	£1.3	£2.2	-£0.9	-67.7%	-£1.0	£0.1
Earmarked commitments	-£0.1	-£0.3	£0.2	-217.4%	£26.1	-£2.9	£29.0	111.1%	£93.3	£67.8	£25.5	27.4%	£25.5	£0.0
Total Programme	£777.5	£777.5	£0.0	0.0%	£7,663.3	£7,663.3	£0.0	0.0%	£9,280.4	£9,280.4	-£0.0	0.0%	-£0.0	£0.0
Total Expenditure	**£788.5**	**£788.5**	**£0.0**	**0.0%**	**£7,709.2**	**£7,709.2**	**£0.0**	**0.0%**	**£9,354.4**	**£9,354.4**	**£0.0**	**0.0%**	**£0.0**	**£0.0**
Surplus / (Deficit)	**-£0.6**	**-£0.6**	**£0.0**		**-£6.3**	**-£6.2**	**£0.0**		**-£7.5**	**-£7.5**	**£0.0**		**£0.0**	**£0.0**

- Key Drivers:
  - Mental health pressures relating to ADHD, Autism and s117.
  - Increased costs associated with All Age Continuing Care.
  - Increased Elective activity, particularly in the IS sector, although whilst M9 flex activity data does indicate a reduction in activity levels, it is not at the pace required.
  - Delays in the identification of savings for a number of schemes, but with delivery and implementation improving.
  - Offset partially with some areas of under spend in the overall position.

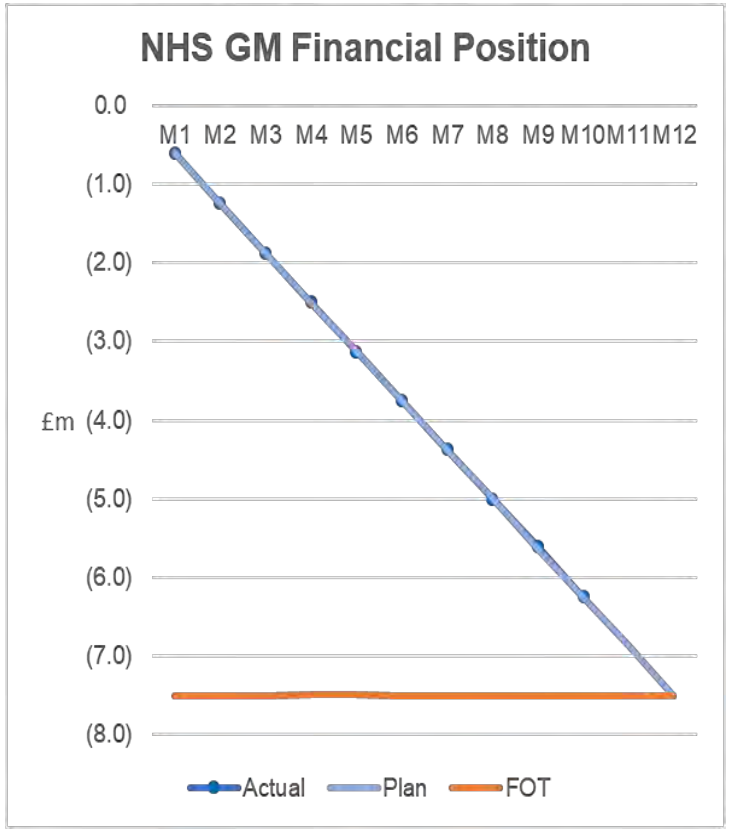
NHS GM Key Messages

Month 10

NHS Greater Manchester

Key Area	Month 10 Overview
Financial position	NHS GM is reporting a £6.3m YTD deficit which is in line with the plan.
Risk	At M10 the reported gross risk relating to NHS GM is estimated to be £56.6m, a reduction of £8.4m compared to M9, which includes the risk associated with delivery of efficiency targets of £15.9m. Other risks relate to pressures associated with Mental Health, increased Independent Sector activity and Placements.
CIP	CIP delivery remains behind plan by £0.2m at Month 10, which is an improvement since M9, with £142.5m delivered against a plan of £142.7m. Of this 64.1% has been delivered recurrently. The forecast CIP position is £175.0m which is in line with plan, although there is associated risk with the delivery of remaining schemes.
Key variance: Acute	The YTD M10 overspend is £18.1m, which is mainly as a result of the expected impact of contract over performance and a continuing delay in delivery of CIP. In relation to IS overperformance, and as a part of the recovery plan, Indicative Activity Plans (IAPs) have been issued to all IS providers, but these are not reducing activity at the pace required.
Key variance: Mental Health	The YTD M10 overspend is £8.3m which reflects an improvement on the position reported at M9 of £9.6m which is due largely to the continued reduction in acute OAPs and spot placements. However, there are on-going pressures for ADHD, Autism and s117. Whilst the recovery plan has been developed, with specific plans in place to reduce the on-going implications of Right to Choose, increased costs have materialised again this month as a result of new providers and backdated invoices being submitted.
Key variance: All Age Continuing Healthcare	YTD All Age Continuing Healthcare is overspending by £7.5m, which is a mix of further increase in the number of high-cost cases, fast tracks and fully funded cases. The FOT has also deteriorated to £8.9m.

The chart below shows the changes in YTD position for NHS GM:



GM NHS Provider Financial Position | Month 10

NHS Greater Manchester

As at Month 10, including receipt of DSF, a £69.5m deficit is reported by the providers, £24.8m worse than plan. The surplus forecast of £7.5m is in line with plan. Excluding receipt of DSF a £200.7m YTD deficit is reported and a £150m forecast deficit.

2025/26 GM Providers Income Statement £m	Including DSF			Excluding DSF		Including DSF			Excluding DSF	
	YTD Plan	YTD Actual	Variance	DSF YTD	YTD Actual	Full Year Plan	Full Year Actual	Variance	DSF FY	Full Year Actual
Income	£6,976.9	£7,131.3	£154.4	£131.2	£7,000.0	£8,388.7	£8,594.6	-£205.9	£157.5	£8,231.2
Pay	-£4,484.4	-£4,610.7	-£126.2		-£4,610.7	-£5,356.3	-£5,520.9	£164.7		-£5,356.3
Non-Pay	-£2,433.4	-£2,505.4	-£72.0		-£2,505.4	-£2,900.4	-£2,966.3	£65.8		-£2,900.4
Non Operating Items	-£103.7	-£84.7	£19.0		-£84.7	-£124.5	-£99.9	-£24.6		-£124.5
TOTAL Provider Surplus/(Deficit)	**-£44.6**	**-£69.5**	**-£24.8**	**£131.2**	**-£200.7**	**£7.5**	**£7.5**	**£0.0**	**£157.5**	**-£150.0**
Surplus/Deficit Breakdown										
Manchester University NHS Foundation Trust	-£14.3	-£25.5	-£11.2	£0.0	-£25.5	£0.0	£0.0	£0.0	£0.0	£0.0
Northern Care Alliance NHS Foundation Trust	-£15.7	-£14.9	£0.7	£48.2	-£63.2	£0.0	£0.0	£0.0	£57.9	-£57.9
Stockport NHS Foundation Trust	-£7.2	-£7.2	£0.0	£36.0	-£43.2	£0.0	£0.0	£0.0	£43.2	-£43.2
Tameside NHS Foundation Trust	-£8.8	-£8.8	£0.0	£26.5	-£35.2	£0.0	£0.0	£0.0	£31.8	-£31.8
Bolton NHS Foundation Trust	-£5.1	-£17.7	-£12.7	£5.4	-£23.2	£0.0	£0.0	£0.0	£6.5	-£6.5
Wrightington, Wigan and Leigh NHS Foundation Tru	£0.2	-£2.1	-£2.3	£7.4	-£9.5	£0.0	£0.0	£0.0	£8.9	-£8.9
Greater Manchester Mental Health Foundation Trus	£0.0	£0.1	£0.1	£7.7	-£7.6	£0.0	£0.0	£0.0	£9.2	-£9.2
Pennine Care NHS Foundation Trust	£0.0	£0.5	£0.5	£0.0	£0.5	£0.0	£0.0	£0.0	£0.0	£0.0
The Christie NHS Foundation Trust	£6.3	£6.3	£0.0	£0.0	£6.3	£7.5	£7.5	£0.0	£0.0	£7.5
Provider Surplus/(Deficit)	**-£44.6**	**-£69.5**	**-£24.8**	**£131.2**	**-£200.7**	**£7.5**	**£7.5**	**£0.0**	**£157.5**	**-£150.0**

Key messages:

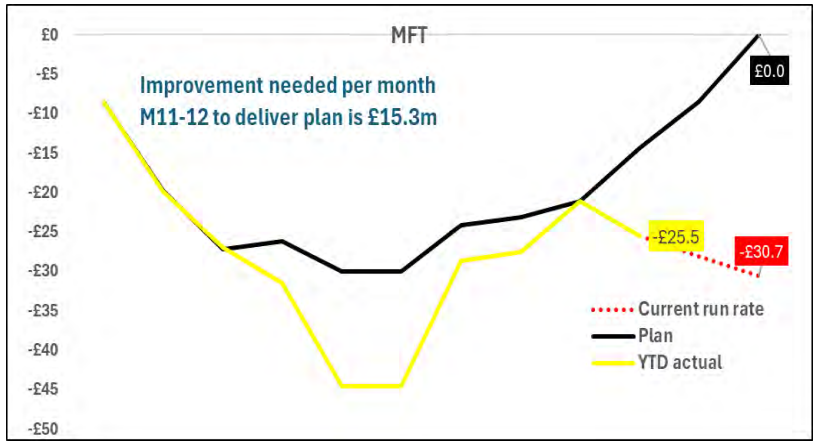
- 3 Providers are reporting adverse variances to plan at Month 10 including DSF, although all providers forecast that they will achieve the 2025/26 plan surplus of £7.5m.
- The main drivers of the YTD variance from plan are:
  - Bolton – Underachievement of CIP
  - WWL – Underachievement of pay CIP

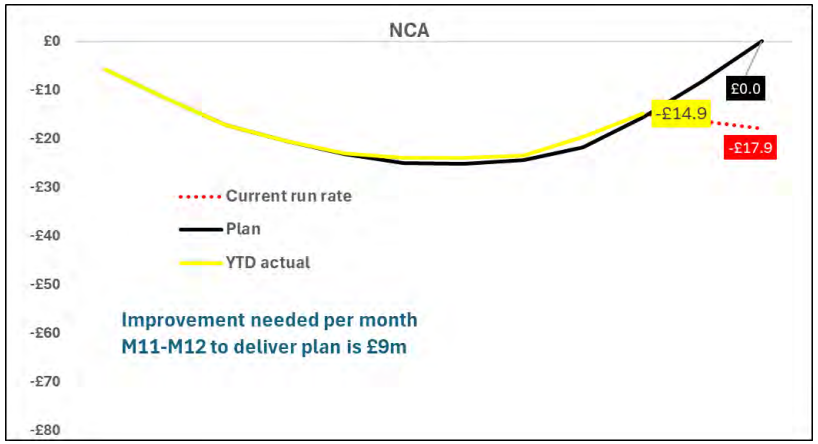
GM NHS Provider Position

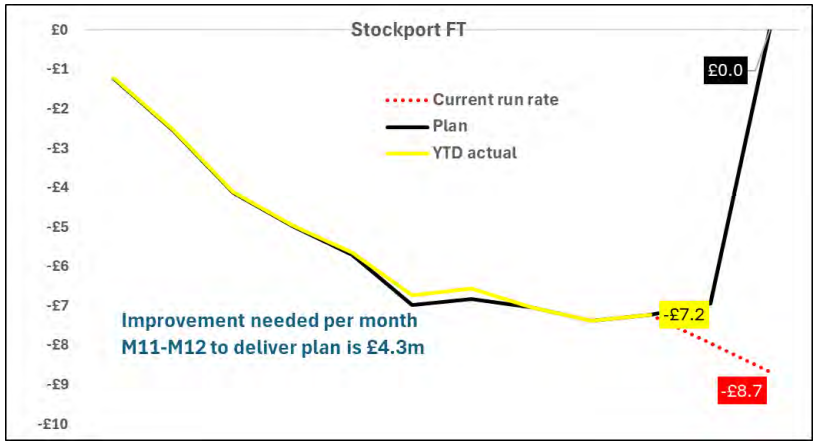
Month 10

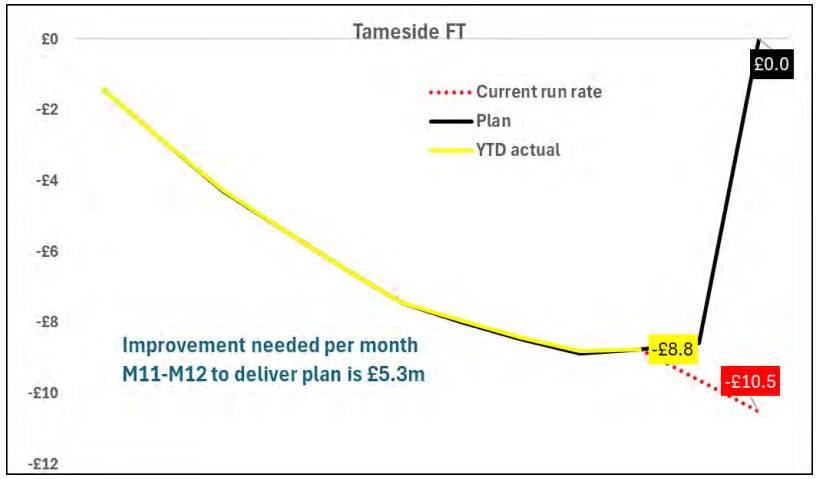
NHS Greater Manchester

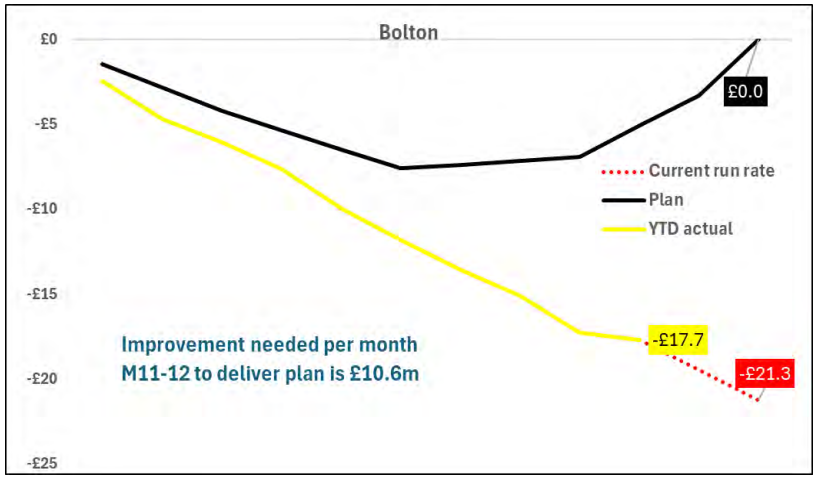
The following slides show the I&E summary and run rate by GM NHS provider (Slide 1 of 2)

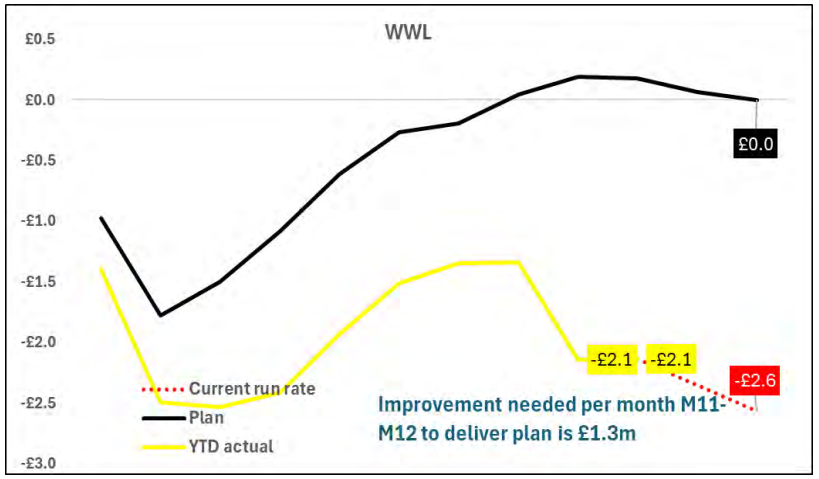










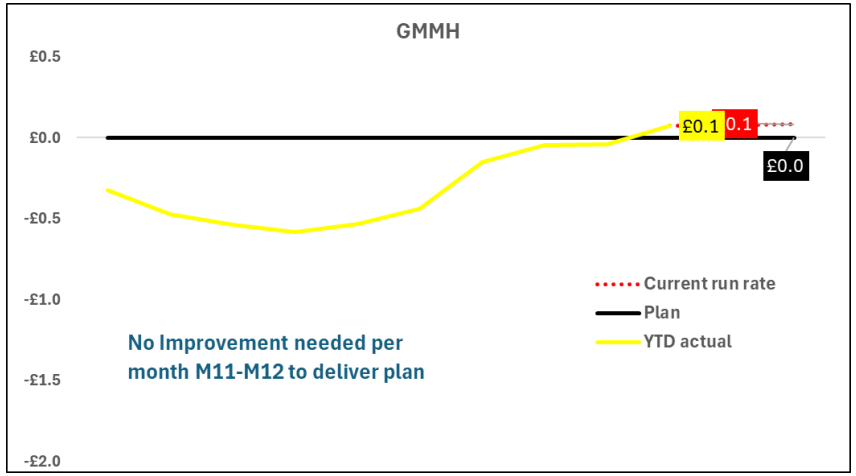


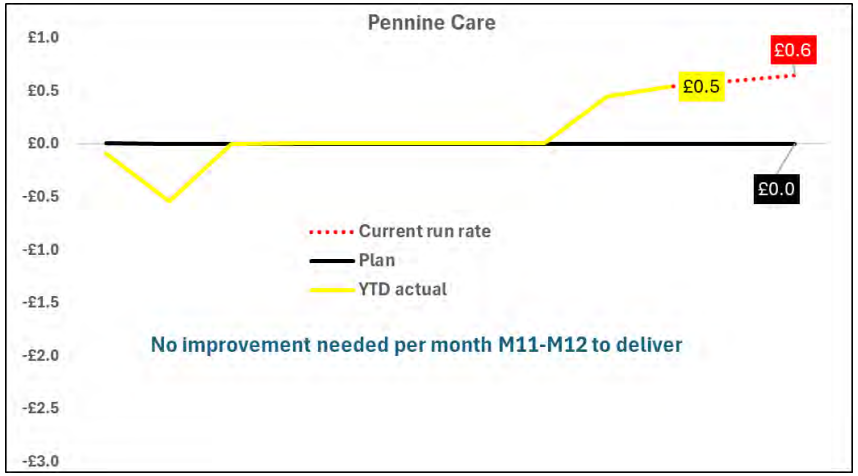
GM NHS Provider Position

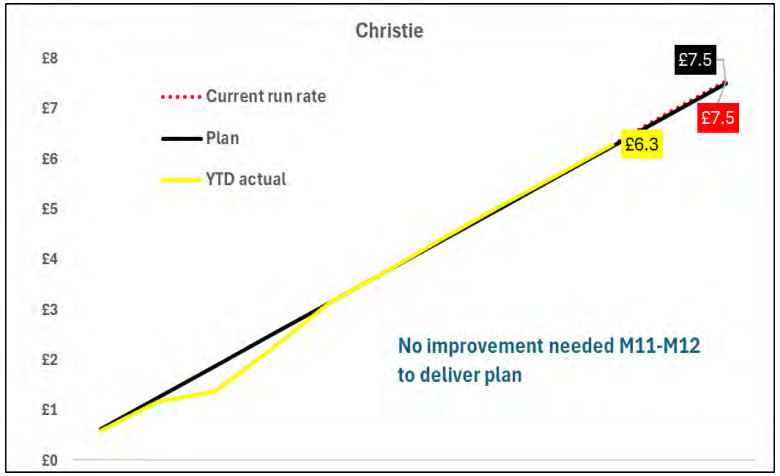
Month 10

NHS Greater Manchester

I&E summary and run rate by GM NHS provider (Slide 2 of 2)







NHS
Greater Manchester

Quality and Performance Board Paper

March 2026

Part of Greater Manchester Integrated Care Partnership

NHS Greater Manchester Board

March 26

Required information.	Details.
Title of report.	Quality and Performance Report
Author.	Zahid Hussain - Performance and Improvement Manager Anita Rolfe, Deputy Chief Nursing Officer Amy Jeffery, Quality Manager
Presented by.	
Contact for further information.	Ed Dyson: *edward.dyson@nhs.net*
Executive summary.	This paper advises the Board on the levels of assurance regarding performance and quality. It is completed using information from localities, system boards and committees within the NHS Greater Manchester (NHS GM) integrated care system. The Board is asked to discuss and agree the levels of assurance set out in this report.
The benefits that the population of Greater Manchester will experience.	The achievement of quality and performance objectives will improve access to services and quality of care for the people of Greater Manchester.
How health inequalities will be reduced in Greater Manchester's communities.	Ensuring delivery of standards across Greater Manchester Services will lessen differences that people may experience in accessing services.
The decision to be made and/or input sought.	The Board / Committee is asked to: 1. Agree the levels of assurance for performance and quality provided in the report.

How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	This supports delivery of operational planning and constitutional standards.
Key milestones.	Monthly and quarterly milestones are in place to delivery performance standards.
Leadership and governance arrangements.	Quality and Performance Committee
Engagement* to date. ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	Engagement is completed within various programmes contributing to both quality and performance delivery. It is not routinely part of preparation of quality and performance reports.
Financial or Legal Implications	Not Applicable

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

Introduction

1.1 This paper advises the Board on the levels of assurance regarding performance and quality. It is completed using information from localities, system boards and committees within the NHS Greater Manchester (NHS GM) integrated care system. The paper highlights material issues for Board. The paper also briefs Board on provider and locality assurance arrangements.

1.2 This report uses the "Assure, Alert and Advise" approach aimed to direct members to the key issues and provide an understanding of the work that is being completed to address these issues.

ALERT: Alert to matters that require escalation for the board's attention or action
ADVISE: Advise of areas of ongoing monitoring or development
ASSURE: Inform the board where assurance has been achieved

1.3 The Board is asked to discuss and agree levels of assurance set out in this report.

Performance

1.4 This section highlights current performance against key deliverables. It references the most recent published data but also highlight more up to date but unvalidated data or forecasts where we have it.

Alert

1.5 In February, 67.6% of patients attending A&E were admitted, transferred, or discharged within **four hours.** Performance was worse than February plan and a 0.2% deterioration compared to the same period last year. Unvalidated data for 8th March 26 shows performance at 72.3%, which is currently worse than the March requirement to reach 78%. As it is the last month of the financial year, the actions to increase performance are largely tactical. These include: additional focus on reducing breach risk in the 4- 4 ½ hour time range, focus on non admitted patients and increased patient tracking in departments. The ICB has weekly meetings with each of the Trust Chief Operating Officers to review progress and actions at a site level. Moving into the new financial year the ICB is working with each Trust, and Place partners, to develop robust plans to demonstrate sustained improvement toward the March '27 target of 82%. Whilst being challenged, the Greater Manchester system has shown sustained improvement over the last three years.

1.6 In February, 12.1% of patients waited **over 12 hours** for admission or discharge from a type 1 emergency department, which was worse than the February plan of 7.6%. Achieving 7.5% at the end of March will be a challenge. Unvalidated data for 8th March shows performance of 9.5% which shows a positive improvement on February. Actions relating to breach avoidance are consistent with those in place for four hour waits. In addition a focus on delays for mental health patients is in place.

1.7 GM Trusts are reporting 23 patients waiting over **65 weeks** for treatment at the end of February. All breaches are at Wrightington, Wigan and Leigh NHS Foundation Trust (WWL). The forecast for the end of March is zero breaches. There is an intense focus on all referral treatment standards, including: no more than 1% of waiting list exceeding 52 weeks and over 61% of people waiting less than 18 weeks. There is weekly review of elective activity against plan, reduction in waiting list and increase in 18 week performance. People at risk of 65 week wait breaches are being overseen by Trusts on a case by case basis. NHSE has provided funding to Trusts to deliver additional activity with a view to overachieving the 18 week target.

1.8 The **average length of stay** in a mental health acute inpatient bed for adults and older adults discharged in the three months to December 25, was 67 days for GM registered patients, which was worse than the December plan of 60.2. The plan is to reduce to 57 days by March 26. The LoS is measured at the date of discharge. Therefore as a number of long stay patients have been discharged this has affected performance against the plan. It is important to note that it is positive that patients who have been in an inpatient setting for a long time have been discharged. We are unlikely to meet the target for 2025/26.

Advise

1.9 In December, 2.3% of the patients in GM Trusts were waiting over **52 weeks** for treatment, worse than the December plan of 1.8%. Unvalidated data for the week ending 1st March shows GM Trusts at 2.2%. Additional NHSE funding has been made available to Trusts in quarter four to support delivery of the end of March plan of no more than 1% over 52 weeks. As of the 9th of March, GM providers are forecasting to reach 1.45% but this could change over the coming weeks.

1.10 In January, 55.9% of GM Trust patients were waiting less than **18 weeks for treatment,** which was behind the January plan of 59%. The GM plan is to achieve 61% by March 26. Additional NHSE funding to Trust in quarter four will support delivery of the plan. As of the 9th of March, GM providers are forecasting to reach 61% but this could change over the coming weeks.

1.11 In January, 62.4% of elective patients in GM Acute Trusts were waiting less than **18 weeks for a first appointment**, which was behind the January plan. The GM target is to increase to 68% by March 26.

1.12 In December 76.6% of **cancer** patients received treatment within **62 days**, better than December plan. Local data shows GM is forecast to be better than plan in January. However, performance is expected to drop to 72.95% in February, which is worse than February plan of 73.5%. The target increases to 75% by March 26.

1.13 At the end of December, 16.6% of patients were waiting more than six weeks for a **diagnostic test** at GM NHS providers. This is a 2.1% deterioration from previous month. Local targets have been set with providers. GM benchmarks favourably in December compared to other ICBs, ranked 7th best performing out of the 42 ICBs. This metric is no

longer an operational planning metric, but GM will continue to closely monitor performance to ensure it does not have an adverse impact on the national cancer and elective targets.

1.14 At the end of December, there were 50 adults with **autism** (with no learning disability) in an inpatient bed, achieving the quarter three plan of no more than 53 adults. However, delivering the year-end plan of 39 will be challenging. Published data for LD metrics are rounded to nearest 5 prevent identification of vulnerable individuals

Assure

1.15 GM continues to achieve the 30-minute target for **Category 2** ambulance calls. In February, the average response time was 23 minutes and 27 seconds.

1.16 GM providers were better than plan for the **cancer faster diagnosis** with 79.7% diagnosed within 28 days in December 25. Local data shows GM is forecast to be better than plan for January and performance is forecast to improve in February to 81.7%, exceeding plan. The target is 80% by March 26.

1.17 The number of **children and young people accessing mental health** services in the 12 months to December 2025 was 55,425, which was better than the November plan of 55,000.

1.18 At the end of December, there were 45 adults with a **learning disability** (and may also be autistic) in an inpatient bed, achieving the quarter three target of no more than 54 adults. Published data for LD metrics are rounded to nearest 5 prevent identification of vulnerable individuals. Larger numbers are also rounded to ensure uniformity across the national datasets.

Quality Update

System Improvement Board Updates

2. Segment 4 Oversight – Greater Manchester Mental Health NHS Foundation Trust (GMMH)

2.1 The independent assurance review confirms that progress has been made across all recommendations from the original 2024 report, but notes it is too early to assess the sustainability or impact of these improvements, particularly given the significant turnover within the Trust's leadership team. The Trust is taking steps to engage staff, service users and carers to ensure that changes to strategies, policies and service models reflect real-world experience and support a shift towards a more open, trusting and co-produced culture. It was noted that the Trust has strengthened governance in key areas, including its suicide prevention strategy, ligature reduction work, and the provision of more transparent and coherent information to the Board.

Segment 4 Oversight – The Northern Care Alliance NHS Foundation Trust (NCA)

2.2 Northern Care Alliance's Salford Surgical Services have been rated Requires Improvement overall in the latest CQC inspection, with inspectors identifying significant concerns across safety, staffing, care quality and governance. As a result, the CQC issued an S29A Warning Notice on 21 October 2025, requiring urgent improvements in safety and governance. The Trust is now finalising an improvement plan, bringing together actions from the Breen Report and the CQC findings, which must be submitted by 13 March. A dedicated Trust working group has been established, with oversight from the NHS England Regional Quality Improvement Group (including the ICB), to monitor delivery, track themes and ensure learning is embedded across services.

2.3 NHS GM are working closely with Specialised Commissioning colleagues to gain assurance from the Trust in relation to haemodialysis services provided across Greater Manchester by the NCA. Assurance meetings have taken place with NHS England and the Trust Executive and an assurance visit was undertaken on Monday 9th March, to ensure that appropriate safety measures are in place following a number of incidents in January 2026.

Key Updates

Alert

2.4 **Paediatric Audiology** remains a system and regional risk. Enacting a model to ensure children, recalled as a result of case reviews across Greater Manchester on 4 sites, have timely access to appropriate treatment is priority and has been put in place in Stockport with a plan to continue across the 3 other sites if required. The commissioning redesign is ongoing and the ICB seeks to mitigate risks through a stratified approach to recall in accordance with priority levels. This remains a risk for the ICB at present – particularly in relation to workforce capacity across ICB, Provider Trusts and Subject Matter Experts. This risk is articulated on the ICB risk register and a collective risk across all 3 North West ICBs has been articulated by the Regional team.

Dr IK Babar and Partners in Rochdale has been rated inadequate by the CQC. There has been significant improvements already made with continued support and monitoring,

Advise

<u>WWL FT – Emergency Department</u>

2.5 The revisit to WWL's Emergency Department identified visible improvements in flow management, digital oversight, and inter-professional working, alongside continued pressures linked to estate constraints and high patient volumes. Corridor care was in use but reduced during the visit, supported by real-time monitoring and strengthened professional standards for decision-making. Safety processes were generally well-embedded, though early-morning visibility of patients in the waiting room requires attention. Positive cultural work was evident through the ASPIRE programme and patient-led initiatives such as the development of a sensory area.

Independent Review of Greater Manchester Community Mental Health Teams

2.6 An independent review of Community Mental Health Teams (CMHTs) across Greater Manchester was commissioned in response to Recommendation 9 of the Shanley Review and has been conducted to provide the ICB and provider boards with a single, evidence-based view of current community mental health functioning. The draft report has been received. Assure

2.7 None to report

Provider Oversight and Assurance

2.8 The Provider Oversight Model continues with the reporting cycle as follows:

2.9 **Provider Oversight Meeting (POM)**: quality and performance assurance continues to be a key feature enabling ICB and Trust executive to-executive discussions to take place and agree any remedial actions or support.

2.10 **Urgent and Emergency Standards of Care Meeting:** ICB chaired meetings to focus on the urgent care system bringing together Trusts and Place leaders to offer additional scrutiny and support to one of the most challenged areas.

Recommendations

2.11 The NHS GM Board is asked to discuss and agree levels of assurance set out in this report:

NHS
Greater Manchester

Primary Care Commissioning Committee

Report of February 2026 meeting

18th March 2026

Part of Greater Manchester Integrated Care Partnership

Greater Manchester Integrated Care Board (Public)

18 March 2026

Report information.

Required information.	Details.
Title of report.	Primary Care Commissioning Committee Report
Authors.	Janna Rigby, Assistant Director Primary Care Operations Ben Squires, Director of Primary Care
Presented by.	Katherine Sheerin, Chief Commissioning Officer / Chair of the GM Primary Care Commissioning Committee
Contact for further information.	Janna Rigby Assistant Director of Primary Care (Operations) Email: Janna.rigby@nhs.net
Executive summary.	To highlight key issues and provide assurance to the Board.
The benefits that the population of Greater Manchester will experience.	To support delivery of high-quality primary care services, providing the GM population with access to the care and treatment that they require.
How health inequalities will be reduced in Greater Manchester's communities.	The appropriate commissioning and management of primary care services, meeting access requirements and responding to local needs

The decision to be made and/or input sought.	The Board is asked to: Note the contents of the report including items for escalation and provide feedback to the Committee Chair.
How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	The actions and determination of GM PCCC delivery of the • GM Primary Care Blueprint. Mitigation of BAF risk SR4. • GM PC risk register: SR2 – by addressing capacity to meet changing demand and pressures on services and delivery of operational standards; and SR3 – addressing the quality of care and patient experience.
Key milestones.	GM PCCC Meetings 9th February 2026
Leadership and governance arrangements.	This is a summary report following the Primary Care Commissioning Committee meeting as detailed above.
Engagement* to date.	Draft report shared with the Chair for comments.
Financial or Legal Implications	Not applicable

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*	*Yes*	*Yes*	*No*	*No*	*Yes*

Table 2: Assurance needed about the document.

Report from:	**Primary Care Commissioning Committee**
Date of Meeting:	9th February 2026
Chair:	Katherine Sheerin, Chief Commissioning Officer
Quoracy Achieved:	Yes~~/No~~

Key escalations and discussion points from the meeting:

Alert
1. **National Dental Contract Reforms** to be introduced 1st April 2026. • Mandated **8.2% urgent care requirement** and new complex care pathways create immediate operational and financial risk for practices. • Overlap identified with GM's **urgent dental care provision** and **PAQS**, creating duplication and potential unfunded cost pressures from April 2026. • Need to review GM urgent care and PAQS specifications to avoid duplication. • Financial modelling underway; early indications suggest potential significant financial pressure without national uplift 2. **Palliative Care Pharmacy Stockholding** • There is currently variation of arrangements and specification across 10 localities is unsustainable and presents additional risks • Work has progressed transition to GM-wide service specification and formulary agreed by all clinical providers • Preferred contracting route for future delivery is as **Local Enhanced Service** from community pharmacies, reducing administrative burden and enabling standardisation. • In implementation transition there is risk of unmanaged **expired stock claims** and provider instability if not governed tightly.
Advise
1. **GM Digital Strategy (10-year vision)** – Requires PCCC approval before progressing to Chief Officers; sets out GM as future digital exemplar. 2. **GM Protected Learning Time Policy** (PLT) for General Practice – Comprehensive GM-wide approach has been drafted by DMOG (The NHS GM Primary Care Leads

network). PCCC supported implementation from **1 April 2026** recognising the considerations required to address current variation in arrangements across the localities

3. **Section 7A National and Local programme** changes for 2026/27 were reported for information, noting the national changes in cancer screening and ante-natal and new-born programmes as well as commissioning of vaccination delivery in primary care. Details have been shared with providers.

Assure

1. **Winter Primary Care delivery**
   GM-wide approach to winter planning continues with GP winter surge hub delivery, and additional community pharmacy and optometry services activated. Indication of additional winter capacity is the c.9,000 extra GP appointments in Tameside alone

2. **GM Digital Strategy (10-year vision)** – The draft GM Primary Care Digital Strategy was reviewed before progressing through further GM governance. It sets out GM as future digital exemplar. The Strategy provides long-term roadmap, with Phase 1 work already underway (triage tools, NHS App optimisation, data sharing improvements

3. **PCN Capacity and Access Improvement (CAIP)** assurance arrangements for 2025/26 were considered in light of national guidance and assurance of post-payment verification considerations. CAIP (as reported to the committee in June 2025) is designed to support improved general practice for all populations.

Risks discussed and new risks identified

There is risk of financial and delivery impact of the national contract reforms for dentistry. The commissioning and finance teams are modelling impacts to better understand inform appropriate management of this for GM.

Learning for sharing

Nothing to note

NHS
Greater Manchester

NW Specialised Commissioning Committee Report

18 March 2026

Part of Greater Manchester Integrated Care Partnership

NHS Greater Manchester

Integrated Care Board

18 March 2026

Required information	Details
Title of report	NW Specialised Commissioning Committee Report
Author	Dr Ruth Hussey, Chair, NW Specialised Commissioning Committee.
Presented by	Katherine Sheerin, Chief Officer for Commissioning
Contact for further information	Katherine Sheerin
Executive summary	To highlight key risks and issues associated with the commissioning of specialised services and provide assurance to the Board.
The benefits that the population of Greater Manchester will experience.	Access to high quality specialised services to improve health and clinical outcomes.
How health inequalities will be reduced in Greater Manchester's communities.	The work of the NW Specialised Services Committee will be supported by a Health Inequalities Task Force to ensure that inequalities in access and outcome are central to commissioning programmes.
The decision to be made and/or input sought	The Board is asked to: Note the contents of the report.
How this supports the delivery of the strategy and mitigates the BAF risks	This supports delivery of BAF risks 2, 4 and 5:- - Recover core health and care services - Help people to stay well and detect illness earlier - Achieve financial sustainability
Key milestones	N/A
Leadership and governance arrangements	This is a summary report following the last NW Specialised Commissioning Committee meeting.
Engagement* to date ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	NW Specialised Commissioning Committee comprises members (clinical, managerial and NEDs) from across the 3 NW ICBs and NHSE. Each programme has its own arrangements for wider engagement.
Financial or Legal Implications	N/A

Table 1 - core information relating to the content and creation of paper

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

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

Meeting of the NW Specialised Services Committee

11 December 2025

Highlight report of the Chair of the NW Specialised Services Committee

Committee Chair: Ruth Hussey, Non-Executive Director, NHS Cheshire and Merseyside

Highlight report of the Chair of the North West Specialised Services Committee

Committee Chair	Ruth Hussey, Non-Executive Director, NHS Cheshire and Merseyside
Terms of Reference	
Date of meeting	11 December 2025

Key escalation and discussion points from the Committee meeting

Alert

- Nil to report

Advise

- The committee endorsed a direct award approach for NW Osteochondral Allograft transplantation (OCA) and Autologous Chondrocyte Implantation (ACI) Services under the Provider Selection Regime.

Assure

- The committee reviewed the financial planning process for specialised services, noting the importance of triangulation with contract teams to support assurance frameworks.

Specialised Commissioning Programmes and Areas of Focus

Service Programme / Focus Area	Key actions/discussion undertaken
Planning	• The committee reviewed the financial planning process for specialised services, noting the importance of triangulation with contract teams to support assurance frameworks. • Emphasis was placed on managing fixed contract risks and ensuring alignment across systems, particularly for high-cost pathways such as AAA screening and intervention. • Growth allocations (£51m) were highlighted as a concern, with boards expected to scrutinize spending rigorously given current overspend pressures. **Action:** Convene on 8 January for an update on financial planning and confirm if additional meetings are required before February submission.
Items for decision/endorsement	**Osteochondral Allograft transplantation (OCA) and Autologous Chondrocyte Implantation (ACI) Procurement** • The committee endorsed a direct award approach for OCA/ACI contracts under the Provider Selection Regime (PSR), citing service stability and defensibility. • Assurance was provided that elective services, including AAA interventions, cannot be capped and must respond to referrals within agreed clinical criteria. • Outcome data requirements were emphasized, including PROMs, to demonstrate effectiveness and value for money. Future contracts will include these requirements. **Decision:** The committee agreed to support the recommendation for a direct award, noting associated risks and the need for ongoing monitoring.

NHS
Greater Manchester

Transition Committee Report

18 March 2026

Part of Greater Manchester Integrated Care Partnership

NHS
Greater Manchester

Integrated Care Board

18 March 2026

Required information	Details
Title of report	Transition Committee Report
Author	Rachel Egan, Non-Executive Director / Co-Chair of Transition Committee Sue Bailey, Non-Executive Director/ Co-Chair of Transition Committee
Presented by	Rachel Egan, Non-Executive Director / Co-Chair of Transition Committee Sue Bailey, Non-Executive Director/ Co-Chair of Transition Committee
Contact for further information	Rachel Egan, Non-Executive Director / Co-Chair of Transition Committee Sue Bailey, Non-Executive Director/ Co-Chair of Transition Committee
Executive summary	To highlight key issues and provide assurance to the Board.
The benefits that the population of Greater Manchester will experience.	N/A
How health inequalities will be reduced in Greater Manchester's communities.	N/A
The decision to be made and/or input sought	The Board is asked to: • Note the contents of the report and provide feedback to the Committee Chair. • Acknowledge the position and the risk of failure to deliver against targets and consider how these impact on the GM Single Improvement Plan through the undertakings.
How this supports the delivery of the strategy and mitigates the BAF risks	N/A
Key milestones	N/A
Leadership and governance arrangements	Overview of discussions at the Transition Committee
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 - core information relating to the content and creation of paper

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

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

NHS Greater Manchester

Report from:	**Transition Committee**
Date of Meeting:	4 February 2026
Chair:	Dame Sue Bailey
Quoracy Achieved:	Yes

Key escalations and discussion points from the meeting:

Alert

- **Updated BAF and Corporate Risks Report:** The committee raised concerns on risk **PC010** regarding loss of organisational knowledge and talent due to Reform. The committee were informed of the supporting mitigations in place.

Advise

- **Maternity Assurance Update:** The committee were provided with an update on maternity and neonatal safety, including progress on perinatal pelvic health service implementation, CQC maternity survey results and the CNST process. The committee were made aware of the ongoing challenges, assurance mechanisms and the need for improved integration of maternity neonatal risks. The need to ensure adequate focus on areas such as children and young people was raised.

Assure

- **Alert & Assurance Reports – Chief Clinical Officer Report:** The committee were informed of the efforts to maintain quality and safety, including oversight of corridor care with UEC Board and Quality Team working together to keep track of the national guidance and oversight over winter whilst supporting staff.
- **Alert & Assurance Reports – Chief Strategy, People and Partnerships Officer:** The committee were made aware of the ongoing monitoring of staff well-being, sickness absence and annual leave uptake which was conducted through the People and Culture Sub-Committee, with escalation procedures for critical gaps and targeted support for staff requiring adjustments.
- **Updated Committee Work Plans / Finalise the top four priorities for the new committees for 2026/27:** The committee were advised on the methodology for reviewing and updating committee workplans to ensure statutory duties were met, avoid duplication and align with the new

governance structure, with a focus on transferring, closing, or reassigning work as appropriate.

Risks discussed and new risks identified

Risks scoring above 16 that are monitored via the Transition Committee:

- **BAF and Corporate Risks Report:** The committee discussed the status of the BAF and Corporate Risks, noting changes in risk scores for Dermatology, People & Culture, Urgent & Emergency Care (UEC) and Elective Care. The committee were made aware of the plan to conduct a deep dive on BAF risk **SR1** – Population Health at the March 2026 Audit Committee to draw out recommendations for improving risk reporting and management with the intention to apply the improvements across other BAF risks in future.

Learning for sharing

Summary of learning points to share from the Transition Committee February meeting.

- **Alert & Assurance Reports – Chief Commissioning Officer:** The committee were informed on the procurement process for community dermatology services, the challenge from providers, the national panels recommendation to return to an earlier step and the need to ensure service continuity whilst options were appraised and lessons learned were documented.
- Suggestion raised to include appreciation box in future reporting.

NHS
Greater Manchester

Report from:	**Transition Committee**
Date of Meeting:	4 March 2026
Chair:	Rachel Egan
Quoracy Achieved:	Yes

Key escalations and discussion points from the meeting:

Alert
No alerts were raised.
Advise
• **Preparations for New Governance – Progress Report:** The committee were informed of the proposed sub-committee structures for the People & Resources and Strategic Commissioning Committee. The committee raised the need to ensure sufficient board oversight was considered for Primary Care Commissioning within the new structure. The committee also requested an ongoing review and iteration of the governance structure with checkpoints to assess the effectiveness of the new governance. • **Alert & Assurance Reports – Chief Commissioning Officer Report:** The committee discussed the delays in appointment of a single major trauma clinical lead and raised the importance of system-wide ownership and ongoing communication with national stakeholders. The need for timely updates to NHS England regarding any reprofiling of implementation timelines was also emphasised. • **Alert & Assurance Reports – Chief Clinical Officer Report:** The committee were informed of the alert regarding children without health needs being placed in hospital beds due to breakdowns in placement. The committee discussed the need for intensive wraparound care and improvement approaches similar to those used for Mental Health crises, with commitment to further collaborative work involving local authorities and place-based teams. • **Alert & Assurance Reports – Medicines Optimisation & Strategic Commissioning 2026/27:** The committee were informed of the centralisation of the medicines optimisation team, the use of horizon scanning to align budget setting with anticipated prescribing needs and the achievement of significant cost improvements. The committee raised the importance for strategic commissioning to support long-term health outcomes and patient engagement in medicines optimising to address concerns.
Assure

- **Strategic Commissioning Plan: Next Steps and confirming priorities for 2026/27:** The committee were provided with an update on the Strategic Commissioning Plan. It was explained that the plan aimed to ensure that individual programme outcomes would collectively achieve the high-level five-year objectives.
- **Alert & Assurance Reports – Chief Strategy, People and Partnerships Officer:** The committee were made aware of the ongoing challenges with staff morale due to reform and low annual leave uptake. Assurances were provided of the measures in place to include communications through managers and leaderships and the offer for annual leave rollover. The committee discussed the role of leadership in modelling healthy work boundaries, supporting staff to take breaks and restoring a sense of control and empowerment.

Risks discussed and new risks identified

Risks scoring above 16 that are monitored via the Transition Committee:

- **BAF and Risks Report:** The committee raised concerns regarding the rationale of reducing risks for Population Health, Good Employment, Finance and Emergency Incident given the current uncertainties of ongoing reform and transition.

Learning for sharing

Summary of learning points to share from the Transition Committee March meeting.

- **Strategic Commissioning Plan: Next Steps and confirming priorities for 26/27:** KS and JN to work with DII colleagues to ensure robust data is shared ahead of the Board Development Session.
- **Alert & Assurance Reports – Chief Commissioning Officer Report:** VM and MK to meet to clarify local interpretations of the new GP contract to ensure clinical pathways are appropriately governed and strong local relationships are maintained.

Appreciative

Summary of the appreciation shared from the Transition Committee March meeting.

- **Alert & Assurance Reports – Medicines Optimisation & Strategic Commissioning 2026/27:** The committee thanked and acknowledged the

collaborative work of the medicines optimisation and finance team for the preparation of the 2025/26 financial year horizon scanning to enable NHS GM to anticipate any major changes in the medicines landscape, ensuring a pathway that prioritises prevention, delayed disease progression, supporting system sustainability and aligning with NHS GM's clinical strategy.

- **Strategic Commissioning Plan: Next Steps and confirming priorities for 26/27:** The committee thanked KS and the team for sharing the updated commissioning plan which included the recent feedback shared from the committee for a focus on children and young people.
- **Alert & Assurance Reports – Chief Strategy, People and Partnerships Officer:** The committee acknowledged the work of the People & Culture team working collaboratively with colleagues across the organisation to support ongoing staff consultation through the management of the Voluntary Redundancy schemes, meeting with our trade union partners and receiving and processing consultation feedback.
- **M10 Finance Report:** The committee thanked and acknowledged all of the work that had taken place from everyone in the ICB and all the Executive team for the significant financial improvement through addressing challenges and issues over the year to get to the current position.

NHS Greater Manchester

Minutes

Greater Manchester Transition Committee

Date: 7 January 2026

Time: 14:00pm - 16:00pm

Venue: Microsoft Teams

(Public)

Present	Apologies
In attendance: Rachel Egan (RE) – Non-Executive Director (Chair) Dame Sue Bailey (SB) – Non-Executive Director (Co-Chair) Colin Scales (CS) – Acting Chief Executive and Chief System Reform Officer Sir Richard Leese (RL) – Chair, NHS GM Leigh Vallance (LV) – VCSE Partner Member Prof. Manisha Kumar (MK) – Chief Clinical Officer Richard Paver (RP) – Non-Executive Director and Chair of Audit Kal Kay (KK) – Non-Executive Director Owen Williams (OW) – Chief Executive, NCA Jackie Njoroge (JN) – Deputy Chair/Senior Independent Director Sean Fielding (SF) – Partner Member Chris Gaffey (CG) – Associate Director of Corporate Services Claire Connor (CC) – Director Communications and Engagement Katherine Sheerin (KS) – Chief Healthcare Commissioning Officer Stephen Downs (SD) – Deputy Chief Finance Officer Vish Mehra (VM) - GP/Partner Member Jo Street (JS) - Programme Director- Transition Faye Vaughan (FV) – Governance Advisor (Minutes)	Anthony Hassall (AH) - Chief Executive, Pennine Care NHS Foundation Trust Alison Mckenzie-Folan (AMf) – Wigan Place Lead Charlotte Bailey (CB) – Chief Strategy, People and Partnerships Officer Kathy Roe (KR) - Chief Finance Officer

Item No.	Topic	Action
1.	**Welcome, Introductions and Apologies** RE welcomed everyone to the meeting and the above apologies were noted.	
2.	**Declarations of Interest** RE 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. VM informed the committee of his new role as Chief Medical Officer for Health Innovation Manchester.	

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3.	**Matters Arising** A request was made for the Executives to review all actions to identify the actions still relevant to create one single action log for the committee. **ACTION:** CS to coordinate the creation of a single action log through the team.	**CS**
4.	**Transition Committee Purpose and Closedown Arrangements for Abolished Committees** The committee acknowledged the work that had taken place from all teams involved and thanked all formal partners who had contributed to the committees that had been stood down. The continued commitment post the Transition Committee to ensure the right mechanisms for involvement and decision making would be in place was noted. During this period of change, it was explained that the NHS GM Integrated Board and Transition Committee would oversee the assurance across all the key areas of work previously received through the committees that had been stood down. It was confirmed that they were preparing for the new committee model to be in effect from April 2026. The committee were made aware that a Finance Sub-Committee had been stood up. Confirmation was received that the membership would remain the same as the Finance Committee membership, and that the sub-committee would take on the responsibilities and Terms of Reference of the previous Finance Committee. A discussion took place regarding the number of Finance Sub-Committee meetings that would take place as the organisation moved into Business-as-Usual arrangements. The committee were informed of the intention to run through the course of Q4. The importance of having the same authority as the previous Finance Committee to ensure scrutiny of finance reports and budget submissions remained was raised. Concerns were raised regarding the committee membership and the value in connectivity with wider colleagues understanding the work of the ICB, which was identified as a risk if those engagements were lost. A suggestion was raised to provide a brief paragraph to wider colleagues to be informed of the discussions that would take place in the committee meetings. **ACTION:** CC to create and share summaries from Transition Committee meetings to stakeholders to keep partners engaged during the transition period. The committee questioned the confidence levels around how the committee was actively shaping transition and not just managing the closedown. It was further questioned how they would ensure that they managed any governance gaps. CS explained that updates would be brought to the committee that required input from wider committee members. It was confirmed that succession arrangements of the new governance structures work were underway. CG informed the committee of the work that had taken place at the end of 2025 for the two committees proposed. It was explained that the challenges and issues that had been raised would be picked up through the engagement of Chief Officers	**CC**

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	and Non-Executive Directors to shape the arrangements. The committee were made aware of the aim to present to the NHS Integrated Board in March 2026 to finalise the committees. A request was made for the top four priorities for the next 12 months to be understood and prepared for April 2026. Assurance was provided that as part of the planning; priorities would be picked up to ensure a continuation of the Good Governance Institute (GGI) Well Led work. It was confirmed that a clearly defined process for the commissioning intentions and plans would be available in advance of April 2026. **ACTION:** Engagement work to take place with Chief Officers and Non-Executive Directors to identify the key priorities for the new committees to be brought back to February 2026 meeting to finalise.	**CG**
5.	**Board Assurance Framework (BAF) and Corporate Risks Report** This report provided an update to the Transition Committee on the corporate risks across the committees of the ICB and the November 2025 BAF Risks. The committee were made aware that the Senior Officers reviewed the corporate risks on a regular basis. CG proposed that they would need to be shared with the Operational Leadership Group to ensure a further level of consideration. The summary of the Transition Committee Risk Register based on previous committees were shared in the paper. It was confirmed that meetings were also taking place with risk leads. LV highlighted the significant role of the Voluntary, Community and Social Enterprise (VCSE) and suggested a mechanism would need to be in place to create conditions for the voluntary sector to escalate concerns or vulnerabilities into the commissioning process. **ACTION:** Meeting to take place to discuss and resolve the escalation routes for VCSE to create conditions for the voluntary sector to raise concerns or vulnerabilities on the commissioning process. RP raised that there were inconsistencies in the current BAF regarding the risks that were specific to the ICB and those that were system-wide risks. The People & Culture risks were highlighted as an example of risks that focused on the system rather than the ICB. The need for more clarity in the future refreshed BAF was requested. The importance of strengthening the lines of defence by incorporating clear evidence, data and outcomes to ensure that assurance would be based on demonstrable progress and risk mitigation was also raised. KS highlighted that the risk report did not include a risk on the impact of ICB staff. SB suggested considering a more dynamic way of collecting information through the exploration of external best practices to learn and improve the current risk reporting. **ACTION:** Explore and evaluate dynamic risk reporting approaches used outside of the organisation to improve the current risk reporting.	**LV/CS** **CS/CG**

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	VM suggested reviewing all committee risks to calibrate risk scores across risk reporting. A further suggestion was raised to clarify the distinctions between risks and issues with a proposed method for categorising them appropriately. **ACTION:** Updated progress towards the revised BAF and risk management approach to be shared at February 2026 meeting, including an update on the current status of the dermatology risk previously rated at 20 and the calibration of risk scores across committee risks. **The Committee:** • **Considered the corporate risks included within the report.** • **Considered the November 2025 BAF risks.**	**CS/CG**
6.	**M8 Finance Report** The report provided the committee with an update on the overall Month 8 ICS financial position for Greater Manchester as of 30th November 2025. SD informed the committee that there was still a significant financial risk and material year-to-date deficit. It was reported that 2025/26 GM ICS final plan following the receipt of Deficit Support Funding (DSF) was breakeven. As at M8, it was reported that the year-to-date deficit of £83m was an improvement from previous months. With the system stabilising its financial position, it was explained that there would be an aim to reduce the deficit further by year-end, supported by a positive run rate and risk reduction. The committee were made aware that NHS England had confirmed that the Deficit Support Funding (DSF) would be received for Q4 which would provide essential cash flow relief. The need to ensure that the requirements would be delivered to prevent funding being reclaimed was raised. The committee discussed the financial impact of industrial action and the ICBs cash position. SD explained that providers would be given some compensation for the recent industrial action that took place in November and December 2025. It was further explained that providers cash positions were manageable if the plans were delivered, and the ICBs cash management had supported providers, however, it may result in a year-end cash deficit. The committee reflected on the extraordinary achievement taken place and highlighted that the ICB was one of the few to secure DSF. The committee were made aware that Bolton faced significant challenges due to legacy staffing increases. It was explained that there was uncertainty about the future deficit support and recovery timelines for providers ending the year in deficit. OW highlighted the significant challenges for the following year and the lack of clarity regarding expectations for providers finishing the year in deficit, with upcoming deadlines for budget declarations and the uncertainty about the approach to deficit recovery. **The Committee:** • **Noted the Month 8 year to date reported financial position for GM ICS of £83.0m deficit, against a planned deficit of £70.2m, resulting in a variance against plan of a £12.8m deficit.** • **Noted that the in-month position is a further reduction in actual**	

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	spend for the GM system, a reduction in the forecast run rate position and a reduction in overall reported risk. • **Noted the breakeven forecast outturn position in line with NHSE reporting requirements.** • **Noted the year-to-date delivery of CIP as at Month 8 of £388.4m against a plan of £362.8m, an over delivery of £25.6m.** • **Noted the forecast capital position is expected to be brought back into a balanced position.** • **Noted the risk to the system wide cash position which will require close monthly monitoring.** • **Noted the on-going risk of the DSF funding for Q4 being withheld if the system can't demonstrate and provide assurance that there is a credible plan to deliver a balanced FOT position.** • **Noted the on-going system meetings to provide assurance on the delivery of the overall system financial plan, and to address the current shortfall in CIP delivery and confirm recovery plans to mitigate reported pressures.**	
7.	**Performance Update – Winter** The slides were shared with the committee, detailing the preparation that had taken place across the system with ICB engagement with provider, primary care and VCSE colleagues for winter performance and system pressures. CS highlighted the key points from the slides: • System wide efforts had taken place to reduce bed occupancy to around 80% before Christmas, enabling better management of January and February 2026 pressures. It was noted that the system remained at OPEL 3, avoiding escalation to the highest alert level. • It was reported that the performance position on 4-hour performance for December 2025 was higher than December 2024. The committee were made aware of the significant influx of patients with flu, with most hospitals running one or two dedicated flu wards which had an impact on performance. • Cat 2 Ambulance Performance was also reported to have improved by two minutes than the previous year. A discussion took place regarding the strategic shift that would need to be prioritised in Q4 towards integrated community urgent care services, such as virtual wards and urgent community response teams, to reduce hospital admissions and support patient flow during winter. It was confirmed that work was taking place closely with provider Chief Executives and their Chief Operating Officers to ensure that they were supporting the system management of the pressures. The committee were made aware of the Quality Walk rounds that intended to support pressures, whilst keeping an eye on experiences of patients during the busy period. The committee were also made aware of the new guidance on safe corridor care. MK reported that the system had exceeded the national flu vaccination targets. The committee were also made aware that the week 51 data for epidemiology had shown that a peak for Influenza A had started to decrease. It was reported that Respiratory Syncytial Virus (RSV) and other respiratory viruses had also declined. MK informed the committee that the new combined team would be looking at how	

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	they could harness the joint capabilities of Nursing, Medical, Pharmacy and AHP teams to reinvigorate some of the quality oversight metrics. VM highlighted the recent cold snap and questioned whether there was any evidence of any impact on urgent care system. CS explained that they had not seen any suggestions of impact but confirmed that the data would be analysed once received. SB and CS discussed the need to gather evidence on patient outcomes for those managed in the community to build clinical confidence in out-of-hospital care and use the learning to inform investment and planning for future winter periods. **The Committee:** • **Noted and supported the contents of the report.**	
8.	**Committee Work Plans** The report provided the committee with the workplans for the committees that had been stood down to ensure oversight and discussion on plans for subsequent Transition Committee meetings for the remainder of the financial year. MK provided a brief overview of the Quality & Performance Committee workplan and explained that the section on annual reports would need to report into the new model. A suggestion was raised to use this opportunity to look at thematic areas as well as areas of rising risk. JS outlined the People and Culture Committees approach to prioritising statutory reporting. It was explained that several internal and system priorities would need to continue. From a system point of view, it was identified that there were two major high impact programmes that were overseen through the committee, the System Workforce Efficiency programme and the Transforming People Services programme. The committee were made aware that both programmes had Working Groups for continued scrutiny to ensure that they were on track. It was suggested that they would need to maintain focus on those out of the committee and work would take place to identify how to report those into the new committee structures going forward. It was confirmed that there was a Sub-Committee structure that would continue to drive those through, however, it was suggested that the annual reports would need to come to the Transition Committee due to their importance. The committee were assured that critical reports such as Freedom to Speak Up would be scheduled appropriately within the new structure. The committee discussed and agreed that future reporting would need to be shorter and more succinct using the Alert, Advise, Assure reporting method as a joint report for quality and clinical effectiveness. It was suggested that Chief Officers and the Operational Leadership Group would need to come together to plan through how they would report the entirety of the commission services in a work plan. A suggestion was raised to review committee work plans, stripping out non-essential activities to free capacity for strategic priorities, whilst ensuring that statutory and high-impact programmes were maintained. **ACTION:** Workplans to be reviewed and streamlined to focus only on critical items necessary for assurance and strategic priorities during the transition period, removing non-essential activities. Draft Workplans for the new committees to be shared at the next meeting.	**CS/CG**

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	The Committee: • **Considered the workplans appended to the report, and considered what information would be required for subsequent meetings for the remainder of the financial year.**	
9.	**Any other business** The committee reflected on the meeting and confirmed that it had provided a valued opportunity to review all work plans, the risks across all committees and provided committee members with confidence on the work that would take place going forward to align the strategic commissioning against the chosen prioritised objectives.	
	Date and time of next meeting: **Wednesday 4 February 2026**	

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NHS Greater Manchester

Minutes

Greater Manchester Transition Committee

Date: 4 February 2026

Time: 14:00pm - 16:00pm

Venue: Microsoft Teams

(Public)

Present	Apologies
In attendance: Dame Sue Bailey (SB) – Non-Executive Director (Chair) Rachel Egan (RE) – Non-Executive Director (Co-Chair) Colin Scales (CS) – Acting Chief Executive and Chief System Reform Officer Sir Richard Leese (RL) – Chair, NHS GM Leigh Vallance (LV) – VCSE Partner Member Prof. Manisha Kumar (MK) – Chief Clinical Officer Richard Paver (RP) – Non-Executive Director and Chair of Audit Kal Kay (KK) – Non-Executive Director Jackie Njoroge (JN) – Deputy Chair/Senior Independent Director Chris Gaffey (CG) – Associate Director of Corporate Services Claire Connor (CC) – Director Communications and Engagement Katherine Sheerin (KS) – Chief Healthcare Commissioning Officer Vish Mehra (VM) - GP/Partner Member Charlotte Bailey (CB) – Chief Strategy, People and Partnerships Officer Kathy Roe (KR) - Chief Finance Officer Gareth Robinson (GR) - Interim Chief Reform and Improvement Officer Sarah Owen (SO) - Associate Director of Maternity Assurance (ICB/LMNS) Faye Vaughan (FV) – Governance Advisor (Minutes)	Anthony Hassall (AH) - Chief Executive, Pennine Care NHS Foundation Trust Owen Williams (OW) – Chief Executive, NCA Sean Fielding (SF) – Partner Member Alison Mckenzie-Folan (AMF) – Wigan Place Lead

Item No.	Topic	Action
1.	**Welcome, Introductions and Apologies** SB welcomed everyone 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, matters arising and actions from previous meeting held on 7 January 2026** The minutes were accepted as a true record of the previous meeting held on 7 January 2026.	
4.	**Action Log** Action log updated.	
5.	**Updated BAF and Corporate Risks Report** The report provided an update to the committee on the ongoing work to develop the Board Assurance Framework (BAF), the January 2026 BAF Risks and the corporate risks. CG outlined the status of the BAF and corporate risks, noting changes in risk scores for Dermatology, People & Culture, Urgent & Emergency Care (UEC) and Elective Care. The committee were made aware of the plan to conduct a deep dive on BAF risk SR1 – Population Health at the March 2026 Audit Committee to draw out recommendations for improving risk reporting and management with the intention to apply the improvements across other BAF risks in future. RP raised concerns regarding the absence of maternity risk on the risk register and risk PC010 regarding loss of organisational knowledge and talent due to reform. Assurance was provided that the risk register was carried through the LMNs to ICB with close work taking place to escalate any risks that sat above 16 post mitigation. CB informed the committee of the range of factors and mitigations in place in relation to risk PC010 such as the tight criteria set around voluntary redundancy to assess each application. It was confirmed that supporting mitigations were in place around risk of knowledge and talent. The committee were also made aware of the established Transition Hub, working with a range of partners including the voluntary sector to establish a hub for teams to access. CB further informed the committee of a number of career fairs that had also been held. LV highlighted risk PH4 and discussed the challenges in operationalising voluntary sector commitments, highlighting resource constraints and the need for improved commissioning and market development of the sector into the commissioning plans. It was identified that collaborative work at place level and inclusion in the organisational development plan would intend to strengthen relationships and resilience. The committee discussed the sequencing of deep dives on risks. It was agreed that there were other risks that would require further deep dives, however, it was identified that Population Health risk was a timely one to do in the first instance. The Chief Officers agreed to look into the timings to carry out deep dives on other risks in a safe and occurrent way for the future. The committee noted the serious concerns raised that would need to be reflected with evidence shared of cross-executive solutions to work with.	

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	The Committee: • **Considered the January 2026 BAF risks.** • **Considered the corporate risks included within the report and confirmed any additional actions required.**	
6.	**Alert & Assurance Reports from each function area / Maternity Assurance Update** <u>Chief Clinical Officer Report:</u> The paper provided the committee with an overview of NHS Greater Manchesters statutory duties during a period of organisational and governance transition. MK reported on the winter pressures, noting a decrease in flu and other illnesses, however, reported that systems were still under significant pressure reaching OPEL 4. The committee were informed of the efforts to maintain quality and safety, including oversight of corridor care with UEC Board and Quality Team working together to keep track of the national guidance and oversight over winter whilst supporting staff. The committee questioned the distribution of statutory responsibilities and assurance during the transition period. It was clarified that accountabilities would remain with the ICB until they were safely transferred. The importance of the organisational development plan and use of established commissioning principles and robust contract management was raised. **The Committee:** **1. Acknowledged the progress in strengthening statutory quality, safety and safeguarding functions during the transition period, including the updated contractual requirements and alignment with national guidance.** **2. Supported the ongoing review and revision of subcommittee governance, ensuring streamlined structures, clearer accountability, and improved escalation and reporting routes under the new Model ICB arrangements.** **3. Noted the emerging system-wide approach to improvement, recognising that further design and alignment across portfolios is required as the improvement function develops.** **4. Endorsed the strengthened winter quality oversight within UEC, including targeted quality visits, enhanced surveillance, and system-level actions to maintain safety during periods of high pressure.** **5. Received ongoing updates as these areas progress and as the new governance and assurance structures embed.** <u>Maternity Assurance Update:</u> The report provided an update on maternity and neonatal safety assurance across Greater Manchester. It was confirmed that robust assurance and escalation arrangements remained in place through established LMNS and ICB governance routes, with clear mechanisms for managing and escalating maternity risks. SO provided an update on maternity and neonatal safety, including progress on perinatal pelvic health service implementation, CQC maternity survey results and the CNST process. The committee were made aware of the ongoing challenges, assurance mechanisms and the need for improved integration of maternity neonatal risks.	

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	The committee highlighted the need to ensure adequate focus on areas such as children and young people. **The Committee noted the information and plans for improvement.** <u>Chief Commissioning Officer:</u> The paper provided the committee with an overview of NHS Greater Manchesters statutory duties during a period of organisational and governance transition. KS described the procurement process for community dermatology services, the challenge from providers, the national panels recommendation to return to an earlier step and the need to ensure service continuity whilst options were appraised and lessons learned were documented. KS outlined progress on major programmes including arterial vascular surgery and cardiac surgery reconfiguration, development of pre-consultation business cases and the timeline for engagement and Board approval. The committee were also updated on the neonatal critical care programme, noting the lengthy process due to national requirements and NHS England capacity. KS provided assurance on the implementation of a single major trauma centre, including programme planning and reporting. VM declared an interest in the item from his previous role in GP Federation during the time of the initial bid, however, informed the committee that there was no involvement in the bid. The effectiveness of the current procurement approaches given frequent legal challenges was questioned. It was agreed that there was a need to explore more strategic options within the provider selection regime and to share lessons learned across ICBs. **The Committee:** • **Noted the report from the Chief Commissioning Officer.** <u>Chief Strategy, People and Partnerships Officer:</u> The paper alerted the committee to the impact of recent NHS Reform developments on the workforce and mitigating actions in place. CB presented on the workforce changes due to reform, including voluntary redundancies, staff well-being, new structures and the organisational development plan, with discussion on capacity, priorities and support mechanisms in place. The committee were made aware that approximately 200 staff left the organisation at the end of January 2026, with mitigations in place to address gaps, prioritise critical work, provide well-being support, including increased HR engagement and leadership briefings. CB reported on the ongoing monitoring of staff well-being, sickness absence and annual leave uptake which was conducted through the People and Culture Sub - Committee, with escalation procedures for critical gaps and targeted support for staff requiring adjustments. **The Committee:** • **Noted the report.**	

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	Chief Reform and Improvement Officer: GR highlighted that UEC performance was 2.2% behind plan, with pressures from OPEL 4 incidents and IT failures. The committee were made aware of the improvements compared to previous years and ongoing oversight. Elective care was reported slightly behind plan, with a Q4 sprint and close monitoring taking place. It was reported that the pre-market engagement for GPIT services closed on time, with the process moving to business case development. GR highlighted the GPIT Stakeholder Group and confirmed that representative GP structures would be included in future for accountability and input.	
7.	**M9 Finance Report** The report provided an update to the committee on the overall Month 9 ICS financial position for Greater Manchester as of 31st December 2025. KR presented the Month 9 finance report, highlighting positive trends but ongoing risks to financial balance and the need for continued focus on recovery plans. It was confirmed that scenario planning for potential trust underperformance would take place KR reported improvements in year-to-date and forecast outturn, over-delivery on cost improvement plans and reduced risk, but emphasised the challenge of meeting targets with eight weeks remaining and the inability to draw on reserves. **For the System Financial position, the Committee:** **1. Noted the Month 9 year to date reported financial position for GM ICS of £76.0m deficit, against a planned deficit of £66.0m, resulting in a variance against plan of a £10.0m deficit.** **2. Noted the in-month improvement in the deficit position, a reduction in the extrapolated run rate for the GM providers of £18.6m (excluding IA costs), a reduction in reported gross risk of £0.4m, a further reduction in net risk of £4.2m for NHS GM as a result of the on-going delivery of recovery plans, and a £6.6m improvement against the recovery plan forecast trajectory for providers.** **3. Noted the breakeven forecast outturn position in line with NHSE reporting requirements.** **4. Noted the year-to-date delivery of CIP as at Month 9 of £445.8m against a plan of £422.1m, an over delivery of £23.8m.** **5. Noted the forecast capital position is expected to be brought back into a balanced position.** **6. Noted the risk to the system wide cash position which continues to be closely monitored.** **7. Noted that full DSF has been received, but there remains a risk that this is subject to clawback if a balanced position for the system is not delivered.** **8. Note the on-going system meetings to provide assurance on the delivery of the overall system financial plan, and to address the current shortfall in CIP delivery and monitor delivery of recovery plans to mitigate reported pressures.**	
8.	**Updated Committee Work Plans / Finalise the top four priorities for the new committees for 2026/27** The report provided the committee with the workplans for the abolished committees to ensure oversight and discussion on plans for subsequent Transition	

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	Committee meetings for the remainder of the financial year. CG described the methodology for reviewing and updating committee work plans to ensure statutory duties were met, avoid duplication and align with the new governance structure, with a focus on transferring, closing, or reassigning work as appropriate. CS explained the focus on the ICBs strategic priorities and also informed the committee of an OD plan being developed. The importance that the priorities for 2026/27 reflected the significant work that needed to take place to establish the new organisation was raised. SRL emphasised the importance of clear delegation, recording of decisions and audit trails. RE raised concerns regarding the treatment of Population Health in the work plan, prompting commitments to address this in the future iterations. **ACTION:** CG to update Population Health workplan and share evidence at the next meeting. The committee discussed the need for clear, focused strategic priorities, the importance of deprioritising non-essential work and the necessity of aligning short-term & long-term objectives within the three-year planning cycle. SRL raised the need for the ICB strategic objectives to be at the centre of the operating plan. **The Committee considered the workplans appended to the report and considered what information would be required for subsequent meetings for the remainder of the financial year.**	**CG**
9.	**Any other business** The committee reflected on the meeting, highlighting that the reports provided easier reading with clarity on the challenges faced. A suggestion was raised to include an appreciation box in future reporting.	
	Date and time of next meeting: **Wednesday 4 March 2026**	

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