NHS
Greater Manchester

Agenda

Greater Manchester Integrated Care Board (Public)

Date: 21st January 2026

Time: 2.00pm to 4.30pm

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: Manisha Kumar (Jim Ritchie deputising)	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	Chief Executive's Update including Reform	Paper	Discussion	Colin Scales, Acting Chief Executive
Strategic Updates						
6.	2.25	10 mins	Constitution Review	Paper	Decision	Charlotte Bailey, Chief Strategy, People and Partnerships Officer
7.	2.35	10 mins	Board Assurance Framework	Paper	Discussion / Approval	Charlotte Bailey, Chief Strategy, People and Partnerships Officer
8.	2.45	10 mins	EPRR Assurance Process	Paper	Information	Colin Scales, Acting Chief Executive
9.	2.55	10 mins	IVF	Paper	Decision	Katherine Sheerin, Chief Commissioning Officer
10.	3.05	10 mins	Housing Tripartite	Paper	Decision	Paul Lynch, Assistant Director - Strategy & Collaboration
10 MIN BREAK						

Assurance Reports and Updates						
11.	3.20	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.	3.30	10 mins	Quality and Performance: • Quality & Performance Committee Report • Quality & Performance Report	Paper Paper	Information Approval / Discussion / Information	Sue Bailey, Non-Executive Director / Chair of the Quality & Performance Committee Jim Ritchie, Deputy Chief Medical Officer (Interim)
13.	3.40	5 mins	Audit Committee: Audit Committee Report	Paper	Information	Richard Paver, Non-Executive Director / Chair of Audit Committee
14.	3.45	5 mins	Remuneration Committee	Verbal	Information	Rachel Egan, Non-Executive Director / Chair of the Remuneration Committee
15.	3.50	5 mins	Primary Care Commissioning Committee	Paper	Information	Katherine Sheerin, Chief Commissioning Officer
16.	3.55	5 mins	Transition Committee	Paper	Information	Rachel Egan/Sue Bailey, Non-Executive Directors / Co-Chairs of the Transition Committee
For Information						
17.	4.15	15 mins	Approved minutes of Committees: • People and Culture Committee • Finance Committee • Audit Committee (DRAFT) • Quality and Performance	Paper	Information	-
18.			Any other business	Verbal	-	Sir Richard Leese, Chair
19.			Date and time of next meeting: 11th February 2026, 1-3pm	Verbal	Information	

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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.

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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
Roe, Mrs. Kathryn Anne	Y	Non-financial personal interest	Loyalty interests	My son, Evan Roe, is a Finance Apprentice 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	
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

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
McKenzie Folan, Alison	Y	Financial interest	Outside employment	Chief Executive at Wigan Council		2019	Ongoing

NHS Greater Manchester

Minutes

Greater Manchester Integrated Care Board (Public)

Date: Wednesday 17th December 2025

Time: 1.30pm to 3.00pm

Venue: Boardroom, Tootal Buildings

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
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 (via MS Teams)
Dr Vish Mehra	VM	Board Member bringing the perspective of Primary Care, General Practitioner
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 (Items 1-21 only)
Colin Scales	CS	Deputy CEO, NHS GM
Kathy Roe	KR	Chief Finance Officer, NHS GM
Mandy Philbin	MP	Chief Nursing Officer, NHS GM
Professor Manisha Kumar	MK	Chief Medical Officer, NHS GM
Executives:		
Charlotte Bailey	CB	Chief People Officer, NHS GM
Katherine Sheerin	KS	Chief Officer for Commissioning, 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 and Assurance, NHS GM (Item 3 only)
Apologies:		
Cllr Sean Fielding	SF	Board Member bringing the perspective of Local Authorities, Bolton Council
Alison McKenzie-Folan	AMK	Chief Executive Wigan Council, Place Based Lead Health & Care for Integrated Care Partnership

	Topic	Action
1.	<u>Welcome, Introductions and Apologies</u> RL welcomed attendees and members of the public to the Board meeting. Apologies were noted. Welcome to Jackie Njoroge, who would be joining NHS GM as Deputy Chair/Senior Independent Director in January 2026.	
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. OW declared an interest in item 3 – planning submission and left the room for part of this discussion.	
3.	<u>Approval of 2026/7 planning submission</u> CS presented the first formal planning submission for the NHS Greater Manchester Integrated Care Board (ICB) covering 2026/27 and 2027/28 national requirements. The plan set out the ICB's intent to deliver against core NHS standards for performance, workforce, and finance, while supporting the 'left shift' to prevention and upstream care. The submission reflected a consolidated and compliant position. The Board Assurance statement acknowledged that further efforts are needed to ensure objectives are met within the financial allocation. This would be done prior to the final submission in February noting the Board meeting would need to be rescheduled from the 18th to the 11th to meet the final deadline. Board was asked to approve this initial submission and the accompanying Board assurance statements. CS welcomed ED to the meeting, noting that while the initial deadline was today, work would continue throughout January and February to get to where we needed to be before the final submission. He noted the changes to the planning process emphasising that there was no consolidated system submission, but the GM system had worked together to create an aligned plan, in keeping with previous	

	years. The Board assurance showed areas of risk in certain areas which would be included in the submission, but Board agreed that further work was required. Next steps included using the January cycle of Provider Oversight Meetings to gain greater assurance. KR highlighted the challenging financial allocation adding this was more challenging than ever before despite being uplifted. The cost uplift factor (CUF) for healthcare contracts was 2.03%, but after deducting a 2% national efficiency requirement, the net increase was just 0.03%. This results in effectively flat funding, posing significant challenges for provider organisations. Notable uplifts included prescribing that was only 0.1% for growth and inflation which would be a cost pressure to the ICB. She drew the Board's attention to the table on page 10 of the report which indicated a run rate of £114m but by the time growth was added including pressures this would leave the ICB with a plan of £169m deficit. Members thanked colleagues for the report noting it was not easy to balance conflicting priorities. It was confirmed that responsibility for Trusts in a deficit position sat with the ICB but expectations not clear or accounted for. The narrative summarised the challenging position, but it was suggested that the wording in the assurance statements should be enhanced to reflect the high level of risk in the plan. The table on page 8 or the report showed the planning expectations and proposing submission showing a compliant submission noting significant work would be required to greater assurance of delivery next time. Also need to understand assumptions and risk across organisations as well ambitions. Query whether data was available to identify health inequalities and how they would be addressed noting the need to deliver sustainability plans to keep people out of hospital. ED thanked members for their comments and confirmed he would update the Board assurance statements prior to submission. Metrics would include a full description, and ambitions would be reviewed. He would also make reference to health inequalities next time. AH emphasised the point that provider deficit was a system issue and need to commission care differently to bridge the gap. LV queried the impact on the voluntary sector and the need to invest in the sector to be able to deliver the left shift. CS reiterated that this was a challenging process not without significant risk. Need to orchestrate fundamental change over next 8 weeks, through commissioning intentions. The level of ambition was high and need to deliver by changing the way services were delivered but engagement was good so far. **ACTION: JN to reschedule February Board meeting from the 18th to the 11th and arrange seminar in January.** **The Board:** • **Noted the contents of this report**	

	• **Approved submission of this first compliant plan submission** • **Approved the Board assurance statement for submission with the plan** • **Agreed the assessment of risks and issues** • **Agreed further work required to gain greater levels of assurance in advance of the 12th February planning submission.**	
4.	Board and Committee Transition Arrangements The Chair presented proposed transitional arrangements for Board / Committee meetings for Q4 of 2025/26, whilst new Committee arrangements were designed and implemented in time for April 2026. It was noted that new structures had not yet been agreed and need to use next three months to arrange development for committees. **The Board:** • **Considered and agreed the proposed transition arrangements for the rest of the financial year.**	
5.	M7 Finance Report The Board was updated on the financial position for Greater Manchester as at 31st October 2025. KR reported an improvement as at M7 with the CIP programme ahead of plan and things moving in the right direction. She noted progress being made in terms of recovery plans which was echoed by the Chair of the Finance Committee. It was flagged that the ICB would not receive the full redundancy costs so would be a pressure that we were being asked to cover. NHS GM was the only ICB in the NW that would receive Deficit Support Funding (DSF) for M8 and M9 and was going to apply for Q4 funding noting his would only be allocated if the system could demonstrate and provide assurance that there was a credible plan to deliver the FOT position. **For the System Financial position, the Board:** • **Noted the Month 7 year to date reported financial position for GM ICS of £82.2m deficit, against a planned deficit of £71.8m, resulting in a variance against plan of a £10.4m deficit.** • **Noted that the in-month position is a further improvement in the run rate for the GM system.** • **Noted the breakeven forecast outturn position in line with NHSE reporting requirements.** • **Noted the year-to-date delivery of CIP as at Month 7 of £325.6m against a plan of £307.7m, an over delivery of £17.9m.** • **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**	
10.	<u>Any Other Business including reflections of the meeting</u> Thanks were noted to MP who was leaving the organisation and the Chair wished her well for the future on behalf of the Board.	
21.	<u>Date and time of next meeting:</u> Wednesday 21st January 2026, 2pm – 4.30pm, Tootal Buildings.	

NHS Greater Manchester

Minutes

Greater Manchester Integrated Care Board (Public)

Date: Wednesday 19th November 2025

Time: 2.30pm to 5.00pm

Venue: Peterloo 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
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
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
Mark Fisher	MF	Chief Executive, NHS GM
Colin Scales	CS	Deputy CEO, NHS GM
Kathy Roe	KR	Chief Finance Officer, NHS GM
Executives:		
Charlotte Bailey	CB	Chief People Officer, NHS GM
Katherine Sheerin	KS	Chief Officer for Commissioning, 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
Anita Rolfe	AR	Deputy Chief Nursing Officer, NHS GM (Nominated Deputy for MP)
Claire Lake	CL	Deputy Medical Officer, NHS GM (Nominated Deputy for MK)
Sandy Bering	SBe	Strategic Lead Clinical Commissioner / Consultant (Mental Health & Disabilities), NHS GM
Majid Hussain	MH	Director of Equality and Inclusion, NHS GM
Apologies:		
Cllr Sean Fielding	SF	Board Member bringing the perspective of Local Authorities, Bolton Council
Mandy Philbin	MP	Chief Nursing Officer, NHS GM
Alison McKenzie-Folan	AMK	Chief Executive Wigan Council, Place Based Lead Health & Care for Integrated Care Partnership
Professor Manisha Kumar	MK	Chief Medical Officer, NHS GM

	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. OW declared an interest in item 10 and would be asked to leave the meeting for this discussion and subsequent decision.	
3.	<u>Minutes of previous meetings</u> The minutes of the public and private Board meeting on Wednesday 17 September were approved. <u>Matters Arising</u> There were none. The action log would be updated accordingly.	
4.	<u>Chair's Briefing</u> The Chair referenced updates in the CEO report including his heartfelt condolences to all those tragically affected by the terrorist attack in Manchester on 2nd October and his immense gratitude to the frontline health and care staff who acted so swiftly in their response, alongside our other emergency services colleagues noting the paper on the agenda today.	

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	The Board noted the verbal update provided.	
5.	Chief Executive's Update MF highlighted the Board's decision not to formally adopt the National Federated Data Platform (FDP). A more detailed paper to support a review of the deferred decision and outlining how NHS GM propose to move forward would be tabled at a future Board Meeting. He welcomed the Medium-Term Planning Framework, which shifts planning from short-term annual cycles to longer-term, locally-led delivery that aligns with the 'GM Way' of partnership, prevention, and place-based working noting that CS would provide an update including what decisions or endorsements were required from the Board. He advised that the Voluntary Redundancy (VR) scheme had been launched with the first window open before the release of new proposed organisational structures expected in the new year. The Board recognised the ongoing wellbeing of staff. **The Board:** • **Noted the contents of the CEO's Report to the Board.** • **Disseminated and cascaded the necessary key messages and information as appropriate.**	
6.	Planning Framework CS provided the Board with a unified update on planning that sat within the NHS Medium-Term Planning Framework informing members this was a must do. He noted that the first submission would be presented to Board on 17th December when members would see commissioning intentions and the longer-term commissioning plan. He handed over to KR to provide an update on allocations which arrived late on Monday evening. The headlines were that this was going to be a difficult allocation round, more cash but an increase in inflation meant we were facing real term cuts. There would be a reduction in deficit support funding, but repayments would be paused. There had been a shift in finance rules, but NHSE colleagues had indicated no more funding would be available. She reiterated there would be some difficult decisions and this was going to be the toughest planning round to date. CS drew the Board's attention to the access standards on page 5 of the report which reflected where we were to date. Currently at 65% but looking to get to 80% by next April which was significant. Provider colleagues agreed this was a tough ask and need to reduce workforce expectations highlighting the impact this would have on people. Other partner members agreed this was everyone's responsibility and need to encompass voluntary sector as well as primary care. Need to balance quality standards including patient experience and understand what we get for our money since Covid. It was acknowledged we were in a strong position in terms of the process, and had indicative figures for year 2 but not year	

	3 yet although conversations with providers at every level had already started. **The Board**: • **Endorsed system programme director sign off of ICB planning template numbers as an assurance control.** • **Noted and endorsed the integrated timeline between Providers and ICB with initial planning figures used to develop a system-wide view.** • **Noted that providers would submit their final planning returns directly to NHSE, with the ICB coordinating as part of its commissioning role.** • **Endorsed the sign off of ICB planning template numbers as an assurance control.** • **Noted the outcomes of the self-assessment of foundational planning activities and the accompanying Board Assurance Support Packs, which include the Board Assurance return for the first submission to NHSE.**	
7.	<u>Board Assurance Framework (BAF)</u> CS provided an update to the Board on the updated strategic risks for the organisation noting comments received previously. He noted any business continuity decisions would be made through the lens of the BAF including reform. RP commented that this and the risk register were on the Audit Committee agenda next month. He queried some of the assurance levels which would be picked up by the Committee. **The Board:** • **Considered and approved the updated strategic risks with caveats above.**	
8.	<u>Draft Clinical Strategy</u> CL presented the proposed Greater Manchester Clinical Strategy, developed through extensive engagement with clinical leaders, stakeholders, and partners noting a link to the planning papers to help inform the 5-year commissioning plan. She noted that the document was actively in development and engagement. As could be seen in the overview, it included four strategic intentions underpinned by clinical governance. Next steps include finalising the strategy on a page and Board approval of the full document ahead of implementation. Board members welcomed the strategy that said things we'd been saying for a while but how to we stop ourselves from falling foul of financial challenges. Need clarity to ensure we do what we say we would do. KS reassured members that we had clear commissioning intentions, and this would be year one of the 5-year commissioning plan. AR added that the strength of the strategy was that it had a shared purpose with the planning framework and commissioning plan. The next Board strategy session would get into the detail of this to ensure we don't get off course with additional assurance to be provided by the Executive Team.	

	ACTION: Commissioning intentions including plan to be presented to Board at strategy session in December. **The Board:** • **Approved the proposed Clinical Strategy framework and principles.**	
9.	<u>Adults ADHD</u> SBe updated the Board on the improvement work, public consultation and next steps in the ICB plans to improve adults ADHD services in Greater Manchester (including related evidence-based changes to All-Age Neurodevelopmental Care Pathways to reduce waiting times for those in most clinical need and support required ICB sustainability plans). He introduced himself as a clinical commissioner and explained the context of what we were trying to do. This had taken time and over the last 10 years we were able to better understand autism and ADHD which could be a strength if supported in the right way. However, given the scale of numbers, partly due to better understanding, more people had been asking for diagnosis and support and waiting lists had become unmanageable. The consultation was launched two years ago noting we were the only ICB to have done so. As seen in the media recently, the system wasn't working so needs to change to manage current and expected waiting lists. We need to change the model to ensure those with significant needs continue to be supported. CC reminded members that Board asked for a full-scale consultation and confirmed this had been done. Between April and June, the team had spoken to over 2000 people across GM plus a digital survey. Key themes included: • Frustration over waiting times and inequalities • Diagnosis was important to access support • Need advice for mental health, anxiety and sleep as well as employment • Need to raise awareness in schools etc • Not one size fits all • Keen to work with VCFSE sector. Option A was recommended as the preferred solution subject to Board approval. Members were supportive of the work to date and recognised the need to change the model noting the opportunity for system working. In response to queries raised, SBe confirmed that people already in the queue had been invited to take part in the consultation and engagement with schools was already underway but we need to get on with this as it would take two years to cleanse the waiting list. In response to a further query regarding how the waiting list was prioritised currently, he clarified this was based on articulation of risk but really need independent assessment about who should be seen first. KK queried how the system approach would make efficiencies with hubs in localities as well as Right to Choose. Concerns were raised regarding health inequalities i.e. those who were most able to advocate for themselves, but the proposed approach was based on clinical need to ensure equitable access for	

	those with the most complex or urgent need. CC added that she was confident we had a representative sample of the waiting list e.g. drug and alcohol groups, those living in deprivation, men's groups as well as women's for all the reasons outlined above. SRL reflected on Right to Choose noting that work was being done on a national specification so private providers not profiteering. KS added the difference was that we will have a specification which we don't currently. Comments were welcomed and thanks were noted to the team. **The Board:** • **Approved the outcome of the Consultation undertaken by NHS Greater Manchester in relation to adults ADHD services – namely implementation of Option A and a pan GM triage model for NHS-funded Diagnostic ADHD Assessments with support** • **Noted the plans to proceed through NHS Greater Manchester's governance with the recommended option for change and aligned work to direct the limited resources (workforce and finance) to changed all-age pathways of support**	
10.	<u>Major Trauma</u> OW left the room for this item. MF introduced the paper asking Board to accept the recommendations with reports back to Board via the Quality and Performance Committee (QPC) highlighting the need to move at pace. KS outlined NHS Greater Manchester's approach to commissioning Major Trauma for the population which proposed a model for a single, clinically led Greater Manchester Major Trauma model. She thanked Jennie Gammack for the work to date which had been simple and was not an easy choice. Lots of time had been spent on developing and reviewing the options had helped to understand opportunities and our commissioning approach in line with national intentions and clinical strategy. SB reminded Board that NHS GM had not been compliant for some time and asked the CEO for assurance that all the people involved could implement the decision made with an immediate ask for compliance, clinical safety and long-term sustainability to be reported back to QPC. Members reflected on previous conversations noting that timescales were absent so need to be included in the paper back to QPC to be clear what we are commissioning and by when. **ACTION: Assurance on compliance, clinical safety and long-term sustainability including timescales for the NHS GM Major Trauma model to be provided to QPC.** RL stressed that NHSGM will be commissioning a singe service which is therefore	

	fundamentally different to current and previous arrangements. SB queried what the backstop position would be should the providers not work together to deliver in this way. MF explained that if not change does not happen, NHSGM will need to directly commission changes to pathways and this would require statutory consultation. As such, this would a considerable length of time so the proposed commissioning arrangement is recommended. RE highlighted that it needs to be explicit that NHSGM will be commissioning one service with one offer, not a joint service. MF confirmed that by accepting the recommendations we were addressing the concerns identified in the peer review. **The Board:** • **Approved the approach to commissioning Major Trauma services for the population of Greater Manchester as set out in this paper. The key components of this were as follows: -** o **The immediate implementation of the actions outlined in Section 4 to address peer review findings.** o **Establishment of the model for a Single Greater Manchester Major Trauma Network.** o **Reaffirmation of the Greater Manchester Major Trauma Hospital as the principal receiving site for adult major trauma.**	
11.	<u>Community tensions</u> CB provided an update on the strategic response to the increasing incidents of hate, racism, antisemitism, and Islamophobia affecting our workforce and communities following recent events. MH outlined the lived experiences of staff, impact, and the leadership actions being taken to ensure our health and care system remains a place of safety, respect, belonging, and inclusion for all. He thanked the Chair for requesting a paper to come to Board to highlight the issues but reported we were possibly in a worse position than we were as well as the level of abuse people were experiencing including colleagues not dressing in the way they want to for example. He outlined a four-pronged approach: • Build trust and confidence to report incidents • When incidents are reported that management have skills and experience to deal with concerns • Support in place e.g. polices etc • Need a system approach. He felt it was not enough for Board to adopt the statement; we need to understand how this would work in practice e.g. may need uniform guidance, but the message was clear that discrimination would not be tolerated. Board was asked to adopt the statement and implement actions with regular updates to Board to track progress.	

	KK shared personal experience at every level of her career. VM agreed it was tough and getting worse. Primary care providers were feeling particularly vulnerable as they were out and about in communities and would welcome NHS GM support. Members all agreed that no one should feel threatened particularly at work. OW added that he had been trying to encourage staff to complete staff survey but had been challenging and BAME were low responders who need their voice to be heard. It was noted GMP had taken a strong stance against perpetrators with a suggestion that GM NHS should do the same. SB made a plea for students on placements who report incidents, but no action was taken then ultimately leave their professions. It was recognised that there were uncomfortable conversations that need to happen to understand why discrimination still exists, working with the Deputy Mayor and GMP. Need to get people to speak up. It was not the first time the Board had discussed this, but conversations need to continue as part of development sessions. **The Board:** • **Publicly endorsed the NHS's zero tolerance stance on antisemitism, Islamophobia, racism, and all forms of discrimination.** • **Ensured this commitment would be embedded in organisational culture, communications, and policies to promote safe, inclusive environments for staff, patients, and communities.** • **Would receive updates and monitor progress to ensure accountability and delivery of local plans and national expectations as outlined in the letter of 16th October 2025.**	
12.	<u>Fit for the Future</u> CC summarised the key learning gained from the Fit for Future (FFF) public engagement programme highlighting the key themes including: • The public want us to get the basics right, appreciating we are in tough and challenging times • They want us to fix the NHS but quite sceptical about how we do this • Concerns over data sharing and security • Feeling that that people didn't have a voice in their own care but keen to engage with us • Use of language e.g. left shift not recognised by the public. This insight had been helpful in feeding into clinical and commissioning strategies as well as planning. Board members thanked CC and her team for this excellent piece of work and felt that it told us something we didn't already know but were keen to understand next steps including actions.	

	CC advised the team were already developing action plans noting the sample size was small but still lots of rich data into how people were feeling. She added that the follow up was fit for winter to really get until the skin of what we've heard. The Chair commented on the fact that people were more willing to engage in discussions about reducing waste noting the need for better communications both from services to patients and between providers. **The Board:** • **Noted the contents of the reports** • **Were mindful of the findings as described in this report when undertaking Board business, including both discussions and in decision making.**	
13.	<u>Finance</u> <u>Finance Committee Report</u> KK presented the summary report following the October and November Finance Committee meetings taking it as read reporting that while some aspects of ISFE2 were functioning, there were significant ongoing issues, including staff access problems that had persisted for over a month. The Month 6 year to date reported a £19.1m year-to-date deficit against plan, with an in-month position improvement in the run rate for the GM system. **The Board:** • **Noted the contents of the report.** <u>Finance Report</u> The Board was updated on the on the financial position for Greater Manchester as at 30th September 2025 noting that things were moving in the right direction. As at Month 6 the ICS deficit plan is £77.5m, with an actual deficit of £96.6m, which equates to a £19.1m adverse variance to plan, which was an improvement of £0.7m from the prior month. A further update would be provided in the private part of the meeting. **For the System Financial position, the Board:** • **Noted the Month 6 year to date reported financial position for GM ICS of £96.6m deficit, against a planned deficit of £77.5m, resulting in a variance against plan of a £19.1m deficit.** • **Noted that the in-month position was an improvement in the run rate for the GM system.** • **Noted the breakeven forecast outturn position in line with NHSE reporting requirements.** • **Noted the YTD delivery of CIP as at Month 6 of £267.1m against a plan of £254.2m, an overachievement of £12.9m.** • **Noted the forecast capital position was expected to be brought back into a balanced position.**	

	• **Noted the risk to the system cash position which would require close monthly monitoring.** • **Noted the on-going risk of the DSF funding for Q3 and Q4 being withheld if the system couldn't demonstrate and provide assurance that there was a credible plan to deliver the FOT position.** • **Noted the participation in mid-review meetings with NHSE and 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.**	
14.	Quality and Performance Quality & Performance Committee Report SB provided an overview of discussions at the Quality & Performance Committee highlighting shared learning which was helpful. **The Board:** • **Noted the contents of the report.** Quality & Performance Report On behalf of MP, AR advised the Board on the levels of assurance regarding performance and quality and the report was taken as read. **The Board discussed and agreed levels of assurance set out in this report.**	
15.	People and Culture People and Culture Committee Report KK provided the summary report following the November People & Culture meetings which was taken as read including an appreciation section next time. **The Board:** • **Noted the contents of the report** People and Culture report CB provided an overview of the People and Culture activity in September and October including to date workforce reports for both NHS GM and wider GM NHS workforce. It was noted that national immigration rule changes pose a number of risks to the current NHS workforce, a review was currently being undertaken across the system to understand the potential impact of the change which would affect the whole sector. **ACTION: Freedom to Speak Up report to be shared with RP.** **The Board:** • **Noted the contents of the report.**	

16.	Remuneration Committee RE provided a verbal update from the September meeting including Voluntary Redundancy (VR). **The Board:** • **Noted the contents of the verbal report.**	
17.	Population Health Committee The overview of discussions at the October Population Health Committee was taken as read noting that the Committee had endorsed the GM breastfeeding Strategy. The fragility of the VCFSE sector was noted with discussions to come back to the Committee with actions to mitigate any issues. **The Board:** • **Noted the contents of the report**	
18.	Approved Minutes of Committees The following minutes were shared for information: • People and Culture Committee • Finance Committee • Audit Committee (DRAFT) • Quality and Performance • Primary Care Commissioning • Population Health Committee	
10.	Any Other Business including reflections of the meeting Meeting closed to the public for private session (members only).	
21.	Date and time of next meeting: Wednesday 21st January 2025, 2pm – 4.30pm, Tootal Buildings.	
22.	Part B (Private) Finance Recovery Plan including VR Month 6 Update KR updated the Board on the progress made against the finance recovery plans in place to mitigate the financial risks to the delivery of the 2025/26 financial plan for Greater Manchester noting early signs that we were seeing improvement and for first time in M6 a surplus. She highlighted the main areas of concern including CIP delivery for NHS GM as well as the GM Providers. Recovery plans continue to be developed, with some improvements reported in the	

	M6 position but still approx. £34m risk. Considerable progress had been made in M7 but remaining 4 or 5 months were going to be difficult. Discussions ongoing with systems. KK provided an update deficit support funding and cash which was an issue, but further updates would be presented each month to Finance Committee. **The Board:** **For NHS GM:** • **Noted the continued risk to the delivery of the financial plan for 2025/26.** • **Noted the progress to date compared to M5.** • **Noted the additional Finance Recovery plan developed to support the reduction in spend for Individualised Packages of Care for Non CHC.** • **Requested updates from SROs on progress to accelerate recovery plans to mitigate the remaining risks of delivery reported at M6.** **For GM Providers:** • **Noted the provider risk and impact of recovery plans.** • **Noted that recovery plans are on track as at month 6.** • **Noted that those Bolton, Stockport and Tameside are developing plans to deliver further improvement.** • **Noted that the actual deficit in month 6 was lower than in the previous 5 months.** • **Noted the provider risk and impact of recovery plans.** • **Noted that further updates would be presented each month to Chief Officers, Finance Committee and Board.** <u>Acceleration Review</u> KR updated the Board on the requirement to accelerate action plans to support the delivery of the recovery plan and mitigate the financial risks to the delivery of the 2025/26 financial plan for Greater Manchester noting this pushed and stretched the organisation even further. It was noted that BECCOr was under review with system wide conservations underway including TPC on Friday. In response to concerns raised, KR confirmed that this wouldn't include anything already contracted. Primary Care Board was supportive of the review but there was a risk this would be pushed into next year. CS reported the shortfall on CIP noting it was difficult trying to balance the statutory duty to achieve financial balance. **The Board noted:** • **The additional schemes that were being deployed to generate additional savings to manage the ICB financial risks and contribute to the system risk** • **The phasing of the savings with a number occurring in month 12** • **The support that is required to deliver savings in pay and non-pay**	

	VR MF reported that we had now received a nationally approved redundancy scheme and a percentage of funding to progress with the ICB reform, to delivery against the £19 per head by 1 April 2026. He asked Board to note the organisational change and voluntary redundancy update provided. Thanks were noted to staff for pulling the information together so quickly.	

No	Date	Item	Details of action agreed	Action Lead	Deadline	Status	Further Detail
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
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	TBC		Timescales to be confirmed
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
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

NHS
Greater Manchester

CEO's Report to the Board 2025-2026

Part of Greater Manchester
Integrated Care Partnership

Board

21 January 2026

Report for Information

Required information.	Details.
Title of report.	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. Urgent and Emergency Care (UEC) plans as we approach the Winter for 2025/26. Proactively responding to the new national television junk food ad ban.
How health inequalities will be reduced in Greater Manchester's communities.	As part of the Public Consultation Processes, NHS GM will consider and act accordingly. The work highlighted and to coincide with Race Equality Week.

The decision to be made and/or input sought.	The Board is asked to note the contents of the Acting 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. Learning from patient and service user feedback as a result of the Public Consultation Process.
Key milestones.	Key messages in the context of NHS Reform and the public consultation process on service redesigns.
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 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. NHS GM taking decisions to supporting the financial recovery.

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 November 2025.

1.3. Following Sir Richard's message to all NHS GM staff and our wider stakeholders, in addition to the press statement made externally, the substantive CEO Mark Fisher has stepped aside from his CEO duties to allow for an internal investigation to take place in response to allegations received. I can confirm that this action has been taken in line with our governance procedures and does not imply any presumption of outcome. As the Deputy CEO, I was asked by Sir Richard to provide interim leadership for NHS GM whilst the investigation takes place. This is primary to provide stability and ensuring the organisation continues to deliver our day-to-day business.

1.4. During the November 2025 Board Meeting we discussed the terrorist attack in Manchester on 2nd October 2025. I would like to reflect on this and highlight how moving forward, addressing anti-racism is part of the four organisational priorities for the second half of this financial year 2025/26 for NHS Greater Manchester (GM) Integrated Care Board (ICB). The other three priorities being finance & performance, NHS reform and getting ready for next year 2026/27. Members of the Board and NHS GM staff will be well aware of this, following our internal communication out to staff on 28th November 2025.

1.5. On the topic on anti-racism, I wanted to draw the Board's attention to Race Equality Week 2026: #ChangeNeedsAllOfUs. Race Equality Week runs from 2nd to 8th February and gives us an important opportunity to reflect honestly on where we are, both nationally and here in GM. Over the past three years, Race Equality Matters has gathered insights from more than 16,000 people across UK organisations. Their findings are striking with 85% of respondents having witnessed or experienced microaggressions, yet only around a third feel their organisation is taking meaningful action, and over half report little or no impact from current initiatives. This highlights a clear gap between lived experience and the progress people expect to see and we need to deliver, it also reminds us that while some positive steps are underway, more sustained action is needed.

1.6. Race Equality Week also reinforces three simple messages being every one of us has a role to play, action drives meaningful change, and every action counts. Through day-to-day behaviours, conversations with colleagues, or working alongside staff networks, each of us can contribute to a more inclusive workplace. Even small steps inspire others and build momentum across teams and services. Our own Workforce Race Equality Standard (WRES) data reflects similar challenges in NHS GM, including gaps in senior

representation and ongoing concerns around bullying, harassment, and access to development. Addressing these issues requires genuine, shared responsibility.

1.7. To support this work, we are partnering with BRAP, an organisation with deep experience in helping teams and leaders understand and tackle inequality. On 5th February, we will launch Let's Talk: Race and Racism, followed by leadership workshops designed to build confidence, capability, and accountability. This BRAP work complements other initiatives already underway across the organisation, ensuring we learn, act, and reinforce change at every level. By listening, learning, and taking action together, we can ensure that #ChangeNeedsAllOfUs is more than a message.

1.8. Board members will be aware of the anticipated changes in respect of the future requirements of Integrated Care Boards (ICBs) since the respective announcements made by the Prime Minister and Secretary of State for Health and Social Care in 2025. We are aiming to launch the staff consultation and share the proposed new structures with staff at the end of January, although at the time of writing my CEO Report to the Board, I cannot confirm the date at this time. I have also confirmed to staff that there will be a second window for voluntary redundancy (VR). Our commitment remains to open this window at the same time as the structures are published, so both will run concurrently.

1.9. Whilst this work in underway structurally, NHS GM still has organisational priorities to address. Colleagues across the organisation are supporting others either fulltime or through matrix working cross-functions, to support the four areas of priority for NHS GM's finances. Members of the Board will have seen a greater focus, grip, control and scrutiny in our Committees and Board meetings.

1.10. Board members may well be aware of the new national television junk food advertisements ban, which came into effect from 5th January 2026. The intention being to protect children from exposure to junk food advertisements, in a bid to tackle childhood obesity. Adverts for less healthy food and drinks will be banned on television before 9pm and online at all times. I have also provided the link to the Government's press release: Landmark junk food ad ban. However, addressing this issue is now new to GM. NHS GM, in partnership with the Greater Manchester Combined Authority (GMCA), the GM Public Health Network (GMPHN) and Transport for Greater Manchester (TfGM) have already undertaken a significant amount of work around junk food advertising on locally owned out of home advertising estates. The wider GM Integrated Care System (ICS), recognise the importance of the commercial determinants of poor health. As such GM were included as being a key partner in the production of the National Harmful Products Framework, which I have provided the following link for: Three-Biggest-Killers-Regional-Toolkit.pdf

1.11. NHS GM has recently supported the GMPHN to produce a submission to the Government around the issue of junk food and healthy weight and has given evidence to the Government Health Select Committee. As part of our future integration with the GM Public Health Network from 2026/27, NHS GM will be looking to accelerate this work which will include co-producing a comprehensive GM plan around healthy weight and preventing obesity. This will also include continuing to work with the GMCA and TfGM to reduce the exposure of children to junk food advertised on public realm advertising spaces in GM, particularly in relation to public transport.

1.12. I would like to take this opportunity to highlight the childhood obesity consultation 'The Real Picture' which we carried out in 2025. The link to the video is here: The Real Picture. This is a multi-award winning campaign and highlights the need to do more locally, regionally and nationally on childhood obesity. In NHS GM we are using this work to help shape our future plan and collective GM action.

1.13. On 29th December 2025, we saw the release of His Majesty the King's New Years Honours list, which saw health and care recipients being recognised both locally and nationally. This includes Kathy Cowell OBE DL, who is the Chair of Manchester University NHS Foundation Trust (MFT). Kathy has been awarded a CBE for services to the NHS. Sir Richard and I would like to congratulate Kathy and all the other recipients for their well-deserved recognition and dedication to the NHS and wider health and care services. I have provided two links below for the Board to see those recognised both locally and nationally, on the NHS England website:

NHS England — North West » North West NHS celebrates outstanding contributions of regional staff in New Year's Honours

NHS England » NHS former chief executive among health service honours

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. As referenced within the CEO's Report to the Board in November 2025, the revised Chief Officer portfolios have now been finalised following feedback on the draft Operating Model. The revised portfolios are as follows and I have included a table shown below as Figure 1, which details the respective portfolio areas of responsibility.

- My own substantive post – Deputy CEO
- Manisha Kumar – Chief Clinical Officer (CCO)
- Kathy Roe – Chief Finance Officer (CFO)
- Katherine Sheerin – Chief Healthcare Commissioning Officer
- Charlotte Bailey – Chief Strategy, People & Partnerships Officer

2.2. The new Chief Officer structure came into effective from 1st January 2026, which is an important step as we prepare to consult the whole workforce on new structures for the

rest of the organisation. While we start to see some line management handover, what we do across place and portfolios, does not change until we have gone through the wider organisational reform programme.

2.3. Given my own interim arrangements as Acting CEO, earlier this month I asked Gareth Robinson to also act up to cover the Chief Reform and Improvement Officer duties of my substantive role. This is to ensure immediate business continuity and resilience while the appropriate governance and recruitment processes are progressed. Board members will be familiar with Gareth who was our Interim Chief Officer for System Improvement (COSI) and has full Fit and Proper Person checks in place. This has enabled Gareth to step in at pace on a temporary basis.

2.4. Running alongside this, on 8th January 2026, I shared the plans for a short-term development opportunity for a member of the ELT, to act up into my substantive executive role, but without the Deputy CEO duties. This will be a time-limited opportunity and forms part of our wider approach to maintaining leadership capacity while also supporting development and progression. I hope to appraise the Board on the developments of this when we meet informally in February and formally in March.

Figure 1

	Chief Strategy, People and Partnership Officer (CSPPO)	Chief Finance Officer (CFO)	Chief Healthcare Commissioning Officer (CHCO)	Deputy CEO and Chief System Reform Officer (CSRO)	Chief Clinical Officer (CCO)
Commissioning Cycle	Everything starts with our people and ways of working. We need to have in place our strategies across health and care; so we know our joint long-term goals and ambitions	Our resources across our influenceable and controllable spend need to be planned for across a multi-year planning cycle with clear strategies to deliver and good oversight we are delivering best value	Once we have our strategies, we can start to convert these into our longer-term and shorter-term commissioning intentions, strategies and plans; pinning down what we are going to do differently in health and care and what outcomes we want for our people across GM	Once we have decided what we want, and we implement it together, we need to ensure it's delivering what we expected and support reform across our system to enable it to happen and be sustainable. We need to oversee the outcomes, evaluate and review what we do, continuously improving	Our clinical input at every stage is critical; everything from our big plans, to what we do differently and how we do it ensuring its safe, of high quality, in line with best practice and clinical standards
Teams	• Strategy and Strategic Planning • People and Culture • Communications and Engagement • Patient Services • Risk Management (Board and BAF) • Health Inequalities • Corporate Governance • Estates • Place and DPL point of contact • Adult Social Care Transformation • Population Health, Live Well • ICB Reform and Transition	• Finance • Contracting • Procurement • Place Finance • Recovering and Improvement PMO	• Healthcare Commissioning • Referral Teams • CHC – individualised packages of care • Maternity/CYP • SEND • Primary Care Commissioning	• Operational Planning • Performance Improvement & Assurance • Digital and DII • QI and Improvement • Provider and System Collaboration • EPPR	• Clinical Standards • Clinical and Care professional leaders • Clinical Networks • Place Clinical Leaders • Clinical Quality Assurance and Safety • Population Health clinical leadership • Vaccs and Imms • Safeguarding • Meds Optimisation • Public Health Consultants • Primary Care Transformation • Mental Health
Accountabilities	• Overall system sustainability strategy • Corporate standards, policy and regulation • Public engagement • Wider system relationship management • Place relationship management • VCSFE relationship management • Workforce regulation and practice	• Resource planning and allocation • Contracting and contractual oversight • Strategic financial development • Financial governance • Operational finance delivery • Financial sustainability • Cost Improvement Programme	• Commissioning intentions • Commissioning strategies • Commissioning plans • Commissioning service specifications and contracts • Commissioning policy • Health economics	• Contract outcomes and delivery framework • Transformation standards and methodology • Constitutional compliance • Provider relationship management/oversight • Delivery of GM sustainable acute services strategy • Performance reporting • Digital strategies and plans	• Clinical governance and effectiveness • Definition of clinical standards and outcomes for inclusion in contracts • Clinical and quality assurance and improvement • HEI strategic relationship management • Clinical interface management and multi organisational engagement • Quality strategy • Clinical research and innovation
Lead area	• Communications, Engagement and People & Culture Plan	• Financial Plan	• Commissioning Plan	• Operational Plan	• Clinical Strategy and Plan
Lead for system priorities	• Neighbourhood and Place (Integrated Teams) • Prevention Demonstrator • Relations with GMCA		• Major Trauma • Relations with independent sector • Community service review • Children's services • Maternity	• UEC, elective and cancer achievement of constitutional standards • Finance Recovery Plan • Cost Improvement Plan	• Mental Health • LD and Autism • Primary Care Transformation • Long Term Conditions

Note: some areas will be delivered differently over time and some deployed into Place while managed under CO's portfolios. Portfolios and System Lead roles are delivered through pan-organisational teams and pan-system teams

2.5. Although this was reported to the Board's Informal Meeting in December 2025, I would like to thank to Mandy Philbin, who until 31st December 2025, was the Chief Nursing Officer (CNO) for NHS GM. Myself and Sir Richard would like to thank Mandy and have it formally noted of our gratitude to her, as she moves into her next phase of early retirement and we wish her all the best.

2.6. Sir Richard attended the Live Leadership Briefing (LLB) session with all NHS GM staff on Monday 1st December 2025, where he announced his own well-deserved retirement, which will see Sir Richard's term of office end on 30th June 2026 as Chair for NHS GM. On behalf of the Board and colleagues across the whole health and care system in GM, I would like to personally thank and recognise Sir Richard's dedication to health and care. Sir Richard was the Health Portfolio holder for the GMCA from March 2020 before being appointed as Chair of NHS GM in November 2021. I trust that Board members may wish to voice their own personal thanks for noting during the Board meeting itself, as well as in the coming weeks and months. A joint recruitment process with NHS England is now underway to appoint Sir Richard's successor. Charlotte Bailey is overseeing this process in collaboration with her counterparts at NHS England, and she will be able to appraise the Board as and when appropriate.

2.7. Sir Richard and I would like to welcome Jackie Njoroge who is the Chief Strategy & Data Officer at University of Salford (UOS) and has been appointed as our new Deputy Chair / Senior Independent Director (SID) Non-Executive Director (NED). I am aware that members of the Board, including myself have had the opportunity to meet Jackie already, prior to attending January's Board Meeting.

Supporting Financial Recovery

2.8. For completeness, I wanted to report on the wider stakeholder communication which was issued to GM ICS colleagues regarding the temporary delays to NHS funded care delivered by independent sector (IS) hospitals in GM. Due to financial pressures and high demand across the system, some IS providers of routine planned (elective) care have been asked to pause new routine NHS referrals and the start of new treatment pathways until 31st March 2026. This temporary measure supports fair and clinically appropriate management of waiting lists across GM.

2.9. In response to some of the other decisions to support financial recovery we have published a number of web pages to provide public information and support professionals in their conversations with patients. The webpage information explains why some appointments at IS may be delayed or postponed and re-booked. The information provided also explained which services are not affected, including cancer referrals, urgent or time critical care, emergency care, and ongoing treatment. Moreover, what patients should do if their symptoms worsen or they are concerned about their health, as well as providing answers to some frequently asked questions. I have provided three useful links below:

Temporary delays to NHS-funded care delivered by independent hospitals in Greater Manchester

Weight management drugs

ADHD and autism assessments

NHS GM Operating Model: making it work, from vision to reality

2.10. Over the past year, NHS GM has been on a journey of change. The last few months especially have brought uncertainty, shifting priorities, and fast-moving decisions. Sir Richard and I want to personally thank everyone for their continued professionalism and commitment. In readiness for the changes to the Chief Officer portfolios, I met with the GM NHS Trust CEOs in December 2025. We are evolving how we work together across portfolios, Places, and the wider system, to deliver the ambitions of the NHS 10 Year Plan and build a healthier, more sustainable future for GM.

2.11. The Chief Officers, Place Based Leads (PBLs), Deputy Place Based Leads (DPBLs) and Portfolio Leads have spent the last few weeks sharing with colleagues, our partners and wider stakeholders our vision behind the operating model and how we make it a reality. Together, we are building something ambitious, and we want everyone to be part of it.

2.12. The Board will be aware from the update in November 2025, that NHS GM still has organisational priorities to address through Quarter 4 (Q4). Colleagues across the organisation, including from localities and pan-GM functions, continue to support the four areas of priority for NHS GM's finances. Members of the Board will have seen a greater focus, grip, control and scrutiny in our Committees and Board meetings on the following four areas: Mental health commissioning specifically Adult Attention Deficit Hyperactivity Disorder (ADHD) and Autism, All Aged Continuing Healthcare (AACC) which includes Continuing Healthcare (CHC) and individualised packages of care (IPOC), the independent sector for elective activity and the Cost Improvement Programme (CIP) delivery to ensure financial recovery. Acceleration actions have been developed to drive progress forward at pace and are fully embedded in the four key areas. These actions further add robustness and rigour to the programmes. These were also being discussed in our GM System Delivery Meeting / ICB Quarter 2 Assurance Meeting with Louise Shepherd and her team earlier this month.

Urgent and Emergency Care (UEC) Response Update

2.13. During the festive period, GM's health and care system delivered a coordinated response to winter pressures, achieving a notable reduction in bed occupancy dropping below 80% on Christmas Eve, which was almost 2% lower than the previous year. This was accomplished through proactive surge actions, including elective stand-downs, accelerated discharge processes, and increased community capacity, all underpinned by

robust leadership and daily operational oversight. Initiatives such as real-time dashboards, strengthened discharge protocols, and targeted provider schemes ensured patient flow and supported safe, timely discharges.

2.14. Emergency Department (ED) performance showed improvement, with the GM-wide 4-hour standard rising by 3.2% compared to last year, though only some providers exceeded their December 2025 plans. Ambulance handover delays were reduced and Category 2 response times improved by over three minutes year-on-year. Despite these gains, several sites experienced sustained operational pressures, particularly post-New Year, with some acute and mental health services operating at or near escalation thresholds. These challenges were managed through daily system coordination and escalation protocols, maintaining service resilience.

2.15. Looking ahead, the system's priorities include sustaining these improvements, progressing demand management initiatives, and continuing weekly leadership engagement. There is a need to further strengthen data quality, ensure timely mobilisation of resources, and enhance the routine capture of community surge plans. Ongoing focus on alternatives to ED attendance and the continuation of the UEC Reform Programme will be key to maintaining progress through the remainder of winter.

2.16. Running alongside this UEC work, I would like to draw the Board's attention to the separate item being the Emergency Preparedness, Resilience and Response (EPRR) Annual Report 2025/26. This report provides the Board with the outcome of the self-assessment undertaken by NHS GM for the 2025/26 EPRR assurance process. For 2025/26, NHS GM declared an overall compliance rating of 68%, which represents a slight reduction in compliance compared to 2024/25 when compliance was 72%. NHS GM will implement an improvement action plan to raise the organisation's overall compliance before the next self-assessment due to be undertaken in 2026/27. Should Board members wish to explore UEC or EPRR is more detail, this can be followed up directly with the GM UEC Programme Director / Interim EPRR Director.

Life saving programme preventing heart attack and strokes

2.17. NHS GM's preventative care programme has helped prevent around 380 serious health emergencies in the past year, including 180 heart attacks and 200 strokes. Part of the Beyond Core Contract Reviews (BeCCoR) initiative, it targets the region's high cardiovascular disease rates, which is over twice the national average. This is through by offering enhanced reviews for at-risk patients checking blood pressure, cholesterol, and improving management of conditions such as atrial fibrillation and diabetes. Focused on deprived areas, the programme has saved lives and reduced NHS costs by an estimated £6–8 million, demonstrating the impact of proactive, targeted healthcare in tackling health inequalities.

NHS GM Virtual Member of Parliament (MP) Briefing Session

2.18. On Friday 30th January, I will be hosting a virtual briefing session, to all the MPs with constituencies across the ten GM cities and boroughs. I will be updating the MPs on the progress made for NHS Reform, along key messages and system updates. Should members of the Board wish to join the virtual session, they are welcome to do so, or feel free to share any of your own questions and comments in advance. I will update the Board accordingly at our informal Board Meeting in February and formal Board Meeting in March as appropriate.

Obesity pathways transformation bid

2.19. The Obesity Pathway Innovation Programme (OPIP) is a 3-year initiative funded by Innovate UK, designed to transform obesity care through an integrated model. The ambition is to replace fragmented tiered services with a system that connects data, communities, and clinical care. Health Innovation Manchester (HInM) and partners had led a project over the past 18 months to deeply understand and reimagine the obesity pathway across GM, which put GM in a strong position to bid for the maximum £8m through the OPIP fund.

2.20. The bid was co-developed with several partners and submitted in November 2025. The proposed model combines behavioural, digital, and pharmacological interventions, supported by a central coordination hub and partnerships across general practice, community pharmacy, school nursing, specialist providers, and Voluntary, Community, Faith, and Social Enterprise (VCFSE) organisations. It targets high-need cohorts and emphasises scalability, equity, and sustainability, underpinned by strong governance and evaluation. The GM bid has been recognised nationally as 'what a great bid looks like' with interview stage and final outcome in January 2026.

Collaboration with industry award

2.21. HInM were proud to announce that their collaboration with Eli Lilly and Company (Lilly UK) to improve obesity care across GM has been shortlisted for the Best Pharmaceutical Partnership with the NHS at the 2026 HSJ Partnership Awards, which recognise outstanding dedication to improving healthcare and effective collaboration with the NHS.

2.22. The HSJ Partnership Awards have become the most recognised and respected mark of the strongest relationships between suppliers and the NHS. Following the thorough judging process, Eli Lilly and Company (Lilly UK) & HInM was included in the organisations, projects and individuals that made the final shortlist amid the hundreds of entries for the 2026 awards. Winners will be announced at the awards ceremony on 19th March 2026, and I am sure the Board will join me in recognising this work and wish them the best of luck.

Real-world trial first patient visit

2.23. On 1st December 2025, (Lilly) announced that the first patient visit has taken place for SURMOUNT-REAL UK, Lilly's five-year, randomised, real-world trial taking place in GM. This will evaluate the long-term effectiveness of tirzepatide on obesity outcomes when given in primary care settings. The study aims to enrol up to 3,000 participants for the trial across the region over the next 5 years.

GM Care Record (GMCR) clinical and productivity benefits

2.24. The Government's NHS's 10-Year Health Plan, known as Fit for the Future, includes three priorities. One of the three priorities is transforming from analogue to digital. As such I thought it would be appropriate to refer to the success of the GMCR. The GMCR continues to underpin clinical care across GM, with 35% annual increase in patient records accessed and 16% in distinct users, with over 400K patient records accessed by 27K distinct users each month. This usage is projected to give £19m productivity benefit from clinical time saved alone. The GMCR is accessible in over 30% of Community Pharmacies and also surfaces integrated care plans, including over 6K active end of life care plans across GM.

Public Consultations Update

2.25. From previous updates to the Board, members will be aware of NHS GM's consultations. The GM IVF (In Vitro Fertilisation) Cycles Public Consultation saw more than 2,200 people get involved during the eight-week consultation between Wednesday 18th June and Tuesday 29th July 2025. Those who participated either completed a survey, emailed or texted their views, attended a focus group or workshop, or shared their thoughts at one of our pop-up stalls.

2.26. People strongly supported standardising the number of cycles across the whole of GM. However, there was widespread frustration and concern about changing to a GM-wide one cycle plus an additional attempt should this be cancelled or abandoned, known as the 1+ option. Many cited clinical evidence and personal experiences that only one cycle was insufficient for most women to achieve a successful pregnancy.

2.27. Some respondents described the first IVF cycle as a "trial run" or "exploratory," with further cycles offering the opportunity for "bespoke treatment". The impact any change could have on an individual's mental health was also raised, as was the price of further private treatment being unaffordable and out of reach for many couples. There was a strong feeling that the offer should be "levelled up" to meet NICE guidelines, which currently recommends a three-cycle offer.

2.28. We are very grateful to everyone who took the time to respond to this consultation. These findings, along with clinical evidence, will inform the final service model. NHS GM will keep Board members and stakeholders informed on how this progresses. The full report is available on our website and for more information on the consultation visit:

https://getinvolved.gmintegratedcare.org.uk/en-GB/projects/ivf-consultation. Members of the public can also contact: gmhscp.engagement@nhs.net or 07786 673762 to call, text or WhatsApp.

GM ahead of global Human Immunodeficiency Virus (HIV) targets

2.29. Members of the Board will be well aware of the health and public health work programmes regarding HIV, which have been underway for many years across the ten respective GM localities, well before the creation of NHS GM. One such piece of work has been our ambitious programme to end all new transmission of HIV in GM by 2030. National figures from the UK Health Security Agency (UKHSA) confirm that GM is ahead of the global UNAIDS 95-95-95 targets, which aims for almost everyone living with HIV to know their status, access treatment, and have an undetectable viral load.

2.30. This work is part of GM's wider commitment as an international Fast-Track City. GM joined the initiative in 2018, alongside 400 cities committed to ending new HIV transmissions and eliminating HIV-related stigma by 2030. I have provided the link to World Aids Day information, which was published on 1st December 2025 by the George House Trust George House Trust. The commitment was signed by Mayor of GM Andy Burnham, on behalf of GM. Some of GM's achievements include:

- During 2025 there's been a decrease in the number of new HIV diagnoses.
- 95% of people living with HIV know their status.
- Furthermore, there has been a 63% reduction in the number of new HIV diagnoses in Greater Manchester between 2014 and 2024.

2.31. NHS GM has published further information, should Board members wish to share more widely: Greater Manchester ahead of global HIV targets as World AIDS Day approaches | Greater Manchester Integrated Care Partnership

2.32. The work specifically done in GM has seen:

- More than 1.1 million BBV tests have been done across the 9 ED sites- this includes HIV, Hep B and C.
- Over 500,000 HIV tests.
- More than 170 new HIV diagnoses.
- 470 new hepatitis B diagnoses.
- 525 new hepatitis C diagnoses.
- Many others already living with these conditions reconnected to treatment.

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.

NHS
Greater Manchester

Constitution Review

Part of Greater Manchester
Integrated Care Partnership

Integrated Care Board

21 January 2026

Report information.

Required information.	Details.
Title of report.	Constitution Review
Author.	Jenny Noble, Board Secretary
Presented by.	Charlotte Bailey, Chief Strategy, People and Partnerships Officer Chris Gaffey, Associate Director of Corporate Services
Contact for further information.	Jenny Noble, Board Secretary
Executive summary.	This report proposes changes to the Constitution following updated guidance, as well as other mandated changes to Board composition to reflect a new Chief Officer structure from 1st January 2026, and to ensure that the governance framework continues to be fit for purpose.
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 Integrated Care Board is asked to: 1. Consider the proposed amendments for approval.
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. A clear constitution will support the delivery of the ICP Strategy, as well as ensure focus on the Board Assurance Framework.
Key milestones.	N/A
Leadership and governance arrangements.	The Chief Strategy, People and Partnerships Officer is the Lead Chief Officer responsible for Corporate Governance arrangements, supported by the Associate Director of Corporate Services, however these arrangements affect the whole Chief Officer cohort.
Engagement* to date. ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	N/A
Financial or Legal Implications	No formal legal or financial implications as part of this report.

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

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

Table 2: Assurance needed about the document.

Introduction

1.1. The Constitution and Standing Orders came into effect as approved by NHSE in July 2022 and technical amendments to the GM NHS Constitution were approved by the Board in October 2022 as part of a review ICB Governance.

1.2. This was reviewed in September 2023 and subsequently approved by NHSE. Updated guidance on integrated care board constitutions and governance was published by NHSE in 2024 and we were asked to make amendments to our constitution as our next opportunity, and these changes are captured as part of this review. It should be noted that we have been mandated by region to update the Board membership to reflect current Chief Officer roles although we will need further NHSE approval on the proposed changes.

1.3. Proposed amendments have been presented to Chief Officers for consideration following an initial review by the Corporate Governance Team who have been working closely with the regional team and are recommended for approval by the Board.

Summary of Proposed Changes to the Constitution

1.4. As set out in section 1.6.1, the procedure for proposal and agreement of variations to the Constitution is as follows:

a) Proposed amendments to this constitution may be submitted by the Chair and/ or the Chief Executive for consideration and approval by the Board, prior to such amendments being submitted to NHS England.

b) Proposed amendments to this constitution will not be implemented until an application to NHS England for variation has been approved.

1.5. The proposed changes to the Constitution are outlined in more detail in Appendix 1. The changes are proposed as part of the formal review of the constitution, conducted by the Board Secretary and Associate Director of Corporate Services in line with updated NHSE guidance. The changes have been considered by Chief Officers (and shared with the Chair in advance of the meeting) and are presented to the Board for approval before being submitted to NHSE.

1.6. The key changes to the constitution relate to the Board's composition. The Chair/Acting Chief Executive have proposed that all Chief Officers become voting members of the Board. The proposed Board composition would therefore be as follows:

a) Chair

b) Chief Executive

c) two Partner Members NHS and foundation trusts

d) one Partner Member primary medical services

e) one Partner Member local authorities

f) five Non-executive Members

g) Chief Finance Officer

h) Chief Clinical Officer

i) one Ordinary Member VCFSE

j) Deputy Chief Executive

k) Chief Strategy, People and Partnerships Officer

l) Chief Commissioning Officer

1.7. Consideration has been given to quorum and whether this should be the Chief Clinical Officer and / or another Executive Director, however it is important to ensure a clinical voice on the board. Chief Officers agreed this should be the Chief Clinical Officer or their nominated deputy as agreed with the Chair.

1.8. In terms of the proposed changes around board composition, early engagement with NHSE has taken place. The approval process via NHSE can take up to eight weeks, however it is hoped that this early engagement will reduce the length of the process. This has been done in parallel with NHSE taking the proposed amendments to their Regional Executive Team meeting before they formally go to our public board.

1.9. Other amendments to our constitution that we are proposing to make include:

- Making one of the non-executive board members – but not the audit chair – also the deputy of the board. *Jackie Njoroge was appointed to the Board as Deputy Chair/Senior Independent Director in January 2026.*

- In line with the governance requirements of NHS trusts and foundation trusts regarding senior independent directors, ICBs should make one of their non-executive board members the senior non-executive member to support the NHS England regional director in the appraisal of the chair and their compliance with the fit and proper person test, and to act as a sounding board for the chair and – if necessary – to mediate between the chair and other board members. *Again, Jackie Njoroje was appointed to the Board as Deputy Chair/Senior Independent Director in January 2026.*

- Ensuring that the chair's period of office is expressed clearly as a maximum rather than a fixed term, recognising that interim chair appointments (approved by the Secretary of State) may be necessary.

- Confirming that a proposal for the chair or a non-executive to serve on the board for longer than 6 years will be subject to rigorous review to ensure their ongoing

independence, and they will not serve as a board member for longer than 9 years in total, consistent with the Code of Governance for NHS provider trusts.

- Updating the reference to procurement rules to take account of the introduction of the provider selection regime (PSR).

- Removing the clauses related to the establishment of ICBs. *Already done as part of previous review.*

1.10. For reference against the table of proposed changes set out in appendix 1, the current NHS GM Constitution can be found on the NHS GM website.

Next Steps

1.11. As set out in section 1.7.3 d) of the Constitution, the ICB Governance Handbook brings together all the ICB's governance documents so it is easy for interested people to navigate. It includes:

- The Scheme of Reservation and Delegation (SoRD)

- Functions and Decision map

- Standing Financial Instructions

- Terms of reference for all committees and sub-committees of the board that exercise ICB functions.

- Delegation arrangements for all instances where ICB functions are delegated, in accordance with section 65Z5 of the 2006 Act, to another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one of those organisations in accordance with section 65Z6 of the 2006 Act.

- Terms of reference of any joint committee of the ICB and another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one of those organisations in accordance with section 65Z6 of the 2006 Act.

- The up-to-date list of eligible providers of primary medical services under clause 3.6.2

1.12. In addition, key policy documents are also included in the Governance Handbook including:

- Standards of Business Conduct Policy

- Conflicts of Interest Policy and Procedures

- Policy for Public Involvement and Engagement.

1.13. Unlike the Constitution, the Governance Handbook does not need to be submitted to NHSE although some of the documents within it will require Board approval.

1.14. Further changes will be required to the contents of the Governance Handbook, including the SoRD, which will be reviewed and updated following reform. In the meantime, relevant areas listed for the previous Chief Officer structure will be the responsibility of the relevant Chief Officer in the new structure, and the responsibilities of the previous Committees will be the responsibility of the Transition Committee and Finance Sub-Committee (as per the proposals agreed by the Board at their meeting on 19 December 2026).

Recommendations

1.15. The Integrated Care Board is asked to:

1. Note the contents of the report;
2. Approve the proposed amendments to the constitution;
3. Note that an application for these changes to NHS GM's Constitution will be sent to NHS England for approval; and
4. Give delegated authority to the Acting CEO and Chair to agree any minor changes required following the ICB meeting or by NHS England, and note that any such changes will be reported to the Board.

Appendix 1

Summary of Proposed Constitutional Changes following latest guidance NHS England » Guidance on integrated care board constitutions and governance

Section or Page No	Title of Section	Proposed Amendment
Page No 3	**Contents**	**Remove:** Medical Director and Director of Nursing **Add:** Chief Clinical Officer and additional Chief Officers
2.1.5	**Background**	**Updated to include suggested wording from region**
2.2.2	**Board Membership**	**Amend a):** Voluntary, Community and Social Enterprise (VCSE) sector to Voluntary, Community, Faith and Social Enterprise (VCFSE) sector **Add:** Additional Chief Officers
2.2.3	**Board Membership**	**Remove h and i):** Medical Director and Director of Nursing. **Add:** Chief Clinical Officer and additional COs to be included as a voting members. **Amend j):** one Ordinary Member VCSE to one Ordinary Member VCFSE
3.3.4	**Chair**	**Amend:** The term of office for the Chair in line with updated guidance
3.8 and 3.9	**Medical Director and Director of Nursing**	**Amend:** Replace with Chief Clinical Officer
3.11	**Chief Strategy, People and Partnerships Officer**	**Add**
3.12	**Chief Commissioning Officer**	**Add**
3.13	**Ordinary Member - VCSE**	**Amend:** VCSE to VCFSE throughout.
3.13.6	**Five non-executive members**	**Add:** Deputy Chair/Senior Independent Director
4.7.1	**Quorum**	**Amend:** To include Chief Clinical Officer or their nominated deputy as agreed with the Chair
7.4.3	**Scrutiny and decision-making**	**Update the reference to procurement rules to take account of the introduction of the provider selection regime**
Appendix 2 – 4.4.2	**Chair of a meeting**	**Amend:** Deputy Chair arrangements.

NHS
Greater Manchester

NHS Greater Manchester Constitution

Part of Greater Manchester Integrated Care Partnership

Version	Date approved by the ICB	Effective date
V1.0	n/a	1 July 2022
V2.0	19 October 2022	
V3.0	20 September 2023	14 December 2023
V4.0	21 January 2026 (TBC)	

Contents (to be updated following approval)

1 Introduction

1.1 Background

i. NHS Greater Manchester Integrated Care Board (ICB) is part of the Greater Manchester Health and Care Partnership. This constitution builds on the Memorandum of Understanding (MOU) agreed between all local authority members of the Association of Greater Manchester Authorities (AGMA) and all Greater Manchester Clinical Commissioning Groups (CCGs) (together known as GM) with NHSE as part of the devolution of health and social care responsibilities to the accountable, statutory organisations in Greater Manchester in 2016.

ii. The Integrated Care Board will work to deliver the strategy set by our Integrated Care Partnership (ICP). It will support the ten place-based partnerships in Greater Manchester (Bolton, Bury, Heywood Middleton and Rochdale, Manchester, Oldham, Tameside, Trafford, Salford, Stockport and Wigan) as part of a well-established way of working to meet the diverse needs of our citizens and communities.

iii. The core purposes of the GM ICS are:
   a) to improve outcomes in population health and healthcare
   b) to tackle inequalities in outcomes, experience and access
   c) to enhance productivity and value for money
   d) to help the NHS support broader social and economic development.

iv. The GM ICB will use its resources and powers to achieve demonstrable progress on these aims, collaborating to tackle complex challenges, including:

- improving the health of children and young people
- supporting people to stay well and independent
- acting sooner to help those with preventable conditions
- supporting those with long-term conditions or mental health issues
- caring for those with multiple needs as populations age
- getting the best from collective resources so people get care as quickly as possible.

1.2 Name

1.2.1 The name of this Integrated Care Board is NHS Greater Manchester (“the ICB”).

1.3 Area covered by the Integrated Care Board

1.3.1 The area covered by the ICB is co-terminus with the administrative boundaries of the local authorities listed at 3.7.1.

1.4 Statutory Framework

1.4.1 The ICB is established by order made by NHS England under powers in the 2006 Act.

1.4.2 The ICB is a statutory body with the general function of arranging for the provision of services for the purposes of the health service in England and is an NHS body for the purposes of the 2006 Act.

1.4.3 The main powers and duties of the ICB to commission certain health services are set out in sections 3 and 3A of the 2006 Act. These provisions are supplemented by other statutory powers and duties that apply to ICBs, as well as by regulations and directions (including, but not limited to, those made under the 2006 Act).

1.4.4 In accordance with section 14Z25(5) of, and paragraph 1 of Schedule 1B to, the 2006 Act the ICB must have a constitution, which must comply with the requirements set out in that Schedule. The ICB is required to publish its constitution (section 14Z29). This Constitution is published on the Greater Manchester Integrated Care website - https://gmintegratedcare.org.uk/

1.4.5 The ICB must act in a way that is consistent with its statutory functions, both powers and duties. Many of these statutory functions are set out in the 2006 Act but there are also other specific pieces of legislation that apply to ICBs. Examples include, but are not limited to, the Equality Act 2010 and the Children Acts. Some of the statutory functions that apply to ICBs take the form of general statutory duties, which the ICB must comply with when exercising its functions. These duties include but are not limited to:

a) Having regard to and acting in a way that promotes the NHS Constitution (section 2 of the Health Act 2009 and section 14Z32 of the 2006 Act).
b) Exercising its functions effectively, efficiently and economically (section 14Z33 of the 2006 Act).
c) Duties in relation to children including safeguarding, promoting welfare etc (including the Children Acts 1989 and 2004, and the Children and Families Act 2014).
d) Adult safeguarding and carers (the Care Act 2014).
e) Equality, including the public-sector equality duty (under the Equality Act 2010) and the duty as to health inequalities (section 14Z35).

f) Information law, (for instance, data protection laws, such as the UK General Data Protection Regulation 2016/679 and Data Protection Act 2018, and the Freedom of Information Act 2000).
g) Provisions of the Civil Contingencies Act 2004.

1.4.6 The ICB is subject to an annual assessment of its performance by NHS England which is also required to publish a report containing a summary of the results of its assessment.

1.4.7 The performance assessment will assess how well the ICB has discharged its functions during that year and will, in particular, include an assessment of how well it has discharged its duties under:

a) section 14Z34 (improvement in quality of services)
b) section 14Z35 (reducing inequalities)
c) section 14Z38 (obtaining appropriate advice)
d) section 14Z40 (duty in respect of research)
e) section 14Z43 (duty to have regard to effect of decisions)
f) section 14Z45 (public involvement and consultation)
g) sections 223GB to 223N (financial duties)
h) section 116B(1) of the Local Government and Public Involvement in Health Act 2007 (duty to have regard to assessments and strategies).

1.4.8 NHS England has powers to obtain information from the ICB (section 14Z60 of the 2006 Act) and to intervene where it is satisfied that the ICB is failing, or has failed, to discharge any of its functions or that there is a significant risk that it will fail to do so (section 14Z61).

1.5 Status of this Constitution

1.5.1 The ICB was established on 1 July 2022 by Integrated Care Boards (Establishment) Order 2022,~~,~~ which made provision for its Constitution by reference to this document.

1.5.2 This Constitution must be reviewed and maintained in line with any agreements with, and requirements of, NHS England set out in writing at establishment.

1.5.3 Changes to this Constitution will not be implemented until, and are only effective from, the date of approval by NHS England.

1.6 Variation of this Constitution

1.6.1 In accordance with paragraph 15 of Schedule 1B to the 2006 Act this Constitution may be varied in accordance with the procedure set out in this paragraph. The Constitution can only be varied in two circumstances:

a) Where the ICB applies to NHS England in accordance with NHS England's published procedure and that application is approved.
b) Where NHS England varies the Constitution of its own initiative, (other than on application by the ICB).

1.6.2 The procedure for proposal and agreement of variations to the Constitution is as follows:

a) Proposed amendments to this constitution may be submitted by the Chair and/ or the Chief Executive for consideration and approval by the board, prior to such amendments being submitted to NHS England.
b) Proposed amendments to this constitution will not be implemented until an application to NHS England for variation has been approved.

1.7 Related documents

1.7.1 This Constitution is also supported by a number of documents which provide further details on how governance arrangements in the ICB will operate.

1.7.2 The following are appended to the Constitution and form part of it for the purpose of clause 1.6 and the ICB's legal duty to have a Constitution:

a) **Standing Orders** which set out the arrangements and procedures to be used for meetings and the process to appoint the ICB committees.

1.7.3 The following do not form part of the Constitution but are required to be published:

a) **The Scheme of Reservation and Delegation (SoRD) –** sets out those decisions that are reserved to the board of the ICB and those decisions that have been delegated in accordance with the powers of the ICB and which must be agreed in accordance with and be consistent with the Constitution. The SoRD identifies where, or to whom, functions and decisions have been delegated to.

b) **Functions and Decision map –** a high level structural chart that sets out which key decisions are delegated and taken by which part or parts of the system. The Functions and Decision map also includes decision

making responsibilities that are delegated to the ICB (for example, from NHS England).

c) **Standing Financial Instructions –** set out the arrangements for managing the ICB's financial affairs.

d) **The ICB Governance Handbook –** brings together all the ICB's governance documents so it is easy for interested people to navigate. It includes:

- The above documents a) – ~~c~~d).
- Terms of reference for all committees and sub-committees of the board that exercise ICB functions.
- Delegation arrangements for all instances where ICB functions are delegated, in accordance with section 65Z5 of the 2006 Act, to another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one of those organisations in accordance with section 65Z6 of the 2006 Act.
- Terms of reference of any joint committee of the ICB and another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one of those organisations in accordance with section 65Z6 of the 2006 Act.
- The up-to-date list of eligible providers of primary medical services under clause 3.6.2

e) **Key policy documents** which should also be included in the Governance Handbook, or linked to it - including:

- Standards of Business Conduct Policy
- Conflicts of Interest Policy and Procedures
- Policy for Public Involvement and Engagement.

2 Composition of the Board of the ICB

2.1 Background

2.1.1 This part of the Constitution describes the membership of the Integrated Care Board. Further information about the criteria for the roles and how they are appointed is in section 3.

2.1.2 Further information about the individuals who fulfil these roles can be found on our website - https://gmintegratedcare.org.uk/

2.1.3 In accordance with paragraph 3 of Schedule 1B to the 2006 Act, the membership of the ICB (referred to in this Constitution as "the board" and members of the ICB are referred to as "board members") consists of:

a) a Chair
b) a Chief Executive
c) at least three Ordinary Members.

2.1.4 The membership of the ICB (the board) shall meet as a unitary board and shall be collectively accountable for the performance of the ICB's functions

2.1.5 NHS England Policy, requires the ICB to appoint the following additional ordinary members:

a) three executive members, namely:
- Director of Finance
- Medical Director
- Director of Nursing. These roles are now covered by the portfolios of the Executive roles referenced in clause 2.2.3

b) At least two non-executive members.

2.1.6 The Ordinary Members include at least three members who will bring knowledge and a perspective from their sectors. These members (known as Partner Members) are nominated by the following, and appointed in accordance with the procedures set out in Section 3 below**:**

- NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description
- the primary medical services (general practice) providers within the area of the ICB and are of a prescribed description
- the local authorities which are responsible for providing social care and whose area coincides with or includes the whole or any part of the ICB's area.

While the Partner Members will bring knowledge and experience from their sector and will contribute the perspective of their sector to the decisions of the board, they are not to act as delegates of those sectors.

2.2 Board membership

2.2.1 The ICB has four Partner Members:

a) two Partner Members bringing the perspective of NHS and foundation trusts, one of which will have knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness
b) one Partner Member bringing the perspective of primary medical services
c) one Partner Member bringing the perspective of local authorities.

2.2.2 The ICB has also appointed the following further Ordinary and Executive Members to the board:

a) one Ordinary Member bringing the perspective of the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector
b) Deputy Chief Executive
c) Chief Strategy, People and Partnerships Officer
~~b)~~d) Chief Commissioning Officer.

2.2.3 The board is therefore composed of the following members:

a) Chair
b) Chief Executive
c) two Partner Members NHS and foundation trusts
d) one Partner Member primary medical services
e) one Partner Member local authorities
f) five non-executive members
g) ~~Director of Finance~~Chief Finance Officer
h) ~~Medical Director~~Chief Clinical Officer
~~i) Director of Nursing~~
~~j)~~i) one Ordinary Member ~~VCSE~~VCFSE
j) Deputy Chief Executive
k) Chief Strategy, People and Partnerships Officer
~~k)~~l) Chief Commissioning Officer.

2.2.4 The Chair will exercise their function to approve the appointment of the Ordinary Members with a view to ensuring that at least one of the Ordinary Members will have knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness.

2.2.5 The board will keep under review the skills, knowledge, and experience that it considers necessary for members of the board to possess (when taken together) in order for the board effectively to carry out its functions and will take such steps as it considers necessary to address or mitigate any shortcoming.

2.3 Regular participants and observers at board meetings

2.3.1 The board may invite specified individuals to be participants or observers at its meetings in order to inform its decision-making and the discharge of its functions as it sees fit.

The board specifically invites the Health and Care Portfolio Lead for GM as a participant at meetings. ~~The Board also invites those Executive Directors who are not formal members of the Board to attend all Board meetings.~~

2.3.2 Participants will receive advance copies of the notice, agenda and papers for board meetings. They may be invited to attend any or all of the board meetings, or part(s) of a meeting by the Chair. Any such person may be invited, at the discretion of the Chair to ask questions and address the meeting but may not vote.

2.3.3 Observers will receive advance copies of the notice, agenda and papers for board meetings. They may be invited to attend any or all the board meetings, or part(s) of a meeting by the Chair. Any such person may not address the meeting and may not vote.

2.3.4 Participants and/ or observers may be asked to leave the meeting by the Chair in the event that the board passes a resolution to exclude the public as per the standing orders.

3 Appointments process for the board

3.1 Eligibility criteria for board membership:

3.1.1 Each member of the ICB must:

a) Comply with the criteria of the 'fit and proper person test'.
b) Be willing to uphold the Seven Principles of Public Life (known as the Nolan Principles).
c) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.
d) At all times act in line with the vison and values of Greater Manchester ICB.
e) Demonstrate their commitment to tackling health inequalities within GM.

3.2 Disqualification criteria for board membership

3.2.1 A Member of Parliament.

3.2.2 A person whose appointment as a board member ("the candidate") is considered by the person making the appointment as one which could reasonably be regarded as undermining the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise.

3.2.3 A person who, within the period of five years immediately preceding the date of the proposed appointment, has been convicted:

a) in the United Kingdom of any offence
b) outside the United Kingdom of an offence which, if committed in any part of the United Kingdom, would constitute a criminal offence in that part, and, in either case, the final outcome of the proceedings was a sentence of imprisonment (whether suspended or not) for a period of not less than three months without the option of a fine.

3.2.4 A person who is subject to a bankruptcy restrictions order or an interim bankruptcy restrictions order under Schedule 4A to the Insolvency Act 1986, Part 13 of the Bankruptcy (Scotland) Act 2016 or Schedule 2A to the Insolvency (Northern Ireland) Order 1989 (which relate to bankruptcy restrictions orders and undertakings).

3.2.5 A person who, has been dismissed within the period of five years immediately preceding the date of the proposed appointment, otherwise than because of redundancy, from paid employment by any health service body.

3.2.6 A person whose term of appointment as the Chair, a member, a director or a governor of a health service body, has been terminated on the grounds:

a) that it was not in the interests of, or conducive to the good management of, the health service body or of the health service that the person should continue to hold that office
b) that the person failed, without reasonable cause, to attend any meeting of that health service body for three successive meetings
c) that the person failed to declare a pecuniary interest or withdraw from consideration of any matter in respect of which that person had a pecuniary interest
d) of misbehaviour, misconduct or failure to carry out the person's duties.

3.2.7 A Health and Care Professional or other professional person who has at any time been subject to an investigation or proceedings, by any body which regulates or licenses the profession concerned ("the regulatory body"), in connection with the person's fitness to practise or any alleged fraud, the final outcome of which was:

a) the person's suspension from a register held by the regulatory body, where that suspension has not been terminated
b) the person's erasure from such a register, where the person has not been restored to the register
c) a decision by the regulatory body which had the effect of preventing the person from practising the profession in question, where that decision has not been superseded
d) a decision by the regulatory body which had the effect of imposing conditions on the person's practice of the profession in question, where those conditions have not been lifted.

3.2.8 A person who is subject to:

a) a disqualification order or disqualification undertaking under the Company Directors Disqualification Act 1986 or the Company Directors Disqualification (Northern Ireland) Order 2002, or
b) an order made under section 429(2) of the Insolvency Act 1986 (disabilities on revocation of administration order against an individual).

3.2.9 A person who has at any time been removed from the office of charity trustee or trustee for a charity by an order made by the Charity Commissioners for England and Wales, the Charity Commission, the Charity Commission for Northern Ireland or the High Court, on the grounds of misconduct or mismanagement in the administration of the charity for which the person was responsible, to which the person was privy, or which the person by their conduct contributed to or facilitated.

3.2.10 A person who has at any time been removed, or is suspended, from the management or control of any body under:

a) section 7 of the Law Reform (Miscellaneous Provisions) (Scotland) Act 1990(f) (powers of the Court of Session to deal with the management of charities)
b) section 34(5) or of the Charities and Trustee Investment (Scotland) Act 2005 (powers of the Court of Session to deal with the management of charities).

3.3 Chair

3.3.1 The ICB Chair is to be appointed by NHS England, with the approval of the Secretary of State for Health and Social Care.

3.3.2 In addition to criteria specified at 3.1, this member must fulfil the following additional eligibility criteria:

a) The Chair will be independent.

3.3.3 Individuals will not be eligible if:

a) They hold a role in another health and care organisation within the ICB area.
b) Any of the disqualification criteria set out in 3.2 apply.

3.3.4 The term of office for the Chair will be ~~four~~ three years. The Chair shall be eligible for reappointment but may not serve more than ~~two~~ three consecutive terms or ~~eight~~ nine years in total, whichever is lesser.

~~3.3.4~~3.3.5 Where the individual in the post of Chair of the ICB is being proposed to serve on the Board for longer than six years, the ICB will undertake a rigorous review to ensure the individuals ongoing independence.

3.4 Chief Executive

3.4.1 The Chief Executive will be appointed by the Chair of the ICB in accordance with any guidance issued by NHS England.

3.4.2 The appointment will be subject to the approval of NHS England in accordance with any procedure published by NHS England.

3.4.3 The Chief Executive must fulfil the following additional eligibility criteria:
a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.

3.4.4 Individuals will not be eligible if:

a) any of the disqualification criteria set out in 3.2 apply
b) subject to clause 3.4.3(a), they hold any other employment or executive role.

3.5 Partner Members - NHS Trusts and Foundation Trusts

3.5.1 These Partner Members are jointly nominated by the following Partner NHS trusts and/ or foundation trusts which provide services for the purposes of the health service within the ICB's area and meet the forward plan condition or (if the forward plan condition is not met) the level of services provided condition.

a) Bolton NHS Foundation Trust
b) The Christie NHS Foundation Trust
c) Greater Manchester Mental Health NHS Foundation Trust
d) Manchester University NHS Foundation Trust
e) The Northern Care Alliance NHS Foundation Trust
f) North West Ambulance Service NHS Trust
g) Pennine Care NHS Foundation Trust
h) Stockport NHS Foundation Trust
i) Tameside & Glossop Integrated Care NHS Foundation Trust
j) Wrightington, Wigan & Leigh NHS Foundation Trust

3.5.2 These members must fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be an executive director of one of the NHS trusts or foundation trusts within the ICB's area.
b) One must have knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness.
c) One must have knowledge and experience such that they can bring the perspective of NHS trusts or foundation trusts providing acute services.
d) Any other relevant criteria as may be set out in any NHS England guidance.

3.5.3 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply
b) Any relevant exclusion criteria set out in NHSE guidance apply

3.5.4 This member will be appointed by a panel convened by the Chief Executive subject to the approval of the Chair.

3.5.5 The appointment process will be as follows:

a) Joint nomination:

- When a vacancy arises, each eligible organisation listed at 3.5.1 will be invited to make one nomination.

- Eligible organisations may nominate individuals from their own organisation or another organisation.
- All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within five working days being deemed to constitute agreement. If they do agree, the list will be put forward to step b) below. If they don't, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

b) Assessment, selection, and appointment subject to approval of the Chair under c):

- The full list of nominees will be considered by a panel convened by the Chief Executive.
- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.5.2 and 3.5.3.
- In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.

c) Chair's approval:

- The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

3.5.6 The term of office for these Partner Members will be three years and the total number of terms they may serve is three terms.

3.6 Partner Member - providers of Primary Medical Services.

3.6.1 This Partner Member is jointly nominated by providers of primary medical services for the purposes of the health service within the ICB's area and that are primary medical services contract holders responsible for the provision of essential services, within core hours to a list of registered persons for whom the ICB has core responsibility.

3.6.2 The list of relevant providers of primary medical services for this purpose is published as part of the Governance Handbook. The list will be kept up to date but does not form part of this Constitution.

3.6.3 This member must fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Any relevant other criteria set out by NHS England's guidance.
b) General practitioners who provide primary medical services to a registered list of patients under a General Medical Services, Personal

Medical Services or Alternative Provider Medical Services contract in the ICB area.

c) The member must be engaged to provide Primary Medical Services for at least two sessions a week.

3.6.4 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.
b) Any relevant exclusion criteria set out in NHSE guidance apply.

3.6.5 This member will be appointed by a panel convened by the Chief Executive subject to the approval of the Chair.

3.6.6 The appointment process will be as follows:

a) Joint nomination:

- When a vacancy arises, each eligible organisation described at 3.6.1 and listed in the Governance Handbook will be invited to make one nomination.
- The nomination of an individual must be seconded by one other eligible organisation.
- Eligible organisations may nominate individuals from their own organisation or another organisation.
- All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within five working days being deemed to constitute agreement. If they do agree, the list will be put forward to step b) below. If they don't, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

b) Assessment, selection, and appointment subject to approval of the Chair under c):

- The full list of nominees will be considered by a panel convened by the Chief Executive
- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.6.3 and 3.6.4
- In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.

c) Chair's approval:

- The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

3.6.7 The term of office for this Partner Member will be three years and the total number of terms they may serve is three terms.

3.7 Partner Member - local authorities

3.7.1 This Partner Member is jointly nominated by the local authorities whose areas coincide with, or include the whole or any part of, the ICB's area. Those local authorities are:

a) Bolton Council
b) Bury Council
c) Rochdale Borough Council
d) Manchester City Council
e) Oldham Council
f) Tameside Metropolitan Borough Council
g) Trafford Council
h) Salford Council
i) Stockport Council
j) Wigan Council.

3.7.2 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be the Chief Executive or hold a relevant executive level role of one of the bodies listed at 3.7.1.
b) Any other relevant criteria set out by NHS England's guidance.

3.7.3 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.
b) Any relevant exclusion criteria set out in NHSE guidance.

3.7.4 This member will be appointed by the Chief Executive subject to the approval of the Chair.

3.7.5 The appointment process will be as follows:

a) Joint nomination:

- When a vacancy arises, each eligible organisation listed at 3.7.1.a will be invited to make one nomination.
- Eligible organisations may nominate individuals from their own organisation or another organisation.
- All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within five working days being deemed to constitute agreement. If they do agree, the list will be put forward to step b)

below. If they don't, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

b) Assessment, selection, and appointment subject to approval of the Chair under c):

- The full list of nominees will be considered by a panel convened by the Chief Executive.
- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.7.2 and 3.7.3.
- In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.

c) Chair's approval:

- The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

3.7.6 The term of office for this Partner Member will be three years and the total number of terms they may serve is three terms.

3.8 ~~Medical Director~~Chief Clinical Officer

3.8.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.
b) Be a registered Medical Practitioner.
c) Any other relevant criteria set out by NHS England's guidance.

3.8.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.
b) Any relevant exclusion criteria set out in NHSE guidance apply.

3.8.3 This member will be appointed by shortlisting of eligible candidates in response to an external advertisement. The shortlisting shall be carried out by a panel convened by the Chief Executive. All eligible candidates shall be subject to an appointment process which will be convened by the Chair. The process shall assess candidates against the eligibility criteria set out in para 3.1, disqualification criteria as set out in para 3.2 and person specification and shall have regard to the ICB's commitment to improve the

diversity of its leadership. Recruitment and selection processes will be

designed to take account of equality, diversity and inclusion at each stage of the process. The appointment will be subject to the approval of the Chair.

~~3.9 Director of Nursing~~

~~3.9.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:~~

~~a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.~~
~~b) Be a registered nurse.~~
~~c) Any other criteria set out by NHS England's guidance.~~

~~3.9.2 Individuals will not be eligible if:~~

~~a) Any of the disqualification criteria set out in 3.2 apply.~~
~~b) Any relevant exclusion criteria set out in NHSE guidance apply.~~

~~3.9.3 This member will be appointed by short listing of eligible candidates in response to an external advertisement. The shortlisting shall be carried out by a panel convened by the Chief Executive. All eligible candidates shall be subject to an appointment process which will be convened by the Chair. The process shall assess candidates against the eligibility criteria set out in para 3.1, exclusion criteria in para 3.2 and person specification and shall have regard to the ICB's commitment to improve the diversity of its leadership. Recruitment and selection processes will be designed to take account of equality, diversity and inclusion at each stage of the process. The appointment will be subject to the approval of the Chair.~~

~~3.10~~3.9 ~~Director of Finance~~Chief Finance Officer

~~3.10.1~~3.9.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.
b) Any other relevant criteria set out by NHS England's guidance.

~~3.10.2~~3.9.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.
b) Any relevant exclusion criteria set out in NHSE guidance apply.

~~3.10.3~~3.9.3 This member will be appointed by short listing of eligible candidates in response to an external advertisement. The shortlisting shall be carried out

by a panel convened by the Chief Executive. All eligible candidates shall be subject to an appointment process which will be convened by the Chair. The process shall assess candidates against the eligibility criteria set out in para 3.1.1, exclusions in para 3.2 and person specification. and shall have regard to the ICB's commitment to improve the diversity of its leadership. Recruitment and selection processes will be designed to take account of equality, diversity and inclusion at each stage of the process. The appointment will be subject to the approval of the Chair.

~~3.11~~3.10 Deputy Chief Executive

~~3.11.1~~3.10.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

c) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.

d) Any other relevant criteria set out by NHS England's guidance.

~~3.11.2~~3.10.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.

b) Any relevant exclusion criteria set out in NHSE guidance apply.

3.10.3 This member will be appointed by short listing of eligible candidates in response to an external advertisement. The shortlisting shall be carried out by a panel convened by the Chief Executive. All eligible candidates shall be subject to an appointment process which will be convened by the Chair. The process shall assess candidates against the eligibility criteria set out in para 3.1.1, exclusions in para 3.2 and person specification. and shall have regard to the ICB's commitment to improve the diversity of its leadership. Recruitment and selection processes will be designed to take account of equality, diversity and inclusion at each stage of the process. The appointment will be subject to the approval of the Chair.

3.11 Chief Strategy, People and Partnerships Officer

3.11.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

e) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.

f) Any other relevant criteria set out by NHS England's guidance.

3.11.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.

b) Any relevant exclusion criteria set out in NHSE guidance apply.

3.11.3 This member will be appointed by short listing of eligible candidates in response to an external advertisement. The shortlisting shall be carried out by a panel convened by the Chief Executive. All eligible candidates shall be subject to an appointment process which will be convened by the Chair. The process shall assess candidates against the eligibility criteria set out in para 3.1.1, exclusions in para 3.2 and person specification. and shall have regard to the ICB's commitment to improve the diversity of its leadership. Recruitment and selection processes will be designed to take account of equality, diversity and inclusion at each stage of the process. The appointment will be subject to the approval of the Chair.

3.12 Chief Commissioning Officer

3.12.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

g) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.

h) Any other relevant criteria set out by NHS England's guidance.

3.12.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.

b) Any relevant exclusion criteria set out in NHSE guidance apply.

3.12.3 This member will be appointed by short listing of eligible candidates in response to an external advertisement. The shortlisting shall be carried out by a panel convened by the Chief Executive. All eligible candidates shall be subject to an appointment process which will be convened by the Chair. The process shall assess candidates against the eligibility criteria set out in para 3.1.1, exclusions in para 3.2 and person specification. and shall have regard to the ICB's commitment to improve the diversity of its leadership. Recruitment and selection processes will be designed to take account of equality, diversity and inclusion at each stage of the process. The appointment will be subject to the approval of the Chair.

~~3.12~~3.13 Five non-executive members

~~3.12.1~~3.13.1 The ICB will appoint five non-executive members.

~~3.12.2~~3.13.2 These members will be appointed by a panel convened by the Board and be subject to the approval of the Chair.

~~3.12.3~~3.13.3 These members will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Not be an employee of the ICB or a person seconded to the ICB.
b) Not hold a role in another health and care organisation in the ICS area.
c) One shall have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Audit Committee.
d) Another should have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Remuneration Committee.
e) Any other relevant criteria set out by NHS England's guidance applies.

~~3.12.4~~3.13.4 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.
b) They hold a role in another health and care organisation within the ICB area.
c) Any relevant exclusion criteria set out in NHSE guidance apply.

3.13.5 The term of office for a Non-Executive Member will be three years and the total number of terms an individual may serve is three terms or nine years, whichever is lesser after which they will no longer be eligible for re-appointment. Where the individual in the post of Non-Executive Mem of the ICB is being proposed to serve on the Board for longer than six years, the ICB will undertake a rigorous review to ensure the individuals ongoing independence.

~~3.12.5~~3.13.6 One of the Non-Executive Members will be appointed to the position of Deputy Chair of the ICB Board. Appointment to the position of Deputy Chair will be undertaken by the Chair following an application and interview process. The term of office will be agreed with the Chair and individual and will be in line with the existing agreed term of the individual. A key role for the Deputy Chair will be to undertake the appraisal of the ICB Chair and to collate the multi-stakeholder feedback for the Regional NHS England Director to undertake and sign off the appraisal conversation. It is also expected that the Deputy Chair will be the ICBs named Senior Independent Director, although another ICB Non-Executive Member including the Audit Committee Chair could take on this named role. The Senior Independent Director will take responsibility for ensuring the compliance of the Chair with the Fit and Proper Person Test and making the return to the Regional NHS England Director for their sign-off.

~~3.13~~3.14 Ordinary member - ~~VCSE~~VCFSE

~~3.13.1~~3.14.1 The ICB will appoint one Ordinary Member bringing the perspective of the Voluntary Community and Social Enterprise sector.

~~3.13.2~~3.14.2 This member will be appointed by a panel convened by the Chief Executive and be subject to the approval of the Chair. All appointments will

be accordance with agreed ICB policies and national regulations and will take into account national guidance.

~~3.13.3~~3.14.3 These members will fulfil the eligibility criteria set out at 3.1, person specification and also the following additional eligibility criteria:

a) Not be an employee of the ICB or a person seconded to the ICB.
b) Be a senior leader from the ~~VCSE~~VCFSE sector within the ICB area.
c) Have significant experience in a ~~VCSE~~VCFSE organisation in the ICB area so they can bring the perspective of the ~~VCSE~~VCFSE sector.

~~3.13.4~~3.14.4 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.
b) Any relevant exclusion criteria set out in NHSE guidance.

~~3.13.5~~3.14.5 The term of office for an Ordinary Member will be three years and the total number of terms an individual may serve is three terms or nine years,

whichever is lesser after which they will no longer be eligible for re-appointment.

~~3.13.6~~3.14.6 Initial appointments may be for a shorter period in order to avoid all non- executive members retiring at once. Thereafter, new appointees will ordinarily retire on the date that the individual they replaced was due to retire in order to provide continuity.

~~3.13.7~~3.14.7 Subject to satisfactory appraisal the Chair may approve the re-appointment of an Ordinary member up to the maximum number of terms permitted for their role.

~~3.14~~3.15 Board members: removal from office

~~3.14.1~~3.15.1 Arrangements for the removal from office of board members is subject to the term of appointment, and application of the relevant ICB policies and procedures.

~~3.14.2~~3.15.2 With the exception of the Chair, board members shall be removed from office if any of the following occurs:

a) If they no longer fulfil the requirements of their role or become ineligible for their role as set out in this Constitution, regulations or guidance.
b) If they fail to attend a minimum of 75% of the meetings to which they are invited unless agreed with the Chair in extenuating circumstances.
c) If they are deemed to not meet the expected standards of performance at their annual appraisal.
d) If they have behaved in a manner or exhibited conduct which has or is likely to be detrimental to the honour and interest of the ICB and is likely to bring the ICB into disrepute. This includes but it is not limited to dishonesty, misrepresentation (either knowingly or fraudulently), defamation of any member of the ICBS (being slander or libel), abuse of position, non-declaration of a known conflict of interest, seeking to manipulate a decision of the ICB in a manner that would ultimately be in favour of that member whether financially or otherwise.
e) Are deemed to have failed to uphold the Nolan Principles of Public Life.
f) Are subject to disciplinary proceedings by a regulator or professional body.

~~3.14.3~~3.15.3 Members may be suspended pending the outcome of an investigation into whether any of the matters in 3.13.3 apply.

~~3.14.4~~3.15.4 Executive Directors (including the Chief Executive) will cease to be board members if their employment in their specified role ceases, regardless of the reason for termination of the employment.

~~3.14.5~~3.15.5 The Chair of the ICB may be removed by NHS England, subject to the approval of the Secretary of State for Health and Social Care.

~~3.14.6~~3.15.6 If NHS England is satisfied that the ICB is failing or has failed to discharge any of its functions or that there is a significant risk that the ICB will fail to do so, it may:

a) a terminate the appointment of the ICB's Chief Executive
b) direct the Chair of the ICB as to which individual to appoint as a replacement and on what terms.

~~3.15~~3.16 Terms of appointment of board members

~~3.15.1~~3.16.1 With the exception of the Chair and Non-executive members, arrangements for remuneration and any allowances will be agreed by the Remuneration Committee in line with the ICB remuneration policy and any other relevant policies published on the ICB website - https://gmintegratedcare.org.uk/ - and any guidance issued by NHS England or other relevant body. Remuneration for Chairs will be set by NHS England. Remuneration for Non-executive members will be set by the Remuneration Committee with the addition of further members so that conflicted Non-executive members can be excluded from discussion and decision.

~~3.15.2~~3.16.2 Other terms of appointment will be determined by the Remuneration Committee.

~~3.15.3~~3.16.3 Terms of appointment of the Chair will be determined by NHS England.

4 Arrangements for the exercise of our functions.

4.1 Good governance

4.1.1 The ICB will, at all times, observe generally accepted principles of good governance. This includes the Nolan Principles of Public Life and any governance guidance issued by NHS England.

4.1.2 The ICB has agreed a code of conduct and behaviours which sets out the expected behaviours that members of the board and its committees will uphold whilst undertaking ICB business. It also includes a set of principles that will guide decision making in the ICB. The ICB code of conduct and behaviours is published in the Governance Handbook.

4.2 General

4.2.1 The ICB will:

a) comply with all relevant laws including but not limited to the 2006 Act and the duties prescribed within it and any relevant regulations
b) comply with directions issued by the Secretary of State for Health and Social Care
c) comply with directions issued by NHS England
d) have regard to statutory guidance including that issued by NHS England
e) take account, as appropriate, of other documents, advice and guidance issued by relevant authorities, including that issued by NHS England
f) respond to reports and recommendations made by local Healthwatch organisations within the ICB area.

4.2.2 The ICB will develop and implement the necessary systems and processes to comply with (a)-(f) above, documenting them as necessary in this Constitution, its Governance Handbook and other relevant policies and procedures as appropriate.

4.3 Authority to act

4.3.1 The ICB is accountable for exercising its statutory functions and may grant authority to act on its behalf to:

a) any of its members or employees
b) a committee or sub-committee of the ICB.

4.3.2 Under section 65Z5 of the 2006 Act, the ICB may arrange with another ICB, an NHS trust, NHS foundation trust, NHS England, a local authority,

combined authority or any other body prescribed in regulations, for the ICB's functions to be exercised by or jointly with that other body or for the functions of that other body to be exercised by or jointly with the ICB. Where the ICB and other body enters such arrangements, they may also arrange for the functions in question to be exercised by a joint committee of theirs and/or for the establishment of a pooled fund to fund those functions (section 65Z6). In addition, under section 75 of the 2006 Act, the ICB may enter partnership arrangements with a local authority under which the local authority exercises specified ICB functions or the ICB exercises specified local authority functions, or the ICB and local authority establish a pooled fund.

4.3.3 Where arrangements are made under section 65Z5 or section 75 of the 2006 Act the board must authorise the arrangement, which must be described as appropriate in the SoRD.

4.4 Scheme of Reservation and Delegation

4.4.1 The ICB has agreed a scheme of reservation and delegation (SoRD) which is published in full on the ICB website - https://gmintegratedcare.org.uk/

4.4.2 Only the board may agree the SoRD and amendments to the SoRD may only be approved by the board.

4.4.3 The SoRD sets out:

a) those functions that are reserved to the board
b) those functions that have been delegated to an individual or to committees and sub-committees
c) those functions delegated to another body or to be exercised jointly with another body, under section 65Z5 and 65Z6 of the 2006 Act.

4.4.4 The ICB remains accountable for all of its functions, including those that it has delegated. All those with delegated authority are accountable to the board for the exercise of their delegated functions.

4.5 Functions and Decision Map

4.5.1 The ICB has prepared a Functions and Decision Map which sets out at a high level its key functions and how it exercises them in accordance with the SoRD.

4.5.2 The Functions and Decision Map is published on the ICB website - https://gmintegratedcare.org.uk/

4.5.3 The map includes:

a) Key functions reserved to the board of the ICB.
b) Commissioning functions delegated to committees and individuals.
c) Commissioning functions delegated under section 65Z5 and 65Z6 of the 2006 Act to be exercised by, or with, another ICB, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body.
d) Functions delegated to the ICB (for example, from NHS England).

4.6 Committees and sub-committees

4.6.1 The ICB may appoint committees and arrange for its functions to be exercised by such committees. Each committee may appoint sub-committees and arrange for the functions exercisable by the committee to be exercised by those sub-committees.

4.6.2 All committees and sub-committees are listed in the SoRD.

4.6.3 Each committee and sub-committee established by the ICB operates under terms of reference agreed by the board. All terms of reference are published in the Governance Handbook.

4.6.4 The board remains accountable for all functions, including those that it has delegated to committees and sub-committees and therefore, appropriate reporting and assurance arrangements are in place and documented in terms of reference. All committees and sub-committees that fulfil delegated functions of the ICB, will be required to comply with reporting and assurance arrangements set out in their terms of reference.

4.6.5 Any committee or sub-committee established in accordance with clause 4.6 may consist of, or include, persons who are not ICB Members or employees.

4.6.6 All members of committees and sub-committees that exercise the ICB commissioning functions will be appointed by the Chair. The Chair will not appoint an individual to such a committee or sub-committee if they consider that the appointment could reasonably be regarded as undermining the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise.

4.6.7 All members of committees and sub-committees are required to act in accordance with this Constitution, including the standing orders as well as the standing financial instructions and any other relevant ICB policy.

4.6.8 The following committees will be maintained:

a) **Audit Committee**: This committee is accountable to the board and provides an independent and objective view of the ICB's compliance with its statutory responsibilities. The committee is responsible for arranging appropriate internal and external audit.

The Audit Committee will be chaired by a non-executive member (other than the Chair of the ICB) who has the qualifications, expertise or experience to enable them to express credible opinions on finance and audit matters.

b) **Remuneration Committee**: This committee is accountable to the board for matters relating to remuneration, fees and other allowances (including pension schemes) for employees and other individuals who provide services to the ICB.

The Remuneration Committee will be chaired by a non-executive member other than the Chair or the Chair of Audit Committee.

4.6.9 The terms of reference for each of the above committees are published in the Governance Handbook.

4.6.10 The board has also established a number of other committees to assist it with the discharge of its functions. These committees are set out in the SoRD and further information about these committees, including terms of reference, are published in the Governance Handbook.

4.7 Delegations made under section 65Z5 of the 2006 Act

4.7.1 As per 4.3.2 The ICB may arrange for any functions exercisable by it to be exercised by or jointly with any one or more other relevant bodies (another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body).

4.7.2 All delegations made under these arrangements are set out in the ICB Scheme of Reservation and Delegation and included in the Functions and Decision Map.

4.7.3 Each delegation made under section 65Z5 of the Act will be set out in a delegation arrangement which sets out the terms of the delegation. This may, for joint arrangements, include establishing and maintaining a pooled fund. The power to approve delegation arrangements made under this provision will be reserved to the board.

4.7.4 The board remains accountable for all the ICB's functions, including those that it has delegated and therefore, appropriate reporting and assurance mechanisms are in place as part of agreeing terms of a delegation and

these are detailed in the delegation arrangements, summaries of which will be published in the Governance Handbook.

4.7.5 In addition to any formal joint working mechanisms, the ICB may enter into strategic or other transformation discussions with its partner organisations on an informal basis.

5 Procedures for making decisions

5.1 Standing Orders

5.1.1 The ICB has agreed a set of standing orders which describe the processes that are employed to undertake its business. They include procedures for:

- conducting the business of the ICB
- the procedures to be followed during meetings; and
- the process to delegate functions.

5.1.2 The standing orders apply to all committees and sub-committees of the ICB unless specified otherwise in terms of reference which have been agreed by the board.

5.1.3 A full copy of the standing orders is included in Appendix 2 and forms part of this Constitution.

5.2 Standing Financial Instructions (SFIs)

5.2.1 The ICB has agreed a set of standing financial instructions which include the delegated limits of financial authority set out in the SoRD.

5.2.2 A copy of the SFIs is published in the Governance Handbook.

6 Arrangements for conflict of interest management and standards of business conduct

6.1 Conflicts of interest

6.1.1 As required by section 14Z30 of the 2006 Act, the ICB has made arrangements to manage any actual and potential conflicts of interest to ensure that decisions made by the ICB will be taken and seen to be taken without being unduly influenced by external or private interest and do not, (and do not risk appearing to) affect the integrity of the ICB's decision-making processes.

6.1.2 The ICB has agreed policies and procedures for the identification and management of conflicts of interest which are published on the website - https://gmintegratedcare.org.uk/

6.1.3 All board, committee and sub-committee members, and employees of the ICB, will comply with the ICB policy on conflicts of interest in line with their terms of office and/ or employment. This will include but not be limited to declaring all interests on a register that will be maintained by the ICB.

6.1.4 All delegation arrangements made by the ICB under Section 65Z5 of the 2006 Act will include a requirement for transparent identification and management of interests and any potential conflicts in accordance with suitable policies and procedures comparable with those of the ICB.

6.1.5 Where an individual, including any individual directly involved with the business or decision-making of the ICB and not otherwise covered by one of the categories above, has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the ICB considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this Constitution, the Conflicts of Interest Policy and the Standards of Business Conduct Policy.

6.1.6 The ICB has appointed the Audit Chair to be the Conflicts of Interest Guardian. In collaboration with the ICB's governance lead, their role is to:

a) Act as a conduit for members of the public and members of the partnership who have any concerns with regards to conflicts of interest.
b) Be a safe point of contact for employees or workers to raise any concerns in relation to conflicts of interest.
c) Support the rigorous application of conflict of interest principles and policies.

d) Provide independent advice and judgment to staff and members where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation.
e) Provide advice on minimising the risks of conflicts of interest.

6.2 Principles

6.2.1 In discharging its functions, the ICB will abide by the following principles:

a) The seven principles of public life (known as the Nolan Principles).
b) Ensuring clear policy guidance is provided to all those performing a role on behalf of the ICB and complying with all applicable guidance as published from time to time.
c) Monitoring compliance in accordance with published guidance.
d) Ensuring interests are proactively declared at the point individuals become involved in decision-making.
e) Adopting a proportionate, common sense approach to the management of conflicts of interest.
f) Keeping an audit trail of actions taken.

6.3 Declaring and registering interests

6.3.1 The ICB maintains registers of the interests of:

a) members of the ICB
b) members of the board's committees and sub-committees
c) its employees.

6.3.2 In accordance with section 14Z30(2) of the 2006 Act registers of interest are published on the ICB website - https://gmintegratedcare.org.uk/

6.3.3 All relevant persons as per 6.1.3 and 6.1.5 must declare any conflict or potential conflict of interest relating to decisions to be made in the exercise of the ICB's commissioning functions.

6.3.4 Declarations should be made as soon as reasonably practicable after the person becomes aware of the conflict or potential conflict and in any event within 28 days. This could include interests an individual is pursuing. Interests will also be declared on appointment and during relevant discussion in meetings.

6.3.5 All declarations will be entered in the registers as per 6.3.1.

6.3.6 The ICB will ensure that, as a matter of course, declarations of interest are made and confirmed, or updated at least annually.

6.3.7 Interests (including gifts and hospitality) of decision-making staff will remain on the public register for a minimum of six months. In addition, the ICB will retain a record of historic interests and offers/receipt of gifts and hospitality for a minimum of six years after the date on which it expired. The ICB's published register of interests states that historic interests are retained by the ICB for the specified timeframe and details of whom to contact to submit a request for this information.

6.3.8 Activities funded in whole or in part by third parties who may have an interest in ICB business such as sponsored events, posts and research will be managed in accordance with the ICB policy to ensure transparency and that any potential for conflicts of interest are well-managed.

6.4 Standards of business conduct

6.4.1 Board members, employees, committee and sub-committee members of the ICB will at all times comply with this Constitution and be aware of their responsibilities as outlined in it. They should:

a) act in good faith and in the interests of the ICB
b) follow the Seven Principles of Public Life; set out by the Committee on Standards in Public Life (the Nolan Principles)
c) comply with the ICB Standards of Business Conduct policy, and any requirements set out in the policy for managing conflicts of interest.

6.4.2 Individuals contracted to work on behalf of the ICB or otherwise providing services or facilities to the ICB will be made aware of their obligation to declare conflicts or potential conflicts of interest. This requirement will be written into their contract for services and is also outlined in the ICB's Standards of Business Conduct policy.

7 Arrangements for ensuring accountability and transparency

7.1.1 The ICB will demonstrate its accountability to local people, stakeholders and NHS England in a number of ways, including by upholding the requirement for transparency in accordance with paragraph 12(2) of Schedule 1B to the 2006 Act.

7.2 Principles

7.2.1 In ensuring accountability and transparency, the ICB will:

a) publish our constitution and other key documents including the Governance Handbook
b) manage actual or potential conflicts of interest in line with NHS England's statutory guidance
c) hold meetings of the board in public (except where we believe that it would not be in the public interest)
d) publish an annual strategy that takes account of priorities in the health and wellbeing strategy
e) procure services in a manner that is open, transparent, non-discriminatory and fair to all potential providers
f) involve the public, in accordance with its duties under section 14Z2 of the 2006 Act
g) comply with local authority health overview and scrutiny requirements;
h) meet annually in public to present an annual report which is then published
i) produce annual accounts which are externally audited
j) publish a clear complaints process
k) comply with the Freedom of Information Act 2000 and with the Information Commissioner Office requirements regarding the publication of information
l) provide information to NHS England as required; and
m) be an active member of the local Health and Wellbeing Board or other locally determined strategic leadership boards.

7.3 Meetings and publications

7.3.1 Board meetings, and committees composed entirely of board members or which include all board members, will be held in public except where a resolution is agreed to exclude the public on the grounds that it is believed to not be in the public interest.

7.3.2 Papers and minutes of all meetings held in public will be published.

7.3.3 Annual accounts will be externally audited and published.

7.3.4 A clear complaints process will be published.

7.3.5 The ICB will comply with the Freedom of Information Act 2000 and with the Information Commissioner Office requirements regarding the publication of information relating to the ICB.

7.3.6 Information will be provided to NHS England as required.

7.3.7 The Constitution and Governance Handbook will be published as well as other key documents including but not limited to:

- Conflicts of Interest Policy and procedures
- Registers of interests

7.3.8 The ICB will publish, with our partner NHS trusts and NHS foundation trusts, a plan at the start of each financial year that sets out how the ICB proposes to exercise its functions during the next five years. The plan will explain how the ICB proposes to discharge its duties under:

- sections 14Z34 to 14Z45 (general duties of integrated care boards), and
- sections 223GB and 223N (financial duties).

And

a) proposed steps to implement the Greater Manchester joint local health and wellbeing strategy(ies)

7.4 Scrutiny and decision-making

7.4.1 ~~At least three~~ Nnon-executive members will be appointed to the board including the Chair; and all of the board and committee members will comply with the Nolan Principles of Public Life and meet the criteria described in the Fit and Proper Person Test.

7.4.2 Healthcare services will be arranged in a transparent way, and decisions around who provides services will be made in the best interests of patients, taxpayers and the population, in line with the rules set out in the NHS Provider Selection Regime.

7.4.3 The ICB will comply with the requirements of the NHS Provider Selection Regime ~~once it is introduced~~, and will comply with existing procurement rules including:

a) following NHS policy
b) promoting the NHS and its statutory partners.
c) achieving best value.
~~a)~~d) delivering for Greater Manchester while utilising and drawing upon the

expertise within the ICS and securing the best possible outcomes for residents.~~until the NHS Provider Selection Regime comes into effect~~.

~~7.4.3~~7.4.4 The ICB will comply with local authority health overview and scrutiny requirements.

7.5 Annual Report

7.5.1 The ICB will publish an annual report in accordance with any guidance published by NHS England and which sets out how it has discharged its functions and fulfilled its duties in the previous financial year. An annual report must in particular:

a) explain how the ICB has discharged its duties under section 14Z34 to 14Z45 and 14Z49 (general duties of integrated care boards)

b) review the extent to which the ICB has exercised its functions in accordance with the plans published under section 14Z52 (forward plan) and section 14Z56 (capital resource use plan)

c) review the extent to which the ICB has exercised its functions consistently with NHS England's views set out in the latest statement published under section 13SA(1) (views about how functions relating to inequalities information should be exercised)

d) review any steps that the ICB has taken to implement any joint local health and wellbeing strategy to which it was required to have regard under section 116B(1) of the Local Government and Public Involvement in Health Act 2007.

8 Arrangements for determining the terms and conditions of employees

8.1.1 The ICB may appoint employees, pay them remuneration and allowances as it determines and appoint staff on such terms and conditions as it determines.

8.1.2 The board has established a Remuneration Committee which is chaired by a Non-Executive member other than the Chair or Audit Chair.

8.1.3 The membership of the Remuneration Committee is determined by the board. No employees may be a member of the Remuneration Committee but the board ensures that the Remuneration Committee has access to appropriate advice by:

a) authorising it to obtain legal and/ or other independent professional advice and/or
b) securing the attendance of anyone with relevant experience and expertise if it considers this necessary.

8.1.4 The board may appoint independent members or advisers to the Remuneration Committee who are not members of the board.

8.1.5 The main purpose of the Remuneration Committee is to exercise the functions of the ICB regarding remuneration included in paragraphs 18 to 20 of Schedule 1B to the 2006 Act. The terms of reference agreed by the board are published in the Governance Handbook.

8.1.6 The duties of the Remuneration Committee are set out in the terms of reference contained in the Governance Handbook.

8.1.7 The ICB may make arrangements for a person to be seconded to serve as a member of the ICB's staff.

9 Arrangements for public involvement

9.1.1 In line with section 14Z54(2) of the 2006 Act the ICB has made arrangements to secure that individuals to whom services which are, or are to be, provided pursuant to arrangements made by the ICB in the exercise of its functions, and their carers and representatives, are involved (whether by being consulted or provided with information or in other ways) in:

a) the planning of the commissioning arrangements by the Integrated Care Board
b) the development and consideration of proposals by the ICB for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals (at the point when the service is received by them), or the range of health services available to them
c) decisions of the ICB affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

9.1.2 In line with section 14Z54 of the 2006 Act the ICB has made arrangements to consult its population on its system plan:

a) Through a systemwide strategic approach in the Greater Manchester Integrated Care Partnership's People and Communities Engagement Framework. This sets out a series of agreed best practice principles for gold-standard engagement, which have been co-designed and agreed by all partners within the GM ICS. The framework will ensure that regardless of where the engagement is being delivered (either at system, place or neighbourhood level), or by whom, the methodology and application will be of a consistently high level.

9.1.3 The ICB has adopted the ten principles set out by NHS England for working with people and communities:

a) Put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS.
b) Start engagement early when developing plans and feed back to people and communities how it has influenced activities and decisions.
c) Understand your community's needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect.
d) Build relationships with excluded groups – especially those affected by inequalities.
e) Work with Healthwatch and the voluntary, community and social enterprise sector as key partners.

f) Provide clear and accessible public information about vision, plans and progress to build understanding and trust.
g) Use community development approaches that empower people and communities, making connections to social action.
h) Use co-production, insight and engagement to achieve accountable health and care services.
i) Co-produce and redesign services and tackle system priorities in partnership with people and communities.
j) Learn from what works and build on the assets of all partners in the ICS – networks, relationships, activity in local places

9.1.4 These principles will be used when developing and maintaining arrangements for engaging with people and communities.

9.1.5 These arrangements include:

a) Using public engagement and insight to inform decision-making
b) Redesigning models of care and tackling system priorities in partnership with staff, people who use care and support and their carers and representatives (if any)
c) Working with Healthwatch and the voluntary, community and social enterprise sector as key transformation partners
d) Understanding the community's experience and aspirations for health and care
e) Reaching out to excluded groups, especially those affected by inequalities
f) Providing clear and accessible public information about vision, plans and progress to build understanding and trust
g) Using community development approaches that empower people and communities, making connections to social action.

Appendix 1: Definitions of terms used in this Constitution

Term	Definition
2006 Act	National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022
ICB board	Members of the ICB
Area	The geographical area that the ICB has responsibility for, as defined in part 2 of this Constitution
Committee	A committee created and appointed by the ICB board.
Sub-committee	A committee created and appointed by and reporting to a committee.
Integrated Care Partnership	The joint committee for the ICB's area established by the ICB and each responsible local authority whose area coincides with or falls wholly or partly within the ICB's area.
Place-Based Partnership	Place-based partnerships are collaborative arrangements responsible for arranging and delivering health and care services in a locality or community. They involve the Integrated Care Board, local government and providers of health and care services, including the voluntary, community and social enterprise sector, people and communities, as well as primary care provider leadership, represented by Primary Care Network clinical directors or other relevant primary care leaders.
Ordinary Member	The board of the ICB will have a Chair and a Chief Executive plus other members. All other members of the board are referred to as Ordinary Members.
Partner Members	Some of the Ordinary Members will also be Partner Members. Partner Members bring knowledge and a perspective from their sectors and are and appointed in

	accordance with the procedures set out in Section 3 having been nominated by the following**:** • NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description • the primary medical services (general practice) providers within the area of the ICB and are of a prescribed description • the local authorities which are responsible for providing Social Care and whose area coincides with or includes the whole or any part of the ICB's area.
Health service body	Health service body as defined by section 9(4) of the NHS Act 2006 or (b) NHS Foundation Trusts.
Health Care Professional	An individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002.

Appendix 2: Standing Orders

1 Introduction

1.1 These standing orders have been drawn up to regulate the proceedings of NHS Greater Manchester Integrated Care Board so that the ICB can fulfil its obligations as set out largely in the 2006 Act (as amended). They form part of the ICB's Constitution.

2 Amendment and review

2.1 The standing orders are effective from 1 July 2022.

2.2 Standing orders will be reviewed on an annual basis or sooner if required.

2.3 Amendments to these standing orders will be made as per 1.6 of the Constitution.

2.4 All changes to these standing orders will require an application to NHS England for variation to the ICB Constitution and will not be implemented until the Constitution has been approved.

3 Interpretation, application and compliance

3.1 Except as otherwise provided, words and expressions used in these standing orders shall have the same meaning as those in the main body of the ICB Constitution and as per the definitions in Appendix 1.

3.2 These standing orders apply to all meetings of the board, including its committees and sub-committees unless otherwise stated. All references to board are inclusive of committees and sub-committees unless otherwise stated.

3.3 All members of the board, members of committees and sub-committees and all employees, should be aware of the standing orders and comply with them. Failure to comply may be regarded as a disciplinary matter.

3.4 In the case of conflicting interpretation of the standing orders, the Chair, supported with advice from the Executive Member responsible for Governance, will provide a settled view which shall be final.

3.5 All members of the board, its committees and sub-committees and all employees have a duty to disclose any non-compliance with these standing orders to the Chief Executive as soon as possible.

3.6 If, for any reason, these standing orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the board for action or ratification and the Audit Committee for review.

4 Meetings of the Integrated Care Board

4.1 Calling board meetings

4.1.1 Meetings of the board of the ICB shall be held at regular intervals at such times and places as the ICB may determine.

4.1.2 In normal circumstances, each member of the board will be given not less than one month's notice in writing of any meeting to be held. However:

a) The Chair may call a meeting at any time by giving not less than 14 calendar days' notice in writing.
b) One third of the members of the board may request the Chair to convene a meeting by notice in writing, specifying the matters which they wish to be considered at the meeting. If the Chair refuses, or fails, to call a meeting within seven calendar days of such a request being presented, the board members signing the requisition may call a meeting by giving not less than 14 calendar days' notice in writing to all members of the board specifying the matters to be considered at the meeting.
c) In emergency situations the Chair may call a meeting with two[100] days' notice by setting out the reason for the urgency and the decision to be taken.

4.1.3 A public notice of the time and place of meetings to be held in public and how to access the meeting shall be given by posting it at the offices of the ICB body and electronically at least three clear days before the meeting or, if the meeting is convened at shorter notice, then at the time it is convened.

4.1.4 The agenda and papers for meetings to be held in public will be published electronically in advance of the meeting excluding, if thought fit, any item likely to be addressed in part of a meeting is not likely to be open to the public.

4.2 Chair of a meeting

4.2.1 The Chair of the ICB shall preside over meetings of the board.

4.2.2 If the Chair is absent or is disqualified from participating by a conflict of interest, the Deputy Chair of the ICB Board will take on the role and responsibility of chairing the Board meeting or agenda item in question. The

Deputy Chair will not be expected to undertake the other duties of the ICB Chair when deputising in this way. If both the Chair and Deputy Chair are disqualified at the same time from participating by a conflict of interest then one of the other Non-Executive members on the ICB board other than the Audit Committee Chair will take on the role and responsibility of chairing the Board meeting or agenda item in question~~the members present shall agree who will preside over the meeting in the Chair's absence~~.

4.2.3 The board shall appoint a Chair to all committees and sub-committees that it has established. The appointed committee or sub-committee Chair will preside over the relevant meeting. Terms of reference for committees and sub-committees will specify arrangements for occasions when the appointed Chair is absent.

4.3 Agenda, supporting papers and business to be transacted

4.3.1 The agenda for each meeting will be drawn up and agreed by the Chair of the meeting.

4.3.2 Except where the emergency provisions apply, supporting papers for all items must be submitted at least seven calendar days before the meeting takes place. The agenda and supporting papers will be circulated to all members of the board at least five calendar days before the meeting.

4.3.3 Agendas and papers for meetings open to the public, including details about meeting dates, times and venues, will be published on the ICB's website - https://gmintegratedcare.org.uk/

4.4 Petitions

4.4.1 Where a valid petition has been received by the ICB it shall be included as an item for the agenda of the next meeting of the board in accordance with the ICB policy as published in the Governance Handbook.

4.5 Nominated deputies

4.5.1 With the permission of the person presiding over the meeting, the Executive Directors and the Partner Members of the board may nominate a deputy to attend a meeting of the board that they are unable to attend. The deputy may speak but not usually vote on their behalf, unless in exceptional circumstances and by the discretion of the Chair.

4.5.2 The decision of the person presiding over the meeting regarding authorisation of nominated deputies is final.

4.6 Virtual attendance at meetings

4.6.1 The board of the ICB and its committees and sub-committees may meet virtually using telephone, video and other electronic means when necessary, unless the terms of reference for any committee or sub-committee prohibit this.

4.7 Quorum

4.7.1 The quorum for meetings of the board will be six members, including:

a) either the Chief Executive or the ~~Director of Finance~~Chief Finance Officer
b) either the ~~Medical Director~~Chief Clinical Officer or ~~the~~ their nominated deputy as agreed with the Chair~~the Director of Nursing~~
c) at least one Non-Executive member
d) at least one Partner Member.

4.7.2 For the sake of clarity:

a) No person can act in more than one capa]city when determining the quorum.
b) An individual who has been disqualified from participating in a discussion on any matter and/ or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum.

4.7.3 For all committees and sub-committees, the details of the quorum for these meetings and status of deputies are set out in the appropriate terms of reference.

4.8 Vacancies and defects in appointments

4.8.1 The validity of any act of the ICB is not affected by any vacancy among members or by any defect in the appointment of any member.

4.8.2 In the event of vacancy or defect in appointment the following temporary arrangement for quorum will apply:

a) The Chair and/ or Chief Executive with at least one Independent Member and one Partner Member will agree the arrangements for quorum for that meeting.

4.9 Decision-making

4.9.1 The ICB has agreed to use a collective model of decision-making that seeks to find consensus between system partners and make decisions based on unanimity as the norm, including working though difficult issues where appropriate.

4.9.2 Generally, it is expected that decisions of the ICB will be reached by consensus. Should this not be possible then a vote will be required. The process for voting, which should be considered a last resort, is set out below:

a) All members of the board who are present at the meeting will be eligible to cast one vote each.
b) In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote but this does not preclude anyone attending by teleconference or other virtual

mechanism from participating in the meeting, including exercising their right to vote if eligible to do so.

c) For the sake of clarity, any additional participants and observers (as detailed within paragraph 5.6. of the Constitution) will not have voting rights.
d) A resolution will be passed if more votes are cast for the resolution than against it.
e) If an equal number of votes are cast for and against a resolution, then the Chair (or in their absence, the person presiding over the meeting) will have a second and casting vote.
f) Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

Disputes

4.9.3 Where helpful, the board may draw on third party support to assist them in resolving any disputes, such as peer review or support from NHS England.

Urgent decisions

4.9.4 In the case urgent decisions and extraordinary circumstances, every attempt will be made for the board to meet virtually. Where this is not possible the following will apply.

4.9.5 The powers which are reserved or delegated to the board, may for an urgent decision be exercised by the Chair and Chief Executive (or relevant lead director in the case of committees) subject to every effort having made to consult with as many members as possible in the given circumstances.

4.9.6 The exercise of such powers shall be reported to the next formal meeting of the board for formal ratification and the Audit Committee for oversight.

4.10 Minutes

4.10.1 The names and roles of all members present shall be recorded in the minutes of the meetings.

4.10.2 The minutes of a meeting shall be drawn up and submitted for agreement at the next meeting where they shall be signed by the person presiding at it.

4.10.3 No discussion shall take place upon the minutes except upon their accuracy or where the person presiding over the meeting considers discussion appropriate.

4.10.4 Where providing a record of a meeting held in public, the minutes shall be made available to the public.

4.11 Admission of public and the press

4.11.1 In accordance with Public Bodies (Admission to Meetings) Act 1960 All meetings of the board and all meetings of committees which are comprised of entirely board members or all board members, at which public functions are exercised will be open to the public.

4.11.2 The board or committees of the board may resolve to exclude the public from a meeting or part of a meeting where it would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

4.11.3 The person presiding over the meeting shall give such directions as he/she thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the board's business shall be conducted without interruption and disruption.

4.11.4 As permitted by Section 1(8) Public Bodies (Admissions to Meetings) Act 1960 as amended from time to time) the public may be excluded from a meeting to suppress or prevent disorderly conduct or behaviour.

4.11.5 Matters to be dealt with by a meeting following the exclusion of representatives of the press, and other members of the public shall be confidential to the members of the board.

5 Suspension of Standing Orders

5.1 In exceptional circumstances, except where it would contravene any statutory provision or any direction made by the Secretary of State for Health and Social Care or NHS England, any part of these standing orders may be suspended by the Chair in discussion with at least 2 other members.

5.2 A decision to suspend standing orders together with the reasons for doing so shall be recorded in the minutes of the meeting.

5.3 A separate record of matters discussed during the suspension shall be kept. These records shall be made available to the Audit Committee for review of the reasonableness of the decision to suspend standing orders.

6 Use of seal and authorisation of documents.

6.1 The ICB group may have a seal for executing documents where necessary.

6.2 The following individuals or officers are authorised to authenticate its use by their signature:

a) the Chief Executive
b) the Chair
c) the Chief Finance Officer

6.3 The following individuals are authorised to execute a document on behalf of the group by their signature:

a) the Chief Executive
b) the Chair
c) the Chief Finance Officer
d) other managers as per the Delegated Financial Limits

Requirements to Seal

6.4 It is a legal requirement to place any property transactions, e.g. purchase, sale, lease, under seal. Other contracts/ documentation should be approved by an authorised signatory 'under hand' i.e. signed.

6.5 Before any building, engineering, property or capital document is sealed it must be approved and signed by the Chief Finance Officer and authorised and countersigned by the Chief Operating Officer, or an officer nominated by them who shall not be within the originating directorate.

6.6 As a general guide, the following should be placed under seal:

a) All contracts for the purchase/lease of land and/or building
b) All contracts for capital works exceeding £100,000
c) All lease agreements where the annual lease charge exceeds £10,000 per annum and the period of the lease exceeds beyond five years
d) Any other lease agreement where the total payable under the lease exceeds £100,000
e) Any contract or agreement with organisations other than NHS or other government bodies including local authorities where the annual costs exceed or are expected to exceed £100,000

6.7 The Accountable Officer or nominated representative shall keep a register, an entry of every sealing shall be made and numbered consecutively in a register provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. Reports of all sealing shall be made to the ICB at least annually. (The report shall contain details of the seal number, the description of the document and date of sealing).

NHS
Greater Manchester

Board Assurance Framework

21st January 2026

Part of Greater Manchester
Integrated Care Partnership

NHS
Greater Manchester

Integrated Care Board

21st January 2026

Required information	Details
Title of report	Board Assurance Framework
Author	Chris Gaffey, Associate Director of Corporate Services Rick Thompstone, Assistant Director Risk & PMO
Presented by	Charlotte Bailey, Strategy People & Partnerships Chief Officer
Contact for further information	Rick Thompstone, Assistant Director Risk & PMO – rick.thompstone@nhs.net
Executive summary	This report provides an update to the 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 Board is asked to: • Consider and approve the updated strategic risk descriptions
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	Chief Officers meeting – January 2026 Formal Board consideration – January 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 by the relevant Committee(s) regularly. The BAF is considered by Chief Officers as part of regular management oversight.

	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. Risk Appetite statements will be managed by each committee and used to consider decisions and recommendations.
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 their development and revisions at their relevant committee(s).

2.0 Strategic Risks

2.1 Since the November 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 March 2026 update). Appendix One contains the details for each of the risks but headline messages are identified below:

- BAF Risks SR6 (Workforce) and Risk SR9 (Emergency Incidents) are both reporting increased risk scores for this return
- All other BAF risks are reporting static scores from the November report – though worth noting that most BAF risks have not returned a Q4 score as this will be confirmed for the March report.
- Risks SR6 (Workforce), SR7 (Finance), SR9 (Emergency Incident) and SR10 (Reform) are all showing a significant variation between current score and year-end target score. This has been raised with all risk owners and will be considered for the March update.

2.3 As we approach the end of the financial year, a further review of our BAF risks will be conducted to ensure these align with our priorities and commissioning intentions moving into the new financial year. The BAF was recently discussed at both the Audit Committee and Transition Committee, and as part of the Q4 review, work will take place to address some of the views raised in relation to sources of assurance, clarity between ICB and system risks, and will aim to create a more dynamic, evidence-based report.

NHS GM Board Assurance Framework
January 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 3 (L) x 5 (I) = **15**	Current Score 4 (L) x 5 (I) = **20**	Current Score 3 (L) x 5 (I) = **15**	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 5 (L) x 4 (I) = **20**	Current Score 3 (L) x 4 (I) = **12**	Current Score 4 (L) x 4 (I) = 16	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 Recommendations

3.1 The Board is asked to:

- Consider and approve the updated strategic risks

Appendix 1: Strategic Risks Update

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.

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		2	1	
Impact	5	5	5	5		5	5	2028
Risk Level	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; People Communities 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; GM Tripartite Agreement Core Group; GM Housing First Board	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 - 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	March 2026	Delivery Plan and associated governance is under development	
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. Delivery Plan to be agreed and implemented.	
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. New Operating Model to be developed to mitigate the challenges of transition.	March 2026	Programme of ICB Reform is ongoing but has faced significant disruption. However, the focus on left shift has remained a priority	

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. Aug data published in Oct shows 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; Learning disability and autism inpatients. Further development of the function is required to respond to the ICB reform requirements including oversight arrangements. Financial constraints is a contributory factor along with industrial action.

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 meets no less than weekly to oversee operational activities and escalation. Other operational groups meeting no less than weekly to oversee activities, including patient level coordination. Operational Delivery Meetings (ODMs) in place oversee implementation and impact of performance improvement plans.
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 and Locality assurance meetings in place to gain assurance regarding delivery. Escalation meetings in place for Trusts which provider clearer tracking of action plans at senior level

Gaps in Control or Assurance

Limited scope for additional investment in mitigating actions, such as investing to support additional activity. 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)	Acceptable
2nd Line	System Group meetings to review operational performance for their respective thematic area; provider contract meetings; provider oversight meetings; Locality assurance meetings; GM monthly ODMs; Quality & Performance Committee. Monthly report and scrutiny from Committee.	Acceptable
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	New action	
3	Full implementation of the elective care transformation fund.	March 2026	New action	
4	Q3 and Q4 LAM agendas have ceased and replaced by targeted meetings addressing the most significant challenges.	March 2026	New action	

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

Significant progress has been made against the NHS GM Single Improvement Plan with NHSE with key milestones and deliverables being met. The ICB have received positive feedback especially with regard to the governance of quality oversight, and a full robust action plan is in place. The NHS GM provider oversight model is now well embedded with regular review of providers in line with NHS England guidance outcomes of which are regularly fed into Quality and Performance Committee, current models are being reviewed in light of model ICB and model region guidance. Improvements have been seen within GMMH and formal exit from the National Recovery Support Programme (RSP) was agreed in October 2025. An Independent Assurance review is being carried out by Niche and Oliver Shanley to monitor progress made against the recommendations within the Shanley report published in January 2024. The ICB submitted a summary of actions taken in July and follow up interviews have taken place in August. There is a possibility that the NHS Reforms may impact on the delivery of our statutory duties with unknowns around the future presence of professional voice within the ICB. In addition, we are yet to develop robust processes that include Quality Impact Assessments that need to be carried out against proposed changes in each statutory function. 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.

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. • Locality Assurance Mechanism (LAM) is established with oversight of locality approach to the statutory quality duties. • Quality Assurance Framework established/aligned to meet the National Quality Board Standards. • Provider Oversight Sub Committee meetings (POSOM) in place to identify segmentation and KLOES for the POMs.	• Quality Impact Assessment processes established – guidance approved by QPC • GM System Quality Group in place supporting the good governance from place/localities to ICB to region (Terms of Reference align to assurance process). • Reporting, audits and actions in place for safeguarding assurance (aligns to Safeguarding Policy). • MIAA Audit findings/actions • Annual reports (Quality Accounts / Safeguarding Report /Complaints annual report). • Assurance meetings with NHSE. • Submission to RSQG with escalations as part of business as usual. • External audits. • External inspections by regulators e.g. SEND.

Gaps in Control or Assurance

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

	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	12	1

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	Quality and Performance Committee; Greater Manchester System Quality Group; Provider Oversight Sub-committee; Reporting into locality board; External assurance via statutory bodies; ICB System improvement board	Acceptable
3rd Line	Regional SQG; Single Improvement Plan responding to Enforced Undertakings Assurance meetings with NHSE; Internal Audit	Acceptable

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.	

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 currently in the process of sign 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 development of 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 Treasury confirmation of WorkWell 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

	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	2	March 2029
Impact	4	4	4	4		4	4	
Risk Level	16	16	16	16		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; People Communities 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 going through final governance. To go through ICB Board in Feb.	
2	Confirmation of future funding for WWP, Primary Care Innovation Fund and Health and Growth Accelerator	March 2026	WWP – 3 years funding confirmed but will come in via Integrated Settlement to GMCA with the requirement for ICB Governance Primary Care Innovation Fund – funding confirmed and expected this month Accelerator still awaiting NHSE confirmation	
3	Delivery of GMS under a new delivery framework	March 2026	Delivery of GMS under a new delivery framework	
4	ICB reform and transition process to ensure new Operating Model is capable of mitigating BAF risk	March 2026	Awaiting Operating Model (Jan 2026) which will guide structures and capacity/capability to deliver controls	

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. There continues to be a significant uncertainty around the NHS Reform which will undoubtedly impact on delivery of key programmes.

Risk Scoring and Tolerance

	Inherent risk score	Q1	Q2	Q3	Q4	In year Target	Long Term Target	Long Term Target Date
Likelihood	4	4	4	4		3	1	March 2029
Impact	4	4	4	4		4	4	
Risk Level	16	16	16	16		12	4	

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

Lines of Defence	Sources of Assurance	Assurance Level
1st Line	ICB twice weekly Chief Officers meetings; Strategy, Innovation and Population Health directorate SLT meetings; Weekly Population Health function SMT; Strategy, Innovation and Population Health 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 – includes articulation of key risks and issues.	Acceptable

Action		
	Complete/BAU	On Track
	Delayed	Problematic

No	Action Required	Due Date	Progress	BRAG
1	Development and approval of an ICB Left Shift Strategy	June 2025	Engagement draft produced and being socialised. To be included as an appendix to the 5 year strategic commissioning plan	
2	Confirmation of future funding for WWP, Primary Care Innovation Fund and Health and Growth Accelerator	June 2025	Budget approved at ICB on 21/5/25. Some STAR and FSOD approvals gained but several still delayed.	
3	Model ICB Transformation that incorporates Left Shift focus and ensures capacity, expertise and ability to influence is retained to effectively deliver strategic aims and objectives designed to improve the health of the population and reduce inequalities	March 2026	Programme of ICB Reform is ongoing despite significant disruption. However, the focus on a left shift strategic approach has remained a priority.	

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 (formerly Finance 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.

Key Controls

- The enhanced levels of grip and control and financial assurance established during 2024/25 continue across the GM system, including CIP, Provider Oversight and Locality Assurance meetings.
- Comparison of the centralised ICB model and Trust Financial Recovery Plans is being undertaken to ensure agreement on underlying assumptions to bridge material differences.
- The medium-term financial plan and financial strategy will be developed during Q2 & Q3 (In line with NHSE requirements) to identify key principles to support financial sustainability; this will be reviewed by Chief Officers, Finance Committee and GM Board.
- NHS GM led Capital Prioritisation group supported the submission in 2025/26 of a compliant capital plan.
- ICB has revised the reporting pack with a focus on run rate to allow identification of potential issues so a mitigation plan can be implemented to address the risks on in year delivery. Run rates will become a focus within the finance item of LAMs from July.

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	
Impact	4	4	4	4		3	3	31/03/26
Risk Level	20	20	20	20		12	12	

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

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 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.	31/03/26	Regular updates will be provided to Finance Committee	

2	CIP plans are further being developed and implemented to realise efficiencies along with commissioning intentions that will deliver efficiencies while improving services. Work ongoing through PMO. All CIPs are subject to a quarterly deep dive to ensure they remain on track and determine if there is any opportunity for stretch.	30/09/25	Regular updates provided to Finance 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	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.	31/03/26	Updates will be provided to Finance Committee.	
4	ICB to develop an integrated financial model to inform discussions with Providers during Q2 this work has been delayed from its original date of July 2025 as a consequence of the impact of the NHS reforms.	30/09/25	Updates will be provided to Finance Committee.	
5	Medium and long-term financial plans will be approved by the Board in Q4 to ensure expenditure is within the funding allocated to NHS GM.	31/03/26	Updates will be provided to Finance Committee and Board,	
6	Localities and system Boards fully engaged in the process and developing commissioning intentions that may also include service redesign and decommissioning of services. Those localities who are forecasting a deficit are being offered additional support to identify and deliver further recovery plan schemes and are now in an accelerated assurance process with Execs.	Ongoing	Updates will be provided to Finance 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 Q3 25/26 reflects a Likelihood of 4 that is related to the EPRR team staffing position. The team has longstanding gaps in it's structure and recent departures and long term sickness have further impacted this. This together with new and ongoing workloads mean the team's delivery of training and exercising for NHS GM staff with a potential incident response role remains subject to limitations. Furthermore, the announcement of ICB reform in Q3 24/25 has disrupted the process for recruiting to structures going forward. The reform announcement has also prompted a pause to implementation of revised on-call arrangements for NHS GM, as the requirement to make significant cuts to organisation head count means there is uncertainty about the future cohort of staff that may be involved with incident response. Notwithstanding the position for the ICB's EPRR team, the wider ICS continues 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 2 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 is now progressing to 2 band 7 posts for the team, which if successful will regain 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.

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	4		3	2	TBC
Impact	4	4	4	4		3	3	
Risk Level	16	12	12	16		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	Progress is delayed due to the staffing Gaps in the team	
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.	

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	Colin Scales — Reform Programme Board
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:

- We have been engaging with staff and external stakeholders around our new operating model – series of engagement sessions with stakeholders were undertaken to familiarise them with the OM - 77 lines of the feedback from colleagues received. Work is now being undertaken to finalise the OM with the plan to publish the final version in January 2026.
- 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.
- VR Scheme (Phase 1) was launched on 24th November – closed on 5th December with VR Panel due to meet on 18th December, with outcome letters issues on 22nd December.
- Portfolio and Place Leadership Cells have been initiated – key stakeholders been tasked with pulling together documentation to inform consultation document – on target to be published mid-January.
- Transfers workstream, including Regional Do Once programme had been progressed with formal governance now being stood up for Pop Health, GP IT and IFR.

Key Controls

- Programme dedicated resource in place (with additional resource recently agreed) in order to minimise capacity issues within current BAU programmes.
- External (consultancy) support has been sourced to support the People services team to ensure we are able to meet the timeline on the organisational restructure process.
- 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	April 2026
Impact	4	N/A	4	4		3	2	
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 meeting - 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 Meeting – 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	On Track
			Delayed	Problematic

No	Action Required	Due Date	Progress	BRAG
1	Organisational restructure implementation to ensure the organisation is meeting its £19ph obligations from April 2026.	March 2026	In the process of developing consultation document that – to be published in mid-January. Concurrently we will be 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 March 2026.	

NHS
Greater Manchester

Emergency Preparedness, Resilience and Response (EPRR) Annual Report

2025-2026

Part of Greater Manchester Integrated Care Partnership

Greater Manchester Integrated Care Board (Public)

14th January 2026

Report information.

Required information.	Details.
Title of report.	Emergency Preparedness, Resilience and Response (EPRR) Assurance Process (2025 - 2026)
Author.	Alison Whitehead Assistant Director of EPRR
Presented by.	Colin Scales, Acting Chief Executive
Contact for further information.	Alison Whitehead Assistant Director of EPRR A.whitehead7@nhs.net
Executive summary.	This report provides the Board of NHS Greater Manchester with the outcome of the self-assessment undertaken by NHS GM for the 2025/26 EPRR assurance process. For 2025/26, NHS GM declared an overall compliance rating of 68% ('non-compliant', achieving 32 out of the 47 standards), which represents a slight reduction in compliance compared to 2024/25 when compliance was 72%. NHS GM will implement an improvement action plan to raise the organisation's overall compliance before the next self-assessment due to be undertaken in 2026/27.

The benefits that the population of Greater Manchester will experience.	The annual NHS EPRR assurance process monitors the compliance of ICBs and providers with EPRR requirements. NHS GM will ensure that it has effective oversight and co-ordination of the NHS when responding to incidents. This will be enhanced through the implementation and monitoring of the EPRR improvement action plan.
How health inequalities will be reduced in Greater Manchester's communities.	The annual EPRR assurance process and associated improvement action plan will reduce health inequalities by ensuring that the needs of a diverse range of communities are considered when planning for and responding to incidents.
The decision to be made and/or input sought.	The Board is asked to: 1. Note the resource challenges within the EPRR function over the past 12 months 2. Note the outcome of the EPRR core standards assurance process 2025 – 2026 and associated improvement action plan
How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	The assurance process supports with the delivery of the NHS GM overarching strategy. This works relates to SR9 on the BAF Risks,
Key milestones.	Improvement action plan to be developed and approved by the end of February 2026. An EPRR Steering Group will be established to monitor progress. An update will be provided to Board within 6 months of approval of the improvement action plan.

Leadership and governance arrangements.	GM Local Health Resilience Partnership (20th November 2025) NHSE Assurance Meeting (2nd December 2025) Internal EPRR Steering Group to be established to maintain oversight of the Improvement Action Plan Senior Responsible Officer – Acting Chief Executive
Engagement* to date. ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	Clinical engagement as required
Financial or Legal Implications	Agreed funding – EPRR subject matter experts required on an ongoing basis to maintain statutory duties under the Civil Contingencies Act 2004

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*	*No*	*No*	*No*	*Yes*

Table 2: Assurance needed about the document.

Introduction

All NHS-funded organisations are required to complete an annual emergency preparedness, resilience and response (EPRR) self-assessment. This aligns to the NHS England national annual assurance process and formally documents the current level of organisational readiness for responding to incidents and emergencies and records compliance against the NHS England Core Standards for EPRR.

This report provides NHS Greater Manchester (NHS GM) Board with the outcome of the self-assessment undertaken by NHS GM for the 2025/26 EPRR assurance process.

1.0 2025/26 EPRR Assurance Process

1.1. In his letter of 1 July 2025, the National Director of NHS Resilience, NHS England, Dr Mike Prentice, notified Accountable Emergency Officers (AEOs) and Local Health Resilience Partnership (LHRP) co-chairs of the start of the 2025/26 EPRR assurance process and the initial actions required of them.

1.2. The number of applicable core standards (across 10 domains) for each NHS organisation is different. For the 2025/26 EPRR assurance process, the applicable number of standards that contributed to the overall rating of organisational compliance were:

62 standards for acute trusts

59 standards for specialist Trusts and community trusts

58 standards for mental health trusts

47 standards for integrated care boards

1.3. The overall EPRR assurance rating (overall statement of compliance) is based on the percentage of core standards each organisation assesses itself as being fully compliant with. For the 2025/ 26 assurance process:

Fully compliant	The organisation is fully complaint against **100%** of the relevant EPRR Core Standards
Substantial compliance	The organisation is fully complaint against **89-99%** of relevant EPRR Core Standards
Partial compliance	The organisation is fully complaint against **77-88%** of relevant EPRR Core Standards
Non-compliant	The organisation is fully complaint up to **76%** of relevant EPRR Core Standards

1.4. Typically, each year a deep dive is conducted to gain additional insight in a specific area. However, a deep dive was not conducted for 2025/26.

1.5. Within Greater Manchester, the assurance process for 2025/26 was coordinated by the NHS GM EPRR team. GM Trusts were asked to submit their self-assessment and statement of compliance by 30 September 2025. NHS GM also completed a self-assessment and statement of compliance using the template issued by NHS England.

1.6. Prior to the final submission deadline, GM Trusts were informed that following an initial review of the self-assessments by NHS GM, a member of the EPRR team would visit the Trusts to discuss the outcomes of the self-assessment with the EPRR leads. Site visits were scheduled in advance of the self-assessment submission deadline and Trust EPRR leads were provided with an indication of the visit format.

1.7. During October 2025, the NHS GM EPRR team visited all 9 of the NHS Trusts within GM. Each site visit included: discussion about the outcome of self-assessment; an evidence review of selected standards; and a discussion about general EPRR risks and mitigations. After each site visit, the NHS GM EPRR team prepared a draft summary of the discussions with each Trust. The draft summary documents were shared with Trust Accountable Emergency Officers and EPRR leads for review and amendment before a final version was issued.

1.8. Following these site visits, the NHS GM EPRR team prepared a report on the annual EPRR assurance process 2025/26 for GM Local Health Resilience Partnership (LHRP). The report summarised the overall compliance ratings for GM NHS organisations, including NHS GM. The trend analyses also highlighted some common clusters of standards rated as ‘partially compliant’ or ‘non-compliant’ by the Trusts.

1.9. At the meeting of GM LHRP on 20 November 202, the LHRP co-chairs led discussions with the Trust Accountable Emergency Officers about the outcomes of their self-assessment and the final LHRP EPRR Assurance Reporting Template for the 2025/26 assurance process was agreed. This report was then submitted to the NHS England North West (NHSE NW) EPRR team outlining the overall compliance statement for NHS GM, the process followed for this year’s submission, along with a thematic review of standards, risks, issues identified and noted good practice.

1.10. On 2 December 2025, NHS GM’s AEO, UEC Programme Director and Assistant Director of EPRR joined an assurance meeting with colleagues from NHSE NW to review the contents of the NHS GM EPRR Assurance Report and to discuss the process undertaken by NHS GM. The regional team accepted the findings presented by NHS GM and acknowledged positive feedback on NHS GM’s collaborative approach to the EPRR assurance process.

EPRR Core Standards Assurance Process Outcomes

2.0 Overview of NHS GM (ICB)

2.1. For the 2025/26 EPRR assurance process, NHS GM self-assessed 32 out of the 47 core standards applicable to ICBs as fully complaint. This resulted in an overall compliance score of 68%, putting NHS GM in the 'non-compliant' category (where an organisation is fully compliant with up to 76% of the relevant standards).

2.2. In 2024/25, NHS GM self-assessed overall compliance to be 72% with 34 out of the 47 core standards applicable to ICBs as fully complaint. Despite an overall reduction in compliance rating from 72% to 68%, NHS GM has shown improvement upon last year's self-assessment in relation to the number of non-compliant standards:

	2025 - 2026	2024 - 2025
Overall compliance	Non compliant	Non compliant
Percentage compliance	68%	72%
Standards 'fully' compliant	32	34
Standards 'partially' compliant	14	10
Standards 'non' compliant	1	3

2.3. It is important to note that the NHS GM EPRR team has been under resourced during 2025/26, due to both unplanned absence and staff vacancies. As such, predicted progress in some areas of the core standards has not been achievable.

2.4. In relation to the 10 domains, the following detail the areas self-assessed as either non or partially complaint with EPRR resource, duty to maintain plans, training and exercising and business continuity requiring the most significant focus to improve on for 2026/27.

2.5.

Domain	Standards non / partially compliant
Governance	1 / 6 standards rated non-compliant *Standard: 5 - Resource*
Duty to maintain plans	3 / 8 standards rated partially compliant

	Standards: 13 - new and emerging pandemics, 14 - countermeasures, 16 - evaluation and shelter
Training and exercising	3 / 4 standards rated partially complaint *Standards: 22 - EPRR training, 23 - EPRR exercising and testing programme, 25 - staff awareness and training*
Response	2 / 5 standards rated partially compliant *Standards: 26 - Incident Co-ordination Centre, 29 - decision logging*
Business continuity	6 / 10 standards rated partially compliant *Standards: 47 - business continuity plans, 48 - testing and exercising, 49 - Data Protection and Security Toolkit, 50 - BCMS monitoring and evaluation, 51 - BC audit, 52 - BCMS continuous improvement process*

2.6. Despite the non-compliant rating overall, NHS GM continues to meet its statutory duties as a Category 1 responder, as demonstrated by the organisation's responses to incidents during and beyond the assurance period and by its continuing co-operation, coordination and sharing of information with local multi agency partners.

2.7. NHS GM has been involved with planning for and responding to incidents including the terror attack outside the Heaton Park synagogue and responding to localised adverse weather and business continuity incidents during which NHS GM staff supported multi-agency coordination efforts.

3.0 Overview of NHS Trusts Compliance

3.1. As reported to the GM LHRP, all 9 provider Trusts undertook their self-assessment, with 7 showing an overall positive increase in their reported compliance level and 2 remaining at the same reported compliance level, but with an improved overall position in relation to the number of fully compliant standards.

The following table highlights the changes for the 9 providers.

Organisation	Organisation type	Overall 2024/25 rating (%)	Overall 2025/26 rating (%)
Bolton Foundation Trust	Acute, community	Substantial (89%)	Substantial (97%)
Greater Manchester Mental Health	Mental health	Non-compliant (69%)	Partial (79%)
Manchester University Foundation Trust	Acute, community	Substantial (94%)	Substantial (95%)
Northern Care Alliance	Acute, community	Partial (74%)	Substantial (92%)
Pennine Care	Mental health	Partial (81%)	Partial (81%)
Stockport Foundation Trust	Acute, community	Partial (77%)	Partial (77%)
Tameside & Glossop Integrated Care	Acute, community	Partial (77%)	Partial (87%)
The Christie	Specialist	Non-compliant (61%)	Substantial (90%)
Wrightington, Wigan and Leigh	Acute	Substantial (89%)	Substantial (94%)
NHS Greater Manchester	ICB	Non-compliant (72%)	Non-compliant (68%)

3.2. The following areas had the highest level of overall partial / non-compliance rating and therefore risk across GM:

EPRR resource

Evacuation and shelter

Testing, exercising and EPRR awareness

Business continuity and DPST

Next Steps

4.0 An NHS GM EPRR improvement action plan will be developed to address the core standards rated as partially compliant or non-compliant. This will be monitored and progressed via a newly formed NHS GM EPRR Steering Group. NHS GM's Accountable Emergency Officer and Executive Committee will maintain oversight of the improvement action plan and will receive a progress update at least every 3 months

4.1. This report fulfils the requirement for NHS GM to formally present the outcome of the self-assessment against the EPRR core standards, along with a statement of compliance, to a public board meeting for approval and sign off.

Recommendations

5.0 Greater Manchester Integrated Care Board is asked to:

- Note the contents of this report.
- Ensure the Executive Committee has oversight of the implementation of the improvement action plan to improve NHS GM compliance against the EPRR Core Standards ahead of the self-assessment process for 2026/27.

NHS
Greater Manchester

Standardisation of NHS GM Funded IVF Cycles Project Update

Part of Greater Manchester
Integrated Care Partnership

Required information	Details
Title of report	IVF Cycles Project Update
Author	Harry Golby, Associate Director Delivery & Transformation, NHS GM (Salford)
Presented by	Katherine Sheerin, Chief Commissioning Officer, NHS GM
Contact for further information	harry.golby@nhs.net
Executive summary	NHS GM has undertaken a single option public consultation on its Assisted Conception Clinical Policy Statement, against a preferred option of standardising to a policy of 1+ cycles. This paper presents the Consultation Report and recommends Board agrees to standardise the policy to 1+ cycles with effect from 1 April 2026.
The benefits that the population of Greater Manchester will experience.	The project will deliver a standardised IVF policy for all parts of NHS GM
How health inequalities will be reduced in Greater Manchester's communities.	The project will deliver a standardised IVF policy for all parts of NHS GM
The decision to be made and/or input sought	Board is asked to standardise the NHS GM policy to 1+ cycles
How this supports the delivery of the strategy and mitigates the BAF risks	Supports delivery of SR4 - widening health inequalities and continued poor health outcomes due to a reduced focus on prevention for the GM population
Key milestones	Recommendation is new policy to come into effect from 1 April 2026.
Leadership and governance arrangements	Lived Experience Advisory group, working to, IVF Project Group, with range of clinical and non-clinical representation, consideration through Chief Officers, Executive Committee, Clinical Effectiveness & Governance Group and Commissioning Oversight Group prior to Board.
Engagement to date	See Consultation Report

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

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

Introduction

NHS GM inherited an Assisted Conception Clinical Policy Statement[i] from its predecessor organisations such that eligible patients are entitled to different numbers of NHS GM funded IVF cycles depending on the locality of their GP practice. It is clearly unsustainable and avoidable for NHS GM to have such variation in access written into its policy so a project to standardise the number of IVF cycles is underway.

During June and July 2025, NHS GM held a 6-week public consultation on a proposal to standardise the number of IVF Cycles. The Consultation Report (Appendix 1) sets out feedback from over 2,000 people many of whom gave personal testimony and spoke very passionately about their own experience and views. Key themes from the report are:

- There was a strong appetite for a standardised IVF offer across Greater Manchester,
- The overwhelming majority of respondents did not support NHS GM's preferred option of standardising to an offer of 1 cycle plus an additional attempt should this cycle be abandoned or cancelled (i.e. 1+ cycles),
- There were many different views relating to what would make the GM Policy "fair" or "equitable" and how any change should be implemented,
- Many inequality issues were raised including impact on low-income households, same-sex couples, long term conditions, gender issues, religious and cultural sensitivities, mental health, etc.

This paper presents the Consultation Report and provides the output from the work in order that the Board can make a decision regarding standardisation of the policy across Greater Manchester. Much of the background information to the project was included in the paper that was discussed by Board in May 2025, and is not repeated in this paper.

Given the outputs from this project, in particular the issues raised in the consultation, the need for standardisation across GM and in the context of the approach by the majority of ICBs in England, the recommendations to the Board are:-

1. To consider the paper and its appendices
2. To confirm standardisation of the NHS GM Assisted Conception Policy Statement with the following statement included in the commissioning policy:

– *For women aged 39 and under NHS Greater Manchester commissions 1 full cycle of IVF (and allows a second attempt at a full cycle if the first attempt is abandoned or cancelled)*

3. To confirm that the new policy should come into effect on 1 April 2026 and apply to new referrals of eligible patients received by NHS GM commissioned IVF clinics on, or after, this date.
4. To endorse the NHS GM IVF Cycles Project group to oversee implementation of the change. This will involve clear patient and stakeholder communications and bringing forward recommendations to mitigate significant risks and issues that have emerged during the project.

1. BACKGROUND

1.1 Health inequalities are unfair and avoidable differences in health across the population and between different groups within society. NHS Greater Manchester (NHS GM) has committed to address unwarranted and harmful disparities in health and care access, experiences and outcomes for the population it serves. Many peoples' lives within Greater Manchester are affected by health inequalities alongside wider inequality gaps along demographic, socio-economic and geographical fractures formed by deeply rooted structural and systemic inequalities.

1.2 Around 1 in 7 heterosexual couples in the UK seek advice at some time in their lives about difficulties in getting pregnant.[ii] Treatment of infertility can be a long and emotionally challenging clinical pathway. With the right advice and clinical input many women do receive a positive pregnancy test however this cannot be guaranteed. For some women In Vitro Fertilisation (IVF) is the final, specialist treatment option. IVF births are increasing, in 2023 3.1% of all UK births were IVF births – approximately one child in every classroom - but the number of IVF births which are NHS funded is falling.[iii]

1.3 NHS GM has inherited an Assisted Conception Clinical Policy Statement from the ten former Greater Manchester Clinical Commissioning Groups such that eligible patients are entitled to different numbers of NHS GM funded IVF cycles depending on the locality of their GP practice. The current (version 3.1, Nov 2021) policy states:

For women aged 39 and under:

- *Bolton, Bury, HMR, Manchester, Oldham and Trafford all commission 1 complete cycle of IVF (and allow a second attempt at a full cycle for a cancelled or abandoned cycles),*
- *Salford, Stockport and Wigan all commission 2 cycles (includes abandoned or cancelled cycles)*
- *Tameside commissions 3 cycles (includes abandoned or cancelled cycles).*

1.4 This is the only part of the current policy that differs across GM; in every other respect (e.g. definition of childlessness, definition of a full cycle, how obesity affects eligibility, women aged 40+, same sex couples, etc.) the policy is the same. In early 2024 a project was established to standardise the number of cycles across GM.

NHS GM Public Consultation

1.5 The NHSGM Board received a project update in May 2025[iv] which provided background to the issues and summarised how the project had been followed NHS England's June 2023 Major Service Change Handbook[v] to identify a short list of policy options. The Board approved a recommendation to undertake a public consultation.

1.6 During June and July 2025, NHS GM held a 6-week public consultation on a proposal to standardise the number IVF Cycles, with a preferred option of 1+ cycles. The Consultation Report (Appendix 1) sets out feedback from over 2,000 people and organisations many of whom gave personal testimony and spoke very passionately about their own experience and views around IVF.

1.7 In December 2025 the Greater Manchester Joint Health Scrutiny Committee reviewed the level of consultation undertaken by NHS GM and noted the plan for Board to receive a recommendation to

standardise the policy.

1.8 The Consultation Report should be considered in full and in detail; some of the key points are summarised in the chart below.

1.9 Many of the themes in the Consultation Report build on those reported during an IVF public engagement exercise carried out by NHS GM in the spring of 2024. It highlighted the strength of feeling amongst the respondents and gave an opportunity to explore specific issues, for example alternatives to NHS GM's preferred 1+ cycle option and how a change should be implemented.

1.10 The people who responded to the consultation highlighted many of the factors that the Board will need to balance when making its decision. Legal and ethical considerations, and concepts of distributive and procedural justice come into play. Perhaps the most commonly and powerfully expressed sentiments relate to equity – how to treat people fairly according to their needs. An equitable approach requires more than a decision to standardise the number of cycles policy across GM; whatever option Board chooses some people will feel they have not been treated fairly, and there is further work to address inequalities associated with IVF.

Key points for decision makers to consider

Some of the key points which have been raised which decision makers need to consider, include:

- Carefully consider the strength of opinion of respondents agreeing that there was a need to standardise the number of IVF cycles, to make the offer fair.
- Consider that there are many different views relating to what actually makes an offer 'equitable'.
- Carefully consider all the feedback on the current proposal to standardise to 1+ cycles, particularly the concerns raised and the potential impact on health inequalities.
- Consideration needs to be given to those people already on their IVF journey and the impact on their mental health and wellbeing, when implementing any policy change to the number of cycles available.
- When reviewing the proposals, consider relating to any potential knock-on effect with demand for other health services increasing, which may have future cost implications e.g. GP and mental health service appointments.
- When reviewing the policy, ensure that infertility is a medical condition and the impact of infertility as a life-changing issue is recognised.
- Recognise and be aware of the value of IVF to those people who need it.
- Carefully review all the alternative proposals put forward against the evidence to see whether they would be appropriate for implementation and preferred against the option consulted on.
- Consider how to incorporate the feedback into the Equality Impact Assessment and include any mitigations that need to be implemented.
- Consider the feedback from the consultation and any other engagement in any future review of the eligibility criteria.

Options for Consideration

1.11 Prior to the consultation the IVF Cycles Project had been through a process to identify a long list of eight options. Through further testing, these were subsequently reduced to a shortlist of three which were presented to the Board in May 2025 before the Board endorsed the preferred option of 1+ cycles for consultation.

1.12 Section 8 of the Consultation Report covers the alternatives to 1+ cycles suggested by respondents. Most of these alternatives had already been considered by the IVF Cycles project group, but some had not (see paragraphs 1.19 and 1.22).

1.13 The project group is made up of individuals with a range of perspectives and could not reach a consensus on its preferred option. However, having considered all the suggestions made during the consultation, as well as the original long list, it was agreed the Board should reconsider three shortlisted options (i.e. 1+ cycles, 2+ cycles and 3 cycles.) These are summarised in the table in section 2.

Activity & Finance Modelling

1.14 The project group developed a finance and activity model to estimate the number of first / second / third cycles NHS GM currently commissions, to predict how many cycles would be commissioned if the policy was changed, to predict how many women / couples would be affected and the impact on NHS GM's finances. This modelling has proved complex for a variety of reasons. There are untested assumptions within the modelling and varying levels of confidence in the output - some options use small sample sizes.

1.15 The May 2025 Board paper used modelling based on data from 2023/24 whilst the figures in this paper are based on the average of 2023/24 and 2024/25. The expenditure on IVF each year by NHS GM across the four provider is as follows:-

- **2023/24 £2,627,000**
- **2024/25 £3,042,000**
- **Average £2,834,000**

1.16 An IVF cycle begins with stimulation of the ovaries, involves collecting eggs and sperm, then fertilising the eggs outside the woman's body, and ends with implanting the embryos into the womb. The number of eggs collected, fertilised and resultant embryos implanted varies from cycle to cycle. With several different procedures to each cycle, and differences between cycles, it is complicated to translate procedure activity data into the number of cycles, and the number of women / couples affected. The modelling methodology has been updated since figures were reported to Board in May 2025.

1.17 The model estimates that on average across the two financial years NHS GM commissioned a total of 821 IVF cycles and, of these, 662 were first cycles of IVF for a woman / couple.

1.18 NHS GM's policy (and NICE) defines a "full cycle" as ending with either a live birth or the transfer

of all embryos, a "cancelled" cycle as one where eggs are not collected and an "abandoned" cycle as one where eggs are collected but an embryo is not implanted. The model assumes approximately 1 in 9 cycles do not result in an embryo being implanted. The project group agreed both continuing to commission "full" cycles and explicitly considering abandoned and cancelled cycles was important (the "+" in the 1+ cycle policy refers to the second attempts for some women / couples.) These two, unchanged, aspects of the policy maximise the number of chances a woman / couple has to become pregnant with each commissioned cycle. Other ICBs use different definitions and differ in terms of whether abandoned and / or cancelled cycles count towards a woman's / couple's entitlement – which means fewer chances.

1.19 A few respondents to NHS GM's consultation suggested introducing means testing or partial funding for IVF cycles which would reduce NHS GM's expenditure but is explicitly contrary to national and GM policy. Department of Health & Social Care Guidance[vi] on NHS patients who wish to pay for additional private care is very clear and referenced in the NHS GM Individual Funding Request Operational Policy.

NICE Guidance

1.20 National Institute for Health & Care Excellence (NICE) clinical guideline CG156[vii] is relevant. NICE clinical guidelines are advisory rather than compulsory but should be taken into account when planning care. CG156 makes numerous recommendations which are reflected in the current GM policy, but the recommendation of 3 cycles currently only applies in Tameside.

1.21 NICE commenced a major review of CG156 in 2022, the expected publication date of the updated NICE guideline is March 2026. NHS GM is registered as a stakeholder for the updated guideline, has responded to the draft, for consultation, update and is in continuing dialogue with NICE with respect to its implementation. The draft guideline signals several potential changes. It covers the full pathway for people seeking assessment and treatment of health-related fertility problems, from initial advice through to specialist treatments and technologies (e.g. medical and surgical management of male and female factor fertility problems, IVF, etc.) The draft recommends against the use of several IVF treatment "add-ons" which are popular despite no clear evidence that they work, and a broadening of access for NHS fertility preservation services. Amongst the IVF related changes, the draft guidelines recommend considering 3 further full cycles of IVF for women under 40 who have not conceived after the first 3 NICE recommended cycles (i.e. 6 in total), and also not offering NHS funded IVF for women aged 42.

1.22 NHS GM's Consultation Report notes "*A notable number of responses called for unlimited or as many cycles as medically feasible, especially where there is a clear cause of infertility or where additional cycles could statistically increase the chance of success."* The project has previously considered, but has not shortlisted, "more than 3 cycles" as an option. The proportion of women who progress to a subsequent cycle reduces with each additional cycle. At a population level therefore, there may be little difference between an "Unlimited cycles" or a "6 cycles" policy. Once NICE has published its update to CG156 it will need to be considered in totality. Reform proposals are being considered which may lead to NHS GM working more closely with other ICBs across the North West region to review such policies in future.

Policy Implementation

1.23 Any decision to standardise the GM policy, whether that is to increase or reduce the number of cycles, impact individual women / couples. How the decision is implemented will also impact individuals so the IVF Cycles project was clear that a recommendation to standardise the number of cycles needs to be accompanied with a recommendation of when the new policy should come into effect and where in the pathway it is implemented. Section 6 of the Consultation Report considers implementation, and the approach was discussed with the IVF providers.

1.24 Providers stressed the need for clear, transparent communications from NHS GM to IVF clinics, referrers (i.e. primary and secondary care clinicians) and patients to help consistent implementation.

1.25 There was an agreement amongst the group that if the Board confirms the preferred option of 1+ cycles this policy change could come into effect on 1 April 2026 and should apply to new referrals of eligible patients received by NHS GM commissioned IVF clinics on or after this date.

Discussion

1.26 The recommendations to Board have been shaped through discussions at NHS GM internal governance meetings (Chief Officers, Commissioning Oversight Group and Executive Committee). This section of the report aims to give a sense of those discussions and to explain the rationale behind the recommendations.

1.27 The strength of feeling expressed during the consultation must be recognised. Every individual woman's / couple's experience differs; the consultation report helps tell multiple different stories; but it is hard to overemphasise the importance of fertility treatment generally, and IVF specifically, to infertile women / couples. Any decision to standardise the GM policy, whether that is to increase or reduce the number of cycles, will of course impact people; precisely how it impacts each individual will depend upon their personal circumstances.

1.28 Infertility treatment carries profound personal meaning for individuals, couples and families. Fertility treatment can be a long and emotionally challenging journey, raising the possibility that individuals' entitlement to NHS funded care may change has increased some peoples' worries and anxieties. Any policy change must be communicated clearly and consistently so that women / couples and the health professionals who support them have clarity and certainty. A reduction in cycles has the potential to for adverse emotional and psychological impact and additional pressures on mental health and primary care services.

1.29 The IVF Cycles project was established to standardise the number of cycles commissioned across GM. The consultation showed there was strong support for a standardised policy.

1.30 There are health inequalities associated with fertility treatment and IVF, noted through the Equality Impact Assessment and the Consultation Report. Whilst many of these inequalities will continue irrespective of whether the number of cycles is standardised across GM and further, broader work is required to consider these, it is clear that reducing the number of NHS funded cycles across GM will indirectly adversely affect some of those people who are already impacted by these inequalities. The Consultation Report states *"Many were concerned that the policy change could push*

individuals and families into poverty due to the financial burden of accessing fertility treatment privately, creating a two-tier system, where only those who can afford to pay for additional cycles are able to have a family". As an increasing proportion of IVF is self-funded rather than NHS funded[viii], if the number of NHS GM commissioned cycles reduces this is likely to further accelerate this trend.

1.31 If NHS GM is to standardise its policy there is a clear rationale to standardise to a 1 cycle policy. It is already the policy across most of Greater Manchester. The ICBs surrounding Greater Manchester each commission 1 cycle. 70% of the NHS Integrated Commissioning Boards across England have a 1 cycle policy and this number is rising - many people are aware of NICE's current recommendation of 3 cycles and expect this to be reflected in the policy; however the reality of the NHS is very different from NICE's recommendation – only 3 ICBs across England currently have a 3 cycle policy.[ix]. The recommendation to standardise to 1+ full cycles maximises the number of opportunities a woman / couple has to become pregnant with that 1 cycle.

1.32 Almost all of the respondents to the consultation felt that 1 cycle was not enough, the majority advocated for at least 2. Many people considered the first cycle to be a "*trial run"*; clinicians describe following standard protocols during the first cycle but then being able to adapt these to the individual during subsequent cycles. Many factors influence success rates and much of the published research considers the cumulative success rates (i.e. the probability of achieving a live birth after 1, 2 or 3 IVF cycles), so it was difficult to find published evidence demonstrating the additional benefit associated with the more personalised approach to the second cycle.

1.33 Many respondents to the consultation felt that standardising to a 1+ cycles policy was a *"cost cutting exercise".* NHS GM's spend on IVF increased from £2,627k in 2023/24 to £3,042k in 2024/25, this 16% increase is larger than the modelled saving associated with a 1+ cycle policy. So if NHS GM had established the project to cut costs it would have needed to consider changes beyond standardising the number of cycles – the project was established solely to remove the inequity written into the current policy and to standardise the number of cycles.

1.34 This does not mean that the investment required to standardise to a 2+ or 3 cycles policy was not a consideration. In July 2024 the Board formally accepted "undertakings" agreed with NHS England; since then all decisions taken in 4 thematic areas of leadership & governance, performance & assurance, financial sustainability and quality of care have come under very close scrutiny. Agreeing a balanced financial plan and achieving cost improvement plans remains a significant challenge. Against this context it has not been possible to bring forward a recommendation to prioritise IVF for investment ahead of other services, some of which are already facing cuts.

1.35 The majority of respondents to the consultation felt that any reduction in the number of cycles should only apply to people who had not yet been *"approved"* for IVF and that applying it to people mid-journey would be *"cruel"*, emotionally and financially damaging and break a *"promise"*. These comments need to be considered against the context of what is meant by someone's IVF journey. Some respondents talked about trying to have a baby for many years, others described long waits for gynaecology services prior to referral to an IVF service, but the IVF clinical pathway can be considered to start after infertility has been diagnosed and other treatment options discounted. There was a consensus amongst the IVF providers that any policy change should not apply to people who had already been referred to an IVF clinic. The 4 IVF providers confirmed if the policy

only applied to women / couple's referred after the implementation date they would be able to consistently apply the new policy to new patients and ensure those already in the system would be managed in line with the previous policy.

1.36 IVF providers agreed that the policy implementation date of 1 April 2026 would be deliverable. Despite the fact that NHS GM engaged with thousands of women / couples regarding IVF, initially in Spring / Summer 2024 and then more formally Summer 2025, there will be some who are not aware a policy change is under consideration. Some may have been waiting to see a gynaecologist for months before a referral to an IVF clinic can be made; it is possible that an appointment had been cancelled or an unexpected test result requires further investigation. Those women / couples may feel that an implementation date of 1 April 2026 is too soon. Whilst those specific women / couples may benefit from a later implementation date, others would be similarly impacted by a later implementation date. The Greater Manchester Individual Funding Request team may receive appeals on grounds of exceptional circumstances; but would be unlikely to approve them as there would be multiple women / couples who might have had a similar experience.

Other Related Considerations

1.37 Several other risks and issues have emerged during the lifetime of the project that will not be directly addressed by the standardisation of the number of cycles. These include:

- Addressing the inequalities associated with the diagnosis and treatment of fertility issues, beyond just those relating to IVF, through better data and understanding of patient experience.
- Ensuring NHS GM's IVF providers optimise patient outcomes from NHS GM funded IVF cycles.
- Ensuring NHS GM has a clear and sustainable approach with respect to fertility preservation (i.e. sperm and embryo freezing).
- Reflecting on feedback from same sex couples and single women – noting that updated NICE guidance will relate to people seeking fertility treatment for health related issues only.

1.38 The NHS GM IVF Cycles Project group will continue to meet for a time limited period to oversee implementation of the new policy and bring forward recommendations to address these issues.

2. Short Listed Options

Options	1+ Cycles	2+ Cycles	3 Cycles
Detail	1 cycle (plus a second attempt if first one is abandoned or cancelled)	2 cycles (plus a third attempt if at least one of the first two is abandoned or cancelled)	3 cycles (includes abandoned or cancelled cycles)
Comparison with current policy	This is the current policy of Bolton, Bury, HMR, Manchester, Oldham and Trafford. 64% of GM women aged 20-39 live in these localities.	No areas of GM currently have this policy. Salford, Stockport and Wigan have a 2-cycle policy but do not allow a 3rd attempt. 29% of GM women aged 20-39 live in these localities.	This is the current policy of Tameside. 6% of GM women aged 20-39 live in this locality
Estimated no. of women eligible each year	662	662	662
Estimated no. of NHS GM funded cycles each year	735	966	1004
Impact on accessibility	No change for most of GM, a reduction in cycles for the rest of GM.	An increase in cycles for GM - an additional cycle for some localities, an additional 3rd attempt for a few women from some localities. A reduction in cycles for one locality.	An increase in cycles for GM. No change for one locality, one or two additional cycles for the rest of GM.
Total estimated annual recurrent cost	£2,537k	£3,335k	£3,466k
Short term / non recurrent impact	Some people are already in the clinical pathway under the previous policy – so the new policy will take a little time to come into effect.	Many people may become entitled to additional cycles, some people are already in the clinical pathway under the previous policy – so activity and costs may increase in the short term before settling	Many people may become entitled to additional cycles, some to more than one additional cycle – so activity and costs may increase substantially in the short term before settling
Workforce impact	The project has concluded there are no major workforce concerns associated with any of the three options		
Cost effective	The project has concluded that all three options are cost effective		
Compliant with NICE CG156	No	No	Yes
Comparison with other ICBs	71% have 1-cycle policies which are similar but not identical	21% have 2-cycle policies which are similar but not identical	8% have 3-cycle policies which are similar but not identical
Risks	There is the highest level of confidence in the activity and finance modelling of this option	There is some uncertainty associated with the activity and finance modelling of this option	There is significant uncertainty associated with the activity and finance modelling of this option

3. Recommendations

Given the outputs from this project, in particular the issues raised in the consultation, the need for standardisation across GM and in the context of the approach by the majority of ICBs in England, the recommendations to the Board are:-

1. To consider the paper and its appendices
2. To confirm standardisation of the NHS GM Assisted Conception Policy Statement with the following statement included in the commissioning policy:

– *For women aged 39 and under NHS Greater Manchester commissions 1 full cycle of IVF (and allows a second attempt at a full cycle if the first attempt is abandoned or cancelled)*

3. To confirm that the new policy should come into effect on 1 April 2026 and apply to new referrals of eligible patients received by NHS GM commissioned IVF clinics on, or after, this date.
4. To endorse the NHS GM IVF Cycles Project group to oversee implementation of the change. This will involve clear patient and stakeholder communications and bringing forward recommendations to mitigate significant risks and issues that have emerged during the project.

Appendix 1 – Consultation Report (final)

Appendix 2 – Equality Impact Assessment (26/11/25)

Appendix 3 – Quality Impact Assessment (v0.4)

References & Notes

[i] See clinical policies section Greater Manchester Individual Funding Request (GM IFR) Service | Greater Manchester Integrated Care Partnership (gmintegratedcare.org.uk)
[ii] Fertility | Topic | NICE
[iii] Research and data | HFEA
[iv] 20250521-nhs-gm-integrated-care-board.pdf
[v] Major Service Change: An Interactive Handbook - June 2023 :: North West Clinical Senate (nwcsenate.nhs.uk)
[vi] NHS patients who wish to pay for additional private care - GOV.UK.
[vii] Overview | Fertility problems: assessment and treatment | Guidance | NICE
[viii] Human Fertilisation & Embryology Authority, Fertility Treatment 2022 – preliminary trends and figures, July 2024 Research and data | HFEA
[ix] NHS-funded in vitro fertilisation (IVF) in England - GOV.UK

NHS
Greater Manchester

Standardising IVF Cycles

Consultation Report

September 2025

Standardising IVF Cycles Consultation Report

Version control

Date	Version	Updates from	Reason for change
15.09.2025	V1	R Whitehead, A Mitton, M Atack, T Clarke	1st draft
19.09.2025	V2	H Golby, R Whitehead	Minor amendment, as suggested by Commissioner and members of the IVF Lived Experience Advisory Group
26.09.2025	V3	R Whitehead	Minor amendment, as suggested by GM IVF Project Group suggested amendments.
30.09.2025	V4	H Golby	Minor amendments removing “draft” from title and watermark. V4 to be used for internal NHS GM governance (i.e. Chief Officers, Exec Comm, COG)
10.11.2025	V5	R Whitehead	Clarified language relating to the IVF journey length of same sex and single persons to reflect this view is a patient’s perspective and not a factual statement.

Contents

Executive summary

During June and July 2025, a 6-week public consultation was held to seek the views on a proposal to standardise the number of NHS-funded IVF Cycles offered to eligible people, as part of Greater Manchester Assisted Conception Policy.

This consultation report sets out the feedback from the over 2,000 people who engaged with NHS Greater Manchester (NHS GM) in a variety of different ways, including: a survey, focus groups, community workshops and at pop-up events across Greater Manchester. Some also participated by sharing their views via 1:1 telephone calls, submitting texts, letters and emails.

Through the consultation we clearly heard that there was a strong appetite to provide a consistent and equitable offer across Greater Manchester. People told us that this would make it fair for all those eligible to receive treatment and was the “right thing to do”.

Despite this, many people did not support NHS GM’s preferred option which formed the basis of the consultation, to replace the existing various offers to a universal 1 cycle plus an additional attempt should this be cancelled or abandoned (1+) option, voicing very strong opposition.

It was viewed by many as a cost-cutting exercise, an opportunity to “level down” and a “backward step”. For some there was a strong belief that infertility should be treated in the same way as other medical conditions, and reducing funding for this service indicated that it was not.

People feel that the proposal will increase health inequalities, particularly affecting same-sex couples, people with disabilities, and other marginalised groups including low-income households.

Many were concerned that the policy change could push individuals and families into poverty due to the financial burden of accessing fertility treatment privately, creating a two-tier system, where only those who can afford to pay for additional cycles are able to have a family.

People are concerned that these changes could lead to significant mental and emotional health challenges for many hoping to have a family.

There were a number of alternative options suggested, with almost all advocating towards a more favourable offer, for all.

When considering the roll out of any proposed change, opinions varied depending on whether the change was an increase or decrease of cycles. If cycles are being decreased, many believed the fairest course of action was to apply it only to those who have not yet been approved for IVF as those already on their journey were expecting to get more cycles. If the cycles are being increased, it is fairest to apply to everyone wherever they are in their journey.

The report contains much more detail about the consultation, how it was promoted, who engaged with us and how, and what we were told.

It will be considered – alongside other information, to review the proposals and inform the final decision on how the policy will be changed.

Thank you to everyone who contributed throughout the consultation.

Section 1: Introduction and overview

Introduction

NHS Greater Manchester held a public consultation to seek feedback from residents, communities, stakeholders and staff about the number of In vitro fertilisation (IVF) cycles eligible people should be offered across Greater Manchester.

In vitro fertilisation (IVF) is one of several ways available to help people with fertility problems. People with fertility problems may find it harder to get pregnant. People who need IVF can get one or more tries on the NHS, if they meet the criteria. Each try is known as a cycle.

At the moment, depending on where a person lives in Greater Manchester, they will get offered a different number of cycles – from 1 cycle to 3 cycles. We believe that this isn't fair and needs to change.

So, we are reviewing the policy to make sure that wherever someone lives in Greater Manchester, they get offered the same number of NHS funded cycles. As part of this review, we held a 6-week consultation asking if people agreed with a proposal of 1 cycle, plus an additional attempt should this be cancelled or abandoned (referred to as 1+) offered to eligible women aged 39 and under.

Through the consultation we heard from over 2,000 people who shared their views about our proposals. This consultation report sets out the feedback from those people so commissioners and decision-makers can consider it alongside all available evidence when they make a decision.

Our thanks go to all our colleagues and partners who have supported us to involve people. Our greater thanks go to all those who took the time to engage with us and share their experiences, thoughts and ideas – we are very grateful. Particular gratitude goes to the members of our Lived Experience Advisory Group (LEAG), including representatives from Fertility Network and LGBT Foundation, who have worked with us for over 12 months, advising, challenging and supporting throughout the development of the plans and the consultation. We'd like to extend a special thanks to The Fertility Alliance who not only had representation on our LEAG but were also members of the GM IVF Cycles Project Group, over the past 18 months.

This report will be published on our website and shared widely. If you would like it in a different format or language, would like a printed copy, or have any questions, please contact us.

Email: gmhscp.engagement@nhs.net

Call, text or WhatsApp: 07786 673762

What people told us – the key themes

- People strongly supported standardising the number of cycles across Greater Manchester, with some wanting it standardised nationally.
- Most people strongly disagree with the proposal to standardise at 1+ cycle across Greater Manchester.
- People feel the proposal will increase health inequalities with some communities, particularly for low-income households, same-sex couples, people with disabilities, amongst others.
- There was a strong feeling that infertility is a medical condition and should be viewed and treated as such, which it's believed not to be currently.
- There was concern that the policy change could push people into poverty.
- People were concerned that this would create a two-tier system with only those able to pay for more cycles able to have a family.
- There was concern that this would cause significant mental and emotional health impacts.
- People felt that this was a cost-cutting exercise and levelling down of a service rather than creating equity.
- Most people felt that any reduction in cycles should only be applied to people who are yet to be assessed and approved for IVF with all people currently in the system having their initial number of cycles offered honoured.

Section 2: Consultation delivery

How we engaged

In total, we engaged with over 2,200 people through a variety of methods, both online, face-to-face, in the community, over email and telephone.

Online survey (support offered over the phone)

1,074 people completed the survey, either online themselves or with help through our phone number. We have also had printed surveys and promoted the survey and involvement at all events across Greater Manchester. The details of who responded is in the next section.

Focus groups

We held 5 focus groups - 2 online and 3 face to face. The face-to-face focus groups were held in Tameside, Salford and Stockport; one was booked for Wigan, but was cancelled due to lack of interest. The focus groups were open to anyone interested in the consultation to share their thoughts and feelings with us – they were predominantly attended by people with lived experience.

We also visited 8 community groups to hold targeted focus groups with their members, and 1 group – Fertility Action – held a focus group themselves and shared the feedback with us.

In total, 123 people engaged with us through focus groups.

Locality engagement

We took our survey and information out into each locality on our information and engagement stalls throughout the period of engagement. Through this we interacted with approximately 829 people over 28 events across Greater Manchester.

Other engagement opportunities

On top of the activities above, we attended a number of meetings with colleagues and organisations across Greater Manchester to promote the consultation.

We also received:

- 18 emails
- 1 phone call
- 3 texts/WhatsApp messages
- 1 letter (not including posted surveys)

Promotion

We promoted the consultation as widely as we could.

This included paid for advertising in local newspapers across Greater Manchester, social media (more details below), and communications across our networks with a reach of over 10,000 people without social media.

We also put up posters across Greater Manchester promoting both local engagement opportunities and the consultation more generally.

Social media

Throughout the engagement period we published 29 posts across our Facebook, Instagram, X, and LinkedIn accounts, not including the paid for promotion.

The posts were seen a total of 22,700 times, with an engagement rate of 2.8%, which is above industry average.

In terms of engagement, our posts were shared or reposted 230 times, liked 179 times and there were 25 comments on our social media posts, all of which have been fed into the consultation responses to be included in this report.191 people clicked the link to find out more and take part in the engagement.

Three posts were boosted across Facebook with paid for advertising. These boosted posts reached 120,000 people and 2,704 people clicked on them.

We promoted the consultation activity in local community Facebook groups, which increased our local, targeted reach. This approach led to people taking the time coming down to speak to us at engagement stalls across Greater Manchester.

Partners from across Greater Manchester, including hospital trusts, Healthwatch, community groups, local councils and fertility charities also shared on their social media platforms to promote the activity to increase our reach, and we thank them all for this.

Website

During the consultation, we had 4,600 visitors to the IVF consultation page, making a total of 7,893 visits.

The news items on the website were visited 413 times, and pop-up reminders which appear when entering the page were visible during both the first week and the last week of the consultation and were seen 30,651 times.

The translation tool on the website was used to translate the consultation information 272 times into Polish (32%), Arabic (13%), Urdu (13%), Portuguese (12%), Chinese (10%), Punjabi (8%), Bengali (6%) and Romanian (6%). We also had the postcards and posters translated into Urdu and produced in easy read.

Media

We paid for advertising in local papers, including:

- Bury – Bury Times
- Bolton – The Bolton News (5 consecutive days)
- Manchester – Manchester Evening News (M.E.N) best circulation day (Friday)
- Oldham – The Oldham Times, Oldham Reporter
- Rochdale – Rochdale Observer, Heywood and Middleton Guardian
- Salford – Salford Post
- Stockport – Stockport Express
- Tameside – Tameside Reporter
- Trafford – Sale and Altrincham Messenger
- Wigan – Wigan and Leigh Journal, Wigan Observer

The collective estimated readership for these papers is 358,282 people.

As well as paid for advertising, we released 2 press releases, 1 at the beginning to announce the launch, and a follow up part way through the consultation.

This led to 22 articles or media pieces:

- 18 June – Manchester World, MSN, Wigan Today, news item on Granada Reports.
- 19 June – About Manchester, BBC online, BBC Radio Manchester (news bulletin)
- 21 June – Mancunian Matters
- 22 June – Manchester Evening News
- 23 June – Progress Educational Trust (PET), Bio News (PET's specialist publication)
- 25 June – BBC Radio Manchester (drivetime interview with Katherine Sheerin)
- 26 June – Press Reader (note: Press Reader is a digital newsstand platform providing access to newspapers and magazines from around the world)
- 15 July – Not Really Here Media Tameside (local independent website)
- 27 July – Bolton News
- 29 July – Manchester Evening News
- 4 August – Health Service Journal (included mention of NHS Greater Manchester in context of wider ICB IVF proposals)

Who we engaged with

We wanted to make sure that we engaged with people from across Greater Manchester, with a particular focus on Salford, Stockport, Tameside and Wigan where people would be most impacted by the proposals. Table 1 sets out how many people we reached in each locality, and how that compares to the Greater Manchester population.

We also targeted some specific demographic communities based on the information from the equality impact analysis. This is set out in Table 2.

We also liaised with our internal colleagues, including patient services department, who shared correspondence with patients who either had enquiries and complaints relating to IVF services, with the relevant also being included within the findings of this report.

The number of people accessing IVF treatment across Greater Manchester each year is approximately 900, so it was anticipated that we may not hear a large number of personal testimonies, outside of those participating in focus groups. The majority of participant discussions were believed to arise from those linked to organisations and individuals from cohorts we were specifically targeting. It was therefore no surprise that we heard many testimonies from those who passionately spoke about their experiences and shared their views about the IVF proposals.

What we had not anticipated was the sheer number of people we randomly met and spoke to across Greater Manchester whilst engaging at public events, in such settings as libraries, who had either received fertility treatment themselves or had a family member or friend who used IVF services. It was also a humbling experience to meet so many IVF children and adults along the way, hear their stories and the gratitude they had for the NHS and the chance of welcoming a “miracle” into their family.

Table 1. Reach by locality

Locality	Survey response**	Face-to-face reach	Total	% GM population	% of total response
Bolton	82	31	113	10.3%	5.4%
Bury	62	27	89	6.8%	4.3%
Manchester	140	36	176	19.2%	8.5%
Oldham	68	51	119	8.4%	5.7%
Rochdale	44	169	213	7.8%	10.3%
Salford*	122	117	239	9.4%	11.5%
Stockport*	192	136	328	10.3%	15.8%
Tameside*	94	150	244	8.1%	11.7%
Trafford	90	31	121	8.2%	5.8%
Wigan*	127	228	355	11.5%	17.1%
GM/ Other	38	42	80	-	3.8%
Totals	**1,060****	**1,018**	**2,078****	**100%**	**100%**

*Localities that were targeted

**15 people did not answer this question; the totals include these 15 people.

Table 2. Targeted engagement activities by demographic

Target group	Groups we engaged with:
Women under 40	• GM Maternity and Neonatal Voices Partnership Leads • Flourish Together (Trafford & Stockport) • Feel Good Family Picnic (Rochdale) • Westwood Women's Community (Oldham)
Adults with a disability	• Disabled People's community health equity sounding board (Manchester)
Long term condition or prescribed medication that impacts fertility	• Fertility Action Network (GM) • The Wait UK (GM)
People with learning disability	• Manchester People First • Listening to People (Salford)
Black African / Caribbean communities	• BHA for Health • De-butterfly (Stockport) • SAWN (Oldham) • Flourish Together (Stockport) • The Wait UK (GM)
South Asian communities	• Kashmir Youth Project (Rochdale) • Westwood Women's Community (Oldham)
Same sex couples	• Pride in Leigh (Wigan)
Deprived communities	Stalls in: • Bolton Skills Fair (Bolton) • Wythenshawe Forum (Manchester) • Pendleton Gateway (Salford) • Broughton Hub (Salford) • Eccles Gateway (Salford) • Brinnington Library (Stockport) • Mersey Way Shopping Centre (Stockport) • Ashton Library (Tameside) • Armed Forces Day (Tameside) • Hattersley Library (Tameside) • Atherton Library (Wigan) • Grand Arcade (Wigan)

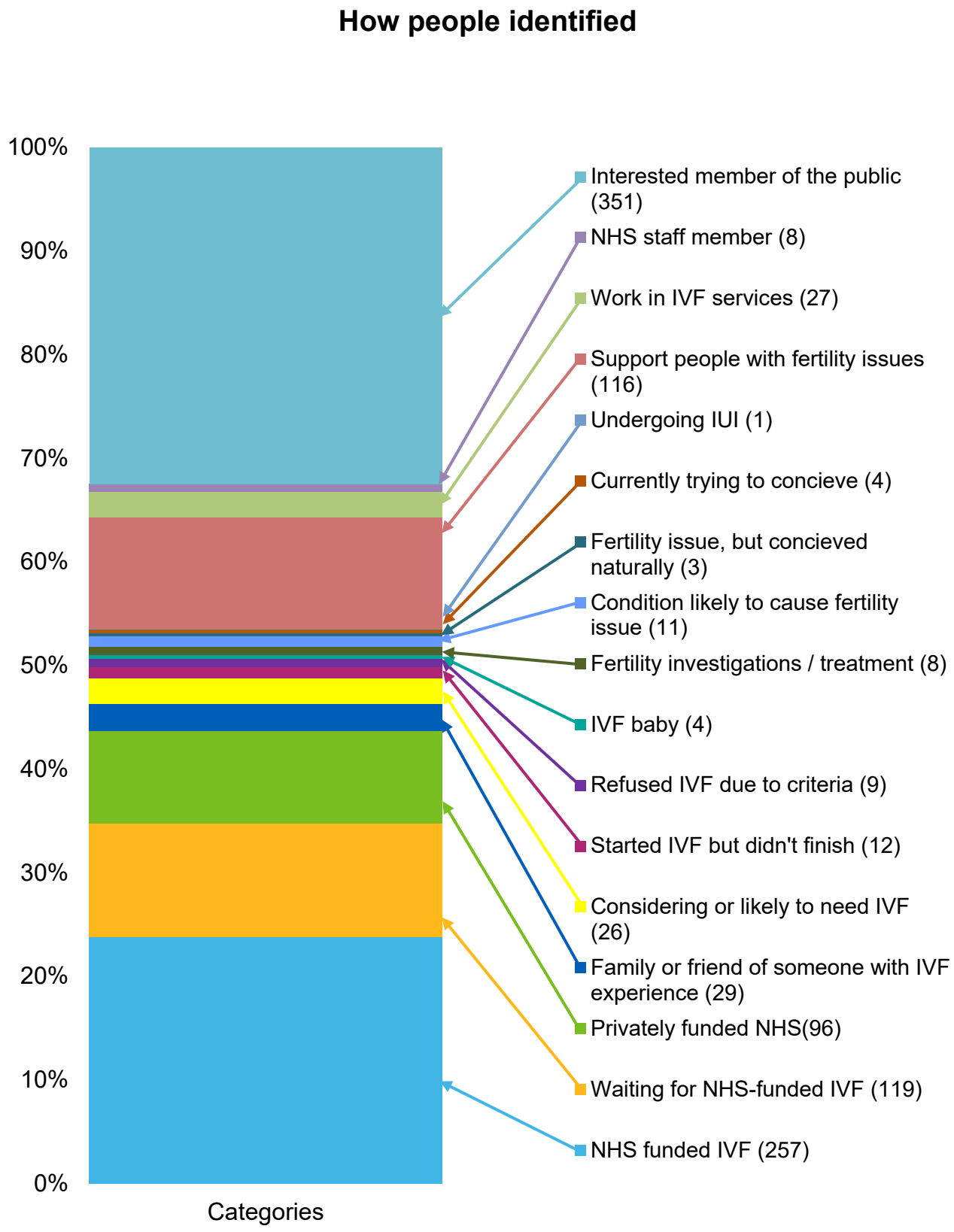
Who answered our survey

Whilst we were unable to collect demographic details in pop-up stalls or community groups, everyone who took part in the survey was asked to complete demographic questions, but this was optional. Nearly 1,000 people chose to answer at least 1 of the questions. An overview of this demographic data is included below, with full details in Appendix 1.

As can be seen in the charts below the survey was mostly completed by people who have experience of IVF or infertility in different ways.

Please note that some people identified as more than one category, for example, both as having IVF on the NHS and privately.

Chart 1. The numbers of the different people who completed the online survey



Partnership work

To enable us to reach as many people as possible to have their say, we reached out to lots of organisations and contacts. We provided information in numerous ways including a facilitator pack to deliver own sessions to engage, one to one conversations, presentations and generic emails.

Whilst we don't know what happened with all these organisations, we know that many of these contacts reached out wider to audiences they related to. Examples of the organisations can be seen on the next page, with a full list in Appendix 2.

Prior to launching the consultation, the engagement team identified and reached out to a range of stakeholders, including many groups and organisations, in an attempt to set-up a series of focus groups. We were particularly interested to hear from those from protected characteristic groups, who we had identified in the equality impact assessment as likely to be disproportionately impacted by a change in policy. We managed to arrange almost 30 sessions, but unfortunately not all ended up taking place due to some organisations struggling to bring group members, likely to be due to the sensitive nature of the discussions.

We reached out to some organisations who work with people with learning disabilities as we were aware that this group already experience some health inequalities. We wanted to obtain individuals views on IVF but were informed that this would prove difficult as many in this cohort do not have a basic level of sexual health knowledge, which may prevent participation. We therefore contacted parent and carer support organisation to involve family members in the discussions.

On these occasions, we offered to hold 1:1 telephone conversations or signposted members to the online survey so they could still share their views.

Throughout the consultation period, we also continued to identify and contact new groups and organisations who we believed would be interest in participating.

- Local Councils in all 10 localities
- Local infrastructure organisations
- Manchester Community Explorers
- Pennine Mencap
- Wigan Life Centre
- Local Participation and Equality Groups
- St Marys Reproductive Medicine
- SAWN Oldham
- Proud to be Parents
- Local NHS provider trusts
- GP practices across GM
- Endometriosis UK
- LGBT Foundation
- Breakthrough-UK Manchester
- Stockport Family Partnership Board
- GM Maternity and Neonatal Voices Partnerships
- Maggie's Manchester
- GM Indian Association
- Local Healthwatches
- GM VCFSE Leadership Group
- Gambian Women's Organisation
- Manchester People First
- Salford Disability Forum
- Greater Manchester Cancer Alliance
- Lived Experience Advisory Group Alliance
- Holy Trinity Church
- Salford Visionaries Group

Section 3: Writing the report

This report has been written by NHS GM's engagement team with the support of artificial intelligence (AI) analysis tools. This has included NHS GM's Go Vocal system which uses AI to support coding and theming of the thousands of responses and to identify trends. It is important to note that whilst AI has been helpful it has not been solely relied on but has been used to support the manual analysis.

Section 4: Political, clinical and organisational responses

We had several responses from MPs, councillors and clinicians involved in the delivery of the services as part of the formal consultation. In addition to The Fertility Alliance's continued involvement throughout the entirety of this change programme, we also received an organisational response from another charity that supports people with their fertility journey, who too campaign for improved access to care and equitable policies.

Summaries of these are included below, with the full submissions in Appendix 5.

Fertility Action

Fertility Action Charity strongly opposes the preferred option and sees it as an "unjustified levelling down". They advocate for maintaining a minimum of 2 cycles across Greater Manchester with a plan to expand to the NICE-recommended 3 cycles.

They believe the policy is harmful because:

- It undermines the principles behind the NHS of providing care on clinical need, not by postcode or personal wealth.
- It will worsen mental health outcomes with 1 cycle being clinically and psychologically out of step with those who need the service.
- It will deepen health inequalities and create a 2-tier system for those who can afford private treatment.
- It disregards NICE guidance and clinical evidence.
- It undermines trust in the NHS.

They also recommend further engagement with people who have lived experience of people who face infertility and ensuring that the policies enhance equality and support people from diverse communities.

Navendu Mishra, MP for Stockport

Navendu Mishra, MP, raised concerns about the proposed changes. They highlight that the current services do not meet NICE guidelines and suggests that the objective should be to level up, not down.

This concern was due to:

- The first cycle being a trial run due to success rates being low to start with.
- This perpetuating health inequalities and disproportionately affect those on a low income.

- It will intensify the mental health implications that can be associated with fertility related health problems, negatively impacting the wider family and support networks too.

They urge “decision makers to fully consider all responses to the consultation, thoroughly assess all available options, and thoughtfully evaluate impacts on patients’ physical and mental health.”

Rebecca Long-Bailey, MP for Salford

Rebecca Long-Bailey, MP, also expressed their concern at the proposal to reduce NHS funded IVF and asked NHS GM to reconsider the decision, instead exploring how the provision can be maintained or improved.

They highlight the *“profound and distressing impact on individuals and couples in Salford and across Greater Manchester who are already facing the emotional, physical, and financial strain of infertility*” and raise that *“The current proposal disregards both clinical guidance and human dignity.”*

Further concerns include:

- Failure to meet NICE guidelines.
- Undermining health equity, placing additional pressure on people who are experiencing emotional and physical hardship.
- Ethical concerns in limiting medical treatment for a recognised condition based on local finances, which would not happen for hip replacement or cancer care.
- The human right enshrined in article 16 of the Universal Declaration of Human Rights to start a family.

Councillor John Merry and Councillor Mishal Saeed, Salford City Council

Councillor Merry, Lead member for adult social care and health, and Councillor Saeed, Executive support member for social care and mental health, from Salford City Council expressed their strong opposition to the proposals to reduce the IVF cycles in Salford. They are concerned about the impact this would have on their residents and feel the decision would be unjust and harmful.

They ask that the following is considered:

- National guidance and best practice of 3 full IVF cycles for women under 40.
- The profound emotional and psychological impact of infertility, which is a recognised medical condition.
- The moral and economic imperative to support people to access fertility treatment when national birth rates are declining.

- The alignment with the Greater Manchester Integrated Care Partnership Strategy vision for improving access to care and tackling health inequalities.

They urge NHS GM to maintain the current offer, consider aligning it with the NICE guidelines by expanding the offer, and engage meaningfully with local communities, clinicians, residents and stakeholders before making a final decision.

Healthwatch Stockport

Healthwatch Stockport submitted their response to the consultation on behalf of the local members and community representatives who they engaged with on the topic of IVF.

They raise the following points:

1. They strongly support the proposal to standardise IVF provision across Greater Manchester as a consistent, GM-wide policy which would help reduce health inequalities and be fair and equitable.
2. They support a recommendation that 3 cycles should be offered in line with NICE guidelines as the fairest and most clinically appropriate approach.
3. A standard offer must also include *"transparent, inclusive and evidence-based eligibility criteria"* that does not discriminate against single individuals or single-sex couples, avoids additional financial or lifestyle-based criteria, and has clear and accessible information on eligibility, timelines and the referral process.
4. There is a need for emotional support alongside IVF treatment as part of the wider fertility pathway.

Manchester University NHS Foundation Trust

Ursula Martin, Chief Executive Officer Specialist Hospitals Clinical Group submitted a response on behalf of Mark Cubbon, Chief Executive Officer Manchester Foundation Trust, highlighting some key considerations regarding the proposed "1+" cycle model.

Whilst recognising the need to reducing the disparity in current access, if this proposed model is implemented then, understandably this will significantly impact patients who are currently eligible for two or three cycles and may lead to:

Access and Patient Equity

- Perceived inequity, particularly among those from lower socio-economic backgrounds who are unable to proceed for private/fee paying treatment if unsuccessful from their funded cycles.
- Potential impact on Mental health and relationship strains, as highlighted in ICB-led engagement, which may have an impact on wider services.

- A likelihood of increased patient dissatisfaction and complaints directly into the service, which would require additional resources to manage and address these concerns. The service already receives a high volume of complaints related to the funding cycles provided which would be likely to increase with greater restrictions.

Financial Impact and Service Sustainability

Proceeding with this option would have a direct impact on the number of cycles which are currently provided at MFT, with a projected reduction per annum. It is unknown what the conversion would be from funded cycles to a fee-paying model, noting that there are alternative providers for such a service.

Acknowledging the approach that is currently being undertaken, we respectfully request that the following is undertaken:

- To continue with the collaborative engagement with ourselves and other providers to co-design a model that balances equity, affordability, and service viability.
- Ensure that tariff arrangements are sustainable under a cost-and-volume model in order for any proposed model is viable for the future.

Section 5: Proposal of standardising to 1+ cycles

Summary

There was significant support from respondents for the number of NHS funded IVF cycles to be standardised across Greater Manchester.

Despite this, most respondents strongly oppose the change to a 1+ cycle offer citing clinical evidence, personal experiences, and concerns about “real equity” and the impact any change could have on individuals’ mental health.

Almost all supported maintaining the current higher offers in those localities which offer 2 or 3 cycles, with many also wanting to see an increase in the number of funded cycles, in line with NICE guidelines.

Many respondents expressed strong opposition to reducing to a single cycle, citing that one cycle was insufficient for most women to achieve a successful pregnancy. Many referenced anecdotal clinical data that success rates per cycle typically range between 20 - 35%, and shared personal experiences of initial IVF attempts being unsuccessful.

Respondents frequently described the first IVF cycle as a “trial run” or “exploratory,” with further cycles offering the opportunity for “bespoke treatment” and much improved outcomes.

Some individuals reported that success was only achieved on the second or third attempt, reinforcing the need for multiple cycles.

There was widespread frustration and concern about implementing a GM-wide offer of 1+ cycles, especially reducing the current offers in those localities which currently provide more (Tameside - 3, Salford - 2, Stockport - 2, and Wigan - 2).

There was a strong feeling that the offer should be “levelled up” to meet NICE guidelines and not “levelled down” to the number of cycles offered by the majority of other Integrated Care Boards, across the country.

While the majority supported funding three cycles, a significant number proposed at least two cycles as a fair compromise.

Many viewed the proposal as a cost-cutting measure disguised as fairness, which could widen existing health inequalities, particularly for those unable to afford privately funded IVF treatment. This approach was viewed to increase financial hardship and emotional strain for individuals unable to self-fund additional attempts.

Respondents highlighted the emotional distress and mental health challenges associated with limiting IVF to a single cycle, with pressure of having only one chance being viewed as potentially impacting positive treatment outcomes.

A small minority supported limiting or removing NHS-funded IVF altogether, citing financial constraints and reallocating this funding to other front line health services or being used to bring down waiting lists for treatment.

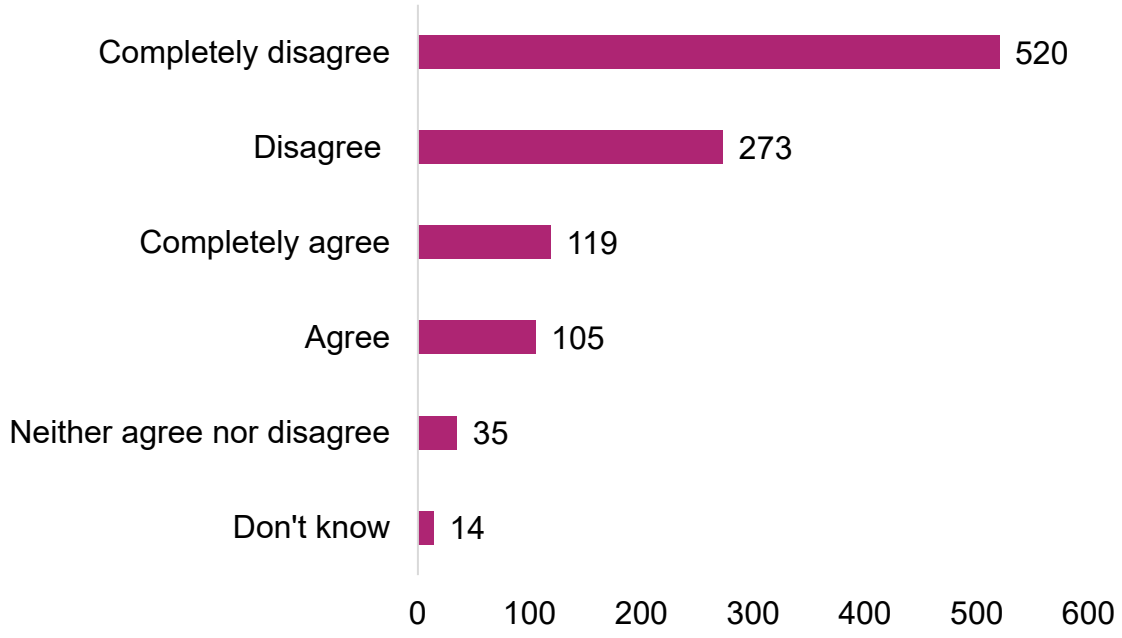
To conclude, respondents strongly opposed the implementation of a policy which reduces the number of NHS funded cycles offered to those eligible to receive IVF treatment across Greater Manchester.

Feedback

What people told us

Within the survey, we asked participants to say whether they agreed with the proposal to standardise the NHS funded number of cycles across all localities of Greater Manchester to 1+ cycles. Most either completely disagreed or disagreed with the proposal. Some agreed with setting the universal offer with only a very few not deciding either way. The chart below has more details.

Chart 2: To what extent do you agree or disagree with our preferred option of a 1+ cycle offer.



This section will highlight the reasons provided from both those who participated in the survey as well as those who attended focus groups.

It will demonstrate the strength of feeling, theming conversations as well as using direct quotes received during the consultation process.

There was a level of scepticism from some people, who believed that the decision had already been made prior to consultation and that this was merely a “tick box exercise”, which was challenged at face-to- face events.

Cycle offer variations

Many respondents who completed the survey and participated in focus groups criticised the current “different offer” based upon where someone was registered with a GP and strongly argued that standardisation was required and overdue.

Everyone should be treated the same regardless of where they live. Standardisation should be put in place to implement equal opportunities and diversity for all”.

“I strongly agree that no matter where you live, you should be entitled to the same amount of treatment cycles”.

“The NHS system is founded on the idea that care should be based on need, NOT location or ability to pay”.

Many respondents said that this offer was insufficient to ensure a reasonable chance of pregnancy, with many stating that the proposed reduction was a “backward step”.

There was also some significant frustration that reducing provision was a “race to the bottom” and that standardisation should represent a raising of access to the highest level, not cutting it to the lowest, therefore in reality for many this change did not truly represent equity and fairness.

“If inequality between boroughs is the reason for the change, then surely other boroughs should be brought in with the highest amount of care, rather than bringing all boroughs down to only 1 round”.

There were a few comments especially from Oldham residents who were surprised NHS GM were proceeding with such a low IVF cycle of, in the “birthplace of IVF”.

Alternative offer

As previous stated, the 1+ proposal was not widely supported by many, and a range of alternative options were suggested to be considered. There was most support for a universal two cycle offer, closely followed by three or more, with a minority of people suggested no NHS funded cycles should be offered at all. There were also a few wanting the offer to be increased to more than three cycles. The rationale provided by respondents can be found throughout this section.

“Funding two IVF cycles through the NHS provides a more equitable and clinically effective pathway for individuals facing infertility. Statistically, the success rate of IVF increases significantly across multiple attempts, offering a realistic chance of conception than a single cycle may not deliver”.

Equity & fairness

The word ‘equity’ was mentioned a significant number of times, but respondents’ interpretation of the meaning differed somewhat.
Whilst most acknowledged the importance of standardisation, some argued that implementing only one cycle wasn’t fair nor did it make things equitable for all.

“Creating equity by everywhere receiving worse access should not be an aim!”

Equity was raised as a major concern by many, with a significant number of respondents believeing that moving to a single cycle provision didn't actually represent this, as the true meaning should be interpreted as remedying existing inequalities, with this proposed shift actually making the offer worse for many.

"Restricting 1 cycle for all is likely to result in a discrepancy between different economic groups creating a divide between those who can afford private treatment and those and those who are denied a further chance because they cannot afford it".

Many viewed fairness as making a situation better or more beneficial, whereas this move would in fact do the opposite and detrimentally impact more people than the existing different locality offers currently do.

Therefore, many believed that equity and fairness could only be truly achieved by increasing the provision in areas with fewer cycles.

"This approach is not equitable, compassionate or clinically responsible. Infertility is a recognised medical condition, not a lifestyle choice".

NICE guidelines

There was some support from both respondents and participants for NHS GM to implement NICE guidelines, which would mean applying a universal offer of three cycles for all eligible women under 40 across Greater Manchester. This was mentioned by some as being the appropriate benchmark for care which would be a much fairer and more compassionate approach. There was also some anger, with many citing funding as the real reason why the GM proposal wasn't pitched higher.

"Your 'preferred option' does not reflect evidence-based healthcare. NICE guidance does not say that you should fund whatever number from 3 cycles that you feel you can afford".

"You quote NICE guidance when it suits you – but ignore it when it doesn't".

A small number of respondents voiced concerns about NHS GM ignoring clinical effectiveness and alignment with national guidelines.

There were also a couple of people who supported the implementation of a national IVF cycles offer, with NICE guidance being mentioned as the preferred offer, should this happen.

First time success rates

As previously stated, some participants from both groups highlighted that IVF rarely works the first time, with success rates commonly cited between 25–35%.

The view that the first round of IVF was more of "trial and error" procedure, "trial run" or "test" was a common one amongst some of the respondents.

"From personal experience, the first cycle is a complete gamble".

As many viewed the success rate of a single round of IVF being relatively low, it was also perceived that this was an opportunity for clinicians to assess how a patient

responds to medication and treatment. It was therefore the common belief by those who thought this that any subsequent cycles would significantly lead to better outcomes, as adjustments could be made based on the initial response.

"It is not unusual for a patient's first cycle to be a 'trial run'. Sometimes it takes the first cycle to understand what's going on".

Many respondents shared personal stories or accounts from friends and family who only achieved a successful pregnancy after two or more IVF cycles. Several highlighted that success on the first attempt is uncommon, reinforcing the argument for funding multiple cycles to improve overall effectiveness, with a few suggesting that there might be little point providing just one as it would not be "cost effective" and a waste of NHS resources.

"Doctors told us that the first round was a trial to understand how the body reacted to the drugs, this was followed with fine tuning in rounds 2 and 3 to be successful".

This raised the issue of the importance placed on individualised treatment as this process could also be successful in identifying any previously unknown underlying medical conditions. This issue was thought to be a more flexible and compassionate approach which recognises the clinical realities of fertility treatment and the emotional needs of patients.

"I think it should be tailored to each individual couple how many rounds are provided based on individual circumstances rather than one size fits for all. Base the number of rounds on the likelihood of success rate factoring in a couple's individual health problems and circumstances".

"Only one cycle available to women increases the pressure, stress and anxiety incredibly, in what is already an extremely stressful and worrying process".

There were many personal stories and experiences shared by respondents which reinforced the view that multiple attempts are typically required for many to achieve a successful pregnancy.

This did raise the issue by a few people who had used both NHS and private clinics believing there was a clear difference in the care received from different providers, with much better care and more empathy being displayed within an NHS setting. Private clinics were perceived to be more modern and technologically advanced in their approaches.

IVF funding

Many participants believed that a reduction in IVF funding reductions was being justified due to it being a divisive treatment and therefore not worthy of finding additional resources to increase the offer and "level up". It was believed by a few that this approach of "levelling down" across GM could create a regional variation and increase inequalities further.

"This feels like levelling down and making IVF an easy target for cuts".

Some acknowledged the pressure on local and national NHS finances, with some having little sympathy for funding infertility services, which a few viewed as being "a luxury the NHS could no longer afford". This group felt resources allocated to IVF could be used more effectively across the healthcare system, to reduce waiting lists or spent on lifesaving treatments.

"It is such an expense - and other treatment I think has to be prioritised - one session is at least an opportunity".

"I think 1 cycle is enough as we have to consider the cost and how the budget is affected for other serious conditions".

"The health service is under significant financial pressure and all services need to be reviewed in order to continue prioritise the most important work done".

Impact on mental health

For some, the stress and anxiety whilst having IVF was described as "immense" and should the chance of having a child be restricted to just one attempt, this could significantly increase the "psychological pressure" to potentially being "too much to bear", to the extent where this could have a detrimental impact on the IVF outcome.

"Knowing we could have had a second round really took the pressure and worry off going through the first for us, which meant we could focus on staying healthy and happy during such an emotive, uncertain time".

"The pressure that is put on us as couples by reducing the number of funded rounds is ridiculous, and pressure causes stress, stress reduces your chances".

"Reducing NHS-funded IVF to just one cycle per patient would be deeply damaging to women's mental and emotional wellbeing."

A few who took part in focus groups spoke of the stress leading to suicidal feelings.

Some clinical staff working in fertility clinics believed that consideration should be given to provide support to those couple impacted by any negative change to those expecting to receive more cycles, when starting their IVF journey.

It was also viewed by a few people that should the number of IVF cycles be standardised to the suggested 1+, the cost of providing mental health support to those individuals and couples could exceed the cost of an IVF cycle.

Affordability of privately funded cycles

Many respondents spoke about the high cost of privately funded IVF treatment available in the UK, as well as abroad, with figures ranging between £7-12k being stated as the cost per IVF cycle. This was identified as a barrier to having a family, as the price was unaffordable and out of reach for many couples.

Of those who spoke about the financial burden, for those who still proceeded with IVF in their desperation to have a child, this could result in getting into debt, either from borrowing money from parents or in the form of bank loans.

“The financial debt is overwhelming, and it's hard to see a way out”.

“The debt is crushing for many families”.

This step was said to have had long-term implications some including, living in inadequate housing without the finances to move and having to make “impossible financial choices” which added stress, impacted couples and wider family relationships and their health and wellbeing. Having to take these measures to have a family were viewed as being unfair and preventable if more NHS-funded cycles were available.

"It is heartbreaking not to be able to have my own child without support and do not have loads of money to be able to go private".

For many who couldn’t raise the funds to pay for private treatment or chose not to go into debt and proceed with privately funded IVF treatment, the decision was said to have left a devastating impact on their mental health.

“The psychological pressure of IVF is bad enough, but to think this is your one and only shot at having a baby, the stress is crippling not affording to go private”.

For a few who spoke at a focus group, this resulted in an “empty feeling” with some people describing later feelings of “remorse” and “regret” for not finding a way to proceed.

One suggested option was to ‘means test’ eligibility based upon family income, providing an extra cycle for those who fell below a pre-determined threshold.

Right to a family

For some, there was a strong feeling that everyone deserved the right to have the chance to start a family with the assistance of NHS-funded cycles and that for many a reduction in the current policy would negatively impact the possibility.

“Having a child should be treated as a right we should all be entitled to, not a luxury”.

"Anyone who wants it enough to put their body through the sacrifices of hormone treatments and IVF has the right to experience parenthood”.

“Having a family is important. NHS needs to give people best chance”.

Again, many of those who held this view stated that a denial could have a serious impact on their mental health and wellbeing. During one conversation, a couple from the South Asian community said that children were expected by their community, as a condition of marriage and that should this not happen then they would be “shunned” by family members, with one woman stating that regardless of circumstances she would be blamed. It was believed that if she could not have a child, it would be acceptable grounds for her husband to take another wife.

A few respondents didn't believe that the NHS should be funding IVF treatment at all and that this wasn't a commitment within the NHS constitution, as treatment and funding for procedures should be preserved for saving lives and improving health.

There were alternative suggestions for those who couldn't have children, which included fostering and adoption.

There were a couple of people feeling even more strongly, believing it was ethically the wrong thing to do, from a creationist standpoint.

"Nobody has a right to reproduce if their body just doesn't function in that way.

Impact on population decline

There were some participants who voiced their views on the potential impact of offering a universal cycle offer of 1+, citing that this could further compound the declining UK birthrate which was already being affected by people choosing to have children later in life. This was said by a few to have implications for some GM community populations and also could financially affect the wider UK economy, with less people making future tax contributions.

"This limitation would further reduce the population when it is already declining. It would put further strain on the NHS due to a loss of tax revenue from a lower birth rate and lacks sufficient big picture thinking".

"Fertility rate is decreasing in the UK, a rate now that cannot maintain a stable population. It is now more than ever to direct resources to prevention and proactive care".

There were some other issues raised by a small number of respondents including that:

- IVF should be means tested for those with greatest need and with the most complex health conditions.
- The assessment and treatment of those with infertility treatment was inconsistence, depending on who and where you received care.
- The use of Metformin medication, used in the control of diabetes was prescribed in other countries for the successful treatment of polycystic ovaries and that this should also be prescribed in the UK.
- By not providing a fair and "fit for purpose" NHS funded IVF service went against the NHS constitution, NHS principles and values, specifically relating to equality and an individual's ability to pay.
- Although one person also felt providing NHS principles were being contravened, but this was because they felt that IVF treatment didn't provide best value for the taxpayer.
- A reduction of NHS-funded treatment could increase the number of people seeking cheaper unregulated treatment abroad.

Health Inequalities

Some of the comments raised related to the existing health inequalities already faced by individuals from protected characteristic groups, including some people with long-term fertility conditions, such as endometriosis, polycystic ovaries and disabilities such as cystic fibrosis. For those who raised this point, they viewed that a "blanket offer" did nothing to reduce existing health inequities, and that decreasing the number of cycles would widen this issue even further.

"As someone with cystic fibrosis and a partner with a uterine abnormality we are unable to conceive naturally. NHS should be funded for us as we have no other option to have children... This is simply discrimination".

"Fertility treatment and women's healthcare should be improving not going backwards".

"The failure rate is too high for one cycle to be enough, particularly when people have underlying gynae issues".

It was felt by a few that women often get blamed for having fertility issues prematurely, with the common belief that the issue couldn't relate to a man. This was further reinforced during a conversation with a couple of women from the South Asian community who spoke of shame being cast of the female in a relationship, regardless of the medical history.

It was also widely felt by this cohort of people, that infertility should be treated in the exact same way as for those people with a medical condition and other treatments and should not solely come down to cost, just because it only impacts a small number of the GM population.

"Framing cost cutting as fairness is deeply dishonest and a betrayal of the women who live in the region".

This was the same view from those few people who highlighted that many same sex couples and single women too already experienced "discrimination" as it was often perceived that their journey to access IVF was much longer, due to having to firstly go through self-funded rounds of Intrauterine Insemination (IUI), commonly known as 'artificial insemination'. This form of fertility treatment is required prior to acceptance for IVF and the required number of treatments can be extremely costly and out of reach for many.

"Currently fertility treatment is not available to women in same-sex relationships. If you wish to address equity you need to first address this. Why should a heterosexual couple be offered this with no private treatment, but we had to spend thousands before being considered".

Those who voiced this opinion strongly felt that two cycles was a much fairer offer, to not only increase the chance of pregnancy but also to mitigate the previous financial outlay and subsequent cost of privately funding additional IVF cycles.

There were a couple of comments which viewed the proposed policy change as targeting women and “sexist” with one describing it as being “medical misogyny” designed to discriminate against women.

“I think it's a sexist policy only adding to women's rights being restricted”.

“This is a misogynistic and completely unfair policy”.

There were strong views and much empathy from many respondents for those couples from low-income families would be specifically discriminated against, especially from those localities where the current offer is higher than the proposal.

“Tameside has a lower average income than other areas, therefore prospective parents are less likely to be able to afford further rounds of IVF themselves”.

This cohort of respondents felt that a negative cycles policy change could effectively end some people’s chances of having a family or further push them into poverty, should they make the decision to go into debt, in an attempt to have a child. This could mean that those with the financial means to pay for additional IVF cycles had a much-increased chance of having children meaning that the working classes were disadvantaged and a “two tier system”.

“Restricting to 1 cycle for all is likely to result in a disparity between different economic groups creating a divide between those who can afford private treatment and those who are denied a further chance because they cannot afford it”.

More information relating to health inequalities can be found in Section 7.

Section 6: Applying the policy

Summary

People felt that the policy should be applied fairly and consistently, however there were different reasons for what people thought was a fair application.

The majority of people felt that any negative change should only apply to people who had not yet been approved for IVF and that applying it to people mid-journey would be emotionally and financially damaging and break a “promise”.

If the change was positive, people were more likely to think that the policy should be implemented at the same time for everyone so that more people got the opportunity to have more chance for success.

Feedback

The majority of people felt that any reduction to the number of cycles offered under the policy should not be applied to people or couples who had already started their IVF in any way.

“People who are already in the process should be allowed to finish what they started”.

“You cannot in good conscience take away from someone who is already on their journey”.

“It’s quite cruel to apply it to people when they are already on the IVF journey. It’s like pulling the rug from under people”.

In contrast, a significant minority of people felt that the policy should apply to everybody at the same time regardless of where they were in the journey.

“More important things to spend NHS money on”.

“Rules are rules. It should apply to everyone”.

“The waiting list and current backlog across the NHS has not helped some patients who require further investigations prior to IVF…hence the policy should apply to all irrespective of stage in referral, diagnosis or treatment”.

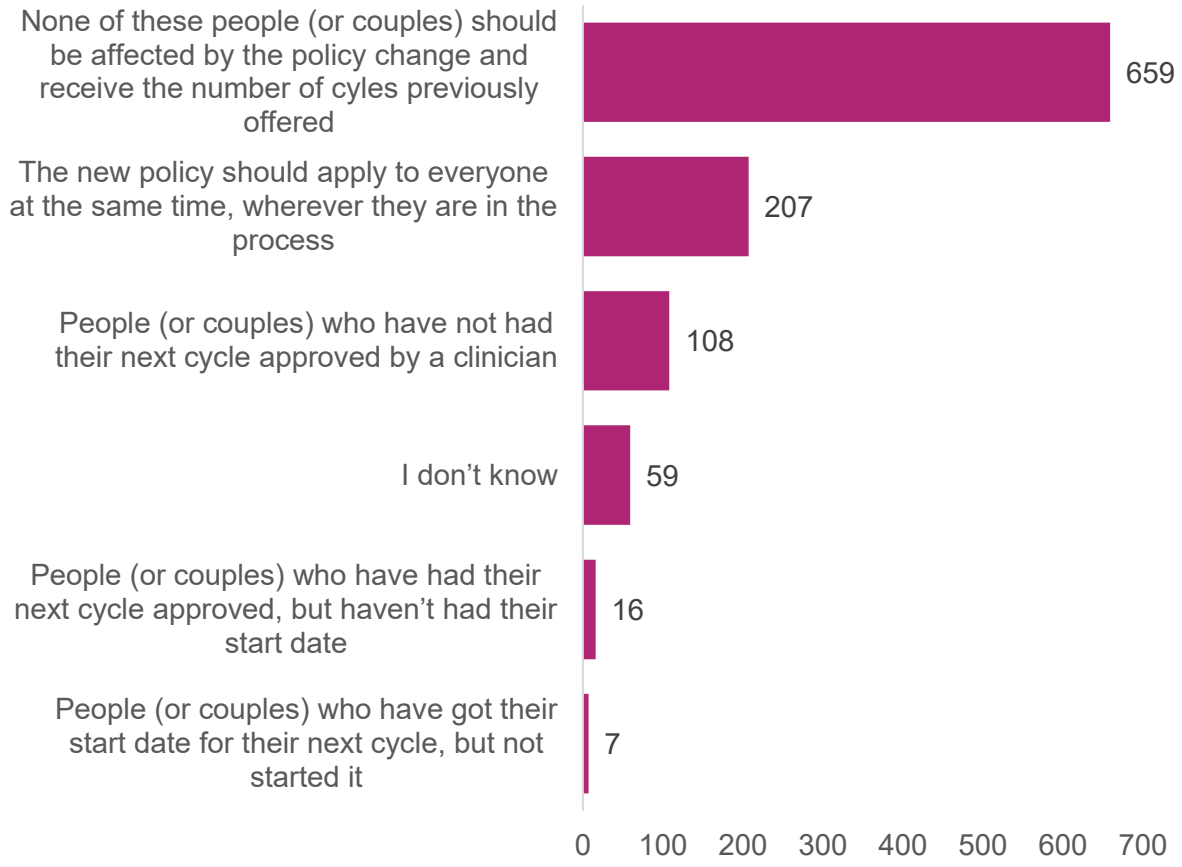
A few people felt that the policy should apply to people at a particular part of their journey.

This was consistent across both the survey and face-to-face engagement activities.

There were wider suggestions made that any change should only be implemented a few years after the policy change was approved to allow people time to come to terms with it.

Most of the feedback was about fairness and equity and not changing goalposts which would create emotional distress.

Chart 3: Who the policy should be applied to



Reasons for the choices

The reasons people gave for feeling the policy should be applied at a certain point in the process, centred around fairness and the impact on people of changing how many cycles they could have once they were in the process. There were differing and sometimes contradictory reasons for why one application of the policy would be fairer than others.

There were also some nuances depending on if policy change means more or less cycles. If the cycles are going up, people think that the policy change should apply to everybody wherever they are in the process, but if the cycles are going down, it should only apply to people who haven't yet begun the IVF process and been approved for funding.

"Just because a person started treatment earlier should not mean they benefit from more cycles".

"It would be soul destroying for people already in the process to get more attempts. Everyone should be given the chance".

"I've been through months and months of waiting on the NHS waiting list, seen counsellors, seen numerous doctors, nurses, injected myself with hormones, had an invasive procedure, had 2 weeks off work on sick. Would you not include me in this new policy? Just because I'm a few months late from the change happening."

More details on the reasons people gave for their choice of when the policy should be applied are set out below under each choice.

None of these people should be affected

- This is the only fair and ethical way to implement any change.
- People already in the system should be protected.

Most of the comments were about the impact of not applying changes in this way.

- It would be unfair and unethical to "move the goalposts" after people have been approved as eligible for IVF and would create emotional distress and potential long-term psychological harm.
- Approval for IVF under a particular policy was considered a promise that changing the offer would break and undermine trust in the NHS.
- All other options are "cruel" or "insensitive".
- Not applying the policy in this way could disproportionately impact low-income households most.

Policy should apply to everyone

- A uniform approach was considered the most fair and equitable approach.
- If the number of cycles goes up for some areas, then this would mean everyone would get access to the increase.
- Concerns that any approach that staggers the policy implementation could lead to resentment among different groups of people, particularly if there were delays due to service challenges and waiting times.

Next cycle not yet approved

- People who have not had their cycle approved are not as far along in the process and so may have to accept any changes.

Cycle approved, but no start date

- It is fair to prioritise those who have already been approved as they are further down the process.
- This provides a clear and transparent cut-off.
- Delay to approval may have been outside their control and so they could be penalised by having a

cycle removed for reasons outside of their control.

Not started the next cycle but have a date

- Most people who chose this were concerned about the prioritisation of NHS resources and felt that whilst emotive, it was not life-saving treatment and that this was the quickest way to make financial savings.

Don’t know

- There are individual circumstances that need considering and a nuanced approach is required.
- Don’t have enough information or knowledge to give an informed answer.

Overall, the key themes from the feedback are that the change needs to be applied fairly and negatively impact as few people as possible. There will be an emotional, mental health and financial impact on changing the policy part way through the journey that needs to be considered.

If the number of cycles is decreased, delays due to waiting times, services, and factors outside the control of the couple may mean that they are unfairly disadvantaged. This and other individual circumstances should be taken into account.

This needs to be weighed against the small number of comments that IVF is not a life-saving service and in the current financial climate is not essential.

Section 7: Health inequalities

Summary

Throughout the consultation, concerns were raised about a particular impact on some communities that were expected to be more affected by the proposals.

The most commonly reflected challenge was the cost of additional cycles for people on a low income. This was seen to be heightened by the added impact on single-sex couples and single women who already have to pay for some parts of the pathway.

Further and significant concerns were raised about the impact on people with long term health conditions or disabilities that may either reduce fertility or make it harder to get pregnant and reach full term. It was regularly raised that infertility is a medical condition.

Many people highlighted the potential impact of the policy and infertility on long term mental and emotional health.

Finally, infertility and IVF is already a sensitive issue in some faiths and cultures and there were concerns that this could exacerbate these.

Feedback

It was commonly raised throughout the engagement that implementation of these proposals could widen health inequalities for a number of reasons. These are set out below.

Financial impact on low-income households

It was considered by many that this policy could cause considerable financial hardship on deprived communities and low-income households. If the first cycle was unsuccessful, they would either have to take on the financial burden of funding their own next cycles or give up on their IVF journey.

People with more financial stability or on higher incomes are more likely to be able to afford to privately fund additional cycles, creating a two-tier system based on income and wealth, with those families who can afford it more likely to be able to have a baby.

"Many people can't afford the costs to go private. It's totally unachievable amount of money".

"Only the select few can afford privately funded IVF treatment".

"The IVF process is heartbreaking and devastating without having to consider the financial burden as well, and why is the choice of if I can have a child down to Greater Manchester council?"

"We're just a working-class couple and this would place us in loads of debt".

Same-sex couples

This is a particular concern to single women and same-sex couples with people saying that the proposals is discriminatory to them as they already have to pay and go through a longer process to prove that they are infertile.

"I'm in a same sex relationship and may need to use IVF. I'm in my 30s and my fertility may already reducing. I have no other option if I have difficulties but need to pay for God knows how many rounds of IUI first. This means it already costs same sex couples much more even before they start IVF. This is discriminatory."

"I think there would be a greater impact on LGBTQ communities because straight couples have more chance to conceive naturally."

Long term conditions

Women in particular were likely to share their concerns that infertility and long-term conditions that make it harder for women to get pregnant or carry a baby to term are likely to be more impacted by these proposals.

This is because they are more likely to need additional cycles in order to have a successful outcome.

"I've got endometriosis and even though my AMH levels seemed to be okay for a 35 year old woman, I know that statistics and from the information doctors have shared with me that the process of getting pregnant can take more than 2 cycles. Without the support from the NHS, many women won´t be able to pay for their IVF."

"I have stage 4 endometriosis, PCOS (Polycystic Ovaries Syndrome) and I am 30 years old. All of which make it desperately harder to conceive. One cycle of IVF may not work, and I do not have thousands of pounds lying around to go private."

"My husband has cystic fibrosis and it's therefore impossible for us to conceive naturally".

Some women express that they feel the proposals treat infertility as a "women's issue" and ignore the fact that infertility is a medical condition and should be treated like other medical conditions, with IVF seen as a "luxury".

"What next - you can only have one cycle of cancer treatment? One round of immunosuppression if you have rheumatoid arthritis? Infertility doesn't go away for people, just like these diseases don't go away."

"I have PCOS and one fallopian tube. Which is not my fault".

Gender

Some women express that they feel the proposals treat infertility as a "women's issue" and that this adds to a broader inequality in health care for women.

"As a woman I have spent my life facing medical gaslighting and having my health needs neglected because of my gender."

"Women are constantly unfairly impacted by medication they take on a daily basis because said medication is not tested enough on women to observe the consequences it has on us. Therefore, I believe taking away IVF rounds would negatively impact many women in Greater Manchester who struggle with the unfairness of the medical and pharmaceutical systems."

"[I have] infertility due to Endometriosis, Adenomyosis and PCOS (which are already under researched and underfunded leading me and other people in my position being at an already higher disadvantaged and suffering from health inequity)"

There is concern from a couple of people that the proposals undermine the biological role of women and their identity.

"If my body can't do what its biologically built for then what's the point?"

"If I can't be a mother what's the point of life? That's literally what women are biologically built to do".

In contrast, there were also concerns raised that infertility is seen as too much of a women's issue, even when there is male infertility present which was described as "de-masculating".

"Men are as vulnerable as women regarding IVF as infertility is such a stigma with men and may be ridiculed. I supported someone who was called a "[anonymised]". He laughed along with the toxic masculinity, but it affected him emotionally so much".

Religious and cultural sensitivities

For some communities, there are additional barriers to access for IVF that may be made worse by the proposals.

One couple shared that they have been trying for a baby for 15 years with no success, they had no family or friends support and due to cultural issues, the male could not talk to anyone within his community due to shame and embarrassment. They felt lost and abandoned and that the system and services are too rigid and not designed for them due to cultural, religious and language barriers.

Mental health

Many respondents highlighted the significant impact of infertility on the mental health of the couple, particularly the woman. The emotional burden of being unable to start a family can lead to depression, anxiety and in some cases, suicidal thoughts and self-harm. This can be heightened by a reduction in cycles.

"I was aware that I only had 1 cycle so there was more pressure. Thankfully I didn't need more than 1 but it does already start your journey off with pressure before you even start taking medication."

"I am currently undergoing my first cycle of IVF. My clinic has informed me that I am eligible for 2 cycles, and this is in my written plan. If the 2nd cycle is taken away from me, I will not be able to afford privately funded IVF. This will significantly impact my mental wellbeing."

"Having fertility issues is already a very tough mental and physical draining issue to go through, IVF gives hope and a chance. To take funding away when your already in a process is going to have a massive emotional and detrimental affect on a lot of people's mental health."

"I am a GP and it impacts on a lot of my patients…I see the impact it has mentally on couples."

"Had I not been successful eventually I truly do not know if I could have carried on living."

Section 8: Alternative proposals

A number of alternative proposals were submitted through the consultation for consideration. Some of these were detailed and specific, while others were more general in nature.

Almost all of those who responded emphasised that if the aim is to achieve standardisation, the offer of cycles should be levelled up rather than reduced.

These proposals will all need to be considered and assessed by decision makers.

Alternative proposal: 2/2+ Cycles

Almost all respondents felt that offering only 1 IVF cycle would not be enough and would also not be fair. The majority strongly advocated for a minimum of 2 cycles to be available to those eligible, with many emphasising that 2 cycles should be standardised across all regions to ensure equity.

There was also support for the 2+ model, where a third cycle is offered if 1 of the first 2 is cancelled or abandoned.

In summary, the most widely supported alternative proposal is that at least 2 IVF cycles should be offered as standard to those eligible.

"All couples should be entitled to 2 cycles at least"

"2 cycles, as during the first cycle, timings etc are not always right so with a second cycle there is more chance of a positive outcome if changes are made learning from mistakes from the first cycle.''

"Instead of lowering our commitment to the bare minimum, we should be striving to provide the level of care that the community they serve both need and deserve. Anything less is a step and undermines the progress GM has made as a lead in the IVF sphere."

Alternative proposal 2: 3 Cycles and NICE Guidance

Some respondents suggest that 3 IVF cycles should be offered as standard to anyone eligible, with many comments just stating, "3 cycles".

Several respondents highlighted that 3 cycles would provide a fairer chance of overall success and would reduce stress related to only one chance, especially given the emotional and financial toll of infertility and IVF.

Some respondents noted that offering less than 3 cycles could lead to increased mental health issues and greater long-term costs for the NHS and reduce people seeking unregulated treatment abroad.

Many referenced NICE guidance directly and called for local policy to match national recommendations. Some highlighted the importance of equity and consistency

across regions, mentioning that financial considerations should not override evidence-based recommendations.

"NHS greater Manchester should follow the NICE guideline and offer all eligible couples the recommended 3 cycles''.

"3 full IVF cycles should be standard for all eligible patients".

"You should reconsider 3 cycles in line with NICE guidance''.

"Healthwatch Stockport supports the recommendation that up to three full IVF cycles should be funded for eligible individuals and couples, in line with NICE clinical guidelines (CG156). NICE recommends three cycles because evidence shows that cumulative success rates significantly improve with multiple cycles, especially for younger women or those with unexplained infertility'.'

Alternative proposal 3: Unlimited cycles

Many respondents stated that IVF is rarely successful on the first attempt and that offering only one cycle significantly reduces the chances of having a family.

A notable number of responses called for unlimited or as many cycles as medically feasible, especially where there is a clear cause of infertility or where additional cycles could statistically increase the chance of success.

A few respondents suggested a cap based on embryos rather than cycles or continuing until a live birth is achieved.

"A minimum of 3 cycles on the NHS should be offered and if achieve a pregnancy to birth no further cycles available, some people will achieve a pregnancy/birth on 1st attempt, others 2nd or 3rd…. Others maybe on 4th/5th or more".

"I am an IVF baby and would not be here if it wasn't for this process and more than one go this makes me so grateful".

"IVF isn't simple or straightforward. Multiple rounds are needed".

Alternative Proposal 4: Individual circumstances

A few people support tailoring the number of cycles to individual circumstances, such as offering more cycles to those with medical conditions affecting fertility (e.g. PCOS, endometriosis) younger women same-sex couples or those affected by cancer treatments.

Respondents most frequently emphasised the need for a personalised, case-by-case approach to IVF provision, rather than a "one size fits all" model.

As mentioned, many respondents felt strongly for the offer to be more than 1 cycle, some suggesting a nuanced approach where eligibility for further cycles depends on individual factors and outcomes.

Some suggested cycles should be increased for those with no chance of natural conception or who received only one egg in a round.

There was repeated mention of the importance of thorough diagnostic testing and health checks before starting IVF, to identify treatable conditions and improve chances of success, by following the clinical evidence. Some respondents highlighted gaps in current testing protocols and the need for tailored treatment protocols from the start.

"It depends on the age and health issue of the people involved. A cancer survivor [that affected fertility] is more a case for 2 cycles than unexplained fertility."

"Consider the people receiving the treatment and treat people as human's not numbers. Have some compassion. You are not trying to get a robot pregnant."

"We urge the Board to reconsider this proposal and uphold the NHS's duty to provide evidence-based, compassionate, and equitable care to all who need it."

Alternative Proposal 5: Means tested/part-funded

Another suggestion made by a few respondents is to introduce means testing or partial funding for IVF cycles. This was proposing that those on higher incomes could contribute towards the cost of additional cycles, while those on lower incomes would continue to receive full funding.

A few other respondents suggested a sliding scale where the first cycle is fully funded, and subsequent cycles are partially funded or discounted.

Another option by a respondent is to target funding to areas with greater deprivation or health inequalities.

Other ideas around this area made by individual respondents were:

- offering a set funding window rather than a fixed number of cycles
- subsidising private treatment or providing discounts for further cycles
- funding a certain number of embryo transfers rather than cycles and allowing patients to pay for supplementary treatments or additional testing to improve outcomes.

"Subsidise private treatment to help those with low incomes. Means test people as part of consideration to give more cycles".

"The first cycle should be free, the second charged at 25% of cost the third at 50% of cost then full cost for any further attempts".

Alternative Proposal 6: Stay the same

A few respondents expressed a preference for keeping things as they are to ensure that existing offers or provisions in certain areas are protected and not reduced.

"Whatever the offer was in areas should be protected".

Alternative Proposal 7: 0 cycles/do not fund via NHS

A few respondents strongly oppose NHS funding for IVF, with comments explicitly recommending zero cycles or no IVF provision at all.

Several suggest IVF should be privately funded or only available in very limited circumstances, such as clear medical indications or genetic diagnosis.

A few respondents expressed concern about NHS resources and prioritisation, with respondents arguing that IVF is not an essential procedure, and that funding should be directed towards more urgent health needs.

There are also comments about personal responsibility, with some feeling that individuals should pay for their own fertility treatments and that NHS support encourages dependency.

Within the few people who felt this way it was questioned whether fertility should be considered a health issue at all.

"I think 0 cycles is correct. If we cannot afford new medication for existing people, we can't afford to bring new people into the world. I don't object to privately funded IVF".

"I don't think IVF treatment should be offered on the NHS".

A few other suggestions in relation to other alternatives were as follows:

- Phased implementation or pilot in one locality first. One respondent suggested phasing in the change in one area before rolling out across GM.
- Applying policy by age group. One idea which was raised in a group discussion was to apply the policy only to patients under 35, as older patients may need more cycles.
- Use of grants for disabled people. A suggestion was made to provide grants to support disabled people with infertility.
- As an alternative to IVF, use new and existing fertility drugs.

Section 9: Wider feedback

In the process of engaging and getting feedback on the service and the proposals, we have heard lots of wider comments of importance or for consideration, but that don't naturally have a home within this report as they are out of scope of the consultation. However, it is important that they are acknowledged.

The feedback will be forward to the relevant team within the organisation for review and held on file should it be relevant to future reviews.

Eligibility criteria and support for access

- The eligibility criteria for same sex couples and single women needs to be reviewed as it is currently discriminatory, due to the extended timeframe proving attempts to conceive and additional costly steps prior to IVF treatment.
- Genetic testing should be part of the eligibility criteria, as standard.
- GPs need to be better informed about the eligibility policy as there are inconsistencies in the messages being shared with patients, e.g. length of wait, providers.
- Health advice messages for couples who are trying to conceive.
- Support for those after miscarriage, to then access IVF treatment.

Frozen embryos

- Frozen embryo storage time – review policy to extend storage or allow a financial contribution to do this and also the option to transfer embryos to other providers.

Fertility testing

- Change the process of an hour slots for men to provide a sperm sample, as this adds undue pressure.
- Provide more rigorous and earlier fertility testing and diagnostics before IVF takes place, to reduce delays and improve outcomes.

Support before and during treatment

- Additional weight loss support, to achieve BMI for IVF.
- Ongoing mental health and wellbeing support offered as standard throughout IVF, due to the difficult emotional journey.

- Additional information and advice from private IVF providers on how to maximise positive results. This was viewed as already being provided by the NHS.

Fertility advice and information

- Additional information and education to be provided to people, on how to increase their fertility.

Feedback on existing services

- A small number of people shared their experiences of using IVF both NHS and private services. Comments ranged from helpful, kind and positive staff to state of the art to poor and crumbling building. This feedback will be shared directly with the providers.

Employment

- Some people don't tell their employers about IVF as they believe some don't have IVF friendly policies and may discriminate against people who are receiving or exploring IVF. Employment law protection as part of information should be available for employers.

National policy

- A regional or national policy, so there's a fair and equitable offer across the whole of England and Wales.

Process and consultation

- It was believed that the numbers of people reportedly receiving IVF treatment during the consultation in GM is inaccurate as it doesn't include people having private treatment and at home and overseas. This information should be made clearer.
- For a few they believed that the process was a tick box exercise and that consulting on one option meant that NHS GM's mind had already been made up. Therefore, it was asked not to proceed with a one option consultation in the future.
- A few believed there was not enough data to enable them to make an informed decision during the consultation.
- There was not enough information relating to the number of cycles and a breakdown of their success rates.

Section 10: Key points to consider and next steps

Key points for decision makers to consider

Some of the key points which have been raised which decision makers need to consider, include:

- Carefully consider the strength of opinion of respondents agreeing that there was a need to standardise the number of IVF cycles, to make the offer fair.
- Consider that there are many different views relating to what actually makes an offer ‘equitable’.
- Carefully consider all the feedback on the current proposal to standardise to 1+ cycles, particularly the concerns raised and the potential impact on health inequalities.
- Consideration needs to be given to those people already on their IVF journey and the impact on their mental health and wellbeing, when implementing any policy change to the number of cycles available.
- When reviewing the proposals, consider relating to any potential knock-on effect with demand for other health services increasing, which may have future cost implications e.g. GP and mental health service appointments.
- When reviewing the policy, ensure that infertility is a medical condition and the impact of infertility as a life-changing issue is recognised.
- Recognise and be aware of the value of IVF to those people who need it.
- Carefully review all the alternative proposals put forward against the evidence to see whether they would be appropriate for implementation and preferred against the option consulted on.
- Consider how to incorporate the feedback into the Equality Impact Assessment and include any mitigations that need to be implemented.
- Consider the feedback from the consultation and any other engagement in any future review of the eligibility criteria.

Next steps

This report will be shared with those people responsible for commissioning IVF services. We will also update the equality impact assessment (EIA) using the feedback and the things we have learnt.

Commissioners will give the feedback and updated EIA careful consideration. They will use the feedback along with wider evidence to consider the number of cycles

that should be offered across Greater Manchester and how to implement it any change.

The recommendation will go through our governance process with this report and the equality impact assessment, along with any other relevant evidence. The NHS Greater Manchester Board will make a final decision.

The report will be published on our website and shared with those directly involved through focus groups etc, along with regular updates on what has changed as a result of the engagement.

If you would like to be kept up-to-date, or get involved in the next steps, please contact us:

Email: gmhscp.engagement@nhs.net

Ring, text or WhatsApp: 07786 673762

Section 11: Glossary and Accessibility

Glossary

Assisted conception

Treatments which help people conceive by controlling the way that the sperm and the egg are brought together.

Body mass index

The ratio of your weight in kilograms to the square of your height in metres. Your BMI is an indicator of whether your weight is healthy. A healthy weight increases the chance of successful IVF treatment.

Cervix

The cervix is the lower portion or 'neck' of the womb which opens into the vagina.

Clinical pregnancy

A confirmed pregnancy, shown by both high levels of hCG (hormone) in the blood and ultrasound confirmation of a fetal heartbeat.

Crystorage

The preservation of blastocysts, unfertilised eggs, or sperm, at very low temperatures for use in future treatment cycles.

Cycle

The IVF treatment cycle describes the complete round of treatment, incorporating all stages of IVF.

Egg collection

The process of collecting eggs from the follicles in your ovaries during IVF treatment.

Embryo

A fertilised egg where the cells have begun to divide. After five or six days, the embryo becomes a blastocyst.

Embryo transfer

The process of transferring embryos from the culture in which they have been developing in the lab, into the womb.

Embryologist

Clinical scientist working in the field of fertility. The embryologist is responsible for checking fertility levels, collecting eggs and sperm and processes of bringing them together during fertility treatment. Embryologists are also involved in research, supporting IVF and other fertility treatments.

Endometriosis

Condition in which tissue similar to the lining of the womb (endometrium) grows in other parts of the body, most commonly on the ovaries. It can contribute to infertility.

Frozen embryo transfer

The process of transferring embryos into your womb, using embryos which have been frozen after previous IVF treatments. The embryos will have been carefully thawed for use in the current treatment.

IVF

IVF is often used as the shortened clinical name for ‘in vitro fertilisation’. A fertility treatment used to help individuals with infertility issues conceive a baby.

IUI

IUI is the shortened name for Intrauterine insemination. This is a procedure to help you get pregnant. Sperm are put directly into your womb (uterus) when you're ovulating. It's also called artificial insemination.

Miscarriage

Loss of a pregnancy in the first 23 weeks.

Multiple birth

The birth of more than one baby from a single pregnancy, usually twins or triplets.

NHS GM

The shortened name of NHS Greater Manchester, otherwise referred to as Greater Manchester Integrated Care Board.

Ovaries

Part of the female reproductive system, the two ovaries are attached to the womb by the fallopian tubes. When functioning normally, they produce and release eggs as part of the menstrual cycle. They also produce hormones which are essential for reproduction. Problems with the ovaries may be a cause of fertility problems in women.

Ovary stimulation

The use of drugs to stimulate the ovaries to develop follicles and thus produce more eggs.

Polyscystic ovaries

Polycystic ovary syndrome is a condition in which small cysts develop around the ovaries. This can affect hormone production and hence fertility, as it can result in no ovulation taking place.

Uterus

Part of the female reproductive system and another name for a woman’s womb.

Accessibility and translation

If you would like this information in another format, or translated into a different language, please email gmhscp.engagement@nhs.net

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Section 12: Appendices

Appendix 1: Survey Equality Monitoring Data

Chart 1: Age

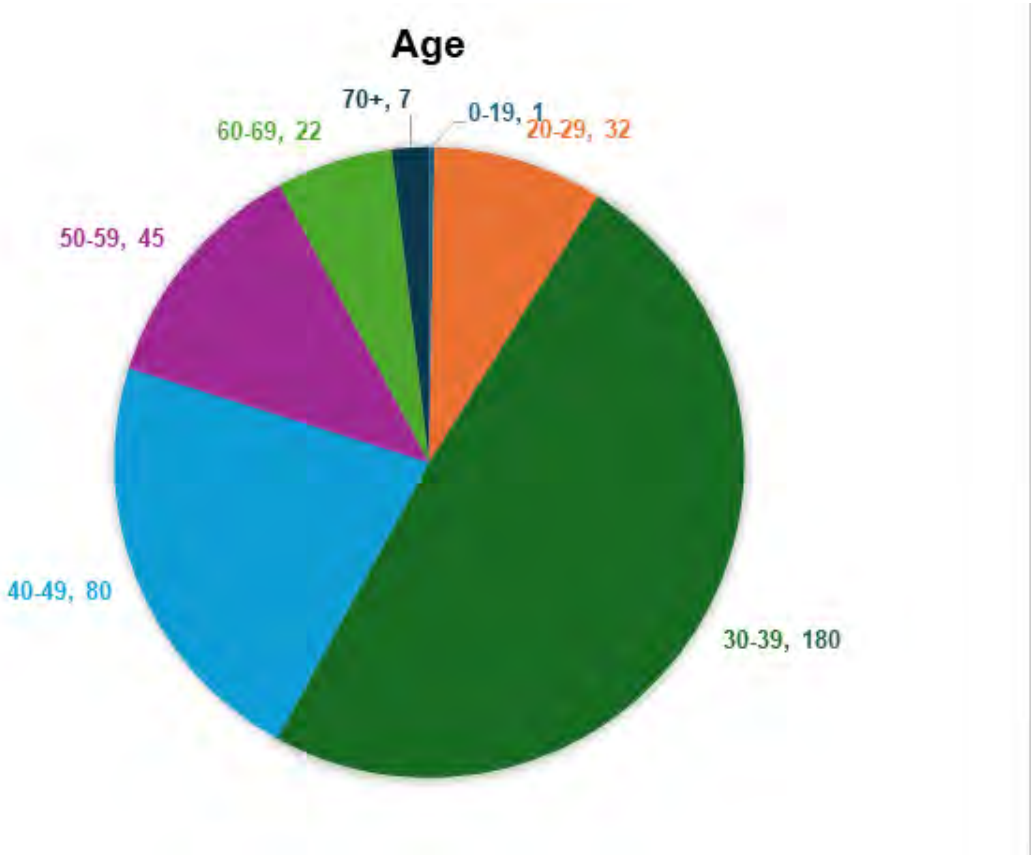


Chart 2: Ethnicity

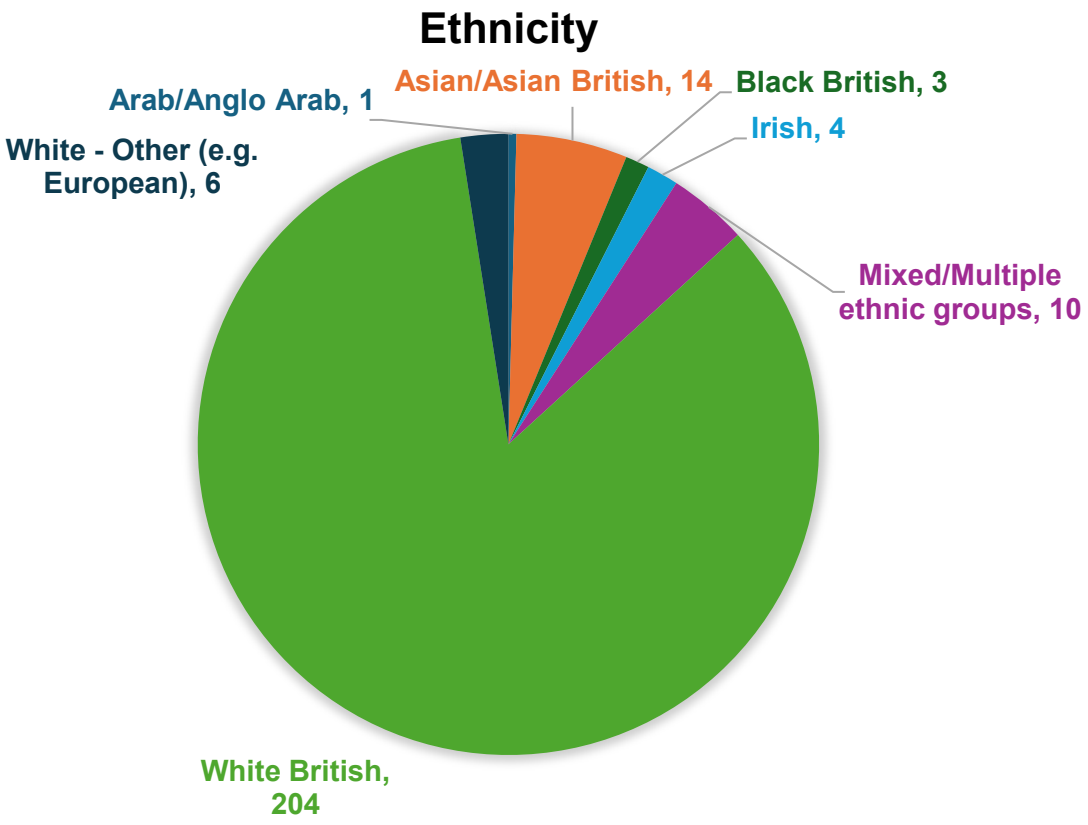


Chart 3: Gender

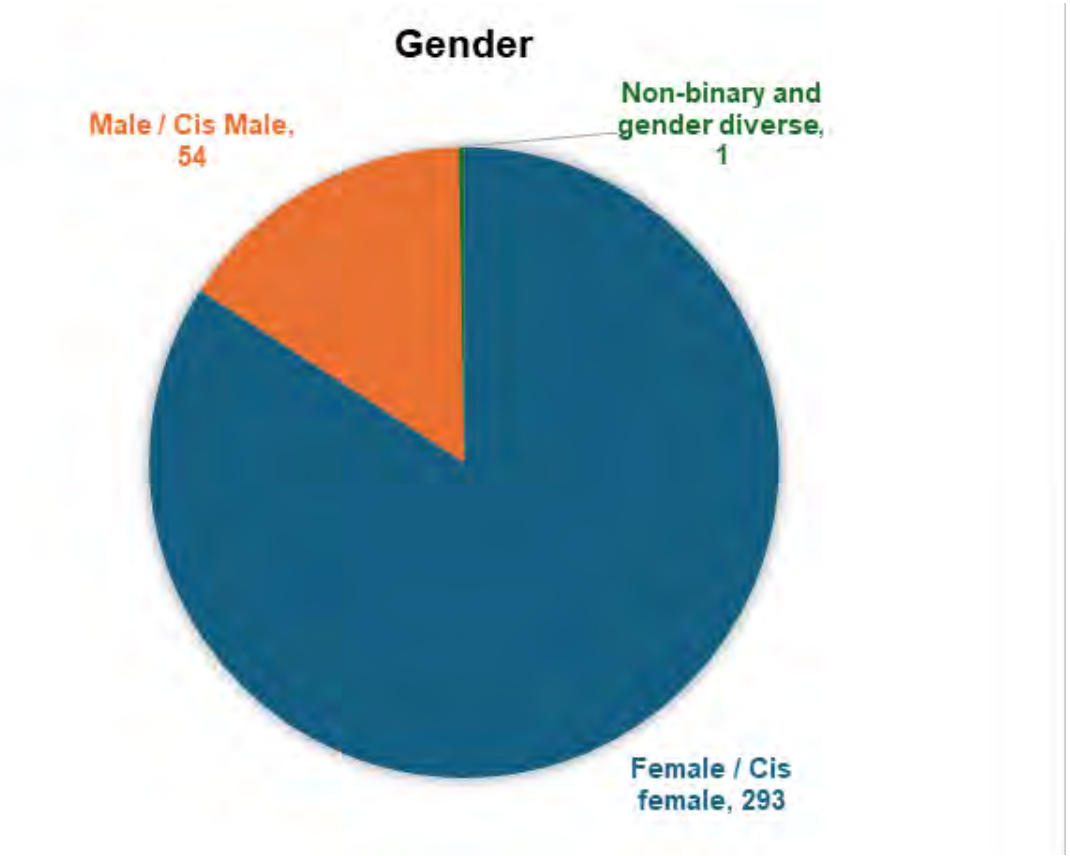


Chart 4: Transgender

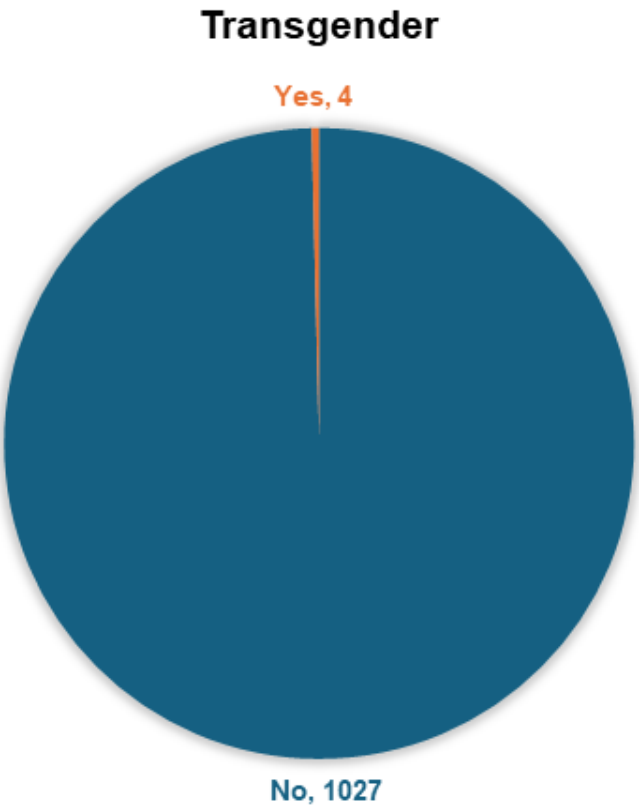


Chart 5: Relationship status

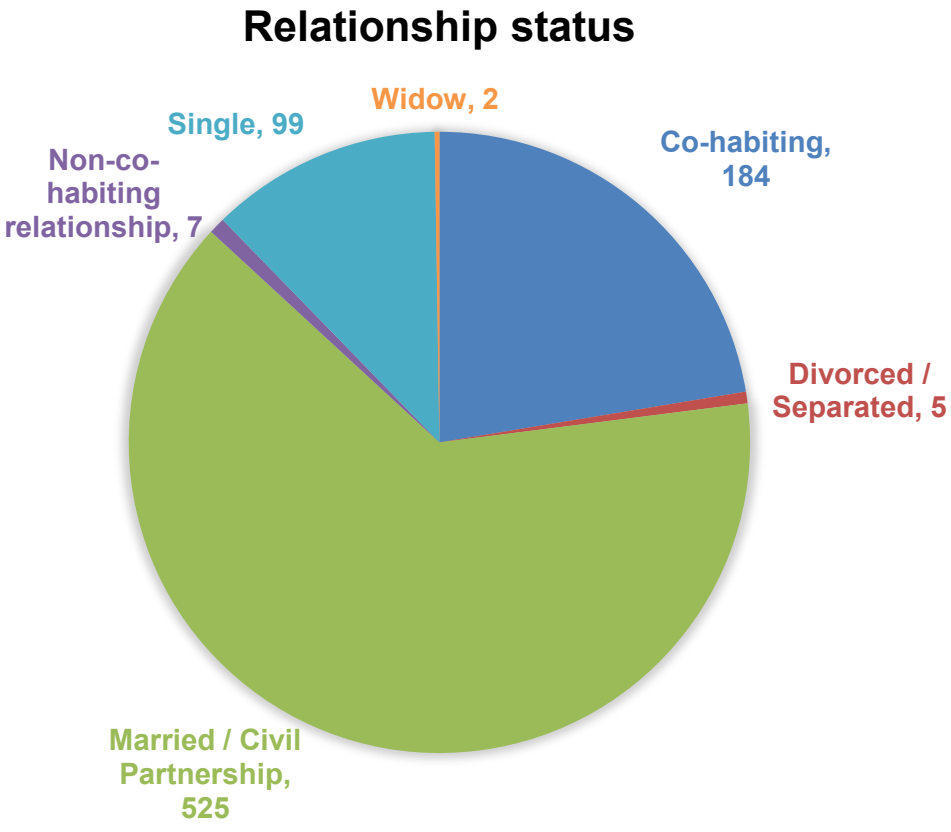


Chart 6: Faith

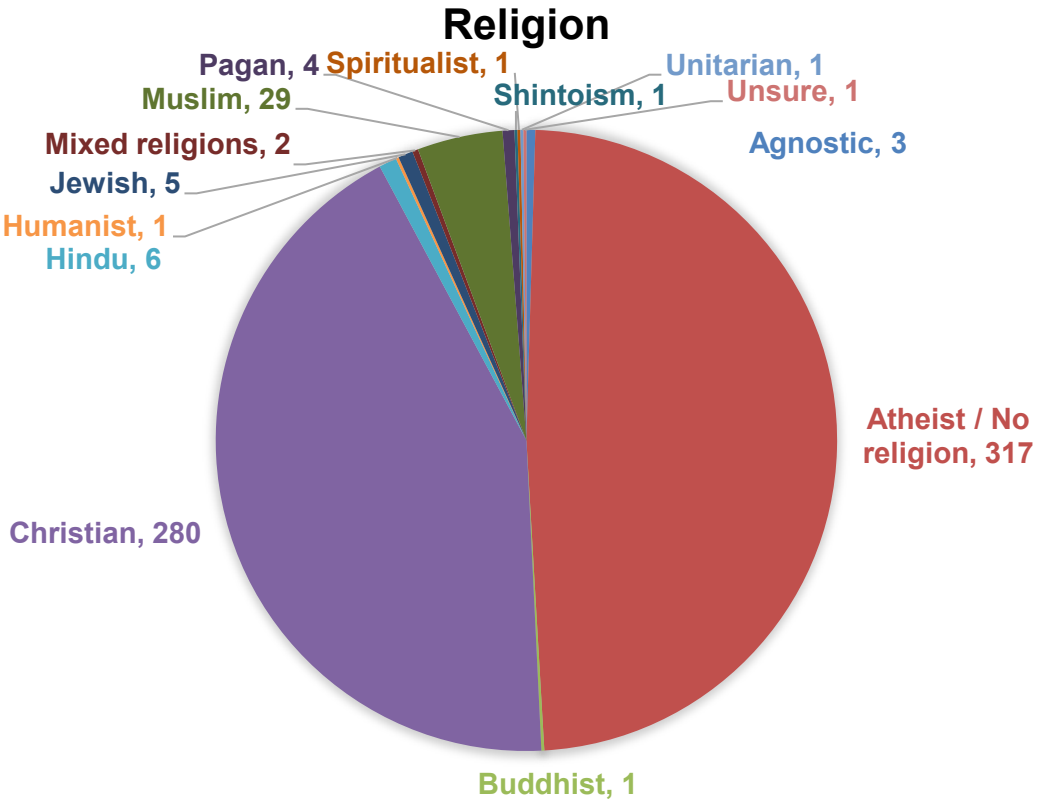


Chart 7: Sexual orientation

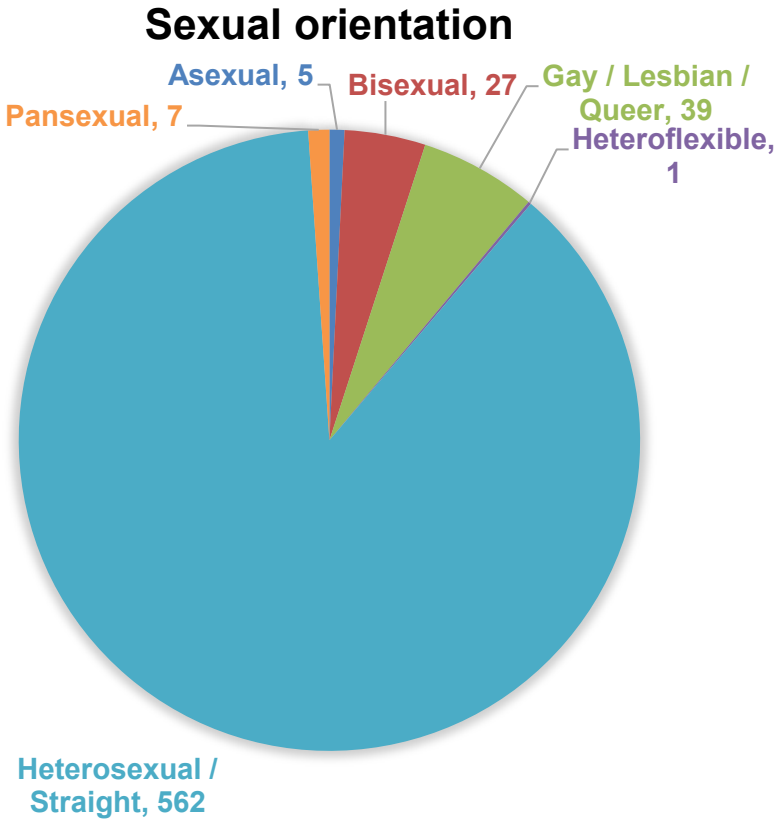


Chart 8: Employment status

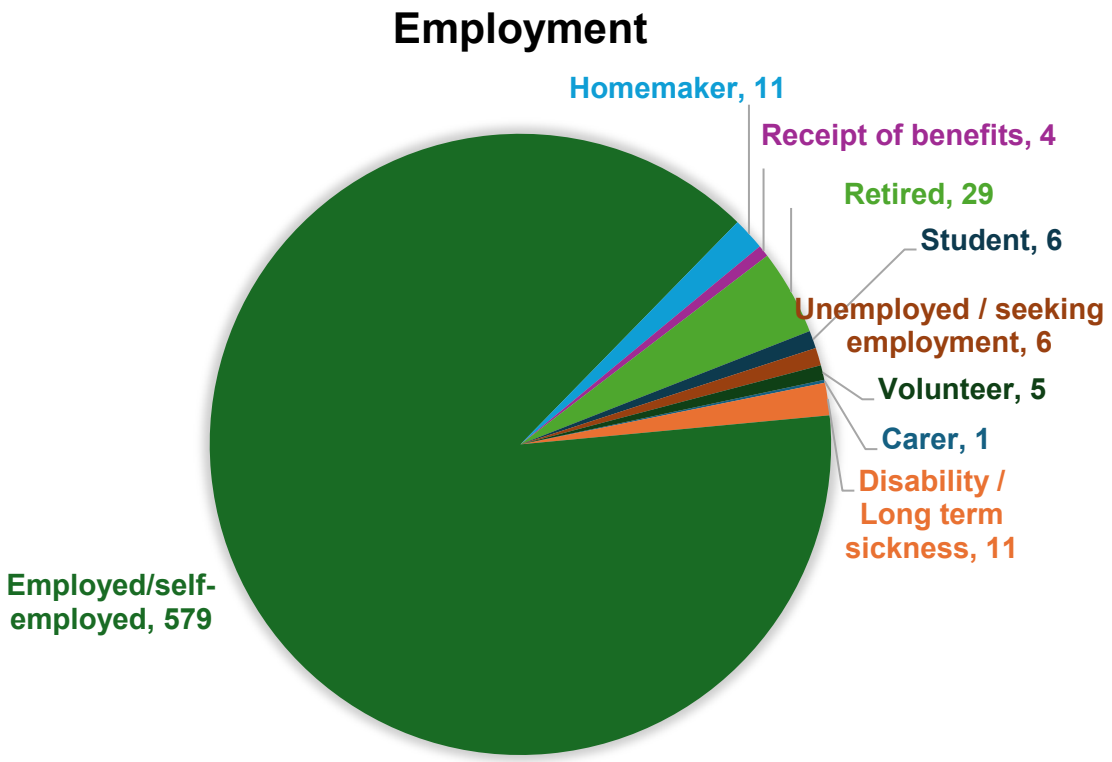


Chart 9: Disability

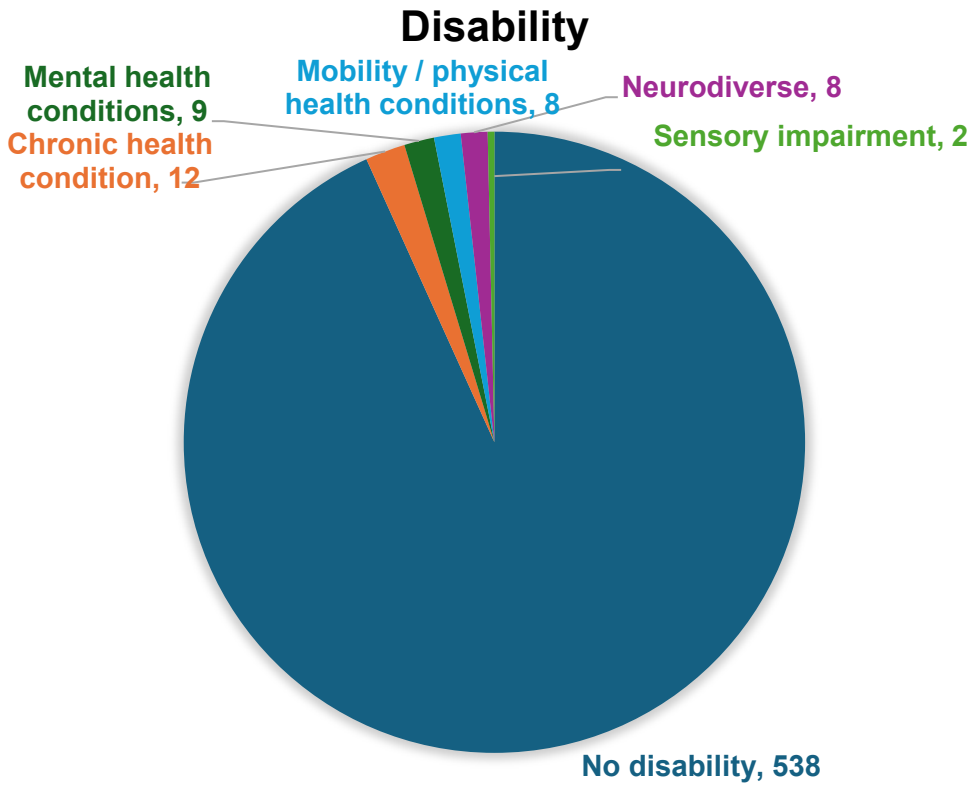


Chart 10: Armed forces (currently serving and veterans)

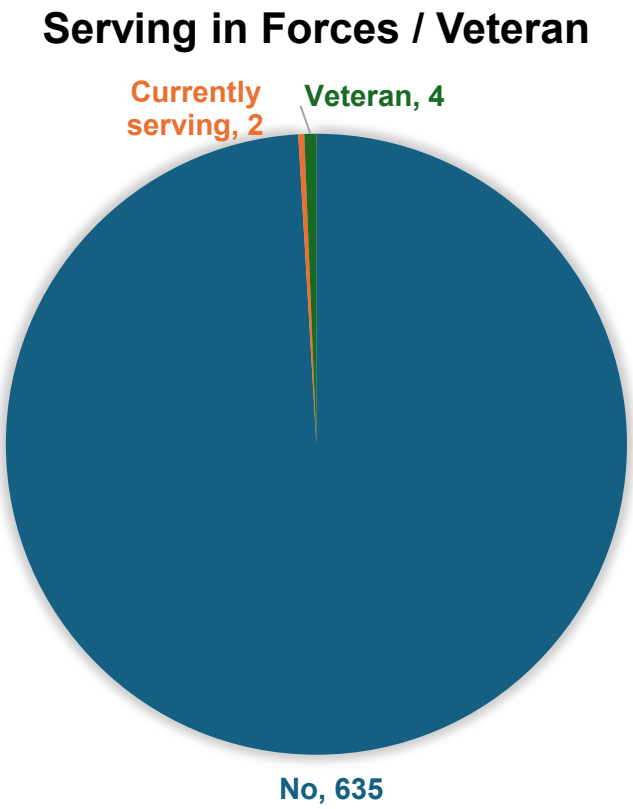
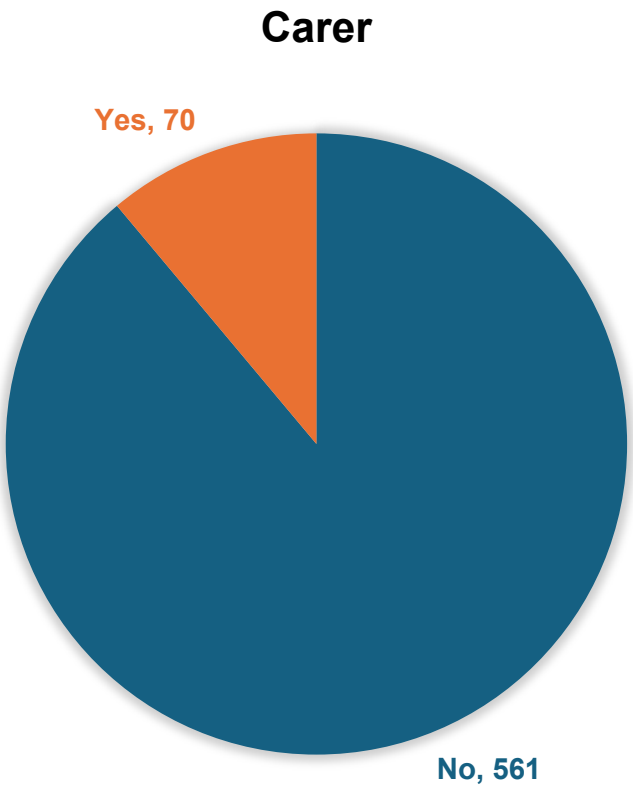


Chart 11: Carers



Appendix 2: Focus groups write ups

Online Focus Group – 26th June 2025

Attendees:

RW, HG, ML, TC, MA and 4 participants who will remain anonymous.

Context

Participants discussed proposals to standardise the number of NHS-funded IVF cycles across Greater Manchester. The focus was on the option of making it one cycle (plus another if abandoned or cancelled) of IVF treatment in all areas of Greater Manchester. This would reduce the offer in 4 areas (Tameside, Salford, Wigan and Stockport) of GM however make it an equitable offer across the geographical footprint. There was also significant discussion around patient experience, cost-efficiency, fairness, and the importance of transition planning.

Participants were all at different stages of their IVF experience and were all women under the age of 42.

Key Themes and Insights

Opposition to Reducing to One NHS Cycle

- Two participants expressed strong disagreement with the proposal to reduce funded IVF cycles to one and two participants said they neither agreed nor disagreed.
- People mentioned the common perception of the first IVF cycle as a "trial" or "learning" cycle, helping clinics tailor treatment. Success often comes in later attempts from experience.
- Reducing to one cycle risks significantly decreasing chances of success and increases emotional burden on patients.

Personal Experience and Cost Implications

- One participant shared a detailed personal story of how being unable to self-fund embryo genetic testing likely contributed to multiple failed transfers and a miscarriage.
- They highlighted that allowing patients to pay privately for certain add-ons (like embryo testing) could save the NHS thousands by avoiding repeated failed treatments.
- Mental health costs, time off work, and wider societal costs were also raised as overlooked financial impacts.

Inequities in the Current System

- Participants criticised the postcode lottery, where access to number of cycles and clinic options depends on where you live.

- A specific example from Wigan was cited, where the local policy restricted the right to choose where treat took place, unlike the offer in other boroughs.
- One person shared that simply changing GP practice to a neighbouring borough made them eligible for preferred treatment — a workaround seen as unfair.

Call for Transparent Transition Planning

- Many raised concerns about how changes would apply to those already in treatment or with cycles approved.
- There was confusion over who qualifies under which stage (e.g., approved but not started, waiting to be approved, etc.).
- Clarity and communication about timelines and criteria are essential to avoid distress and uncertainty.

Support for Self-Funding Top-Ups

- Several participants supported the idea that if NHS funding is reduced, patients should be allowed to self-fund second or third cycles or certain elements (e.g. testing), without losing access to NHS care or breaching policy.
- This would make treatment more accessible while reducing overall NHS burden.

Same-Sex Couples and Eligibility Gaps

- A participant raised that same-sex couples are often excluded or face inequitable criteria in accessing NHS IVF, even though it's their only route to conception.
- The group agreed this issue needs to be addressed within any future review to ensure fairness.

The Broader Value of IVF

- IVF was framed not as a lifestyle choice but as treatment for a medical condition — often caused by endometriosis, blocked tubes, or other diagnosed reproductive issues.
- Participants urged decision-makers to consider the true value of helping people become parents, rather than focusing narrowly on upfront costs.

Recommendations

- Retain at least two funded cycles, aligning with NICE guidance.
- Allow self-funding of embryo testing or additional cycles without penalty.
- Ensure clear and consistent transition rules, so those currently approved for multiple cycles don't lose access.
- Review clinic access inequalities across different localities (e.g., Wigan's restriction on private clinic access).
- Include same-sex couples' access in future policy reviews.

- Consider long-term cost savings and health system burden when evaluating funding cuts.

Summary

While participants welcomed efforts to ensure fairness and consistency across Greater Manchester, there was broad concern that reducing IVF provision to one cycle would negatively impact success rates, emotional wellbeing, and financial efficiency. The group advocated for greater patient choice, transparency, and equitable access, especially for underrepresented groups and those already in treatment.

Pendleton Gateway (Salford) Face to Face Focus Group – 2nd July 2025

This focus group was attended by just one person which involved a short presentation and full explanation given as to what the consultation was.

Issues here centred around communication difficulties with a clinician. This person had been to GP about 3 years ago after having fertility issues, but she was told that she was not eligible for IVF. Because of a potential language barrier, she did not challenge this at the time and had been left wondering why she is not eligible. She felt "abandoned" with no advice or explanation given and felt there was nowhere to turn to for help. She felt her GP was very unhelpful.

Holy Trinity Church (Tameside) Face to Face Focus Group – 8th July 2025

This focus group was not a group discussion, rather than 2 separate conversations.

A South Asian couple spoke of experiencing fertility issues, which had been compounded due to cultural and religious issues.

They have been trying for a baby for 15 years without success, and due to this felt alienated by family, friends and the wider community who offer no support. The male could not talk to anyone and wanted to speak to a male from outside of his community, at the focus group. The couple felt abandoned and lost, alongside feelings shame. They were also embarrassed at the process of providing samples, required to access fertility support, prior to potentially receiving IVF.

They felt that the system in its current form is too rigid and is not geared for them, there needs to be more flexibility. They found it very difficult to navigate the system due to cultural, religious and language barriers. They also feel great shame because they cannot conceive and their family is expecting them to have children, with the female very anxious because she is worried about her relationship if she cannot get pregnant, fearful that her husband will leave her and remarry, which is also adding extra pressure onto them.

One of the other females who attended felt extremely strongly that the 1+ cycles was not enough as she had conceived using IVF services getting pregnant on the second round of treatment. She said that that if the 1+ offer was only available she would not have her precious baby, as additional treatment would have been unaffordable to her.

Flourish Together (Trafford) Face to Face Focus Group – 16th July 2025

Attendees:

MA (NHS GM), TC (NHS GM), 3 members of Flourish Together Network.

Participants at the session had a wide and varied mix of experience:

- Experience of using IVF (NHS and self-funded)
- Having a family member or friends who have used IVF
- Advocate for those who are going through IVF
- Volunteer with Fertility Matter in the Workplace
- Working in NHS/HR/Wellbeing & IVF training
- HR and networking
- Social media and support groups relating to IVF.

These women are based in Stockport, Trafford and Manchester.

Background to Flourish Together - Flourish Together is a Community Interest Company that supports women changemakers and helps them create positive change in the communities. They have hubs based in Stockport and Trafford and were keen to promote the IVF Cycles consultation with their contacts and host a discussion group at their hubs. They are supporting over 20 people who are currently going through the IVF process across Greater Manchester.

Background to Fertility Matters at Work – Fertility Matters at work is an accredited CIC training provider for fertility support in the workplace. They are dedicated to improving fertility support at work. They have a large social media following.

Agenda for the session

- Welcome and introductions
- Background to NHS GM IVF Cycles consultation
- Discussion on suggestion to move to 1+ cycle
- Discussion on when to implement change
- Other comments and ideas.

Welcome and introductions

The facilitator welcomed all to the session and asked all to introduce themselves. All introduced themselves.

The member from Flourish Together apologised that not as many people had turned up as expected. She suggested that as IVF was such an emotional topic, some may not have attended the session as it was personal to them and may have sent their comments in via the online survey instead. NHS GM recognised there may be some reluctance to share personal experiences in a group setting and sought support from members at the session to help promote other ways to get involved or share any feedback directly to the engagement team, so that they can understand any impact further.

Background to the NHS GM IVF Cycles consultation

NHS GM provided some background to the IVF Cycles Consultation using a short presentation. They advised that NHS wished to standardise the number of NHS-funded IVF cycles across Greater Manchester. The focus was on the option of making it one cycle (plus another if abandoned or cancelled) of IVF treatment in all areas of Greater Manchester. This suggestion would reduce the offer in 4 areas (Tameside, Salford, Wigan and Stockport) of GM however make it an equitable offer across the geographical footprint. The consultation is only focused on the cycles and is not about the criteria to access IVF. This may be considered by NHS GM at a later date.

The consultation would run until 29 July and people are able to have their say via online survey, attending focus and discussion groups (online and face to face), or visit our pop-up stalls. NHS GM is keen to gain further insight from those who have used IVF services, considering IVF and those who may possibly impacted by any change (highlighted from our Equality Impact Assessment).

General discussion

Standardisation

The group all agreed that everyone should be entitled to the same offer across Greater Manchester.

"We all pay national insurance so should get the same offer".

"It'll end the unfair and confusing postcode lottery".

The group had time to reflect on the background information and were able to ask general questions, to seek further clarification.

NHS GM provided further clarification regarding:

- The main driver for the consultation was to ensure standardisation of cycles across GM. This was based on evidence collected so far, including feedback from people using IVF services. 1 cycle is affordable for NHS GM.
- The reason why localities have different offers was because there were 10 Commissioning Groups who made decisions about healthcare in Greater Manchester. These were replaced by one organisation known as NHS Greater Manchester in July 2022. One participant advised: *"I'm amazed that Oldham doesn't offer 3 cycles, especially as it's the birthplace of IVF".*
- The difference between an abandoned or cancelled cycle. A cancelled cycle is one where the ovaries are stimulated, but the egg collection procedure is not undertaken. An abandoned cycle is one where the eggs are collected, but they are not implanted into the uterus.

Thoughts on NHS GM's proposal to move to 1+ cycle

We asked participants their thoughts on the proposal to move to 1+ cycle for everyone across Greater Manchester. Key themes and thoughts raised by participants are listed below.

- Effectiveness of One IVF cycle
- Most people do not have success with one cycle
- One cycle often serves as a trial to understand the body's reaction
- 29%–41% success rates depending on age, with lower rates in older people
- Offering only one cycle is not cost-effective and may waste NHS resources
- One cycle offer may put additional anxiety on couples, which may have negative outcome
- An increased wellbeing support offer may help increase effectiveness.

"Most people I know haven't been successful on their first cycle, it's often seen as a trial. Throwing money at just 1 cycle is a pointless exercise".

"Often the first cycle will be used to understand how the body reacts to the treatment and can be tweaked on the 2nd cycle. It's a complete waste of time and money just going for one cycle only".

"One cycle puts so much pressure and anxiety on individuals going through IVF as they worry this may be the only chance they will get".

"Everyone I know who has had IVF treatment had to have at least 2 tries". If you're only considering 1 cycle, I'd rather it go into cancer instead".

"The NHS seems to go from step to step without really investing in wellbeing and undertaking any route cause analysis to help people have the best chance of having a successful pregnancy. If this happened, then the 1 cycle option could potentially work for more people. But not as it is at the moment".

Equity and Access to Treatment

- A one-cycle policy creates a two-tier system (rich vs. poor)
- The change disproportionately impacts those unable to self-fund further cycles
- Concerns about fairness across Greater Manchester (GM) and nationally.

"Does the NHS really think those living in areas of deprivation or on benefits can afford to self-fund? It's cruel to stop those on lower incomes not to have the same chance to have a baby as those who can afford to self-fund".

Value for money, Funding and Policy Decision-Making

- Financial constraints driving decision-making (2 or 3 cycles may not affordable)
- Question raised on how many decision-makers have IVF experience
- Value for money concerns from taxpayers—some prefer funds go to other services like cancer treatment if IVF is ineffective.

"How many of your board have experience of IVF? How can they make an informed decision without emotional intelligence?"

"As a taxpayer, I don't want to see my money get wasted by the NHS only offering 1 cycle which does not seem to achieve a very good outcome for most people".

"The NHS needs to fund at least 2 cycles otherwise its a total waste of resources. This preferred option does not seem to provide value for money in my eyes".

Holistic and Preventative Approaches (maybe put this under anything else)

- NHS IVF service lacks holistic support (nutrition, sperm/egg health)
- Success stories from private clinics with a more holistic approach
- Calls for NHS to incorporate education, lifestyle, and nutritional support into its offer.

"I think it would be more cost effective for the NHS to learn from private clinics and focus on education re diet / nutritionists / therapies to help increase chances of IVF treatment being successful rather than just focusing on cycles and treatment".

"This is a big gap in the NHS. I was the person being treated on the NHS but actually the issue was that my husband's sperm count was low. After meeting with the Nutritionist after paying to go private, my husband changed his diet and his sperm count went up 450%. I had a successful pregnancy".

Emotional and Psychological Impact

- IVF journey is emotionally and physically draining.
- Anxiety increases when only one cycle is offered.
- Many avoid telling employers due to stigma and fear of discrimination.
- Social media negativity significantly impacts mental health.

"The term 'just have IVF" is so hurtful. People don't understand the pain and heartache people go through with IVF".

"They don't know we often have to fight to even be accepted onto NHS funding".

"After having unsuccessful IVF, my sister has never spoken to anyone about it as it pained her so much".

Fertility Education and Awareness

- Need for more fertility education for young people (15–30 age group)
- Encouragement to consider egg/sperm freezing earlier
- America highlighted as a model for early education and action.

"People assume that men's sperm health quality stays good until late in life and this is wrong. Many men's sperm health decreases with age."

"Young people need to be told about the options to them if they are planning to delay starting a family, so they are more prepared".

Employment and IVF

- Lack of IVF-friendly policies and inclusive workplace culture
- Financial burden on small employers to support IVF or maternity leave
- IVF support may be seen as burden by employers
- Reduced support from employers may lead to increased anxiety and stress for those considering or using IVF, which may impact on effectiveness of IVF.

"Businesses are facing real challenges because of National Insurance increases and increases in minimum wage and may not be as flexible to offer people support".

"I'm a caring employer but the financial challenges put additional pressure on small social enterprises to support their employees well".

"Many staff members won't tell an employer that they are going through IVF as they don't want to be penalised by the employer. This might cause undue stress on the person which might impact the effectiveness of the IVF treatment".

Declining Fertility and Societal Trends

- Declining fertility rates across Europe and UK
- Causes: sperm health issues, environmental factors, delayed parenthood, socio-economic challenges
- If unaddressed, long-term demographic and economic risks.

"It seems strange that the NHS wishes to reduce its offer to help people conceive when fertility is declining".

"I'd think the NHS would want to help those with infertility problems more, not punish them."

"If the NHS does not put provision in place to support people with fertility issues to get pregnant, we will have too big a gap to help the economy thrive".

"If fertility rates keep declining there won't be enough people to support the older generation and there won't be sufficient people to run the businesses".

Gender and Cultural Considerations

- Male infertility under-discussed; education and stigma around male infertility
- Cultural sensitivity required in policy and support
- Inclusive language (people vs. women) encouraged.

"Men are as vulnerable as women regarding IVF as infertility is such a stigma with men and may be ridiculed. I supported someone who was called a "jaffa". He laughed along with the toxic masculinity but it affected him emotionally so much".

"We get an increasing number of men on our webinars now compared to 3 years ago, but still low proportions, but at least more men are talking about infertility these days".

"In our organisation we try to ensure we use language like people rather than women to ensure we don't exclude men in our fertility education and conversations".

Younger people are delaying parenthood

- High house prices and rentals mean it is difficult to move out of family
- Reduced employment, challenges with childcare costs
- Relying on building a carer or being more financially stable
- Many will be seeking IVF treatment when their fertility rates may have dropped, making one cycle less effective.

"There's nowhere affordable for younger people to bring up a family, so they have to delay parenthood".

"UK childcare costs are the highest in the world".

People with certain medical conditions may be negatively affected

- Endometriosis - has an 8-10 year diagnosis rate, which means many start IVF treatment later

- Those with conditions such as PCOS and fibroids can be affected by infertility
- Those with disabilities taking medication which could affect their fertility and asked by clinicians to hold off trying to conceive (such as high-risk diabetics, those with multiple sclerosis, parkinsons)
- People born with two wombs
- Overweight, underweight.

Self-funding considerations

- Financial Barriers and Inequality
- Not everyone can afford to self-fund: IVF is expensive, and the ability to self-fund creates an inequitable system where only those with sufficient financial means can continue treatment after NHS-funded cycles.
- Socioeconomic disparity: Policy changes that reduce funded cycles may disproportionately impact those on lower incomes, increasing inequality in access to fertility treatment.

"As my sister was only entitled to one IVF cycle she had to delay a further cycle because of cost – it took her ages to save up for another cycle."

"Poorer people with limited finances and infertility (which is increasing) will not be able to have children. This is mean"

Delays Due to Financial Constraints

- Saving up causes treatment delays: Patients often need time to gather the money for additional cycles, which may result in long breaks between treatments, potentially reducing success rates due to aging or changes in fertility status.
- Emotional Toll of Financial Stress
- Added emotional pressure: The financial burden adds another layer of stress to an already emotionally and physically demanding process.
- Difficult decisions: Couples or individuals may be forced to choose between financial security and trying to conceive.
- Ethical Considerations in Policy
- Policies should not assume everyone can self-fund: Reducing access to NHS-funded cycles under the assumption that people can pay privately fails to acknowledge the financial realities of many patients.
- Emphasis on fairness: There's a strong desire to design equitable policies that support those who cannot afford private IVF.
- Impact on Planning and Readiness
- People may need time to plan or recover financially: Delays between cycles due to self-funding needs should be factored into any transition period following a policy change.

"The cost-of-living crisis, expensive housing and high rental costs means people have less capacity to self fund".

"Many of the areas affected have areas of deprivation, how can this be fair to reduce the number of cycles?"

"My sister had to delay a further cycle because of cost – she had to save up for another cycle."

Implementing the policy fairly

We asked the group how we should apply any change in policy. There was general support for protecting those already in the system, especially those:

- Awaiting clinician approval
- With approval but no start date
- With a start date but treatment not begun

Below are the key themes raised by participants:

Fairness and Clarity in Policy Application

- Clear cut-off date is essential: Most agreed a cut-off date is needed to ensure fairness and transparency.
- New policy should apply only after the cut-off: Many participants felt that those already in the process (even early stages) should not be affected.
- Everyone needs to know where they stand: Communication is key to prevent confusion and distress.

"People need time to plan."

"Any change needs clear communications so everyone knows and understands – the current offer is so confusing".

Transitional Planning and Lead Time

- Adequate lead time needed (18–24 months): Suggested to allow individuals already in the system enough time to complete existing or planned cycles.
- Comparisons made to other public health policy changes (e.g. smoking bans) – successful when well-communicated and implemented with sufficient notice.
- Short notice (6–12 months) seen as unreasonable, given the long duration and complex nature of IVF treatment and recovery between cycles.

"An 18-24 month cut off seems reasonable".

"If it went to two tries everywhere, then maybe people who would have normally only had one, may hold back and take their time and have a successful pregnancy after one cycle".

"NHS needs to think more about application to change management to ensure any change is supportive and clearly understood".

Impact on Individuals Undergoing IVF

- Emotional and psychological burden: Sudden changes can negatively affect mental health and wellbeing
- Medical and financial barriers delay treatment: Recovery time after complications (e.g. OHSS), emotional readiness, and financial capacity can all delay subsequent cycles
- Important to factor in downtime between cycles – people cannot immediately proceed to next cycle due to health or personal reasons.

"I had to take a 6-month break for emotional recovery before I moved onto my next cycle. The process is physically and emotionally draining".

Risk of System Overload

- Anticipated surge before the cut-off date: People might rush to begin cycles before the new policy takes effect, straining existing capacity
- Could result in longer waiting times and delays for prep work like required testing.

Any other option we should consider?

Participants were asked if there was any other option we should consider? All agreed that the NHS should standardise the offer to either 2 or 3 cycles.

They cited the following reasons:

- one cycle is not cost effective because it often doesn't work first time
- helps reduce anxiety in people starting IVF for the first time, which could help achieve a better outcome on the first and subsequent cycle
- a second try can be used to tweak treatment during the first perceived "trial" cycle which hopefully will be more effective
- cost of living financial burdens mean many people won't be able to afford to pay privately for a 2nd or 3rd cycle.

"Poorer people with limited finances and infertility (which is increasing) will not be able to have children. This is mean"

"Why not 2 cycles for everybody? Why not 3 cycles? That's fair and equitable too".

Anything else you wish NHS GM to know?

The following were other things that participants wished to share with NHS Greater Manchester:

- NHS IVF services lack basic wellbeing and holistic support (nutrition and exercise advice, sperm/egg health,). It was suggested that if the IVF funded service also included emotional, physical and lifestyle advice and support, as this may lead to improved patient experience and outcomes for those going through IVF.

"I felt like I was on a conveyer belt at my NHS IVF appointments - have these drugs, it doesn't work, have these drugs, it doesn't work. They were so clinical, no wellbeing advice".

"The NHS IVF service is very limited already and it doesn't offer things that might help women have a successful pregnancy with one cycle. Nobody really analyses what is going on or offers advice and support on how to stay the healthiest you can. My private clinic looked at my egg quality, sperm health, provided holistic advice too."

"This is a big gap in the NHS. I was the person being treated with IVF on the NHS but actually the issue was that my husband's sperm count was low. After meeting

with the Nutritionist my husband changed his diet, and his sperm count went up 450%. I had a successful pregnancy".

"Holistic and preventative work to support IVF is key to the NHS IVF offer and this is lacking".

- Better awareness regarding infertility - Participants suggested that more awareness raising was required for women/people aged 15-30 to discuss fertility, egg freezing - especially as younger people may delay having children.
- NHS GM and National statistics anomalies: A participant advised that IVF is underrepresented in HFEA statistics due to overseas data not being captured.
- Criteria - The policy for same sex couples isn't fit for purpose and it needs reviewing. *"IUI requirements for same sex and solo women means that the NHS IVF process can take much longer for these people. So there definitely needs to be sufficient lead time for any proposed change to be implanted to ensure these are not disproportionally affected, as it's seems so unfair".*
- Private companies may increase cost of IVF.

"If the NHS doesn't fund more than one cycle then I'm presuming the private sector has free reign on what will charge further cycles".

"Pharmaceutical companies will be pleased too".

- "Infertility is defined by the World Health Organisation as a disease of the reproductive system, so why doesn't the NHS treat it like a disease?"

Close

The facilitator thanked all for their contributions and advised that feedback from the consultation would be presented to NHS GM Board later this year or early in 2026.

Guild Hall (Stockport) Face to Face Focus Group – 23rd July 2025

Attendees:

3 attendees, 2 men 1 woman

Feedback:

Feel very strongly about what's going on in NHS in general, much wider issues than this particular one. Wider longer-term trend of constraints in the economy

Do not want to see this implemented!

Why are we not following NICE guidelines?

Why are we not waiting until NICE have done their consultation?

NICE, revised guidance – how long will this take, also NICE guidance is much broader than number of cycles.

Just because 70% of the country offers 1 cycle does not mean this is right for GM.

Can a question be put to the board – why they are pushing through this policy now and not waiting for NICE?

What are the CLINICAL benefits of doing this?

Too many people don't know about this consultation/proposal.

HW Stockport report 2019 stated that the consultation (then) was not fit for purpose and should be suspended.

Asked whether we were aware of MP enquiry from Karen Smith – KS had been asked whether her department had been in discussion with NHS GM on the proposal. She responded that there had not been any discussion, and she expected ICBs to implement NICE guideline services.

Thoughts on proposal

Strongly disagree (all 3 people) that we should go to 1 cycle.

Decision should be made on clinical need – we should be levelling up not down.

It is about finance, rationalising NHS services – there are other services too – discriminates against women (women's health in general is a concern) – someone with damaged ovaries should be dealt with like any other illness – discrimination on people on grounds of socio-economic position – saving up for treatment could take so long they would be over the age limit

The WHO definition of infertility is that it is a disease.

The 1+ option has consequences on other things – GP services, MH services etc. What impact does infertility have on these services?

What would happen to services offered to women who have/had cancer – freeze eggs?

Even if service was preserved for women with cancer would they fail in 1 cycle and have to find funding moving forward?

Geographical disparity across GM – reframing question could put different complexion on how someone would answer the question – it's not about equity it's about budgets!

''There is nothing good about this proposal''.

No one knows if they are going to need this until they need the treatment, it could affect a whole generation.

Treatment should be given NOW for condition not pushed to future when it may be too late to do anything (someone with polycystic ovaries told to leave for now and come back when looking to have children and then can start treatment)

Commit to preventative treatment at earlier stage for other conditions linked to fertility.

METFORMIN – GPs cannot prescribe for polycystic ovaries (but this is prescribed in other countries)

Lack of metformin in gm

Entire generation who won't have a say on this consultation as they won't know they need this service for another 10/20 year's time.

1+ (make sure the provider is very clear what the + means and make sure there are some regulations around that).

Clinical need of population is not being met with 1 cycle. Need should be adequately met by levelling up not down.

Fertility Action Network Focus Group (Greater Manchester) – 28th July 2025

Context

The discussion explored participants' views on Greater Manchester ICB's consultation proposing to standardise NHS-funded IVF treatment at one cycle plus an additional attempt if the first is cancelled/abandoned.

Participants were all women with lived experience of infertility and/or IVF.

They were asked about fairness, emotional and financial impacts, and what they felt would be an acceptable number of cycles.

Things which came out of the discussion

Unfairness and Inequality

Strong sense of unfairness between neighbouring areas (e.g., Stockport vs Oldham; Manchester vs Wigan) where eligibility differs despite close proximity. Reducing to one cycle felt like levelling down, not levelling up. Several participants argued that the NICE guidance of three full cycles should be the national benchmark.

One Cycle is Not Enough

Participants repeatedly stressed that IVF rarely works on the first attempt, many times protocols are adjusted, and learning happens over multiple rounds.

One participant said, *"Limiting IVF to a single round assumes one try is enough, but it's not."*

Offering only one attempt was seen as giving false hope and sending the wrong message that IVF is a quick fix.

Two cycles minimum, with three as the gold standard in line with NICE. Participants felt two cycles would at least give couples a chance to adjust treatment and improve success rates. Consensus that reducing to one is unacceptable.

Financial Burden

All participants said they would struggle to afford further treatment privately. Some would need loans or credit cards. Some would rely on family support. A few had been saving for years, but said it was an enormous strain. Concern that financial stress compounds emotional stress and may leave families in debt without a child.

Emotional & Mental Health Impact

All participants described profound emotional stress. Feelings of grief, loss, and being "a shell" of themselves. Social isolation and difficulty relating to peers having children. Strain on relationships; differences in how men and women are treated in clinics. Several spoke openly about suicidal thoughts linked to infertility and fear that

reducing cycles would push more women into crisis. The belief is that this could increase NHS mental health costs long-term.

Infertility

Infertility often treated as a “women’s problem”, even when male factor issues are present. Men seen as secondary in consultations, with women bearing most of the testing, interventions, and emotional burden. Fertility treatment still perceived by policymakers as a luxury rather than a medical necessity.

Quotes

“It’s like giving someone one heart operation and saying, if it doesn’t work, that’s it.”

“One cycle is stripping people of their families – you’re deciding their future.”

“The bar is already too low. Instead of raising it, you’re lowering it further.”

“The difference between one round (31% success) and three (62%) is life changing.”

Summary

- Strong opposition to the proposal to reduce to one cycle.
- Genuine concern about mental health, financial inequity, and loss of hope if the policy is adopted.
- Participants urged Greater Manchester ICB to raise provision to at least two cycles and ideally three, aligning with NICE.
- Belief that cutting back now will cause greater long-term harm and costs to both individuals and the NHS.

Online Focus Group – 29th July 2025

Attendees:

3 participants who have either used IVF services or are due to use IVF services.

1 participant from an IVF provider service.

RW, MA (NHS GM)

Introduction

A presentation was delivered with introductions, along with background and context to the consultation.

A copy of the presentation will be shared along with the notes from the session.

Participant Introductions

Participants introduced themselves and shared their experiences and reasons for attending the focus group:

- One male explained that he and his partner will be starting their IVF journey having discussions currently with GP, they discovered information about the consultation only a couple of weeks ago and know this proposal will impact them as they live in Tameside. They know IVF is necessary for them and are keen to learn more and ask questions.
- A female participant introduced herself as a trainee embryologist based at a clinic in South Manchester. She works in the fertility industry and is attending in a professional capacity.
- A female participant shared her personal experience with fertility treatment, noting that she was only eligible for one NHS-funded cycle in her area and has since paid for multiple private cycles.
- A female participant joined the group around an hour into the discussion. She was the partner of the male who had been on the call from the start.

A question was asked about the clarity of the definition of abandoned and cancelled which is described in the 1plus option.

Response:

A cancelled cycle refers to any IVF cycle that is stopped before egg retrieval, for example due to poor response to medication or adverse reactions.

An abandoned cycle occurs after egg collection, such as when no eggs fertilise, or the process cannot continue for another reason.

Question - What do you think about the proposal to offer 1+ cycles to everyone across Greater Manchester?

This generated discussion which covered numerous reasons for participants responses which are detailed below.

In summary 3 participants strongly disagreed with the proposal and one participant disagreed.

Question - Why do you think that?

- The first cycle is often a "practice" round, with learning that informs better outcomes in future cycles.
- The proposal places too much emphasis on consistency across Greater Manchester, which is arbitrary and unfair.
- NICE recommends three cycles, and reducing access undermines equity and clinical best practice.
- It would be ethically wrong to change entitlements for those already in the system who were expecting more cycles.
- There is a need for better planning to allow people to access private IVF cycles through NHS clinics, which are more affordable than private ones.
- Question around where the cost savings from reduced IVF cycles would go and a call for transparency on whether these funds would stay within fertility services.
- It was highlighted that fertility should be treated like any other health condition, and limiting access sends a message that it's less important.

Importance of Multiple Cycles

Concern was expressed around limiting patients to one cycle:

  - Reduces the opportunity to refine treatment based on clinical learning from the first attempt.
  - Could force patients into expensive private care to pursue improved outcomes.
  - Represents a shift toward a "minimum standard" rather than striving for best practice, especially disappointing in Manchester—the birthplace of IVF.

Transparency and Community Engagement

- This feels like a tick box exercise and is tokenistic given there is only one option.
- Appreciate efforts put into the consultation and transparency.
- Not seen this advertised anywhere, it was by chance we found out about it. Concerned it may not have reached those who may want to answer. *''I'm a bit concerned about as to how you know how you have managed to capture the views accurately of the people that is going to be directly impacted.''*
- Recently been sat with GP discussing this very issue yet not been told about the consultation.

- It was made clear the board's decision to consult on "One Plus" was not unanimously supported by clinicians.

Fairness

There was challenge around the logic of reducing cycles if only a small percentage of people are successful on the first round:

  - Argued that if Greater Manchester currently meets NICE guidelines, this should be maintained.
  - Expressed concern about disproportionate impacts on more deprived areas like Tameside.
  - Parts of Tameside come under Glossop and therefore Derbyshire which is important for residents to understand as that again will be a different policy.
  - It seems unjust and unfair.
- A participant shared they have a medical condition necessitating IVF and asked whether exceptions would be considered under the new policy. They stressed that for some, IVF is not a choice but a medical necessity, and a 'one cycle' policy risks being inequitable.
- Is there a process to appeal?

Emotional and Mental Health Support

- Participants emphasised the need for ongoing emotional and psychological support for those who do not conceive after their first NHS-funded IVF attempt.
- Concerns were raised that patients could be left with no support structures after their funded cycle ends, particularly if they are unable to afford further treatment.

Access to Further Treatment and Private Sector Considerations

- There were questions about the accessibility and affordability of private IVF treatment, especially for those needing to continue their fertility journey after one NHS cycle.
- Some participants highlighted cost discrepancies between private clinics and NHS-affiliated providers offering private options - *"I choose to pay privately in an NHS clinic because it's still far cheaper."*
- Concern was raised over the potential surge in private demand, and whether private providers in Greater Manchester are equipped to meet increased need.
- The lack of regulation and inconsistency in private sector pricing was seen as problematic and should be reflected in the consultation report.

Quality of Care

- There was concern about the continuity of care if patients are pushed into the private sector—highlighting potential risks of fragmented care and reduced communication between private and NHS providers.
- One attendee flagged the risk of patients turning to less reputable clinics due to lack of guidance and oversight, emphasising the need for transparency, patient protection, and standards if more people are expected to go private.

Question - Who do you think any new policy should be applied to?

Timing of Eligibility and Fairness

- All participants were strongly united in the view that anyone already referred by their GP for NHS-funded IVF should retain access to the offer in place at the time of referral.
- Several individuals expressed concern about the absence of formal “start dates” in IVF treatment journeys, which makes the proposed implementation criteria unclear and potentially unfair.
- It was argued that changing entitlements mid-journey is not only ethically questionable but also logistically confusing, especially as many people wait months between referral and actual treatment.
- There was a consensus that the date of GP referral should be used as the fair and logical cut-off for any policy changes.

Financial Implications

- Reducing from two or three cycles to just one was seen as financially pressurising and emotionally distressing, especially for patients who had structured their fertility plans and finances around the original offer.
- People often save during their first and second cycles with the understanding they will have a third opportunity privately, removing a second cycle without notice could leave families unable to continue treatment.
- There was concern that a sudden change could lead to confrontational experiences for clinical staff, who would be expected to explain a complex and unpopular change to patients.

Accessibility and Communication

- The lack of clear terminology around “start dates”, “cycles”, “cancelled”, and “abandoned” treatments was noted as a barrier to understanding—especially for patients new to the fertility journey.
- Participants suggested the need for plain-language information about what the policy means in practice, including examples and defined terms, to support informed consent and planning.

Strategic Decisions

- Participants stated the One Plus proposal aligns with NICE guidelines, which still recommend up to 3 cycles.
- It was argued that limiting access forces couples into strategic and emotionally difficult decisions, such as who in a couple gets to try, particularly when only one cycle is guaranteed.
- This could be the difference in becoming a biological parent or not, this could lessen the chance of success.

Impact on Trust and Patient Experience

- Several attendees highlighted that care through the NHS is trusted and better regulated, whereas private services may lack transparency and continuity of care.
- There was anxiety about private sector motivations and the loss of holistic, NHS-based emotional support if people are forced to go private.
- IVF terminology needs to be clear, general members of the public need things explaining.

Inclusivity and Representation

- A concern was raised that men's voices, and the experiences of male partners may be underrepresented in the consultation, fertility issues affect all genders.
- There was appreciation that the engagement had targeted diverse groups, including those with disabilities, long-term conditions, and from racially minoritised and lower-income backgrounds, but a suggestion that more explicit male representation may be needed.

Final thoughts and Close

The team confirmed that survey responses will be cross-referenced by respondent type, such as whether someone has had IVF themselves, is currently receiving treatment or is supporting someone else will allow NHS GM to understand views from different groups within the consultation. The public consultation closes at midnight on the day of this session (29th July 2025). A draft report will be produced within 8 weeks, using survey data, focus group input, correspondence from individuals, MPs, and councillors and any other additional data.

Participants were encouraged to view:

- **The business case**
- **The options appraisal**
- **The assisted conception policy**
- **Consultation document**

Thanks, and close

NHS GM team thanked participants for engaging in such a sensitive discussion. Attendees appreciated the opportunity to understand the process more clearly and have their voices heard.

Appendix 3: Face-to-face engagement

Dates and locations

- 18 June 25 – Presentation, Wythenshawe MNVP members
- 18 June 25 – Information stall, Merseyway Shopping Centre, Stockport
- 18 June 25 – Presentation, Salford LPG
- 19 June 25 – Presentation, Trafford LPG
- 19 June 25 – Information stall, Bolton Learning skills and Job Fair
- 24 June 25 – Information stall at Stockport Sports Village
- 26 June 25 – Presentation, Stockport Public Involvement Network
- 26 June 25 – Information stall, Kashmiri Youth Group, Rochdale
- 27 June 25 – Information stall, Spa Medica, Bolton
- 28 June 25 – Information stall, Tameside armed forces, Denton
- 1 July 25 – Information stall, Ashton library stall, Tameside
- 1 July 25 – Information stall, Healthwatch Salford Health Fair
- 2 July 25 – Focus group, Pendleton Gateway, Salford
- 3 July 25 – Online focus group
- 3 July 25 – Information stall, Broughton Hub, Salford
- 4 July 25 – Information stall, One Riverside, Salford
- 7 July 25 – Information stall, Oldham Integrated Care Centre
- 7 July 25 – Information stalls, Hattersley Library/Tesco/Community centre
- 8 July 25 – Focus Group, Holy Trinity Church, Tameside
- 9 July 25 – Discussion, Manchester People First
- 9 July 25 – Information stall, Eccles Gateway, Salford
- 10 July 25 – Presentation, Engagement & Insight Group
- 10 July 25 – Presentation, GM MNVP Coordinators
- 10 July 25 – Presentation, Healthwatch Board, Tameside
- 10 July 25 – Presentation, Tameside Community Engagement Practitioners
- 11 July 25 – Presentation, De-Butterfly, Stockport
- 12 July 25 – The Wait focus group
- 15 July 25 – Information stall, Grand Arcade Shopping Centre
- 16 July 25 – Information stall, Spinning Gate Shopping Centre
- 16 July 25 – Focus group, Flourish Together, Altrincham, Trafford
- 18 July 25 – Information stall, Cheadle Hulme Library, Stockport
- 18 July 25 – Information stall, Walkden Gateway, Salford
- 18 July 25 – Presentation, Stockport Family Partnership meeting
- 21July 25 – Information stall, Mill Gate Shopping Centre, Bury
- 21 July 25 – Information stall, Wigan Warriors and Latics Training Day, Wigan
- 22 July 25 – Information stall, Ashton Mass Leisure Park, Tameside
- 22 July 25 – Discussion, One Stop, Sale Moor, Trafford
- 23 July 25 – Information stall, Limelight Health and Wellbeing Hub
- 23 July 25 – Focus group, Stockport
- 24 July 25 – Information stall, Wythenshawe Forum
- 24 July 25 – Presentation, WCWA Women's Group
- 25 July 25 – Information stall, Brinnington Library, Stockport

- 26 July 25 – Information stall, Pride in Leigh, Wigan
- 28 July 25 – Focus Group, Fertility Action Network
- 28 July 25 – Information stall, Atherton library, Wigan
- 29 July 25 – Presentation, Disabled Peoples Sounding Board, Manchester
- 29 July 25 – Online focus group
- 29 July 25 – Information stall, Feel Good Family Picnic, Rochdale
- 29 July 25 – Presentation Healthwatch Stockport

Appendix 4: Communications

Key partners and colleagues

- Clinical lead
- Commissioning Lead
- Project leads
- Programme Management
- NHS GM Board
- Chief Officer
- Chief Officer for Strategy & Innovation
- Chief Medical Officer
- Chief Pharmacist
- Deputy Place Based Leads
- NHS England
- NHS GM Chief Officers
- Clinical Effectiveness Committee
- Executive Committee
- GM ICP Board
- Primary Care Blueprint Delivery Group
- Trust Provider Collaborative
- Primary Care Provider Board
- GM Locality Boards
- Extended Leadership Team
- NHS Trust Boards via Chair & Chief Execs
- Council Chief Execs
- Directors of Public Health
- Equalities Lead
- Equalities Lead for GMCA
- Provider Service Leads (Trafford General Hospital: Care Fertility, Manchester Foundation Trust, Wigan, Wrightington and Leigh and Care First)
- Trusts Comms Lead
- Council Comms Leads
- Locality Participation Groups
- Programme Director for Commissioning Development
- Deputy Chief Medical Officer
- GM PLCV Policy Development Steering Group (EUR?)
- GM IVF Programme Board
- GM IVF Cycles Project Group

GM Partners

- GMCA
- GM Healthwatch
- 10GM
- GM Equals

Foundation Trusts or hospitals

- Pharmacy
- Dentistry
- Primary Care leads
- Provider services
- System Participation Group
- IAG
- Health Innovation Manchester
- Joint Scrutiny Committee
- Local HOSCs
- Community Pharmacy GM
- GM Local Medical Council (LMCs)
- Primary Care Network Leads

External bodies, networks and patient groups

- Lived Experience Advisory Group
- LGBT Foundation
- Fertility Network
- Fertility Alliance
- The Wait UK
- Action Together Tameside
- Action Together Oldham
- Action Together Rochdale
- Maternity and Neonatal Voices Partnerships

Locality groups for targeted engagement

VCFSE organisations representing equality groups (via NHS GM Engagement Team)

- ABCollectables CIC
- Access to all areas
- Achieve
- Active Tameside
- African and Caribbean Women's Centre
- African Caribbean Care Group
- Age UK Bolton
- Ahmed Iqbal Ullah Education Trust
- Akhlaq Dar Ul Uloom Mosque
- Alexandra Children's Centre
- All FM - Dragons voices (Chinese radio)
- Al-Quba Mosque & Shahporan Islamic Centre
- Ananna (previously M/Cr Bangladeshi women's organisation
- Anna Sukoon Women's Group
- Arising Futures CIO
- Art For You CIC
- Asian Elders' Resource Centre
- ASPECS - Autistic Spectrum People of Every Category of Sexuality
- AspireHer Consultancy CIC
- Associate Director of Delivery & Transformation (Trafford), NHS GM
- Autistic Society Greater Manchester
- Autistic Wigan
- Autizma
- Baby Basics Bolton and Bury
- Backup North-West
- BAND
- Barbodhan Muslim Welfare Society
- Base X
- Be Strong Project
- BHA for Equality
- BIG in Mental Health
- Black Girls Hike
- Bollyfit
- Bolton Carers Support
- Bolton CVS (Bolton Community and Voluntary Services)
- Bolton Maternity Voices
- Bolton Solidarity Community Association
- Bolton VCSE team
- Boothstown and Worsley WI
- Boroughwide Community Network (newsletter)
- Bridge community church pantry & community lounge (Radcliffe)
- Bridges Partnership
- British Muslim Heritage Centre
- Bury Council Communications Team
- Bury Libraries
- Bury - on-line directory
- Bury Together
- Can Survive UK
- Caring and Sharing Rochdale
- Caribbean African Health Network (CAHN)
- Chinese Health Information Centre
- Collaborative women (housing and support)
- Communities 4 all
- Community Health Equity Manchester (CHEM)
- Community Hub – Bolton
- Community Revival
- Connecting Steps Manchester Project
- DarulUloom Islamia
- Dar-us-Salam Mosque & Islamic Centre
- Disability Action Group
- Disability Awareness Training
- Disabilities Forum (Wigan Council run)

- Diverse Women's support group
- Early Break
- East Bury Community Hub
- Eccles WI
- Elite Community Hub
- Embrace
- Eritrean community In Greater Manchester
- Ethnic Health Forum
- Europia
- Fact - Autism support group
- First Point Family Support Services
- Food Pantry – Parkhills
- Food Pantry – Whitefield
- Global Vision Initiative
- GM Homebirth Support Group
- Greater Manchester Coalition of Disabled people
- Friends, Families & Travellers
- Halal Fusion Food Bank / Bury Active Women's Centre
- Happy Women's group Whitefield
- Hattersley & Longdendale Community Explorers
- Healthwatch Wigan & Leigh
- Home Start
- Hopewell
- Hopewell CIC
- Housing 21
- Indian Association
- Ingeus Hub, Bury Town Centre
- Islamic Academy of Manchester
- Anderton Centre (LOAI) Lancashire Outdoor Activities Initiative
- Leap
- Leigh Deaf Club
- Let's Talk
- LGBT Foundation
- Lifted
- Limelight health and wellbeing hub, Trafford
- Listening to families
- Listening To People
- Lowton Women's institute
- MADDchester
- Makki Masjid
- Manchester BME Network
- Manchester Central Mosque
- Manchester Congolese Organisation
- Manchester Council of Mosques
- Manchester Islamic Centre & Didsbury Mosque
- Manchester Maya Project
- Manchester People First
- Manchester Refugee Support Network
- Manchester Students Union
- Manchester Youth Zone
- Manna House
- Markaz Dar-ul-Ehsan Manchester
- MASH
- Maternity Voices Greater Manchester & Eastern Cheshire
- Maternity Voices Network - Manchester and Trafford
- Maternity voices partnership
- Mencap
- Men in sheds
- Merseyway shopping centre
- Millgate Shopping Centre, Bury
- My Life, Standish & Leigh
- Mustafia Sharif Charity
- Neesa Well Women
- Next Steps
- North Bury Community Hub
- North Manchester Maternity Voices Partnership
- North Manchester Maternity Voices Partnership
- Oldham Council
- Oldham Council Commissioner
- Oldham Council youth worker
- Olive Pathway
- Olympic Sports Gym
- Organic Soul
- Pennine Mencap
- Point
- Positive Steps
- Prestwich Community Hub

- Prestwich Social Prescribers
- Rainbow Haven
- Rainbow Noir
- Rainbow Surprise
- Red Door
- Restore Life
- Rethink
- Rethink Rebuild Society – Syrians
- Roshani
- Saheli
- SalahAdeen Al Ayubi Mosque
- Salford Angels WI
- Salford Autism
- Salford Deaf community
- Salford Disability Forum
- Sendiass Service – Tameside
- Shah Jalal Mosque
- Shree Radha Krishna Mandir
- Six Town Housing
- Social Prescribers for Bury
- Social Prescribers in Wigan
- Standish Lipreading Society
- St Andrew's Community hub
- Stockport Libraries
- Stockport Race Equality Partnership
- Stockport Women and Girls Network
- Support and Action Women's Network (SAWN)
- Tameside College
- Tameside Community adult education centre
- Tameside Diversity Network (Action together)
- Tameside LGBT+ Peer Support Group
- Tameside women and families support services
- Tameside Women's Community Cycling Group
- The Attic Project
- The Better Inclusion Centre
- The carers centre, Tameside
- The Fed Manchester
- The Flowhesion Foundation
- The Greater Manchester Step Change Consortium
- The Jamia Mosque
- The National Association of Women's Groups
- The Proud Trust
- The Salford Poverty Truth Commission
- The Sikh Association Manchester
- The Studio Women's Gym
- The Sugar Group
- Think Ahead Community Stroke Group
- Time out for carers
- Topping Fold Community Centre
- Total Fitness women's only gym
- Trafford community collective (collective of VCFSE orgs in Trafford)
- Trafford Council, Public Health Director
- Trust House Redvales, Bury
- UKIM - Manchester North - Khizra Mosque
- VCFA Bury
- VCSE Leaders Network
- Voice of BME Trafford
- Wai Yin Society
- Well Women
- West Bury Community Hub
- Whitefield Community Hub
- Whitefield Social Prescribers
- Who cares, support group
- Wigan Borough Community Partnership
- Wigan Deaf without speech society
- Wigan & Leigh Warblers
- Wigan Maternity voices
- Women Arise
- Women of Worth
- Women with wings
- Women's Diverse community café
- Women's Voices
- Yaran Northwest CIC

- Zimbabwe Women's Organisation-ZIWO
- Manchester Metropolitan University
- Greater Manchester Youth Network
- 4CT
- 42nd Street
- Abraham Moss Warriors
- Anson Cabin Youth Project
- Dimobi Children Disability Trust
- Connect Support
- Manchester's Got Talent Youth Group
- ReflecTeen Hub
- Rehoboth for families, children & young people
- Mohebban Al Mahdi Youth Foundation
- Nicky Alliance Centre/Mcr Jewish Community Care
- Trinity House
- Moss Side Millenium Powerhouse
- Moss Side Social stitching group
- SASCA
- Martenscroft Children's Centre
- Across Ummah
- Little Lions
- 422 community Hub
- Save the children
- Brunswick Church
- North Moor Community Association
- Manchester People First
- Better Things
- Lifted
- Talbot House
- Rethink Mental Illness Manchester Group
- Manchester Users Network
- Manchester Hearing Voices
- Moodswings
- African Caribbean Mental Health Services
- Manchester Mind
- Self Help Services
- Together Dementia Support CIC
- Himmat
- Henshaws
- Greater Manchester Coalition of Disabled People
- RNIB
- Sign Health
- Action for Blind People
- Dyslexia Institute UK
- Breakthrough UK
- Stroke Association
- Lords Taverners
- Hulme Library and Leisure Centre
- Longsight Library
- Tahera Better We
- Longsight learning centre
- Mermaids
- Maternity Voices Network - Manchester and Trafford
- GM Homebirth Support Group
- Barlow Moor Community Association
- Women Arise
- Restore Life
- The Men's Room
- Survivors Manchester
- Men's Shed, Openshaw
- Andy's Man Club
- Bideford Community Centre
- Carers Manchester Contact Point
- Manchester Carers Network
- Manchester Carers Forum
- The Gaddam Centre
- Mustard Tree
- Coffee for Craig
- Barnabus
- Back on Track
- Lifeshare
- TS4E
- MRSN
- City of Sanctuary
- The Boaz Trust
- Women Asylum Seekers Together
- Revive Manchester
- British Red Cross

- TS4SE Cooperative Ltd
- Migrant Support
- FM Radio - Chinese community

Organisations and system wide boards, committee's groups and individuals

- NHS GM Involvement and Assurance Group
- NHS GM Clinical effectiveness committee
- NHS GM Executive Committee
- NHS GM Board
- Greater Manchester ICP board
- NHS GM Clinical Effectiveness Committee
- NHS GM Executive Committee
- NHS GM Primary Care Blueprint Delivery Group
- GM Trust Provider Collaborative
- GM Primary Care Provider Board
- GM Locality Boards
- NHS GM Extended Leadership Team
- NHS Trust Boards
- Equalities Lead for Greater Manchester Combined Authority
- GM SEND Oversight Board
- GM Mental Health Partnership Board
- NHS GM Associate Programme Director Children & Young people
- NHS GM Programme Director for Commissioning Development
- NHS GM Deputy Chief Medical Officer
- NHS GM Programme Director Mental Health
- Salford Safeguarding Children Partnership/Chair of a peer support network for neurodiversity
- NHS GM Adult ADHD Steering Group
- NHS GM Neurodiversity Staff Peer Support Group
- NHS GM AADHD Steering Group
- NHS GM Head of MH Strategic Commissioning
- NHS GM Clinical Director for Mental Health
- NHS GM Assistant Director of Mental Health Strategic Commissioning Children and Young People
- NHS GM Head of Mental Health Clinical Effectiveness
- NHS GM Director of Contract Management
- Ancoats Urban Village Medical Practice
- GMMH Associate Director of Strategic Development and Performance
- NHS GM Integrated Commissioning Manager (Learning Disabilities/Complex Needs) Salford
- NHS GM Head of Mental Health, Learning Disabilities, Autism & Neurorehabilitation (Manchester)
- NHS GM Head of Mental Health and Learning Disability
- NHS GM Head of Programmes - Bury Integrated Delivery Collaborative
- NHS GM Assistant Director of Delivery & Transformation (Wigan)
- Pennine Care Foundation Trust, Network Director of Operations
- NHS GM Associate Director of Transformation and Delivery (Heywood, Middleton and Rochdale)
- NHS GM Adults Mental Health Transformation & Delivery Commissioning Manager (Heywood, Middleton and Rochdale)
- NHS GM Programme Management Officer – Mental Health, Learning Disabilities & Autism Strategic Mental Health Commissioning Team

- NHS System Participation Group
- GM Placed Based Leads
- GM Deputy Place Based Leads
- Directors of Adult Social Services (via NHS Trust communications leads)
- GM Councils: Chief executives, Directors of Education, Directors of Public Health, Exec Leads for Health, Council Chief Execs and Communication Leads
- Locality Participation Groups
- GM VCSE Leadership Group
- Transport for Greater Manchester

External boards

- GM Joint Health Overview and Scrutiny Committee
- Local Health and Overview and Scrutiny Committee chairs

Political

- MP's & LA Councillors
- GM Mayor
- Deputy Mayor
- Exec Leads for Health

Other external

- Media – North-West and GM wide
- Specialist media

Appendix 5: Organisational, clinical and political responses

Fertility Action

Submission from Fertility Action Charity on the Proposed IVF Policy Change – Manchester ICB Consultation (July 2025)

29th July 2025

Dear Greater Manchester ICB,

On behalf of **Fertility Action Charity**, we write to express our strong opposition to the proposed change in the IVF funding policy that would reduce provision across Greater Manchester to **one NHS-funded cycle**, with a second only in the event of cancellation or abandonment ("1+" model).

This change represents a serious and unjustified "**levelling down" of care**, particularly for patients in boroughs like **Tameside (currently offering 3 cycles)** and **Stockport, Wigan, and Salford (currently offering 2)**. Equalising access to IVF should be about **raising the standard** of care across all boroughs, not aligning to the **lowest common provision**. Equality in healthcare should mean **equal access to adequate treatment**, not equal access to inadequate care.

As one of our founding Trustees Dr Carole Gilling-Smith says "there is no justification for the NHS to exclude fertility treatment from funding when NICE guidelines clearly state that 3 cycles of IVF should be offered in cases where fertility is unexplained or due to male factor, tubal disease etc. This is based on reasonable cumulative rates of conception being achieved after 3 fresh cycles and all associated frozen cycles as opposed to a single cycle".

Why This Proposal Is Harmful:

1. It undermines the principles of the NHS

The NHS was founded on the principle of providing care based on **clinical need, not postcode or personal wealth**. Infertility is a recognised medical condition by the **World Health Organization**, and IVF is a **medically recommended treatment** for around 1 in 6 people - we must stop treating it as an elective luxury. The current proposal contradicts these principles by restricting access to those who cannot afford private care and reducing medically supported options for those who need more than one cycle to conceive.

2. It will worsen mental health outcomes

We have submitted evidence of the **extreme emotional and psychological toll** of infertility and unsuccessful treatment. Our charity supports **40–50 people every week** across Greater Manchester in our support groups, and that number is **rapidly growing**. Many of these individuals are navigating not only the physical and financial demands of fertility treatment but also the **devastating emotional aftermath** of failed IVF attempts.

The idea that one funded cycle is enough is **clinically and psychologically out of step** with the lived experience of those undergoing treatment. The NICE guideline clearly recommends **up to three cycles** for women under 40, because success rates improve significantly with multiple cycles. Reducing access to only one undermines both science and compassion.

3. It deepens health inequality rather than achieving your desired "fair approach for everyone"

If implemented, the "1+" model would **strip access from those who previously qualified for two or three cycles**, while **failing to raise the standard** for those with only one. This is not equity - it's austerity masked as fairness.

In reality, this policy would **create a two-tier system**:

- Those who can afford private IVF will continue treatment.
- Those who can't will face the trauma of halted care after a single failed attempt.

This disproportionately affects **low-income families, minority ethnic groups, and those already facing barriers to healthcare access**, including single people, members of the **LGBTQIA+ community** and those with medical complexities.

4. It disregards clinical evidence and established medical guidelines

The **NICE guidance** (CG156) recommends up to **three full IVF cycles** for eligible women under 40 because this significantly increases the chance of success. It also reduces emotional stress, as couples are not burdened with the unrealistic expectation that IVF must work on the first try. Success rates increase significantly (~62%) with 3 cycles whilst offering fewer cycles leads to worse outcomes and wasted investment. This is a long-term investment which leads to taxpayers and contributors to the economy - which in a country with a severely declining Fertility Rate - is something we need to seriously consider. It is important to consider also that this will encourage increased reliance on unregulated or unsafe overseas fertility options.

5. It undermines trust in the NHS

When guidelines like those from NICE are ignored or inconsistently applied, it not only damages the trust in the fairness and integrity of the NHS, but it also signals to the public that their needs are secondary to short-term budget concerns. Fertility treatments are continually under-prioritised.

Other Considerations

1. Male fertility needs focus

Evidence shows that **education surrounding male fertility and preliminary testing/early diagnosis is extremely poor in the UK currently** (with 80% of GP's that we surveyed saying they have no education on this topic. We know that men contribute to up to 50% of infertility/sub-fertility diagnosis, and have recently sent this submission to The Men's Health Strategy to highlight this important issue.

2. Other countries provide better - the UK is falling behind

Sweden, Finland, Denmark and France all offer more cycles, better access and include single people and those from the LGBTQIA+ community, setting an international standard of reproductive support. The UK appears increasingly regressive in stark comparison sending a message that only certain family make-ups are “worthy” of support. Surely our country can do better.

3. We’re not listening to the people who are affected

Our support groups are growing, and we are continually hearing stories of serious mental health impacts. Male fertility is drastically declining. Nutritional and holistic practitioners are telling us that lifestyle factors and choices might improve chances. Research is showing us that DNA Fragmentation testing might avoid recurrent baby loss in females. Fertility and Reproductive Health needs so much more conversation, education and understanding.

What Should Happen Instead:

- Maintain a **minimum of two funded IVF cycles** across all boroughs as a baseline, aligning with the most common current offer in Greater Manchester.
- Create a plan to **expand toward the NICE-recommended three cycles** in future phases.
- Conduct **further consultation with lived-experience groups**, including the voices of the 40–50 individuals we support weekly, who face infertility with resilience but need a system that doesn’t give up on them after one try.
- Ensure **equity-enhancing policies** that support people from **diverse socioeconomic, racial, cultural, and sexual backgrounds** who are already underrepresented in successful fertility outcomes.

Final Statement from Katie Rollings, Founder & CEO of Fertility Action:

Reducing funded IVF cycles to a single attempt is not equality - it is, simply put, **levelling-down** medical treatment. In the name of “consistency,” we risk making care worse for thousands of people across Greater Manchester who already face tremendous barriers and trauma in accessing fertility treatment.

We urge the Board to reconsider this proposal and uphold the NHS’s duty to provide **evidence-based, compassionate, and equitable** care to all who need it.

Yours sincerely,

Katie Rollings

Founder & CEO
Fertility Action Charity
www.fertilityaction.org
Registered Charity number: 1212260

Navendu Mishra, MP for Stockport

Sir Richard Leese
NHS Greater Manchester
4th Floor
3 Piccadilly Place
Manchester
M1 3BN

Via email and post

2nd July 2025

Dear Sir Richard Leese,

I am writing to voice my concerns regarding the future of NHS funded in vitro fertilization (IVF) treatment in Greater Manchester and Stockport.

As I am aware, NHS Greater Manchester are considering plans to scale back NHS funded IVF treatment in numerous boroughs across Greater Manchester, including Stockport Metropolitan Borough. From my understanding, the proposal is that only one full IVF cycle will be available to people with uteruses aged 39 and under, plus an additional attempt if the first cycle is cancelled or abandoned. Currently, as I am aware, Stockport offers two free cycles as does Salford and Wigan. Tameside is the only borough to offer three cycles.

The National Institute for Health and Care Excellence (NICE) fertility guidelines recommend that three cycles should be offered to those under 40. Thus, even current provision falls short of recommendations.

In recent days, I have been contacted by constituents and a national charity expressing their deep concerns and distress over this proposal. As you may be aware, the first cycle of IVF is often considered a trial run, as success rates are likely to be low initially, so one cycle alone is seemingly wholly inadequate.

It is important to note that this decision will further perpetuate health inequalities across the region and Stockport. Simply, it is almost certain that this will disproportionately affect those with a lower income, who will likely struggle immensely to fund further treatment cycles themselves.

Not only this, but I am also aware from correspondence with constituents that this will continue and likely intensify the mental health implications that can come from fertility related health problems. This will not only negatively impact the patient but also their partners, family, friends and wider support networks.

I am aware that a factor behind this proposal is to standardise the availability of IVF treatments across the boroughs in Greater Manchester, as currently Trafford, Manchester, Oldham, Rochdale, Bury and Bolton offer only one cycle. While I understand the need to ensure equality between boroughs and eliminate the experience of a ‘postcode lottery’, I believe that the objective should be to level up the availability of IVF treatment across boroughs, not level down.

I am pleased to see that NHS Greater Manchester is currently consulting on these plans until 29th July 2025, and I hope and encourage that all those concerned share their opinions and experiences. As such, I urge decision makers to fully consider all responses to the consultation, thoroughly assess all available options, and thoughtfully evaluate impacts on patients' physical and mental health.

With this, I should also note that I intend to raise this issue in the Chamber of the House of Commons.

Finally, I would like to extend my sincere thanks and gratitude to all NHS staff in Greater Manchester, their care and determination continues to be a great source of strength and comfort for many.

I look forward to your response.

Yours sincerely,

Navendu Mishra MP

Member of Parliament for Stockport

Rebecca Long-Bailey, MP for Salford

Mr Mark Fisher
Chief Executive
Greater Manchester ICB

Sent by email.

Our Ref: RL28221 11 July 2025

Dear Mark,

Re: Proposed Reduction in NHS-Funded IVF Cycles

I am writing to express concern to the Greater Manchester Integrated Care Board's proposal to reduce the number of NHS-funded IVF cycles from two to one. This move would have a profound and distressing impact on individuals and couples in Salford and across Greater Manchester who are already facing the emotional, physical, and financial strain of infertility.

A Salford constituent recently shared with me the deeply personal challenges she has faced in her ongoing IVF journey. She suffers from endometriosis, adenomyosis and polycystic ovary syndrome (PCOS), all of which significantly impair fertility. Her treatment has already involved multiple abandoned or cancelled cycles, considerable personal expense for medication and investigations, and the heartbreaking loss of a pregnancy. While she currently has one embryo remaining from her funded cycle, the future remains uncertain.

Her experience is not unique. Infertility is a recognised medical condition, and treatment should reflect this. IVF is not elective—it is necessary healthcare for those who need it. The current proposal disregards both clinical guidance and human dignity.

The National Institute for Health and Care Excellence (NICE) recommends that eligible women under 40 should receive up to three full IVF cycles. Reducing the already limited provision to one funded cycle not only falls short of these guidelines but exacerbates the existing postcode lottery that governs fertility treatment access across England. This undermines health equity and places additional pressure on people already enduring significant emotional and physical hardship.

Furthermore, this policy raises broader ethical concerns. It is unacceptable to effectively limit access to medical treatment for a recognised condition based on local financial decisions. Just as we would not deny a second hip replacement or cancer treatment cycle due to cost, we should not ration fertility treatment in this manner. The right to try to conceive and start a family—enshrined in Article 16 of the Universal Declaration of Human Rights—must be respected and supported by our public health system.

I know many local Councillors and residents share these concerns, particularly in relation to mental wellbeing, equality of access, and consistency with NICE recommendations. I am therefore seeking greater clarity on the policy and financial

rationale for this proposal and, critically, its likely impact on patient outcomes in Salford and Greater Manchester.

I would be most grateful if the ICB would reconsider this decision and instead explore how current IVF provision can be maintained—or ideally improved—so that those affected by infertility in our community are not left behind.

I look forward to your reply.

Yours sincerely,

Rebecca Long-Bailey MP

Member of Parliament for Salford

Councillor John Merry and Councillor Mishal Saeed, Salford City Council

Mark Fisher
Chief Executive
NHS Greater Manchester Integrated Care

Colin Scales
Deputy Chief Executive
NHS Greater Manchester Integrated Care

Sent via email

21st July 2025

Dear Mark and Colin

Objection to Proposed Reduction in NHS-Funded IVF Cycles

We write to express our strong opposition to any proposal by the Greater Manchester Integrated Care Board to reduce the number of NHS-funded IVF cycles to one. In Salford, we are extremely concerned about the impact this would have on our residents, many of whom have expressed deep worry and distress over the potential change.

One resident shared, “This is shocking, I was an IVF baby—and a second round one at that,” powerfully illustrating how critical access to multiple cycles can be. Another stated, “Money shouldn't be a barrier to healthcare, and equality of service doesn't mean giving everyone less,” reflecting a widespread concern that this proposal undermines the very principle of equity. Residents have also emphasised that “IVF should be equitable, non-discriminatory, and treated with the same dignity as any other health condition.”

Perhaps most poignantly, a mother who struggled to conceive for eight years said, “Reading the IVF engagement report brought back all the pain… it’s disgraceful we’d even consider reducing residents’ rights to having a family by 50%, especially considering NICE guidelines are three cycles.” These voices must not be overlooked. They reflect a community that feels this decision would not only be unjust, but deeply harmful.

1. Upholding Equity and Access

Greater Manchester has long championed health equity and reducing inequalities. Moving to a policy of only offering a single IVF cycle risks undermining this commitment by disproportionately affecting those who cannot afford private treatment, exacerbating existing disparities in reproductive healthcare.

In Salford, the current offer of two NHS-funded IVF cycles remains in place, and we are deeply concerned that reducing this to a single cycle would violate the principle of equitable healthcare and risk causing significant harm to our residents. While the intention behind the proposal is to promote equity, reducing the number of cycles available does not feel equitable in practice.

Salford has a higher proportion of residents living in areas of deprivation compared to the national average. For many, private fertility treatment is simply not an option. Making equitable access to NHS-funded services all the more critical.

2. National Guidance and Best Practice (NICE)

The National Institute for Health and Care Excellence (NICE) recommends offering up to three full IVF cycles for eligible women under the age of 40. While we recognise that Integrated Care Boards (ICBs) have discretion in commissioning services, a reduction to just one cycle would move Greater Manchester further away from national best practice and risk deepening the postcode lottery in fertility care.

This proposal also represents a further reduction in NHS-funded IVF provision for Salford. In the early 2000s, residents were able to access the full three-cycle offer recommended by NICE. This latest cut is a blow for our community, further limiting access to essential reproductive healthcare.

3. Emotional and Mental Health Impact

Infertility is a recognised medical condition with profound emotional and psychological consequences. Reducing access to treatment may increase mental health pressures on individuals and couples already facing significant distress.

At a time when national birth rates are in decline, restricting access to fertility services appears counterintuitive. There is both a moral and economic imperative to ensure that residents are supported in accessing fertility treatment, recognising its importance to individual wellbeing and the broader demographic landscape.

4. Strategic Alignment

The Greater Manchester Integrated Care Partnership Strategy (2023–2028) outlines a vision for improving access to care and tackling health inequalities. We believe that maintaining or enhancing IVF provision aligns more closely with this vision than reducing it.

5. Call to Action

We urge the ICB to:

- Maintain the current provision of two NHS-funded IVF cycles.
- Consider aligning with NICE guidance by expanding access where possible.
- Engage meaningfully with local communities, clinicians, residents and stakeholders before finalising any changes.
- Provide timely updates to elected representatives and ensure they are actively included in the decision-making process.

We would welcome the opportunity to meet with you to discuss this matter further and ensure that Greater Manchester continues to lead the way in equitable, compassionate healthcare.

Yours sincerely,

Councillor John Merry Councillor

Lead Member Executive Support Member, Salford Council City

Councillor Mishal Saeed

Adult Social Care and Health Social Care and Mental Health, Salford City Council

Healthwatch Stockport

Healthwatch Stockport Response to Greater Manchester IVF Consultation

Date: July 2025

Submitted by: Healthwatch Stockport Website: www.healthwatchstockport.co.uk Contact: 0161 974 0753

Response to IVF Provision Consultation (July 2025)

Healthwatch Stockport welcomes the opportunity to respond to the Greater Manchester Integrated Care Partnership's consultation on proposed changes to the provision of NHS-funded IVF. https://gmintegratedcare.org.uk/announcement/ivf-consultation-launching-this-month/

As the independent champion for people using health and social care services in Stockport, we have engaged with our local members and community representatives on this issue. We are submitting this response on their behalf, informed by lived experience, feedback, and our commitment to health equality.

Core Feedback

1. Support for Equal Access to IVF Across Greater Manchester

Our members strongly support the proposal to standardise IVF provision across GM. Currently, residents in different boroughs experience varying levels of access, which is perceived as both unfair and inequitable.

We believe that people should not be disadvantaged based on their postcode when accessing reproductive healthcare support. A consistent, GM-wide policy would help reduce health inequalities and ensure that all residents have the same opportunity to try to start a family.

2. Support for Offering 3 IVF Cycles in Line with NICE Guidelines

Healthwatch Stockport supports the recommendation that up to three full IVF cycles should be funded for eligible individuals and couples, in line with NICE clinical guidelines (CG156).

NICE recommends three cycles because evidence shows that cumulative success rates significantly improve with multiple cycles, especially for younger women or those with unexplained infertility.

We believe that aligning NHS provision in Greater Manchester with national guidance is the fairest and most clinically appropriate approach.

3. Ensuring Fair and Inclusive Access Criteria

Our members wish to emphasise that any standardised offer must also include transparent, inclusive, and evidence-based eligibility criteria. Specifically, we encourage GMICP to:

- Ensure access criteria do not unfairly discriminate against single individuals, same-sex couples, or those from different ethnic or socioeconomic backgrounds.
- Avoid introducing additional financial or lifestyle-based barriers that disproportionately affect certain groups.
- Provide clear and accessible information about eligibility, timelines, and the referral process.

4. Access to Emotional Support and Counselling

While not the main focus of this consultation, our members also highlighted the need for emotional support alongside IVF treatment, both during and subsequently and both who experience treatments which have failed or have been successful. Undergoing fertility treatment can be psychologically challenging, and consistent access to counselling and peer support should be part of the wider fertility pathway.

Summary Position

Healthwatch Stockport supports the Greater Manchester-wide move to standardise IVF provision and strongly endorses the option that provides:

3 funded IVF cycles, in line with NICE guidance.

We believe this approach:

- Promotes fairness and consistency across boroughs
- Reduces postcode-based health inequality
- Aligns with national evidence-based standards
- Supports the reproductive rights and wellbeing of GM residents
- Bears the greatest opportunity for potential families.

Contact for Further Discussion

We are happy to provide further insight or share local experiences on this topic. Please contact:

Maria Kildunne, Healthwatch Stockport

Manchester University NHS Foundation Trust

Ursula Martin, Chief Executive Officer Specialist Hospitals Clinical Group submitted a response on behalf of Mark Cubbon, Chief Executive Officer Manchester Foundation Trust, highlighting some key considerations regarding the proposed “1+” cycle model.

Whilst recognising the need to reducing the disparity in current access, if this proposed model is implemented then, understandably this will significantly impact patients who are currently eligible for two or three cycles and may lead to:

Access and Patient Equity

- Perceived inequity, particularly among those from lower socio-economic backgrounds who are unable to proceed for private/fee paying treatment if unsuccessful from their funded cycles.
- Potential impact on Mental health and relationship strains, as highlighted in ICB-led engagement, that may have an impact on wider services.
- A likelihood of increased patient dissatisfaction and complaints directly into the service, which would require additional resources to manage and address these concerns. The service already receives a high volume of complaints related to the funding cycles provided which would be likely to increase with greater restrictions.

Financial Impact and Service Sustainability

Proceeding with this option would have a direct impact on the number of cycles which are currently provided at MFT, with a projected reduction per annum. It is unknown what the conversion would be from funded cycles to a fee-paying model would be, noting that there are alternative providers for such a service.

Recognising that there may be an activity impact and in conjunction to moving to a cost and volume contract for IVF services, there would be a need to review tariff arrangements, in order to ensure that the service remains sustainable. This is in recognition of there being a number of fixed overheads, in order to provide the service given its highly complex and specialist nature.

Acknowledging the approach that is currently being undertaken, we respectfully request that the following is undertaken:

- To continue with the collaborative engagement with ourselves and other providers to co-design a model that balances equity, affordability, and service viability.
- Ensure that tariff arrangements are sustainable under a cost-and-volume model in order for any proposed model is viable for the future.

Equality Analysis Template

Step 1 Evidence | Step 2 Assess | Step 3 Strengthen | Step 4 Monitor | Step 5 Approve

Step 1 Evidence

This equality analysis is being undertaken to prevent my policy, plan or project from adversely affecting people with different protected characteristics or at known disadvantage. I am using this template to identify potential discrimination or disadvantage, propose steps to strengthen against those and record and monitor the success of those strengthening actions.			
Name of your strategy/policy/plan/project	NHS GM IVF Cycles Project		
Contact details for the person completing the assessment	harry.golby@nhs.net, Project SRO		
Design date for the strategy/policy/plan/project	Policy		
Date your equality analysis is completed	Latest update 20th November 2025		
Does this template form part of a business case or investment proposal submission?	~~Yes~~	**No**	~~Unsure~~
Are you completing this as a result of organisation change?	~~Yes~~	**No**	~~Unsure~~
Is there another reason for you completing this template – e.g. renewal of a current service/change to current service – please specify:	Used by NHS GM IVF Cyclces Project, updated following consultation for Health Overview Scrutiny Cmtee, will also inform Board decision on standardising IVF policy		

If you are unsure about any part of this template, please read the accompanying guidance paper before you complete. ALL sections must be completed – N/A is not applicable in this template as it is used to inform legal compliance. If you need to explain your bespoke approach further, please do so in the text boxes.

1. Initial screening assessment

What are the main aims, purpose of your policy, plan or project?

The GM IVF Cycles Project aims to ensure standardise provision across all 10 localities in respect of the number of IVF cycles commissioned by NHS GM.

A single GM Assisted Conception Policy is in place and is consistent throughout NHS GM in every respect other than the number of cycles. The current (version 3.1, Nov 2021) NHS Greater Manchester assisted conception policy states:

For women aged 39 and under:

- Bolton, Bury, HMR, Manchester, Oldham and Trafford all commission 1 complete cycle of IVF (and allow a second attempt at a full cycle for a cancelled or abandoned cycles),
- Salford, Stockport and Wigan all commission 2 cycles (includes abandoned or cancelled cycles)
- Tameside commissions 3 cycles (includes abandoned or cancelled cycles).

The project has been established solely to consider the number of IVF cycles, ensuring standardisation across GM.

During June and July 2025, a 6-week public consultation was held to seek the views on a proposal to standardise the number of NHS-funded IVF Cycles offered to eligible people. Over 2,000 people engaged with NHS Greater Manchester (NHS GM).

What people told us – the key themes

- People strongly supported standardising the number of cycles across Greater Manchester, with some wanting it standardised nationally.
- Most people strongly disagree with the proposal to standardise at 1+ cycle across Greater Manchester.
- People feel the proposal will increase health inequalities with some communities, particularly for low-income households, same-sex couples, people with disabilities, amongst others.
- There was a strong feeling that infertility is a medical condition and should be viewed and treated as such, which it's believed not to be currently.
- There was concern that the policy change could push people into poverty.
- People were concerned that this would create a two-tier system with only those able to pay for more cycles able to have a family.
- There was concern that this would cause significant mental and emotional health impacts.
- People felt that this was a cost-cutting exercise and levelling down of a service rather than creating equity.
- Most people felt that any reduction in cycles should only be applied to people who are yet to be assessed and approved for IVF with all people currently in the system having their initial number of cycles offered honoured.

What is your expected outcome? A revised NHS GM Assisted Conception Policy with a statement regarding the number of cycles that is consistent across every locality in GM.
Who will benefit? The IVF Cycles Project Group will have a better understanding of the impact of any possible changes. The Board of NHS GM, which will ultimately make the decision on the new policy, will have assurance that equality issues have been appropriately considered as options are assessed and considered, and mitigated (potentially by other parallel pieces of work).
Is your project part of a wider programme or strategy (for example, the locality plan)? Yes – the IVF Cycles Project will standardise the number of NHS GM funded IVF cycles. Other work will consider broader pathway issues and, the GM Assisted Conception Policy will consider broader aspects of eligibility for IVF and will be reviewed following publication of updated NICE Clinical Guideline on Fertility Problems: Assessment and Treatment.

2. Are there any aspects/activities of the policy, plan or project that are particularly relevant to equality, socio-economic disadvantage, or human rights?

At this stage, you do not have to list possible impacts, just identify the areas. (E.g. we are commencing a new programme of health care aimed at Caribbean men with diabetes)

Yes – there are many aspects of the broader Assisted Conception policy that are relevant.

Two aspects are particularly relevant to the current inequitable policy:

- Variation of provision – the current arrangements differ across the 10 localities of NHS GM.
- Geographical – a standardised policy will affect patients differently depending on where they live (or more accurately the location of the GP practice where they are registered). Depending on the difference between the current and new policy people from different localities will be eligible for more, fewer or the same number of cycles.

However, a number of groups will be particularly affected by a change in the number of NHS GM funded IVF cycles.

3. What existing sources of information will you use to help you identify the likely impact on different groups of people? (For example, statistics, JSNA's, stakeholder evidence, survey results, complaints analysis, consultation documents, customer feedback, existing briefings, comparative data from local or national external sources).

- Evidence of previous engagement undertaken in localities across GM prior to the establishment of this project
- EIA developed by the Engagement team
- Engagement carried out during this project.
- Public consultation undertaken in 2025 with over 2,000 responses
- National information with regards to other ICB's policies
- Activity information from IVF providers commissioned by NHS Greater Manchester on current provision

4. Evidence gaps

Are there gaps in information that make it difficult or impossible to form an opinion on how your proposals might affect different groups of people? If so, what are the gaps in the information and how and when do you plan to collect additional information? Note this information will help you to identify potential equality stakeholders and specific issues that affect them - essential information if you are planning to consult as you can raise specific issues with particular groups as part of the consultation process. EIAs often pause at this stage while additional information is obtained.

No: Please go on to question 5. (Be sure to have fully considered all communities and parts of communities – e.g. have you considered the needs of gypsies, travellers and Roma communities, other transient communities, do you need to better understand take up of your service by Muslim women or Orthodox Jewish men, for example.)

Yes: Please explain briefly how you will fill any evidence gaps. You might want to start with contacting research or policy colleagues to see whether they can point you in the right direction. Our third sector colleagues will also be pleased to offer support and direction.

Evidence gap	**How will the evidence be collated**	**Individual or team responsible and timeframe**
Insight from previous engagement is quite old and incomplete. Further engagement has been carried out to help address these gaps.	Summarised by engagement team	NHS GM Engagement Team
Activity information regarding current provision is limited. NHS GM does not routinely collect detailed information on current provision in a way that can be aggregated to describe the impact on different groups.	Project team has contacted providers direct and aggregated data.	Project Team

Engagement exercise and information from stakeholders during the project has provided significant insight, further engagement (full consultation) is recommended.	Consultation report	NHS GM Engagement Team and Project Team

5. Involvement and Engagement

Note: You are required to involve and consult stakeholders during your assessment. The extent of the consultation will depend on the nature of the policy, plan or project.

(Don't forget to involve trade unions and inclusion staff groups if staff are affected and consider socio-economic impact as well as community and third sector groups for different protected characteristics. If there is potential for different impact across different neighbourhoods, consult your neighbourhood leads)

Engagement and involvement that has taken place, who with, when and how?
Standardising IVF Cycles Consultation 2025: • During June and July 2025, a 6-week public consultation was held to seek the views on a proposal to standardise the number of NHS-funded IVF Cycles offered to eligible people, as part of Greater Manchester Assisted Conception Policy. • This consultation report sets out the feedback from the over 2,000 people who engaged with NHS Greater Manchester (NHS GM) in a variety of different ways, including: a survey, focus groups, community workshops and at pop-up events across Greater Manchester. Some also participated by sharing their views via 1:1 telephone calls, submitting texts, letters and emails. • Through the consultation we clearly heard that there was a strong appetite to provide a consistent and equitable offer across Greater Manchester. People told us that this would make it fair for all those eligible to receive treatment and was the "right thing to do". • Despite this, many people did not support NHS GM's preferred option which formed the basis of the consultation, to replace the existing various offers to a universal 1 cycle plus an additional attempt should this be cancelled or abandoned option, voicing very strong opposition. • It was viewed by many as a cost-cutting exercise, an opportunity to "level down" and a "backward step". For some there was a strong belief that infertility should be treated in the same way as other medical conditions, and reducing funding for this service indicated that it was not. • People feel that the proposal will increase health inequalities, particularly affecting same-sex couples, people with disabilities, and other marginalised groups including low-income households. • Many were concerned that the policy change could push individuals and families into poverty due to the financial burden of accessing fertility treatment privately, creating a two-tier system, where only those who can afford to pay for additional cycles are able to have a family. • People are concerned that these changes could lead to significant mental and emotional

health challenges for many hoping to have a family.
- There were a number of alternative options suggested, with almost all advocating towards a more favourable offer, for all.
- When considering the roll out of any proposed change, opinions varied depending on whether the change was an increase or decrease of cycles. If cycles are being decreased, many believed the fairest course of action was to apply it only to those who have not yet been approved for IVF as those already on their journey were expecting to get more cycles. If the cycles are being increased, it is fairest to apply to everyone wherever they are in their journey.

What people told us – the key themes

- People strongly supported standardising the number of cycles across Greater Manchester, with some wanting it standardised nationally.
- Most people strongly disagree with the proposal to standardise at 1+ cycle across Greater Manchester.
- People feel the proposal will increase health inequalities with some communities, particularly for low-income households, same-sex couples, people with disabilities, amongst others.
- There was a strong feeling that infertility is a medical condition and should be viewed and treated as such, which it's believed not to be currently.
- There was concern that the policy change could push people into poverty.
- People were concerned that this would create a two-tier system with only those able to pay for more cycles able to have a family.
- There was concern that this would cause significant mental and emotional health impacts.
- People felt that this was a cost-cutting exercise and levelling down of a service rather than creating equity.
- Most people felt that any reduction in cycles should only be applied to people who are yet to be assessed and approved for IVF with all people currently in the system having their initial number of cycles offered honoured.

Pre 2025 insight:

- Bury CCG public consultation re IVF cycle provision (consultation 6 Aug to 16 Sept 2018)
- Heywood, Middleton, Rochdale CCG consultation re IVF cycle provision (consultation 3 Dec 2018 to 16 Jan 2019)
- Oldham CCG public consultation re IVF cycle provision (consultation 12 Oct to 3 Dec 2018)
- Stockport CCG public consultation re IVF cycle provision (consultation 9 Sept to 20 Oct 2019)
- Trafford CCG public engagement re IVF cycle provision (7 March 2018 to 19 March 2018)
- GMHSCP Assisted conception and fertility service review public consultation (28 May to 27 July 2021)
- NHS GM IVF cycles engagement exercise which encompassed a public survey, phone interviews and emails (engagement 21 May to 16 June 2024)
    - Action Together Oldham (Telephone call – 23 May 2024) to understand how best to reach South Asian communities.
    - LGBT Foundation (MS Teams call – 4 June 2024) to gain further insight re LGBT and support to promote engagement widely

- GM Equality & Diversity Team (MS Teams call – 11 June 2024) to discuss project and consider how to address gaps during pre-election period.
- Each Engagement Manager emailed their VCFSE contacts across GM to promote opportunity to get involved and asking to attend groups (May 2024)

- IVF Cycles Project Group (MS Team – monthly) multi-agency group established to support the project
- NHS GM Involvement Assurance Group (Face to face meetings - 11 March 2024 and 8 July 2024)
- IVF Lived Experience Advisory Group (MS Teams meetings: 24 June, 9 July and 22 July 2024).

How engagement with stakeholders will continue
Here you need to explain how you continue to engage throughout the course of the delivery to ensure the measures you take to address any disparity are working.

N/A – engagement and consultation has been completed

Involvement group	**Consultation dates**	**Strengthening actions**
NHS GM undertook pre-consultation engagement activity that is open to all and further targeted work in the localities highlighted as having gaps, if response rates for those localities are low. This was in the form of: • A GM-wide online and paper survey (promoted within localities and with VCFSE) • Promotion on social media channels Following a review of our engagement activities and gaps we have updated future mitigations: During any future period of engagement, we will accessibly involve the **voice of lived experience and/or special**	21 May to 16 June 2024	It should be noted that a General Election was announced by the Prime Minister on 22 May and resulting in a pre-election period from 25 May affected what public bodies can do bodies to adhere to. This impacted on NHS GM's ability to promote engagement activities during the majority of the phase 2 engagement period. Therefore: a) the engagement period was extended to mitigate against this. b) we contacted VCFSE organisations to help widen the reach and promote opportunities to get involved. c) we spoke with LGBT foundation, Action Together Oldham (South Asian population) and NHS GM Equality & Diversity Team for more advise and support to reach more audiences. d) In our promotions with VCFSE and on our website we

interest groups and target participants who have been underrepresented in the survey: including those who are **Black, Asian, Indian and Gypsy/Traveller, Disabled.** If found to be affected, we should undertake **targeted engagement in specific localities (should we reduced number of cycles in certain localities).** This should also include those who are **experiencing financial hardship**. We will also engage with possible future users of IVF services. We will aim to develop further insight prior to any formal consultation. Further details can be found below.		highlighted that we were keen to be invited to groups and highlighted " **Inviting us to your group** – we are especially interested in hearing from faith groups, those from different ethnic backgrounds and people or communities experiencing inequalities" e) We know that some communities prefer alternative communication methods such as Whatsapp or to leave telephone messages, therefore we promoted this service.
Voice of those with lived experience	Timescale July 2024 - onwards	To start to address this, we have established an IVF Cycles Lived Experience Advisory Group to help us with future planning and assist us to consider our Equality Impact Assessment further.

Step 2

Assessing impact and opportunities to promote equality and human rights

6. If you have piloted a project you want to roll out, add here what you learnt about communities not taking up, accessing or having poorer outcomes from it and what you have done to address those disparities.

N/A

7. What barriers have you identified for the different groups listed by your proposals?

Add the impacts in the box next to the group. (e.g. we have found that working age people are not taking up our services because of our opening hour restrictions)

Complete the identified barriers for each group and identify which group you have identified
You should complete each category. If you believe there is no adverse impact, you should put an explanation as to why.

Age • Young • Middle age • Older age	Yes - the IVF Cycles Project is considering the number of cycles for women aged 39 and under. All localities use this age (which is in NICE guidance) and the project is not considering changing this aspect. The fact that there is an age cut off means there is a limited amount of time that couples / women are eligible for NHS funded care. Most seek support having undergone 2 years of regular unprotected sex without conceiving and their pathway of investigations and treatment prior to IVF can take some time, engagement identified on the waiting list for IVF. Usually that pathway of investigations and treatment is through Gynaecology services. Gynaecology is one of the hospital specialties with the greatest demand and capacity challenges across Greater Manchester, and therefore some of the longest waiting times. Across Greater Manchester different services have different challenges and waiting times. The IVF Cycles Project group is considering changes to the number of cycles but not changes to the age cut off – so the total time available to access the NHS offer remains the same. The project group has considered waiting times because the longer these are, the older women will be when they access IVF. National information from the HFEA shows that women are tending to access IVF later in life. May 2024: •Women's most fertile period coincides with the crucial period for becoming established in a career. As a result, many women delay childbearing then some may suffer consequences in struggling to conceive as fertility decreases •Moving from initial NHS funded IVF treatment and then onto self-funded •IVF treatment (possibly with a different provider) may lead to longer waiting time and reduction in patient's fertility. Additional information following additional engagement May/June 2024: •Impact of waiting lists on age and fertility: "With wait times of 3 years at the moment, no wonder women are getting older and older with fertility chances reducing significantly in this time period" •Impact of having one chance of IVF on age: "I am a woman in my thirties who has been trying to conceive for 5 years. I'm terrified of blowing my one chance and it has made me hesitate on when the right time is to seek help"

	•Cost: 1 respondent said that IVF "becomes more expensive as you get older" •Policy: 1 respondent queried why someone aged 40 should be treated differently to a 32-year-old person. Following feedback from our Equalities and Inclusion team we discovered, the average age at which patients in the UK start fertility treatment was just over 35 in 2022, nearly six years older than the average age that women in England and Wales give birth (29.2). Early contact with a GP and referral to a fertility clinic, if needed, will help ensure the chances of success are as high as possible - so we need to consider our cultural competencies in our public health messages to ensure we do not widen disparities, as a result of this work.
Disability Types of impairment can be categorised as physical, sensory, psychosocial, and intellectual. There are several types of barrier that cause exclusion including • Physical • Social/attitudinal • Institutional • Communication Complete which *barriers* you will need to consider in your programme.	Whether or not an individual is disabled is not directly associated with the locality of their GP practice. So a change to a standardised policy will indirectly affect this group. However engagement does show that disabled people may be adversely affected if the number of NHS GM funded cycles is reduced in their locality, so this needs to be considered. Engagement may identify issues that need to be considered during the broader Review of GM Assisted Conception Policy. The impact on mental health of untreated infertility / not being able to have a child was a significant theme identified through engagement. A change in the number of cycles commissioned by the NHS would have an impact. From our initial desktop review of engagement insight, we discovered: •Cancer – there will be a range of medical interventions that result in decreased fertility •Mental health - For people with mental health issues, reducing the number of cycles may have a higher impact •Disability - Evidence suggests that around a third of all disabled adults of working age are living in low-income households. This is twice the rate of that for non-disabled adults. This could impact upon disabled resident's ability to pay for IVF treatment privately. From our engagement activity May/June 2024 we discovered, that for those with certain medical conditions, this meant IVF was their only option of having children. After feedback from our Equalities and Inclusion team we have discovered the following and should consider involving:

	•Women with certain disabilities are more likely to have adverse birth outcomes and experience pregnancy complications, in part because some medications interact negatively with pregnancy. Those with learning disabilities and those living with long term health conditions are often restricted from making choices about their health and childbearing.
Sex Identify any potential adverse impact to men or women.	By nature this service is accessed by women, normally (but not exclusively) by heterosexual couples. Engagement may identify issues that need to be considered during the broader Review of GM Assisted Conception Policy. After feedback from our Equalities and Inclusion team we have discovered, the total fertility rate (TFR) decreased to 1.49 children per woman in 2022 from 1.55 in 2021; the TFR has been decreasing since 2010. (ONS) The ONS data also showed that women are tending to have children later: the fertility rate was highest among women aged 30-34, whereas before 2002 it was higher in the 25-29 age group. A range of views were expressed through the consultation in relation to sex. Some women expressed that they feel the proposals treat infertility as a "women's issue" and that this adds to a broader inequality in health care for women, *"As a woman I have spent my life facing medical gaslighting and having my health needs neglected because of my gender",* some men felt that male infertility is stigmatised and men may be ridiculed when it is discussed.
Race Identify any adverse potential impact on different ethnic groups and identify which ethnic groups you may need to specifically consider.	An individual's race and ethnicity is not directly associated with the locality of their GP practice, so a change to a standardised policy will indirectly affect this group. However, engagement does show that some ethnic groups may be adversely affected if the number of NHS GM funded cycles is reduced in their locality, so this needs to be considered. Engagement may identify issues that need to be considered during the broader Review of GM Assisted Conception Policy. Various specific VCSE groups, some of which represented people from different ethnic groups, were targeted during the consultation. The translation tool on the website was used to translate the consultation information 272 times into Polish (32%), Arabic (13%), Urdu (13%), Portuguese (12%), Chinese (10%), Punjabi (8%), Bengali (6%) and Romanian (6%). From desktop review:

	• There is evidence that we have insight from different ethnicities, but once we have undertaken stakeholder analysis, we will be able to undertake more targeted promotion with people of different ethnicities. • Over recent years, engagement exercises associated with Stockport's IVF services has shown a particularly high rate of engagement by residents of Pakistani heritage – 5.6% of all patients, despite making up just 1.04% of the local population. • Evidence indicates that members of Black, Asian and minority ethnic communities are more likely to live in areas of high deprivation and suffer disproportionate levels of health inequalities. Following liaison with the Lived Experience Advisory Group and our Equality and Inclusion team we have discovered the following: • There are disparities in use and outcomes of fertility treatment in the UK by ethnic group using data from 2017-21. This includes Black people less commonly used fertility treatment and more commonly single compared with other ethnic groups. • HFEA's report "Ethnic diversity in fertility treatment 2021" provides us with key information to consider: • Black people started fertility treatment later than other ethnic groups. • People from ethnic minority backgrounds undergoing fertility treatment are less likely to have a baby, with Black patients having the lowest chances of successful treatment. Whilst overall birth rates from fertility treatment have increased and are highest in patients under 35, Black patients aged 30-34 have an average birth rate of 23%, compared to 30% for Mixed and White patients. • It also highlights that 31% of Black fertility patients have fertility problems related to issues with their fallopian tubes, compared to only 18% of patients overall, with Black patients also starting IVF almost two years later (36.4 years old) compared to the average patient at 34.6 years old. • The report also shows that Black patients experienced higher than average multiple births from double embryo transfers, at around 14% from 2014-2018. • The higher the age of Black IVF patients, the higher prevalence of heart conditions in the Black population means that it is particularly important that risks should be seriously considered prior to using double embryo transfers, as multiple births represent the single biggest risk to both mother and babies. While disparities for Black patients are the most notable, other ethnic groups also have worse outcomes when going through fertility treatment. • Asian patients, who represent a larger proportion of IVF users at 14% whilst comprising 7% of the UK population may struggle to

	access donor eggs if needed. The report shows that 89% of egg donors are White, followed by 4% Asian, 3% Mixed and 3% Black, resulting in the use of White eggs in 52% of IVF cycles with an Asian patient. • Some ethnic groups may be less likely to seek/access clinical care for IVF because of adverse past experiences or community perceptions. Black African and Caribbean communities are high in this cohort. • Some ethnic groups may be less likely to get culturally competent care when they do seek clinician care. This includes Black African and Caribbean and Asian groups and GTR communities but will extend to other ethnicities where there are language or cultural barriers or misunderstandings. • Some ethnicities may experience higher levels of community and familiar pressure and consequential infertility distress. This will include some Asian, African and GTR communities (particularly women). This may also be compounded by religion or belief. • Some people may experience language and cultural barriers related to their ethnicity or disability regardless of whether they are in the above cohorts (e.g. Deaf people and those of Chinese ethnicity).
Religion/ belief Identify any adverse potential impact on different religious groups and identify which you may need to specifically consider.	Someone's religion is not directly associated with the locality of their GP practice, so a change to a standardised policy will indirectly affect this group. However, engagement does show that some religious groups may be adversely affected if the number of NHS GM funded cycles is changed in their locality, so this needs to be considered. Engagement may identify issues that need to be considered during Review of GM Assisted Conception Policy. Various specific VCSE groups, some of which represented people from different ethnic groups, were targeted during the consultation. Some people spoke about religious and cultural sensitivities and barriers which affected how they accessed support for fertility issues <u>From desktop review</u>: No specific engagement insight highlighted. No/limited number of respondents highlighted. Evidence available that localities who undertook engagement shared information with different faith groups on how to get involved. <u>From our engagement activity May/June 2024 and discussions with Equality and Inclusion team, we have discovered the following:</u> • One person who is a practising Muslim told us in the survey that some methods of overcoming fertility (such as surrogacy, donated sperm) are not accessible as they conflict with their beliefs. Therefore, IVF is one of their only options of becoming pregnant.

	After discussion with the EDI team we have learnt that IVF is acceptable in Islam, provided that it is for a married couple and both the egg and sperm come from this couple. Some religious organisations take formal positions associated with IVF. For example: • The Catechism of the Catholic Church states that IVF is "morally unacceptable" due to the destruction of embryonic life, the assault on the meaning of the conjugal act and the treatment of the child as a product not a gift IVF. • For Judaism one of the first commandments of the Torah is to be fruitful and multiply, so generally IVF is supported, and by some quarters strongly encouraged, although there is debate around the morality of certain procedures. Within some religions debate continues and some individuals' personal may differ from the formal position within their religion. People who's religious beliefs mean they do not consider IVF to be acceptable will be adversely impacted by a decision to increase NHS GM funding on IVF (as they have other different healthcare priorities), the opposite is true for people who's religious beliefs mean they consider IVF to be a priority.
Sexual Orientation Identify any adverse potential impact on different sexual orientations and identify which sexual orientations you may need to specifically consider.	Someone's sexual orientation is not directly associated with the locality of their GP practice, so a change to a standardised policy will indirectly affect this group. However, engagement does show that some groups may be adversely affected if the number of NHS GM funded cycles is reduced in their locality, so this needs to be considered. Engagement may identify issues that need to be considered during broader Review of GM Assisted Conception Policy. Specific concerns were raised during the consultation by same sex couples (and single women) regarding access criteria being discriminatory to them because they felt they might have to pay for insemination and the process might take longer for them than for heterosexual couples, whilst outside the scope of the IVF cycles project, it has been recommended that this aspect of the policy will need to be reviewed. <u>Desktop exercise Engagement insight has informed us that</u>: • This may affect same sex couples as they are unable to conceive naturally and may be more likely to require some of the specialist fertility services, which could result in them requiring to self-fund IVF treatment. • LGB patients feel discriminated against by not being eligible for NHS funding for IVF fertility testing.

	• Lack of information of services, rights to treatment as same sex couples known by GPs – means same sex couples may not receive sufficient information to inform help inform patient choice. <u>Additional insight from engagement activity May/June 2024 we discovered</u>: • It was suggested by some that there should be IVF standardisation between same sex couples and heterosexual couples. Some patients felt discriminated against due to their sexuality or being single, which they feel has affected their access to treatment. This has a negative impact on same sex couples. It was also suggested that Intrauterine Insemination funding should be re-evaluated. This has been noted for future reference although it is outside the scope of the review.
Transgender Identify any adverse potential impact on transgender or non-binary people.	Whether someone is transgender is not directly associated with the locality of their GP practice, so a change to a standardised policy will indirectly affect this group. However, engagement may show that this group may be adversely affected if the number of NHS GM funded cycles is reduced in their locality, so this needs to be considered. Engagement may identify issues that need to be considered during broader Review of GM Assisted Conception Policy. 4 respondents to the consultation identified themselves as transgender but no specific transgender issues or insight were highlighted.
Carer status	Whether or not someone is a carer is not directly associated with the locality of their GP practice, so a change to a standardised policy will indirectly affect this group. However, engagement may show that carers may be adversely affected if the number of NHS GM funded cycles is reduced in their locality, so this needs to be considered. Engagement may identify issues that need to be considered during Review of GM Assisted Conception Policy. No specific insight highlighted any issues. 70 people who responded to the consultation identified themselves as carers and several Carers specific support VCSE orgnaisations were targeted for the consultation.
Socio-economic status Identify any adverse potential impact because of deprived communities and identify which	Yes – the IVF cycles group is considering the number of cycles couples / women that will be funded by NHS Greater Manchester. There is an option of self-funding which is dependent on socio-economic status. There is variation across the NHS. Socio economic status and issues were often raised during the consultation. People said that policy changes which reduced the number of NHS GM funded cycles would disproportionately impact those on lower incomes,

communities you may need to specifically consider.	because they would not be able to pay for private IVF. *"Poorer people with limited finances and infertility (which is increasing) will not be able to have children. This is mean".* People also raised: • Saving up causes treatment delays: Patients often need time to gather the money for additional cycles, which may result in long breaks between treatments, potentially reducing success rates due to aging or changes in fertility status. • Emotional Toll of Financial Stress • Added emotional pressure: The financial burden adds another layer of stress to an already emotionally and physically demanding process. • Difficult decisions: Couples or individuals may be forced to choose between financial security and trying to conceive. • Ethical Considerations in Policy • Policies should not assume everyone can self-fund: Reducing access to NHS-funded cycles under the assumption that people can pay privately fails to acknowledge the financial realities of many patients. • Emphasis on fairness: There's a strong desire to design equitable policies that support those who cannot afford private IVF. • Impact on Planning and Readiness • People may need time to plan or recover financially: Delays between cycles due to self-funding needs should be factored into any transition period following a policy change Engagement has shown: • Those from low socio-economic backgrounds would be less likely to afford to self-fund IVF. • Those who considered themselves not to be on low incomes felt they may not be able to afford to pay for additional cycles (some mentioned pressure on personal finances or going into debt) • Saving to be able to self-fund additional cycles may take time – resulting in fertility reducing • Considering friend to be donor and using money on baby once born • Consider moving house to an area where the NHS commission more cycles – which is not an option for all people. Engagement showed GPs were the most common place to go when finding out about NHS funded IVF treatment, but online resources were also very commonly used – digital poverty is a consideration. • GM has a high level of poverty across communities and privately financing treatment may not be possible for many people (eg those on lower incomes/in receipt of benefits). Therefore, would be left

	without choice or children. These people may be negatively affected if number of NHS GM funded cycles is reduced. • It may take those on lower incomes/receiving benefits longer to save for IVF treatment, which may mean their fertility decreases whilst trying to save. • Patients with limited or no capacity to self-fund IVF may be at risk of poorer mental health due to stress, anxiety and worry. • Patients may be confused as to the options available to them, as information provided is confusing and difficult to understand, especially for those with lower literacy skills or if English not their first language. Therefore, they may be negatively affected. • If required to self-fund, women may choose to go abroad to access cheaper IVF, but standards may be different to UK and may result in multiple births - putting increased health risks to mothers and babies. • Additional costs if required to travel further for self-funded IVF. • If the number of cycles were reduced this could have a negative impact on the above groups.
Pregnancy or maternity Identify any adverse potential impact because of pregnancy or maternity.	*By nature, this service has a significant impact on the protected characteristic of pregnancy and maternity and views were reflective from women who were pregnant and those who wish to become pregnant.* - *GM IVF engagement Equality Impact Assessment.* (Protection against pregnancy and maternity discrimination under the Equality Act 2010 only begins when pregnancy occurs, or is deemed to have occurred in the case of IVF).
Marriage /civil partnership This category is only required for employment discrimination matters.	Whether or not someone is married or in a civil partnership is in this group is not directly associated with the locality of their GP practice, so a change to a standardised policy will indirectly affect this group. However, engagement does show that this group may be adversely affected if the number of NHS GM funded cycles is reduced in their locality, so this needs to be considered. Engagement may identify issues that need to be considered during Review of GM Assisted Conception Policy. Within the scope of numbers of cycles there were non but within the wider context female same sex couples would experience challenge if needed to evidence regular sexual activity for a period of 2 years. Specific concerns were raised during the consultation by same sex couples (and single women) regarding access criteria being discriminatory to them because they felt they might have to pay for insemination and the process might take longer for them than for heterosexual couples, whilst outside the scope of the IVF cycles project, it has been recommended that this aspect of the policy will need to be reviewed.

Other Are there other discriminations or disadvantages that you think you need to address?	• **Those who are infertile** - There was concern that patients are being penalised for being infertile and that infertility should be treated like other medical conditions. • **Geography** - If there is a reduction in cycles, patients living in those localities that currently offer more than any new proposed number of cycles could be more negatively affected than those that either stay the same or receive more cycles. If there is an increase in cycles, patients living in those localities that currently offer less than any new proposed number of cycles could be more positively affected than those that either stay the same or receive more cycles. • **Relationship status** – Some patients felt discriminated against due to being single, affecting their access to NHS treatment.

8. Can the adverse impacts you identified be justified and the original proposals implemented without making any adjustments to them? If so, please set out the basis on which you justify implementing the proposals without adjustments.

The current inequity based on locality cannot be justified hence the need to move to a standardised policy across GM. The other adverse impacts not directly associated with the locality of someone's GP practice will not be directly affected by the move to a standardise policy, but may be impacted by other parallel work.

9. Having analysed the initial and additional sources of information including feedback from consultation, is there any evidence that the proposed changes will have a *positive* impact on any of these different groups of people and/or promote equality of opportunity? Please provide details of who will benefit from the positive impacts and the evidence and analysis used to identify them.

Should NHS GM standardise the number of IVF cycles across the whole of GM: • **If changes mean to all localities having 3 IVF cycles:** those living in Bolton, Bury, Manchester, Oldham Rochdale, Salford, Stockport, Trafford, Wigan will see a broadly **positive impact.** • **If changes mean all localities having 2 IVF cycles:** those living in Bolton, Bury, Manchester, Oldham, Trafford will see a broadly **positive impact.** In taking the disparities outlined above into account, a new standardised policy should offer more equitable outcomes for all.

10. Is there any evidence that the proposed changes have *no* equality impacts? Please provide details of the evidence and analysis used to reach the conclusion that the proposed changes have no impact on any of these different groups of people.

No, see above for evidence of disparities.

11. Please provide details of how you will consult and involve communities on the proposed changes. If you do not plan to consult and involve, please provide the rationale behind that decision.

- Evidence of previous engagement undertaken in localities across GM prior to the establishment of this project
- Engagement carried out during this project
- Formal public consultation undertaken across GM as part of this project – targeted at those localities and communities more likely to be impacted

Step 3 – Strengthening your policy plan or project

Please use the table below to document your strengthening actions.

12. What changes are you planning to make to your original proposals to minimise or eliminate the adverse equality impacts you have found?

Please provide details of the proposed actions, timetable for making the changes and the person(s) responsible for making the changes.

Adverse impact	Proposed action	Person responsible

13. Describe here how you could further promote equality of opportunity. What action/s do you recommend and when?

This is where you are taking the opportunity to advance addressing inequalities beyond the mitigations you are putting in place, for example, your mitigations when moving a service to digital provision will be to ensure alternatives are available for those who cannot access digital services. Your opportunity to *further promote* equality with a new digital service would be to extend a service to people from their own home where they had previously experienced physical barriers to reaching your surgery.

N/A Engagement and consultation now complete

14. Describe how you could further promote human rights principles. What action/s do you recommend and when? Please provide details.

For example, if you are putting in place improved access to interpreter provision that may enhance the human rights of those that need it to access public services.

By addressing the known preventable causes of infertility can minimise the need for costly and difficult-to-access treatments, as well as significant and lifelong physical, mental, social, and economic consequences. It can also reduce the far-reaching human rights impact of preventable infertility. We will be conscious to tackle and not exacerbate unwarranted privileging the reproduction of some while dissuading the reproduction of others in our measures to harmonise IVF in GM.

15. Describe how you could further reduce socio-economic disadvantage. What action/s do you recommend and when?

For example, if you are undertaking a focused anti-smoking campaign in areas of high deprivation, you can expect to reduce socio-economic disadvantage.

N/A – Engagement and consultation now complete

16. Describe here how you could further promote social value. What action/s do you recommend and when?

For example, you might be able to offer new jobs or apprenticeships to people struggling to get employment or offer contracts to community led social enterprises to deliver your services.

N/A

Step 4 – Monitoring and review

17. You are legally required to monitor and review the proposed changes after implementation of your strategy or programme to check they work as planned and to screen for unexpected equality impacts. Please provide details of how you will monitor, evaluate or review your proposals and when the review will take place.

What	When	How
TBC once new policy is agreed		

Step 5 – Sign off

Strategy, policy, plan, project or service owner or Work Programme Lead*	
[redacted]	[redacted]
EIA Lead (the person completing this form) This equality analysis has been quality-checked and will be passed to the senior responsible officer for final sign off.	
[redacted]	[redacted]
Director or Senior Responsible Owner * This equality impact assessment has been completed in a rigorous and robust manner and I agree with the actions identified. It will now be progressed and published where required.	
Harry Golby	26 November 2025

*By signing off your EIA you are confirming that you are satisfied that the policy/strategy/project/activity/service has been designed with the needs of different equality groups and communities in mind, and that the groups it is intended to serve will be able to access the service and experience similar outcomes from it.

For records, this EIA will also need to be copied to [redacted] to ensure we can evidence our legal duties to undertake equality analysis. However, the original version must be kept with the project documents and pro-actively used to inform the progress of the work, alongside budget, risk and health and safety monitoring.

NHS Greater Manchester

NHS GM Quality Impact Assessment Tool

This tool requires all 'business decisions' to undergo an assessment to identify any potential impacts, positive, negative or neutral on quality or patient/service user safety. The following assessment screening tool will require judgement against all listed areas of risk in relation to quality/risk. Each proposal will need to be assessed whether it will impact adversely on patients /staff/organisations.

Quality Impact Assessment Tool

This assessment tool should be completed in conjunction with an Equality Impact Assessment and used to help consider the relevant sections.

Insert your assessment as positive (P), negative (N) or neutral (N/A) for each point under the relevant sections and record the rationale to support this conclusion within the comments section. If the assessment is negative, you must also produce a risk score for that point.

Title of scheme/project/programme:	Standardisation of NHS GM In Vitro Fertilisation (IVF) Funded Cycles		
SRO/ Management Executive Lead	harry.golby@nhs.net - Harry Golby – Associate Director of Delivery and Transformation (Salford)/SRO		
Author:			
Brief Summary of scheme/project/programme:	A review of IVF Cycles for Greater Manchester. The GM IVF Cycles Project aims to ensure standardisation of provision across all 10 localities in respect of the number of IVF cycles commissioned by NHS GM. A single GM Assisted Conception Policy is currently in place and is consistent throughout NHS GM in every respect other than the number of cycles – from 1 – 3 cycles. A recommendation to standardise to a 1 cycle policy is to be considered by NHS GM's Board.		
Area of Quality	P / N or N/A	Comments (reasons for identifying impact as positive negative or neutral)	Mitigations
Duty of Quality • Compliance with NHS constitution • Impact on partner organisations • Impact on organisations duty to safeguard children and vulnerable adults	N/A		

• Impact on other services within the organisation Any other risk indicators relevant to the Duty of Quality:			
Patient Safety • Impact on patient safety • Impact on avoidable harm • Impact on reliability of safety systems and processes • Impact on clinical workforce levels, competencies, and experience • Impact on treatment times and procedures • Impact on safeguarding • Impact on systems and processes for ensuring that the risk of HCAIs is reduced • Impact upon clean and safe environments Any other risk indicators relevant to patient safety:	Negative Neutral	Standardising to a 1 cycle policy is likely to have avoidable harm impact – levels of anxiety, psychological and emotional distress may increase, especially if the 1 NHS GM funded cycle is unsuccessful. Standardising to a 1 cycle policy is likely to have no / a marginal impact on clinical workforce levels – multiple factors (including number of NHS GM funded cycles) affect total IVF provision and therefore workforce.	Clear and transparent patient and stakeholder communications to set expectations. Change only to apply to new referrals to IVF clinics and not those people already receiving IVF care. N/A
Peoples Experience • Impact on patient informed choice and autonomy • Impact on patient access • Impact on dignity, respect, and compassion • Impact on patients self-reported satisfaction on national/local surveys/FFT • Impact on patients self-reported experience through the complaints process/PALS contacts • Impact on patients waiting times • Impact on provision of individualised care	Negative Neutral	Standardising to a 1 cycle policy has the potential to lead to patients reporting a poorer experience and increase in numbers of complaints / PALS enquiries/ appeals, etc. Patients may be distressed, perceive the change to be unfair, feel it is an indication of a lack of compassion from NHS GM or feel let down that NHS GM is not fully implementing NICE guidance. Formal or informal mechanisms may be used to express these feelings. Standardising to a 1 cycle policy is likely to have no / a marginal impact on IVF waiting times – multiple factors (including number of NHS GM funded cycles)	Clear and transparent patient and stakeholder communications to set expectations. Communications to be clear that decision is by NHS GM, not staff in IVF clinics – so to minimise impact on patient / provider relationship. Change only to apply to new referrals to IVF clinics and not those people already receiving IVF care. N/A

• **Impact on patients carers** Any other risk indicators relevant to patient experience:		affect total IVF demand and therefore wait times.	
Clinical effectiveness • Impact on provision of NICE compliant treatment • Impact on the implementation of evidence-based practise • Impact on clinical outcomes • Impact on clinical leadership • Impact on the promotion of self-care • Impact on clinical engagement Any other risk indicators relevant to clinical effectiveness:	Negative	NHS GM's current Assisted Conception policy is compliant with all aspects NICE guidance CG156 except for the number of cycles commissioned. Currently the NICE recommendation of 3 cycles is not available to patients from 9 of the 10 GM localities. Standardising to a 1 cycle policy will mean the NICE recommendation is not available in all 10 localities, so it would have a negative impact on provision of NICE compliant treatment but only in one locality.	N/A
Non-Clinical/operational impact • Impact on cost effectiveness • Impact on infrastructure • Impact on staff satisfaction and welfare • Impact on the public perception of the organisation • Social value impact	N/A		
Equality A full equality assessment must also be undertaken		Separate Equality Impact Assessment has been undertaken	

Name of person completing initial assessment:	[redacted]
Role	
Signature	
Line Manager approval	Harry Golby
Name & Role	SRO
Date of Assessment	November 2025
Signature	HG
Date	6 January 2026

NHS
Greater Manchester

Greater Manchester Tripartite Agreement

Part of Greater Manchester Integrated Care Partnership

Integrated Care Board

21 January 2026

Report information

Required information.	Details.
Title of report.	Greater Manchester Tripartite Agreement
Author.	Helen Simpson, Tripartite Agreement Director – NHS GM, GMCA, GM Housing Providers
Presented by.	Charlotte Bailey, Chief Strategy, People and Partnerships Officer – NHS GM
Contact for further information.	Helen Simpson, Tripartite Agreement Director – NHS GM, GMCA, GM Housing Providers Helen.simpson11@nhs.net

Executive summary.	The GM Tripartite Agreement connects NHS GM to GMCA, Local Authorities and GM Housing Provider partnership in a joint plan to take action on housing, health and care. This paper sets out an overview of the refreshed Tripartite Partnership Agreement, developed through 2025, to update the previous Agreement and ensure it remains relevant to the changing strategic context for all partners, as an important delivery mechanism for GM system priorities. The refreshed strategy captures six updated workstreams to be delivered jointly across the partners, capturing the contributions to the Greater Manchester Strategy and key system priorities such as Housing First and Live Well. A component part of the refreshed Agreement is development of a Locality Tripartite Framework, which looks to embed the benefits and opportunities of collaboration in local systems and respond to locally identified priorities. The intentions and practical activity captured within the Tripartite Agreement actively support delivery of the NHS GM five-year strategy, the Sustainability Plan and set out practical opportunities to progress the overall NHS GM “left shift” towards prevention and early intervention.
The benefits that the population of Greater Manchester will experience.	Securing the health benefits of improved housing supply, improved housing quality and a greater range of housing with support.
How health inequalities will be reduced in Greater Manchester’s communities.	NHS GM (and HSCP) has historically recognised the housing sector is uniquely positioned to play a key role in our ambitions for health creation and improving health inequalities. We have a long-standing relationship with GMCA and the housing sector and history of joint working to deliver better outcomes for GM residents.

The decision to be made and/or input sought.	The Integrated Care Board is asked to: 1. Approve the GM Tripartite Partnership Agreement 2. Agree to NHS GM becoming a signatory alongside GMCA and GM Housing Providers
How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	This work underpins the Strengthen our Communities and Help People Stay Well and Detect Illness Earlier missions of the GM ICP strategy. It responds to BAF Risk SR3 “Widening health inequalities and continued poor health outcomes due to a reduced focus on prevention for the GM population”
Key milestones.	The Agreement was approved at the full GMCA meeting in November 25 and GM Housing Provider CEO Board in December 25. A delivery plan underpins the final Agreement document, aligned to the GMS Delivery Plan, setting out key delivery milestones for each partner. Year one deliverables are contained within the full Agreement document.
Leadership and governance arrangements.	Oversight of the Tripartite Agreement is supported through nominated leads from the three parties and through the Tripartite Agreement Core Group. Current NHS GM conversations on connectivity with the housing system are coordinated through the NHS GM Tripartite Agreement Steering Group. The Senior Responsible Officer overseeing delivery is Charlotte Bailey.

Engagement* to date. ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	Engagement on the new Agreement has been wide ranging across the three partner organisations. From an NHS GM perspective this has included Strategy, Population Health, Adult Social Care, Deputy Place Leads, MH Trusts and discussion at two previous Executive Committee meetings. It has also included engagement with the GM Mayor and other GM political leaders. Engagement in Localities has focused on Locality Boards, Health and Wellbeing Boards and local Strategic Housing Partnerships. The Agreement was approved at the full GMCA meeting in November 25 and GM Housing Provider CEO Board in December 25.
Financial or Legal Implications	N/A

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

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

Table 2: Assurance needed about the document.

1. Introduction/Background

1.1. The GM Tripartite Agreement is a joint plan between Greater Manchester Combined Authority, NHS Greater Manchester Integrated Care and Greater Manchester Housing Providers to deliver positive change focused on integrated solutions to challenges centred around housing, health and social care.

1.2. The condition, suitability, affordability and security of where we live impacts mental and physical health and wellbeing. Interventions to improve the quality and suitability of living environments, and that ensure we have enough of the right homes in the right places, are effective in keeping our residents healthy and preventing, delaying or reducing demand on wider public services. A healthy, safe place to call home is the cornerstone of a healthy, happy life.

1.3. First published in March 2021, the Agreement has been developed in recognition of the impact good housing can have on health and wellbeing. It brings together joint ambitions and priorities, and formalises how the partners align expertise, resources, influence and capacity to deliver better outcomes, in a more integrated and effective way.

1.4. The activity and relationships connected to the Tripartite Agreement continue to be strategically significant and provide important delivery mechanisms for the Greater Manchester Strategy, particularly Housing First and Live Well. For GMCA and Local Authorities, the Agreement provides the formal mechanism to bring key partners much closer to delivery of housing and growth priorities and to align their resources and expertise alongside ours.

1.5. Throughout the last nine months, the Tripartite Partnership Agreement and its delivery plan have been refreshed to reflect the updated strategic context all partners are working in and to ensure that the work we do together remains relevant and reflects current system requirements.

1.6. This paper sets out an overview of the Tripartite Agreement (included as Appendix A) alongside the workstreams and activity that will be jointly taken forward to deliver the Agreement.

2. Tripartite Agreement Summary

2.1. The refreshed Tripartite Agreement reflects extensive engagement with colleagues from across housing, health and social care, working at Greater Manchester and locality levels, to capture the extensive work and collaboration already underway and also new opportunities and areas where we will challenge one another to go further. It clearly sets out joint outcomes, workstreams and actions that will be taken forward by all partners.

2.2. The refreshed Agreement describes joint work on priorities such as delivery of 10,000 truly affordable energy efficient homes, temporary accommodation, improvements to existing homes, falls prevention and the role of housing within Live Well. It sets out in practical terms the areas where GMCA can benefit from collaboration and joint delivery and allows us to secure the health benefits of improved housing supply, improved housing quality and a greater range of housing with support.

2.3. The Agreement is framed around a set of jointly agreed outcomes and six workstreams, outlined below. Each workstream includes activity that requires contributions from all three partners, with the intention to align activity in a way that allows for delivery against multiple priorities.

Our Joint Outcomes

By continuing to align our collective resources, expertise and capability we will work together to support delivery of **'A Healthy Home for All'.** We will contribute to this through:

- Better collaboration in neighbourhoods across health, housing, care and VCSFE sector through Live Well.
- More homes that support good health.
- More social rented homes built in the right places.
- Less reliance on temporary and crisis accommodation.
- More supported housing options for people who need them.
- Fewer people in hospital when they don't need to be because they are supported to live independently at home.

Tripartite Agreement Workstreams

- Ambition to deliver 75,000 new homes
- Supported and Specialist Housing
- Housing Quality and Retrofit
- Home Improvements and Adaptations
- Homelessness and Inclusion Health
- Support to Live Well at Home

2.4. The refreshed Agreement also takes the opportunity to speak to local action across housing, health and care, in a Locality Tripartite Framework that will be advanced throughout the life of the document. It describes activity that may be beneficial to be pursued at a Locality level, looking to replicate the Tripartite relationships and in support of delivering local priorities across all partners. Establishing a version of the Tripartite Agreement locally has the potential to bring forward a unique set of opportunities that can only be progressed at Place, such as joint commissioning and investment, and integration of delivery into neighbourhood models.

3. Delivery and Governance

3.1. On approval of the new Tripartite Agreement by all partners, the delivery plan that underpins the six workstreams will be reviewed to exactly reflect the intentions and deliverables in the Greater Manchester Strategy Delivery Plan. This strategic alignment will ensure that all partners are clear where activity directly contributes to the delivery of the Greater Manchester Strategy.

3.2. An overview of the delivery activity expected in year one and the longer-term delivery aims of the Agreement can be found on pages 10 – 11 of the Agreement document.

3.3. Delivery of the Agreement will be overseen by the Tripartite Agreement Core Group, membership of which reflects senior leaders from each of the three partner organisations.

3.4. Reporting on delivery against the Tripartite Agreement will be routed through GM Reform Delivery Executive, NHS GM Executive Committee and GM Housing Providers CEO Group.

4. Recommendations

4.1. The NHS GM Integrated Care Board is asked to:

4.1.1. Approve the GM Tripartite Partnership Agreement

4.1.2. Agree to NHS GM becoming a signatory alongside GMCA and GM Housing Providers.

Greater Manchester Tripartite Partnership Agreement 2025 - 2029

1. Introduction

Greater Manchester Tripartite Agreement - A Healthy Home for All

The Greater Manchester Tripartite Agreement is a joint strategic plan between Greater Manchester Housing Providers, Greater Manchester Combined Authority, and NHS Greater Manchester Integrated Care to deliver positive change focused on integrated solutions to challenges centred around housing and health.

As part of our Greater Manchester Strategy, we have committed to creating a healthy, safe, warm space for everyone to call home.

The condition, suitability, affordability and security of where we live impacts mental and physical health and wellbeing. Interventions to improve the quality and suitability of living environments, and that ensure we have enough of the right homes in the right places, are effective in keeping our residents healthy and preventing, delaying or reducing demand on wider public services. A healthy, safe place to call home is the cornerstone of a healthy, happy life.

Published in March 2021, the first Agreement was developed in recognition of the impact good housing can have on our health and wellbeing. It brought together joint ambitions and priorities, and formalised how the three partners aligned expertise, resources, influence and capacity to deliver better outcomes, in a more integrated and effective way. Importantly, it enshrined the relationship across the partners in a formal commitment to collaborate, building on the prior four years of joint working.

This refreshed version of the Tripartite Agreement resets the strategic commitment across the partners to taking joint action on housing, health and care, building on the collaborative work undertaken to date, focused on enabling Greater Manchester residents to live healthy, independent lives. This new Agreement brings a focus on growth as a key part of creating the conditions for good health and describes how practically we will work together to deliver against the Greater Manchester Strategy, Housing First and Live Well.

This new Agreement also takes the opportunity to speak to local action across housing, health and care, in a Locality Tripartite Framework that will be advanced throughout the life of the document. It describes activity that may be beneficial to be pursued at a Locality level, looking to replicate the Tripartite relationships and in support of delivering local priorities across all partners. Establishing a version of the Tripartite Agreement locally has the potential to bring forward a unique set of opportunities that can only be progressed at Place, such as joint commissioning and investment, and integration of delivery into neighbourhood models.

2. Partner profiles

Greater Manchester Combined Authority (GMCA) is one of the country's most successful combined authorities and made up of the ten Greater Manchester Councils and Mayor, who work with other local services, businesses, communities and other partners to improve the city-region. The ten councils (Bolton, Bury, Manchester, Oldham, Rochdale, Salford, Stockport, Tameside, Trafford and Wigan), have worked together voluntarily for many years, prior to recent devolution agreements, on issues that affect everyone in the region, such as transport, regeneration, and attracting investment.

GMCA gives local people more control over issues that affect their area. It means the region speaks with one voice, has the ability to manage local devolved funding to drive the best outcomes for Greater Manchester and can make a strong case for further resources and investment. Our vision is to create the conditions for a thriving city region where everyone can live a good life.

Greater Manchester Housing Providers is a partnership of 26 Registered Providers who form a coalition of the willing to deliver and manage safe, warm and affordable homes across Greater Manchester. Together we own more than 260,000 homes, one in every five people live in a home provided by our partnership.

We are currently delivering more than 2,600 new homes per year and plan to do even more over the next five years. Together we are planning to invest more than £3billion into our existing homes, ensuring all our customers live in a property that meets the Decent Homes Standards. GMHP contribute at least £1.2bn in GVA to the Greater Manchester economy and support more than 28,000 full-time jobs across local communities.

GMHP fully support the Greater Manchester ambition to solve the housing crisis through a Housing First city region. GMHP engage through the Tripartite Agreement and with other stakeholders to find creative solutions and to make delivering positive outcomes for all Greater Manchester citizens as easy and effective as possible.

NHS Greater Manchester (NHS GM) is the Integrated Care Board for Greater Manchester, and is responsible for making decisions about health services across Greater Manchester and in the ten boroughs and cities.

The creation of NHS Greater Manchester, and the Greater Manchester Integrated Care Partnership, on 1st July 2022 gives health and care partners the opportunity to accelerate the journey to improve our population’s health and wellbeing we have been on for the last five years, and so play its part in delivering the city region’s vision.

This involves working closely with all partners and communities who can contribute to improving health and tackling inequalities. The outcome will be a city region where everyone has a fair opportunity to live a good life; has improved health and wellbeing; experiences high quality care and support where and when they need it and where we all work together to make a difference now and for the future.

NHS GM (and previously the Greater Manchester Health and Social Care Partnership) has a strong track record of acting across the breath of wider determinants of health, with a level of experience, knowledge and sophistication that is beyond many ICB peers and that optimises the unique characteristics of the Greater Manchester system.

3. Why our collaboration is important

The Tripartite Agreement provides the formal mechanism for GMCA, NHS GM and GM Housing Providers to come together as strong and capable partners, united around a clear shared commitment to deliver transformative change. As one of the most mature and progressive public sector partnerships in the country, we are committed to collaborating where we believe we can impact on the health and wellbeing of Greater Manchester residents, through housing - creating a healthy, safe, warm space for everyone to call home. . This unique Agreement brings the three partners together to develop delivery mechanisms for specific outputs that are critical to achieving the objecitves set out in the Greater Manchester Strategy.

Home is the place where many of the building blocks for a good life are created. However, for some, the home or housing circumstances are a driver of poor health and this can be for a number of reasons, which can in turn, lead to greater demand for health, social care and other public sector services. Aligning our priorities for housing and health at a strategic level presents the opportunity to integrate our delivery of services for households whose home is adding to the day to day challenges they face.

Exposure to indoor cold suppresses the immune system and increases the risk of cardiovascular, respiratory and rheumatoid diseases as well as hypothermia and poorer mental health. Cold homes are estimated to be responsible for more than a fifth of excess winter deaths each year.

The respiratory effects of damp and mould in the home can cause serious illness and, in the most severe cases, death, with older people and children the most at risk. Improvements to the condition of homes have been shown to have a number of positive impacts on health, including lower rates of mortality, improved mental health and lower rates of contact with GPs.

Homes with poor safety levels and hazards can lead to preventable falls or other injuries. In Greater Manchester, falls account for around 8% of all hospital admissions for people over 65, costing an estimated £250m per year. The provision of home improvements and adaptations are cost-effective interventions that support people to live independently and reduce the risk of falls in the home. Improving the quality, warmth and energy efficiency of homes in Greater Manchester, through our Housing First commitments, will contribute to mitigating these risks to health, particularly for groups such as older people and children.

Research undertaken on behalf of NHS GM assessing the return on investment in prevention demonstrated that interventions addressing social determinants of health were found to have the highest median ROI, with the highest overall being from adapting homes where a serious fall is otherwise likely to occur.

It is not only the physical fabric of our homes that impacts on our health and wellbeing. Living in any precarious housing circumstances including homelessness, temporary accommodation, overcrowding and housing insecurity, constitutes a risk to health. Inability to meet mortgage or rent payments, or spending a high percentage of income on housing costs can impact negatively on mental health and ability to pay for other necessities such a food and fuel bills.

People experiencing homelessness face significant health inequalities and poorer health outcomes than the rest of the population. They face multiple barriers to accessing health and social care services, which can address through embedding an Inclusion Health approach to service delivery.

The combined impact of poor housing is estimated to cost the NHS in England at least £1.4bn per year[1].

In Greater Manchester, we plan to deliver more homes and improve the ones we have, through our Housing First approach, respond to many of these problems and begin to tackle the difficult issues where housing and housing circumstances are impacting on the health and wellbeing of Greater Manchester residents. Ensuring access to good quality, truly affordable homes in the right places, that promote independence and good health through access to green space, amenities and transport, provides the foundation to ensure that people are able to live healthy lives.

The Greater Manchester and national focus on delivery of new homes is an important part of this response and the Tripartite partners have clear, collectively agreed priorities on the numbers and types of homes we want to deliver. Many issues in the housing market such as unaffordability, lack of available properties, lack of 'flow' through the market, lack of accessible and supported homes, are driven or exacerbated by undersupply. Fundamentally, more homes are needed to increase capacity in the housing market which in turn will increase choice, affordability and mean that we are able to make the best use of the housing we have.

Significantly increasing the proportion of social rented homes will help to alleviate pressure on Local Authority housing demand and consequently the cost burden of Temporary Accommodation, with GMHP committed to delivering many more social rented homes to meet our needs. However, delivery of social rented homes, and truly affordable energy efficient homes in particular, presents a financial challenge in terms of viability, with significant public subsidy currently required to offset the costs. The new Social and Affordable Homes Programme will be the route to much of this required investment, with GMCA influence over how the programme is spent to build the homes that we need. Implementation of a new approach that delivers this step change in delivery will be complex and require system change across the partners, local authorities, developers and the development community. This requires strong system leadership which the Tripartite Agreement seeks to underpin.

Effective partnership arrangements between GMCA, Local Authorities and housing providers are crucial to making the most of the flexibilities afforded through Devolution to drive delivery of more of the homes we need.

Demand consistently outstrips supply of supported and specialist housing in Greater Manchester across a range of populations, from people experiencing homelessness to people in hospital settings with very complex needs. Upscaling and improving the supported housing offer is integral to delivering better outcomes and promoting independence for some of our most vulnerable residents, while also reducing reliance on more expensive institutional care.

Supporting people to live healthy, independent lives, with access to everyday support in their neighbourhoods will be delivered through our Live Well approach to public services. Embedding a culture of prevention and building on our social, relational and community assets in neighbourhoods is a core part of this model. As we start to move health and care towards people's homes and into neighbourhoods, the importance of a safe, secure and healthy home cannot be understated as part of a core preventative offer. Effective collaboration between housing and Live Well is crucial to ensuring people can be supported to address their housing needs and that housing providers and services are an integral part of joint, place-based working.

[1] Building Research Establishment (2021). 'The Cost of Poor Housing in England'

With all partners working together, we have a once in a generation opportunity to tackle spatial, demographic and socio-economic inequalities. The collaborative work taken forward through the Tripartite Agreement is an important part of this systematic approach to put equality at the heart of all of our plans and embed inclusive practices in everything we do.

4. Strategic context

This refreshed Tripartite Agreement lands at an optimistic time for the housing sector, with a supportive national government position demonstrated through a series of commitments, financial and otherwise, that will support delivery of new homes and improvement of existing homes. It also lands during a period of transition for NHS GM, responding to the nationally mandated changes to Integrated Care systems, although with a welcome shift towards the preventative activity we know keeps people living well at home, and away from crisis responses in hospitals.

This section sets out some of the key Greater Manchester documents and programmes that have shaped the content of the Agreement and that the Delivery Plan provides a direct response to. One of the strengths of the Tripartite Agreement is that it provides the mechanism to bring partners much closer to delivery of these Greater Manchester strategies and to target the strength of collaborative action to delivery of the priorities and pledges in those strategies.

Greater Manchester Strategy

The Greater Manchester Strategy 2025 – 2035 sets out a collective vision for the next decade to see a thriving city region where everyone can live a good life. Greater Manchester is only successful if
every part of our city region and every person in our city region is successful.

With all partners working together, we have a once in a generation opportunity to tackle spatial, demographic and socio-economic inequalities, and create opportunities for everyone of every age and place to live well. Growing the support, control, connections and resources people need to lead a healthy, happy life, fulfilling their potential and sharing in success. This means public services working in a very different way – led by communities and supported by enabling systems.

We will achieve our vision by always focussing on two interlocking areas: growing our economy and making sure all our people can live well.

We will do this through a series of workstreams and pledges, which, together, will fix the foundations in life, make us a greener and more equal city region, help grow our economy and make sure everyone can live well.

From a housing perspective the goal is ‘a healthy home for all’. This means that everyone will live in a good, warm, safe place they can call home. We will have built new homes and improved existing ones, driven up standards for renters, reduced the number of people living in temporary accommodation, and ensured residents have the support they need to access, improve and retain a decent, affordable home.

Putting health at the heart of Greater Manchester 2023 – 2028

This five-year strategy sets out how NHS GM will work with its partners to improve the health of the people of our city-region. This means high quality care from health and care services that work together and are sustainable, but also a shift to a social model, which looks to create the conditions for people to live good lives where they can stay healthy and independent, reducing the the chances of them getting ill and needing medical treatment.

A series of missions and ways of working set out how the strategy will be delivered at different geographical levels – Greater Manchester, Local Place and Neighbourhoods – with action that responds to health system challenges, access to services and improves the health of residents.

The strategy recognises the importance of working alongside partners to improve population health and maximise influence on the wider determinants, taking a 'health in all policies approach', and in moving to a model of care closer to home. This means that instead of waiting for people to fall into crisis or for existing problems to escalate, we will be proactive, investing in prevention, early intervention and community-led health, care and support. In support of this, the 'Strengthening Communities' mission speaks to joint action that builds on strong relationships with the housing sector, including on homeless healthcare and supported housing.

Sat alongside the NHS GM strategy, a national 10-year plan for the NHS has been published that reinforces the importance of prevention and care outside of hospital settings as the things that will improve the NHS. The 10-year plan also sets out a specific proposal for Greater Manchester to become a national Prevention Demonstrator, giving more control and flexibility to deliver a new approach to public services, through exploring opportunities to pool budgets and reprofile public service spending towards prevention, that focusses on preventing ill health and worklessness.

Housing First

Housing First is taking a new approach to solving the housing crisis in Greater Manchester, bringing together all partners across the public and the private sector to collaborate to achieve the housing and economic growth the city region needs. We recognise that our residents cannot be expected to have a good life without a good home.

In order to achieve the bold Housing First ambitions set out in the Mayor's manifesto – and in support of the Government's national ambitions – it is clear that we cannot continue with business as usual in the housing system. The housing crisis is complex, multi-faceted and falls across the remits of multiple public sector organisations at local and national level, so it follows that progress will only be made with a radical, structured and coordinated approach, with multiple connected interventions rather than a small number of 'silver bullets'.

Success in tackling the housing crisis is important in itself, but will also enable us to maximise our contribution to economic growth, relieving cost pressures on our local authorities through more targeted, strategic upstream interventions.

Alongside a national long-term housing strategy expected in October 2025, GMCA is developing a roadmap that points to how we can rebuild, rewire and restore the housing system in Greater Manchester, and blaze the trail for others to follow. It focuses on three key pillars:

- Supply: Working at Greater Manchester level to offer direct and indirect support to drive the delivery of housing supply to ease the housing crisis and contribute to economic growth, including particularly developments which bring forward or enable the construction of TANZ homes and new specialist and supported housing. This includes a plan to deliver 75,000 new homes over the course of this parliament.

- Standards: Working at Greater Manchester level to support the development and delivery of interventions to ensure existing homes are safe, secure, healthy and affordable across all tenures.

- Support: Greater Manchester level activity that transforms how residents are supported to live healthy, independent lives at home, that integrates services and improves ways of working, delivering better outcomes and reducing costs within wider public services. This is integral to and will be closely aligned with the Live Well model and a clear articulation of the housing sector role in prevention.

Live Well

Live Well is Greater Manchester's pioneering new way of enabling people to live healthy lives, shifting spending and effort from crisis to prevention and creating the conditions for people to thrive, whatever their age and wherever they live. Through Live Well, Greater Manchester is reimagining support from the ground up, bringing together the NHS, councils and voluntary groups to provide joined-up support in every neighbourhood - information and advice, volunteering opportunities, , clubs, classes and events, all based in community centres, gardens, cafes and other local places.

The focus of Live Well is on early investment in people and the foundations that support them – from good homes and work to policing and criminal justice, safe and welcoming neighbourhoods to affordable public transport, safe spaces for young people and community spaces to access to nature. Live Well Centres and Spaces, connected to clear offers of support, will enable us to respond better to the needs of individuals and communities, improve outcomes for our people and tackle longstanding health, social and economic inequalities and reduces pressure on public services.

5. Our Joint Outcomes

By continuing to align our collective resources, expertise and capability we will work together to support delivery of **'A Healthy Home for All'.** We will contribute to this through:

- Better collaboration in neighbourhoods across health, housing, care and VCSFE sector through Live Well.
- More homes that support good health.
- More social rented homes built in the right places.
- Less reliance on temporary and crisis accommodation.
- More supported housing options for people who need them.
- Fewer people in hospital when they don't need to be because they are supported to live independently at home.

These outcomes translate to specific outputs that support delivery of the Greater Manchester Strategy Delivery Plan, with a summary below. These are articulated as a series of overarching system shifts that together we will deliver or contribute to, and specific actions to progress against these that can be expected over the first 12 months of the Agreement.

On signing of this Agreement, this will be further developed into a one and five year delivery plan, aligned into the Greater Manchester Strategy Delivery Plan.

System shifts

- 10k Truly Affordable Energy Efficient homes delivered by 2030.
- Building more social housing than we are losing through Right to Buy by 2027.
- GMHP delivering new homes that specifically meet the needs of households in Temporary Accommodation.
- Supported Housing pipeline of at least 10% of the Social and Affordable Homes Programme.
- Referral pathways in 10 localities to improve homes where they are negatively impacting health of residents.
- All 26 GMHP members signed up as full members of the Good Landlord Charter.
- Consistent provision of preventative home improvement and adaptation services in 10 localities.
- Housing Provider integration into the Live Well optimum neighbourhood model in 10 localities.
- Increase the employment rate in social housing residents from 44%.

Year 1 activity – progress measures towards the system shifts

- At least 3000 new homes per annum delivered by GMHP partners.
- Approvals and ‘start on site’ of social housing units through the Social and Affordable Homes Programme, to increase year on year.
- Greater Manchester strategic vision and principles for Supported Housing established.
- Delivery through the Complex Needs programme of an additional 9 new housing schemes to support 25 people out of hospital settings, taking the total to 23 schemes and 75 people supported.
- Launch of the Good Landlord Charter social housing framework.
- At least 900 homes retrofitted through the GM Warm Homes:Social Housing Fund programme and GMHP.
- Continuing delivery of at least 1,900 warm homes offers to people with long term health conditions.
- Greater Manchester Rightsizing framework established.
- GM Housing Provider Live Well offer and interactive map of services and assets across every neighbourhood.
- Health and Housing research model completed, connecting health outcomes to housing conditions to inform our joint work.
- Increased uptake of employment and skills support among GMHP residents.

6. Delivery in collaboration

Delivery against our joint outcomes is through a series of themed workstreams that capture the practical commitment from each organisation to align its capacity, expertise, resources and influence to deliver against jointly agreed priorities. Our programmes are focused on taking action, Recognising that we are able to achieve much more through our collaborative advantage. The workstreams, actions and deliverables in the Tripartite Agreement are integrated into Housing First, cross cutting into Live Well, and driving forward the pledges set out in the Greater Manchester Strategy.

- **An ambition to deliver 75,000 new homes**
- **Supported Housing**
- **Housing quality and retrofit**
- **Home improvements and adaptations**
- **Homelessness and Inclusion Health**
- **Support to 'Live Well' at home**

Each of the workstreams captures joint work already underway and areas where we challenge one another to go further. They set out activity that requires contributions from all three partners and alignment of these actions in a way which allows for delivery against multiple priorities. An outline Delivery Plan can be found at Appendix 1.

The aim of this collective activity is to set out practical approaches towards a model of prevention and upstream support, reducing public sector demands and costs. Whether this is joint responses to Temporary Accommodation or discharge pressures within the NHS, the work we do together demonstrates the effective preventative power of good quality housing.

An ambition to deliver 75,000 new homes

The challenge

We lack the housing we need to make sure all those who want to grow up, get on and grow older in Greater Manchester have a good safe home. Many issues in the housing market such as unaffordability, lack of available properties, lack of 'flow' through the market, lack of accessible and supported homes, are driven or exacerbated by undersupply. Fundamentally, more homes of all types are needed to increase capacity in the housing market which in turn will increase choice, affordability and make the best use of the housing we have.

We also need the right skills and workforce to deliver the homes that we need, which will require investment and a strategic approach to the development of skills and training required across all aspects of delivering new homes, including new methods of construction and net zero.

Within this, the shortage of social and affordable housing is clearly evidenced in Local Authority housing systems, with 90,301 households on housing registers across Greater Manchester and 36% of these with priority through a reasonable preference category. Numbers of homeless households and those in temporary accommodation are also increasing. Between January and March 2025, 5,627 households were assessed as owed a homelessness duty. On the 31 March 2025 there were 5,915 households in temporary accommodation, including 8,651 children.

How we will respond

With the right national support, Greater Manchester can build 75,000 new homes by 2030, including 10,000 truly affordable energy efficient homes. The role of GMHP partners is central to the supply of new social homes for Greater Manchester and the Agreement aligns their delivery capacity to these ambitious plans. GMHP partners have an ambition to deliver as many new homes as possible, thinking differently approaches to investment and delivery. The GMHP partnership have committed to delivering at least 3000 new homes per year, an increase of at least 50% from previous years, with at least 60% of these homes for social rent to redress the balance of those lost through the Right to Buy.

We are committed to building more of the homes our residents need, including single units, family homes and homes that are accessible and inclusive. This will be supported through making best use of flexibilities, investment and powers afforded to Greater Manchester through devolution, including a new relationship with Homes England. It will also enable investment in neighbourhoods through innovative approaches to regeneration.

Greater Manchester is committed to building on the development of the MBacc and expanding our role in technical education and boosting construction skills. This will help support our Growth Pipeline as we seek to build more affordable homes for our residents. We will work through GMHP and their supply chains to improve the apprenticeship offer and unlock more opportunities to build skills and access good quality work.

Supported Housing

The challenge

Supported housing enables delivery of better outcomes and community-based living solutions for some of our most vulnerable residents. It promotes independence and prevents reliance on more expensive institutional care, with the ability to avoid significant costs for the health and care systems. The need for supported housing across a range of cohorts is significant and is growing, without the system conditions to deliver at scale.

Delivering supported housing is expensive and requires long term commissioning of care to support and de-risk new delivery and encourage housing providers to commit to increasing supply. In many cases it requires a variety of capital investment, alongside access to low or nil-cost land to make schemes financially viable. The cost avoidance realised in the health system through effective supported housing provison does not flow back into the sector to enable increased delivery.

The introduction of the Supported Housing (Regulatory Oversight) Act, while welcome in providing much needed regulation in some parts of the supported housing market, risks good, experienced providers exiting the market due to the additional burdens placed upon them.

How we will respond

We will deliver more supported housing, at least 10% of the Social and Affordable Homes Programme, with the right strategic intentions to enable delivery of multiple priorities across the partnership. This will include; support with patient flow, solutions to Out of Area Placements, and reducing the risk of admissions to hospital and residential settings by focusing on preventative care provided at home.

We will do this by taking action across all three partners including; a collaborative approach to commissioning that de-risks new development, prioritisation of investment in new homes into supported housing, making a robust business case for the 'payback' generated through development, and setting a this as a clear priority for the Greater Manchester system to respond to.

Housing quality and retrofit

The challenge

Housing stock condition modelling indicates that 16% of all households across Greater Manchester do not meet the current Decent Homes Standard. The direct effects of poor quality homes on a person's health can include: heart attacks, stroke, respiratory disease, flu, falls and injuries, hypothermia and poor mental health. This in turn can lead to greater demand for health services, without the health system levers in place to improve homes that are impacting on health.

The energy crisis in recent years has highlighted the urgency of improving energy efficiency in our homes to improve warmth and cut energy costs for residents. Intentions to raise the minimum energy efficiency standard required of privately and socially rented homes to EPC C by 2030 will deliver significant energy bill and carbon emissions savings, alongside improvements in health and wellbeing, but has significant cost implications for delivery.

How we will respond

The inquest into the tragic death of Awaab Ishak outlined practical actions the health and housing systems should take together to address the health risks of poor-quality homes. We will build on our work to date to reinforce the importance of formal pathways between all parts of the health system and housing that allow issues to be raised, working alongside the developing Greater Manchester Property Check. The Greater Manchester Good Landlord Charter will encapsulate GM Housing Providers commitment to going above and beyond minimum requirements to give everyone in social housing a good quality home.

GMCA and GM Housing Providers will work together to continue successful delivery of the Warm Homes:Social Housing Fund to improve the energy efficiency of homes and begin a move away from gas installations to support our carbon reduction targets. Increasing referrals through the jointly delivered ECO4 programme will ensure that more people with long term health conditions are able to access the interventions they need to make their home warm and improve their health. A warm home with low energy bills will save residents hundreds of pounds, address fuel poverty and put us on track to deliver our ambition that everyone in Greater Manchester lives in a healthy home.

Our Connected Homes, Inclusive Places plan will introduce smart home systems in social housing to improve tenants' quality of life, improve the effectiveness of environmentally friendly heating systems, support improvements in housing stock and boost safety.

Home improvements and adaptations

The challenge

The provision of home improvements, adaptations and advice can support older and vulnerable people to live independently - preventing, reducing and delaying the need for

formal care. However, significant variation exists in the scale of these services across Greater Manchester, meaning a postcode lottery for residents who want to access them. This reflects the withdrawal of national investment in home improvement interventions and the ability to deliver these at scale has dramatically reduced, despite the fact that these relatively minor interventions can make a major difference to wellbeing and independence.

For some people, home improvements and adaptations are not enough to adequately support independent living and instead their needs could be better met by 'rightsizing' or moving to a more suitable home.

How we will respond

We will work with localities to drive consistent provision in all 10 localities of 'Greater Manchester Healthy Homes' – a holistic home improvement and adaptations offer focused on preventing escalating needs. This builds on excellent practise already in place to deliver a consistent, cross-tenure, baseline service across the whole of Greater Manchester. Supported by NHS GM, these services will be aligned to households at risk of falls in the home, preventing significant costs to the health system and taking a unique opportunity for housing serviced to play a central role in integrated approaches to prevention.

We will develop a Greater Manchester level 'Rightsizing' Framework which will help older residents to find a safe, healthy, right sized home in the right place with the right support for them. This will improve health and wellbeing while helping us to make best use of existing housing stock.

Homelessness and Inclusion Health

The challenge

People experiencing homelessness face significant health inequalities and poorer health outcomes than the rest of the population. Mortality among people experiencing rough sleeping is around ten times higher than the rest of the population and life expectancy is around 30 years less. They also face multiple barriers to accessing health and social care services. Poor health and wellbeing is consistently demonstrated to be a barrier to finding and sustaining a safe, secure home and programmes such as our Housing First approach, which provide both a home and relevant support, have been successful in taking a holistic approach to responding to people's needs.

How we will respond

Embedding an Inclusion Health approach across health commissioning and service delivery will build an inclusive health system, which is flexible, accessible, trauma informed and re-affirms the fundamental rights of homeless people in their access to and interactions with health care. Working with GMCA, NHS GM will re-establish an active programme of work on Inclusion Health to deliver specific workstreams that drive improvements in the parts of the health system where people experiencing homelessness have the most interactions, such as primary care and hospital discharge.

Ensuring the continuation of partner pledges, including NHS GM financial contribution into 'A Bed Every Night' and GMHP continuing to provide 289 active tenancies for Housing First, are important in underpinning continued delivery of existing programmes and homelessness prevention efforts.

Support to Live Well at home

The challenge

For many Greater Manchester residents, current systems of support can feel remote and disjointed, unable to tackle the root causes of problems or provide tailored help and advice. For years, the voluntary, community, faith and social enterprise sector has plugged gaps in our welfare state in providing a co-ordiated offer of support.

Increasing levels of demand are creating a high dependence, high-cost public service that is unsustainable and focuses our resources and investment in high demand crisis services. This is costly, and prevents us from being able to effectively invest in the interventions that reduce likelihood of poor outcomes. To truly achieve the shift towards prevention, we must move towards a more pro-active model of support that creates healthy people living in healthy homes and healthy places, to truly transform the health of the population.

How we will respond

Housing Providers across Greater Manchester are at the forefront of community-led practice in neighbourhoods. As anchor institutions in our neighbourhoods GMHP are committed to providing safe streets and integrated welcoming communities.

In support of Live Well, GMHP will drive consistent outcomes in their extensive community led health and wellbeing approaches, mapping the existing offer, and aligning into Live Well Centres and Spaces, some of which they will facilitate. Consistent offers on financial inclusion and debt management will form part of this, alongside a joint endeavour to scale integrated Employment Support through Live Well to reduce economic inactivity in housing provider households, unlocking more opportunities to access good employment to reduce poverty and improve health.

We will collaborate across the housing and mental health systems to develop a ‘Home First’ blueprint, that supports localities to harness the benefits of working alongside the housing sector to support patient flow, maintain independent living, and avoid admissions for people with mental ill health.

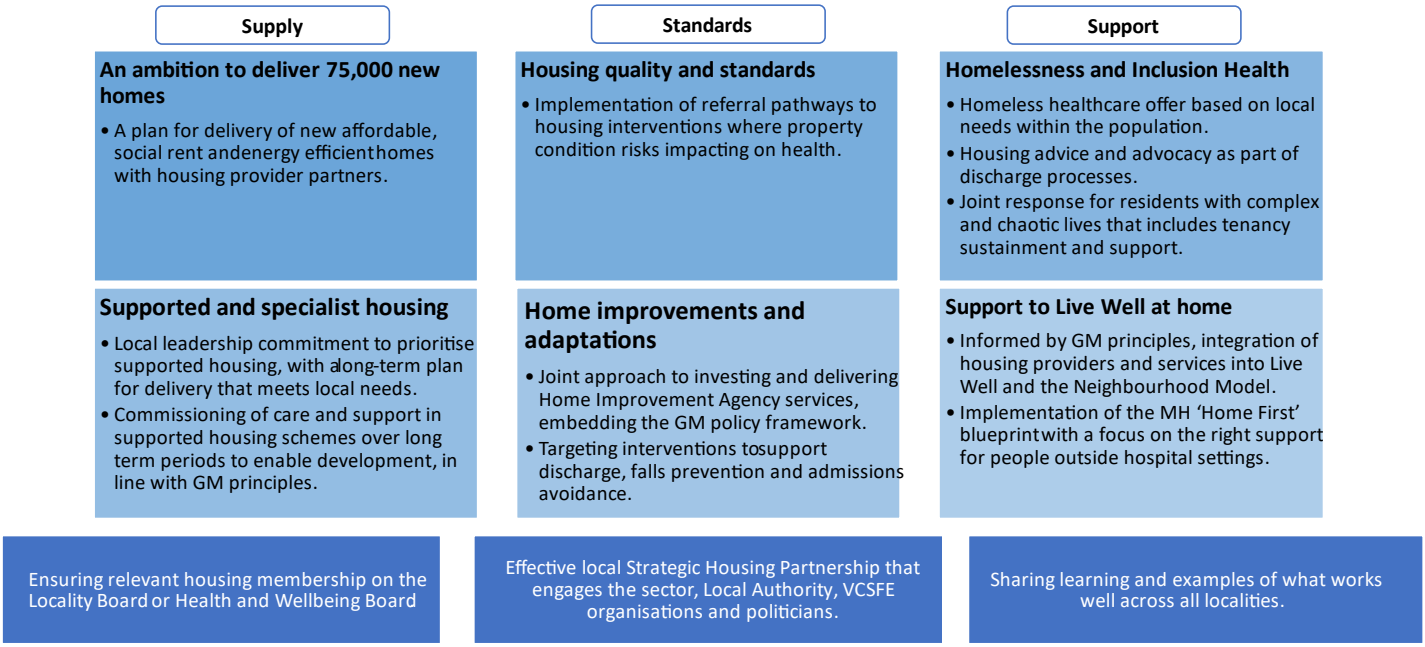
Collectively we will ensure that housing providers and services are a consistent part of the Optimum Neighbourhood Model, drawing on the important role they play, not only in the provision of homes but in supporting residents to sustain their independence, particularly where tenants are experiencing multiple complexities.

7. Locality Tripartite Agreement Framework

This refreshed version of the Tripartite Agreement reaches beyond the current Greater Manchester level programme delivery and into out ten localities, as a mechanism to embed the potential benefits and opportunities of collaboration into local systems. It builds on the GM level relationships and joint work to date to bring forward a unique set of opportunities that can only be progressed at locality level, such as joint commissioning and investment and integration of delivery into neighbourhood models.

A Locality Tripartite Framework provides a description of what practical connected action could look like across housing, health and care and the system conditions required to do this. It is built on practise that we know works and has been informed by colleagues working in localities identifying the areas where collaboration would support delivery of multiple priorities.

The Framework below is presented as a series of potential opportunities where collaboration can add value and support delivery, with the intention that localities determine what this looks like based on the priorities in that place. This can be worked towards over the life of the Agreement, supported by GM colleagues where needed, based on joint decision making and joint accountability between Locality Boards, Health and Wellbeing Boards and Strategic Housing Partnerships that encompass Local Authorities, Housing Providers and the NHS.



8. Enabling successful delivery

This final section sets out ways of working to be implemented by all Partners to give the best chance of successful delivery of our intentions. We want to ensure the contribution of the Tripartite Agreement is visible across all partners and spatial levels, that we continue to be evidence led in our decision making, and demonstrate the impact of work we do together on the residents of Greater Manchester. We also commit to lobbying and influencing with a single voice to have a bigger impact.

Governance and accountability

The Greater Manchester Tripartite Agreement Core Group will continue to hold the accountability for delivery of the Agreement and its Delivery Plan and will direct relevant updates and decisions into GMHP CEO Group, Greater Manchester Reform Delivery Executive, Housing First Board and NHS GM Executive Committee, as the connected governance across the three partners. An annual Tripartite report will share progress into each of these forums.

At a local level, housing representation on Locality Board or Health and Wellbeing Board (to be determined locally) should be sought, alongside embedding a protocol between Local Authorities and Housing Providers on local relationships, accountability and engagement.

Influencing and engagement

Despite the powers and flexibilities already devolved to Greater Manchester and the unique depth of strategic commitment, there are still barriers to delivering the scale of change we want to see and we will need to influence and encourage national Government to amend legislation, invest differently, or devolve power and flexibility if we are to make better progress.

The partners will individually and jointly influence national Government and other stakeholders to further the priorities of the Tripartite Agreement. The reach of the three partners collectively is extensive across the Greater Manchester system, regionally and nationally and we will capitalise on this to share our ambitions and gain support to take them forward. This will be particularly important where we are able to speak with a single voice about the things that are important to us.

Data, research and innovation

The partners commit to collaborating more effectively around data and research, ensuring that we are evidence led in the work we do together.

To inform all of our joint work on housing quality and health, we are developing a Health and Housing Condition Model, which will connect information held on long term health conditions and use of the health system, with understanding of stock condition across all tenures to identify areas of high risk. We are also jointly undertaking research on racial inequalities in the housing system.

Through NHS GM we will align the partnership capacity of the Applied Research Collaborative to support evaluation of the health system impact of the Tripartite Agreement and housing interventions more broadly. There is more we can do in sharing of data and

research across GMCA and GM Housing Providers, with the aim of embedding GMHP data within regular Greater Manchester housing market data reporting.

We also want to utilise the investment opportunities and expertise of GMCA to drive increased delivery against our collective priorities, including social housing delivery, temporary accommodation responses and domestic retrofit interventions.

Signatories

Greater Manchester Combined Authority

Caroline Simpson

Andy Burnham

Paul Dennett

Greater Manchester Housing Providers

Charlie Norman

NHS Greater Manchester Integrated Care

Mark Fisher

Sir Richard Leese

Appendix 1.

Greater Manchester Tripartite Agreement Delivery Plan 2025-2029 – Overview of workstreams and actions

An ambition to deliver 75,000 new homes

- GMHP upscaling delivery by 50% with a focus on social rent and energy efficient homes, supported through Devolution flexibilities and investment
- New ways of working between housing providers and LA's that deliver place-based regeneration
- Joint action on supply of Temporary Accommodation for identified populations
- Coordinated approach to apprenticeships through GMHP
- Defining the capacity of NHS GM to release land, assets and capital that support housing delivery.

Supported and specialist housing

- Clear understanding of supported housing need across all populations.
- Agree system wide strategic vision and principles for supported housing, within the 75,000 new homes.
- Development of shared commissioning approach de-risk development and enable more effective delivery.
- Scale up GM commissioning approach for the Complex Needs Programme.
- Influence SAHP and GM capital programmes to prioritise delivery of Supported Housing, including step-down.
- Sharing practice and guidance across the GMHP partnership and Local Authorities.

Housing quality and retrofit

- Supporting access to warm home interventions for residents with long term health conditions.
- Referral pathways to housing interventions for those living in homes that negatively impact health.
- GMHP members signed up to and supporting development of the Good Landlord Charter.
- Continued successful delivery of domestic retrofit programmes such as Warm Homes Social Housing Fund (WH:SHF).
- Building safety and high-rise activity.

Home improvements and adaptations

- GM Healthy Homes programme – consistent home improvement and adaptations provision.
- Hospital Discharge offer connected into Trusts
- Development of a home improvements 'First Falls' prevention pilot
- Develop and publish Greater Manchester Rightsizing Framework

Homelessness and Inclusion Health

- Continuation of all partner commitments to current homelessness programmes
- Collaboration on delivery of the Greater Manchester Homelessness Prevention Strategy
- Review and refresh the Greater Manchester Homeless Hospital discharge protocols
- Targeted work with health services in neighbourhoods with high levels of homelessness
- Improved migrant health offer

Support to Live Well at home

- Defined GMHP role in delivering Live Well, driving system collaboration and consistency in approach
- Role of housing defined within ‘Home First’ Mental Health strategic commissioning approach
- Scaling joint approaches to integrated Employment Support through Live Well

NHS
Greater Manchester

Finance Committee Board Report

21 January 2026

Part of Greater Manchester
Integrated Care Partnership

NHS
Greater Manchester

Integrated Care Board

21 January 2026

Required information	Details
Title of report	Finance Committee Board Report
Author	Ross Baxter, Governance Advisor
Presented by	Kal Kay, Non-Executive Director and Chair of the Finance 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.	
How health inequalities will be reduced in Greater Manchester's communities.	
The decision to be made and/or input sought	Note the contents of the report.
How this supports the delivery of the strategy and mitigates the BAF risks	Failure to deliver Financial Balance both for NHS GM organisationally and as an ICS
Key milestones	
Leadership and governance arrangements	This is a summary report following the December Finance Committee meeting.
Engagement* to date ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	Draft report shared with the Chair and CFO for comments.
Financial or Legal Implications	N/A

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

NHS Greater Manchester

Report from:	**Finance Committee**
Date of Meeting:	December 2025
Chair:	Kal Kay
Quoracy Achieved:	Yes

Key escalations and discussion points from the meeting:

Alert
GM Month 7 Financial Position - The Month 5 year to date reported a £82.2 million year-to-date deficit against plan, primarily within the provider sector, with NHS GM itself on plan but facing pressures in areas like continuing care, mental health (notably ADHD and autism), elective plans, and CIP delivery. The total system risk improved slightly, with providers mainly at risk due to CIP delivery.
Advise
Contract Report – This report provided an update on the ongoing management of NHS Greater Manchester's healthcare and non-healthcare contracts for 2025/26. It was confirmed that all 2024/25 contracts had now been cleared. For 2025/26, the position had improved compared to the previous year, though the contracting team continued to face significant pressure. Ongoing work to coordinate responses to proposed changes in the new standard contract was highlighted, with the team preparing a submission by the required deadline.
Assure
Finance Recovery Plan CIP - This report provided an update to the Finance Committee on the Financial Recovery Programme's Month 7 performance for the NHS GM (Greater Manchester) System. The key outcomes and actions were summarised. The discussion centred on the progress and challenges of delivering cost improvement targets across the system. An overview was provided, noting positive momentum in recovery actions but stressing the need for all budget holders to tightly manage their positions to prevent deterioration elsewhere. Risks remained in areas such as all-age continuing care and mental health placements, while medicines optimisation was performing well and independent sector activity was showing improvement. Additional capacity had been brought in from localities and corporate teams to support the recovery process, but the remaining £34 million gap was recognised as a significant challenge for the coming months.

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 December 2025 meeting.

NHS
Greater Manchester

Month 8 Finance Report

2025-2026

Part of Greater Manchester
Integrated Care Partnership

NHS Greater Manchester

NHS GM Integrated Board

21st January 2026

Required information	Details
Title of report	Month 8 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 8 ICS financial position for Greater Manchester as at 30th November 2025.
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 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. 2. Note that the in-month position is a further reduction in actual spend for the GM system, a reduction in the forecast run rate position and a reduction in overall reported risk. 3. Note the breakeven forecast outturn position in line with NHSE reporting requirements. 4. Note 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. 5. Note the forecast capital position is expected to be brought back into a balanced position. 6. Note the risk to the system wide cash position which will require close monthly monitoring. 7. Note the risk that Q4 DSF is subject to clawback if a balanced position 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 confirm 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	Circulated to Chief Officers on 22nd December 2025. Presented to Transition Committee on 7th January 2026. Will be presented to the NHS GM Integrated Care Board on 21st January 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 30th November 2025.

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 8 reported position

As at Month 8 the ICS deficit plan is £70.2m, with an actual deficit of £83.0m, which equates to a £12.8m adverse variance to plan.

M8 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	£2.2	-£0.2	-£2.4	-£65.2	-£78.0	-£12.8	£7.5	£7.5	£0.0
NHS GM	-£0.6	-£0.6	£0.0	-£5.0	-£5.0	£0.0	-£7.5	-£7.5	£0.0
ICS Total	**£1.6**	**-£0.8**	**-£2.4**	**-£70.2**	**-£83.0**	**-£12.8**	**£0.0**	**£0.0**	**£0.0**

Key messages of the overall deficit position are:

- Whilst an overall deficit continues to be reported, the NHS GM in-month spend has reduced by £4m and the NHS Provider extrapolated forecast has reduced by £18m compared to M7. In addition, gross reported risk also continues to reduce each month.
- The YTD provider position is now £12.8m behind plan, a deterioration of £2.4m in month, with the reported pressures being due to delays in CIP delivery, and the operational cost of delivery, particularly on workforce.
- NHS GM is reporting a £5.0m 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 increased activity linked to Right to Choose, and on-going increased volume and costs associated with All Age Continuing Care. Pressures associated with Independent Sector elective activity and delays in delivery of savings also continue to be reported. However, Finance Recovery Plans continue to be monitored and updates in M8 indicate that whilst IS activity has reduced slightly and CIP delivery has improved again, MH and All Age Continuing Care run rates have deteriorated slightly. These pressures are currently offset partially with some areas of under spend in the overall position.
- On a YTD basis, CIP delivery is £25.6m ahead of target as a system (£1.7m behind plan by NHS GM, offset by a favourable provider variance of £27.3m). 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 currently been received up to and including Q3 and the ICB has been notified that it will receive Q4 based on assurances given to NHS England that an overall balanced forecast will be delivered.
- 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 8 providers are £27.3m ahead of the YTD plan. NHS GM is £1.7m behind the YTD plan. Weekly monitoring continues to be in place with all NHS organisations submitting updates to NHSE NW on the progress being made 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 8 the ICS gross risk is estimated at £106.4m. £37.0m relates to GM providers and the remaining £69.4m 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 £26.6m in the ICS gross risk from Month 7. The GM system is currently assuming that all risk will be fully mitigated, resulting in zero net risk.

2.5 Recovery Plans

At Month 8 the following is noted in terms of progress being made against the individual Finance Recovery Plans:

- AACC is reporting further increased spend in M8 against the trajectory and overall, resulting in a deterioration of £0.9m in the forecast position.
- ADHD is reporting a slight deterioration against the trajectory in M8, resulting in a further deterioration against the expected FOT position by £1.4m.
- Whilst M7 flex data indicates a reduction in activity levels, Independent Sector activity is still estimated as being slightly behind the recovery plan at this stage.
- CIP is reporting an improvement against the M8 trajectory, due to bringing forward the delivery of some schemes, but this does not improve overall delivery.

Further workforce capacity has now been identified to increase the pace of delivery against the recovery plans wherever possible.

2.6 Capital

Overall, YTD spend for provider capital is £157.9m, compared to a plan of £189.1m. Within this total, a system allocation is issued to GM on both internally generated and IFRS 16 capital expenditure, which is currently £197.3m. At this stage, a balanced forecast outturn position is still assumed.

The NHS GM annual capital plan is £10.9m, £6.6m 'business as usual' capital, £3.4m 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 8 NHS GM had drawn down 67.9% of its annual cash allocation compared to a straight-line rate of 66.7%. This is mainly due to settlement of 2024/25 liabilities and the profiling of the Deficit Support Funding transacted with providers. The allowable cash balance at the end on Month 8 equated to £8.5m with an actual closing balance of £0.8m.

GM providers are £0.5m above the planned cash balance (plan £381.1m), which has decreased since M7. There are continuing concerns with future cash flow for some providers.

The cash position remains challenging for the rest 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 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.
- Note that the in-month position is a further reduction in actual spend for the GM system, a reduction in the forecast run rate position and a reduction in overall reported risk.
- Note the breakeven forecast outturn position in line with NHSE reporting requirements.
- Note 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.
- Note the forecast capital position is expected to be brought back into a balanced position.
- Note the risk to the system wide cash position which will require close monthly monitoring.
- Note the risk that Q4 DSF is subject to clawback if a balanced position is not delivered.
- 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 confirm recovery plans to mitigate reported pressures.

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NHS Greater Manchester Finance Slide Pack Month 8 – November 2025

Part of Greater Manchester Integrated Care Partnership

Presented by: Kathy Roe
Date: 21st January 2026

System Financial Position Overview

NHS Greater Manchester

At Month 8 the total ICS year to date deficit is £83.0m, a £12.8m variance behind plan (Month 7: variance of £10.4m), which is a deterioration of £2.4m compared to last month.

M8 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	£2.2	-£0.2	-£2.4	-£65.2	-£78.0	-£12.8	£7.5	£7.5	£0.0
NHS GM	-£0.6	-£0.6	£0.0	-£5.0	-£5.0	£0.0	-£7.5	-£7.5	£0.0
ICS Total	**£1.6**	**-£0.8**	**-£2.4**	**-£70.2**	**-£83.0**	**-£12.8**	**£0.0**	**£0.0**	**£0.0**

Key points of note for Month 8 are:

- Whilst an overall deficit continues to be reported, the NHS GM in-month spend has reduced by £4m and the NHS Provider extrapolated forecast has reduced by £18m compared to M7. In addition, gross reported risk also continues to reduce each month.
- The YTD provider position is now £12.8m behind plan, a deterioration of £2.4m in month, with the reported pressures being due to delays in CIP delivery, and the operational cost of delivery, particularly on workforce.
- NHS GM is reporting a £5.0m 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 increased activity linked to Right to Choose, and on-going increased volume and costs associated with All Age Continuing Care. Pressures associated with Independent Sector elective activity and delays in delivery of savings also continue to be reported. However, Finance Recovery Plans continue to be monitored and updates in M8 indicate that whilst IS activity has reduced slightly and CIP delivery has improved again, MH and All Age Continuing Care run rates have deteriorated slightly. These pressures are currently offset partially with some areas of under spend in the overall position.
- On a YTD basis, CIP delivery is £25.6m ahead of target as a system (£1.7m behind plan by NHS GM, offset by a favourable provider variance of £27.3m). 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 currently been received up to and including Q3 and the ICB has been notified that it will receive Q4 based on assurances given to NHS England that an overall balanced forecast will be delivered.
- 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 M08	YTD Actual M08	YTD Variance M08	Full Year Budget/ Allocation	Full Year Forecast	Full Year Variance	RAG
Financial position - NHS GM	-£5.0	-£5.0	£0.0	-£7.5	-£7.5	£0.0	G
Financial position - Provider	-£65.2	-£78.0	-£12.8	£7.5	£7.5	£0.0	A
Financial position - ICS	**-£70.2**	**-£83.0**	**-£12.8**	**£0.0**	**£0.0**	**£0.0**	G
CIP	£362.8	£388.4	£25.6	£656.0	£659.3	£3.3	G
Agency (provider) *	£38.9	£44.5	-£5.6	£55.7	£61.5	-£5.8	G*
Capital - NHS GM	£5.8	£5.8	£0.0	£10.9	£10.9	£0.0	G
Capital - Provider (CDEL)	£189.1	£157.9	£31.2	£396.0	£386.0	£10.0	G
Capital - ICS	**£194.9**	**£163.7**	**£31.2**	**£406.9**	**£396.9**	**£10.0**	G
Cash (provider)	£381.1	£381.6	£0.5	£427.9	£305.2	-£122.7	A
Key metrics - ICB only							
MHIS (excluding LD & Dementia)	£552.8	£552.8	£0.0	£829.1	£829.1	£0.0	G
Delegated Specialised Commissioning MHIS **	£79.4	£79.4	£0.0	£119.1	£119.1	£0.0	G
Running costs	£31.1	£31.1	£0.0	£46.4	£46.4	£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

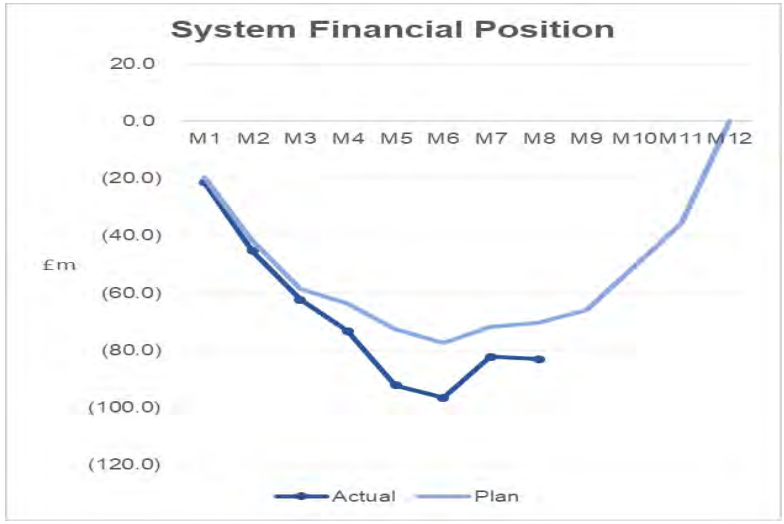
**NHSE have not yet updated the SCMHIS target from £109.4m to £119.1m which reflects the additional allocations in year, the table above is reflective of the allocations received and forecast spend.

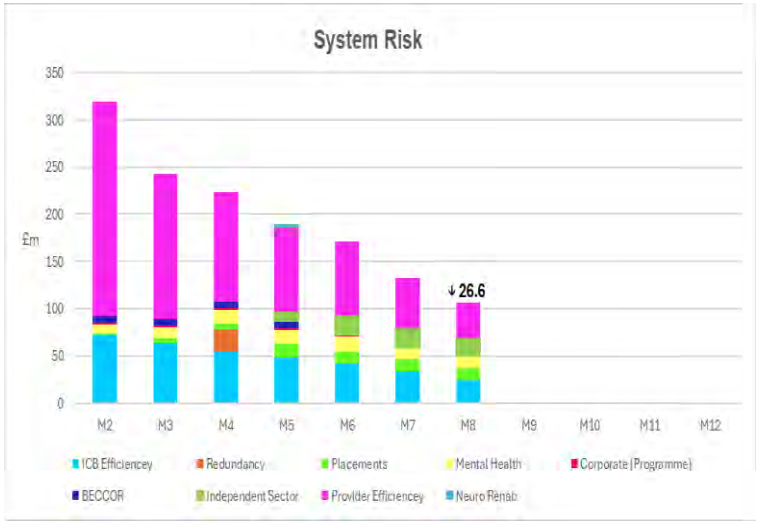
Note: *all numbers are rounded to nearest £0.1m. This may result in small discrepancies when adding together columns/rows or reviewing variances in the table. But all values presented are* calculated using precise values, before rounding is applied.

Key Metrics

Analysis

NHS Greater Manchester





System Financial Position

- The M8 YTD position for the GM NHS System is a £12.8m deficit against plan and is split as follows:
  - £0.0m NHS GM (Month 7: £0.0m)
  - £12.8m GM Providers (Month 7: £10.4m)
- 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.
- In-month a further improvement in the run rate and reduced spend has been reported compared to M7.

System Risk

- The total gross risk has been estimated at £106.4m at M8. This is a further decrease of £26.6m from M7. Of the total:
  - £37.0m relates to providers.
  - £69.4m 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.

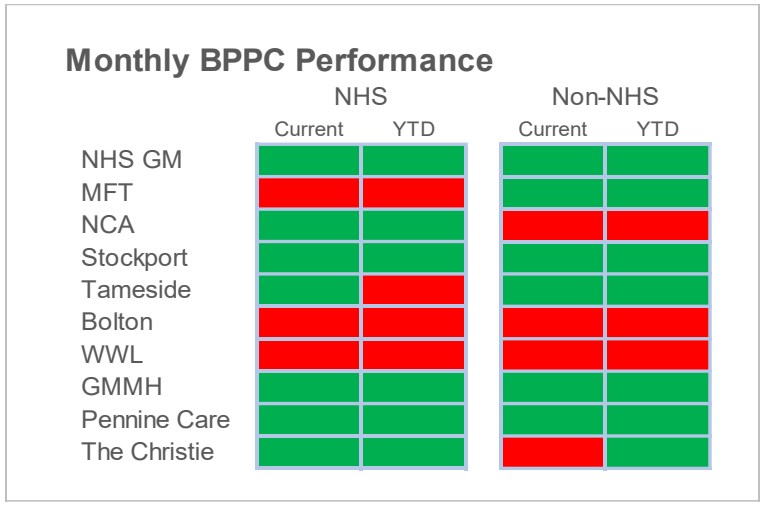
System Efficiency

- The chart above details the savings delivered against an overall system savings target of £656.0m
- YTD savings of £388.4m have been delivered against a target of £362.8m, of which 55.8% has been delivered recurrently. Delivery is currently £25.6m ahead of plan YTD.
- Full year savings of £659.3m are forecast, albeit with risks still being reported.

Key Metrics

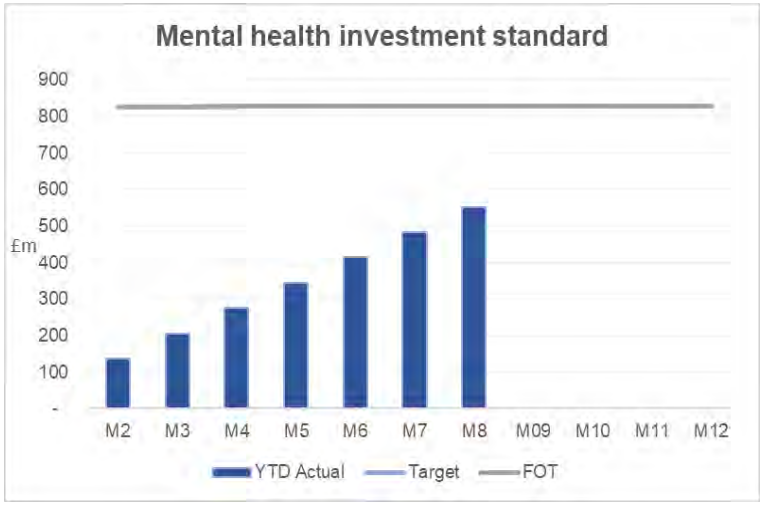
Analysis

NHS Greater Manchester



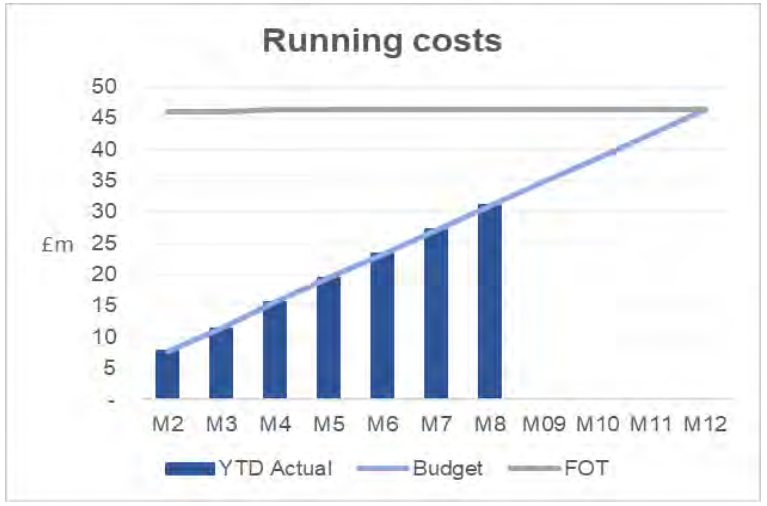
System Better Payment Practice Code

- 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 M8, 3 have worsened their performance from the previous month, (Bolton a worsening of 5.2%, MFT a deterioration of 0.4%, GMMH 0.1%).
- 7 organisations are meeting the target for YTD achievement for Non-NHS organisations.
- For the remaining 3 organisations not achieving the Non-NHS target, all are reporting a deterioration since M6, Bolton 5.4%, The Christie 0.3% and Pennine Care 0.1%.



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 8 NHS GM is reporting expenditure in line with plan for both the MHIS and SCMHIS targets.



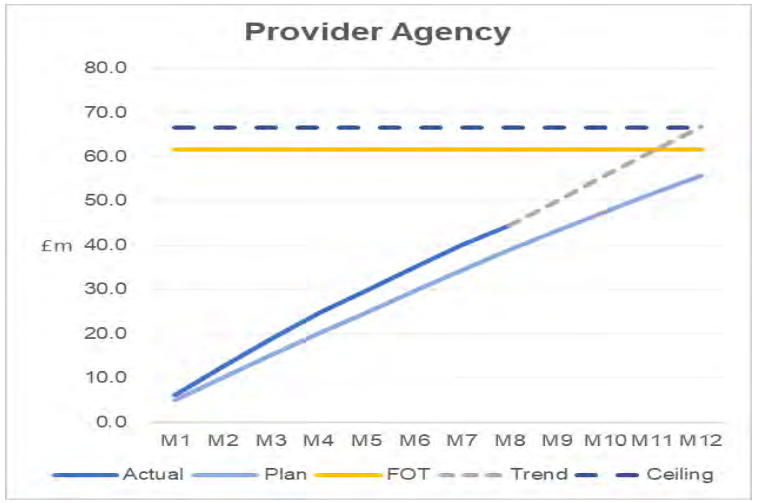
NHS GM Running costs

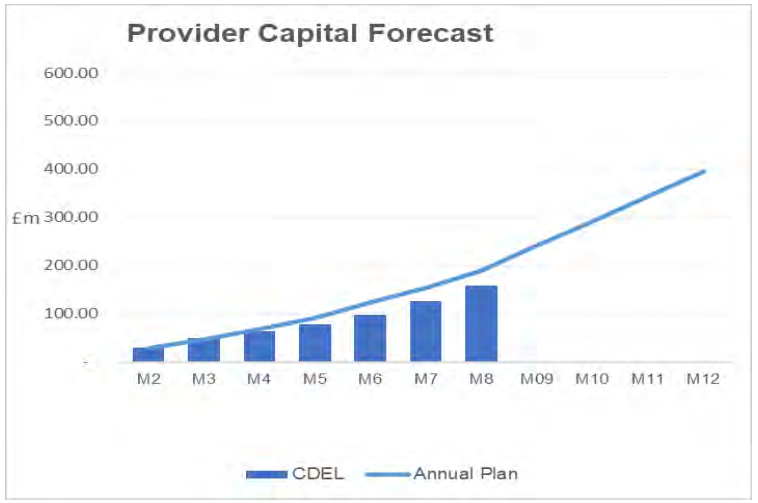
- The YTD running cost allowance for NHS GM at M8 is £31.1m and spend is being reported in line with the plan.
- It is expected that NHS GM will achieve the running cost target and is currently reporting a balanced position in the forecast.
- Whilst plans have now commenced again regarding the NHS Reforms, no actual costs or savings have yet been factored into the financial position.

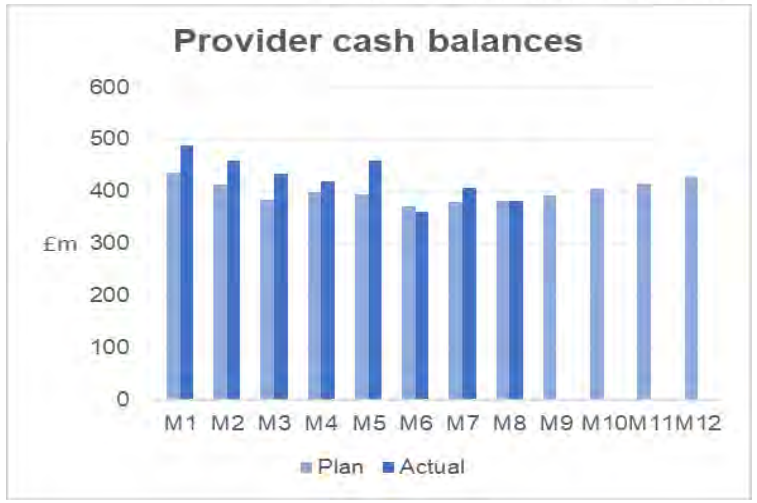
Key Metrics

Analysis

NHS Greater Manchester







Provider Agency

- The M8 YTD agency spend for GM providers is £44.5m which is £5.6m above the plan of £38.9m.
- At present a forecast of £61.5m 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 £386.0m. YTD spend for provider capital is £157.9m, which is below the plan of £189.1m
- Within this total there is a system allocation of £197.3m issued to GM providers for both internally generated and IFRS 16 capital expenditure. Actual spend of £198.4m is reported, an overspend of £1.1m against allocation, which is due to the unvalidated inclusions for both Bolton and MFT, but a balanced forecast outturn position is expected.
- The NHS GM annual capital allocation is £10.9m, with the expectation that all of this will be fully utilised in year.

Cash

- GM providers (as shown in the chart above) are £0.5m above the planned cash balance (plan: £381.1m, actual: £381.6m).
- At M8 NHS GM had drawn down 67.9% of its annual cash allocation compared to straight line of 66.7%. This is due to settlement of 2024/25 liabilities and the profiling of the DSF transacted to providers. The allowable cash balance at the end of M8 equated to £8.5m, with an actual closing balance of £0.8m.
- 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 November 2025 £m	Forecast Outturn Recurrent/Non Recurrent Split (Recurrent / Non Recurrent)	M8 YTD Plan	M8 YTD Actual	M8 YTD Variance	Full Year Plan	Full Year Forecast	Full Year Variance
ICB Savings	68% / 32%	£115.2	£113.6	-£1.7	£175.0	£175.0	£0.0
Breakdown by Provider							
Manchester University NHS Foundation Trust	56% / 44%	£75.2	£90.1	£14.9	£165.8	£165.8	£0.0
Northern Care Alliance NHS Foundation Trust	51% / 49%	£49.0	£68.5	£19.5	£110.0	£113.3	£3.3
Stockport NHS Foundation Trust	66% / 34%	£18.2	£20.2	£2.1	£29.2	£29.2	£0.0
Tameside and Glossop Integrated Care NHS Foundation Trust	64% / 36%	£15.3	£15.9	£0.6	£25.3	£25.3	£0.0
Bolton NHS Foundation Trust	66% / 34%	£17.3	£9.1	-£8.2	£36.9	£36.9	£0.0
Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust	47% / 53%	£24.8	£21.8	-£3.0	£38.4	£38.4	£0.0
Greater Manchester Mental Health NHS Foundation Trust	86% / 14%	£19.4	£20.1	£0.7	£32.5	£32.5	£0.0
Pennine Care NHS Foundation Trust	46% / 54%	£11.7	£12.4	£0.8	£17.5	£17.5	£0.0
The Christie NHS Foundation Trust	45% / 55%	£16.7	£16.7	£0.0	£25.3	£25.3	£0.0
GM Provider Savings	57% / 43%	£247.6	£274.9	£27.3	£481.0	£484.3	£3.3
Total Efficiencies	60% / 40%	£362.8	£388.4	£25.6	£656.0	£659.3	£3.3

- On a YTD basis, delivery is £25.6m ahead of target as a system:
  - £1.7m adverse NHS GM variance, offset by
  - £27.3m favourable provider variance
- As a system it is forecast that CIP targets will be met in full 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.*

GM ICS Supplementary Information

Cash Position

NHS Greater Manchester

The latest cash position for the ICS as at M8 is shown in the following table:

M8 2025/26 ICS Cash Position £m and Operating Cash Days	M8 Actual	M9 Forecast	M10 Forecast	M11 Forecast	M12 Forecast	M8 Operating Cash Days Actual	M9 Operating Cash Days Forecast	M10 Operating Cash Days Forecast	M11 Operating Cash Days Forecast	M12 Operating Cash Days Forecast
Manchester University NHS Foundation Trust	£28.0	£17.0	£8.4	£20.0	£14.9	3	2	1	2	1
Northern Care Alliance NHS Foundation Trust	£50.6	£50.8	£55.1	£60.1	£42.9	9	10	11	11	9
Stockport NHS Foundation Trust	£31.9	£32.7	£28.0	£31.4	£17.9	23	25	22	22	14
Tameside And Glossop Integrated Care NHS Foundation Trust	£11.2	£10.0	£9.2	£7.9	£6.1	11	10	10	7	6
Bolton NHS Foundation Trust	£7.3	£2.7	£2.7	£2.6	£2.6	5	1	2	1	2
Wrightington, Wigan and Leigh NHS Foundation Trust	£8.3	£6.9	£7.2	£11.8	£5.7	5	4	4	7	3
Greater Manchester Mental Health NHS Foundation Trust	£69.3	£62.5	£60.6	£57.4	£51.9	48	45	43	37	37
Pennine Care NHS Foundation Trust	£55.3	£54.9	£54.6	£54.2	£53.9	61	62	62	56	61
The Christie NHS Foundation Trust	£119.6	£118.4	£116.8	£114.2	£109.3	83	85	84	74	78
Total GM NHS Provider Total	**£381.6**	**£355.9**	**£342.6**	**£359.8**	**£305.2**					
NHS GM*	£0.8									
Total GM ICS										

* For NHS GM, the ICB work to an allowable cash balance set by NHSE which was £8.5m (1.25%) for Month 8, with an actual closing balance of £0.8m

Key Messages

Month 8

NHS Greater Manchester

The below table outlines key areas to note for Month 8:

Key area	M8 Overview
Financial plan	The 2025/26 Greater Manchester ICS final plan following the notification 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. To date £150.0m of the £200.0m DSF has been received as an allocation.
Year to date variances	• The YTD provider position has worsened to £12.8m deficit, with reported pressures being due to delays in CIP delivery, and the operational cost of delivery, particularly on workforce. • The NHS GM position has remained on plan, reporting a £5.0m deficit this month. Pressures continue to be reported relating to ADHD, Autism and s117 within Mental Health due to increased activity linked to Right to Choose, and on-going increased volume and costs associated with All Age Continuing Care. Pressures associated with Independent Sector elective activity and delays in delivery of savings also continue to be reported. However, Finance Recovery Plans continue to be monitored and updates in M8 indicate that whilst IS activity has reduced slightly and CIP delivery has improved again, MH and All Age Continuing Care run rates have deteriorated slightly. These pressures are currently offset partially with some areas of under spend in the overall position. • In-month spend has reduced again for both GM providers and NHS GM, and a further improvement in the forecast run rate position.
Efficiencies/ CIP	As at M8 £388.4m of CIP has been delivered against a plan of £362.8m, an overachievement of £25.6m. The forecast CIP position is £659.3m which is above the plan of £656.0m although there are risks associated with delivery.
Capital	The provider capital YTD actual spend, including internally generated (BAU), IFRS 16 (leases) and PDC is £157.9m, compared to a plan of £189.1m. At this stage, even though some overspends are reported, it is expected that a balanced forecast outturn position will be delivered. The capital allocation for NHS GM remains at £10.9m and is expected to be fully utilised by the end of the financial year.
Cash	At present provider cash balances are above plan by £0.5m and cash balances have decreased compared to M7 and there are continuing concerns with future cash flow for some providers. At M8 NHS GM had drawn down 67.9% of its annual cash allocation compared to a straight-line rate of 66.7%, reflecting the need to settle 2024/25 liabilities and the profiling of the DSF which has been transacted with providers. The allowable cash balance at the end of M8 equated to £8.5m, with an actual closing balance of £0.8m. The cash position for the system therefore remains a concern and will continue to be monitored closely to ensure appropriate levels of working capital across system.
Risk & Mitigations	At Month 8 the ICS gross risk is estimated at £106.4m. £37.0m relates to GM providers and the remaining £69.4m 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 £26.6m in the ICS gross risk from Month 7. The GM system is currently assuming that all risk will be fully mitigated, resulting in zero net risk.

Recommendations

Month 8

NHS Greater Manchester

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

- Note 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.
- Note that the in-month position is a further reduction in actual spend for the GM system, a reduction in the forecast run rate position and a reduction in reported net risk.
- Note the breakeven forecast outturn position in line with NHSE reporting requirements.
- Note 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.
- Note the forecast capital position is expected to be brought back into a balanced position.
- Note the risk to the system wide cash position which continues to be closely monitored.
- Note the risk that Q4 DSF is subject to clawback if a balanced position is not delivered.
- 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

Appendix – Individual Organisation Reported Positions

NHS GM Financial Position

Month 8

NHS Greater Manchester

The financial summary for NHS GM by expenditure type as at Month 8 is shown in the table below:

NHS GM Financial Position £m	Budget In Month	Actual In Month	Variance In Month	Variance In Month %	Budget YTD	Actual YTD	Variance YTD	Variance YTD %	Full Year Plan	Full Year Forecast	Variance FOT	Variance FOT %	M07 FOT Variance	Change in FOT
Allocations	**£769.8**	**£769.8**	**£0.0**	**0.0%**	**£6,140.3**	**£6,140.3**	**£0.0**	**0.0%**	**£9,175.4**	**£9,175.4**	**£0.0**	**0.0%**	**£0.0**	**£0.0**
Admin														
Running Costs	£3.8	£3.8	£0.0	0.0%	£31.1	£31.1	£0.0	0.0%	£46.4	£46.4	£0.0	0.0%	£0.0	£0.0
Total Admin	**£3.8**	**£3.8**	**£0.0**	**0.0%**	**£31.1**	**£31.1**	**£0.0**	**0.0%**	**£46.4**	**£46.4**	**£0.0**	**0.0%**	**£0.0**	**£0.0**
Programme														
Mental Health	£81.2	£81.0	£0.2	0.3%	£651.3	£661.7	-£10.4	-1.6%	£975.5	£983.8	-£8.3	-0.9%	-£9.4	£1.1
Acute	£355.1	£352.7	£2.5	0.7%	£2,808.3	£2,822.1	-£13.7	-0.5%	£4,212.1	£4,225.1	-£12.9	-0.3%	-£12.8	-£0.1
Specialised Commissioning	£82.8	£82.8	£0.0	0.0%	£665.8	£665.8	£0.0	0.0%	£997.7	£997.8	£0.0	0.0%	£0.0	£0.0
Primary Care	£7.8	£7.4	£0.3	4.2%	£67.7	£66.1	£1.7	2.4%	£104.2	£101.8	£2.5	2.4%	£3.3	-£0.8
GP Medical, Pharmacy, Dental and Optometry	£92.1	£92.4	-£0.3	-0.3%	£711.3	£710.1	£1.1	0.2%	£1,070.8	£1,071.6	-£0.9	-0.1%	-£1.6	£0.8
Prescribing	£48.5	£48.4	£0.0	0.0%	£397.0	£396.7	£0.3	0.1%	£599.4	£596.7	£2.7	0.5%	£0.6	£2.1
All Age Continuing Healthcare	£23.9	£24.9	-£1.0	-4.1%	£194.0	£200.0	-£6.0	-3.1%	£287.4	£295.2	-£7.8	-2.7%	-£5.8	-£2.0
Community Health Services	£66.7	£65.3	£1.5	2.2%	£530.3	£531.1	-£0.8	-0.2%	£793.0	£792.5	£0.6	0.1%	£1.2	-£0.7
Programme Operating Costs	£10.4	£10.7	-£0.3	-2.8%	£66.5	£65.5	£1.0	1.4%	£100.3	£100.5	-£0.2	-0.2%	-£3.2	£3.0
Other expenditure	£1.4	£1.3	£0.1	4.4%	-£3.0	-£2.6	-£0.4	13.7%	£3.9	£5.1	-£1.2	-31.1%	-£0.8	-£0.4
Earmarked commitments	-£3.3	-£0.4	-£3.0	89.4%	£25.0	-£2.3	£27.3	109.2%	-£7.8	-£33.4	£25.6	-328.8%	£28.6	-£3.0
Total Programme	**£766.6**	**£766.6**	**£0.0**	**0.0%**	**£6,114.2**	**£6,114.2**	**£0.0**	**0.0%**	**£9,136.5**	**£9,136.5**	**£0.0**	**0.0%**	**£0.0**	**£0.0**
Total Expenditure	**£770.5**	**£770.4**	**£0.0**	**0.0%**	**£6,145.3**	**£6,145.3**	**£0.0**	**0.0%**	**£9,182.9**	**£9,182.9**	**£0.0**	**0.0%**	**£0.0**	**£0.0**
Surplus / (Deficit)	**-£0.6**	**-£0.6**	**£0.0**		**-£5.0**	**-£5.0**	**£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 M7 flex activity data indicates a reduction.
  - 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.

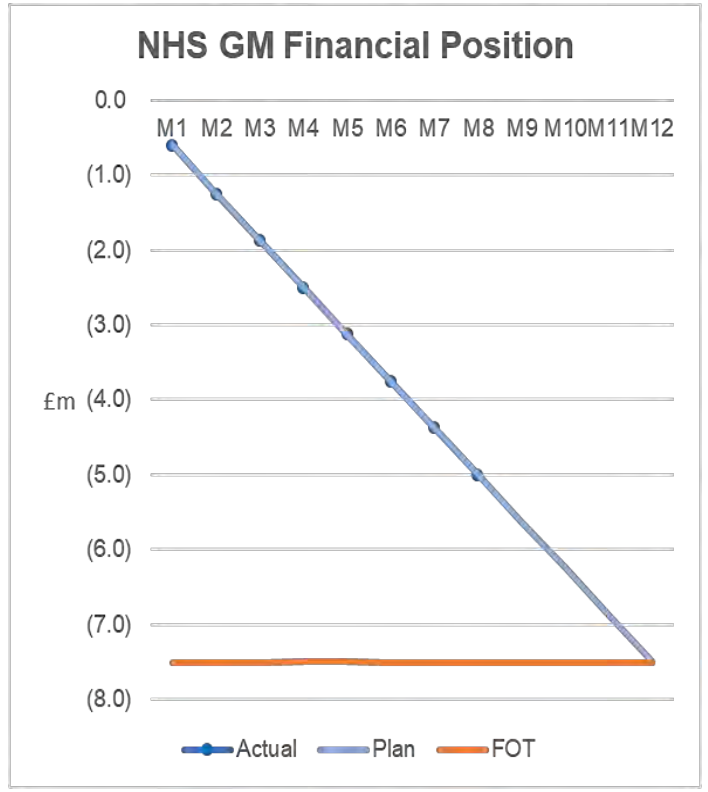
NHS GM Key Messages

Month 8

NHS Greater Manchester

Key Area	Month 8 Overview
Financial position	NHS GM is reporting a £5.0m YTD deficit which is in line with the plan. The key movements in the YTD and FOT position are explained in the following slides.
Risk	At M8 the reported gross risk relating to NHS GM is estimated to be £69.4m, which includes the risk associated with delivery of efficiency targets of £24.3m. Other risks relate to pressures associated with Mental Health, increased Independent Sector activity, Placements, and Corporate Costs.
CIP	CIP delivery remains behind plan by £1.7m at Month 8, which is an improvement since M7, with £113.6m delivered against a plan of £115.2m. Of this 62.9% 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 M7 overspend is £13.7m, which is mainly as a result of Elective IS activity overperformance. As part of the recovery plan, Indicative Activity Plans (IAPs) have been issued to all IS providers, M7 flex activity data has indicated a reduction in activity levels but not quite at the levels of the trajectory of the recovery plan.
Key variance: Mental Health	The YTD M7 overspend is £10.4m and the main reasons for the increase in spend at M8 relates to continued pressures on-going pressures for ADHD, Autism, s117 aftercare and high-cost individual LD placement costs.
Key variance: All Age Continuing Healthcare	YTD All Age Continuing Healthcare is overspending by £6.0m, which is a mix of further increase in the number of high-cost cases, fast tracks and fully funded cases.

The chart below shows the changes in YTD position for NHS GM:



NHS GM Key Messages

YTD movement

NHS Greater Manchester

NHS GM is reporting a YTD position in line with the planned deficit of £5.0m. However, in-month movements are noted in the following areas:

Expenditure Area - £m	M8 YTD Variance	M7 YTD Variance	Movement	Key Year to Date Pressures and Movements
Mental Health	-£10.4	-£10.6	£0.2	The main reason for the slight improvement at M8 relates to a reduction in average OAPS and SPOT placements to 37, however, the on-going pressures for ADHD, Autism and s117 continues. Whilst the recovery plan has been developed to mitigate and reduce costs, with specific plans in place to reduce the on-going implications of Right to Choose, increased costs have materialised after transitioning to the new ISFE2 ledger.
Acute	-£13.7	-£17.1	£3.4	The improvement in month is due to the transfer of the Acute CIP which has been delivered centrally. In relation to IS overperformance, and as part of the recovery plan, Indicative Activity Plans (IAPs) have been issued to all IS providers. M7 flex activity data has indicated a reduction in activity levels but not quite at the levels of the trajectory of the recovery plan.
GP Medical, Pharmacy, Dental & Optometry	£1.1	£1.4	-£0.3	The in-month deterioration relates to an overspend within the GP Medical and Ophthalmic contracts offset by reduced Pharmacy costs.
Prescribing	£0.3	£0.3	£0.0	The YTD variance remains constant, with pressures against central drugs and locality recharges offset by favourable variances against main prescribing and rebates.
All Age Continuing Care	-£6.0	-£5.0	-£1.0	The deterioration in-month relates to a further increase in the number of high-cost cases, fast tracks and fully funded cases.
Community Health Services	-£0.8	-£0.9	£0.1	The slight improvement relates to reduced Neuro Rehab costs.
Other Variances	£2.4	£3.9	-£1.5	Primary Care and Programme Operating Costs are still showing a favourable variance year to date but at a reduced level compared to the previous month.
Central Mitigations	£27.1	£28.0	-£0.9	There has still been a requirement to utilise central mitigations this month until the full impact of the finance recovery plans materialise but this has reduced slightly in-month again.
YTD Variance	**£0.0**	**£0.0**	**£0.0**	

NHS GM Key Messages

FOT movement

NHS Greater Manchester

NHS GM is reporting in line with the overall deficit plan of £7.5m, although in-month movements are noted in the following areas:

Expenditure Area - £m	M8 FOT Variance	M7 FOT Variance	Movement	Key Forecast Outturn Pressures and Movements
Mental Health	-£8.3	-£8.8	£0.5	The improvement in the forecast position is as a result of reduced OAPS and SPOT placements. However, the ADHD, ASD and s117 forecast position continues to deteriorate, as a result of additional invoices received following the transition to ISFE2.
Acute	-£12.9	-£12.5	-£0.4	The slight worsening in the forecast position is a reflection of an omission at M7 relating to pressures for drugs and devices with providers. IS Elective overperformance is still forecast to be £12.2m after the actions taken as part of the recovery plan.
GP Medical, Pharmacy, Dental & Optometry	-£0.9	-£1.6	£0.7	The improvement is driven by the benefit of an additional allocation received to cover Pharmacy contract costs previously committed.
Prescribing	£2.7	£1.4	£1.3	The price of a widely used SGLT2 drug dapagliflozin (Dapa) has reduced significantly due to its patent expiring and the benefit has been partially built into the forecast. The potential saving could be more than is currently reflected, however as the price has reduced the usage has increased, this is being monitored and will be updated as the national data set progresses (current published data is September).
All Age Continuing Health Care	-£7.9	-£7.0	-£0.9	The deterioration in the forecast position relates to the impact of in-year assessment of packages costs and movement in case mix along with an increase in care packages.
Programme Operating Costs	-£0.2	-£2.4	£2.2	An improvement in the forecast position is mainly as a result of the delivery of further CIP in Population Health, along with savings relating to Digital procurement and resilience funding.
Other Variances	£1.8	£2.1	-£0.3	There has been a worsening in the forecast position relating to community eyecare in the Wigan and Bolton localities.
Central Mitigations	£25.6	£28.8	-£3.2	There has been a reduction in the requirement to utilise central mitigations this month as the impact of the finance recovery plans starts to materialise.
FOT Variance	**£0.0**	**£0.0**	**£0.0**	

GM NHS Provider Financial Position | Month 8

NHS Greater Manchester

As at Month 8 including receipt of DSF, a £78m deficit is reported by the providers, £12.8m worse than plan. The surplus forecast of £7.5m is in line with plan. Excluding receipt of DSF a £157.5m YTD deficit is reported and a £150.0m 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	£5,582.5	£5,667.2	£84.7	£105.0	£5,562.2	£8,388.7	£8,483.7	-£95.0	£157.5	£8,231.2
Pay	-£3,606.4	-£3,685.8	-£79.4		-£3,685.8	-£5,356.3	-£5,436.4	£80.2		-£5,356.3
Non-Pay	-£1,958.9	-£1,993.0	-£34.0		-£1,993.0	-£2,900.4	-£2,937.8	£37.4		-£2,900.4
Non Operating Items	-£82.4	-£66.5	£15.9		-£66.5	-£124.5	-£102.0	-£22.5		-£124.5
TOTAL Provider Surplus/(Deficit)	**-£65.2**	**-£78.0**	**-£12.8**	**£105.0**	**-£183.0**	**£7.5**	**£7.5**	**£0.0**	**£157.5**	**-£150.0**
Surplus/Deficit Breakdown										
Manchester University NHS Foundation Trust	-£23.2	-£27.6	-£4.4	£0.0	-£27.6	£0.0	£0.0	£0.0	£0.0	£0.0
Northern Care Alliance NHS Foundation Trust	-£24.4	-£23.6	£0.8	£38.6	-£62.1	£0.0	£0.0	£0.0	£57.9	-£57.9
Stockport NHS Foundation Trust	-£7.0	-£7.0	£0.0	£28.8	-£35.8	£0.0	£0.0	£0.0	£43.2	-£43.2
Tameside NHS Foundation Trust	-£8.5	-£8.4	£0.0	£21.2	-£29.6	£0.0	£0.0	£0.0	£31.8	-£31.8
Bolton NHS Foundation Trust	-£7.2	-£15.1	-£7.9	£4.3	-£19.4	£0.0	£0.0	£0.0	£6.5	-£6.5
Wrightington, Wigan and Leigh NHS Foundation Trust	£0.0	-£1.3	-£1.4	£5.9	-£7.3	£0.0	£0.0	£0.0	£8.9	-£8.9
Greater Manchester Mental Health Foundation Trust	£0.0	£0.0	£0.0	£6.2	-£6.2	£0.0	£0.0	£0.0	£9.2	-£9.2
Pennine Care NHS Foundation Trust	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0
The Christie NHS Foundation Trust	£5.0	£5.0	£0.0	£0.0	£5.0	£7.5	£7.5	£0.0	£0.0	£7.5
Provider Surplus/(Deficit)	**-£65.2**	**-£78.0**	**-£12.8**	**£105.0**	**-£183.0**	**£7.5**	**£7.5**	**£0.0**	**£157.5**	**-£150.0**

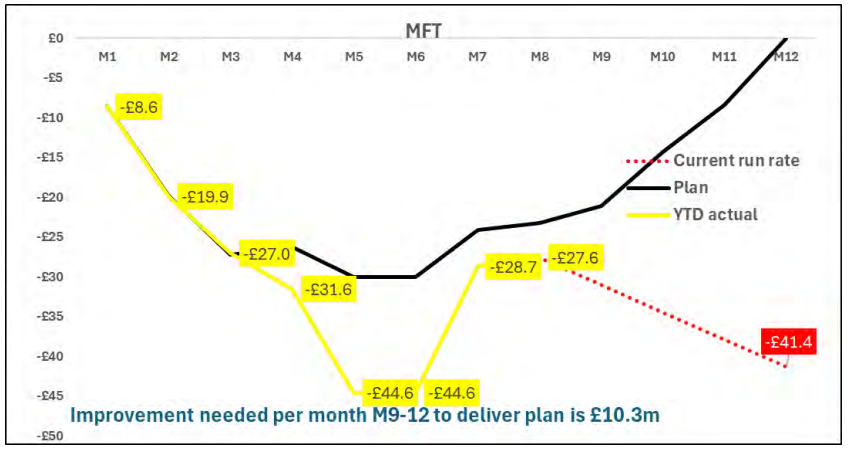
- 3 Providers are reporting adverse variances to plan at Month 8 including DSF, although they are all reporting that they will achieve the 2025/26 plan surplus of £7.5m.
- The main drivers of the YTD deficit position are as follows:
  - MFT – Pay overspends including premium staffing costs and Industrial Action; and non-pay overspends.
  - Bolton – Underachievement of CIP
  - WWL – Underachievement of pay CIP

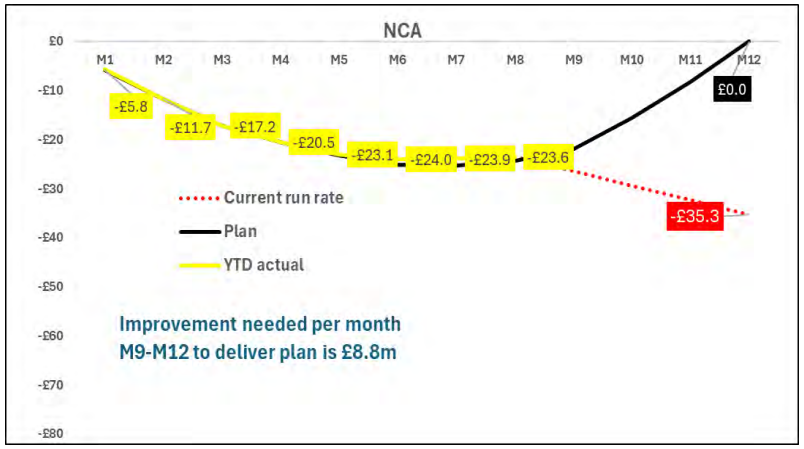
GM NHS Provider Position

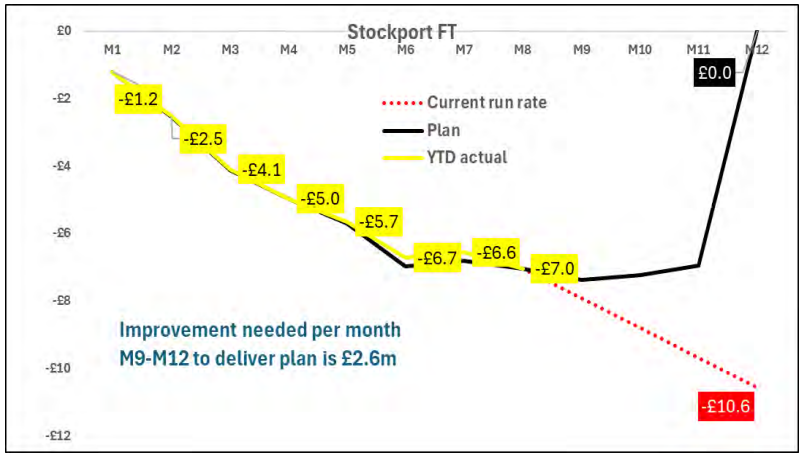
Month 8

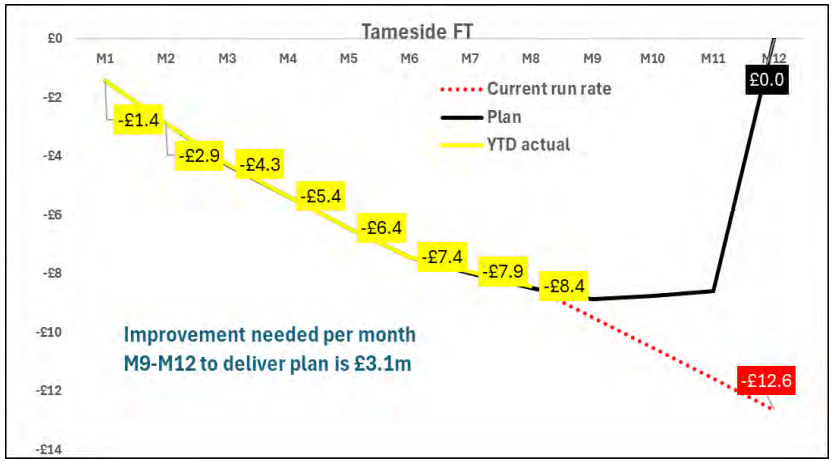
NHS Greater Manchester

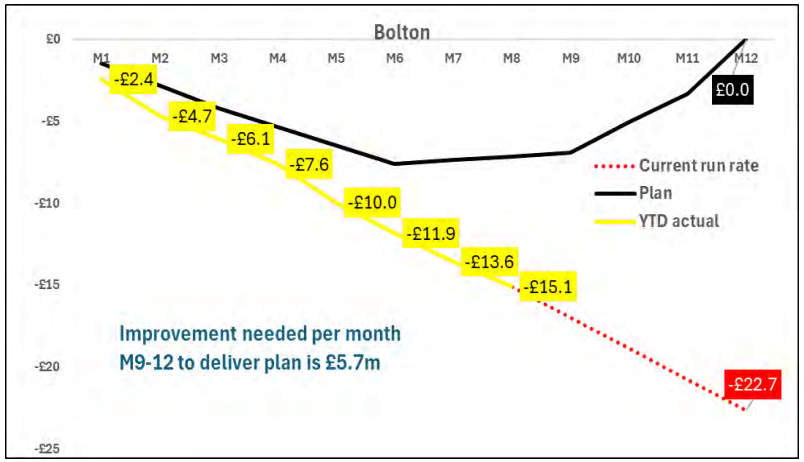
The following slides show the I&E summary and run rate by GM NHS provider (Slide 1 of 2)

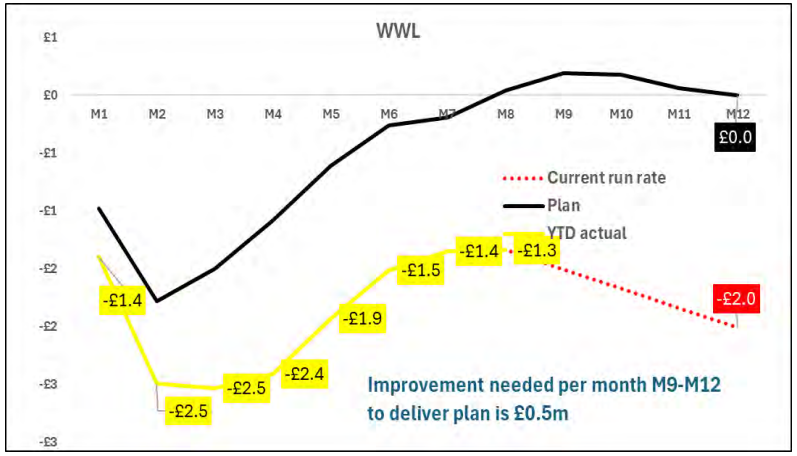










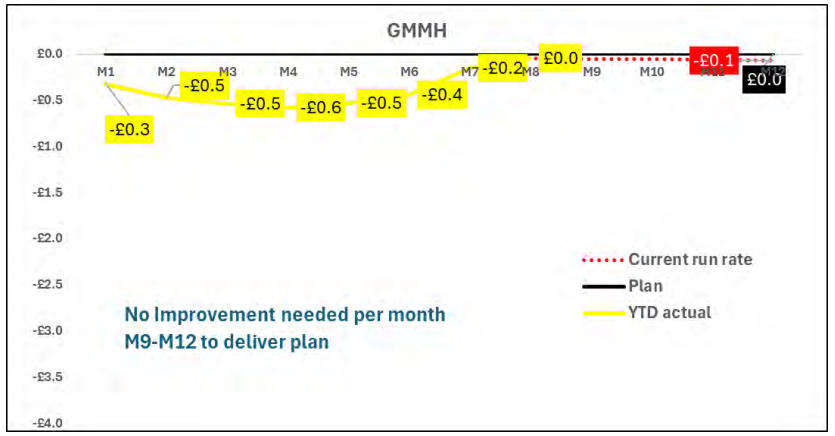


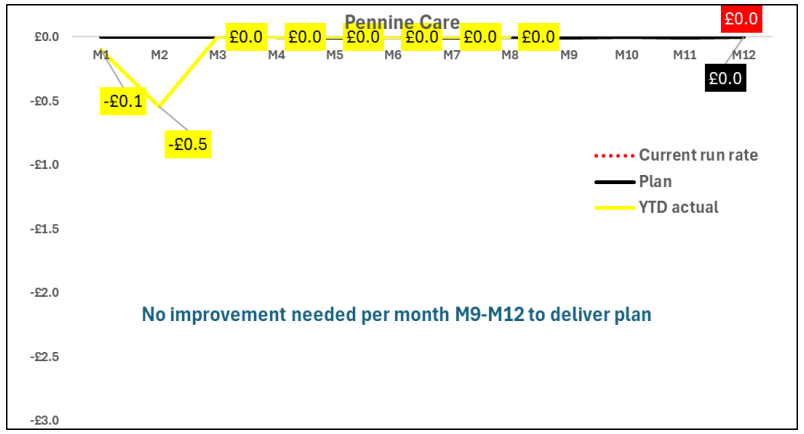
GM NHS Provider Position

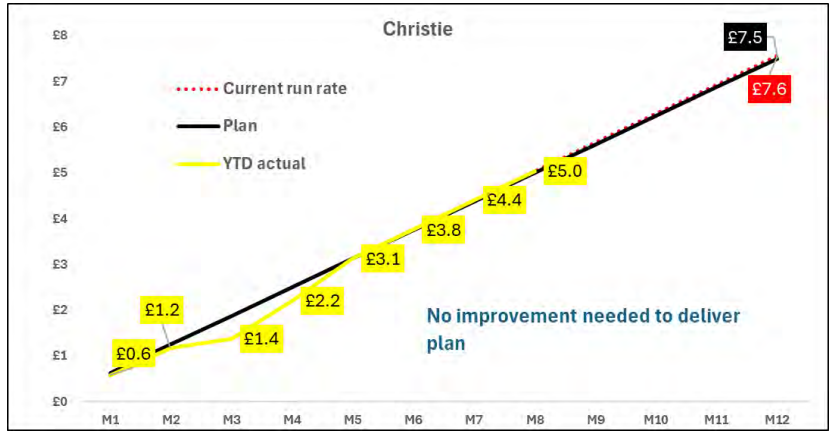
Month 8

NHS Greater Manchester

I&E summary and run rate by GM NHS provider (Slide 2 of 2)







NHS
Greater Manchester

Quality & Performance Committee Report

21 January 2026

Part of Greater Manchester Integrated Care Partnership

NHS Greater Manchester

Integrated Care Board

21 January 2026

Required information	Details
Title of report	Quality & Performance Committee Report
Author	Sue Bailey, Non-Executive Director/Chair of the Quality & Performance Committee
Presented by	Sue Bailey, Non-Executive Director/Chair of the Quality & Performance Committee
Contact for further information	Sue Bailey, Non-Executive Director/Chair of the Quality & Performance 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 this impacts 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 Quality & Performance 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:	**Quality & Performance Committee**
Date of Meeting:	3 December 2025
Chair:	Dame Sue Bailey
Quoracy Achieved:	Yes

Key escalations and discussion points from the meeting:

There were no escalations to Board.

All concerns noted in the November meeting of Q and P remain.

Arising from discussion on item 4. Risk Report, the question was raised as to where the interplay between performance and finance would best be managed. The committee were made aware of the ongoing interplay between affordability and delivering of performance standards with productivity and transformation as the bridging enablers. There was a clear view that this should be a key focus for ICB Board due to the trade-off between finance, performance and quality.

The committee also approved the decision taken by the IAG to provide partial assurance for the Oral & Maxillofacial Surgery Services for MFT to be taken to the Board.

Additionally noted throughout the 3 December Q and P Agenda, the value and need for our VCSFE partner involvement in delivering the system objectives of tackling inequalities and delivery of quality improvements as being essential ingredients in achieving success. Concern expressed that without appropriate VCSFE commissioning arrangements being in place we face a significant risk to the delivery of our objectives. However this would be mitigated by moving the VCSFE Commissioning Principles' already agreed by the ICB with a VCSFE market development strategy into the ICB operational delivery plans.

Alert

- **CNO Report:** Provider oversight BAF SR5 care experience impact.
  1. **Northern Care Alliance S29A -** Warning notice issued following onsite inspection of Surgical services at Salford Royal Hospital some good practice was highlighted along with some areas of concern particularly, staffing and subsequent impact on patient care around environment. Actions will be overseen via Contract Performance meeting and the Quality and Safety Assurance meeting. 5 year look back for paediatric audiology patients on the Salford site as part of the National Paediatric Hearing Service Improvement Programme. Action the review will determine if children need re assessment. NCA, GMNHS and Region working together to determine the impact and extent of mitigation actions required
  2. **Stockport FT – Paediatric Audiology** - Sufficient progress has not been made given issues being reported since February 2025. Reflected in Q and P risk register and raised with Chief Officers. Action:
     A. Additional commissioned support is now in place to address the waiting list for Stockport patients.

B. Forward action – Plans to utilise the support of the designated Subject Matter Experts to run clinics to see any recall patients.
C. Stockport FT have successfully recruited a clinical lead post to lead the improvement work and increase Capacity in the team.

3. **Maternity Services across providers** – Three services remain on Alert and the remainder on Advise. Manchester FT was under enhanced surveillance along with Stockport FT and Tameside FT. Actions:

- Guidance has now been issued in relation to the Maternity Regulation 28, Prevention of Future Deaths Report issued for SOS, NHSE, Royal College of Midwives, Royal College of Obstetrics and Gynaecology and NICE.
- It was noted and accepted that MFT had acted timely and appropriately in the intervening period between the care episode and the coroner's outcome
- Work continues with the LMNS to embed learning across Greater Manchester.

- **Chief Medical Officer Report:**
  Mental Health Quality Assurance:

- Manchester Locality-Pressures on Clinically Ready for Discharge patients.
- Out of area placements.
- Community Integration and Workforce Capability and Package Delays.
- Mitigations in place with some progress.

Obesity management CVRM pathway:
Cost pressures due to combination of new product launches and proposed NICE guideline changes. Actions:

- Ongoing consultation with NICE.
- Monitoring of prescribing data.
- Collaboration with all partners.
- Focus on ensuring the design of pathways and access routes do not create or worsen health inequalities.

Advise

- **Chief Medical Officer Report:** Structured Diabetes Education should be offered to people diagnosed with diabetes, uptake to date has been low. Actions:

- Redesign of the SDE offer.
- Single GM service specification being developed.
- More culturally appropriate SDE models being tested with South ASIAN, visually impaired, Black Afro Caribbean and deaf hard of hearing communities.

Assure

- **Annual Medicines Optimisation 2024/25 Report:**
  - Gives assurance despite short term disruption effective transitions can be made across teams with both improved efficiency, significant

cost improvement, better team working, laying the foundations for future work in keeping with the ten year plan. Changes introduced allowing the team to remain innovative, focused on addressing ongoing challenges in prescribing while staying flexible and adaptable to respond to new system priorities.

Risks discussed and new risks identified

Risks scoring above 16 that are monitored via the Quality & Performance Committee risk register:

Risk Report – Urgent and Emergency Care:

- **QUP21/10/24:** Target for waits - as recommended by members of Q and P at November meeting.
- **QUP09/01/23**: Risk rating has been raised from 16 to 20 it is unlikely NHS GM will achieve the 78.4 percentage 4-hour before end of March 2026. All actions are progressing, there remains a continued risk to patient safety.
- GM Mental Health Programme Risks - Following the latest Mental health Partnership group, the co chairs requested a number of their risks are resubmitted to Q and P for a one off update in December with them being rated at <than 16. Reviewed and accepted given the range of ongoing actions and interventions in place and opportunities arising.
- Progress noted on the Complaints Management Risk Update.
- Elective programme risks:
    - **ERR3** NEW - there is a risk of non-delivery of financial control [change in financial regime].
    - **ERR16** NEW - there is a risk that ICB control of its provider landscape and activity is significantly limited.
- Although these 2 risks centre around financial impacts the ask of Q and P is to report both to Q and P and decide whether they feel that these risks also require reporting to Q and P as the impact described in both cases effect operational delivery.
- Q and P through the transitional committee restructure would wish to see the relevant papers but as the new structures come into place are of the view that the interplay between quality safety performance and finance should be informed through the new 2 committee structure but should be the focus of the ICB board itself.

Learning for sharing

Summary of learning points to share from the Quality & Performance Committee December meeting.

- **Annual Medicines Optimisation 2024/25 Report:** Gives positive shared learning of effective team functioning during a period of transition despite short term disruption with consequent significant cost improvements - **Medicines Optimisation Annual Report 24/25**
- **Medicines Management Annual Report:** **7-minute Briefing Medicines in pregnancy**

NHS
Greater Manchester

Quality and Performance Board Paper

January 2026

Part of Greater Manchester Integrated Care Partnership

NHS Greater Manchester Board

January 26

Required information.	Details.
Title of report.	Quality and Performance Report
Author.	Ed Dyson, Director of performance, improvement and assurance Zoe Mellon, Associate Director of performance, improvement and assurance 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 November, 69.1% of patients attending A&E were admitted, transferred, or discharged within **four hours,** which was worse than November. More recent unvalidated data shows that between the 1st and 30th of December performance was at 67.6%, currently worse than December plan of 71.3%. Once data is validated, performance usually increases by an average of 1.5%. The target is to achieve 78% on March 26.

1.6. There is a requirement to eliminate 65 week waits by the 21st of December. As of the 31st of December, GM Trusts are reporting 38 patients waiting **over 65-weeks** for treatment by the 21st of December (made up of 23 breaches at Wrightington, Wigan and Leigh NHS Foundation Trust, 8 at Northern Care Alliance NHS Foundation Trust, 3 at Bolton NHS Foundation Trust, and 4 at Stockport NHS Foundation Trust). The forecast for the end of December is 41 breaches, all of which have operation or treatment dates booked in January and therefore the end of January forecast is zero.

1.7. In October, 3% of the patients in GM Trusts, were waiting over **52 weeks** for treatment, worse than the October plan of 2.4%. The target for March 26 is to achieve less than 1% of the total waiting list, which based on current performance will be a significant challenge.

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 October 25, was 62.9 days for GM registered

patients, which was worse than the October plan, but an improvement from the previous month. The plan is to reduce to 57 days by March 26.

Advise

1.9. GM continues to achieve the 30-minute target for **Category 2** ambulance calls. In November, the average response time was 27 minutes and 20 seconds. Unvalidated data shows that between the 1st and 29th of December the average response time deteriorated to 28 minutes and 34 seconds.

1.10. In November, 10.8% of patients waited **over 12 hours** for admission or discharge from a type 1 emergency department, which worse than the November plan. More recent unvalidated data shows between 1st and 29th December, performance improved slightly to 10.4%, but worse than December plan of 9.5%. GM benchmarks well, with the latest ranking data for September shows GM ranked 20th out of 42 ICBs.

1.11. In October, 56.1% of GM Trust patients were waiting less **18 weeks for treatment,** which was worse than the October plan of 57.2%. The GM plan is to achieve 61% by March 26.

1.12. In October, 60.9% of elective patients in GM Acute Trusts were waiting less than **18 weeks for a first appointment**, which was worse than October plan. Performance has remained static since April. The GM target is to increase to 68% by March 26.

1.13. GM providers were better than plan for the **cancer faster diagnosis** with 78.3% diagnosed within 28 days in October 25. Local data shows GM is forecast to be slightly worse than the November plan. The target increases to 80% by March 26.

1.14. In October 71.8% of **cancer** patients received treatment within **62 days**, worse than October plan of 72.1%. Local data shows GM is forecast to be better than plan in November. The target increases to 75% by March 26.

1.15. At the end of November, 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 will be challenging. Published data for LD metrics are rounded to nearest 5 prevent identification of vulnerable individuals

1.16. At the end of October, 15.8% of patients were waiting more than six weeks for a **diagnostic test** at GM NHS providers. This is a 1.8% improvement from previous month. Local targets have been set with providers. GM benchmarks favourably in October compared to other ICBs, ranked 11th 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 waiting time targets.

Assure

1.17. The number of **children and young people accessing mental health** services in the 12 months to October 2025 was 55,245, which was better than the October plan of 55,000.

1.18. At the end of November, 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

Segment 5 Oversight – Greater Manchester Mental Health NHS Foundation Trust (GMMH)

1.19. GMMH has been allocated to Segment 4 from segment 5 under the NHS Oversight Framework (NOF) revised segmentation system. This reflects the exit from the National Recovery Support Programme.

Segment 3 Oversight – Wrightington, Wigan and Leigh NHS Foundation Trust (WWL)

1.20. WWL have dropped from Segment 3 to Segment 4 under the revised NHS Oversight Framework. Primarily focused on the metrics for Cancer and Elective Care, further work is underway to understand the quality and safety impact on patient outcomes.

Segment 4 Oversight – The Northern Care Alliance NHS Foundation Trust (NCA)

1.21. Quality and Safety Assurance Meetings (QSAM) for the NCA continue on a six weekly basis. The Trust has remained allocated to Segment 4 under the NOF revised segmentation process.

1.22. The Care Quality Commission has issued a S29A Warning Notice following an onsite inspection of the Surgical Services at Salford Royal Hospital. The full requirements will require further understanding to reach full assurance, this will take place through the NHS England Quality Management Group and the QSAM.

Key Updates

Alert

1.23. Paediatric Audiology remains a concern for NHS GM. The ICB continues to lead the Paediatric Hearing Services Improvement programme in GM on behalf of the national team. There are 4 Trusts who are currently subject to review and recall processes. The ICB acknowledge that there has not been sufficient movement to resolve the issues which have been reported since February 2025. This is reflected on the Quality and Performance Committee (QPC) risk register and has been raised at the Chief Officers Meeting. Additional commissioned support is now in place to address the waiting list for Stockport patients as well as further work to enhance Trust capacity. A super clinic

model is being finalised to draw on clinical expertise from the national team to expedite the activity and ensure that all children and young people are assessed and on the correct treatment pathway as quickly as possible.

1.24. The recent coroner's inquest and subsequent Regulation 28, Prevention of Future Deaths Report following an out-of-guidance maternity home birth have triggered urgent National action to strengthen the safety, governance and consistency of homebirth services, with a focus on ensuring robust care planning, risk assessment, escalation and cross-sector communication, alongside improved workforce competence, supervision and oversight in community settings.

Nationally, NHS England has instructed all Trusts to undertake an urgent review of homebirth services, with findings reported to Trust Boards and escalated to Regional Teams where concerns are identified, while recipient bodies must formally respond to the Regulation 28 report by January 2026.

Regionally, the Northwest is implementing a standardised four-step improvement programme, including benchmarking, gap analysis, development of a regional Homebirth Charter and ongoing monitoring through MPPOP, to reduce unwarranted variation and establish minimum safety standards.

Locally within Greater Manchester, assurance activity has intensified through Safety SIG oversight, LMNS-led task and finish work, annual provider assurance visits and closer alignment with regional programmes, with likely next steps including intrapartum homebirth audits against NICE guidance, strengthened intrapartum skills pathways for community midwives, improved understanding of workforce exposure to homebirth practice, and consideration of future commissioning approaches to ensure safe, standardised and measurable homebirth provision across the system.

Advise

1.25. Following the ICB-led Quality Visits which were undertaken across all Greater Manchester Emergency Department throughout summer, a programme of follow-up visits are currently underway. The outcomes will be fed back to the UEC Board for triangulation with other intelligence and as part of the ongoing winter planning process; this is in addition to oversight through the existing provider oversight arrangements.

1.26. Whilst a high number of backlog reviews for Continuing Healthcare (CHC), Fast track and Funded Nursing Care (FNC) remain, numbers have started to decrease for CHC and Fast Track reviews since last reported to the Board. Previously Unassessed Periods of Care (PUPoC) and Court of Protection/Deprivation of Liberty (COP/DOLs) continue to be a concern for NHS GM due to the financial risk and lack of legal compliance with the CHC Framework regarding COP/DOLs reviews. Progress continues to be impacted by workforce challenges such as vacancies and sickness within several Greater Manchester localities. The vacancy rate reported for November was 6.2% with the absence rate reported at 8.4%. Vacancies and sickness are reported to the ICB monthly; however, it is anticipated this will decline further in the coming months due to the NHS Reform.

A contract between NHSE Professionals and the other Northwest Integrated Care Boards is in the final sign off stages which is regarding the potential use of bank staff to support stability in teams instead of using agency staff. As previously reported mutual aid is put in where required across NHS GM.

1.27. Oldham locality continues to lead the Rapid Quality Review for Cygnet, Kenney House following the receipt of a Section 29A Warning Notice from the CQC in September 25. An extensive action plan has been implemented, and assurance has been received that progress is being made. Close monitoring remains in place whilst improvements continue to be embedded.

Assure

1.28. Progress continues to be made by the NHS GM complaints team in addressing the back log of primary care complaints. There are currently 8 outstanding complaints which is a reduction of 105 since July.

Provider Oversight and Assurance

1.29. The Provider Oversight Model continues with the reporting cycle as follows:

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.

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.

Provider Oversight Sub-Committee Meeting (POSM) are continuing with agreed actions being taken forward through the relevant meeting or where required escalated to the Provider Oversight Meeting (POM)

Locality Assurance Meeting (LAM): quality and performance assurance and oversight of the duties delegated to localities.

Recommendations

1.30. The NHS GM Board is asked to discuss and agree levels of assurance set out in this report:

NHS
Greater Manchester

Audit Committee Report

21 January 2026

Part of Greater Manchester
Integrated Care Partnership

NHS
Greater Manchester

Integrated Care Board

21 January 2026

Required information	Details
Title of report	Audit Committee Report
Author	Ross Baxter, Governance Advisor
Presented by	Richard Paver, Non-Executive Director and Chair of the Audit Committee
Contact for further information	Jenny Noble
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 verbal report including items for escalation 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	This is a summary report following the December Audit Committee meeting
Engagement* to date ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	Draft report shared with the Chair for comments.
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:	**Audit Committee**
Date of Meeting:	11 December 2025
Chair:	Richard Paver
Quoracy Achieved:	Yes

Key escalations and discussion points from the meeting:

Alert
Audit Progress and Sector Update: This report provided an update on the progress in delivering Grant Thornton responsibilities as the external auditor at NHS GM for 2025-26. It also summarised emerging national issues and developments that may be relevant to the work of the ICB. The discussion focused on the current stage of the external audit, with it explained that initial planning discussions were underway for the 2025/26 audit, aiming to present the audit plan at the March Audit Committee. There was discussion about the national challenge of transferring balances between financial systems, with concerns about how assurance would be provided for these transfers and whether internal processes or external audit testing would be relied upon. The group agreed on the need to clarify assurance sources, particularly regarding the SBS (Shared Business Services) system, and to ensure that the audit committee is confident in the integrity of transferred balances in the context of mandated change to the financial system mid-year and the impact regarding workarounds and inability to use the system, noting that payments continue to be made. Additionally, the discussion touched on the accounting for redundancies, noting the need for consistent national guidance and the impact of redundancy provisions on financial planning. The team planned to coordinate with national teams to ensure alignment and to bring relevant accounting policy decisions to the committee for approval. **Internal Audit Progress and Follow Up Reports:** This report provided the committee with a summary of the progress made in the completion of the 2024/25 Internal Audit Plan and delivery of the 2025/26 Internal Audit Plan. The discussion focused on the status and assurance levels of various audit reviews, highlighting both completed and ongoing work. It was explained that for the previous year, two reviews (IT Asset Management and Contract Management Quality of Care) were finalised, both receiving moderate assurance. For the current year, three reports (Financial Recovery Programme, Pod Delegation Review, and Mental Health

Review) achieved substantial assurance, indicating medium and low risk recommendations.

The Follow Up Report provided the committee with an update on progress made in implementing outstanding internal audit recommendations. The discussion centred on the status of 58 recommendations reviewed since the previous audit committee, with 26 having revised implementation dates and concerns about the frequency of deadline extensions. It was outlined that 17 recommendations were not yet due, 10 were fully implemented, and 31 were in progress or partially implemented, with 27 of these having revised dates. Members discussed the implications of the reform programme and running of the voluntary severance scheme and expressed the need to focus on high-priority recommendations, particularly those related to cyber controls and EPRR, which have been outstanding for several years and pose significant risks.

Advise

Corporate Policies: The Committee was presented with the Software Control Policy for consideration and approval in line with the SORD. This policy was presented, emphasising its aim to ensure all software installed on the organisation's digital estate was fully controlled and compliant. It was explained that the policy had been reviewed and approved by several governance groups, including the Digital Security Programme Board and the Primary Care Digital Board. Clarification was given on areas on the devices that this covers, and the Committee approved the Policy.

Review of the 2024/25 External Audit: This report provided feedback on lessons learnt from the 2024/25 year end accounts process, and was a joint paper drafted with external audit colleagues. It gave an update on 2023/24 Lessons Learned, 2024/25 Feedback and Key development areas for 2024/25 and their agreed actions.

Update on 2024/25 Auditor's Annual Report Recommendations: This report provided an update on the implementation of the 2024/25 Auditor's Annual Report. In total there were one key recommendation and three improvement recommendations, with the key recommendation confirmed as fully implemented in the September report to the Committee.

Final Annual Report and Accounts Timetable and Plans: This report provided an update to the committee on the approach for the Month 9 and Month 12 annual report and accounts submissions to NHS England for 2025/26.

Assure

Counter-Fraud Progress Report: This report provided a summary of anti-fraud activities undertaken from 1 September 2025 – 30 November 2025. The discussion covered key elements of the fraud plan, compliance with government functional standards, and recent changes in risk assessment processes. The report indicated that the plan was progressing as scheduled, with most compliance areas rated green, though one component was temporarily amber due to the adoption of a new risk assessment methodology requiring significant re-evaluation of fraud risks. The team was optimistic that this would return to green once the assessment was complete. The ongoing gap analysis work related to the "failure to prevent fraud" offence and a joint preventive exercise with Greater Manchester Mental Health on section 12 assessments were highlighted, with both progressing well.

The report provided assurance that no outstanding recommendations were due for update, and overall the committee was satisfied with the clarity and presentation of the report, especially the glossary and acronyms. The discussion also acknowledged the resource-intensive nature of the new risk assessment process but anticipated future updates would be less burdensome.

Risks discussed and new risks identified

The Committee received a formal report setting out the Corporate Risk Register, which also included an update on the BAF development.

The discussion focused on recent efforts to improve risk moderation and the presentation of risks at both the corporate and committee levels. It was explained that feedback from previous meetings had led to more robust moderation processes, including taking the corporate risk register through the operational leadership group for wider scrutiny. There was specific mention of the need to clarify the rationale behind certain risk scores, such as the high score for primary care and the handling of EPRR and finance risks. The committee continued to feel that there was a misinterpretation of the RAG rating of the three lines of assurance and that the impact of various control actions was uncertain. The committee was pleased that there had been a start on separately identifying issues from risks and noted the initial assessment for two service areas.

Learning for sharing

There were no specific areas of learning for sharing from the Audit Committee.

NHS
Greater Manchester

Primary Care Commissioning Committee

Report of meetings

November and December 2025

Part of Greater Manchester Integrated Care Partnership

Greater Manchester Integrated Care Board (Public)

14 January 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 10th November 2025 and 8th December 2025
Leadership and governance arrangements.	This is a summary report following the Primary Care Commissioning Committee meetings 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.

Accessibility element.	Notes.	Have you applied it?
Structure	You have made sure appropriate structure, headings etc is set in your document. You have added captions to any tables or images. You've not pressed enter to create white space in your document. (Your text is a minim of font size 12)	Yes / No
Colour	You have stuck to our corporate brand colours, or checked the colour contrast is okay if you have deviated from this. (Arial, black, font size 12)	Yes / No
Use of images	Any images add to the context of the document. You have added descriptive alt text to any images. You have not screenshotted any tables or infographics which are not accessible. You have not built any infographics within your document using shapes and other elements.	Yes / No
Links	There are no URLs written out in full. You have linked URLs to a descriptive term or word.	Yes / No
Plain English	You have aimed for a reading age of 8 – even if your document is for internal purposes only. There are no abbreviations that aren't explained.	Yes / No
Tables	You have used tables in the correct way, e.g. to support data. Your tables are uniform, they have a column header and no split or merged cells. Someone can toggle along your table and make sense of it.	Yes / No

Table 3: Accessibility checklist.

Table 3 is intended as a guide for the author of the document, it can be deleted before being submitted to board.

Report from:	**Primary Care Commissioning Committee**
Date of Meeting:	10th November 2025 and 8th December 2025
Chair:	Katherine Sheerin, Chief Commissioning Officer
Quoracy Achieved:	Yes~~/No~~

Key escalations and discussion points from the meeting:

Alert
Capacity Access and Improvement Payment (CAIP) Post-payment verification • The Capacity Access and Improvement Payment (CAIP) is part of the Network Contract DES, it is an incentive scheme that aims to improve access to general practice services. It includes two key payments: the National Capacity and Support Payment (CASP), which is automatically paid to PCNs, and the Capacity Access and Improvement Payment. The CAIP funding is contingent on PCN compliance with specific components, including the availability of Online Consultation for patients during core hours. The CAIP aims to support modern general practice access, ensuring consistent and accessible care for patients. • Whilst this PPV process is specific to the Network DES, CAIP Incentive scheme for 2024/25. We acknowledge the general practice contract changes which came into effect from Wednesday 1st October, and require that every GP practice in England must keep their online booking open all day during core working hours (8am-6:30pm) • The PCN Capacity, Access and Improvement Payments (CAIP) PPV Process 2024/25, was presented to Greater Manchester Primary Care Committee (PCCC) in Feb 2025. • The paper outlined the PPV verification process to be undertaken between June – August 2025. A subsequent request was made to PCCC in August 2025, to approve an extension to the timeline to report the full findings of the PCN Network DES, Capacity, Access and Improvement Payment (CAIP) PPV Process to the October 2025 Committee. This request was granted, and a formal communication was issued to each PCN. • The purpose of the Post-Payment Verification (PPV) is to validate 15% (10 PCNs), claims made for the Capacity and Access Improvement Payment (CAIP) domains during 2024/25. This is to ensure they fully meet the requirements, as set out within the Network Contract DES and to ensuring that CAIP funds are paid based on verifiable achievements. • The following components of Modern General Practice must be in place in every Practice and declared as such by the Clinical Director, for the full funding to be paid: 1. Better digital telephony 2. Simpler online requests 3. Faster care navigation, assessment and response

- All PCNs had to declare their achievement of the CAIP Modern General Practice (MGP) domains by the 31st of March 2025. Where a PCN declared as having achieved one or more of the above domains, an indicative payment has been made in accordance with the National DES.

The table below indicates the 10 PCNs selected for PPV and the CAIP domains declared as having achieved as of 31st March 2025.

PCN Name	No. Domains Claimed	Better Digital Telephony payment claim	Simpler Online Requests - payment claim	Faster Care Naviagation - payment claim
PCN A	All 3	Yes	Yes	Yes
PCN B	2 - Telephony and Care Navigation	Yes	No	Yes
PCN C	All 3	Yes	Yes	Yes
PCN D	2 - Online Requests and Care Navigation	No	Yes	Yes
PCN E	All 3	Yes	Yes	Yes
PCN F	2 - Telephony and Care Navigation	Yes	No	Yes
PCN G	All 3	Yes	Yes	Yes
PCN H	All 3	Yes	Yes	Yes
PCN I	All 3	Yes	Recinded	Yes
PCN J	2 - Telephony and Care Navigation	Yes	No	Yes

GM Primary Care Commissioning Committee was asked:

1. To note the outcome of the Post Payment Verification process.
2. To uphold PCN achievement payments for Better Digital Telephony during 2024/25 for all PCNs.
3. To uphold PCN achievement payments for Faster care Navigation and Response during 2024/25 for PCNs confirmed compliant with this domain.
4. To support the ongoing review and further evidence requests for those PCNs identified as being non-compliant for Simpler Online Request and Faster care Navigation and Response.
5. To support the process where resolution isn't achieved by referring any appeals to DCCP for determination.
6. To support payment reconciliations through a phased recovery in year and /or aligned to payments being made to support with cash flow management during winter.

All recommendations were approved.

Advise

Upcoming Procurements and Planning

1) ***Special Educational Settings Sight Testing Service for children and young people with special educational needs and disabilities (SEND)***

This is a nationally mandated service and is part of the operational plan for ICBs for 25/26. The service will offer all children and young people in special educational settings, day, residential and colleges the opportunity for an annual sight test (unless a more frequent interval is clinically indicated). This service will provide benefits to those children and young people in special education settings that may require additional needs and support in accessing sight tests, in the educational setting.

Final consensus of the Primary Care Commissioning Committee: pursue shared procurement with three lots (GM, Cheshire & Mersey, Lancashire & South Cumbria), maintaining GM control and saving costs.

2) ***Dental***

Orthodontic Services

NHS Primary Care Orthodontic Services provide specialist dental treatment to correct teeth alignment and bite issues, primarily for children under 18, offering improved oral health and appearance at no cost to eligible patients.

Primary Care Orthodontic Services are delivered by specialist orthodontists and are provided within High Street dental practices.

Community Dental Services (CDS)

Specialist Community Dental Services (SCDS) support some of the most vulnerable members of our population, providing tailored dental care for individuals with complex needs who cannot be treated in general dental practices. They play a vital role in ensuring equitable access to oral health services across communities. Designed to treat patients whose needs exceed the scope of routine high-street dentistry. These services are typically consultant-led and delivered by teams with advanced training in special care and paediatric dentistry.

The above services are commissioned to deliver services to patients pan-GM.
The current contracts end on 31st March 2026, however Schedule 1C of the contracts provides the option to extend the contracts.

GM PCCC supported the recommendation to invoke the extension clause within the following contracts across Greater Manchester:

- Primary Care Orthodontic Contracts – 12-month extension from 31st March 2026 to 31st March 2027

- Specialist Community Dental Service Contracts – 24-month extension from 31st March 2026 – 31st March 2028

Due consideration has been given to the Provider Selection Regulations (PSR) and advice has been sought from NECS to ensure that there is nothing further needed regarding PSR other than to seek approval via the GM Governance structure. A service review and value for money exercise will be carried out during financial year 2026 in preparation for procurements to begin during summer 2026.

Assure

Winter schemes

GM Urgent and Emergency Care (UEC) Capacity and Discharge (C&D) funding has been scrutinised over summer 2025 to prioritise system safety whilst ensuring value for money. Final C&D funding values were confirmed to localities the w/c 22nd September 2025 and there have been none or minimal reductions to primary care winter funding.

Through the commissioning of additional primary care winter schemes over winter, the population will benefit from:

- Increased universal access to GP winter appointments
- Increased consistency of offer across localities
- Better experience in accessing health and care system services if more activity can be handled in primary care 2 settings (if clinically appropriate to do so)

Risks discussed and new risks identified

Risk score de-escalation: PC10 Capacity of the pan-Greater Manchester Primary Care team workforce

PC10 – current risk score agreed to be de-escalated to an impact score of 4 (from 5) due to following request for alignment to similar risks presented on the NHS GM Corporate Risk Register; acknowledging that mitigations support the management of level of impact. Overall risk score has therefore been reduced from 25 to 20. Ongoing situation review advised to maintain reduced risk level.

Learning for sharing

Nothing to note

NHS
Greater Manchester

Transition Committee Report

21 January 2026

Part of Greater Manchester
Integrated Care Partnership

NHS
Greater Manchester

Integrated Care Board

21 January 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:	7 January 2026
Chair:	Rachel Egan
Quoracy Achieved:	Yes

Key escalations and discussion points from the meeting:

Alert

- **M8 Finance Report:** The committee reviewed the M8 Finance Report, noting stabilisation of the financial position, the confirmed Deficit Support Funding (DSF) received for Q4, ongoing risks related to industrial action, cash flow, provider performance and the need for continued focus on recurring savings and clarity for next year's budgets. The committee were made aware of Bolton facing significant challenges due to legacy staffing increases and noted the uncertainty around future deficit support and recovery timelines for providers ending the year in deficit.

Advise

- **Performance Update – Winter:**
  - The committee were informed of the winter system performance detailed preparations that had taken place across providers. It was reported that system wide efforts had taken place to reduce bed occupancy, enabling better management of January & February 2026 pressures.
  - The committee noted that the system remained at OPEL 3, avoiding escalation to the highest alert level.
  - 4-hour performance position for December 2025 was reported to be 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 reported to have improved by 2 minutes than the previous year.
  - The committee emphasised the importance of a strategic shift 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. The need to gather evidence on patient outcomes for those managed in the community, build clinical confidence in out-of-hospital care, and use the learning to inform investment and planning for future winter periods was raised.
  - The committee were made aware of the recent reports that the system had exceeded the national flu vaccination targets. RSV and other respiratory viruses were reported to be declining.

- **Transition Committee Purpose and Closedown Arrangements for Abolished Committees:** The Committee discussed the importance of ensuring the Transition Committee should focus on key priorities over the next two months as new Committee arrangements were established. A request was made for the top four priorities for the coming 12 months to be understood and prepared ready for April 2026. Confirmation was received that a clearly defined process for commissioning intentions and plans would be available in advance of April 2026.

Assure

- **Committee Work Plans:** The committee discussed the transition to new committee work plans under the new arrangements, emphasising the need to prioritise critical activities, streamline assurance reporting, focus on strategic objectives, and adapt to evolving responsibilities under the new operating model.

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 current approach to risk management and the Board Assurance Framework (BAF), highlighting the need for clarity between ICB and system risks, clarity on lines of defence, and a more dynamic, evidence-based, and integrated risk reporting process.

Learning for sharing

Summary of learning points to share from the Transition Committee January meeting.

- Meeting to take place to ensure an appropriate escalation mechanism is in place for VCSE sector to escalate concerns or vulnerabilities into the commissioning process.
- An exploration of dynamic risk reporting outside of the organisation to take place to consider and improve current risk reporting.
- Stakeholder summaries to be created and shared with stakeholder partners to be kept informed of the discussions held at the Transition Committee.

NHS Greater Manchester

Minutes

NHS Greater Manchester People & Culture Committee Part 1

Date: Tuesday 4th November 2025

Time: 10:00am – 11:30am

Venue: Microsoft Teams

MEMBERS:		
Kal Kay	**KK**	Chair, Non-Exec Member, NHS GM
Mark Fisher	**MF**	Chief Executive, NHS GM
Nicky Littler	**NL**	Mental Health Provider representative
Michelle Hill	**MHi**	Voluntary Sector Representative
Andrew Brass	**AB**	Higher Education Institution representative
James Bull	**JB**	Trade Union representative, Workforce Engagement Forum
Anita Rolfe	**AR**	Deputy Chief Nursing Officer – deputising for Mandy Philbin
Jackie Gardiner	**JG**	Corporate Director of Operational Finance – Financial Management, NHS GM
Steve Voyse	**SV**	Trade Union representative, NHS GM
Hannah Dobrowolska	**HD**	Deputy Place Based Lead
Karen James	**KJ**	Provider Chief Executive and Co-Chair of the System People and Culture Group
Charlotte Bailey	**CB**	Chief People Officer, NHS GM
Jane Seddon	**JS**	Director of People Services
Majid Hussain	**MH**	Director of Inclusion, NHS GM
Owen Williams	**OW**	Chief Executive, NCA
Luvjit Kandula	**LK**	Primary Care Board Representative
Kate Provan	**KP**	Associate Director Clinical Effectiveness and Improvement – deputising for Manisha Kumar
IN ATTENDANCE:		
Anna Cooper-Shepherd	**ACS**	Head of Strategy & Business for the Chief People Office, NHS GM
Faye Vaughan	**FV**	Governance Advisor, NHS GM
Eram Hussain	**EH**	Business Manager, NHS GM
Lynette Harwood	**LH**	Maternity Programme Lead, NHS GM
Michelle Dawes	**MD**	Clinical Workforce Lead, NHS GM
Luzani Moyo	**LM**	Lead Freedom to Speak Up Guardian, NHS GM
Sue Howard	**SH**	Head of Workforce Development, NHS GM
APOLOGIES:		
Jo Finnerty	**JF**	Assistant Programme Director (Workforce) Adult Social Care Transformation
John Herring	**JH**	Director of OD and Culture
Manisha Kumar	**MK**	Chief Medical Officer, NHS GM
Amanda Bromley	**ABr**	Provider HR Director
Mandy Philbin	**MP**	Chief Nursing Officer, NHS GM
Joanne Chilton	**JC**	Director of Social Care, NHS GM

(Public Meeting)	
Item No	**Item**
1.	**Introductions and Apologies (Chair)** KK welcomed all to the meeting and apologies were noted.
2.	**Declarations of Interest/Conflicts of Interest (All)** No interests were declared.
3.	**Minutes of the Previous Meeting (Chair)** The minutes of the meeting held on the 2 September 2025 were presented for sign off. **NHS GM People & Culture Committee APPROVED the minutes from the 2 September 2025.**
4.	**Action Log / Matters Arising** The action log was shared for information and changes noted.
5.	**BAF Review** The paper presented an overview of the BAF Q2 risk score which was shared for ratification. It was reported that the score in Q2 had remained the same. The mitigating actions and controls had been updated based on feedback at the previous meeting. The committee were also made aware that there had been an update made on the committee risk register, to the risk regarding potential reduction to the People and Culture teams across the system. The risk score had been reduced due to the slower pace of Reform taking place at ICB level. **NHS GM People & Culture Committee:** • **Considered and approved the risk score for Q2.**
6.	**Risk Areas** • **Maternity & Neonatal Workforce Plan Delivery Update** The committee were reminded that the Greater Manchester Maternity and Neonatal Workforce Implementation Plan was approved in November 2024. The plan was a response to the directives laid out in the NHS Long Term Workforce Plan setting out an ambitious strategy to Train, Retain and Reform the NHS workforce over the next fifteen years. LH informed the committee of the six-monthly report which showcased some of the work and progress through the GM Maternity Workforce Group. It was reported that the midwifery gap had closed significantly over the last 12 months. LH explained that work was ongoing around midwifery and maternity support workers based around the NHS Longterm Workforce Plan for retention, retain and growth in the workforce. The committee were further informed on the student midwifery profile with increased numbers through the higher education institutions in order to support the midwifery gap. It was reported that student midwives had increased. The committee were made aware of the struggle to provide roles and jobs for student midwives which was being looked at regionally. LH explained that the Department of Health and Social Care had asked providers to offset

	vacancies against those student numbers. Assurance was provided of the work ongoing to ensure stability going forward. A discussion took place regarding equality data. MH offered to support the work on collating data on diverse workforce. It was confirmed that work was taking place at present with business intelligence colleagues to identify what data was being collected on ethnicity on the obstetric workforce as it was recognised that each provider collected data slightly differently. A suggestion was raised to look at recruitment, retention, progression and experience of colleagues. CB questioned the culture elements and whether a cultural focus had taken place in that space. LH confirmed an update could be shared at a future meeting in more detail. Future update in Q4 to be shared with the committee for a more reliable set of data through Provider Workforce Report (PWR) data. **NHS GM People & Culture Committee:** • **Noted the content of the paper and the progress that was being made on the actions detailed in the Greater Manchester Maternity and Neonatal Workforce Implementation Plan.** • **NHS Immigration Changes** The committee were informed that the purpose of the paper was to outline the recent UK immigration changes to sponsorship requirements and salary thresholds, and the associated implications. Potential impact and risk were summarised in relation to existing workforce and considerations for the future workforce. MD highlighted the key elements for the current workforce and employees and their risk to continue to be able to renew their visas, their certificates of sponsorship and subsequently their employment in the UK. A number of ethical considerations such as the potential need for repatriation to their country of origin were also raised. The committee were informed of the long-term plans in place around reduced dependency on international recruitment. MD explained that they had commenced a system wide review to consider what had been put in place to support colleagues across the system and mitigate the risk. A briefing paper had also been developed by Manchester Foundation Trust (MFT) which had been shared more widely. MD informed the committee of the complexities with quantitative data, however, confirmed that they could be shared in the future. MD reported the proposed next steps: - To continue to undertake this review. - To build an operational group to share good practice and a GM model with data collection tools. - To undertake a higher-level risk assessment. It was reported that early legal advice had been shared, with confirmation received that the risk would lie with the sponsors. MD explained that they would need to ascertain how the risks were being managed and questioned whether they would need to consider a system wide risk. - Equality Impact Assessment (EIA) to be undertaken as part of this work. JB informed the committee of the disappointment from trade union members regarding the

	impact of the immigration changes and the concerns for the workers impacted and on colleagues left dealing with the impact of workforce reduction. JB further raised concerns with the GM position referred to in the paper written by MFT which had not been discussed with trade unions. The risk will be further discussed at Workforce Engagement Board in November. Moving forward, it was identified that they would need to ensure all possibilities were explored to avoid any unnecessary dismissals. NL highlighted the need to approach everything in a fair and equitable way. MH suggested a more systemic approach across GM to ensure consistency and fairness and reduce any variation. The committee supported the systematic approach to have an offer to allow parity across GM in terms of support for staff. **ACTION:** JB & MD to meet separately to discuss the points raised. **ACTION:** MD to draft a risk to sit on the Committee Risk Register, for review at the next meeting. Update including a Sitrep to be provided at the next meeting in January 2026. **NHS GM People & Culture Committee:** • **Noted the content of this paper and the collaborative processes that are being undertaken to fully review, and managed, the implications.** • **Provided input regarding the next steps and desired outcomes moving forward.** • **Provided input regarding the primary and associated risks and issues.** • **Supported the suggestion for a risk at system level.**
7.	**Working Group Report Update:** - **Transforming People Services** - **Workforce Efficiency** - **Leadership, Culture & EDI (including FTSU System Report & Final Report of Leadership & Governance Working Group)** The committee were informed that this item provided an overview of the areas of work for the three new reports from Working Groups and progress made to achieve targets in the previous two months. **Transforming People Services** KJ provided an overview of the updates from the Transforming People Services Group: • KJ reminded the committee of the objectives in the workstream; to look at people services and shared working opportunities across recruitment, Occupational Health (OH), payroll and learning and development. KJ explained that work was being undertaken with digital to provide an opportunity to transform what took place at present. The committee were informed of the good progress in all these areas apart from Occupational Health. It was confirmed that legal advice had been received around joint working, with the potential need to go out to external procurement which would be revisited to look at the possible solutions. • JS informed the committee of the newly appointed MFT host following a procurement for the recruitment workstream. • People Portal Chatbox: Five supplier bids had been received. The committee were made aware of the procurement evaluation underway. Further information to be shared in future. • ESR: The committee were informed of the of progress that had been made for the readiness for the new national system. JS reported that the ESR system had been

cleansed and removed over 20k obsolete records in readiness for the new workforce solution.

The Committee were assured by the progress made and the risks outlined.

Workforce Efficiency

CB provided an update:

- The committee were made aware of the work taking place with finance colleagues to align the financial and workforce information in more detail to create an accurate picture of the financial spend on workforce. It was reported that the workforce to financial spend as of Month 6 was £53.1m above plan. CB explained that if it were to continue the trajectory, it would be just over £100.3m off plan on spend on workforce by the end of the financial year.
- Bank / Agency: It was reported that bank figures were down by £22.7m and were hitting the 10% target. Agency spend was reported at £14.2m down at 28.6% against 30% target. Overall, it was reported to be £51.3m over plan. The committee were made aware of the workshop that was due to take place on 11th November 2025 to firm up actions as a collective group to ensure mitigations were in place across the whole finance. CB explained that the current analysis of the drivers behind it were due to industrial action, demand, safer staffing, agency, price cap compliance and sickness. The committee were reminded that sickness was an area that remained high at 6.2%. Further risks were identified such as winter and changes to immigration rules that could impact on agency rates and further industrial action. To address this, it was explained that through the finance lease, recovery plans were in place, working with individual Trusts, specifically, through Chief People Officers who had commenced a review of all current actions to identify further actions that could be taken. It was further reported that work was taking place to look at a national checklist and best practice across the country.

MF informed the committee of the regular Provider Oversight meetings with Trusts to discuss the triangulation between workforce and finance which was also part of the process.

A suggestion was raised to look at an analysis of sickness broken down by Trust, identifying the support in place, the reasons and trends to develop offers. MF explained that the headcount numbers in the ICB were moving downwards due to the continued vacancy controls. The committee were made aware that they had not implemented further headcount reduction yet due to not having the voluntary redundancy scheme to proceed with.

CB further explained that the Trusts and ICB did individually track sickness to see by each NHS establishment. It was reported that in October 2024, an NHSE & NHS GM system peer review of sickness absence had been instigated. The committee were made aware of the main causes of sickness remained mental health which was consistent with other Trusts across the system. CB suggested engaging with JB during the next annual review of the peer review. NL welcomed the continued review to identify whether there was any shared insights and learning.

JS reported that as part of the workforce efficiency programme, Priority Area Groups (PAGs) had reinvigorated sickness absence. The committee were made aware that national trends would be analysed against GM trends to identify best practices across the system and beyond for shared learning.

The Committee were assured by the progress made and the risks outlined.

	• **Leadership, Culture & EDI (including FTSU System Report & Final Report of Leadership & Governance Working Group)** CB provided an update: • CB highlighted the change programmes taking place throughout the system, with a focus on equality impact assessments, workshops and the established rigor panels. It was explained that the digitalisation of the Equality Impact process was at the final stage which would enable themes across the system to be identified and what actions could be taken. • CB informed the committee of the single oversight, with a leadership focus as part of the undertakings. It was confirmed that they were now complaint in that space. • The committee further noted on the GM Transition Hub which was in place for all staff to use to look at jobs across different sectors. CB highlighted the first joint careers fair which was due to take place that week along with enhanced continuity of service offers across a number of public service organisations. LM informed the committee of the FTSU System Report paper, including Trusts, which provided an insight on the different themes across the region. From an assurance perspective, LM explained that as an ICB, they would be looking at quantitative and qualitative data, evidence of impact and reporting by protected characteristics. Due to some organisations not collecting some of this data, LM informed the committee that it would be difficult to draw out comparisons. It was reported that discussions had taken place with individual guardians which had identified that there had never been a standardised report structure that had been put in place. LM informed the committee of the aim to develop a report template from an ICB perspective. MH offered to support the creation of the standardised form for reporting. The committee were made aware that most guardians would welcome a regional meeting to show case challenges and great things taking place to share best practice. AB questioned what the role of students in placements and their ability to feed into the process was. It was confirmed that students were covered in FTSU with most guardians committed to supporting students. The committee identified the importance of implementing and collectively supporting a campaign in GM to provide an opportunity to encourage people to report any bullying and harassment. A suggestion was raised to work with partners outside of the NHS to link in and share learning from others. **The Committee were assured by the progress made and the risks outlined.**
8.	**Focus for Strategy Delivery to the end of 25/26** The NHS GM People and Culture Committee had previously supported the proposal to defer refreshing the strategy until 2026. This decision was taken to provide time to respond to the NHS Ten Year Workforce Plan once published and allow for good progress to be made on NHS Reform. Instead, the committee asked to focus on the work of the three working groups and a handful of key other priorities to support and enhance the delivery of our more long-term strategic objectives in the meantime. ACS informed the committee of the three areas of focus recommended, highlighting that work would also continue in other areas. It was explained that as a committee, they would want to have that focus and oversight to ensure commitment remained as a system to collectively deliver in those spaces.

	JS highlighted that Trusts had collectively raised that improving working lives agenda nationally and locally was a large agenda and suggested to include it in the paper under the areas of focus. **ACTION:** ACS to circulate an update to the committee in December 2025 outside of the formal committee to provide feedback. **NHS GM People & Culture Committee:** • **Endorsed the three areas to be prioritised for delivery in the next six months, to support the delivery of the strategic objectives. Noting measures and targets are to be refined and updated at the next meeting.** **1. Establishing the Greater Manchester Transition Hub: Helping retain talent across Greater Manchester through targeted support.** **2. Supporting the Greater Manchester Strategy: with a focus on creating the skills and capacity to deliver the Live Well programme.** **3. Improving workplace safety: with a focus on by implementing the Anti-Racist Framework.**
9.	**T Level Placement Programme Mid-Year Report** This paper provided an update on the Greater Manchester (GM) Health and Care T Level Placement Programme, a system-wide initiative to expand and improve industry placements across NHS and partner settings. The report outlined progress since launch, early learning, and how GM was aligned with national direction on technical education and skills reform. It highlighted that GM continued to lead nationally, with the programme now influencing practice across the seven ICS footprints funded by the Department for Education (DfE). SH highlighted: - The large shift on a national level around education skills. It was reported that the white paper had been released that month. SH explained that Health & Social Care had been identified as one of eight priority sectors, with new V levels coming to accompany A Levels and T Levels. It was confirmed that they would consolidate some of the more diverse qualifications and streamline the journey for those in that space. - The committee were made aware of the call for a greater focus around employer led skills planning and therefore, may enable an opportunity to inform more detail around some of the curriculum designed to ensure it was a better fit. - It was reported that there were now modular learning becoming available for people to be able to build qualifications over time for a more suitable fit. SH explained that GM were working closely with the Combined Authority, with a third-year focus on technical education. SH informed the committee that the work had been largely funded by the Gatsby foundation and supported by the ICB which had propelled the ICB from ground zero in less than a year to nationally leading. The committee were also made aware of the buy in from system partners around supporting this kind of activity. SH reported that Service Care T Levels were upcoming, however, Gatsby funding was due to end in January 2026. It was confirmed that all avenues were being explored to create additional income to support some of the working. **NHS GM People & Culture Committee:** • **Noted progress and early impact of the T Level Placement Programme.**

	• **Endorsed the continued alignment of the initiative with GM's People and Culture Strategy and wider Future Workforce ambitions, the GM Strategy and the government ambitions around development of technical career pathway routes; to position the region as a national exemplar.** • **Supported the use of this work as a platform for scaling integrated skills pathways across health and care.**
10.	**Community Tensions - Response to increase In Hate Incidents** This paper provided an update on the strategic response to the increasing incidents of hate, racism, antisemitism, and Islamophobia affecting our workforce and communities. It outlined the lived experiences of staff, impact, and the leadership actions being taken to ensure our health and care system remains a place of safety, respect, belonging, and inclusion for all. MH explained that they were seeing people were having issues, however, were not reporting them. The committee were made aware that the paper shared touched on what was taking place collectively as GM and communities of practice with NHS Northwest to identify what others were doing to tackle bullying and harassment. JB asked whether the figures were on the rise and informed the committee of the NHS Staff Council paper which highlighted that report mechanisms needed to become more straightforward. It was questioned how they could develop an understanding of what took place after people reported as concerns had been raised of people becoming fearful of the potential complications after. A discussion took place on the reporting mechanisms, risk assessment and post-incident evaluation. **NHS GM People and Culture Committee:** • **Noted the progress made, provide input into further actions required to strengthen our collective response to hate and discrimination, and support the implementation of agreed actions across the system.**
11.	**Governance discussion – closed discussion** CG informed the committee of the proposed streamlined committee restructure to support the move to the new operating model and ensure a strategic focus with clearer, more succinct reports at committees. The committee provided their feedback which would be shared at November's Board meeting. It was confirmed that further updates would be shared with the committee once known.
12.	**Any Other Business (All) & Reflections of the meeting and items for escalation to the Board** None were raised.
Date and Time of Next Meeting Tuesday 6th January, 10:00am – 11:30am MS Teams	

NHS Greater Manchester

Minutes

NHS Greater Manchester Finance Committee – Public Meeting

Date: Thursday 7 October 2025

Time: 14:00 – 15:00

Venue: Microsoft Teams

MEMBERS:		
Kal Kay	**KK**	Non-Executive Director, Finance Committee Chair
Mark Fisher	**MF**	Chief Executive Officer
Colin Scales	**CS**	Deputy Chief Executive Officer
Kathy Roe	**KR**	Chief Finance Officer
Katherine Sheerin	**KS**	Chief Officer for Commissioning
Vish Mehra	**VM**	GP/Partner Member
IN ATTENDANCE:		
Sue Hill	**SH**	Interim Deputy Chief Finance Officer
Jackie Gardiner	**JG**	Corporate Director of Operational Finance – Financial Management
Nicola Hepburn	**NH**	ICB Recovery and Improvement Programme Director
Kenny Li	**KL**	Chief Pharmacist (deputising for Manisha Kumar)
Ross Baxter	**RB**	Governance Advisor (Minutes)
APOLOGIES:		
Rachel Egan	**RE**	Non-Executive Director
Manisha Kumar	**MK**	Chief Medical Officer
Mandy Philbin	**MP**	Chief Nursing Officer

Item No	Item
	PUBLIC
1.	**Introductions and Apologies** KK welcomed everyone to the meeting and the apologies were noted. **Attendance Matrix & Terms of Reference** The Attendance Matrix and Terms of Reference were shared for information.
2.	**Declarations of Interest/Conflicts of Interest** There were no declarations or conflicts of interest declared at the meeting. The Finance Committee Conflict of Interest Register was shared for information.
3.	**Minutes of the Last Meeting** The minutes of the last meeting were approved as an accurate record.

4.	**Action Log**
5.	**Risk Register** This report provided an update to the committee on the key significant risks identified for 2025/26, including the BAF risks and the risks relevant to this committee. Any changes to the risks were highlighted within the paper, with no new risks identified or any risks de-escalated. The discussion centred on the need for improvements to better reflect the committee's ongoing work and priorities. It was acknowledged that the current versions did not fully meet expectations, particularly in how completed actions were not clearly moved to controls and live actions were not grouped to align with the active recovery plans. A commitment was made to update the register to focus more on the four key risk areas, making it a more targeted and dynamic management tool rather than a static checklist. The significant workload facing the team was recognised, and it was noted that addressing the shortcomings was now a priority. **NHS GM Finance Committee:** • **Confirmed the updated BAF risks scores and assurance assessments as an accurate reflection of the current position** • **Confirmed the updated Committee risks scores and assurance assessments as an accurate reflection of the current position.**
6.	**GM Month 5 Financial Position** This report provided an update to the committee on the financial position for Greater Manchester as at 31 August 2025. A year-to-date deficit of £19.8m was noted, which was entirely within the provider sector, with NHS GM itself remaining on plan but with notable pressures in CHC, Mental Health, Independent Sector elective plans and CIP delivery. The overall system risk had improved slightly compared to the previous month, with providers carrying £89.7m of risk, and NHS GM holding £100.2m split between CIP and other pressures. The efficiency programme was slightly ahead overall, with providers outperforming their targets by £9.1m, and NHS GM behind by £4.3m. A £10m in-month deterioration at Manchester University NHS Foundation Trust was highlighted as significant, driven by ongoing CIP delivery issues, premium staffing costs and contract overperformance. It was clarified that MFT's size means that even small percentage variances appear as large absolute numbers and that oversight was in place to prevent similar issues in other providers. Members discussed the timing and profiling of CIP delivery, noting that early-year gains may not be sustained and that the second half of the year would require ramped-up efforts. The importance of balancing financial recovery with performance metrics was emphasised, with a need for close collaboration and targeted interventions across providers to minimise risks and ensure delivery of the financial plan **NHS GM Finance Committee:**

	• **Noted the Month 5 year to date reported financial position for GM ICS of £92.3m deficit, against a planned deficit of £72.5m, resulting in a variance against plan of a £19.8m deficit.** • **Noted the breakeven forecast outturn position in line with NHSE reporting requirements.** • **Noted the year to date delivery of CIP as at Month 5 of £218.352m against a plan of £209.2m, a shortfall of £9.1m.** • **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 Q3 and Q4 being withheld if the system can't demonstrate and provide assurance that there is a credible plan to deliver the FOT position.** • **Noted the requirement to continue to hold urgent meetings to address the current shortfall in CIP delivery and to identify recovery plans to mitigate reported pressures.**
7.	**Financial Recovery Plan CIP** This report provided an update to the Finance Committee on the Financial Recovery Programme's Month 5 performance for the NHS GM (Greater Manchester) System. The key outcomes and actions were summarised. The discussion focussed on the current risk-adjusted gap of around £30m, which had improved since the last report due to ongoing stretch actions and increased capacity, particularly within the medicines optimisation team. It was noted that while live CIP schemes continue to deliver savings, the challenge remains to achieve the ambitious target of £175m (7% of influenceable spend) with 80% recurrency. The team was intensifying efforts within localities to identify further opportunities and considering bringing forward commissioning intentions to accelerate progress in the second half of the year. A query was raised about the approval hierarchy for decommissioning decisions, and it was clarified that the policy follows the scheme of delegation, with governance aligned to contractual value and performance impact. The overall approach emphasises robust reporting, accountability, and the need for material changes to be managed safely and reputably, aiming to close the financial gap and deliver sustainability against the agreed plan. **NHS GM Finance Committee Noted the information provided and approved the recovery plans as they currently stand.**
8.	**Planning Framework** This report provided the NHS England multi-year Planning Framework, which covers the period from 2026/27 to 2030/31. It was highlighted that the framework was published in September, but there had been a delay in the release of detailed planning guidance and financial allocations, now expected in late October or November. Despite this, it was still expected that Boards would review and sign off plans by December 2025.

	The committee was informed that foundational activities were underway through the GM Planning Club, with a commitment to deliver a compliant plan addressing both finance and performance, though this would be challenging. It was confirmed that the medium-term plan would be brought to the strategy board for review as soon as sufficient information was available, with some planned board discussions having been postponed due to the delayed guidance. The immediate focus would shift to financial recovery and deficit support until the planning details are finalised. **NHS GM Finance Committee noted the requirements outlined in the NHS Planning Framework, supported the approach outlined, and agreed to receive reports on progress and provide constructive challenge to support plan developments.**
9.	**Joint Capital Resource Plan** This report provided the Joint Capital Resource Plan, which was a statutory requirement for the ICB and Trusts to prepare and publish. The plan was presented, noting that it is supported by a draft 10-year infrastructure strategy emphasising digital enablement, affordability and collaboration. The primary priority identified is reducing critical infrastructure risk and backlog maintenance across the provider estate, with the total capital needed for backlog maintenance estimated at £601m. The current year's capital programme totals £404m and includes major projects such as the new hospital at MFT, addressing RAAC issues at Bolton, NCA, and MFT, and digital initiatives such as the EPR for Stockport, Tameside and Glossop. It was confirmed that the plan had been reviewed by the Balance Advisory Committee and the Capital Resource Allocation Group, which includes all provider CFOs. **NHS GM Finance Committee noted the content of the report and the Joint Capital Resource Use Plan 2025-26, and approved the report before publication.**
10.	**Exec Summary – Agenda Link to open Undertakings** This report outlined the current status of the four open undertakings, particularly on the two finance-related ones; delivery of the 2025/26 plan and development of the medium-term financial plan. The financial position and associated risks were noted, including the various recovery plans in place. The system's savings target for the year was £656m, with £218m delivered by month 5, which highlighted the significant challenge ahead due to the back-loaded nature of the delivery plans. Detailed reviews were scheduled after month 6. **NHS GM Finance Committee noted the key themes and any issues identified for escalation as key risks to the Board.**
11.	**Performance Report** This report provided an update on key performance indicators for GM. The indicators included were those considered high risk and/or form part of the undertakings process. **NHS GM Finance Committee Noted the information provided.**

12.	**Work Plan** The Committee Work Plan was noted, with members asked to provide any updates as required.
14.	**Any Other Business** There was no additional business to raise.
15.	**Reflections of the Meeting and Items for Escalation to the Board** Members felt the meeting had been effective and useful, allowing respectful conversation about difficult issues.
16.	**Date and Time of Next Meeting** Tuesday 2 December 2025 14:00 – 15:30

Minutes

Greater Manchester Audit Committee (Part A)

Date: Thursday 11 December 2025

Time: 11.00am to 13.00pm

Venue: 5th Floor, Tootal Buildings, Manchester

Present		
Members:		
Richard Paver	RP	Non-Executive Director and Audit Committee Chair, NHS GM
Sue Greenhill	SG	Independent Member
Anthony Hassall	AH	Partner Member bringing the perspective of Mental Health Providers, Chief Executive of Pennine Care NHS Foundation Trust
Attendees / Participants:		
Kathy Roe	KR	Chief Finance Officer, NHS GM
Stephen Downs	SD	Deputy Chief Finance Officer, NHS GM
Chris Gaffey	CG	Associate Director of Corporate Services, NHS GM
Izhar Chaudhary	IC	Associate Director of Finance – Financial Assurance, NHS GM
Sam Evans	SE	Corporate Director of Finance – Commissioning & Financial Assurance, NHS GM
Patrick Clark	PC	Senior Audit Manager, MIAA
Darrell Davies	DD	Regional Assurance Director, MIAA
Sarah Ironmonger	SI	Engagement Partner, Grant Thornton
Perminder Sethi	PS	Senior Manager, Grant Thornton
Gareth Robinson	GR	(item 9 only)
Phil Scott	PS	(item 11 only)
Ross Baxter	RB	Governance Advisor, NHS GM (minutes)
Apologies:		
David Hopewell	DH	Independent Member bringing Provider Partner perspective
Colin Scales	CS	Deputy Chief Executive, NHS GM
Jackie Gardiner	JG	Corporate Director of Operational Finance – Financial Management
Paul Bell	PB	Head of Anti-Crime Services, MIAA
Kaye Abbott	KA	Associate Director of Finance – Financial Control, NHS GM

	Topic	Action
1.	Welcome, Introductions and Apologies The Chair welcomed members and attendees to the meeting.	
2.	Declarations of Interest (DOI) RP reminded Committee members of their obligation to declare any interest relating to items on the agenda. No interests were declared.	
3.	Minutes from the last meeting The minutes of the last Audit Committee meeting on 11 September 2025 were approved as an accurate record.	
4.	Action Log The action log was reviewed noting that updates had been provided against the open actions, with any closed actions recorded on the log.	
5.	Internal Audit Progress Report This report provided the committee with a summary of the progress made in the completion of the 2024/25 Internal Audit Plan and delivery of the 2025/26 Internal Audit Plan. The discussion focused on the status and assurance levels of various audit reviews, highlighting both completed and ongoing work. It was explained that for the previous year, two reviews (IT Asset Management and Contract Management Quality of Care) were finalised, both receiving moderate assurance. For the current year, three reports (Financial Recovery Programme, Pod Delegation Review, and Mental Health Review) achieved substantial assurance, indicating medium and low risk recommendations. Concerns were raised about the number of revised deadlines and the achievability of the Q4 plan given organisational changes and capacity constraints. It was agreed that a review of outstanding and planned work was needed to prioritise high-risk and mandated audits, with some lower-priority items potentially deferred until after the reorganisation. The importance of focusing on high-risk areas, such as cyber controls, EPRR and data quality, was emphasised, and the need for a line-by-line review of recommendations to assess residual risk and ensure management is compensating for delayed actions was discussed. The process for revising implementation dates was clarified, involving lead officers and chief officers, with a commitment to provide more narrative on the risks associated with deadline extensions. **Action: Q4 work plan to be reviewed to check whether it is still deliverable.** **NHS GM Audit Committee noted the contents of the report.**	

6.	Internal Audit Follow Up Report This report provided the committee with an update on progress made in implementing outstanding internal audit recommendations. The discussion centred on the status of 58 recommendations reviewed since the previous audit committee, with 26 having revised implementation dates and concerns about the frequency of deadline extensions. It was outlined that 17 recommendations were not yet due, 10 were fully implemented, and 31 were in progress or partially implemented, with 27 of these having revised dates. Members expressed the need to focus on high-priority recommendations, particularly those related to cyber controls and EPRR, which have been outstanding for several years and pose significant risks. The importance of understanding residual risk from delayed actions and ensuring that mitigation is in place was highlighted, especially for critical areas like cyber resilience. The process for revising deadlines was explained, whereby lead officers propose extensions, which are then agreed by Chief Officers, and the committee requested more narrative on the risks associated with these extensions. It was acknowledged that due to ongoing organisational change some lower-priority recommendations may need to be deferred, with a comprehensive review planned for March or April to reassess priorities and relevance in the new structure. The committee agreed to focus on managing the most critical risks and to seek assurance that partially implemented recommendations do not leave the organisation exposed. **NHS GM Audit Committee noted the contents of the report.**	
7.	Counter-Fraud Progress Report This report provided a summary of anti-fraud activities undertaken from 1 September 2025 – 30 November 2025. The discussion covered key elements of the fraud plan, compliance with government functional standards, and recent changes in risk assessment processes. The report indicated that the plan was progressing as scheduled, with most compliance areas rated green, though one component was temporarily amber due to the adoption of a new risk assessment methodology requiring significant re-evaluation of fraud risks. The team was optimistic that this would return to green once the assessment was complete. The ongoing gap analysis work related to the "failure to prevent fraud" offence and a joint preventive exercise with Greater Manchester Mental Health on section 12 assessments were highlighted, with both progressing well. Referral statistics were shared, noting 20 referrals in the period, most closed or transferred to NHS England or practice managers, with six still open and one	

	historical investigation ongoing. The report provided assurance that no outstanding recommendations were due for update, and overall the committee was satisfied with the clarity and presentation of the report, especially the glossary and acronyms. The discussion also acknowledged the resource-intensive nature of the new risk assessment process but anticipated future updates would be less burdensome. **NHS GM Audit Committee noted the contents of the report and its implications for NHS GM, and highlighted any other additional information, training or awareness that may be required to ensure full compliance with the pending legislation.**	
8.	<u>EXTERNAL Audit Progress and Sector Update</u> This report provided an update on the progress in delivering Grant Thornton responsibilities as the external auditor at NHS GM for 2025-26. It also summarised emerging national issues and developments that may be relevant to the work of the ICB. The discussion focused on the current stage of the external audit, with it explained that initial planning discussions were underway for the 2025/26 audit, aiming to present the audit plan at the March Audit Committee. A key point raised was the need for approval of the financial control process before starting certain audit work, with delays in this process potentially impacting the audit timeline. The team discussed the importance of being agile to avoid delays, referencing past issues where audits were completed after year-end due to late approvals. There was discussion about the national challenge of transferring balances between financial systems, with concerns about how assurance would be provided for these transfers and whether internal processes or internal audit testing would be relied upon. The group agreed on the need to clarify assurance sources, particularly regarding the SBS system, and to ensure that the audit committee is confident in the integrity of transferred balances. Additionally, the discussion touched on the accounting for redundancies, noting the need for consistent national guidance and the impact of redundancy provisions on financial planning. The team planned to coordinate with national teams to ensure alignment and to bring relevant accounting policy decisions to the committee for approval. **NHS GM Audit Committee discussed and noted the report.**	
9.	<u>Update on VFM Recommendations</u> This report provided an update on the implementation of the 2024/25 External Auditor's Annual Report. In total there were one key recommendation and three improvement recommendations, with the key recommendation confirmed as fully implemented in the September report to the Committee.	

	The discussion centred on the status of recommendations from the previous year and the three improvement recommendations. Progress was reported on two of these, including improved oversight of savings schemes and regular updates to committees on indicator performance. However, concerns were raised about the ongoing issues with data quality, which had been flagged by Grant Thornton for at least two years. Members acknowledged the critical importance of robust data for commissioning and financial management, especially as national policy moves toward activity-based payment mechanisms. Members discussed the challenges in validating community service costs due to inconsistent data and the need for better policies and procedures. The conversation concluded with agreement to revisit data quality assurance, recognising its increasing significance for both finance and service delivery, and to ensure that outstanding recommendations are addressed in the upcoming audit cycle. It was noted that following a recent system delivery meeting, the organisation was set to receive formal notification from NHS England confirming compliance with 34 out of 36 undertakings, with only the finance undertakings remaining. This progress was expected to lead to either a partial or full exit from the undertakings by year-end. As a result, the supporting infrastructure around the single improvement plan and related system improvement boards will be stepped down, marking a significant positive development for the organisation. **NHS GM Audit Committee discussed and noted the updates on the implementation of recommendations.**	
10.	<u>Risk Register/Management Update (including deep dives)</u> This report provided an update to the committee on the corporate risks across the ICB, the progress with BAF risks, the progress with implementing issue management processes, and progress on the implementation of the Datix system. It included the full committee risk registers and the full BAF risks for assurance. The discussion focused on recent efforts to improve risk moderation and the presentation of risks at both the corporate and committee levels. It was explained that feedback from previous meetings had led to more robust moderation processes, including taking the corporate risk register through the operational leadership group for wider scrutiny. There was specific mention of the need to clarify the rationale behind certain risk scores, such as the high score for primary care and the handling of EPRR and finance risks. Concerns were raised about the fragmentation of capacity and organisational change risks across multiple entries, and it was suggested these should be consolidated for greater prominence. It was confirmed that the BAF already	

	included a risk on NHS Reform, which covered the issue of capacity and organisational change. The removal or downgrading of the mental health and neurodiversity risk was also queried, highlighting that the current situation did not justify such a change. These points were acknowledged and agreement was made to review, noting that some changes in risk scores were due to timing issues in report preparation. **Action: CG to review the removal or downgrading of the mental health and neurodiversity risk.** The group also discussed the interpretation of assurance ratings within the risk register, highlighting confusion over whether green ratings indicated effective controls or simply agreement on risk scoring. There was consensus on the need for clearer definitions and more consistent application of assurance ratings, as well as better narrative explanations for changes in risk scores. The discussion concluded with agreement to focus on managing the most critical risks over the next few months, given capacity constraints, and to ensure that risk presentation and assurance processes are uniformly understood and applied across the organisation. **NHS GM Audit Committee considered the corporate risks included within the report, noted the ongoing work on the BAF Risks, identification and management of issues, and the implementation of the Datix system.**	
11.	<u>Corporate Policies</u> <u>Software Control Policy</u> This policy was presented, emphasising its aim to ensure all software installed on the organisation's digital estate was fully controlled and compliant. It was explained that the policy had been reviewed and approved by several governance groups, including the Digital Security Programme Board and the Primary Care Digital Board. Pre-submitted questions were addressed, clarifying that GPIT devices are owned and managed by the organisation, with full visibility and control over installed software, except for minimal exceptions like supplier-provided check-in screens. It was confirmed that third-party providers using organisation-supplied devices must comply with the policy, and that council IT systems, while separate, must also adhere to policy requirements when connecting to the network. It was also noted that all devices are now upgraded to Windows 11, with any remaining Windows 10 devices still supported. It was queried whether the policy covered all mobile and third-party devices, and it was confirmed that this is the case and applies to every device managed by the organisation and connected to its network. **NHS GM Audit Committee approved the Software Control Policy**	

12.	Committee Restructure The Chair advised that an update in this area was not required at the meeting.	
13.	Agree Final Annual Report and Accounts Timetable and Plans This report provided an update to the committee on the approach for the Month 9 and Month 12 annual report and accounts submissions to NHS England for 2025/26. The Month 9 draft accounts would be circulated to members in order to allow comments to be made. **NHS GM Audit Committee noted the approach to ensure delivery of the statutory year end returns required for 2025/26.**	
14.	Greenbury Disclosures This report was provided to agree and recommend to the Accountable Officer the posts covered by NHS GM's Remuneration Report disclosure. There was a specific query about how to account for redundancy payments for staff who will be serving notice at year-end but have not yet received their payments, highlighting the need to determine how these should be disclosed in the remuneration segment. There were also potential complexities noted regarding pension disclosures, particularly where redundancy pay is used to buy additional pension benefits, and the importance of clarifying these points before the March reporting deadline was emphasised. The group agreed that these nuances would need to be considered based on individual arrangements and that further clarity would be provided as part of the year-end process. **NHS GM Audit Committee agreed the posts included within the disclosure and recommended the posts for inclusion in the disclosure to the Accountable Officer.**	
15.	Review changes to standing financial instructions/prime financial policies and changes to accounting policies There were no changes to note.	
16.	Standing Items: Debtors Update This report provided an update on the total level of debt due to the organisation (£26.8m) and specifically the debt values over 90 days (£1.8m). It also covered the value of the bad debt provision (£0.9m) and had been updated to include credit notes raised in the period. Losses/Special Payments	

	There were no updates to note. Tender Waivers and Procurement Report This report highlighted to Audit Committee the volume of waivers that had been completed and submitted for approval in accordance with the Standing Financial Instructions, Financial Scheme of Delegation and Procurement Policy for the period September to November 2025. Conflicts of Interest Guardian There were no updates to note. Use of Corporate Seal This was presented for information. It was noted that there was an error to the title of the document currently labelled "Tootal Building Lease agreement", which should read as "Tootal Building Licence Agreement". This would be updated on the register. Board Summary Report This would be completed noting items during the meeting. **Audit Committee noted the updates provided.**	
17.	Audit Committee Workplan The Audit Committee Workplan for 2025/26 was noted.	
18.	Any Other Business, reflections on the meeting and items for escalation to the Board There were no other items of business for consideration. Reflections on the meeting: Members felt the discussion had been healthy and productive.	
19.	Date and time of next meeting: 19 March 2025, 11am – 2pm	

Minutes

Quality and Performance Committee – Part A

Date: 3 December 2025

Time: 13:30pm - 15:25pm

Venue: Microsoft Teams

Part A (Public)

Present	Apologies
Members: Dame Sue Bailey (SB) – Non-Executive Director (Chair) Leigh Vallance (LV) – VCSE Partner Member Prof. Manisha Kumar (MK) – Chief Medical Officer Richard Paver (RP) – Non-Executive Director and Chair of Audit Colin Scales (CS) – Deputy Chief Executive Officer Mandy Philbin (MP) – Chief Nursing Officer **In attendance:** Ed Dyson (ED) – Director of Performance, Improvement and Assurance Anita Rolfe (AR) – Deputy Chief Nursing Officer Kate Provan (KP) – Associate Director Clinical Effectiveness and Improvement Claire Smith (CSm) – Associate Director Nursing & Quality Assurance Dr Claire Lake (CL) – Deputy Chief Medical Officer Claire Connor (CC) – Director Communications and Engagement Sarah Owen (SO) - Associate Director of Maternity Assurance (ICB/LMNS) Jim Ritchie (JR) - Deputy Chief Medical Officer Kenny Li (KL) – Chief Pharmacist (Item 6) Mark Palmeira (MPa) – Assistant Director Patient Services (Item 8) Gill Gibson (GG) – Deputy Chief Nurse Quality Transformation (Item 9) Waseem Khan (WK) – Head of Quality Oversight and Governance Faye Vaughan (FV) – Governance Advisor (Minutes)	Jackie Driver (JD) – Strategic Lead: Equality and Inclusion Nicola Firth (NF) – Secondary Care Representative Danielle Ruane (DR) – Patient Representative (Healthwatch Greater Manchester) Andrea Patel (AP) – Associate Director for Safeguarding Luvjit Kandula (LK) – Primary Care Representative Sharon Hubber (SH) – Director of Childrens Services, Rochdale Council Alison Mckenzie-Folan (AMf) – Wigan Place Lead Committee (Vice-Chair) Charlotte Bailey (CB) – Chief People Officer

Item No.	Topic	Action
1.	**Welcome, Introductions and Apologies** SB welcomed everyone to the meeting, introductions were made, and the above apologies were noted. The meeting was quorate.	

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. LV declared an interest as newly appointed Chair of Bolton CVS (voluntary sector infrastructure body) who were in receipt of NHS funding. AR declared an interest as newly appointed Chair of Moya Cole Hospice as of 1st December 2025.	
3.	**Minutes, Actions and Matters Arising from previous meeting** The minutes were accepted as a true record of the previous meeting held on 5 November 2025, subject to a minor amendment. <u>Actions</u> The action log was updated.	
4.	**Risk Report** The report provided a monthly update on risks – including the BAF (Board Assurance Framework) risks and the committee risks. Key updates: • **QUP21/10/24 / QUP09/0123:** The committee were made aware of the increased scores and rationale for both Urgent & Emergency Care (UEC) risks. It was highlighted that the description was yet to change following the discussions held at November 2025 meeting regarding the risk to safety and quality would apply across all months. • **QUP7/01/23:** ED explained that the Elective Recovery Fund (ERF) resource had ceased which would impede the number and volume of interventions that could be made to support elected performance. The need to ensure careful investment of the elective recovery money to target the areas highlighted in the detailed modelling as having the highest impact on wait list was raised. • **GMMHPGR1 / GMMHPGR8 / GMMHPGR13**: The committee were made aware that the three risks were included for the December 2025 update despite being below the threshold of risk as requested by the NHS GM Integrated Care Board. MK explained that risks GMMHPGR1 / GMMHPGR8 / GMMHPGR13 had been brought to the committee for visibility. The committee were made aware that other risks were managed within the Partnership groups. It was reported that the ADHD and Autism risk had been split into three due to each requiring different mitigations and responses. A discussion took place regarding the interplay between performance & finance and where it would be best managed. The committee were made aware of the ongoing interplay between affordability and deliverability of performance standards with productivity and transformation enabling to bridge those. The committee were requested to provide their steer on how it would be presented in the risk report. A suggestion was raised to take it to the NHS GM Integrated Board due to the trade-off between finance & quality and performance & quality.	

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	It was reported that Local Spot Placements had been reduced to 18 from 50. The committee were also made aware that Out of Area Placements (OAPs) had been reduced to one. The committee were provided with partial assurance. **The Committee:** • **Agreed contents of paper together with relevant mitigation is in place and to report to board any exceptions.**	
5.	**Chief Officers Report** **a. CNO** The report provided an update to the committee on the relevant statutory duties. AR provided an update on the following areas: • GMMH remained at segment 5, however, AR explained that they would still stay in the Recovery Support Programme. • Northern Care Alliance (NCA) remained at segment 4. It was confirmed that work continued with their Quality Assurance meeting. • Stockport FT Paediatric Audiology issues continued to be worked through. • The committee were informed that Manchester FT Maternity was under enhanced surveillance along with Stockport FT and Tameside FT. • AR reported that guidance had been issued in relation to the Maternity Regulation 28, Prevention of Future Deaths Report issued for the Secretary of State for Health & Social Care, NHS England, NHSE Royal College of Midwives, Nurse and Midwifery Council, Royal College of Obstetrics & Gynaecology and NICE. It was accepted that MFT had acted timely and appropriately in the intervening period between the care episode and the coroner's outcome and work continued with the LMNS to embed wider learning across Greater Manchester. • The committee were made aware of the progress made on reduced backlog of complaints held. The committee discussed the Wigan NHSE and GM Peer Review visits. It was confirmed that the report had been shared with some improvement recommendations. AR advised that a follow up review of Wigan ED would take place the following week in relation to the improvements suggested. CSm informed the committee of the GM Mental Health System Improvement Board that had taken place the previous day which discussed the movement out of the Recovery Support Programme (RSP). The committee were made aware of the thanks extended from Karen Howells, Chief Executive at GMMH to the ICB for the support provided and system working. **The committee:** • **Noted the contents of the report.** **b. CMO** This report provided an update to the committee, in relation to the statutory duties and responsibilities aligned to the Medical Directorate. The committee were made aware of the plans for the next round of industrial	

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	action. It was reported that they were seeing a rise in influenza like illness with an 80% increase over the previous week. MK confirmed that mitigations were being put in place to approach it, looking at vaccination rate, Infection Prevention Control (IPC), emission avoidance and supporting residents in care homes. The need to ensure that it did not compound the impact of the resident doctor strike was raised. It was reported that they were able to maintain performance at the required national ask at the last set of industrial action. The degree of industrial action fatigue that needed to be understood and appreciated was highlighted. The committee were further made aware of the UK / USA Medicines agreement. It was identified as a complex landscape, with a deal of zero tariffs of UK exports into the US which was intended to safeguard a very fragile life sciences industry in the UK. In the short term / medium term, it was reported that the UK would be paying more for medicines. The committee were advised of the work that would need to take place to forecast what it may look like. MK shared some of the key points from the report: • **Long waits for Mental Health Services:** The committee were reminded that the Community Mental Health Transformation was based on the Mental Health and Well-being Strategy. It was reported that there were a few key areas that were interdependent. The committee were made aware of the work that had taken place on Out of Area Placements, Local Spot Placements and independent sector bed usage. • **Manchester Locality – Pressures in Clinically Ready for Discharge (CRFD), Out of Area Placements (OAPs), Community Integration, Workforce Capability and Package Delays:** The committee were made aware of the sustained system pressure across inpatient flow, CRFD, OAPs and LSP beds which impacted length of stay, therapeutic continuity and timely transition into less restrictive settings. • **Community Mental Health (CMH) Services:** The committee were made aware of the transformation programme, led in conjunction with provider Chief Nurses. It was reported that they would be completing the community Mental Health Review as requested by the Shanley Review. • **Children and Young People (CYP) New Neurodevelopmental (ND) Model of Care – Autism & Attention Deficit Hyperactivity Disorder (ADHD) Transformation:** It was explained that the new models of care aimed at creating a more sustainable, needs-led system that supported CYP and their families without requiring a formal diagnosis. The committee were assured that the clinical model for children was approved at the Mental Health Clinical Effectiveness Group (CEG) in November 2025. • **Implementation of the NICE Technology Appraisal (TA) TA1026 and the NICE funding variation for Tirzepatide (Mounjoro ®) for the management of obesity:** The committee were advised of the compliance with NICE Tirzepatide. It was reported that the impact of spending £10mil on the drug for weight loss and diabetes and horizon scanning for what the following year would be looked into. LV highlighted that the papers referenced Out of Area Placements, Dementia and the significant supportive role of the voluntary, community and faith sector organisations (VCFSEs). A request was made to ensure that the intentions set out the previous year would be embedded in the documents to drive the future of commissioning to recognise the value and include the voluntary sector. **The Committee:** • **Noted the alerts within the paper in relation to the Manchester**	

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	Locality – Pressures in Clinically Ready for Discharge (CRFD), Out of Area Placements (OAPs), Community Integration, Workforce Capability and Package Delays and the Cardiovascular, renal, and metabolic (CVRM) Pathway Work and the mitigations in place to address these areas. Updates on these key areas will be provided as the work progresses. **c. Performance Report** This report provided an update on Greater Manchester's (GM) progress in achieving NHS operational planning goals, outlining significant risks faced by providers along with key improvement actions, and presented a summary of quarter three Locality Assurance Meetings (LAMs). ED highlighted the number of challenges set out in the report, however, confirmed that the commitment to meet the performance standards set out in the national planning guidance remained. The committee were made aware of the one correction in the papers for Inpatient Care for Autistic Adults from Alert to Advise following an improvement in performance. ED provided further detail on: • **A&E 4-hour target:** It was reported that there were a number of actions taking place, with every Trust undergoing a set of improvement actions that would be monitored rigorously. The committee were made aware that CS & GG were meeting all Trust Chief Operating Officers on a weekly basis to track improvement plans in place. ED explained that Bolton were in a new capital development for their A&E department, which would start to increase and unlock performance improvement. The committee were further made aware that Tameside had an Elective Care Improvement Support Team (ECIST) to provide support. The committee were advised that Tameside had introduced a GP triage post to increase flow to the Urgent Treatment Centre and had increased the opening hours and same day emergency care to reduce burden on the department and admission to beds. It was reported that Tameside saw a 4% improvement between October and November 2025. • **Elective:** It was reported that there was an expectation to have zero 65-week waiters by 21 December 2025. ED explained that there were 20 risks being worked through on a patient-by-patient basis which sat at Bolton and WWL based upon known capacity gaps. • **Elective:** It was identified that the 52-week wait target was the biggest elective risk, however, regional funding had been received to support further activity. • **Elective:** The committee were made aware that 18-week waits had shown a steady improvement. It was reported that the key initiatives such as advice and guidance, community alternatives (Gynaecology and Ear, Nose and Throat ENT) were planned to close this. • **Cancer:** The committee were made aware of the work taking place with MFT & Wigan on their improvement plans. It was reported that Wigan had seen an improvement in performance in 62-day. ED advised that MFT were in the diagnostic phase which was starting to show improvement. It was explained that both were being tracked and were seeing an upturn in forecast performance at Wigan. It was further reported that MFTs improvement plan was expected to show improvement in the diagnostic stage performance in November 2025 and	

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	the improvement to close pathways had the potential to follow in December 2025. • **Industrial action:** It was identified that this would play into all of the forecasts and affect all of the above. ED informed the committee of the following year and the current performance quality finance challenge: • **A&E** target would require a 4% improvement. • **18-week** target would require a 7% improvement. • **Cancer** target would require a 5% improvement. RP informed the committee of the National Health Service Journal (HSJ) report regarding the waiting list backlog cleaning drive and questioned how it was coordinated. ED explained that the figures would be influenced by a number of factors such as the effectiveness of previous validation exercises. It was explained that the overall quality of how they managed the waiting list would determine how many errors were there in the first place. RP highlighted the 4-hour target to examine where some of the individual Trusts were short of the end of year figures. CS explained that a number of organisations were in a challenged position. It was confirmed that work was taking place intensively with providers to support them to deliver their end of December 2025 plan. A meeting was due to take place with all Chief Operating Officers each Monday to listen to their plans. The committee were made aware of the funding that had been invested in a number of providers from the capacity fund. Confirmation was received that work would continue to take place with providers over the course of Q4 to get to the March 2026 position of 78%. The Committee were provided with partial assurance. **The Committee noted:** • **The operational priorities and risks for 2025/26 and the updates on key themes emerging from LAMs.**	
6.	**Medicines Management Annual Report** The Annual Medicines Optimisation (MO) Report for 2024-2025, outlined the achievements, challenges, and future initiatives. The highlights included the unification of 11 teams, record £25 million in cost improvements, and the highest Pharmacy First activity in England. The report detailed strategic priorities, governance, and ongoing adaptation to NHS reform. The high-level priorities identified for 2024/25 in the paper were aligned to the core pillars and key achievements and shared with the committee. The committee were also made aware that GM was one of the lowest growth ICBs in the country in terms of spend and volume. KL reported on the work taking place to link to drug shortages to keep patients safe. The committee were also made aware of the work on Opioid reduction which had been reduced to 9% in overall Opioid usage. A discussion took place regarding the closure of pharmacies. It was questioned whether engagement was taking place to help the marketplace to develop other suppliers. The Pharmacy First Scheme was highlighted which enabled pharmacists to prescribe a greater number of medicines in future. The committee were also made aware of the recent roll out in community pharmacy for contraception. The committee identified the need to link in national models that	

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	utilised community pharmacy to support the population to understand and recognise as a place to go to. The committee further highlighted the need for Pharmacy, Optum and Dentistry to be a part of the Neighbourhoods in the future model of healthcare and the health creation model. **The Committee:** • **Noted the Annual Medicines Optimisation (MO) Report for 2024/25.**	
7.	**IAG Update** The committee were reminded that the Involvement and Assurance Group (IAG) had been tasked with understanding any risks or issues in relation to how the organisation discharged its public duties on involvement and how it adhered to regulatory standards. CC informed the committee of the single item agenda regarding Manchester Foundation Trust at the last IAG Group. The committee were made aware of their Oral & Maxillofacial Surgery Redesign services that would potentially need to be delivered in different locations across GM. CC informed the committee that they had not carried out any patient engagement work at present. A recommendation was raised to MFT to ensure patient engagement took place to better understand the experiences of those who had used the services at present and the impact on any proposed changes it may have. CC informed the committee that IAG provided MFT with partial assurance until patient engagement took place. The committee agreed with the partial assurance for the Oral & Maxillofacial Surgery Services. **The Committee:** • **Reviewed the assurance information provided and provided assurance to the NHS GM Board deemed as appropriate.**	
8.	**Prevention of Future Death (PFD) Annual Report** This report described how Regulation 28 reports into Prevention of Future Deaths (PFDs) issued by the coroner were managed and responded to by NHS GM and outlined the system learning as a result of such reports. It was reported that NHS GM had received 83 PFD reports in 2024/25, which was an increase from the previous year. The committee were made aware of the improvement made to the Mental Health Strategy and the GM Care Record. It was reported that the Medicines Optimisation Team had a seven-minute briefing on Opioid Usage which could be shared with colleagues as good learning. A discussion took place regarding how they could bring the final report together. It was suggested that as an ICB in the future, all reporting could be incorporated in the ICB Annual Report to capture as learning. The need to understand the operational delivery as a commissioner and how to start to drive changes was raised. The importance to look at all sources of intelligence and enable triangulation was raised as a good opportunity to carry out a reflection piece through case studies to bring learning to life, whilst also reflecting on barriers and challenges faced. SB asked for all committee members to also share their high-level thoughts /	

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	ideas. **ACTION:** All committee members to share their thoughts / ideas on areas that they believe would make a difference for a committee reflection piece. **The Committee:** • **Noted the contents of this report.** • **Approved the widespread distribution of this report across the NHS GM system via the relevant system groups to review and identify any additional necessary actions based on the learning it contains. The groups will review the intelligence and insight relevant to their area of responsibility and determine if there is any further action/improvement needed in relation to this wider review.** • **Assess and review the capacity to support responses and learning related to PFDs at both the GM level and locality, considering recent NHS Reform.**	**ALL**
9.	**Publishes copy of final Area SEND inspection letter for Tameside Local Area Partnership** This report provided the Committee with an update on the outcome of the Tameside Local Area Special Educational Needs and Disabilities (SEND) inspection in May 2025 and outlined the multi-agency priority actions identified. It presented the Tameside Local Area Improvement Plan, including responsibilities for NHS GM and commissioning implications. GG highlighted the summary of the Tameside SEND Improvement Plan in the paper and explained that work was ongoing with specific areas for NHS GM around neurodevelopmental pathway. It was reported that Tameside was being supported with extra resources. MP informed the committee that they would be drawing quality and commissioning together as part of the transformation plan. The need to understand the landscape the ICB work in and find solutions was raised as fundamental and to ensure patient experience would be at the centre. It was also identified that they would need to understand the current position, the future state and what the ICBs intentions would be. The committee discussed the opportunities to pick up neurodiversity at an early stage to support and allow children to thrive. It was confirmed that support was being put in place until March 2026 to triage the waiting list to ensure the children were put into the new offer. **The Committee:** • **Noted the update of the report including the outcome Local Area SEND inspection report and the Priority Actions identified.** • **Noted the Tameside area Improvement Plan to respond to the identified actions.**	
10.	**Any other business** The committee were informed that this meeting would be the last committee meeting MP would attend before retirement. All committee members shared their heartfelt thanks to MP and well wishes on her future endeavours.	
	Date and time of next meeting: **Wednesday 4 February 2026**	

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