Agenda

Greater Manchester Transition Committee (Public)

Date: 4 March 2026

Time: 14:00pm to 16:00pm

Venue: MS Teams

Item No.	Time	Duration	Subject	Paper/ Verbal	For Approval/ Discussion/ Information	By Whom
1.	14:00	5 mins	Welcome, Introductions and Apologies: Attendance Matrix	Verbal Paper	Noting Noting	Rachel Egan *Chair*
2.			Declarations of Interest	Paper	Noting	
3.			Minutes, matters arising and actions from previous meeting held on 4 February 2026	Paper	Approval	
Strategic Updates						
4.	14:05	15 mins	Strategic Commissioning Plan: Next Steps and confirming priorities for 26/27	Paper	Discussion	Katherine Sheerin, *Chief Commissioning Officer*
5.	14:20	35 mins	Preparations for New Governance – Progress Report	Paper	Discussion	Charlotte Bailey, *Chief Strategy, People and Partnerships Officer*
6.	14:55	15 mins	Board Assurance Framework and Risk Report	Paper	Discussion	Gareth Robinson, *Interim Chief Reform and Improvement Officer*
7.	15:10	15 mins	M10 Finance Report	Paper	Discussion	Kathy Roe, *Chief Finance Officer*
8.	15:25	25 mins	Alert & Assurance Reports from each function area	Paper	Information	Chief Officers
For Information						
9.	15:50	10 mins	Any other business Board Paper Escalations Meeting Reflections	Verbal	Discussion	All

Transition Committee Attendance Matrix from January 2026

Key:

Present	Present
Apologies	Apologies
No Explanation	No Explanation

Attendee	***Title***	***Jan-26***	***Feb-26***	***Mar-26***
Dame Sue Bailey	Non Executive Director (Co-Chair)	Present	Present	
Rachel Egan	Non Executive Director (Co-Chair)	Present	Present	
Colin Scales	Acting Chief Executive and Chief System Reform Officer	Present	Present	
Sir Richard Leese	Chair, NHS GM	Present	Present	
Leigh Vallance	NHS GM VCSE Partner	Present	Present	
Manisha Kumar	Chief Clinical Officer	Present	Present	
Richard Paver	Non Executive - Audit Committee Chair (Vice-Chair of QPC)	Present	Present	
Kal Kay	Non Executive Director	Present	Present	
Owen Williams	Chief Executive, NCA	Present	Apologies	
Vish Mehra	GP/Partner Member	Present	Present	
Jackie Njoroge	Deputy Chair/Senior Independent Director	Present	Present	
Sean Fielding	Partner Member	Present	Apologies	
Katherine Sheerin	Chief Healthcare Commissioning Officer	Present	Present	
Chris Gaffey	Associate Director of Corporate Services	Present	Present	
Claire Connor	Director Communications and Engagement	Present	Present	
Kathy Roe	Chief Finance Officer	Apologies	Present	
Anthony Hassall	Chief Executive, Pennine Care NHS Foundation Trust	Apologies	Apologies	
Alison Mckenzie-Folan	Wigan Place Lead	Apologies	Apologies	
Gareth Robinson	Interim Chief Reform and Improvement Officer	Apologies	Present	
Charlotte Bailey	Chief Strategy, People and Partnerships Officer	Apologies	Present	
Invitees/Presenters				
Stephen Downs	Deputy Chief Finance Officer	Present		
Jo Street	Programme Director- Transition	Present		
Sarah Owen	Associate Director of Maternity Assurance (ICB/LMNS)		Present	

Chair, NHS Greater Manchester	Interest Declared	Interest Category	Interest Situation	Interest Description	Comments	CoI Date From	CoI Date To
Leese, Sir Richard Charles	Y	Finanical Interests	Outside employment	Board Member, West Coast Development Partnership Independent Advisory Board		30/03/2025	31/10/2026
Leese, Sir Richard Charles	Y	Indirect interests	Outside employment	Daughter works for a training company that provides training inter alia to NHS organisations		01/11/2011	
Leese, Sir Richard Charles	Y	Non-financial personal interest	Loyalty interests	Honorary President, Manchester City Football Club		01/12/2021	
Leese, Sir Richard Charles	Y	Non-financial professional interest	Outside employment	Honorary Professor, Chair in Integrated Care and Population Health, University of Manchester		01/08/2022	31/07/2025

Employee Name	Interest Declared	Interest Category	Interest Situation	Interest Description	Comments	CoI Date From	CoI Date To
Bailey, Ms. Charlotte Elizabeth	Y			Nil			
Kumar, Dr Manisha	Y	Financial Interest	Outside employment	Salaried GP at the Robert Darbishire Practice - 1 session per week		2004	Ongoing
Kumar, Dr Manisha	Y	Non-financial professional interest	Loyalty interests	Honorary Professor University of Salford		01/05/2023	Ongoing
Kumar, Dr Manisha	Y	Non-financial personal interest	Loyalty interests	Husband has the following roles: • Operations Director - Primary Eye Care Services LTD • Case Examiner – General Optical Council		2021 2019	Ongoing
Njoroge, Jackie	Y	Financial professional interest	Outside employment	Chief Strategy & Data Officer University of Salford		2016	
Njoroge, Jackie	Y	Financial professional interest	Outside employment	First Choice Homes Oldham (FCHO) Independent Non Exec		2025	
Njoroge, Jackie	Y	Financial professional interest	Outside employment	GMCA Independent Audit Committee member		2025	
Njoroge, Jackie	Y	Non-financial professional interest	Outside employment	Transforming Access & Student Outcome (TASO) Trustee		2025	
Njoroge, Jackie	Y	Non-financial professional interest	Outside employment	Deputy Chair Higher Education Strategic Planning Association (HESPA)		2015	
Roe, Mrs. Kathryn Anne	Y	Non-financial personal interest	Loyalty interests	My son works in the finance department at Tameside and Glossop NHS Foundation Trust.		14/10/2024	Ongoing
Scales, Mr. Colin	Y	Non-financial professional interest	Loyalty interests	Honorary Professor of UCLan		2024	
Scales, Mr. Colin	Y	Indirect interests	Outside employment	Wife works at NCA as a nurse		19/09/2024	Ongoing
Sheerin, Mrs. Katherine Mary (Katherine)	Y	Non-financial professional interest	Loyalty interests	Trustee and Deputy Chair of the Board of the The Whitechapel Centre, a charity which works to prevent homelessness and support people who are homeless, operating across the Liverpool City Region.	This is a voluntary role with no remuneration or expenses paid.	01/01/2025	Ongoing

Non-Executive Directors	Interest Declared	Interest Category	Interest Situation	Interest Description	Comments	CoI Date From	CoI Date To
Bailey, Dr Susan Mary	Y	Financial Interest	Outside employment	Independent NED on the board of KOOTH PLC, a mental health online digital platform. I am remunerated for this work. Neither any members of my family or I hold shares in this PLC		2022	Ongoing
Bailey, Dr Susan Mary	Y	Non-financial professional interest	Loyalty Interests	Chair of Centre for Mental Health. The centre and myself advocate for better mental health outcomes for all through the delivery of evidenced based policy briefings and lobbying at a national and Regional level		2018	Ongoing
Bailey, Dr Susan Mary	Y	Non-financial professional interest	Outside employment	Council member university of Salford		2016	
Bailey, Dr Susan Mary	Y	Non-financial professional interest	Loyalty Interests	BEVAN commissioner - Bevan through evidence base support improved health and social care outcomes For the population of Wales.		2014	Ongoing
Egan, Rachel Mrs	Y			Nil			
Kay, Mrs. Khalida (Kal)	Y	Financial interests	Outside employment	Interim FD Derian House Childrens Hospice		06/10/2025	
Kay, Mrs. Khalida (Kal)	Y	Financial interests	Shareholdings and other ownership interests	Director and Shareholder of GSD Financial Consulting Ltd	Set up my own consultancy firm	01/04/2025	
Kay, Mrs. Khalida (Kal)	Y	Non-financial personal interests	Outside employment	Great Academies Education Trust	Trustee (non remunerated)	20/04/2020	
Kay, Mrs. Khalida (Kal)	Y	Non-financial professional interest	Shareholdings and other ownership interests	Association of Camerados	Non Exec, non remunerated director	22/10/2018	
Paver, Mr. Richard	Y			Nil			

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

Minutes

Greater Manchester Transition Committee

Date: 4 February 2026

Time: 14:00pm - 16:00pm

Venue: Microsoft Teams

(Public)

Present	Apologies
In attendance: Dame Sue Bailey (SB) – Non-Executive Director (Chair) Rachel Egan (RE) – Non-Executive Director (Co-Chair) Colin Scales (CS) – Acting Chief Executive and Chief System Reform Officer Sir Richard Leese (RL) – Chair, NHS GM Leigh Vallance (LV) – VCSE Partner Member Prof. Manisha Kumar (MK) – Chief Clinical Officer Richard Paver (RP) – Non-Executive Director and Chair of Audit Kal Kay (KK) – Non-Executive Director Jackie Njoroge (JN) – Deputy Chair/Senior Independent Director Chris Gaffey (CG) – Associate Director of Corporate Services Claire Connor (CC) – Director Communications and Engagement Katherine Sheerin (KS) – Chief Healthcare Commissioning Officer Vish Mehra (VM) - GP/Partner Member Charlotte Bailey (CB) – Chief Strategy, People and Partnerships Officer Kathy Roe (KR) - Chief Finance Officer Gareth Robinson (GR) - Interim Chief Reform and Improvement Officer Sarah Owen (SO) - Associate Director of Maternity Assurance (ICB/LMNS) Faye Vaughan (FV) – Governance Advisor (Minutes)	Anthony Hassall (AH) - Chief Executive, Pennine Care NHS Foundation Trust Owen Williams (OW) – Chief Executive, NCA Sean Fielding (SF) – Partner Member Alison Mckenzie-Folan (AMF) – Wigan Place Lead

Item No.	Topic	Action
1.	**Welcome, Introductions and Apologies** SB welcomed everyone to the meeting and the above apologies were noted.	
2.	**Declarations of Interest** SB reminded board members of their obligation to declare any interest they may have on any issues arising at the meeting which might conflict with the business of the NHS Greater Manchester. No interests were declared.	

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3.	**Minutes, matters arising and actions from previous meeting held on 7 January 2026** The minutes were accepted as a true record of the previous meeting held on 7 January 2026.	
4.	**Action Log** Action log updated.	
5.	**Updated BAF and Corporate Risks Report** The report provided an update to the committee on the ongoing work to develop the Board Assurance Framework (BAF), the January 2026 BAF Risks and the corporate risks. CG outlined the status of the BAF and corporate risks, noting changes in risk scores for Dermatology, People & Culture, Urgent & Emergency Care (UEC) and Elective Care. The committee were made aware of the plan to conduct a deep dive on BAF risk SR1 – Population Health at the March 2026 Audit Committee to draw out recommendations for improving risk reporting and management with the intention to apply the improvements across other BAF risks in future. RP raised concerns regarding the absence of maternity risk on the risk register and risk PC010 regarding loss of organisational knowledge and talent due to reform. Assurance was provided that the risk register was carried through the LMNs to ICB with close work taking place to escalate any risks that sat above 16 post mitigation. CB informed the committee of the range of factors and mitigations in place in relation to risk PC010 such as the tight criteria set around voluntary redundancy to assess each application. It was confirmed that supporting mitigations were in place around risk of knowledge and talent. The committee were also made aware of the established Transition Hub, working with a range of partners including the voluntary sector to establish a hub for teams to access. CB further informed the committee of a number of career fairs that had also been held. LV highlighted risk PH4 and discussed the challenges in operationalising voluntary sector commitments, highlighting resource constraints and the need for improved commissioning and market development of the sector into the commissioning plans. It was identified that collaborative work at place level and inclusion in the organisational development plan would intend to strengthen relationships and resilience. The committee discussed the sequencing of deep dives on risks. It was agreed that there were other risks that would require further deep dives, however, it was identified that Population Health risk was a timely one to do in the first instance. The Chief Officers agreed to look into the timings to carry out deep dives on other risks in a safe and occurrent way for the future. The committee noted the serious concerns raised that would need to be reflected with evidence shared of cross-executive solutions to work with.	

	The Committee: • **Considered the January 2026 BAF risks.** • **Considered the corporate risks included within the report and confirmed any additional actions required.**	
6.	**Alert & Assurance Reports from each function area / Maternity Assurance Update** <u>Chief Clinical Officer Report:</u> The paper provided the committee with an overview of NHS Greater Manchesters statutory duties during a period of organisational and governance transition. MK reported on the winter pressures, noting a decrease in flu and other illnesses, however, reported that systems were still under significant pressure reaching OPEL 4. The committee were informed of the efforts to maintain quality and safety, including oversight of corridor care with UEC Board and Quality Team working together to keep track of the national guidance and oversight over winter whilst supporting staff. The committee questioned the distribution of statutory responsibilities and assurance during the transition period. It was clarified that accountabilities would remain with the ICB until they were safely transferred. The importance of the organisational development plan and use of established commissioning principles and robust contract management was raised. **The Committee:** **1. Acknowledged the progress in strengthening statutory quality, safety and safeguarding functions during the transition period, including the updated contractual requirements and alignment with national guidance.** **2. Supported the ongoing review and revision of subcommittee governance, ensuring streamlined structures, clearer accountability, and improved escalation and reporting routes under the new Model ICB arrangements.** **3. Noted the emerging system-wide approach to improvement, recognising that further design and alignment across portfolios is required as the improvement function develops.** **4. Endorsed the strengthened winter quality oversight within UEC, including targeted quality visits, enhanced surveillance, and system-level actions to maintain safety during periods of high pressure.** **5. Received ongoing updates as these areas progress and as the new governance and assurance structures embed.** <u>Maternity Assurance Update:</u> The report provided an update on maternity and neonatal safety assurance across Greater Manchester. It was confirmed that robust assurance and escalation arrangements remained in place through established LMNS and ICB governance routes, with clear mechanisms for managing and escalating maternity risks. SO provided an update on maternity and neonatal safety, including progress on perinatal pelvic health service implementation, CQC maternity survey results and the CNST process. The committee were made aware of the ongoing challenges, assurance mechanisms and the need for improved integration of maternity neonatal risks.	

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	The committee highlighted the need to ensure adequate focus on areas such as children and young people. **The Committee noted the information and plans for improvement.** <u>Chief Commissioning Officer:</u> The paper provided the committee with an overview of NHS Greater Manchesters statutory duties during a period of organisational and governance transition. KS described the procurement process for community dermatology services, the challenge from providers, the national panels recommendation to return to an earlier step and the need to ensure service continuity whilst options were appraised and lessons learned were documented. KS outlined progress on major programmes including arterial vascular surgery and cardiac surgery reconfiguration, development of pre-consultation business cases and the timeline for engagement and Board approval. The committee were also updated on the neonatal critical care programme, noting the lengthy process due to national requirements and NHS England capacity. KS provided assurance on the implementation of a single major trauma centre, including programme planning and reporting. VM declared an interest in the item from his previous role in GP Federation during the time of the initial bid, however, informed the committee that there was no involvement in the bid. The effectiveness of the current procurement approaches given frequent legal challenges was questioned. It was agreed that there was a need to explore more strategic options within the provider selection regime and to share lessons learned across ICBs. **The Committee:** • **Noted the report from the Chief Commissioning Officer.** <u>Chief Strategy, People and Partnerships Officer:</u> The paper alerted the committee to the impact of recent NHS Reform developments on the workforce and mitigating actions in place. CB presented on the workforce changes due to reform, including voluntary redundancies, staff well-being, new structures and the organisational development plan, with discussion on capacity, priorities and support mechanisms in place. The committee were made aware that approximately 200 staff left the organisation at the end of January 2026, with mitigations in place to address gaps, prioritise critical work, provide well-being support, including increased HR engagement and leadership briefings. CB reported on the ongoing monitoring of staff well-being, sickness absence and annual leave uptake which was conducted through the People and Culture Sub - Committee, with escalation procedures for critical gaps and targeted support for staff requiring adjustments. **The Committee:** • **Noted the report.**	

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	Chief Reform and Improvement Officer: GR highlighted that UEC performance was 2.2% behind plan, with pressures from OPEL 4 incidents and IT failures. The committee were made aware of the improvements compared to previous years and ongoing oversight. Elective care was reported slightly behind plan, with a Q4 sprint and close monitoring taking place. It was reported that the pre-market engagement for GPIT services closed on time, with the process moving to business case development. GR highlighted the GPIT Stakeholder Group and confirmed that representative GP structures would be included in future for accountability and input.	
7.	**M9 Finance Report** The report provided an update to the committee on the overall Month 9 ICS financial position for Greater Manchester as of 31st December 2025. KR presented the Month 9 finance report, highlighting positive trends but ongoing risks to financial balance and the need for continued focus on recovery plans. It was confirmed that scenario planning for potential trust underperformance would take place KR reported improvements in year-to-date and forecast outturn, over-delivery on cost improvement plans and reduced risk, but emphasised the challenge of meeting targets with eight weeks remaining and the inability to draw on reserves. **For the System Financial position, the Committee:** **1. Noted the Month 9 year to date reported financial position for GM ICS of £76.0m deficit, against a planned deficit of £66.0m, resulting in a variance against plan of a £10.0m deficit.** **2. Noted the in-month improvement in the deficit position, a reduction in the extrapolated run rate for the GM providers of £18.6m (excluding IA costs), a reduction in reported gross risk of £0.4m, a further reduction in net risk of £4.2m for NHS GM as a result of the on-going delivery of recovery plans, and a £6.6m improvement against the recovery plan forecast trajectory for providers.** **3. Noted the breakeven forecast outturn position in line with NHSE reporting requirements.** **4. Noted the year-to-date delivery of CIP as at Month 9 of £445.8m against a plan of £422.1m, an over delivery of £23.8m.** **5. Noted the forecast capital position is expected to be brought back into a balanced position.** **6. Noted the risk to the system wide cash position which continues to be closely monitored.** **7. Noted that full DSF has been received, but there remains a risk that this is subject to clawback if a balanced position for the system is not delivered.** **8. Note the on-going system meetings to provide assurance on the delivery of the overall system financial plan, and to address the current shortfall in CIP delivery and monitor delivery of recovery plans to mitigate reported pressures.**	
8.	**Updated Committee Work Plans / Finalise the top four priorities for the new committees for 2026/27** The report provided the committee with the workplans for the abolished committees to ensure oversight and discussion on plans for subsequent Transition	

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	Committee meetings for the remainder of the financial year. CG described the methodology for reviewing and updating committee work plans to ensure statutory duties were met, avoid duplication and align with the new governance structure, with a focus on transferring, closing, or reassigning work as appropriate. CS explained the focus on the ICBs strategic priorities and also informed the committee of an OD plan being developed. The importance that the priorities for 2026/27 reflected the significant work that needed to take place to establish the new organisation was raised. SRL emphasised the importance of clear delegation, recording of decisions and audit trails. RE raised concerns regarding the treatment of Population Health in the work plan, prompting commitments to address this in the future iterations. **ACTION:** CG to update Population Health workplan and share evidence at the next meeting. The committee discussed the need for clear, focused strategic priorities, the importance of deprioritising non-essential work and the necessity of aligning short-term & long-term objectives within the three-year planning cycle. SRL raised the need for the ICB strategic objectives to be at the centre of the operating plan. **The Committee considered the workplans appended to the report and considered what information would be required for subsequent meetings for the remainder of the financial year.**	**CG**
9.	**Any other business** The committee reflected on the meeting, highlighting that the reports provided easier reading with clarity on the challenges faced. A suggestion was raised to include an appreciation box in future reporting.	
	Date and time of next meeting: **Wednesday 4 March 2026**	

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Actions Log: Transition Committee

No	Date	Section	Details of the issue	Details of action agreed	Action Lead	Completion Date	Status	Further Detail
2026/08	04/02/2026	8.Updated Committee Work Plans / Finalise the top four priorities for the new committees for 2026/27	Request raised to include further detail for Population Health workplan	CG to update Population Health workplan and share evidence at the next meeting.	Chris Gaffey	27/02/2026	Closed	

Strategic Commissioning Plan: Next Steps and confirming priorities for 26/27

Transition Committee: March 2026

Part of Greater Manchester
Integrated Care Partnership

1.0 PURPOSE OF THE PAPER AND INTRODUCTION

The purpose of this paper is two-fold.

Firstly, to describe the next steps for NHS Greater Manchester's Strategic Commissioning Plan (2026 – 2031) in order that it is finalised in early 2026/7. The draft version of the Strategic Commissioning Plan was approved by Board for submission to NHS England on 11th February 2026.

It is recognised that we now need to move from moving from a high-level strategic intent to a fully worked-through, operationally credible plan. As part of this, further detail will be developed for each commissioning priority with the aim of finalising the Strategic Commissioning Plan in summer 2026. This paper sets out the process for developing this further detail.

Secondly, to outline how priorities for Board attention during 26/7 and beyond are confirmed, with clear governance processes to ensure their delivery.

2.0 TAKING FORWARD THE STRATEGIC COMMISSIONING PLAN

The Plan on a Page for the Strategic Commissioning Plan sets out the high-level outcomes to be achieved over the next five years and summarises the key activities to be delivered in order that they are achieved. This is shown below. Colleagues are asked to note the inclusion of learning disability as a strategic commissioning priority based on feedback from the Board.

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Strategic Commissioning Plan 2026-2031 – on a Page

Strategic Context	**Greater Manchester Strategy 2025-2035**	**10 Year Health Plan (2025)**	
Our Vision	**A thriving city region where everyone can live a good life**		
Our Priority System Outcomes	To improve Healthy Life Expectancy in GM so that it at least matches the NW of England by 2030	To close the gap in HLE between the most and least advantaged in GM in line with the 10-year ambition to at least halve that gap by 2035	Raise the healthiest generation of children and young people (10 Year Health Plan ambition) *Detailed Metric in Development*
Our Missions	**Strengthen our communities** **Recover core NHS and care services** **Help people get into – and stay in – good work**	**Help people stay well and detect illness earlier** **Support our workforce and our carers** **Achieve financial sustainability**	
Our Strategic Commissioning Priorities	**Preventative and Proactive Care in Neighbourhoods:** • Live Well • The Neighbourhood Model • Primary Care Transformation (Delivering the Blueprint)	**Targeted Action on Population Health and Inequalities** • Population Health Transformation Programmes • Improving Outcomes for Children and Young People • Mental Health and Learning Disability • Improving Cancer Outcomes	**System Transformation:** • Secondary Care Transformation • Elective Care • Urgent and Emergency Care • Digital and Innovation • New Models of Commissioning and Provision

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Work is underway to set out outcomes-based programme level delivery plans for each of the thematic areas, producing . The plans, underpinned by data and intelligence, will set out a clear delivery plan to achieve the outcomes over the next five years.

The plans will identify:

- The overall ambition
- The outcomes to be achieved – ensuring that across all programmes these will deliver the high-level outcomes set out above
- The evidence for how commissioning resources should be invested with an investment profile for each programme – with a consolidated picture to be drawn up across all programmes
- Key milestones for delivery
- Success measures
- Commissioning approach / model

As part of this, further work will be undertaken to expand on the new models of commissioning section, including detail regarding our market development strategy.

A task and finish group is being established to oversee this work, led by the Chief Commissioning Officer with input from all Directorates.

3.0 COMMISSIONING PRIORITIES 2026/27

Whilst this work is underway, clear commissioning intentions for 26/7 which make progress towards the high-level outcomes are still required. This work has been underway since the autumn, with commissioning intentions framed in in the context of:

- Current ICB Strategic Priorities – now set out in the Strategic Commissioning Plan
- NHS Planning Guidance for 26/27
- The developing ICB Clinical Strategy
- How the ICB adds value in driving better outcomes, reducing health inequalities and improving efficiency, in particular through opportunities for 'left shift' / demand management.
- Continuing challenged financial position and requirement to move towards financial balance in 2026/27.

An outline for each of the thematic areas has been shared with Board members previously and is appended for ease of reference (appendix 1). These are aligned to the five year strategic commissioning plan and represent year one delivery. Commissioning Leads have prepared business cases to demonstrate the impact of any investment which will now be reviewed by Chief Officers in advance of Board / Committee oversight.

3.0 PRIORITIES FOR 2026-27

Whilst we need to deliver against each of the strategic commissioning priorities over the five years, we recognise that we can accelerate our progress each year by having a smaller set of priorities which the Board wishes to focus its attention on.

To support the Board in making these choices, there is a range of data presented in the Strategic Commissioning Plan and its supporting documents, which illustrates the challenges we face in Greater Manchester and opportunities for change.

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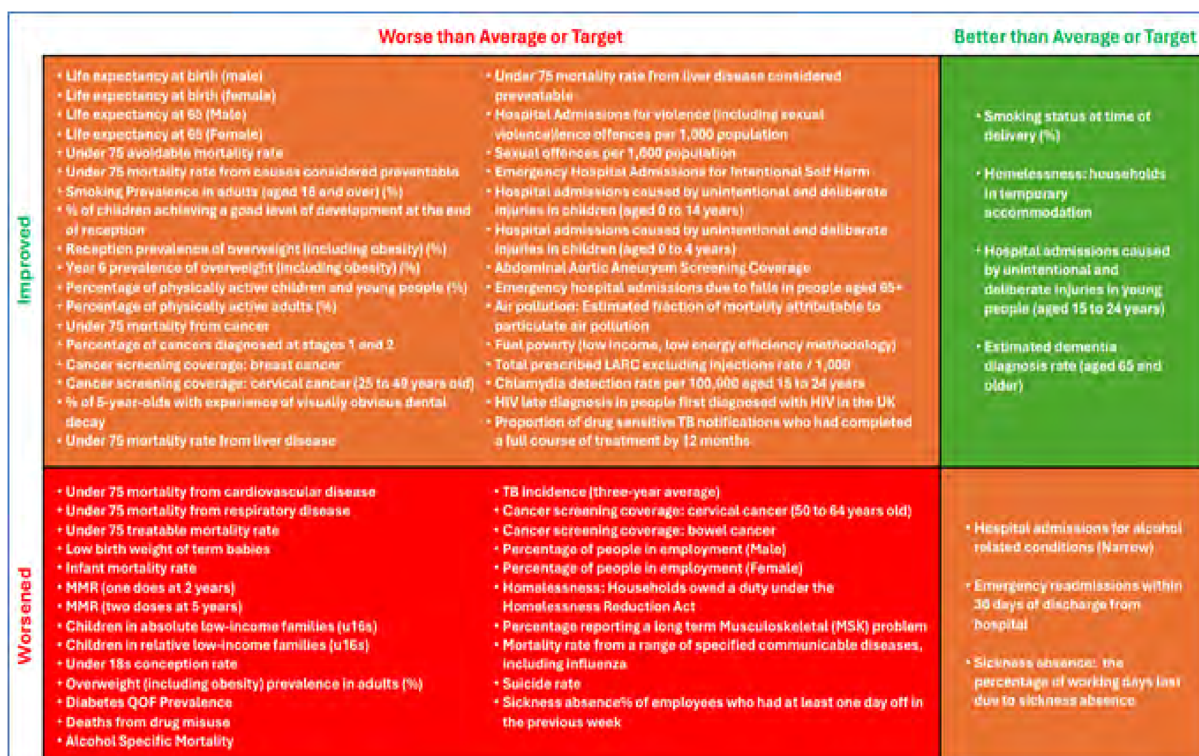
The Strategic Commissioning Plan included a Quadrant Analysis (shown below) of over 60 metrics illustrates that whilst GM has shown improvement in multiple areas, there are several metrics that reveal a worsening performance and widening gaps to the national average.



Within the Quadrant Analysis, there are clusters of metrics that point us towards areas that we need to focus on and require an integrated, system-wide approach through this Commissioning Plan:

- Children and young people during pregnancy and early years, particularly in the context of increased exposure to poverty and deprivation.
- People who are experiencing "lives (and deaths) of despair" and the most significant inequalities characterised by alcohol harm; drug misuse, homelessness, communicable disease such as tuberculosis, financial hardship, and severe/multiple deprivation.
- The opportunity to contribute more fully to economic growth and productivity in GM by addressing health-related barriers to employment and sickness absence, and with a particular emphasis on Musculoskeletal (MSK) conditions.

There has been particular interest from Board members in the need to have a greater focus on children and young people throughout our work. The data underpinning the Quadrant

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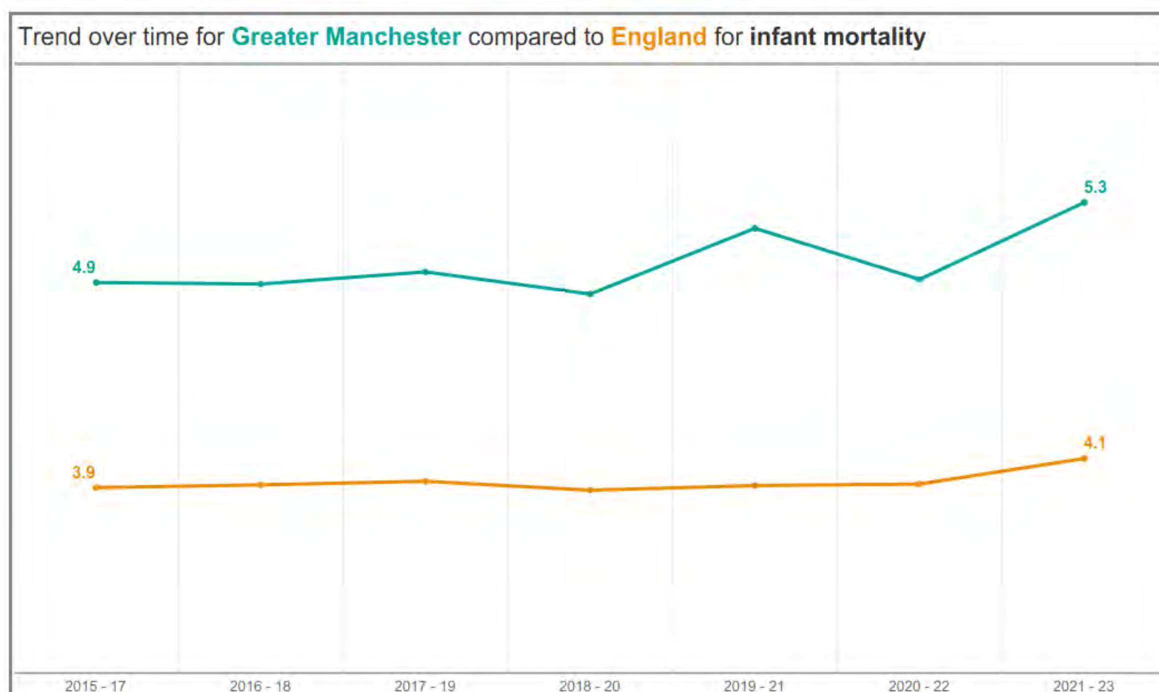
Analysis illustrates that on several metrics there has been a deterioration in the position in Greater Manchester:

- Infant mortality in GM rose from 4.9 per 1,000 births in 2020–2022 to 5.3 per 1,000 in 2021–2023, this is above the national average of 4.1 per 1,000. This increase is despite lower levels of births.



- The percentage of two years old that have received at least one dose of the MMR vaccine has fallen to its lowest point in GM at 87.3%. While the national picture is one of decreasing vaccine uptake, GM appears to be decreasing at a faster rate than the national average.
- The percentage of five-year-olds that have received two doses of the MMR vaccine has fallen to its lowest point in GM at 82.5%. While the national picture is one of decreasing vaccine uptake, GM again appears to be decreasing at a faster rate than the national average, most notably after the 2021/22 period.
- The percentage of 5-year-olds with experience of visually obvious dental decay in 2023-2024 was 29% in GM compared to the England average of 22%

In order to ensure on-going assurance is provided to the Board, it is suggested that a programme of reports outlining progress in relation to priority areas is confirmed for the Commissioning

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Committee, Resources Committee and Board, with attention given to relevant Committee elements. Further discussion on how these priorities are 'hard-wired' into ICB governance would be welcome at the Board development session.

4.0 NEXT STEPS

This paper proposes that between now and the May Board, we take the following steps to strengthen the Strategic Commissioning Plan:

- Use a strategic development session to present options to the Board using similar data to above, to enable the Board to determine the key priorities for its focus in 2026/27 – drawn from the Strategic Commissioning Plan on a Page.
- As part of this, to consider the adoption of a 'fourth shift' in NHS GM towards children and young people.
- Alongside this, outcomes-based plans for each programme will be finalised to produce a fully worked up and credible operational plan.

5.0 RECOMMENDATIONS

The Committee is recommended to:-

1) Note the work to strengthen the draft Strategic Plan to create a fully worked through operationally credible plan.
2) Note the work to confirm Commissioning Intentions for 26/7.
3) Review and discuss the work to develop priorities for 26/7.

Katherine Sheerin

Chief Commissioning Officer

March 2026

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Greater Manchester

Commissioning Intentions 26/7

26/27 Commissioning Intentions:- Elective Transformation Programme

We will proactively manage elective care growth in trusts by doing the following:

- **Extension of the BeCCoR elective initiative** – 2nd year of the GP peer review initiative to address outlier referral rates through GP education and the use of alternatives to secondary care, monitored via locality-specific targets
- **Expansion of Advice and Guidance** – use option to extend pan-GM Consultant Connect service and ensure secondary care providers have job-planned local services where these are required
- **Support shift to "Single Point of Access"** – work with secondary care, primary care and locality teams to implement the NHSE model of specialty-specific SPoA's, including development of straight-to-test pathways incorporating CDC capacity
- **Commissioning of community-based alternatives to secondary care** – ensuring Dermatology community service is embedded, commissioning ENT Tier 2 and Gynaecology community services, implement new community MSK model and develop other services such as in Respiratory, Urology and Cardiology
- **Implementation of new GIRFT pathways for common pathways**: application of GIRFT follow-up protocols with FU activity outside best practice not being funded

26/27 Commissioning Intentions:- UEC Improvement Programme

We will restrict UEC demand growth in trusts by doing the following:

- Continuing to increase hospital@home access and utilisation. Ensuring that these pathways are used for “step-up” admission avoidance, as well as supporting early discharge. This will be supported by reducing the variation in referrals from primary care and other community services. Compliance against the core standards for Hospital@Home will be improved, and a consistent payment model will be implemented, to reduce variation and to maximise efficiencies across Greater Manchester.
- Implementation of ‘model UCR’ principles, maximising referral rates and utilising the versatile clinical skills that these models deliver for patients. Building capacity and improving referrals rates into UCRs, will reduce admissions and support demand coming from HCP and Care Homes.
- Maximising the use of community SPOAs, supporting the reduction of urgent care pathways into each trust. We will work with NWAS and other Health Care Professionals to ensure patients are navigated to available alternatives (such as UCR & Hospital@Home), when clinically appropriate. We will continue to drive a consistent approach across Greater Manchester, utilising the single digital platform and reducing variation.
- Embedding Live Well and Neighbourhood health models across all 10 localities, ensuring the delivery of core standards, such as falls prevention. Leading to reduced ambulance call outs, ED presentations and possible admissions.

*note that activity levels will be specific to each trust

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26/27 Commissioning Intentions:- Cancer and Diagnostics Programme

We will deliver the national requirements relating to cancer and diagnostics and manage activity in GM trusts by doing the following:

- Agree activity plans which are sufficient to meet national standards for cancer and diagnostic pathways, including the national **Cancer Waiting Times** standards for faster diagnosis and treatment.
- **Diagnostics:** Commission diagnostics services through network wide operating models. Recommission direct access diagnostics to ensure effective and efficient use of resources and to support the 'left shift' in GM. Consideration of new commissioning models in discussion with providers. Ensure all contracts due to expire in 2026-7 are recommissioned in line with GM commissioning strategy and national direction. To include optimising the use of the GM CDC resource.
- Commission sufficient activity to address the level of suspected cancer referrals required to meet the national standards for **Early Diagnosis** of cancer, as measured and reported using the Rapid Cancer Registration Dataset and to meet national standards in the 4 cancer screening programmes. Reduce the gap in % early diagnosis of cancer between our least and most deprived communities.
- Ongoing expansion of the GM **Single Queue Diagnostics** programme
- NHSE Providers responsible for operationalisation and tracking of **PSFU** (Personalised Stratified Follow Up)

26/27 Commissioning Intentions:- Children and Maternity

Children & Young People

- Continued delivery of the Greater Manchester Children & Young People Joint Forward Plan
- Increase in Paediatric Surgical Capacity for key pressured areas such as ENT and Oral Surgery
- Review of Paediatric Audiology – development of new model of care / standardised service specification and continuation of interim arrangements to ensure service continuity
- Review of Community Paediatrics (incl. CYP Therapies)

Maternity

- Undertake strategic commissioning review of provision of maternity services including antenatal education, estates, home birth provision

26/27 Commissioning Intentions:- Mental Health, Learning Disabilities and Autism Programme

- Continued system focus on reducing the use of Out of Area Placements and Local Spot Placements as well as Length of Hospital stay (which will include rehabilitation beds and high cost/s117 care package reviews in 2026/27) to deliver system savings into the Mental Health Integrated Fund as the vehicle for the funding of the system priorities (including community services, step up and step down capacity and working with Local Authorities on ensuring appropriate housing is available (Medium Term Planning Framework [MTPF] priority)
- Full implementation of the First Response model and 111/text crisis service (MTPF priority)
- Adult community crisis service expansion and enhancement including Home Treatment Teams and MH ED support - building on the successful Regional Transformation Fund Business Case in 2025/26 (MTPF priority)
- Adult Community Mental Health services expansion - including Assertive Outreach and EIP and linking to the GM Live Well/Neighbourhood model (MTPF priority)
- Deliver of appropriate Shared Care arrangements across MH providers and General Practice – together with more SMI/LDA Annual Health Checks and Action Plans (MTPF priority)
- Improved recovery for people accessing Talking Therapy services (MTPF priority)
- Expansion of specialist peri-natal services and parent infant services to improve access, quality and outcomes.
- Quality transformation of all age inpatient services (including rehabilitation) with a move to a therapeutic model of care and implementing the 10 high impact changes to ensure people are only in hospital when they need to be and receive high-quality, person-centred care, to enable safe and timely discharge as soon as possible.
- Expansion of Mental Health Support Teams to reach 70% of all schools/education settings by the end of March 2027 (MTPF priority)
- Implementation of the mental health support into the Skyline Homes and delivery of the enhanced CAMHs offer to Cared for Children.
- Adult and CYP Eating Disorder services to ensure equitable access across all GM localities
- Expand Individual Placement Support (MTPF priority)
- Reduce the number of people with Learning Disability/Autism in inpatient mental health beds and implement the outcomes of CLDT/LDA services review (MTPF priority)
- Full implementation of the new models of care for neurodiversity for adults and Children and young people, delivering the shift from a medicalised model to a needs-led thrive model

26/27 Commissioning Intentions:- Specialist Commissioning

NHS Greater Manchester

- GM and East Cheshire Arterial Vascular Surgery Service reconfiguration to improve performance and resilience
- GM and East Cheshire Electrophysiology and Ablation (EP) procedures for heart rhythm conditions, Transcatheter Aortic Valve Implantation (TAVI) for aortic valve stenosis and Cardiac surgery Service reconfiguration to improve performance and resilience
- Specialised Neurorehabilitation Services continuation of case management as a core feature of service delivery to ensure that patient needs are met appropriately and adequate patient flow across the pathway
- Optimising Stroke Pathways. Undertake a review of resilience and sustainability of Mechanical Thrombectomy services between 22:00 and 08:00 across all NW services. Continued pathway improvement to comply with national standards.
- Complex Termination of Pregnancy Service. Provider selection exercise to ensure that the NW has regional network capacity to provide locally-based, medically-complex terminations up to 23 weeks and 6 days gestation compliant with national service specification standards
- Establishment of a NW Placenta Accreta Syndrome Service at MFT compliant with national service specification standards

26/27 Commissioning Intentions:- Specialist Commissioning

- Adult Critical Care Transport Service Establishment of a single service for the population of the NW compliant with national service specification standards.
- Paediatric Critical Care Develop improved and consistent models of care to increase capacity and improve safety and resilience of services across the NW
- Implementation of the Renal Transformation Programme Addressing unwarranted variation and pressures in services. Earlier intervention and medicines optimisation for CKD patients. A&E avoidance initiatives.
- Arterial Vascular Surgery - Reconfiguration of adult Vascular Surgery services across Lancashire, South Cumbria, and Wigan in order to improve the safety and quality of services and to ensure the sustainable provision of acute and emergency services into the future.
- Neonatal transformation Programme - NW Neonatal Services to meet national service specification activity standards to ensure best outcomes for our babies, including reducing long term disability and mortality. Supports recruitment, development and sustainability of a multidisciplinary neonatal workforce.

Other services subject to review / new commissioning arrangements in 26/27

NHS Greater Manchester

Urgent & Emergency Care

- Undertake a review of GP Out of Hours services within the context of the wider Primary Care strategy, ensuring integrated urgent care access, consistent standards, and seamless links with NHS 111 and community urgent care pathways
- Review of Walk-in Centres to ensure effectiveness informing future commissioning decision

Community Services

- Implement GM standard service specification for District Nursing
- Implement a set of core standards for Intermediate Care

Other services subject to review / new commissioning arrangements in 26/27

Long Term Conditions

- Frailty / MSK - Commission fracture liaison services in all GM localities
- Implementation of a multi-year, population health approach to obesity and weight management (all age) including prevention, lifestyle and behaviour support, specialist intervention (medical and surgical)
- ME/CFS and Long Covid - commission a new, combined model across GM with dedicated psychological input to support diagnosis and treatment – this will require a redistribution of non-recurrent Long Covid funding
- Commission new GM structured Diabetes Education Service in line with new GM specification

Population Health

- Continuation of in hospital-based support to reduce Alcohol Harm, building upon the current Alcohol Care Team model and Treating Tobacco Dependency. Providers to absorb within existing allocation.
- Continuation of ADVISE service for victims of Domestic Abuse whilst embark on the development of a multi-year plan as part of the 5 year commissioning strategy

NHS Greater Manchester

Preparations for New Governance – Progress Report

4th March 2026

Part of Greater Manchester Integrated Care Partnership

NHS Greater Manchester

Transition Committee

4th March 2026

Required information.	Details.
Title of report.	Preparations for New Governance – Progress Report
Author.	Chris Gaffey, Associate Director of Corporate Services
Presented by.	Charlotte Bailey, Chief Strategy, People and Partnerships Officer
Contact for further information.	Chris Gaffey, Associate Director of Corporate Services
Executive summary.	This paper provides the Transition Committee with an update the development of NHS GM's Committee structure ahead of implementation in April 2026. Further engagement is planned with Committee Chairs, as well as NEDs / Execs on 11th March, ahead of consideration at Board on 18th March.
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 Committee is asked to: 1. Consider the progress to date and next steps set out in the appended slides.
How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	Ensuring good governance arrangements are in place will ensure NHS GM is a well-led organisation, and one of the objectives of moving to a new Committee structure is to ensure that the Board and its Committees has the required strategic focus. This will support the delivery of the ICP Strategy, as well as ensure focus on the Board Assurance Framework.
Key milestones.	January 2026: Implementation of Transition Arrangements March 2026: Agreement of new proposals April 2026: Implementation of new Committee structure.
Leadership and governance arrangements.	Under the new Chief Officer Portfolio structure, 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. The Board is ultimately responsible for the Board and Committee arrangements, and any proposed changes to the Committee structure, as well as to the Scheme of Reservation and Delegation and Financial Scheme of Delegation, will require Board approval.

Engagement* to date. ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	Q3&4 2025/26: Engagement with Chief Officers and NEDs and further development of proposals in engagement with lead officers. 4th March 2026: Transition Committee 11th March: NEDs / Execs 18th March: Board consideration April 2026: Implementation
Financial or Legal Implications	Proposals will require changes to the Governance Handbook, Scheme of Reservation and Delegation, and the Financial Scheme of Delegation.

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	EHIA
No	Yes	No	Yes	No	No	Yes	N/A

*Table 2: Assurance needed about the document. * If yes, then please include narrative in the report itself*

NHS Greater Manchester

Preparations for new Governance – Progress report

Transition Committee – 4th March, 2026

NHS Greater Manchester

Progress report overview

- Background
- Progress to date
- Items for approval
- Key actions for 1 April 2026

Background

NHS Greater Manchester

With a number of changes and drivers on the role and responsibilities of Integrated Care Boards, a review of the Board and Committee structure will be key in ensuring that governance arrangements remain fit for purpose, and are designed to ensure the organisation are able to deliver against its statutory responsibilities.

- The 10 Year Health Plan promised a new commissioning framework for ICBs to turn this ambition into reality.
- The strategic commissioning framework supports all ICBs to meet the ambition for the future of strategic commissioning - Strategic commissioning will be the central purpose of the ICBs of the future.

Transitioning to the Model ICB Blueprint:

- Chief Officer Portfolios have been reviewed to align to the new model
- Board composition has been reviewed and updated to reflect these changes
- Governance and decision-making arrangements need to align to the new operating model
- Reform Programme to align staff to the new operating model remains ongoing
- Support to staff to move them into new roles and new ways of working

New national planning framework allows for medium-term financial strategy and commissioning plans, as well as a clinical strategy - governance structure should be designed to support the delivery of these key plans and strategies.

This review does not currently change the scope of the Audit or Remuneration Committees.

NHS Greater Manchester

Progress to date

- Committee Structure confirmed
- Governance Structure principles developed (presented for Transition Committee approval
- Draft ToR and workplans in development (high-level overview presented to Transition Committee today)
- Sub-Committee Structure developed (presented for Transition Committee approval)

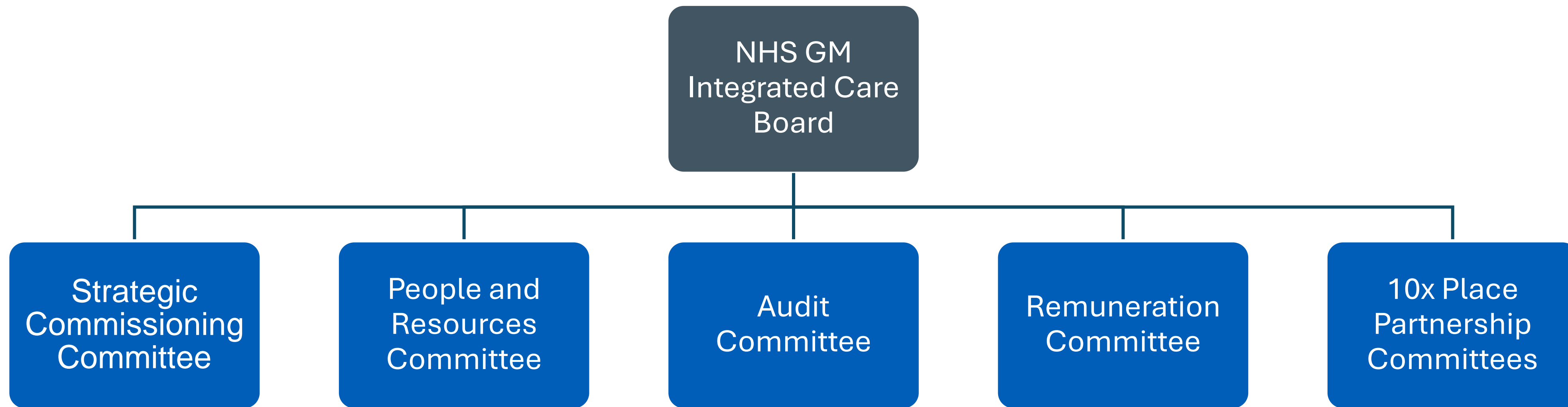
For approval today

- Governance Structure principles
- Sub-Committee Structure

Next Steps (see timeline later in the pack)

- Finalisation of strategic commissioning plan and top priorities for 26/27 (including outcomes framework for Place)
- Finalising committee work plans
- Move to dynamic risk assessment
- Alignment of Board development & Personal objective setting
- Publication of all Governance Architecture (e.g. Place, POMs, system groups)
- Support to workforce to move to new roles and new ways of working

Committee Structure (confirmed)



People and Resources Committee - overview

Greater Manchester

Purpose

The Committee provides assurance to the Board that the ICB is financially sustainable and meeting its statutory duties, while also offering strategic oversight of workforce, organisational culture and staff experience.

Key duties

Strategic Planning and System Sustainability

- Scrutinise and recommend the ICB's financial strategy, medium- and long-term plans, and annual assumptions.
- Oversee delivery of the NHS GM People Plan and workforce elements of the 10-Year Plans.
- Assure enabling strategies (capital, estates, digital, IT) and monitor delivery.

Performance, Outcomes and Assurance

- Assure delivery of statutory financial duties and system financial targets.
- Monitor key workforce indicators including sickness, training, appraisal, recruitment, retention.
- Review staff experience insights, including surveys and Freedom to Speak Up reports.
- Oversee digital and IT performance, information governance and ICB digital accountabilities.

Governance, Compliance and Statutory Duties

- Oversee statutory employer duties, including disciplinary processes, employment policies and compliance with national legislation.
- Review and recommend Standing Financial Instructions and ensure compliance with the Scheme of Delegation.
- Approve business cases, procurements and non-healthcare contracts within delegated limits.
- Ensure compliance with mandatory workforce reporting and monitor progress on Anti-Racism and Sexual Safety commitments.

Culture, People and Organisational Development

- Oversee organisational culture, ensuring a compassionate, inclusive and high-performing environment aligned to NHS GM's values.
- Monitor delivery of culture and OD&D plans across portfolios and Places.
- Oversee workforce planning, organisational change and CQC "well-led" requirements.

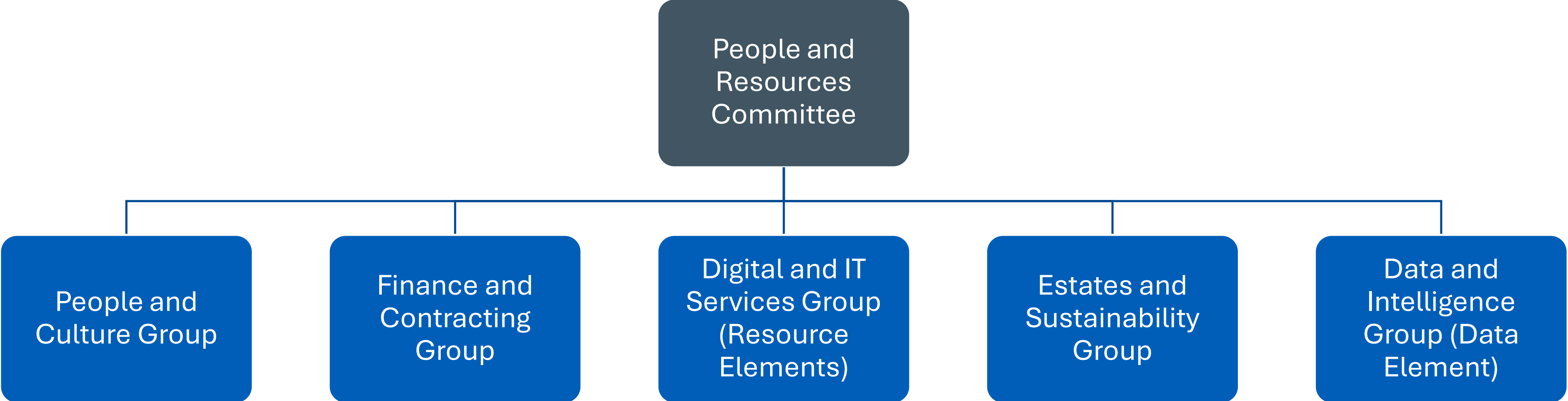
Risk

- Monitor assigned Board Assurance Framework and corporate risks.
- Commission and review deep dives or thematic analyses and escalate where required.

Membership

Non-Executive Member (Chair)
Non-Executive Member
Non-Executive Member
NHS GM Partner Member
NHS GM Partner Member
Chief Executive Officer
Chief Finance Officer
Chief Strategy, People and Partnerships Officer
Chief Reform and Improvement Officer

People and Resources Committee Proposed Sub-Structure (for approval)



People and Resources Committee Proposed Sub-Structure

Greater Manchester

Sub-Group	Key Duties	Delegations
People and Culture	• Full Workforce report • Oversight of the NHS GM People Plan and associated action plans • Culture and local action plans • Risk management • Deep dives	None
Finance and Contracting	• Detailed scrutiny of strategic and operational financial planning. • Receiving assurance on meeting the statutory financial duties for the organisation.	
Digital and IT Services Group (Resource Elements	• Oversee operational resourcing and delivery of digital and IT infrastructure/services to support NHS GM ICB functions and system partners, ensuring value for money, financial sustainability, and alignment with approved strategic priorities. • Manage resource allocation for digital/IT (revenue/capital budgets, supplier contracts, procurement), estates synergies (e.g., infrastructure/connectivity for digital enablement), and workforce implications (e.g., digital skills/training, device standards, change management/EDI in access). • Monitor and assure operational performance, cybersecurity/resilience, data processing/quality (Data Element linkage), supplier management, and compliance with national standards (e.g., Data Security & Protection Toolkit, DCB requirements). • Identify, mitigate, and escalate operational risks related to digital/IT (e.g., system downtime, cyber threats, resource constraints) to the parent committee, while supporting corporate risk management. • Support benefits realisation and efficiency from digital investments at operational level (e.g., productivity tools, hardware upgrades), feeding into financial performance reporting. • Ensure operational alignment with national digital infrastructure (e.g., NHS App connectivity, FDP) and provider-led delivery transitions per Model ICB Blueprint. • Provide resource-focused input to cross-system digital initiatives (e.g., with Health Innovation Manchester, places, providers) on estates/IT enablement.	• Approve operational digital/IT spend, changes, and procurement within delegated financial limits (per Financial Scheme of Delegation/FSoD), escalating major items to People and Resources Committee. • Approve relevant operational policies/procedures (e.g., acceptable use, change management, cyber incident response) and monitor implementation. • Endorse operational plans, performance metrics, and risk mitigations for digital infrastructure before escalation. • Delegate authority to task-and-finish groups for specific resource programmes (e.g., device refresh, cyber training, supplier reviews).

People and Resources Committee Proposed Sub-Structure (Continued)

Sub-Group	Key Duties	Delegations
Estates and Sustainability	TBD	TBD
Data and Intelligence Group (Data Element)	TBD	TBD

Strategic Commissioning Committee - overview

Purpose

The purpose of the Strategic Commissioning Committee is to obtain assurance, on behalf of the Board, that the ICB has the right commissioning strategy and approach, supported by intelligence, which is delivering its quality, performance, population health, and oversight functions in a way that secures continuous improvement, whilst ensuring that the ICB operates as a strategic commissioner.

The Committee will have a strong focus on prevention, population health and the left-shift.

Key duties

Strategy and System Transformation

- Challenge and assure the major strategies shaping commissioning, quality, digital transformation, prevention and population health.
- Oversee development and delivery of the Commissioning Strategy and annual/medium-term plans, ensuring alignment with ICP and GM priorities.
- Ensure digital, data and population health intelligence inform commissioning, pathway redesign, prevention and system left-shift.

Quality, Safety and Improvement

- Assure system clinical governance, patient safety and quality improvement arrangements, including safeguarding, IPC, medicines optimisation and mortality learning.
- Review learning from safety, effectiveness and experience, and monitor provider and locality quality through the Integrated Performance Report.
- Ensure digital tools, analytics and public health insight support quality improvement and reduction of inequalities.

Performance, Outcomes and Population Health

- Assure delivery of constitutional standards, system performance and population health outcomes.
- Use intelligence to identify needs, inequalities and improvement opportunities, and monitor progress on prevention and left-shift ambitions.
- Oversee delivery of statutory and delegated population health responsibilities, including S7A Public Health functions.

Governance, Compliance and Statutory Requirements

- Assure compliance with statutory and policy requirements across service delivery, including complaints, equality, citizen involvement and regulatory standards.
- Scrutinise responses to national directives and regulatory requirements, including digital and data standards.
- Oversee Emergency Preparedness, Resilience and Response (EPRR) arrangements.

Risk and Assurance

- Monitor Board Assurance Framework and corporate risks across commissioning, quality, digital and population health.
- Commission deep dives and escalate issues where required.

Membership

Non-executive Director (Chair)
Non-executive Director (Deputy Chair)
Non-executive Director
NHS GM Partner Member
NHS GM Partner Member
Chief Clinical Officer
Chief Commissioning Officer
Chief Reform and Improvement Officer
Chief Strategy, People and Partnerships Officer

Strategic Commissioning Committee Proposed Sub-Structure (for approval)

Strategic Commissioning Committee Proposed Sub-Structure

Sub-Group	Key Duties	Delegations
Clinical Effectiveness Group (CEG)	• Steers the clinical vision for NHS GM • Overarching framework for clinical governance • Set and aligns clinical strategy with ICS priorities • Drives system wide QI • Strategic clinical decision-making Committee • Shapes system priorities through horizon scanning • Influences research, innovation, and clinical policy • Enable system-wide clinical engagement and leadership • Statutory Duty for Medicines	Approval of Strategies, PGDs, Policies and Pathways
Involvement Assurance Group	• Provide oversight and assurance on all work involving public involvement and promoting inclusion – including: • Monitor delivery against the ICP People and Communities Participation Strategy • Monitor the delivery of the NHS GM's equality objectives • Assess and approve proposed work plans for engagement and equality • Assess engagement and consultation in support of proposed service change against the legal duty to involve, making organisational recommendations on whether formal consultation is required • Assess and approve formal consultation plans and monitor on progress and potential risks • Provide assurance against NHS GM's adherence to the Public Involvement Duty, the Public Sector Equality Duty (PSED) and other associated legislation. • Identify any risks (and mitigations) in relation to engagement and equality and escalate as appropriate	None
Performance Group	Provider Performance • Receive provider operational and contractual performance positions. • Monitor progress against provider plans to identify risks, escalation needs and required support. • Assign ICB leads to work with escalated providers on improvement plans and track their impact. • Maintain a risk-adjusted performance forecast, including period-end and annual outlooks. ICB Performance • Receive and review ICB improvement plans setting out actions and measurable outcomes to close performance gaps. • Monitor progress against agreed trajectories and impact measures. • Identify areas of risk and trigger escalation routes where performance is off-track	None

Strategic Commissioning Committee Proposed Sub-Structure (continued)

Greater Manchester

Sub-Group	Key Duties	Delegations
Quality Group	• Quality strategy and planning • System oversight of Quality Management • Safeguarding • Continuous Improvement • Oversight and management of Strategic risks related to quality • Escalation of quality and care experience risks to SCC.	EQIA
Population Health Group	• Oversee all ICB population health activity, spend and impact, including delivery of priority commitments in the 5-Year Strategic Commissioning Plan. • Ensure the ICB meets its statutory duties on improving population health, reducing inequalities, and contributing to social and economic wellbeing. • Provide oversight of Public Health functions, including healthcare public health, screening, immunisation, health protection, outbreak response and safer communities. • Provide specialist public health advice to inform strategic commissioning and system decision-making. • Ensure strong links with GM, regional and national governance to support improved health outcomes.	Oversight, assurance and decision-making in relation to the proposed s75 agreement between NHS GM and the GM Public Health Network Oversight, assurance and decision-making in relation to s7a Public Health commissioning responsibilities of NHS GM, including any commissioning and finance approval requirements that might sit with the ICB under future OPIC arrangements
Digital and IT Services Group (Strategy Elements)	• Provide strategic oversight and direction for digital and IT transformation across NHS GM ICB functions, ensuring alignment with the 10 Year Health Plan's analogue-to-digital shift, the GM Health and Care Digital Transformation Strategy and the left shift to community/neighbourhood-based, preventative care. • Steer prioritisation of strategic digital investments, roadmaps, and initiatives that enable population health management, proactive/preventative models, personalised care, system efficiency, and reduction of inequalities (e.g., digital first primary care, remote monitoring, shared care records, AI-enabled pathways). • Oversee strategic aspects of digital maturity, interoperability, innovation adoption, and benefits realisation to support commissioning decisions, quality improvement, and system oversight. • Provide strategic input on digital-enabled approaches to population health intelligence, prevention ambitions, and the Integrated Care Partnership Strategy. • Identify and escalate strategic risks related to digital (e.g., cyber resilience as a Plan priority, digital exclusion/EDI implications, alignment to national digital infrastructure). • Ensure digital considerations are embedded in strategic commissioning, using intelligence from the Data and Intelligence Group (Intelligence Element) to inform decisions. • Foster system-wide strategic engagement on digital (e.g., with providers, places, Health Innovation Manchester, and national tools).	• Recommend strategic digital priorities, investment cases, and roadmaps to the Strategic Commissioning Committee (or Board where required) for approval. • Approve detailed strategic plans and changes within approved budgets/strategic frameworks (escalating major spend/decisions per Financial Scheme of Delegation). • Endorse benefits realisation reports, performance metrics, and maturity assessments for strategic digital initiatives before escalation. • Delegate authority to task-and-finish groups for specific strategic programmes (e.g., digital inclusion, AI adoption, pathway redesign). • No operational delegations (e.g., day-to-day IT delivery, infrastructure management)—these remain under People and Resources Committee (Resource Elements) or transfer

Strategic Commissioning Committee Proposed Sub-Structure (continued)

Sub-Group	Key Duties	Delegations
Data and Intelligence Group (Intelligence Element)	TBD	TBD

Governance Structure Principles – for approval

NHS
Greater Manchester

<table>
<tr><th>Governance Tier / Level</th><th>Principles</th></tr>
<tr><td>Tier 1 – Board and Committees</td><td>• Committees to have strategic and Board assurance focus
• Decisions required to be commensurate with level of spend / risk (in line with SORD and FSoD)
• Will meet monthly in line with corporate calendar, meetings to take place on Wednesdays as part of “Board Day”
• Development Sessions to be scheduled as part of workplans
• Supported by the Corporate Governance Team
• Strict adherence to agreed GGI governance principles, to ensure quality and timeliness of papers.
• Meetings held in public, with papers to be published on NHS GM website
• Part 2 (Private) may be required to ensure Board and Committees are sighted on key sensitive issues (agreed with the Chair)
• Consideration to be given as to whether Committee meetings should be held virtually to support capacity and reduce meeting costs (Board to continue in person)</td></tr>
<tr><td>Tier 2 – Direct Sub-Groups</td><td>• Consider more detail and focus on operational matters
• Upward reporting by exception
• Meeting schedules to be agreed by relevant sub-groups to ensure adequate support for main Committees
• Meetings not held in public
• High level notes (potentially AI generated to support capacity) to be captured for each meeting.
• Decision logs (where relevant) to be maintained and transparently communicated</td></tr>
<tr><td>Tier 3 – Departmental Groups</td><td>• To be agreed at portfolio / function level, to support any work of the sub-groups
• No formal minutes required</td></tr>
</table>

NHS Greater Manchester

Committee Development – working brief

The Leadership Development Commission will work in partnership with NHS Greater Manchester to support the relational and cultural development of two newly developed committees: the Commissioning Committee and the Finance & People Committee.

The focus will be on developing high-performing committees. Internal governance development work has already begun and has explored committee form, function, roles, purpose, and expectations. This will be complemented by bespoke development from NHS North West Leadership Academy (NWLA), working in partnership to support the relational and cultural aspects of the transition.

In particular, the development will focus on supporting the transition to the new committees and what this means for individual committee members, their development, and their ability to step into new expectations. There will also be a strong emphasis on the committee operating effectively as a collective and working in alignment with the Board. The scope of the work will include Committee Chairs, committee members, Governance Advisors, and OD advisors.

A key theme of the development will be letting go of previous ways of working and embracing the new structures, with a clear focus on high performance. This will be balanced with acknowledging concerns about the breadth and scope of the committees, while ensuring members remain strategically focused and able to work collectively.

The development will build on existing development activity, including work delivered by Good Governance Institute (GGI) and the findings from the Well-Led Update Review, which identified three strategic priorities. The approach will use a positive transitional lens, recognising the importance of acknowledging the past while creating sustainable, high-performing committees for the future.

Committee Chairs will play a critical role and will be engaged early in the process, including involvement in the selection of the provider. The chosen provider will work in partnership with NHS GM, led by Chris Gaffey (Associate Director of Corporate Services) and Jackie Pratt (Assistant Director of OD & Leadership), supported by a small planning group including Governance Advisors.

Resources to support this work will include bespoke development provision and the remaining three executive coaching places available through NWLA membership for the 2025/26 financial year. The timeline is expected to include early engagement with Chairs in mid-February, followed by potential face-to-face onboarding sessions with committee members. These sessions will focus on bringing expectations to life, clarifying how the committees will work collectively, and identifying development needs and priorities to ensure successful and sustainable outcomes. Further work will be required in the new financial year (beyond March) and subject to membership renewal.

The provider selection process is ongoing, with recommendation on most appropriate provider to be made to the NHS GM Chair in the week commencing 11th March 2026.

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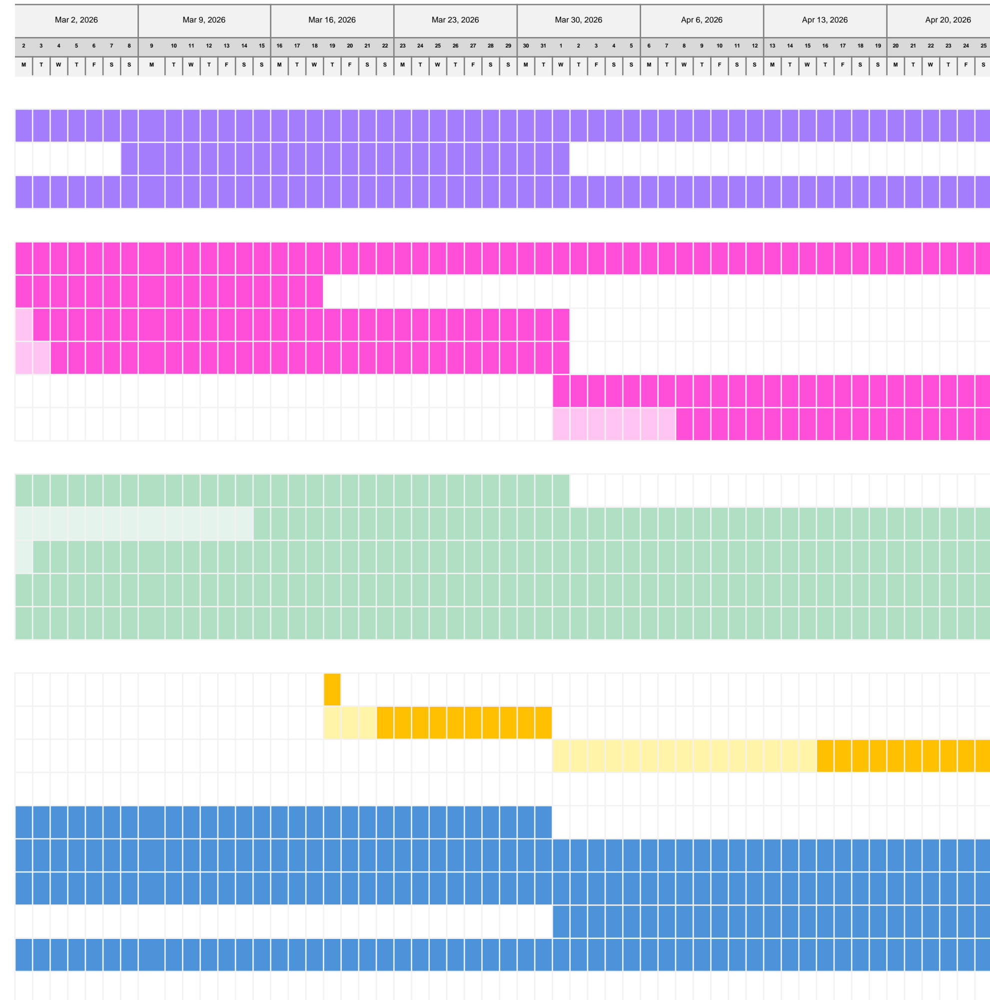
Committee & Board Development

Project start: 3/2/2026

Display week: 1

NHS GM | **Project lead**

TASK	ASSIGNED TO	PROGRESS	START	END
Board Preparations				
Develop Board/Commitee Priorities	TBC	25%	Jan 2, 2026	Aug 3, 2026
Review System Governance Arrangements		0%	Mar 8, 2026	Apr 1, 2026
Reporting writing training		0%	Feb 3, 2026	May 1, 2026
Committee Preparations				
Develop TOR		60%	Jan 1, 2026	18/3/26
Identify Committee priorities		25%	Feb 2, 2026	Mar 18, 2026
Develop workplan		50%	Feb 2, 2026	Apr 1, 2026
First Committee Meeting		50%	Feb 3, 2026	Apr 1, 2026
First report to Board		0%	Apr 1, 2026	May 26, 2026
Develop Committee risk registers		25%	Apr 1, 2026	May 1, 2026
Sub-Committee Preparations				
Confirm required Sub-Committees		50%	Jan 2, 2026	Apr 1, 2026
Develop TOR		60%	Jan 4, 2026	Apr 30, 2026
Develop Workplans		50%	Jan 3, 2026	May 1, 2026
First Sub-Committee Meetings		0%	Jan 4, 2026	May 30, 2026
First report to Committee		25%	Jan 4, 2026	May 26, 2026
Dynamic Risk Reporting				
Deep Dive (Pop Health)		25%	Mar 19, 2026	Mar 19, 2026
Prioritisation analysis of current BAF Risks		25%	Mar 19, 2026	Mar 31, 2026
Finalse updated BAF		50%	Apr 1, 2026	May 1, 2026
Ongoing Committee Development				
Early Engagement & Co-Design			Feb 1, 2026	Mar 31, 2026
Transition Preparation & Onboarding			Mar 1, 2026	Apr 30, 2026
Committee Go-Live				Apr 30, 2026
Embedding & Performance Development			Apr 1, 2026	Jul 31, 2026
Review & Sustainability				Dec 31, 2027



Key milestones

NHS Greater Manchester

4th March – Transition Committee- Update on progress to date and support for next steps

11th March 2026 – NEDs / Execs Workshop

- Finalise proposed Committee structure
- Co-production of 2026/27 Board and Committee Workplans (to be finalised for first meetings of 2026/27)

18th March 2026 – Board

- Board consideration of new Committee Terms of References for approval
- Proposed changes to Scheme of Reservation and Delegation and Financial Scheme of Delegation to be considered

April 2026

- Implementation of new Committee structure – first meeting to land new responsibilities, including risks, finalising workplan, providing further feedback on proposed supporting sub-structures.

April – June 2026

- Standing up of supporting sub-governance structures, including finalisation of ToRs and workplans.
- Support to the workforce to move into new roles and new ways of working
- Move to dynamic risk reporting
- 6. Alignment of Board Development Programme and Personal objective setting

June 2026

- Assessment of new arrangements and continuous review and feedback throughout 2026/27
- Ongoing development sessions for new Committees

Next steps

- Finalise priorities and work plans
- Move to dynamic risk reporting
- Ongoing Board and Committee Development
- Personal objective setting
- Publication of all Governance Architecture (e.g. Place, POMs, system groups)

Task & Finish Group to mobilise final preparations:

- In order to be prepared to operate the new governance arrangements from 1 April, it is proposed that two informal task and finish groups for the two strategic Committees are stood up immediately.
- Chaired by the NED Committee Chair and supported by the relevant Chief Officers.
- Purpose = finalise draft TOR and workplan and ensure readiness for Day 1.
- To be supported by finalisation of the Scheme of Delegation and Financial Scheme of Delegation.

NHS Greater Manchester

Board Assurance Framework and Risk Update

4th March 2026

Part of Greater Manchester Integrated Care Partnership

NHS Greater Manchester

Transition Committee

4th March 2026

Required information	Details
Title of report	Board Assurance Framework and Risk Update
Author	Chris Gaffey, Associate Director of Corporate Services
Presented by	Gareth Robinson, Interim Chief Reform and Improvement Officer Chris Gaffey, Associate Director of Corporate Services
Contact for further information	Rick Thompstone, Assistant Director Risk & PMO – rick.thompstone@nhs.net
Executive summary	This report provides an update to the Transition Committee on the updated strategic risks for the organisation (the BAF is set out in Appendix One). The report also considers the future BAF and Corporate risk reporting and proposals on where these risks will be considered from April 2026.
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 Transition Committee is asked to: • Consider the updated strategic risk descriptions ahead of the March Board meeting • Consider the reporting split for BAF and Corporate Risks between the two proposed new committees • Note the work ongoing on BAF risk review and progressing towards dynamic risk reporting
How this supports the delivery of the strategy and mitigates the BAF risks	This report is directly focused on Risk Management which includes the BAF risks.

Key milestones	Transition Committee – 4 March 2026 Formal Board consideration – 18 March 2026
Leadership and governance arrangements	Each strategic risk has an assigned risk owner, who is a Chief Officer of NHS GM. The BAF is reported to and considered by the Board at each of its meetings, with the strategic risks also considered at the Transition Committee. The NHS GM Risk Policy provides a framework to enable risk management to be embedded across all activities within the organisation
Engagement* to date ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	The BAF and Corporate Risks are considered by the relevant Committee, as well as the NHS GM Chief Officers for management oversight.
Financial or Legal Implications	None.

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

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

1.0 Introduction

1.1 This report provides the update on the Strategic Risks following their development and revisions during February 2026

2.0 Strategic Risks

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

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

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

NHS GM Board Assurance Framework
March 2026

Strategic Objectives									
Strengthen our Communities	Recover core health and care services		Help people get into, and stay in, good work	Help people to stay well and detect illness earlier	Support our workforce and carers	Achieve financial sustainability	Meet our statutory obligations		
Strategic Risks									
SR1	**SR2**	**SR3**	**SR4**	**SR5**	**SR6**	**SR7**	**SR8**	**SR9**	**SR10**
Health of the Population	**Health Outcomes**	**Quality of Care**	**Good Employment**	**Health Inequalities**	**Workforce**	**Financial Sustainability**	**Cyber Security**	**Emergency Incident**	**NHS Reform**
Current Score 2 (L) x 5 (I) = **10**	Current Score 4 (L) x 5 (I) = **20**	Current Score 3 (L) x 5 (I) = **15**	Current Score 3 (L) x 4 (I) = **12**	Current Score 4 (L) x 4 (I) = **16**	Current Score 4 (L) x 4 (I) = **16**	Current Score 5 (L) x 4 (I) = **16**	Current Score 3 (L) x 4 (I) = **12**	Current Score 4 (L) x 4 (I) = 9	Current Score 4 (L) x 4 (I) = 16
Trend: ⇩	Trend: ⇔	Trend: ⇔	Trend: ⇩	Trend: ⇔	Trend: ⇧	Trend: ⇩	Trend: ⇔	Trend: ⇩	Trend: ⇔
Year End Target 2 (L) x 5 (I) = 10	Year End Target 4 (L) x 5 (I) = 20	Year End Target 3 (L) x 5 (I) = 15	Year End Target 3 (L) x 4 (I) = 12	Year End Target 3 (L) x 4 (I) = 12	Year End Target 3 (L) x 3 (I) = 9	Year End Target 4 (L) x 3 (I) = 12	Year End Target 3 (L) x 4 (I) = 12	Year End Target 3 (L) x 3 (I) = 9	Year End Target 3 (L) x 3 (I) = 9
Final Target Score **5** (2028)	Final Target Score **10** (2028)	Final Target Score **10** (2028)	Final Target Score **8** (2029)	Final Target Score **4** (2028)	Final Target Score **9** (2028)	Final Target Score **12** (2025)	Final Target Score **8** (2028)	Final Target Score **6** (2028)	Final Target Score **4** (2026)
Risk Appetite: Open	Risk Appetite: Cautious to Open	Risk Appetite: Cautious to Open	Risk Appetite: Open	Risk Appetite: Open	Risk Appetite: Open	Risk Appetite: Open	Risk Appetite: Cautious	Risk Appetite: Cautious to Open	Risk Appetite: Cautious to Open
10 - 20	**5 - 15**	**5 - 15**	**10 - 20**	**10 - 20**	**10 - 20**	**10 - 20**	**5 -10**	**5 - 15**	**5 - 15**

3.0 Proposed Risk Reporting arrangements following restructure

3.1 Following the restructure it is proposed there will be two committees which will report to the Integrated Care Board. These statutory committees will be:

- Strategic Commissioning Committee
- People & Resources Committee

3.2 The areas that are due to report into each committee are still to be finalised and therefore the division on the risks shown below between the two committees is proposed and subject to change.

3.3 The reporting of the BAF risks prior to being considered in full at the Integrated Care Board, will be split by these two committees. It is important to note that a review of the BAF Risks is due to take place to ensure the risks are fully aligned to, and derived from, the Strategic Objectives.

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

SR6	SR7	SR8	SR10
Workforce	**Financial Sustainability**	**Cyber Security**	**NHS Reform**

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

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

3.6 The corporate risks shown below are taken from the February 2026 Transition Committee Risk Report. The previous committee reference has been included to ensure members are clear where the corporate risks were previously reviewed.

People & Resources Committee Risks

Risk Number	Risk Description
Finance	
FIN2	Financial pressures may lead to a failure of NHS GM to meet NICE TA mandatory requirements which is work carried out by GMMMG.
FIN5	Significant increased or optimised utilisation in estate resource not achieved.
People & Culture	
PC001	**Workforce Integration** There is a risk that we do not have the resource, capacity or capability to adequately support the integration of our health and care workforce.
PC002	**Good Employment** There is a risk of being unable to uphold good employment practices across health and social care.
PC003	**Workforce Wellbeing** There is a significant risk that high levels of sickness absence will reduce workforce productivity across health and social care.
PC004	**Addressing Inequalities** There is a risk that financial challenges and NHS reform could impact on the resource allocated to ICB and organisation level activity to improve the experience of members of our workforce with protected characteristics.

PC005	**Growing and developing our workforce** There is a risk that the increasing headcount restrictions across the system could further prevent recruitment to key shortage areas.
PC006	**System Leadership Collaboration** There is a risk that there will be a reduced level of co-operation and collaboration between leaders across the system.
PC007	**Digital Readiness** There is a risk that low digital readiness will prevent successful implementation of the Transforming People Services Programme.
PC008	**Organisational Change Impact on P&C Teams** There is a risk that ongoing organisational change across NHS Greater Manchester driven by NHS Reform and financial pressures will lead to a reduction in the capacity and expertise of People and Culture teams.
PC009	**ICB Workforce Focus Loss** There is a risk that the remodelled ICBs may not retain a sufficient workforce focus, particularly in relation to People and Culture priorities.
PC010	**Loss of Talent Due to Reform** There is a risk that NHS and wider public sector reform will result in the displacement of staff, leading to the loss of valuable talent, experience, and knowledge across the GM health and care system. This risk is heightened by delays in national redundancy schemes, financial constraints, and ongoing organisational uncertainty.
PC011	**Changes to Immigration Rules** There is a risk that the recent UK immigration rule changes will impact individuals and their families (including ethical, safety and security, financial), colleagues, teams, and wider organisations, potentially patient care. The risk relates to Right to Work status of individuals affected.

3.7 In addition, this Committee will have responsibilities relating to Estates, aspects of Data and Intelligence, and aspects of Digital and IT, and will therefore consider any related corporate risks. All risks will need to be reviewed in line with the responsibilities of the new Committee structure.

Strategic Commissioning Committee Risks

Risk Number	Risk Description
Quality	
QUP25/07/25	There is a risk of limited assurance on the quality of interventions within paediatric audiology services which may cause delayed harm to the CYP population
Performance	
QUP16/11/23	IF the Cancer Alliance projects add operational and / or financial pressure to the GM system given the underlying operational and financial challenges THEN the delivery of the NHS Cancer Programme priorities and targets will be affected. This includes ongoing funding of projects to sustain services once the Cancer Alliance funding allocation to providers and partners in NHS GM ends
QUP19/03/24	If the fragility of the dermatology service is not resolved, there will be a detrimental impact on the operational performance metrics. Furthermore there will be an impact to patient experience and potentially psychological impact.
QUP23/05/24	If investment (non-pay) is not available to deliver improvement initiatives, then there is a significant risk to the delivery of the system planning requirements for cancer performance (28 day, 62 day)
ERR 2	There is a risk of non-delivery of 18/ 52 targets

ERR 3	There is a risk of non-delivery of financial control (change in financial regime)
ERR 4	There is a risk that the interaction of Elective and UEC mitigations conflict, leading to non-achievement of targets and impact on patient outcomes
ERR 6	There is a risk that winter pressures disrupt elective capacity and performance
ERR 14	There is a risk that strategic investment decisions are taken at organisation level and unintended consequences may deteriorate Elective demand and capacity
ERR15	There is a risk that ICB control of its provider landscape and activity is significantly limited
GMMHPGR7	There is a recognised risk that the updated CAMHS specification will lead to commissioned gaps for CYP who meet thresholds for Autism or Attention Deficit Hyperactivity Disorder (ADHD) assessment but do not have a co-occurring mental health condition. These CYP will fall outside the scope of CAMHS, potentially leaving them without a clear referral pathway for diagnostic assessment unless alternative commissioning arrangements are made risk may lead to the following impacts:
QUP21/10/24	IF the GM UEC system does not achieve the 78% 4 hour wait in Emergency Department (ED) standard of care by end March 26 THEN there may be a risk to patient safety.
QUP09/01/23	IF the GM UEC System is overwhelmed due to capacity constraints THEN the possible consequence of this would be more patients attending an ED, overcrowding of EDs, less patients being seen within 4 hours, delays to hospital handover, compromising patient safety and possibly leading to patient harm.
Medical	
CCPL09A	The Clinical Care and Professional Leadership across the GM system is under intense pressure, with reduced resilience; this alongside recruitment freezes will impact on retention and potentially lead to burn out. The implications of changes in relation to NHS Reform will contribute to this across the system. The risk is that this will impact on the ability to ensure that decisions about health and social care across GM are clinically led, clinically challenged, clinically effective which will result in poorer health outcomes for our population as a whole and impact on NHS GM being able to deliver its operating model.
CCPL09B	The Clinical Care and Professional Leadership across the GM system is under intense pressure, with reduced resilience; this alongside recruitment freezes will impact on retention and potentially lead to burn out. The implications of changes in relation to NHS Reform and the Model ICB work will contribute to this across the system. The risk is that this will impact on the ability to ensure that decisions about health and social care across GM are clinically led, clinically challenged, clinically effective which will result in poorer health outcomes for our population as a whole and impact on NHS GM being able to deliver its operating model.
Population Health	
PH1	There is a risk that the financial, operational and performance pressures facing NHS GM and the wider Population Health system lead to a reduction of funding for Population Health and Prevention, or a delay in the approval of activities resulting in disruption to planned activity.
PH2	There is a risk that the financial pressures and organisation change that is facing NHS GM impact on the ability to recruit staff into key roles, and to retain staff who are currently in key roles at locality and pan-GM level.
PH3	There is a risk a lack of capacity, funding and prioritisation will mean that NHS GM will fail deliver the requirements of the GM Green Plan including the required carbon emissions, and failure to fully prepare for the impacts of climate change.
PH4	There is a risk that the issues relating to financial, operational and workforce sustainability within the VCFSE sector, associated with both national and local factors, could create a level of sector fragility that could jeopardise the delivery of

	GM's Population Health ambitions, and the wider system Live Well / Neighbourhood Health plans.
PH5	There is a risk that largescale organisational transformation over the next 18 months, in the context of NHS reform, will cause short-term disruption to the delivery of activity focussed on improving health, reducing health inequalities, and reducing avoidable demand and cost.
PH6	There is a risk that the NHS reform announcement will disrupt the planned formal delegation of screening and immunisations from NHSE to the ICB (planned for April 2026).

3.8 In addition, this Committee will have responsibilities relating aspects of Data and Intelligence, and aspects of Digital and IT, and will therefore consider any related corporate risks. All risks will need to be reviewed in line with the responsibilities of the new Committee structure.

4.0 BAF Risk Review and Dynamic Risk Reporting

4.1. As referred to in February, a full review of current BAF risks will be undertaken to ensure that these remain aligned to our Strategic Objectives. Further development of our risk processes will also support the move towards a more dynamic way of reporting risk, with work already underway. The proposed steps to be taken are as follows:

Action	Timeline
Full review of agreed organisational BAF Risks for 2026/27	Ongoing – to be completed in time for May 2026 Board via engagement with Chief Officers and Board members
BAF Risk Deep Dive – SR1, Population Health	19th March 2026, Audit Committee
Assessment of learning from deep dive for application across risks	By end of March 2026
Prioritisation and schedule for deep-dives of remaining BAF risks	By end of March 2026 (align with drafting of new Committee workplans – may need to be reassessed once list of BAF risks refreshed)
Deep dives completed in all BAF risk areas	By July 2026

5.0 Recommendations

5.1 The Board is asked to:

- Consider the updated strategic risk descriptions ahead of the March Board meeting
- Consider the reporting split for BAF and Corporate Risks between the two proposed new committees
- Note the work ongoing on BAF risk review and progressing towards dynamic risk reporting

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

Rationale for Risk Score and Progress made in the quarter

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

Key Controls

The Greater Manchester Strategy is the main control measure and the deliverability of the strategy including the extent to which the ICB can act as a system influencer and strategic investor is key to mitigating this risk. In the current landscape of NHS reform, it is crucial that the ICB retains the capacity, expertise and ability to act as a collaborative system influencer and co-investor in relation to the building blocks of health which the strategy covers.
Alongside the GMS, another key control is the development of a comprehensive strategic approach to NHS 'left shift' which builds upon our GM Population Health Model and comprehensive Prevention and Early Intervention Framework and underpins ICB reform and future transformational operating model.
An evidence-based, co-produced and fully costed NHS GM Annual Plan for 2025/26 includes a series of actions relating to reducing the prevalence of poor health and scaling up proactive care.
A Fairer Health for All Framework has been agreed by the Integrated Care Board and there are significant implementation plans in place for 2025/26 which will seek to embed tacking inequalities as a focus of the system. The GM Housing Tripartite Agreement ensures a collaborative approach to healthy homes across NHS GM, GMCA and Housing Providers.

Gaps in Control or Assurance

Current reforms have and likely will continue to significantly impact any proactive NHS system involvement in delivery of the various strategic ambitions. Continuation of this will mean programmes develop without relevant health system influence and opportunities are missed to improve the health of the population.
The NHS Reform could impact on the capability of the ICB to provide the resource, skills, expert knowledge and capacity to effectively work across multiple systems in order to fulfil our role in driving the delivery of the GMS. A significant reduction in ICB headcount due to VR and restructuring will mean capacity and expertise gaps will appear. The total impact of the reform is still to be fully understood, however direct impact on Population Health capacity is already apparent with some key programmes of work losing key personnel.
The delay in organisational 'left shift' activity and investment will impact progress of prevention and early intervention opportunities and transformation propositions.

Risk Scoring and Tolerance

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

Number of Linked Risks on Corporate Risk Register

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

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

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

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

Strategic Risk **SR2**	There is a risk that key health and care services become unsafe and unstable due to growing and changing demand, pressures faced by other sectors and workforce, estates and technology gaps. This will result in poorer health outcomes for the GM population and a reduction in quality of care and patient safety and an inability to deliver operational delivery standards.
Strategic Objective	Recover core health and care services
Chief Officer / Committee	Gareth Robinson Transition Committee (formerly Quality and Performance Committee)
Risk Appetite Level	Cautious to Open
Risk Tolerance Range (e.g. 5 to 10)	5 – 15

Rationale for Risk Score and Progress made in the quarter

All organisations remain committed to the plans they submitted. Areas highlighted as high risk are considered such because of the scale of the 25/26 challenge or historical non-achievement. Current plans include significant levels of mitigations and NHS GM is committed to meet its planning objectives. This risk is currently outside of the risk appetite of the organisation. The target risk score moves within risk appetite by March '28. It is important to note that national guidance will require a continued incremental improvement back toward constitutional standards over several years which will mean a continued pressure against these standards. High risk areas continue to be A&E 4 hour waits; Long waits for elective care; Waiting times for Children's and adolescent mental health services including ADHD/ASD and reducing mental health inpatient LOS. Further development of the function is required to respond to the ICB reform requirements including oversight arrangements. Financial constraints is a contributory factor.

Key Controls

Weekly, and daily as required, tracking of activity and operational planning objectives and/or constitutional standards. Mutual aid for elective, cancer and diagnostic care is in place.
Use of independent sector support for elective care, where this is within budget.
Daily monitoring of A&E activity and breaches.
GM system control centre oversees operational activities and escalation of UEC.
Improvement plans refreshed for all high-risk areas, including individual Trust and/or locality level where needed. (UEC, elective, cancer, mental health, diagnostics and inpatients for people with a learning disability).
Provider oversight meetings in place to gain assurance regarding delivery. Escalation meetings in place for Trusts which provider clearer tracking of action plans at senior level

Gaps in Control or Assurance

Limited scope for additional investment in mitigating actions, such as investing to support additional activity.
Locality assurance meetings stepped down until the end of the year when new arrangements will be put in place, Quality and Performance Committee not currently meeting with new arrangements to be put in place from April 2026.
Specific challenges within specialties/sub-specialities which have limiting factors such as available workforce. Some specialty areas where there are workforce shortages nationally. Limited supply of materials for corneal grafts. The prioritisation of these materials is coordinated nationally and cause breaches of waiting times. These are accepted exceptions to ICB Performance management by NHSE.

Risk Scoring and Tolerance

	Inherent risk score	Q1	Q2	Q3	Q4	Year-end Target	Long Term Target	Long Term Target Date
Likelihood	5	4	4	4		4	2	March 2028
Impact	5	5	5	5		5	5	
Risk Level	25	20	20	20		20	10	

Number of Linked Risks on Corporate Risk Register

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

Lines of Defence	Sources of Assurance	Assurance Level
1st Line	Weekly review of key metrics Executive Committee / Chief Officers review key metrics weekly 121s with programme directors (elective, cancer, urgent care, mental health, diagnostics)	Partial
2nd Line	System Group meetings to review operational performance for their respective thematic area; provider contract meetings; provider oversight meetings;	Partial
3rd Line	NHS GM is part of various NHSE (regional and national) oversight relating to elective; urgent and emergency care; and cancer care. Provides access to various external support offers including GIRFT and ECIST	Acceptable

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

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

Strategic Risk **SR3**	There is a risk that the quality of care, patient safety and care experience will decline if the ICB fail to comply with our statutory duties for quality assurance in Quality and Patient Safety within the NHS GM system. This may lead to poorer health outcomes for the GM population.		
Strategic Objective	Recover core health and care services		
Chief Officer / Committee	Manisha Kumar Transition Committee (formerly Quality and Performance Committee)		
Risk Appetite Level	Cautious to Open	Risk Tolerance Range (e.g. 5 to 10)	5 – 15

Rationale for Risk Score and Progress made in the quarter

The NHS GM provider oversight model is now well embedded with regular review of providers in line with NHS England guidance which provides significant mitigation, however some quality oversight processes are currently paused whilst current models and mechanisms for escalation are being reviewed in light of model ICB and model region guidance. Following the system wide recommendations from the Independent Assurance Review into GMMH (The Shanley Review), the ICB has responded to NICHE with evidence of its progress in the identified areas and is awaiting the publication of the final report. Whilst delayed from the original timescale due to data sharing issues, an independent review into community mental health has now been undertaken, with the findings and actions are being finalised.
NHS Reforms have impacted on the delivery of our statutory duties following a reduction in resource and loss of organisational memory, however transition of quality functions to a single clinical portfolio and a matrix-working approach alongside performance and contract colleagues has partly mitigated this. Risk stratification methodology is in place to focus a more limited resource in the most appropriate way to mitigate risk whilst still providing early warning of lapses in quality & safety. Work is ongoing to undertake Quality Impact Assessments against proposed changes in each statutory function. Engagement work has been undertaken to develop the new organisational/operating model for the ICB which includes review of oversight of quality and patient safety as a Strategic Commissioner. Development of new ways of working to strengthen contractual oversight is ongoing.

Key Controls

• NHS trust provider oversight (POM) in place and well established with plans to further develop and further strengthen. • Exec to exec meetings now a regular occurrence, with Quality KLOES identified. • ICB Provider Oversight Framework established in line with National Guidance. • Quality Assurance Framework established/aligned to meet the National Quality Board Standards. • Work underway to strengthen quality in contractual mechanisms to align with the strategic commissioner aim.

• Quality Impact Assessment processes established – • GM System Quality Group currently being reviewed in line with wider governance work underway at the ICB). • Reporting, audits and actions in place for safeguarding assurance (aligns to Safeguarding Policy). • MIAA Audit findings/actions • Annual reports (Quality Accounts / Safeguarding Report). • Assurance meetings with NHSE. • Submission to RSQG with escalations as part of business as usual. • External audits. • External inspections by regulators

Gaps in Control or Assurance

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

Risk Scoring and Tolerance

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

Number of Linked Risks on Corporate Risk Register

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

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

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

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

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

Rationale for Risk Score and Progress made in the quarter

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

Key Controls

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

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

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

Gaps in Control or Assurance

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

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

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

Risk Scoring and Tolerance

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

Number of Linked Risks on Corporate Risk Register

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

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

Action — Key: Complete/BAU; On Track; Delayed; Problematic

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

Strategic Risk **SR5**	There is a risk that health inequalities are widened, and health outcomes are reduced to due to a lack of sustained investment in preventive, proactive and evidence-based services. This will result in increased demand and cost of health and care services and impede economic growth.		
Strategic Objective	Help people to stay well and detect illness earlier		
Chief Officer / Committee	Charlotte Bailey	Transition Committee (formerly Population Health Committee)	
Risk Appetite Level	3 - Open	Risk Tolerance Range (e.g. 5 to 10)	10 – 20

Rationale for Risk Score and Progress made in the quarter

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

Key Controls

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

Gaps in Control or Assurance

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

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

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

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

Action — Key: Complete/BAU; On Track; Delayed; Problematic

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

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

Rationale for Risk Score and Progress made in the quarter

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

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

Key Controls

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

Gaps in Control or Assurance

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

Risk Scoring and Tolerance

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

Number of Linked Risks on Corporate Risk Register

Low (1 - 4)	Mod (6 – 12)	High (15 – 25)
0	1	5

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

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

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

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

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

Rationale for Risk Score and Progress made in the quarter

The risk score is based on the financial plan submitted to NHSE for 2025/26, taking on board the financial grip and control measures currently in place and the financial risk associated with delivering financial balance over the medium term (2 to 5 years) which is rated as high, as there is a significant amount of work to do as an organisation and system to develop robust savings plans that deliver savings on a recurrent basis. A considerable amount of work has already been undertaken, savings plans are being further developed across the whole GM ICS over a medium-term basis to help ensure the ICS can move to an affordable and sustainable financial position within the overall financial resources available to it.
The sustainability plan is developed upon 5 pillars (cost improvement, system productivity, reducing prevalence, proactive care, and optimising care). The financials were developed through a review of all organisations financial sustainability plans to ensure consistency of assumptions and a system approach.
The risk score has decreased from 20 to 16 to reflect the reduced likelihood in not achieving the desired target, this is based on the current financial position and the remainder of the time left in the finical year to meet the required target.

Key Controls

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

Each recovery plan has SMART actions in place which will be monitored through the Financial Recovery Group with Committee and Board scrutiny.
The ICB Recovery plan is now being accelerated to evaluate and approve new options to mitigate the current risk level with appropriate Board governance. Further schemes were developed including:
  - Meds Optimisation stretch target
  - Additional IS contracts activity plans
  - Primary Care
  - Non Pay and Workforce

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

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

Gaps in Control or Assurance

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

Risk Scoring and Tolerance

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

Number of Linked Risks on Corporate Risk Register

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

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

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

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

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

Strategic Risk **SR8**	Significant systemic service disruption occurs as a result of cyber-attack moving quickly across the GM health and care IT estate		
Strategic Objective	Meet our statutory obligations		
Chief Officer / Committee	Gareth Robinson	Executive / Audit Committee	
Risk Appetite Level	Cautious	Risk Tolerance Range (e.g. 5 to 10)	5 – 10

Rationale for Risk Score and Progress made in the quarter

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

Key Controls

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

Gaps in Control or Assurance

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

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

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

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

Action	Complete/BAU	On Track
	Delayed	Problematic

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

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

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

Rationale for Risk Score and Progress made in the quarter

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

Key Controls

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

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

Gaps in Control or Assurance

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

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

Number of Linked Risks on Corporate Risk Register

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

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

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

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

Strategic Risk SR10	There is a risk that the NHS Reform Programme could disrupt delivery of core ICB business due to restructure and staffing reductions. This will result in core ICB business being disrupted during the transition.		
Strategic Objective	Meet our statutory obligations		
Chief Officer / Committee	Charlotte Bailey	Chief Officers meeting	
Risk Appetite Level	Cautious to Open	Risk Tolerance Range (e.g. 5 to 10)	5 to 15

Rationale for Risk Score and Progress made in the quarter

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

Key progress made this quarter:

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

Key Controls

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

Risk Scoring and Tolerance

	Inherent risk score	Q1	Q2	Q3	Q4	In year Target	Long Term Target	Long Term Target Date
Likelihood	4	N/A	4	4		3	2	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	Green
2nd Line	**Chief Officers** - Exec level assurance and approval of BAF risks and other high-level risks within the transition needed to be escalated. They will be provided periodic updates to ensure progress on mitigations. **ICB Board** - Exec level assurance and approval of BAF risks and other high-level risks within the transition needed to be escalated. They will be provided periodic updates to ensure progress on mitigations. **Executive Committee** - Exec level assurance and approval of BAF risks and other high-level risks within the transition needed to be escalated. They will be provided periodic updates to ensure progress on mitigations. **NEDs/Execs** – Assurance of the high-level risks within the transition programme with monitoring to ensure the risks are correctly being mitigated periodically.	Green
3rd Line	NHSE Oversight Meetings – Reporting on progress of the reform and any risks that need to be escalated.	Green

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.	June 2026	In the process of engaging with staff on new organisational structure - concurrently we are running Phase 2 VR scheme. We will then look to undertake filling of posts exercise (including any necessary compulsory redundancies) with the aim to complete by end of May 2026.	Green
2	Assurance Statement for Model Integrated Care Board	February 2026	GM ICB provided NHSE confirmation (through official correspondence) that we are developing our future operating structure in line with the £19 running cost allowance and the Model Integrated Care Board (ICB) Blueprint.	Green

NHS Greater Manchester

Month 10 Finance Report

2025-2026

Part of Greater Manchester Integrated Care Partnership

NHS GM Transition Committee

4th March 2026

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

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

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

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

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

1. Introduction

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

2. Key Messages

2.1 <u>Plan</u>

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 <u>Month 10 reported position</u>

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

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

Key messages of the overall position are:

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

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

2.3 Efficiencies / CIP

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

2.4 Risk and Mitigations

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

2.5 Recovery Plans

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

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

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

2.6 Capital

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

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

2.7 Cash

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

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

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

3. Recommendations

3.1 For the System Financial position, the Transition Committee is asked to:

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

NHS Greater Manchester

Chief Strategy, People and Partnerships Officer - Alert Report

March 2026

Part of Greater Manchester Integrated Care Partnership

NHS Greater Manchester Transition Committee

4th March 2026

Required information	**Details**
Title of report	Chief Strategy, People and Partnerships Officer - Alert Report
Author	Charlotte Bailey, Chief Strategy People and Partnerships Officer
Presented by	Charlotte Bailey, Chief Strategy People and Partnerships Officer
Contact for further information	Charlotte.bailey37@nhs.net
Executive summary	This paper alerts the Transition Committee to the impact of recent NHS Reform developments on our workforce and mitigating actions in place.
The benefits that the population of Greater Manchester will experience.	To support our staff to be their best in order to deliver our ambitions for GM.
How health inequalities will be reduced in Greater Manchester's communities.	To support our staff to be their best in order to deliver our ambitions, including tackling health inequalities for GM and leading by example.
The decision to be made and/or input sought	The Transition Committee is asked to: note the report.
How this supports the delivery of the strategy and mitigates the BAF risks	Relates to the ability of our workforce to perform at their best.
Key milestones	Consultation ongoing and new model due to be in place for April 2026.
Leadership and governance arrangements	This paper is produced for Transition Committee and has not been elsewhere.
Engagement* to date ***Engagement: public, clinical. Analysis:**	There has been no formal engagement on this paper as this paper is produced for Transition Committee and has not been

equality, sustainability, financial. Comments/ approval by groups/ committees.	elsewhere.
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

Report from:	**People & Culture Sub-Group**
Date of Meeting:	Thursday 5th February
Chair:	Charlotte Bailey
Quoracy Achieved:	Yes

Key escalations and discussion points from the meeting:

Alert

- Staff anxiety, morale issues, and workload pressure remain significant
- Annual leave uptake is low (67%) and sickness has risen from 2.6% in Month 8 to 3% in Month 9.
- Mandatory training data is unreliable due to ESR instability following recent exits from the organisation and portfolio changes. IG and safeguarding compliance risks remain;
- For M9, MaST Core Modules with 'noncompliance' below the 95% target: IG & Data Security (86.6%), Fraud Awareness (92.8%), Safeguarding Adults (93%), Safeguarding Children L1 (93.9%), Safeguarding Children L2 (93.1%), Preventing Radicalisation and Basic Prevent Awareness (94.1%), Infection, Prevention and Control (94.3%), NHS Conflict Resolution (94.5%).
- Pulse survey processing is delayed due to capacity constraints; data may be available in the coming weeks.

Advise

- Propose that pragmatic, soft-messaging approaches to mandatory training are in place to reduce staff pressure during transition while maintaining corporate responsibility.
- Workforce reporting will transition to the DII team, but reduced capacity means the culture dashboard and updated workforce metrics will take time to develop.
- Statutory and culture priorities including the OD plan, anti-racist framework, and culture dashboard remain organisational priorities despite reduced delivery capacity.

Assure

- **Core statutory requirements remain safeguarded:**
  The group provided assurance that Information Governance (IG) remains a mandatory annual requirement and will continue to be monitored despite operational pressures, as confirmed in the discussion about legal obligations.
- The Sub-Group also reviewed the full range of workforce metrics to ensure ongoing compliance with statutory and regulatory obligations. This review provided

assurance that all areas are being actively managed, with appropriate oversight, escalation and mitigations in place.
- The Group was satisfied that statutory workforce requirements continue to be met despite operational pressures.

Risks discussed and new risks identified

- The group noted that several risks on the current register (e.g., Workforce Integration, Good Employment and Staff Development, Sickness, Absence and Wellbeing, Equalities and Inclusion) remain relevant but **no longer fully reflect the organisation's immediate priorities** during the transition period

- Existing risks have broadly maintained their previous scores due to stable workforce metrics in some areas (e.g., sickness previously below target), though the context underpinning these scores has shifted as transition pressures increase.

Dynamic transition-period risks identified

The Sub-Group agreed that a set of **short-term, high-priority risks** should be put in place to ensure adequate mitigation is in place. This will include:

- **Loss of talent and organisational knowledge** due to voluntary redundancies, restructures and staff departures.

- **Capacity constraints** affecting core People & Culture functions, Workforce Intelligence, and related teams limiting delivery of statutory duties, culture work, reporting and dashboards.

- **Staff wellbeing and morale risk**, linked to rising anxiety, increased workload, presenteeism, low annual leave uptake and rising sickness trends.

- **Gaps in staff support and line management**, particularly where managers have left through VR, creating potential safeguarding, performance and wellbeing concerns.

- **Mandatory training exposure**, particularly around IG and safeguarding, where compliance may fall due to inaccurate ESR data and reduced capacity.

- **Reduced ability to accurately track and interpret workforce data**, especially mandatory training, due to **frequent changes in ESR records** linked to leavers.

- **Reputational and system-level risks**, including the organisation's capacity to maintain system commitments during a period of reduced workforce availability.

- **Financial risk** linked to future **Real Living Wage compliance**, where national pay awards may not align with RLW increases, impacting Good Employment Charter status.

Learning for sharing
• **Quantitative data alone does not fully reflect organisational reality during large-scale change.** The group recognised that metrics such as sickness, morale and mandatory training can become distorted during transition periods, meaning qualitative intelligence, conversations with staff, and soft indicators are equally important. The Pulse Survey results when issued will support this. • **Wellbeing indicators change rapidly during periods of uncertainty.** The meeting highlighted that how staff feel can shift "conversation by conversation," meaning over-interpreting survey results may be misleading. Instead, closer attention to real-time feedback and psychological safety is needed.
Achievements
• The P&C team to work collaboratively with colleagues across the organisation to support ongoing staff consultation – from managing theVR2 scheme, to meeting with our trade union partners, ensuring all draft JDs are published, to receiving and processing consultation feedback. • The OD and Culture team are continuing to work on the OD plan beyond the consultation so that people are supported into the new organisation in the best way possible, whilst also working to ensure that support offers at the moment continue to be relevant to where people find themselves now.

NHS Greater Manchester

Report from:	Population Health
Date of Meeting:	Population Health Committee is currently paused, meeting last in October 2025.
Chair:	N/A – This a report from the responsible ICB Chief Officer, Charlotte Bailey
Quoracy Achieved:	N/A

Key escalations and discussion points from the meeting:

Alert
• None
Advise
• Following 2 year pause to the delivery of the GM **Make Smoking History** programme, a scaled back programme of campaign activity will launch on 2nd March and run until 12th April. Building upon the highly successful '**what will you miss**' approach taken in late 2023 / early 2024, the campaign will take the same theme but will focus on everyday experiences, rather than lifetime '*set piece*' events. • NHS GM is the lead for the largest of 15 national **WorkWell Partnership** Vanguards and, since October 2024, has supported over 5000 people for whom poor health is a barrier to employment, providing a significant contribution to achieving our GM employment rate ambitions. Funding to continue the vanguard has been agreed for a further 3 years (to 31/3/2029) and and has been included in the GM Integrated Settlement.
Assure
• The **Q3 Public Health Quarterly Oversight Meeting** with the NHSE regional Director of Population Health took place on 9/2/26. No matters of concern were highlighted and no issues were identified for further escalation by the region. • Work is ongoing to reshape the **NHS GM approach to Population Health** delivery through the ongoing organisational change arrangements. This consists of a number of strategically significantly pieces of transformation, including: - Integration of the NHS GM Population Health function (staffing and financial resources) with the GM Public Health Network.

- Development of a responsibility matrix out core population health roles and responsibilities in alignment with the new ICB Operating Model.

- Completion of the NHS GM 5 Year Strategic Commissioning Plan setting out the approach to comprehensive system left shift.

As part of the transformation set out above, collaborative work is ongoing with the **GM Public Health Network** to produce a shared delivery plan for 2026/27. The plan is currently subject to engagement with key partners, with a final version proposed to be shared at the next meeting of the ICB, and is framed around 3 core strategic priorities:

Risks discussed and new risks identified

- 3 BAF risks are currently overseen by the Population Health function. Updates for those have been provided under separate cover.

Learning for sharing

- None

Achievements

- **Roisin Reynolds**, who left NHS GM on VR in early February after decades of service in the NHS, has had her groundbreaking achievements in tackling Alcohol Exposed Pregnancies and Fetal Alcohol Spectrum Disorder recognised by

the **National FASD** charity in the form of an annual lecture being announced in her name. **The Reynolds Lecture** will highlight innovative work being done at a local, regional or national level to help improve services for and/or understanding of the risks of alcohol in pregnancy, and the importance of diagnosis and support for those with FASD. It will take place every September.

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NHS Greater Manchester Transition Committee

Report from Chief Commissioning Officer

4th March 2026

NHS Greater Manchester

Report from:	Chief Commissioning Officer
Date of Meeting:	4th March 2026

ALERT
No alerts this month.

ADVISE

1.'Every Child Achieving and Thriving'

The Schools White Paper 'Every Child Achieving and Thriving' was published on 23rd February 2026. This has significant implications for the work of NHSGM and completely aligns with the ambition to raise the healthiest generation of children, both as a commissioner of healthcare services and in its partnership role with Local Authorities, Education, Providers, VCSFE organisations and the Combined Authority.

Of particular note is the emphasis on transformation of services for children with Special Educational Needs and Disabilities (SEND), with a series of initiatives announced backed by £4bn investment over 3 years. These include:-

- Inclusive mainstream fund: in addition to existing core SEND funding, all schools can expect to receive additional funds to support targeted and small group interventions for children with additional needs.
- "Experts at Hand" service: schools will be able draw on a multi-agency support offer overseen by local authorities, bringing together specialists from speech and language, educational psychology and occupational health. This support will be available to all children, even those without an EHCP.
- National inclusion standards: an evidence-based digital library of resources to guide how schools are meeting the needs of children by 2028.
- Schools will be required to publish an inclusion strategy which explains how resources are deployed to benefit children with SEND. This document will replace the current SEN Information Reports.

The government is also proposing that how pupils access personalised support is also changing, with education, health and care plans (EHCPs) to be reserved for only the most complex cases.

The GM SEND Board will be meeting on 9th March 2026 to prepare a formal response and to explore how the opportunities within the White Paper can be maximised in Greater Manchester.

2.GP Contract Changes 2026/27

NHS England and DHSC have confirmed the final changes to the GP Contract for 2026/27 following the conclusion of the national consultation. The updated contract continues the strategic direction of improving same-day access for clinically urgent needs, strengthening prevention, and modernising quality requirements.

Investment and Capacity

The contract sees a £485m uplift, taking the total value to £13.86bn (3.6% cash growth; 1.4% real-terms). A major change is the introduction of a new practice-level GP reimbursement scheme, funded by repurposing £292m from the former PCN Capacity and Access Payment. This aims to increase GP capacity by enabling practices to recruit additional GPs or increase existing GP sessions. Rules for GP recruitment via the Additional Roles Reimbursement Scheme (ARRS) will also be expanded to allow recruitment of a wider range of GPs with higher reimbursement ceilings.

Access Requirements

Practices will now be contractually required to provide same-day responses for all clinically urgent requests, with practices determining clinical urgency. For non-urgent needs, patients must receive an appropriate response by the end of the next core-hours period. Practices must no longer ask patients to “call back another day”, and online consultation systems must not cap request volumes.

Quality and Outcomes Framework (QOF)

QOF is being refined to reflect updated NICE guidance and shift further toward prevention. Changes include:

- two new obesity indicators focused on structured weight management referrals and medicines optimisation;
- a new diabetes care process indicator covering all eight NICE-recommended checks;
- updates to heart failure and BP indicators;
- improvements to childhood vaccination measures, including new improvement thresholds to incentivise progress in lower-uptake areas.

- These changes are supported by 18 additional QOF points (c. £25m).

Vaccinations

Changes include:

- improvement thresholds for three childhood vaccination indicators;
- extension of the RSV vaccination programme to all adults aged 80+ and residents in care homes for older adults;
- a new requirement for PCNs to ensure eligible care home residents are identified and offered vaccinations, with flexibility around delivery.

System and Governance Requirements

The contract reinforces system working through:

- a new requirement for practices to engage with ICB support where unwarranted variation is identified (e.g., access, urgent care, risk of breach);
- embedding Advice and Guidance within core funding;
- mandatory participation in the General Practice Staff Survey;
- expanded data requirements to support monitoring of access and patient experience;
- updates to registration processes, pharmacy nominations, and practice communication requirements (including monitored dedicated email for pharmacy communications).

Implications for ICBs

ICBs will have strengthened roles in:

- supporting practices with access improvements and urgent-care performance;
- enabling PCN workforce flexibility through Additional Roles changes;
- overseeing updated vaccination responsibilities and neighbourhood alignment work;
- ensuring consistent adoption of digital and data requirements across practices.

However, it is noted that this comes at a time of significant change within the ICB and Localities regarding primary care contracting, transformation and development.

A responsibility matrix has been developed to ensure that key tasks are covered across Place teams and the core NHSGM team, albeit within reduced capacity.

3.Reconfiguration of Arterial Vascular Surgery and Cardiac Surgery

Further to the update provided to the Transition Committee in February 2026, the North East Clinical Senate review has been confirmed for Tuesday 24th and Wednesday 25th March 2026. This is a critical step in assessing reconfiguration proposals, where independent clinical expertise will be used to review the case for change and assess the options appraisal, thus providing the ICB with independent assurance.

The review team will focus on the key test set by NHSE that such service changes are based on clinical evidence, fits with national best practice and clinical sustainability, and that the options appraisal includes consideration of a network approach, cooperation and collaboration with other sites and / or organisations.

4.Procurement of the Community Dermatology Service

As reported to the Committee in February, following review by the Independent Patient Choice and Procurement Panel on the provider selection process conducted by NHSGM, the procurement of the Community Dermatology Service has been paused.

In order to maintain service delivery, discussions are underway with existing independent and NHS providers to agree to transitional arrangements beyond 1 April in recognition of the procurement challenge and subsequent delay in mobilising the new community service.

Alongside this, a paper is being prepared for the Resources Committee to consider options for how the procurement should be taken forward in April 2026.

ASSURE

1.Major Trauma Commissioning and Implementation Planning

As set out to the Committee in February, work in now underway to take forward the decision by the Board of NHSGM to commission a single Greater Manchester Major Trauma Service, with a single Major Trauma Centre Service delivered across two sites.

The programme plan with achievement against milestones has been included at appendix A.
LEARNING FOR SHARING
None this month.

NHS Greater Manchester

Appendix 1 – Timeline for Implementation of Single Major Trauma Centre Service

Action	Responsible	Timeline
Approve commissioning model	ICB	Nov 2025
Agree and implement programme governance	ICB	Jan 2026
First meeting of Programme Board and Clinical Oversight Group to confirm work plan	ICB	Jan 2026
Appointment of Single Clinical Lead	Programme Board	Feb 2026
Agreement of standardised, compliant, and transparent pre-hospital triage and transfer pathways	Clinical Oversight Group	Apr 2026
Agreement of system-wide clinical standards	Clinical Oversight Group	Apr 2026
Confirmation of workforce model for the single GMMTCS with shared rota model for critical specialties to improve resilience	Clinical Oversight Group	Apr 2026
Confirmation of governance arrangements for the on-going delivery of the service	Programme Board	May 2026
Agreed workforce development and training plan	Programme Board	May 2026
Agreed plan for integration of digital and data, including shared dashboards and National Major Trauma Registry (NMTR) linked data	Programme Board	May 2026
Agreed 3 year financial plan for the service and confirmation of commissioning arrangements, including any risk / gain share approaches across providers	Programme Board	May 2026
Agreed route map for full compliance with national specification	Programme Board	Jun 2026
Establishment of new governance arrangements to govern, lead and operationally manage the single GMMTCS.	New Board	Jun 2026
Programme close down report	SRO	Jul 2026

Owner	Marie Pilling, Project Manager
Last updated	06/02/2026

Purpose: Outlines the key workstreams/phases and activities as part of the pillar, with clear identification of who owns activities and the estimated scheduling. Guidance on how to fill is provided as comments within the cells

Progress Key	Definition
Not started	Activity not yet started
Delayed with risk	Activity delayed by 1-2 weeks
Delayed with manageable risk	Activity delayed by 2+ weeks
On track	Activity expected to be completed by planned end date
Completed	Activity completed

Ref No.	Workstream/Phase	Owner	Planned Start Date	Planned End Date	Days remaining	Progress	Comments
1	**Mobilisation and Governance Set Up**		**18/12/2025**	**27/02/2026**	**21**	On track	
1.1	**Identify Scope & develop PID**						
1.1.1	Agree the programme PID in collaboration with key stakeholders in preparation for first full Board meeting.	Katherine Sheerin	18/12/2025	02/02/2026	--	Completed	**15/01/26:** Following an initial discussion with colleagues at MFT and NCA in December the ToR's where discussed at the Board pre-meet and some final tweaks have been agreed. **02/02/26:** PID approved following some final amendments .
1.2	**Implementation Programme Board**						
1.2.1	Establish the Implementation Programme Board with key stakeholder from the ICB, NCA and MFT. Agree frequency , duration and secure dates in diaries.	Katherine Sheerin	18/12/2025	02/02/2026	--	Completed	**15/01/2026**: Pre-meet took place and it was agreed that the timeline for completion is brought forward to June 2026. **23/01/2026:** Date of the fist board as been agreed s the 02 February with further bards yet to be confirmed. **02/02/2026:** Key stakeholders identified for future boards. **05/02/2026:** Agreed that the meetings will take place 2nd Monday of the month.
1.2.2	Agree the Terms of Reference for the Implementation Programme Board and wider Board membership	Katherine Sheerin	18/12/2025	02/02/2026	--	Completed	**15/01/2026:** ToR's were discussed as part of the Board pre-meet and some final tweaks were agreed head of the first formal meeting in February. **02/02/26:**ToRs approved following some final amendments .
1.3	**Leadership appointments & Clinical Authority**						
1.3.1	Appoint Joint Single Service Clinical Lead	Manisha Kumar, Rafik Bedair, Matt Makin & Chris Grant	15/01/2026	27/02/2026	21	On track	**02/02/26:** Initial conversations have taken place and the Clinical Lead for Service Start Up role description has been developed.
1.3.2	Confirm Interim Single Service Operational and Programme Leadership	Katherine Sheerin, Owen Williams & Darren Banks	15/01/2026	27/02/2026	21	On track	**02/02/2026:** Work continues to identify programme lead.
2	**Clinical Pathway and Service Delivery**		**02/02/2026**	**30/06/2026**	**144**	**Not started**	
2.1	**Clinical Working Group**						
2.1.1	Establish a clinical working group to drive pathway design, agree workforce models, rotas and a SOP for the Single Service in collaboration with NCA, MFT and NWAS.	Manisha Kumar, Rafik Bedair, Matt Makin & Chris Grant	02/02/2026	27/02/2026	21	Not started	
2.1.2							
2.2	**Clinical Pathways & Standards**						
2.2.1	Design standardised pre-hospital triage and transfer pathways	Clinical Working Group	02/02/2026	30/04/2026	83	Not started	
2.2.2	Develop system wide clinical standards and SOPs	Clinical Working Group	02/02/2026	30/04/2026	83	Not started	
2.2.3	Develop and publish a new GM MT Directory of Service	Clinical Working Group	02/02/2026	30/04/2026	83	Not started	
2.3	**Workforce Model & Rotas**						
2.3.1	Develop single service workforce model	Clinical Working Group	02/02/2026	30/04/2026	83	Not started	
2.3.2	Create and agree workforce development and training plan	Clinical Working Group	02/02/2026	29/05/2026	112	Not started	
2.4	**Compliance with National Service Specification**						
2.4.1	Agreed roadmap for full compliance with national standards with agreed timelines is in place with clear accountability for delivery.	Clinical Working Group	02/02/2026	30/06/2026	144	Not started	
3	**Digital & Data**		**02/02/2026**	**29/05/2026**	**112**	**Not started**	
3.1							
3.1.1	Agreed plan for integration of digital and data, including shared dashboards and National Major Trauma Registry (NMTR) linked data	TBC	02/02/2026	29/05/2026	112	Not started	
3.1.2	Develop a joint dashboard for reporting and performance management	TBC	02/02/2026	29/05/2026	112	Not started	
3.1.3	Agree system-wide audit mechanisms	TBC	02/02/2026	29/05/2026	112	Not started	
4	**Finance & Commissioning**		**02/02/2026**	**29/05/2026**	**112**	**Not started**	
4.1							
4.1.1	Agreed 3 year financial plan for the service and confirmation of commissioning arrangements, including any risk / gain share approaches across providers	TBC	02/02/2026	29/05/2026	112	Not started	
4.1.2	Approve digital & data integration delivery plan for business as usual phase	TBC	02/02/2026	29/05/2026	112	Not started	
4.1.3							
4.1.4							

18/12/2025	25/12/2025	01/01/2026	08/01/2026	15/01/2026	22/01/2026	29/01/2026	05/02/2026	12/02/2026	19/02/2026	26/02/2026	05/03/2026	12/03/2026	19/03/2026	26/03/2026	02/04/2026	09/04/2026	16/04/2026	23/04/2026	30/04/2026	07/05/2026	14/05/2026	21/05/2026	28/05/2026	04/06/2026	11/06/2026	18/06/2026	25/06/2026	02/07/2026	09/07/2026	16/07/2026	23/07/2026	30/07/2026

5	Finalisation & Readiness Phase		01/05/2026	31/07/2026	175	Not started	
5.1	Single Service established & move to BAU						
5.1.1	Confirm ongoing governance arrangements to move to business-as-usual including agreement of hosting arrangements and accountability	Implementation Board	01/05/2026	29/05/2026	112	Not started	
5.1.2	Formal establishment of new operational board	Implementation Board	01/05/2026	30/06/2026	144	Not started	
5.1.3	Programme close-down report	Katherine Sheerin	01/05/2026	31/07/2026	175	Not started	
5.1.4							
6							
6.1							
6.1.1							
6.1.2							
6.1.3							
6.1.4							

Greater Manchester

Report from Chief Officer, System Reform & Improvement

March 2026

Part of Greater Manchester Integrated Care Partnership

NHS Greater Manchester Transition Committee

Required information	Details
Title of report	Report from Chief Officer, System Reform & Improvement
Author	Gareth Robinson, Chief Officer, System Reform & Improvement
Presented by	Gareth Robinson, Chief Officer, System Reform & Improvement
Contact for further information	Gareth.robinson7@nhs.net
Executive summary	This paper provides the Transition Committee with an overview of the issues relating to the portfolio of the Chief Officer for System Reform & Improvement
The benefits that the population of Greater Manchester will experience.	The portfolio is responsible for the system wide delivery of operational performance, system operational planning and financial recovery along with the Data Insight & Intelligence and IT functions to corporate ICB functions, locality teams and GP practices. The delivery of these is closely linked to the delivery of constitutional standards and the improvement in population health outcomes
How health inequalities will be reduced in Greater Manchester's communities.	All delivery and improvement work is designed to support the reduction in health inequalities
The decision to be made and/or input sought	The Transition Committee is asked to: Note the report from the Chief Officer for System Reform & Improvement
How this supports the delivery of the strategy and mitigates the BAF risks	This supports mitigation of the following BAF risks:- SR1 - Health of the Population SR2 – Health Outcomes SR3 – Quality of Care SR5 – Health Inequalities SR7 – Financial Sustainability
Key milestones	These are set out within the different sections of the report.
Leadership and governance arrangements	This paper is produced for Transition Committee and has not been elsewhere.
Engagement* to date ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	There has been no formal engagement on this paper as this paper is produced for Transition Committee and has not been elsewhere.

Financial or Legal Implications;	These are set out in the report.

4th March 2026

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

Overall Portfolio

The Chief Officer for System Reform & Improvement covers a number of NHS GM Functions:

- Performance & Planning
- Elective Care & Recovery
- Urgent and Emergency Care, including System Control Centre and EPRR (UEC)
- Data Insights & Intelligence
- IT
- Financial Recovery

This report sets out a summary for each area. Elective Care and UEC are incorporated within the Performance function summary. The impact of Financial Recovery is included within the Chief Finance Officer report and is not replicated her

Performance function

Attached as Appendix One is the summary position for the 2025/26 National Priority Metrices Alert/ Advise/ Assure summary from the latest Performance Report that is submitted to the Quality & Performance Committee. The QPC continues to interrogate performance across all areas.

In order to support delivery of the year end metrics, recognising the risk attached to the delivery of the plan, two sprints (one each covering Elective Care and Urgent & Emergency Care) are currently in operation. These sprints have attracted additional funding streams to incentivise further performance improvement in both areas. NHS Greater Manchester is working with all providers through weekly locality oversight meetings to maximise performance delivery for 2025/26.

Area	Metric	Alert	Advise	Assure
Urgent and Emergency Care (UEC)	A&E % of patients managed within 4 hours (GM Providers)			
	A&E (type 1) % waits over 12 hours (GM providers)			
	CAT 2 response times			
	Average ambulance handover times			
Elective	% of incomplete RTT pathways of 52 weeks or more			
	% of incomplete RTT pathways of 18 weeks or less			
	% of pathways waiting no longer than 18 weeks for a first appointment			
Diagnostics	6 week diagnostic performance (not a planning metric but key enabler for elective and cancer delivery)			
Cancer	% of patients receiving communication of diagnosis within 28 days			
	% of patient with cancer receiving treatment within 62 days			
Mental Health	Access to CYP MH services			
	Average Length of Stay in Adult Acute Mental Health Beds			
Learning Disabilities	Inpatient care for Adults with LD			
	Inpatient care for Autistic Adults			
Primary Care	Appointments in General Practice			
	% of resident population seen by an NHS dentist			
Prevention	% of patients with hypertension treated according to NICE guidance			
	% of patients with GP recorded CVD, who have their cholesterol levels managed to NICE guidelines			
Total		6	4	8

IT function

Alert	The GM-wide Online Consultation & Triage procurement for GP practices is behind schedule. A mitigation plan is being developed to extend contract extensions into H1 for 2026/27 that will allow the successful conclusion of this programme, including an enhanced approach to stakeholder engagement. Leadership arrangements for the programme delivery have been reviewed and enhanced
Advise	- The Service Level Agreement for Trafford Locality IT support is to be extended for 3 months whilst NHS GM IT can complete the transition of approximately 70 NHS staff from Trafford Council Services - NHS GM IT is currently undergoing a full ISO re-certification audit. A Service Desk Institute (SDI) accreditation audit is also planned for March 2026, although dates may need to be rescheduled due to current NHS GM IT resource shortages - Progress
Assure	- The NHS GM IT team maintained strong performance and exceeded all key service SLA KPIs. The call answer times, abandonment rates and first-time fix targets were all achieve in January 2026, the first time within the last 13-month reporting period. This enables GP practices to access timely support and minimises disruption to frontline services - The cyclic refresh deployment of the second tranche of 1,397 GP desktops continues, alongside the final deployment of those remaining in first tranche. A capital funding bid has been submitted to NHS England to replace further GP devices - Delivery of a Network Switch Refresh by March 2026 is on track. - Network Access Control has been successfully configured to 15 of 16 clinical pilot sites. Deployment will now progress to full-scale rollout. - The NHS GM IT Security Software Suite has been renewed for the next 3 years. Security Vulnerability update compliance is at 92% for software patches that were released over 28 days ago. These patching levels are lower for GP laptops due to usage across the estate in the last 30 days being 83%. A cyber incident response exercise took place on the 4th February, involving NHS GM ICS member organisations.

Data Insights & Intelligence Function

Alert	No alerts required to Transition Committee
Advise	- Health Innovation Manchester has written to the NW Regional Director to highlight a risk to their delivery of research and innovation in the City Region because national policy on Secure Data Environments is hindering local progress - The CSU/DSCRO have served notice on their contract effective from Dec 26. NHSE need to make provision to supply the ICB with commissioning data. There is

	a risk that a solution or the capacity to support a solution is slow in coming and the ICB will need to have a backup plan with providers to ensure we still get this data
Assure	• Work associated with GMCA and the prevention demonstrator is starting to accelerate. One of the components of this work is to establish a civic data unit and the DII team, having established the infrastructure to manage NHS data, is being sought after to support this wider work. We require a clear steer as to how much resource the ICB should be looking to commit to support the prevention demonstrator work • The progress we have made to support the BeCCoR work is significant so we can not create cohorts of patients where action is required. However, for action to be taken with these patients, we need to develop and implement our re-id capability. There is a high level of expectation about having this capability available but limited capacity to put to this in the near term due to reform

NHS Greater Manchester

Chief Clinical Officer Report

March 2026

Part of Greater Manchester Integrated Care Partnership

NHS Greater Manchester Transition Committee

4th March 2026

Required information	Details
Title of report	Chief Clinical Officer Report
Author	Claire Lake, Deputy Chief Medical Officer Jim Ritchie, Deputy Chief Medical Officer Anita Rolfe, Deputy Chief Nursing Officer Mel Maguinness, Programme Director Commissioning Development Sandeep Ranote, Clinical Director Mental Health Claire Smith, Associate Director Nursing and Quality Assurance Kate Provan, Associate Director of Clinical Effectiveness, and Improvement
Presented by	Professor Manisha Kumar, Chief Clinical Officer, NHS GM
Contact for further information	Kate.provan@nhs.net
Executive summary	This paper provides the Transition Committee with an overview of NHS Greater Manchester's statutory duties during a period of organisational and governance transition. Its purpose is not to provide full assurance against all statutory requirements, but rather to set out the current statutory context, highlight areas where duties intersect with ongoing programme activity, and identify key matters that require continued oversight as new governance arrangements are established.
The benefits that the population of Greater Manchester will experience.	Our statutory Quality and Clinical Governance functions ensure that people across Greater Manchester experience safe, effective, and continuously improving services. Through targeted quality improvement, strengthened oversight, and refreshed governance pathways, we are better able to identify risks earlier, intervene more consistently, and reduce unwarranted variation. This directly improves care experience, outcomes, and population health.
How health inequalities will be reduced in Greater Manchester's communities.	The work described in this report aligns with NHS GM strategic priorities and the ICP strategy, including early identification of inequality-related risks in urgent care, mental health, medicines optimisation, and system

	improvement programmes
The decision to be made and/or input sought	The Transition Committee is asked to: • Receive and note the updates on key statutory-linked quality and safety matters. • Support the system-wide actions underway, including urgent workstreams, Trust improvement plans, and programme redesign activity described in the report. • Agree that continued monitoring of these areas is undertaken through established governance mechanisms, with escalation to the Transition Committee where risks increase or additional decision-making is required. • Endorse the approach to embedding learning from recent incidents and regulatory findings across NHS GM and partner organisations
How this supports the delivery of the strategy and mitigates the BAF risks	The areas within this report and progress made to improve these relate to BAF risk SR5
Key milestones	These are set out within the different sections of the report.
Leadership and governance arrangements	This paper is produced for Transition Committee and has not been elsewhere but is formulated from intelligence and papers from NHS GM Clinical Effectiveness and Governance Groups (and related subgroups) and the NHS GM Mental Health Partnership Group.
Engagement* to date ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	There has been no formal engagement on this paper as this paper is produced for Transition Committee and has not been elsewhere. The intelligence and papers used to formulate this report have come from the NHS GM Clinical Effectiveness and Governance Groups (and related subgroups) and the NHS GM Mental Health Partnership Group
Financial or Legal Implications;	*Financial Implications:* There are no direct financial decisions arising from this paper. However, several areas described involve ongoing or anticipated financial impact, including investment associated with: • capital developments such as the Skyline programme for CYP provision; • service improvement programmes responding to regulatory action; • operational pressures linked to unscheduled system incidents (e.g., Independent Sector correspondence

	issue). Any material financial implications will be brought forward through the appropriate ICB financial governance processes as required. *Legal Implications:* The issues highlighted engage the ICB's statutory duties relating to quality, safety, safeguarding, clinical governance, and equitable access to services. Regulatory requirements arising from the CQC's S29A Warning Notice for NCA, and the statutory responsibilities around CYP provision and audiology recall pathways, continue to require active oversight. No additional legal advice is required at this stage, but legal input will be sought where regulatory actions or contractual matters indicate the need.

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

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

Purpose of Report

This paper provides the Transition Committee with an overview of NHS Greater Manchester's statutory duties during a period of organisational and governance transition. Its purpose is not to provide full assurance against all statutory requirements, but rather to set out the current statutory context, highlight areas where duties intersect with ongoing programme activity, and identify key matters that require continued oversight as new governance arrangements are established.

NHS Greater Manchester, as an Integrated Care Board, holds a broad set of statutory duties under the Health and Social Care Act. These include duties relating to the commissioning of safe and effective services; continuous improvement in quality and outcomes; clinical governance and clinical effectiveness; upholding statutory digital and information-governance requirements; securing clinical leadership; and ensuring the system delivers care that reduces inequalities, improves population health, and meets national oversight requirements. These duties also encompass system-wide responsibilities for quality, performance, safeguarding, medicines optimisation, research and innovation, and digital clinical safety, including compliance with mandated standards for the safe deployment and use of digital systems.

Given the transition of committees and assurance pathways, this report provides a focused summary of statutory-linked areas that require continued attention. It aligns with ongoing work to streamline risk, performance, and quality reporting during the transition period, as highlighted through preparatory work for the new governance model and the Transfer to Transition Committee arrangements.

ALERT
System Response to CYP Requiring Care in Non-Specialist NHS Settings During February 2026, a small number of children and young people (CYP) across Greater Manchester required care in NHS settings that were not designed to meet their specific needs because suitable community or social care placements were not available. This is not in the best interests of the child and it also places pressure on NHS services, reducing capacity for other children who require timely care. Multi-agency teams from health and local authorities have worked closely together to put alternative arrangements in place for most of these young people, and work is continuing at pace to secure the right support for the remaining child. These situations have highlighted a clear and significant gap in appropriate provision for CYP with highly complex needs, particularly those presenting in crisis who do not require hospital admission. Recent national changes to regulation have limited the ability to provide intensive support in unregulated settings, while the availability of regulated social care placements has not increased at the pace required. This is a national issue, not unique to Greater Manchester, and regional partners will be undertaking a formal review to support learning and improvement. Locally, the ICB has committed capital investment to the Skyline development, which is expected to expand future capacity for some of these young people. However, Skyline will not open for several years and, when it does, it will only meet part of the overall need across the system. Demand for residential and crisis-appropriate social care placements continues to rise, affecting CYP with and without mental-health-related needs. In response, Greater Manchester partners have agreed to establish an urgent whole-system workstream—led by local authorities with support from health—to strengthen pathways for CYP with complex needs who present in crisis but do not require NHS admission. Alongside

this, each recent case will be reviewed to identify learning, with action plans developed and shared through the appropriate governance forums, including the Commissioning Committee.

NCA – CQC Report on Salford Surgical Services

The Care Quality Commission has published its inspection report for Northern Care Alliance's Salford Surgical Services, resulting in an overall rating of *Requires Improvement*. Key issues highlighted include:

- **Safety Concerns:** Inconsistent safeguarding practice and incomplete risk assessments, increasing the potential risk of patient harm.
- **Staffing and Care:** Ward staffing levels were insufficient to reliably meet patient need, contributing to delays in pain relief and reluctance from some patients to seek assistance.
- **Declining Standards:** The *Caring* domain deteriorated to *Requires Improvement*, mirroring the ratings for Safe, Effective, Responsive and Well-Led.
- **Regulatory Action:** An S29A Warning Notice was issued on 21 October 2025, requiring urgent improvements in safety and governance.

The NCA is finalising an improvement plan, incorporating and reframing actions previously developed in response to the Breen Report to ensure a single, coherent plan. This is due to be submitted to the CQC by 13 March. A Trust-led working group has been established to oversee delivery, with monitoring through the NHS England Regional Quality Improvement Group, of which the ICB is a member. The Trust's response to the Warning Notice is being reported directly to the CQC, with themes and learning to be tracked through the Quality Improvement Group.

ADVISE

WWL FT – Emergency Department

A revisit to Wrightington, Wigan and Leigh FT's Emergency Department identified visible improvements in flow management, digital oversight, and inter-professional working. These positive developments were observed alongside continued pressures arising from estate constraints and sustained high patient volumes. Corridor care remained in use but was reduced at the time of the visit, supported by strengthened real-time monitoring and clearer professional standards to guide decision-making. Safety processes were generally well embedded; however, early morning visibility of patients in the waiting room requires further attention. Cultural improvement work was evident, including progress through the ASPIRE programme and patient-led initiatives such as the development of a sensory area.

Independent Sector – MSK Physiotherapy Correspondence Issue

In mid-February, multiple Manchester GP practices reported receiving more than 100 unexpected consultation letters from an Independent Sector MSK Physiotherapy Provider following an electronic system fault between 13–16 February. The failure triggered a bulk release of non-urgent correspondence across Greater Manchester, creating significant administrative burden and raising clinical safety concerns.

Practices identified duplicate letters for some patients, with conflicting information on treatment stage or injury assessment, making it difficult to determine the most current clinical position. This introduced a risk of harm if correspondence was not reviewed and actioned in the correct sequence. As the provider is located in Newcastle and may hold contracts beyond Greater Manchester, further checks are underway to determine whether this was an isolated

incident or part of a wider system fault.

Paediatric Audiology

Paediatric Audiology continues to present a significant system and regional risk. Ensuring that children recalled following the Greater Manchester case reviews across four sites receive timely access to appropriate assessment and treatment remains the priority. A revised model has been implemented in Stockport and is planned for rollout across the remaining three sites.
Commissioning redesign work is ongoing, and the ICB is mitigating risk through a stratified recall approach based on clinical priority. Capacity issues persist for under-5s due to a lack of age-appropriate estate; however, Stockport is progressing this as a priority and remains on track to have dedicated under-5s facilities operational by mid-March. Despite this progress, the overall position remains a material risk for the ICB.

Recommendations

The Transition Committee is asked to:

- Receive and note the updates on key statutory-linked quality and safety matters.
- Support the system-wide actions underway, including urgent workstreams, Trust improvement plans, and programme redesign activity described in the report.
- Agree that continued monitoring of these areas is undertaken through established governance mechanisms, with escalation to the Transition Committee where risks increase or additional decision-making is required.
- Endorse the approach to embedding learning from recent incidents and regulatory findings across NHS GM and partner organisations.

NHS
Greater Manchester

Medicines Optimisation & Strategic Commissioning 2026/27

March 2026

Part of Greater Manchester Integrated Care Partnership

NHS Greater Manchester

NHS Greater Manchester Transition Committee

Date 4th March 2026

Required information	Details
Title of report	Medicines Optimisation & Strategic Commissioning 2026/27
Author	Kenny Li, Chief Pharmacist Lara Shah, Deputy Chief Pharmacist Nigel Dunkerley, Value Portfolio Lead Pharmacist, NHS GM, Anna Pracz, Secondary Care Integration and Commissioning Portfolio Lead Pharmacist, NHS GM
Presented by	Professor Manisha Kumar Chief Clinical Officer, NHS GM
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Executive summary	This paper has two purposes. One is to provide an overview of the Medicines Optimisation Horizon Scanning process and its growing strategic importance during a period of significant financial and operational pressure. The other is to describe how medicines optimisation is becoming a strategic commissioner of medicines across the system, and how that improves the lives of our populations and can contribute to a left shift investment. As part of the preparation for the 2025/26 financial year, horizon scanning and strengthened system governance enabled NHS Greater Manchester to deliver substantial financial benefits, including approximately £40 million in CIP reductions and nearly £20 million additional in system-wide savings, with £15.6 million achieved through high-cost drug optimisation. These collaborative efforts have materially improved GM's financial resilience and set the foundation for future planning. Looking ahead, the minimum funding requirement for 2026/27 is £605.9 million, representing a 4.3% uplift on the previous

	year. This figure reflects the absolute baseline budget needed to maintain clinical quality and financial sustainability. However, risk-inclusive scenarios—driven by factors such as NICE Guidance 28 guideline uptake, community pharmacy volatility, GLP1/SGLT2 prescribing pressures, and the potential early adoption of semaglutide for cardiovascular prevention—could increase requirements to between £650.2 million and £754.7 million. These are not discretionary 'wish lists' but honest reflections of demand and policy pressures that must be actively managed. Medicines Optimisation is now transitioning towards a strategic commissioning role, viewing medicines as long-term therapeutic investments within integrated care pathways. This approach prioritises pathway optimisation, prevention, and delayed disease progression, supporting system sustainability and aligning with NHS GM's clinical strategy. By adopting this strategic perspective, NHS GM can proactively manage financial pressures, enable left-shift investment, and ensure medicines are positioned as key enablers of population health improvement and long-term affordability Furthermore, through GMMMG, the system also supported the managed entry of new medicines, ensuring their timely, safe, and affordable implementation. This included working in close collaboration with the National Institute for Health and Care Excellence (NICE) to enable effective planning of more expensive technology appraisals, including medicines for weight management, ensuring rollout remained clinically appropriate, financially sustainable, and aligned with national and local pathways. These outputs now underpin system planning for key pathways including diabetes. The foundations of the horizon scanning process are now critically important to underpin how medicines optimisation transforms their responsibilities to strategic

	commissioners of medicines in line with the National ICB Operating Model Blueprint and the associated Medicines Optimisation Good Practice Guide. It will continue to play a central role in ensuring accurately and effectively set budgets for 26/27 and beyond as we move towards multiyear financial planning. As GM prepares for the 2026/27 financial year, the Horizon Scanning process will continue to provide the intelligence, foresight and assurance required to maintain clinical quality and financial sustainability across the system.
The benefits that the population of Greater Manchester will experience.	Through systematic early identification of new clinical evidence, drug launches, biosimilar opportunities, patent expiries and medicines-related risks, the Horizon Scanning process ensures that people across GM receive safer, more consistent, and more cost-effective care. This enables: • earlier adoption of proven, cost-effective therapies, • targeted reduction in unwarranted variation, • proactive management of safety concerns (e.g., polypharmacy, drug interactions, high-risk switches), • increased reinvestment into evidence-based care through CIP savings including reinvestment opportunities linked to CVRM, diabetes and obesity pathways • more resilient prescribing pathways aligned to population needs. For patients, this translates directly into safer prescribing, improved health outcomes, and better value from NHS resources.
How health inequalities will be reduced in Greater Manchester's communities.	Horizon Scanning supports NHS GM's aims to reduce inequalities by ensuring that planning for new therapies, guidelines and clinical pathways includes systematic consideration of:

	• equitable access to new treatments, • differential impact of medicines pressures in deprived and high-need communities, • variation in polypharmacy, cardiovascular risk management and diabetes outcomes, • the burden of chronic disease across the population, • safeguards to prevent inequity in rollout of NICE guidance NG28, GLP1/SGLT2 agents and obesity medicines including structured cohort phasing and Blueteq governance. This forward-looking approach allows GM to intervene earlier where inequalities risk widening — particularly in diabetes, obesity, cardiovascular disease, respiratory conditions and mental health — and to align new medicines pathways with prevention and population health priorities.
The decision to be made and/or input sought	The Transition Committee is asked to: • Note the contribution of the 2025/26 Horizon Scanning analysis and its contribution to financial sustainability and significant CIP contrition to the GM health economy. • Endorse the Horizon scanning analysis undertaken for 2026/27 by the NHS GM Medicines Optimisation team including the financial pressures, cost improvement opportunities and associated budget setting methodology, with a minimum funding requirement of £605.9m (circa 4.3% uplift) reflecting the absolute baseline budget, but not including several risk scenarios (requirements ranging from £650.2m–£754.7m), including NG28 uptake. • Recognise the impact of Horizon scanning on system wide priorities including the GM Clinical Strategy, Long Term Conditions programmes of work, the prevention and the “Left Shift” agenda. This will inform the development of the medicines and pharmacy strategy as a key enabler to ensure affordability, sustainability, and left shift investment

	• Support the development of a Medicines and Pharmacy strategy aligned to the clinical strategy to be submitted to a future meeting.
How this supports the delivery of the strategy and mitigates the BAF risks	The Horizon Scanning function directly supports delivery of the GM Clinical Strategy by enabling: • safe and consistent implementation of evidence-based medicine pathways. • strategic planning to manage financial risk (BAF risks SR2 & SR5). • robust clinical governance and oversight of high-risk areas such as diabetes, obesity, cardiovascular conditions and high-cost drugs. • alignment with population health aims and prevention priorities. • progression towards strategic commissioning of medicines, supporting earlier pathway intervention and enabling left-shift investment
Key milestones	These are set out within the different sections of the report.
Leadership and governance arrangements	This paper is produced for Transition Committee and has not been elsewhere but is formulated from intelligence and papers from NHS GM Clinical Effectiveness and Governance Groups and GM Medicines Management Group
Engagement* to date ***Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.**	There has been no formal engagement on this paper as this paper is produced for Transition Committee and has not been elsewhere. The intelligence and papers used to formulate this report have come from the NHS GM Clinical Effectiveness and Governance Group and GM Medicines Management Group
Financial or Legal Implications;	**Financial Implications** The Horizon Scanning process identifies prescribing pressures that significantly exceed the national 0.1% growth assumption for 2026/27, creating a material financial implication for the ICB. The intelligence generated provides an evidence-based basis for accurate budget setting, highlights the scale of unfunded national policy impacts

	(e.g., NICE Guidance NG28, GLP1/SGLT2 growth, biosimilars, community pharmacy volatility), and informs the resource discussions with NHS England. It ensures the system has a clear understanding of the financial envelope required and the mitigations needed to maintain sustainability. **Legal Implications** The ICB has statutory duties relating to safe, equitable and consistent implementation of NICE Technology Appraisals, commissioning policies and high-risk medicines governance. Horizon Scanning provides the foresight needed to meet these obligations, supporting compliance with eligibility criteria, safety monitoring, and assurance requirements. Its outputs ensure that changes—such as GLP1 expansion, valproate safety actions, and biosimilar adoption—are introduced in a controlled and legally compliant way across all localities.

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

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

Executive Summary

Horizon scanning has evolved into a core system function, enabling NHS GM to anticipate major changes in the medicines landscape, respond proactively to NICE guidance, monitor emerging safety risks, and implement clinically led, cost-effective pathways at pace. It also plays a central role in ensuring NHS GM can accurately and effectively set budgets for 26/27 and beyond as we move towards multiyear financial planning.

As part of the preparation for the 2025/26 financial year, horizon scanning and improved system governance, materially strengthened GM's financial position, describing the forthcoming anticipated pressures and opportunities to reduce expenditure. In summary, it has supported the delivery of c£40m Cost Improvement Programme (CIP) reductions, and a further ~£20m in system savings, achieved partly through a successful collaboration across providers generating £15.6m in high-cost drug savings.

Furthermore, through Greater Manchester Medicines Management Group (GMMMG), the system also supported the managed entry of new medicines, ensuring their timely, safe, and affordable implementation. This included working collaboratively with the National Institute for Health and Care Excellence (NICE) to enable effective planning of more expensive technology appraisals, including medicines for weight management, ensuring rollout remained clinically appropriate, financially sustainable, and aligned with locally pathways. These outputs now underpin system planning for key pathways including diabetes.

The foundations of the horizon scanning process are now critically important to underpin how medicines optimisation transforms their responsibilities to strategic commissioners of medicines in line with the National ICB Operating Model Blueprint and the associated Medicines Optimisation Good Practice Guide. It will continue to play a central role in ensuring accurately and effectively set budgets for 26/27 and beyond as we move towards multiyear financial planning.

For 2026/27 financial year, the expected minimum funding requirement of £605.9m (circa 4.3% uplift) reflects the absolute baseline budget but does not include several risk scenarios (ranging from £650.2m–£754.7m), including NICE Guidance NG28 uptake (new guidance for the management of Diabetes) . These scenarios are not discretionary 'wish lists'; they are honest reflections of demand and policy pressures that the system will experience unless actively managed.

As medicines optimisation moves into their role as strategic commissioners, it will be necessary to generate financial efficiencies and headroom for these unfunded pressures whilst also strengthening a pathway approach, ensuring treatment is optimised and appropriately sequenced in a cost-effective way. This reinforces the need to align NHS GM's clinical strategy with a robust medicines and pharmacy strategy positioning it as a key enabler of affordability, pathway optimisation, and long-term sustainability.

1. Horizon scanning

1.1 Context and background

Horizon scanning is a process undertaken by Medicines Optimisation and Finance to determine the most likely pressures, risks, opportunities and mitigations that will impact on the prescribing budgets for the coming year. Given the demands for the use of new, evidence-based therapies and the financial constraints of the health system, horizon scanning allows medicines optimisation to inform budget setting methodologies. The process involves gathering national and local intelligence and interpreting it from a financial perspective. The rigour of this work in the last year has prevented, in 2025/26, the recurrence of previous budgeting issues, and strengthened GM's financial resilience ahead of the 2026/27 cycle. This work has been undertaken between October 2025 and February 2026.

Crucially, the effectiveness of the horizon scanning process relies on key stakeholders providing timely and detailed intelligence on planned work, emerging pressures and pipeline developments for 2026/27. This intelligence aligns with strategies across long-term conditions, population health management, health innovation and provider-led programmes of work. Maintaining this outward looking, collaborative approach is essential to enable NHS GM to fulfil its role as a strategic commissioner of medicines, supporting both operational resilience and the longer-term ambitions of system transformation.

As well as informing the budget setting process for the coming year, horizon scanning also identifies opportunities for the Cost Improvement Programme (CIP). In 2025/26 the CIP achievement is c£40m, with further system savings approaching £20m, including £15.6m relating to the use of high-cost drugs in hospital trusts.

The horizon scanning methodology applied has ensured that the budget provided was almost exactly what was required, with the main prescribing budget showing a very slight underspend at month 10.

In terms of planning for 2026/27 this has provided:

- detailed modelling of £44m–£70m prescribing pressures for 2026/27,
- robust modelling for the introduction of obesity medicines, diabetes pathways and CVRM therapies,
- GM-wide alignment on biosimilar adoption timelines and implementation planning.

1.2 Budget Setting for 2026/27

The out-turn for the main primary care prescribing budget for 2025/26 is currently forecast to be £580.8m. The national assumption of growth in prescribing for 2026/27 is 0.1% on out-turn which is £580k based on the 25/26 budget position. The three emerging models of budget request, and their percentage uplifts, for 2026/27 are:

Budget model	Low (£m)	(%) increase	Medium (£m)	(%) increase	High (£m)	(%) increase
Minimum requirement request	605.90	4.3	632.10	8.3	663.60	14.3

Minimum requirement plus risks	650.20	11.9	699.80	20.4	754.70	29.9
Minimum requirement plus risks plus additional risk	668.95	15.1	727.93	25.3	792.20	36.4

The minimum requirement of £605.9m (circa 4.3% uplift) reflects the absolute baseline once known pressures and credible mitigations are accounted for; it assumes minimal uptake of NG28 and a stable No Cheaper Stock Obtainable (NCSO)/community pharmacy environment.

The risk-inclusive scenarios, ranging from £650.2m–£754.7m, are driven by NG28 uptake (40%–80%+), community pharmacy pressures, and the semaglutide CVD prevention scenario if uptake runs ahead of national assumption. These scenarios are not “wish lists”; they are honest reflections of demand and policy risk that the system will experience unless managed.

1.3 Pressures and Risks for 2026/27

Looking ahead to 2026/27, the level of cost pressure identified through horizon scanning is significantly higher than the 0.1% growth assumption recommended through the national budget setting methodology. NHS GM has a statutory responsibility to deliver NICE Technology Appraisals and the national 0.1% prescribing growth assumption is insufficient to fund this national mandate. NHS GM has modelled and risked the difference and has escalated these concerns nationally. Some notable pressures are now discussed.

1.3.1 NICE NG28 and GLP1/SGLT2 prescribing growth.

The intersection of NICE Technology Appraisal TA1026 for tirzepatide, the revised NICE Guideline NG28, and likely cardiovascular prevention indications creates a complex governance and affordability picture. GM will continue the phased rollout for tirzepatide in line with commissioning statements and the national funding variation, maintaining strict eligibility and Blueteq controls, and monitoring uptake through structured cohort phasing to manage demand safely. For NICE Guidance NG28 and associated GLP-1 receptor agonists (medicines used for the management of diabetes and weight management) and SGLT2 inhibitors (a class of diabetes medicine e.g. dapagliflozin) use, GM will align the Cardiovascular Renal and Metabolic (CVRM) and diabetes pathways to support safe sequencing, proactive monitoring and equity safeguards — ensuring value is maintained while outcomes improve.

1.3.2 Semaglutide Cardiovacular prevention (NICE ID6441).

Horizon scanning considers a part-year effect of the widespread introduction of this NICE TA in preparation, with potential local implementation ahead of national uptake assumptions. GM will treat this as an explicit risk, with commissioning statements and monitoring to avoid unmanaged growth.

1.3.3 NCSO/price concessions volatility and community pharmacy pressures.

The model carries a conservative assumption at low uplift, but a rapid increase would require in-year mitigations and, if necessary, recourse to the risk-inclusive budget line.

1.3.4 Workforce and operational capacity.

Biosimilar and primary care switch value depends on pharmacy, homecare and GP capacity; mitigations include gainshare funded capacity, early SOPs, and prioritised sequencing so that large programmes do not collide with winter or service constraints.

1.3.5 Tariff movement of key biologics.

If certain drugs move into the national tariff, the system risks reduced visibility and weakened gainshare mechanisms. GM is modelling both outcomes, maintaining specialty engagement and seeking clear national positions to preserve best-value implementation.

1.3.6 Locality variation and innovation creep.

Uncoordinated case-finding or unmanaged expansion of new therapies can erode value and exacerbate health inequalities. GM will keep a single approval and monitoring route for new locality programmes with rapid evaluation and firm stop/go criteria.

1.4 CIP Opportunities for 2026/27

Horizon scanning for 2026/27 has identified potential system savings of c£25.9m gross opportunity in primary and secondary care with a risk-adjusted figure of c£16.35m at the time of writing, recognising that some schemes are in early workup and others depend on partner delivery (e.g., BeCCoR, homecare, ophthalmology services). Some of these programmes of work are now discussed.

1.4.1 Primary care medicines optimisation

The primary care medicines optimisation programme for 2026/27 focuses on a set of high value, clinically led interventions that reflect both national Medicines Optimisation opportunities and GM system priorities. Each workstream has been selected for its ability to improve patient safety, strengthen pathway consistency, and deliver predictable and sustainable financial benefit. Priorities are aligned to national areas of focus such as Direct Oral Anticoagulant (DOAC) optimisation, SGLT2 stewardship, biosimilars adoption, and key safety workstreams including valproate, AMR/AMS and polypharmacy. Local priorities mirror the Long-Term Conditions (LTC) programme and Population Health Management (PHM) approach, particularly left-shift activity across Cardiovascular Renal and Metabolic (CVRM). GM will also aim to work more closely with other NW ICBs to develop consistency in financial methodologies and grow regional policies.

- **SGLT2 class optimisation** will standardise onboarding and switching to cost-effective first-line choices (e.g., dapagliflozin). The programme is clinically led and designed to avoid safety and equity risks associated with mass switches, with strong patient communication and GP decision support embedded.
- **Polypharmacy and deprescribing** will target cohorts with the highest avoidable harm and unwarranted cost, using GM intelligence and national indicators (e.g., anticholinergic burden, opioids and dependence-forming medicines. The primary aim is improved patient

safety, with credible and evidenced financial benefit as a secondary outcome. This aligns with national safety priorities and the ICB's commitment to reducing medicines-related harm at population level.

- **DOAC reviews and antimicrobial stewardship** are included as part of BeCCoR, delivering measurable impact. These areas remain national priorities for safety, value, and unwarranted variation reduction.
- **Other opportunities:** The Levetiracetam switch activity and ONS (oral nutritional supplements) optimisation will progress to their next phases, with enhanced clinical governance and outcomes monitoring.

These core programmes will operate alongside locality innovation streams — a controlled environment where places can scale proven ideas (e.g., lipid optimisation in high QRISK cohorts) using clear entry/exit criteria and rapid evaluation. This protects the system from unfunded growth while maintaining space for local best practice to emerge and spread.

1.4.2 Secondary care high-cost drugs (HCD) and biosimilars

The HCD plan will maintain a disciplined biosimilar first approach. Providers will be enabled through active gainshare arrangements that support switch capacity in pharmacy, homecare and clinics. Aflibercept 2mg is expected to underpin ophthalmology savings, with further system benefit expected from upcoming omalizumab biosimilars and continued tocilizumab optimisation. The GM specialty forums and the High-Cost Drugs Subgroup remain central to ensuring clinical ownership, rapid implementation and adherence to GM's best value stance.

2.0 Moving towards strategic commissioning for medicines

Building on the successes of horizon scanning and strengthened governance across the system, the medicines optimisation function will progress its capability towards strategic & value based commissioning, where medicines are viewed not simply as a cost saving or a cost pressure, but as therapeutic interventions along integrated care pathways which prevents disease progression, reduce demand on acute services and shift care up-stream.

This will represent a deliberate transition from focussing on high cost, late-stage interventions in acute settings (unplanned admissions, high-cost biologics and end stage specialised commissioning demand) to proactive investment in medicines much earlier on in pathways that can alter disease trajectories, deliver long-term population health benefit and maintain future system sustainability.

2.1 An example for change

A real-world example of where this approach needs to evolve includes the introduction of SGLT2 inhibitors within the Cardiovascular Renal and Metabolic (CVRM) pathway, which this year, highlighted the tension between annual financial constraints and longer-term system value. While prescribing pressures were immediate and visible within in-year budgets, the benefits of these medicines are predicted to accrue over multiple years through reduced acute activity and delayed demand for high-cost services such as dialysis. Although the clinical view for rapid adoption was clear, uptake had to be phased more slowly due to budget pressures.

This experience highlights the need to change our approach through better capturing of longer-term system outcomes to enable left shift investment. This would allow for timely adoption of NICE-recommended treatments where these deliver invest-to-save benefits across the system.

2.2 Enablers to move to strategic commissioning of medicines

To realise the long-term value of medicines, NHS GM must evolve and integrate the learning from our current horizon scanning approach to a more strategic commissioning approach with a clear emphasis of whole-system outcomes where investment in medicines is more aligned to reducing disease progression, preventing acute admissions and delaying demand for high cost services such as dialysis. Key enablers to grow:

- **A long-term medicines & pharmacy strategy -** enables affordability, sustainability, and left shift investment by turning medicines from an unmanaged cost into a long-term planned investment that prevents illness, reduces demand, stabilises budgets, and funds transformation over time.
- **Population health data** – to work closely with business intelligence teams to identify high risk populations, quantify future service demand and start to model and evidence the system wide impact over multiple years through health economics. This ensures commissioning decisions are evidence based and outcomes focussed.
- **Focussed System Outcomes** - Defining clear, measurable system outcomes and aligning prescribing decisions and guidance with this, whilst also monitoring real-world data to provide confidence of benefits and to invest at scale.
- **Multi-year financial planning and integration:** Aligning budgets across the system can allow recognition that higher medicines spend today can reduce downstream costs. Multi-year planning ensures benefits are realised across the system.
- **Clinical leadership and pathway ownership:** Strong leadership and agreed pathways ensure medicines are positioned as core disease-modifying interventions, with consistent messaging to clinicians about the importance of prescribing decisions.
- **Implementation and adoption capability:** Investment will only deliver value when translated into practice through education, pathway redesign, prescribing decision support, and scaled medicines optimisation support.
- **Assurances and accountability:** own system outcomes in the long-term and ensure success includes avoided activity and a return on investment.

Whilst moving to this approach is important, it is still crucial to maintain robust medicines stewardship including waste, cost saving opportunities and medicines safety

By building these capabilities, NHS GM can shift from reactive, acute-focused care toward strategic medicines commissioning that drives population health improvement, system sustainability, and equitable, long-term outcomes, while still delivering value and maintaining safety in the day-to-day management of medicines

3.0 Recommendations

The Committee is asked to:

- Note the contribution of the 2025/26 Horizon Scanning analysis and its contribution to financial sustainability and significant CIP contrition to the GM health economy.
- Endorse the Horizon scanning analysis undertaken for 2026/27 by the NHS GM Medicines Optimisation team including the financial pressures, cost improvement opportunities and associated budget setting methodology, with a minimum funding requirement of £605.9m (circa 4.3% uplift) reflecting the absolute baseline budget, but not including several risk scenarios (requirements ranging from £650.2m–£754.7m), including NG28 uptake.
- Recognise the impact of Horizon scanning on system wide priorities including the GM Clinical Strategy, Long Term Conditions programmes of work, the prevention and the "Left Shift" agenda. This will inform the development of the medicines and pharmacy strategy as a key enabler to ensure affordability, sustainability, and left shift investment
- Support the development of a Medicines and Pharmacy strategy aligned to the clinical strategy to be submitted to a future meeting.

4.0 Glossary of Terms

Aflibercept
A biologic medicine used primarily in ophthalmology for conditions such as wet age-related macular degeneration. A biosimilar version offers a lower cost alternative with equivalent clinical effectiveness.

BeCCoR
Better Care, Closer to Residents — a GM programme supporting primary-care quality improvement, including prescribing indicators and structured review activity.

Biosimilar
A biologic medicine highly similar to an existing licensed biologic (the “reference product”), offering equivalent safety and effectiveness at reduced cost.

Blueteq
An electronic approval system used to ensure that high-cost and specialised medicines are prescribed in accordance with commissioning criteria.

CAT-M
Category M of the Drug Tariff, which adjusts reimbursement prices paid to community pharmacies and contributes to cost variation in primary-care prescribing.

CIP (Cost Improvement Programme)
A programme of planned efficiencies designed to ensure financial sustainability while maintaining safety and quality.

CVRM (Cardiovascular Renal and Metabolic)
A set of interventions aimed at reducing risk of cardiovascular disease in populations, often linked with diabetes pathways, lipid management and hypertension control.

Deprescribing
A structured process of reducing or stopping medicines where harms outweigh benefits or where treatment goals have changed.

DOAC (Direct Oral Anticoagulant)
A class of anticoagulant medicines used to prevent strokes and blood clots; subject to structured review programmes to ensure safe and cost-effective use.

GLP-1 receptor agonists
A class of medicines used to treat type 2 diabetes and, more recently, obesity. Includes semaglutide, liraglutide and others.

GM (Greater Manchester)
Refers to the Greater Manchester Integrated Care System and its constituent organisations.

HCD (High Cost Drugs)
Specialised medicines normally commissioned through secondary care, often with higher unit costs and separate reimbursement processes.

Homecare
A service that supplies and administers medicines to patients in their home, commonly used for high-cost biologics.

ICB (Integrated Care Board)
Statutory body responsible for NHS planning and resource allocation at system level.

ID6441 (Semaglutide Cardiovascular Prevention Technology Appraisal in development)
The NICE appraisal examining semaglutide for cardiovascular prevention; significant future financial impact.

Long-Term Conditions (LTCs)
Chronic conditions such as diabetes, cardiovascular disease, COPD and asthma that require ongoing management.

NCSO (No Cheaper Stock Obtainable)
A designation indicating temporary supply or pricing issues where pharmacies can claim higher reimbursement, leading to cost volatility.

NG28 (NICE Guideline 28)
NICE guideline covering the management of Type 2 Diabetes in adults — recent updates have major prescribing implications.

NICE (National Institute for Health and Care Excellence)
The national body that issues clinical guidelines, technology appraisals and evidence-based recommendations with significant financial and pathway impact.

ONS (Oral Nutritional Supplements)
Products used in nutritional support; a focus of optimisation to ensure appropriate use and avoid unnecessary cost.

Polypharmacy
The use of multiple medicines, often associated with increased risk of adverse events; a key focus for safety optimisation.

SGLT2 inhibitors
A class of diabetes medicines increasingly used for cardiovascular and renal protection; includes dapagliflozin and empagliflozin.

Tariff
The payment mechanism for hospital activity; moving a drug into tariff can change how it is funded and where financial responsibility sits.

Tirzepatide (TA1026 – NICE Technology Appraisal)
A dual incretin therapy for type 2 diabetes, with major implications for obesity pathways and future cardiovascular indications.