

Agenda

Greater Manchester Strategic Commissioning Committee (Public)

Date: 1 April 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 purpose of first meeting	Verbal	Information	Dame Sue Bailey <i>Chair</i>
2.			Declarations of Interest	Paper	Noting	
3.			Minutes from Transition Committee meeting held on 4 March 2026	Paper	Approval	
Strategic Updates						
4.	14:05	15 mins	Terms of Reference – Update & Next Steps	Paper	Information / Discussion	Dame Sue Bailey <i>Chair</i>
5.	14:20	15 mins	Sub Groups & Draft Workplan – Introductory Discussion	Verbal	Discussion	Dame Sue Bailey <i>Chair</i>
6.	14:35	15 mins	Risk Report	Paper	Information	Nicola Hepburn, <i>Acting Chief Reform and Improvement Officer</i>
7.	14:50	15 mins	Chief Officers Update Reports	Paper	Discussion	Manisha Kumar, <i>Chief Clinical Officer / Katherine Sheerin, Chief Commissioning Officer</i>
8.	15:05	15 mins	Strategic Commissioning Plan – Assurance Approach & Reporting Cycle	Paper	Discussion	<i>Paul Lynch Director of Strategy</i>
9.	15:20	10 mins	Place Outcomes Framework / Outcomes Driven Commissioning	Verbal	Information	Charlotte Bailey, <i>Chief Strategy, People and Partnerships Officer</i>
10.	15:30	10 mins	Performance Report	Paper	Information	Nicola Hepburn, <i>Acting Chief Reform and Improvement Officer</i>

11.	15:40	10 mins	Winter Vaccination Update	Paper	Information	Manisha Kumar, <i>Chief Clinical Officer</i>
For Information						
12.	15:50	10 mins	Any other business	Verbal	Discussion	All
			Board Paper Escalations			
			Meeting Reflections			
Date and time of next meeting: Wednesday 6 May 2026, 14:00pm – 16:00pm MS Teams						

Employee Name	Interest Declared	Interest Category	Interest Situation	Interest Description	Comments	Col Date From	Col 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
Hepburn, Mrs. Nicola	Y	Financial interests	Clinical private practice	From 29 April 2025 I have been an associate clinical nurse assessor for MHS clinical services. MHS often complete work for MIAA. I do not complete any work on behalf of MHS across Greater Manchester or work commissioned by NHS GM. I complete all work via my own personal company outside of my contracted substantive role.		29/04/2025	Ongoing
Hepburn, Mrs. Nicola	Y	Non-financial professional interest	Outside employment	I am a volunteer Clinical Board Advisor for Now Your Talking a talking based National therapy service.		07/10/2025	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							
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			
Partner Members							
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	

Minutes

Greater Manchester Transition Committee

Date: 4 March 2026
 Time: 14:00pm - 16:00pm
 Venue: Microsoft Teams

(Public)

Present		Apologies
<p>In attendance: Rachel Egan (RE) – Non-Executive Director (Chair) Dame Sue Bailey (SB) – Non-Executive Director (Co-Chair) Colin Scales (CS) – Acting Chief Executive and Chief System Reform Officer Sir Richard Leese (RL) – Chair, NHS GM Leigh Vallance (LV) – VCSE Partner Member Prof. Manisha Kumar (MK) – Chief Clinical Officer Richard Paver (RP) – Non-Executive Director and Chair of Audit 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 Nicola Hepburn (NH) - ICB Recovery and Improvement Programme Director Faye Vaughan (FV) – Governance Advisor (Minutes)</p>		<p>Owen Williams (OW) – Chief Executive, NCA Kal Kay (KK) – Non-Executive Director Anthony Hassall (AH) - Chief Executive, Pennine Care NHS Foundation Trust Sean Fielding (SF) – Partner Member Alison Mckenzie-Folan (AMF) – Wigan Place Lead</p>
Item No.	Topic	Action
1.	<p>Welcome, Introductions and Apologies</p> <p>RE welcomed everyone to the meeting and the above apologies were noted.</p>	
2.	<p>Declarations of Interest</p> <p>RE reminded board members of their obligation to declare any interest they may have on any issues arising at the meeting which might conflict with the business of the NHS Greater Manchester. No interests were declared.</p>	

<p>3.</p>	<p>Minutes, matters arising and actions from previous meeting held on 4 February 2026</p> <p>The minutes were accepted as a true record of the previous meeting held on 4 February 2026.</p> <p>There were no live actions on the action log.</p>	
<p>4.</p>	<p>Strategic Commissioning Plan: Next Steps and confirming priorities for 26/27</p> <p>The paper was presented to the committee with an update on the Strategic Commissioning Plan, outlining the process for developing outcomes-based programme plans, identifying board priorities, with a particular focus on children and young people.</p> <p>It was reported that the strategic commissioning plan had been submitted to NHS England and that commissioning leads were tasked with developing outcomes-based programme plans. It was explained that the plan aimed to ensure that individual programme outcomes would collectively achieve the high-level five-year objectives, with strengthened references to learning disabilities based on feedback.</p> <p>The committee were made aware of the use of quadrant analysis to identify priority areas, with a particular emphasis on children and young people due to concerning data on infant mortality, vaccination rates and dental decay.</p> <p>The committee were further made aware of the Board Development Session that was due to take place to review data and discuss priority areas, including how to ensure board oversight and leadership for the priorities. It was reported that the session would also consider shifting investment towards children and young people and finalise outcomes-based plans for each programme.</p> <p>JN emphasised the need for robust data quality and clear metrics to benchmark improvement. A suggestion was raised to provide the data in advance of the development session for more effective discussions.</p> <p>Concerns were raised around maintaining focus on strategic priorities within operational pressures and ensuring that providers and partners were resourced and engaged in delivering the priorities.</p> <p>The importance of addressing culture, co-production and system-wide readiness was further raised.</p> <p>The committee requested for the feedback to be incorporated on culture, data, market readiness and financial alignment into the agenda for the development session. It was agreed that KS and JN would link in with Data Insight & Intelligence colleagues on data that would be useful for the session.</p> <p>The Committee:</p> <ul style="list-style-type: none"> • Noted the work to strengthen the draft Strategic Plan to create a fully worked through operationally credible plan. • Noted the work to confirm Commissioning Intentions for 2026/7. • Reviewed and discuss the work to develop priorities for 2026/7. 	

<p>5.</p>	<p>Preparations for New Governance – Progress Report</p> <p>The paper provided the committee with an update on the development of NHS GM Committee structure ahead of implementation from April 2026.</p> <p>It was reported that further engagement was planned to take place ahead of consideration at the NHS GM Integrated Board on Wednesday 18 March 2026.</p> <p>The proposed sub-committee structures for the People & Resources and Strategic Commissioning Committee were outlined, including the scope of each sub-group and the principles for governance. It was reported that the structure had been designed to be leaner, with ongoing work taking place to finalise the Terms of Reference and Workplans.</p> <p>A discussion took place regarding the placement of Primary Care Commissioning within the new structure. The need to consider alternative structure options to ensure sufficient board oversight was raised.</p> <p>Concerns were raised regarding the committee memberships, the interplay between the sub-committees and the potential risk of the committees working in silos.</p> <p>The importance of ongoing review and iteration of the governance structure with checkpoints to assess effectiveness and address duplication or delays was raised.</p> <p>The Committee:</p> <ul style="list-style-type: none"> • Considered the progress to date and next steps set out in the appended slides. 	
<p>6.</p>	<p>Board Assurance Framework and Risk Report</p> <p>The report provided an update to the committee on the updated strategic risks for the organisation. The report also considered the future Board Assurance Framework (BAF) and corporate risk reporting and proposals on where the risks would be considered from April 2026.</p> <p>CG reported an increased risk for workforce and reduced risks for Population Health, Good Employment, Finance and Emergency Incident. The committee questioned the rationale for downgrading risks in Population Health and Good Employment and suggested that risk reductions were premature given the present uncertainties of ongoing reform and transition.</p> <p>The proposals for allocating BAF and Corporate Risks to the new People & Resources and Strategic Commissioning Committee were shared. A suggestion was raised to carry out practical exercises to clarify risk ownership and reporting.</p> <p>The potential duplication of safeguarding risks was highlighted. It was agreed that both risks would be reviewed and consolidated.</p> <p>The committee highlighted the importance to align terminology and ensure that risk management processes remained responsive during the transition.</p> <p>It was suggested that the committee would need to review the risk descriptions and reporting structures again once the feedback had been incorporated.</p> <p>The Committee:</p>	

	<ul style="list-style-type: none"> • Considered the updated strategic risk descriptions ahead of the March Board meeting. • Considered the reporting split for BAF and Corporate Risks between the two proposed new committees. • Noted the work ongoing on BAF risk review and progressing towards dynamic risk reporting. 	
7.	<p>M10 Finance Report</p> <p>The report provided an update to the committee on the overall Month 10 ICS financial position for Greater Manchester as of 31 January 2026.</p> <p>It was confirmed that the system was on track to meet financial targets despite a year-to-date deficit. It was reported that there were improvements in run rate, risk reduction and CIP over-delivery. The ongoing pressures in recovery areas and the need for continued vigilance in the final weeks of the financial year was raised.</p> <p>The committee thanked and acknowledged all the work that had taken place from everyone for the significant financial improvement through addressing challenges and issues over the year to get to the current position.</p> <p>For the System Financial position, the Committee:</p> <ul style="list-style-type: none"> • Noted 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. • Noted 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. • Noted 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. • Noted the breakeven forecast outturn position in line with NHSE reporting requirements. • Noted 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. • Noted the risk to the system wide cash position which continues to be closely monitored. • Noted 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. • Noted the on-going system meetings to provide assurance on the delivery of the overall system financial plan, and to address the current shortfall in CIP delivery and monitor delivery of recovery plans to mitigate reported pressures. 	
8.	<p>Alert & Assurance Reports from each function area</p> <p>Chief Strategy, People and Partnerships Officer:</p>	

	<p>The paper alerted the committee to the impact of recent NHS Reform developments on the workforce and mitigating actions in place.</p> <p>The ongoing challenges with staff morale due to reform, low annual leave uptake and the need to encourage staff to take leave was highlighted. It was confirmed that there were measures in place to include communications through managers and leadership as well as allowing some annual leave rollover.</p> <p>The committee were made aware of the changes in electronic staff records due to voluntary redundancies that had affected data accuracy for mandatory training. It was reported that soft messaging had taken place to maintain compliance on core modules.</p> <p>The committee discussed the role of leadership in modelling healthy work boundaries, supporting staff to take breaks and restoring a sense of control and empowerment.</p> <p>The Committee:</p> <ul style="list-style-type: none"> • Noted the report. <p><u>Chief Commissioning Officer:</u></p> <p>KS summarised the key shifts in the Every Child Achieving and Thriving White paper, including broader approaches to children’s well-being, changes to the legislative framework for SEND and the requirement for area-based plans to access new funding.</p> <p>The delays in appointing a single major trauma clinical lead was raised. The committee discussed the importance of system-wide ownership and ongoing communication with national stakeholders. The need for timely updates to NHS England regarding any reprofiling of implementation timelines was emphasised.</p> <p>The implications of the new GP contract were discussed, including the potential collective action and the importance of maintaining strong local relationships. It was agreed that VM and MK would collaborate to clarify local interpretations to ensure clinical pathways were appropriately governed.</p> <p>The Committee:</p> <ul style="list-style-type: none"> • Noted the report. <p><u>Chief Reform and Improvement Officer:</u></p> <p>The paper provided the committee with an overview of the issues related to the portfolio of the Chief Officer for System Reform and Improvement.</p> <p>The Committee:</p> <ul style="list-style-type: none"> • Noted the report. <p><u>Chief Clinical Officer Report:</u></p> <p>The paper provided the committee with an overview of NHS Greater Manchester statutory duties during a period of organisational and governance transition.</p> <p>The committee were informed of the recent cases of children with complex trauma or safeguarding histories, but no acute health needs that had been placed in</p>	
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	<p>hospital beds due to lack of suitable placements. The committee discussed the need for intensive wraparound care and improvement approaches similar to those used for Mental Health crises, with commitment to further collaborative work involving local authorities and place-based teams.</p> <p>The Committee:</p> <ul style="list-style-type: none"> • Received and noted the updates on key statutory linked quality and safety matters. • Supported the system wide actions underway, including urgent workstreams, Trust improvement plans, and programme redesign activity described in the report. • Agreed 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. • Endorsed the approach to embedding learning from recent incidents and regulatory findings across NHS GM and partner organisations. <p><u>Medicines Optimisation & Strategic Commissioning 2026/27:</u></p> <p>The paper provided an overview of the Medicines Optimisation Horizon Scanning process and its growing strategic importance during a period of significant financial and operational pressure.</p> <p>The paper also described how medicines optimisation was becoming a strategic commissioner of medicines across the system and how that would improve the lives of the population and contribute to a left shift investment.</p> <p>The committee were informed of the centralisation of the medicine's optimisation team, the use of horizon scanning to align budget setting with anticipated prescribing needs and the achievement of significant cost improvements.</p> <p>The need for strategic commissioning to support long-term health outcomes was also highlighted.</p> <p>The committee agreed on the importance of viewing medicines as therapeutic interventions rather than solely cost pressures.</p> <p>VM declared an interest in the item as the Chief Medical Officer at Health Innovation Manchester.</p> <p>The committee questioned the management of medicines budgets within a constrained financial envelope, the impact of external factors on drug pricing and the risks of overspending. It was explained that a collaborative approach to budget setting, the use of horizon scanning and ongoing national discussions regarding the adequacy of budget uplifts for prescribing were taking place.</p> <p>The importance of patient engagement in medicines optimising to address concerns and ongoing communication efforts was raised.</p> <p>The Committee:</p> <ul style="list-style-type: none"> • Noted the contribution of the 2025/26 Horizon Scanning analysis and its contribution to financial sustainability and significant CIP contribution to the GM health economy. • Endorsed the Horizon scanning analysis undertaken for 2026/27 by the NHS GM Medicines Optimisation team including the financial 	
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	<p>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.</p> <ul style="list-style-type: none"> • Recognised 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. • Supported the development of a Medicines and Pharmacy strategy aligned to the clinical strategy to be submitted to a future meeting. 	
9.	<p>Any other business</p> <p>None were raised.</p>	

Strategic Commissioning Committee Terms of Reference

NHS GM Strategic Commissioning Committee

1 April 2026

Report information.

Required information.	Details.
Title of report.	Strategic Commissioning Committee Terms of Reference
Author.	Chris Gaffey, Associate Director of Corporate Services
Presented by.	<p>Sue Bailey, Non-Executive Director and Chair of the Strategic Commissioning Committee</p> <p>Charlotte Bailey, Chief Strategy, People and Partnerships Officer</p>
Contact for further information.	<p>Chris Gaffey, Associate Director of Corporate Services</p> <p>chris.gaffey@nhs.net</p>
Executive summary.	<p>This report provides the Committee with Terms of Reference for the Strategic Commissioning Committee that were approved by the Board in March 2026.</p> <p>A three-month post-implementation review of the two newly established Committees will be conducted to further identify areas of potential improvement and amendment to the arrangements, which may include further changes to the Terms of Reference. Any changes will be considered by the Committee, before consideration by the Board for approval.</p>

<p>The benefits that the population of Greater Manchester will experience.</p>	<p>Ensuring good governance arrangements are in place will ensure NHS GM is a well-led organisation, which will benefit the population of Greater Manchester.</p>
<p>How health inequalities will be reduced in Greater Manchester’s communities.</p>	<p>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.</p>
<p>The decision to be made and/or input sought.</p>	<p>The Committee is asked to:</p> <ol style="list-style-type: none"> 1. Note the Committee Terms of Reference (Appendix One).
<p>How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.</p>	<p>Ensuring good governance arrangements are in place will ensure NHS GM is a well-led organisation, and one of the objectives of moving to a new Committee structure is to ensure that the Board and its Committees have the required strategic focus. This will support the delivery of the ICP Strategy, as well as ensure focus on the Board Assurance Framework.</p>
<p>Key milestones.</p>	<p>17 December 2025 – Agreement of Transition Arrangements by Board</p> <p>4 March 20026 – Consideration of proposals by Transition Committee</p> <p>11 March 2026 – Further consideration and refinement by NEDs / Execs.</p> <p>18 March 2026 – Board approval</p> <p>1 April 2026 – Implementation</p>

<p>Leadership and governance arrangements.</p>	<p>The Chief Strategy, People and Partnerships Officer is responsible for Corporate Governance arrangements, supported by the Associate Director of Corporate Services.</p> <p>The Strategic Commissioning Committee will be chaired by Sue Bailey, Non-Executive Director.</p>
<p>Engagement* to date.</p> <p>*Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.</p>	<p>The Terms of Reference were drafted via working group meetings including officers from across functions, which were followed by working group meetings between NEDs and lead Chief Officers. Further discussions then took place at NEDs / Execs meeting on 11th March 2026, before final comments and views were incorporated into the proposals which were approved by Board on 18th March 2026.</p>
<p>Financial or Legal Implications</p>	<p>No formal legal or financial implications as part of this report, however the new arrangements do propose that the Strategic Commissioning Committee will have financial approval limits in line with the financial scheme of delegation (however further engagement in this area is required before limits are confirmed).</p>

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

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

Table 2: Assurance needed about the document.

NHS Greater Manchester
Strategic Commissioning Committee
Terms of Reference

<p>Purpose</p>	<p>The purpose of the Strategic Commissioning Committee ('the Committee') is to obtain assurance, on behalf of the Board, that the ICB has the right <u>commissioning strategy</u> and approach, supported by intelligence, which is delivering its quality, performance, population health, and <u>oversight</u> functions in a way that secures continuous improvement, whilst ensuring that the ICB operates as a strategic commissioner.</p> <p>The Committee will have a strong focus on improvement, prevention, population health and the left-shift as set out in the 10-Year Health Plan.</p> <p>The Committee will operate within an agreed shared governance model with the People and Resources Committee to ensure clarity of decision flow, avoid duplication, and prevent delays in financial approvals.</p> <p>The Strategic Commissioning and People and Resources Committees collectively provide Board assurance across the end-to-end strategic commissioning cycle, from assessment of population need and outcomes, through prioritisation and design, to resource enablement, implementation, performance, value and learning. The Strategic Commissioning Committee leads on commissioning intent, outcomes, service models and priorities, and provides assurance that these are clinically, population and evidence-led.</p> <p>The Committees will share information, risks, and escalations in a systematic and timely way to support effective Board oversight.</p>
<p>Duties</p>	<p>The Committee will:</p> <p>Strategic Commissioning</p> <ul style="list-style-type: none"> - Apply constructive challenge to the strategic commissioning arrangements, and make recommendations to the Board or People and Resources Committee regarding procurement, and evaluation of contractual delivery. - Oversight of development and implementation of the Commissioning Strategy, ensuring this is developed within the resources available. - Ensure that opportunities for service redesign in line with the Commissioning Strategy are optimised. - Where proposals fall within approved budgets and the financial scheme of delegation, the Strategic Commissioning Committee will retain decision making responsibility. Where proposals exceed budget or require material financial variation (as set out in the financial scheme of delegation), the

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

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

Clinical strategy

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

Performance and Planning

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

System oversight

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

Continuous improvement

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

Digital Strategy

- Apply constructive challenge to the strategic role of digital and IT in transforming commissioning, care delivery, system performance and outcomes.
- Oversee and obtain assurance on the development, implementation, and embedding of strategic digital priorities within the ICB's Commissioning Strategy, Population Health functions, and Integrated Care Partnership Strategy.
- Provide strategic oversight of alignment with the GM Health and Care Digital Transformation Strategy 2023-2027 and national digital infrastructure.

Population Health

- Take comprehensive action and exert influence across the organisation to ensure the delivery of the core aims of the ICB as they relate to improving health, reducing inequalities, retaining people in good health for longer, and driving whole system left shift.
- Provide assurance to the ICB that NHS GM is meeting its statutory responsibilities in relation to population health (including those responsibilities discharged through localities).
- Provide assurance that population health intelligence and analytical capabilities are robust in generating insight on population needs and inequalities, and that these insights are utilised to drive improvement action through a population health management approach.
- Ensure that the opportunities for the ICB to work with partners to improve the health of the population are maximised

Data and Intelligence

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

Delegated NHS England Responsibilities

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

	<p>of this area will be provided by the Primary Care Commissioning Group.</p> <p>Strategic risks</p> <ul style="list-style-type: none"> - Monitor and provide assurance to the Board on <u>BAF risks</u> assigned to the committee, as well as relevant Corporate Risks. <p>Statutory Functions</p> <ul style="list-style-type: none"> - Apply constructive challenge to the delivery of the ICB <u>key statutory and policy requirements</u>, including All Age Continuing Healthcare (AACHC), complaints, mortality and learning from deaths, safeguarding adults and children, SEND, infection prevention and control, equality and diversity in relation to service delivery, patient safety incident response, medicines optimisation and safety and citizen involvement. <p>Other duties</p> <ul style="list-style-type: none"> - Apply constructive challenge to the ICB's response to all relevant (as applicable to quality) Directives, Regulations, national standard, policies, reports, reviews and best practice as issued by the DHSC, NHSE and other regulatory bodies / external agencies (e.g. CQC, NICE) to gain assurance that they are appropriately reviewed and actions are being undertaken, embedded and sustained. - Apply constructive challenge to the oversight of <u>EPRR arrangements</u>.
Membership	<p>The membership of the committee shall comprise of the following members:</p> <ul style="list-style-type: none"> • 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 <p>Only members of the Committee have the right to attend Committee meetings.</p>
Attendees	<p>Where any conflicts arise, the Chair may ask any or all of those who may be conflicted, including members, to withdraw from the meeting.</p> <p>Other individuals or partners will be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter including representatives from the Health and Wellbeing Board(s), Secondary and Community Providers.</p> <p>The Chief Executive should be invited to attend the meeting at least annually.</p>

	<p>The Chair of NHS GM may also be invited to attend one meeting each year in order to gain an understanding of the Committee's operations.</p>
<p>Delegated authority</p>	<p>The Committee is established by the Board as a Committee of the Board in accordance with its constitution.</p> <p>The Committee has delegated responsibility by the Board to:</p> <ul style="list-style-type: none"> • Investigate any activity within its terms of reference • Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these terms of reference • Commission any reports it deems necessary to help fulfil its obligations • Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice. • The Committee may establish a sub-committee and arrange for the functions exercisable by the Committee to be exercised by the sub-committee. <p>For the avoidance of doubt, the Committee will comply with the ICB Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation.</p> <p>Members will be expected to conduct business in line with NHS GM values and behaviours, including demonstrably considering the equality and diversity implications of decisions they make.</p>
<p>Meeting management</p>	<p>Frequency</p> <p>The Committee shall meet monthly a minimum of 10 times per year. Any arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.</p> <p>Meetings will be held in public, however there may be occasions where items will need to be considered in private. And decisions to consider items in private will be evidenced, and be by agreement with the Chair.</p> <p>Agenda and papers</p> <p>The agenda and papers for meetings will be distributed five working days in advance of the meeting.</p> <p>Attendance and Quorum</p> <p>A quorum shall consist of 3 committee members, including The Chair or Vice Chair, and the Chief Clinical Officer or Chief Commissioning Officer (or nominated Clinical</p>

Deputy as agreed by the Chair).

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

Support

The Corporate Governance team will support the committee.

Conflict of interest

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

Reporting

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

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

Annual self-assessment

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

Date agreed by the Strategic Commissioning Committee:	
Date approved by the Board:	18 March 2026
Review date:	June 2026

Appendix: Constructive challenge

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

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

Board Assurance Framework and Risk Report

Strategic Commissioning Committee

1st April 2026

Strategic Commissioning Committee

1st April 2026

Required information	Details
Title of report	Board Assurance Framework and Risk Report
Author	Chris Gaffey, Associate Director of Corporate Services
Presented by	Nicola Hepburn, Acting Chief Reform and Improvement Officer
Contact for further information	Rick Thompstone, Assistant Director Risk & PMO – rick.thompstone@nhs.net
Executive summary	<p>This report confirms the BAF and Corporate Risks that will be considered by the newly established Strategic Commissioning Committee (SCC).</p> <p>As a new Committee of the Board, the SCC will be responsible for consideration and monitoring of these risks, and to provide the Board with the appropriate assurance that they are being appropriately managed.</p> <p>The relevant BAF risks are set out in Appendix One.</p>
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	<p>The Strategic Commissioning Committee is asked to:</p> <ul style="list-style-type: none"> Consider the risks presented in this report.
How this supports the delivery of the strategy and mitigates the BAF risks	This report is directly focused on Risk Management which includes the BAF risks.
Key milestones	Strategic Commissioning Committee – 1 st April 2026
Leadership and governance arrangements	Each strategic risk has an assigned risk owner, who is a Chief Officer of NHS GM.

	<p>The BAF is reported to and considered by the Board at each of its meetings, with some strategic risks also considered at the Strategic Commissioning Committee and others at the People & Resources Committee.</p> <p>The NHS GM Risk Policy provides a framework to enable risk management to be embedded across all activities within the organisation</p>
<p>Engagement* to date</p> <p>*Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.</p>	<p>The BAF and Corporate Risks are considered by the relevant Committee, as well as the NHS GM Chief Officers for management oversight.</p>
<p>Financial or Legal Implications</p>	<p>None.</p>

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 accessibility of report

1.0 Introduction

- 1.1 This report confirms the BAF and Corporate Risks that will be considered by the newly established Strategic Commissioning Committee (SCC).

2.0 Strategic Risks

- 2.1 The strategic risks for the SCC 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. The assignment of these risks to the Committee have been considered and agreed by the now disestablished Transition Committee, as well as the Board at their March 2026 meeting.
- 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).

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			
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Strategic Risks

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

3.0 Risk Update

3.1 The areas to report into each committee have been finalised and approved at the ICB. The risks shown below are the BAF risks and corporate risks agreed to be considered by the Strategic Commissioning Committee.

3.2 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.

3.3 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

3.4 Appendix One contains the details for each of the risks but headline messages are identified below:

- SR4 (Good Employment), and SR9 (Emergency Incident) are reporting a reduced risk score for this quarter.
- All remaining risks are reporting a static risk score this quarter
- Risk SR5 (Health Inequalities) is showing a variation between current score and year-end target score.

3.5 Work towards a more dynamic way of reporting risks is ongoing, with a Deep Dive conducted on SR1 (Population Health) at the Audit Committee on 19 March 2026. The Committee discussed how lines of assurance may be presented more effectively, providing evidence to support assurance, including the use of data and intelligence; the need to be clear around IBC v system responsibilities in relation to mitigations; and developing the BAF to ensure it is an effective tool for driving agendas and prioritisation.

3.6 Learning from this deep dive will be incorporated into ongoing work on developing the BAF, and it was agreed that a further Deep Dive would be scheduled in April (BAF risk to be confirmed).

3.7 The corporate risks shown below are taken from the February 2026 Transition Committee Risk Report, alongside risks and issues from Data, Insight and Intelligence. The previous committee reference has been included to ensure members are clear where the corporate risks were previously reviewed.

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
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 <u>system planning</u> 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).
Data, Insight & Intelligence	
DII039	Misalignment Between GM SDE and NW SDE Impacting Funding. There is a risk that a lack of alignment between the GM SDE and NW SDE programmes could result in reduced national funding, affecting both business-as-usual activities and the SDE programme.
DII058	Sustainability of New Commissioned Services. There is a risk that ongoing maintenance of newly commissioned services via DII cannot be sustained
DII068	NHS Reform Threatening Continuity of CSU Support. There is a risk that NHS reforms may lead to the dissolution or restructuring of Commissioning Support Units (CSUs), including Arden & GEM, threatening continuity of critical support services.
DII083	There is a risk that GP Data Controllers and Local Medical Committees (LMCs) do not agree to or sign the new Joint Data Controller Agreement for the GM Care Record / ADSP, particularly for secondary use and research purposes, resulting in data being unable to legally flow across the system.

Strategic Commissioning Committee Issues

Data, Insight & Intelligence	
DII005	DII is unable to fulfil stakeholder requirements because of ongoing capacity limitations, reduction in roles on the new structure and unfilled staff positions.
DII007	The DII Data Governance team is experiencing significant capacity shortfalls, impacting its ability to deliver key statutory requirements of the ICB.
DII011	There is insufficient capacity to support the refresh of the Health & Care Intelligence Strategy, as required by NHS GM and ICP colleagues for the System Improvement Plan.
DII053	The NHS GM DII team lacks sufficient capacity across PMO, Data Governance, and Technical roles to support the BETA SDE programme.
DII057	The SDE programme is not currently recognised as a priority by the ICB.

3.10 In addition, this Committee will have responsibilities relating to aspects 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 Recommendations

4.1 The Strategic Commissioning Committee is asked to:

- Consider the risks presented in this report.

Strategic Risk SR1	There is a risk that the health of the population will worsen due to wider economic and social conditions deteriorating. This could include societal challenges and structural inequalities that relate to poverty / socio-economic disadvantage, housing and local infrastructure, early years experiences and educational attainment, access to good employment, crime and safety, air quality and transport. This will result in poorer health, unsustainable demand on health and care services and will impede economic growth.		
Strategic Objective	Strengthen our communities		
Chief Officer / Committee	Charlotte Bailey Strategic Commissioning 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 tackling inequalities as a focus of the system. The GM Housing Tripartite Agreement ensures a collaborative approach to healthy homes across NHS GM, GMCA and Housing Providers.			
Gaps in Control or Assurance			
Current reforms have and likely will continue to significantly impact any proactive NHS system involvement in delivery of the various strategic ambitions. Continuation of this will mean programmes develop without relevant health system influence and opportunities are missed to improve the health of the population. The NHS Reform could impact on the capability of the ICB to provide the resource, skills, expert knowledge and capacity to effectively work across multiple systems in order to fulfil our role in driving the delivery of the GMS. A significant reduction in ICB headcount due to VR and restructuring will mean capacity and expertise gaps will appear. The total impact of the reform is still to be fully understood, however direct impact on Population Health capacity is already apparent with some key programmes of work losing key personnel. The delay in organisational 'left shift' activity and investment will impact progress of prevention and early intervention opportunities and transformation propositions.			

Risk Scoring and Tolerance								
	Inherent risk score	Q1	Q2	Q3	Q4	Year-end Target	Long Term Target	Long Term Target Date
Likelihood	3	3	3	3	3	2	1	2028
Impact	5	5	5	5	5	5	5	
Risk Level	15	15	15	15	15	10	5	
Number of Linked Risks on Corporate Risk Register								
Low (1 - 4)			Mod (6 - 12)			High (15 - 25)		
0			0			6		
Lines of Defence	Sources of Assurance							Assurance Level
1 st 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
2 nd 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
3 rd 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 28 th 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	Nicola Hepburn Strategic Commissioning 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	
Impact	5	5	5	5		5	5	March 2028
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
1 st 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
2 nd Line	System Group meetings to review operational performance for their respective thematic area; provider contract meetings; provider oversight meetings;							Partial
3 rd 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/B AU	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 Strategic Commissioning 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			
<p>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.</p> <p>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.</p>			
Key Controls			
<ul style="list-style-type: none"> 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. 		<ul style="list-style-type: none"> Quality Impact Assessment processes established – GM System Quality Group currently being reviewed in line with wider governance work underway at the ICB). Reporting, audits and actions in place for safeguarding assurance (aligns to Safeguarding Policy). MIAA Audit findings/actions Annual reports (Quality Accounts / Safeguarding Report). Assurance meetings with NHSE. Submission to RSQG with escalations as part of business as usual. External audits. External inspections by regulators 	
Gaps in Control or Assurance			
Gaps in Assurance whilst organisational structures are being confirmed. Compliance with the statutory assurance frameworks.			

Risk Scoring and Tolerance								
	Inherent risk score	Q1	Q2	Q3	Q4*	Year-end Target	Long Term Target	Long Term Target Date
Likelihood	4	3	3	3	3	3	2	March 2028
Impact	5	5	5	5	5	5	5	
Risk Level	20	15	15	15	15	15	10	
Number of Linked Risks on Corporate Risk Register								
Low (1 - 4)		Mod (6 – 12)			High (15 – 25)			
0		9			0			
Lines of Defence	Sources of Assurance							Assurance Level
1 st 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
2 nd 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
3 rd 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 Strategic Commissioning 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: <ul style="list-style-type: none"> • 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
1 st 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
2 nd 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
3 rd Line	GM Public Health Leadership Group which consists of 10xLocal Authority Directors of Public Health, NHS GM, OHID, UKHSA and NHSE NW; NW Population Health Board; GMCA and Health Scrutiny							Acceptable
Action							Complete/BAU Delayed	On Track Problematic
No	Action Required	Due Date	Progress					
1	Completion and launch of Get GM Working Plan with accompanying implementation plan.	February 2026	Get GM Working Plan formally approved by the CA in December 2025 and agreement to a GM Integrated Settlement with a strong focus on work and health. Delay to Implementation plan due to staff shortages – now expected June 2026.					
2	Confirmation of future funding for WWP, Primary Care Innovation Fund and Health and Growth Accelerator	March 2026	Funding confirmed. From 2026/7 they will form part of the GM Integrated Settlement provided greater GM-level flexibility and accountability for delivery and improved outcomes					
3	Delivery of GMS under a new delivery framework	Ongoing throughout 26/27	the delivery plans and associated governance are now well advanced and provide confidence around delivery of the strategy					
4	ICB reform and transition process to ensure new Operating Model is capable of mitigating BAF risk	March 2026	Structures and capacity/capability to deliver controls still being established					

Strategic Risk	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.		
SR5			
Strategic Objective	Help people to stay well and detect illness earlier		
Chief Officer / Committee	Charlotte Bailey	Strategic Commissioning 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 tackling 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
1 st 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
2 nd 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
3 rd Line	GM Public Health Leadership Group which consists of 10xLocal Authority Directors of Public Health, NHS GM, OHID, UKHSA and NHSE NW; NW Population Health Board; GMCA and Health Scrutiny							Acceptable
Action							Complete/BAU Delayed	On Track 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.	Yellow				
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	Blue				
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	Green				
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	Green				

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	Nicola Hepburn Strategic Commissioning 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			
<p>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.</p> <p>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.</p> <p>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.</p>			
Key Controls			
<ul style="list-style-type: none"> 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. <p>Regular updates are provided to Chief Officers on the progress of the recruitment and the risks in the workload.</p>			
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
1 st Line	Meetings within the EPRR team and with the NHS GM Accountable Emergency Officer.							Partial
2 nd Line	Meetings and workshops with NHS GM staff with a potential incident response role.							Partial
3 rd 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 health 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					

Chief Clinical Officer Report

April 2026

NHS Greater Manchester Strategic Commissioning Committee

1st April 2026

Required information	Details
Title of report	Chief Clinical Officer Report
Author	Claire Lake, Deputy Chief Medical Officer Jim Ritchie, Deputy Chief Medical Officer Kenny Li, Chief Pharmacist 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	<p>This report provides assurance on how NHS Greater Manchester Integrated Care Board is discharging its statutory duties for quality, safety and clinical governance across the organisation and the system as a whole. It brings together intelligence from established governance routes and demonstrates how statutory clinical governance and quality functions are being exercised to identify and manage risk, reduce unwarranted variation, and support safe, effective and equitable care across Greater Manchester.</p> <p>The report highlights key areas of assurance and oversight, including medicines optimisation decisions endorsed by CEG, clinical policy and audit assurance, progress on mental health quality improvement, and the system response to nationally significant patient safety issues such as corridor care. It also draws attention to specific risks requiring continued oversight, including paediatric audiology, specialised renal services, and organisational capacity within mental health governance.</p> <p>Collectively, the report provides evidence of strengthened governance, clearer escalation routes, and closer alignment between clinical quality, commissioning decisions and system priorities, supporting delivery of the NHS GM strategy and mitigating Board Assurance Framework risk SR5</p>
The benefits that the population of Greater Manchester will experience.	<p>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.</p>

<p>How health inequalities will be reduced in Greater Manchester's communities.</p>	<p>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</p>
<p>The decision to be made and/or input sought</p>	<p>The Committee is asked to:</p> <ul style="list-style-type: none"> • Note the identified patient safety risks highlighted within the report, including paediatric audiology, specialised renal services and corridor care, and to support continued system-level oversight and escalation through established provider assurance, regional review and executive governance routes, in line with national expectations and GIRFT Clinical Operational Standards. • Note the findings and advice arising from independent reviews and external assurance, particularly in relation to mental health services and provider-led improvement, and to support the continued development of ICB capability and capacity to provide robust clinical quality oversight during ongoing system change. • Endorse the recommendations previously approved by the Clinical Effectiveness and Governance Committee, including Greater Manchester Medicines Management Group decisions and Clinical Policy Audit and Standards recommendations, and to note the assurance gained from national clinical audits and the agreed approach to ongoing monitoring and improvement.
<p>How this supports the delivery of the strategy and mitigates the BAF risks</p>	<p>The areas within this report and progress made to improve these relate to BAF risk SR5</p>
<p>Key milestones</p>	<p>These are set out within the different sections of the report.</p>
<p>Leadership and governance arrangements</p>	<p>This paper is produced for Strategic Commissioning 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.</p>
<p>Engagement* to date</p> <p>*Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.</p>	<p>There has been no formal engagement on this paper as this paper is produced for Strategic Commissioning 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</p>

Financial or Legal Implications;	<p>There are no direct new financial or legal implications arising from this report. Decisions with a material financial impact, including medicines optimisation and gainshare opportunities, are being progressed through the appropriate executive and financial governance routes in line with existing NHS GM policies.</p> <p>The report reflects continued compliance with statutory clinical governance responsibilities, including adherence to NICE Technology Appraisals, national clinical audit requirements, and patient safety guidance. Where innovation or service change is proposed, additional digital, information governance and legal assurance is being sought prior to implementation.</p> <p>No formal public engagement has been undertaken specifically for this report, as it consolidates assurance from established governance routes. Conflicts of interest, legal advice and financial advice have been considered in line with standard committee reporting requirements, with no issues requiring escalation at this stage.</p>
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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 accessibility of report

Alert

Paediatric Hearing Service Improvement Programme

GM ICB is working collaboratively with colleagues across the North-West Region to drive the improvements for Paediatric Audiology. Despite extensive work in this area over the last 18 months, there remains some system risks which will ultimately impact on the children and young people who require these services. There is a robust oversight plan in place which reports into the regional Rapid Quality Review for Paediatric Audiology and the ICB monitors the improvement plans for each individual organisation whilst also working to develop a new way of commissioning for the future.

Current risk and impact centres around a short supply of subject matter experts to independently review casework, high levels of scrutiny leading to services who have 'oversight fatigue', high rates of sickness and longstanding estates issues which all impact on the timeliness of reviews and recall for assessment and treatment.

Improvement plans with timescales are actively monitored and regular escalation discussions held with Trusts through Provider Oversight Meetings.

Northern Care Alliance NHS Foundation Trust (NCA) – Renal Dialysis Unit

Following 3 significant incidents the specialist provision is currently under scrutiny, led by Specialised Commissioning colleagues and NHS GM, and supported by the North-West Regional Kidney Network. A quality assurance visit has been undertaken, and improvement actions are being addressed in relation to workforce and equipment.

Advise

The Independent Assurance Review of Greater Manchester Mental Health NHS Foundation Trust

The independent assurance review confirms that progress has been made across all recommendations from Professor Shanley's 2024 report, but notes it is too early to assess the sustainability or impact of these improvements, particularly given the significant turnover within the Trust's leadership team. The Trust is taking steps to engage staff, service users and carers to ensure that changes to strategies, policies and service models reflect real-world experience and support a shift towards a more open, trusting and co-produced culture. Despite the challenges, the Trust has strengthened governance in key areas, including its suicide prevention strategy, ligature reduction work, and the provision of more transparent and coherent information to the Board.

The review highlights areas of focus for NHS GM including the ICB-led independent review of community services, which remains ongoing, and the development of the ICB's own mental health expertise and oversight capacity - noting gaps in seniority and specialist knowledge required to identify early quality concerns. The report also identifies risks linked to loss of organisational memory and disrupted working relationships due to continued organisational change.

Bolton NHS Foundation Trust

An external report was commissioned following a number of incidents at the Trust related to gynaecology laparoscopic surgery. The ICB is currently reviewing the outcomes and related improvement actions.

Corridor Care – Getting It Right First Time (GIRFT) Delivery Plan

The Corridor Care Improvement Guide (published March 2026) sets out national expectations and practical actions to reduce, and ultimately eliminate, the use of corridor care across urgent and emergency care pathways. The guide positions corridor care as a significant patient safety risk and makes clear that it should never be considered standard practice, with delivery accountability resting with trust executive leadership and requiring whole-system action.

Central to the guidance is the adoption of GIRFT Clinical Operational Standards (COS) as a consistent, trust-wide framework to improve patient flow, enable timely senior clinical decision-making, and reduce reliance on corridor care. The guide recognises that elimination of corridor care is a longer-term ambition and emphasises the need for clear system-level plans, agreed red lines, and sustained executive oversight.

The guidance establishes a set of minimum safety red lines, including:

- a maximum 45-minute ambulance handover standard;
- zero tolerance for Emergency Department stays exceeding 24 hours once emergency care is complete;
- explicit limits on corridor care within Full Capacity Protocols, with any breach triggering formal review and learning at executive level.

The guide also provides a standardised approach to defining and reporting corridor care activity, supported by clear criteria relating to clinical safety, privacy and dignity, and duration. This is intended to support consistent measurement, transparency, and system learning, rather than normalisation of corridor care.

Five inter-dependent areas of focus are identified to reduce corridor care, spanning the whole urgent and emergency care pathway:

- system access and ambulance receiving arrangements;
- Emergency Department streaming, assessment and time-to-treatment;
- alternatives to admission, including same day emergency care (SDEC), frailty, urgent community response and virtual wards;
- inpatient flow, length of stay reduction and discharge;
- culture, leadership and operational grip.

Across Greater Manchester, delivery of the corridor care improvement approach is being taken forward through alignment with existing urgent and emergency care improvement programmes, strengthened provider oversight, and system-level collaboration. This includes embedding GIRFT Clinical Operational Standards, clarifying escalation thresholds, and supporting trusts to translate national guidance into locally owned delivery plans.

Assure

Joint Health Scrutiny Committee

A valuable conversation was started with Greater Manchester Councillors in relation to the ICB approach to quality assurance. The report was well received and focused on current CQC ratings and prompted a request for further conversations and assurances on improvement work and our approach to the Independent Sector.

NHS GM approach to Quality & Safety Oversight

The Quality and Safety function are working closely with Provider colleagues to ensure a smooth transition to a new model of working. Existing Quality and Safety Assurance Meetings will be replaced by Quality Review Meetings which are structured to enable assurance against contract compliance, detailed review of improvements and challenges and a forum for discussing any early warning signals. Trust colleagues have welcomed the approach.

Summary of items considered at CEG (March 2026)

The Clinical Effectiveness and Governance (CEG) Committee met in March 2026 and considered a wide range of statutory clinical governance and system improvement matters. The discussion reflected both substantive clinical decision-making and the evolving governance context associated with the ICB transition.

The Committee was briefed on ICB governance reforms, including the reduction in formal sub-committees and the removal of delegated decision-making authority. It was confirmed that, going forward, CEG will operate as a system clinical governance forum, providing collective clinical advice, scrutiny and consensus, with final sign-off of recommendations resting with the Strategic Commissioning Committee (SCC). Members supported the importance of retaining strong, collective clinical discussion and challenge within this new model.

CEG considered and supported the following key items:

Item	Key assurance / outcome	Implications / next steps
GMMM clinical recommendations (including Entresto, Estelcocinib and SGLT2 commissioning guidance)	CEG supported the clinical recommendations, noting the distinction between clinical governance approval and separate consideration of financial impact and affordability through appropriate forums. An interim position was agreed where further financial analysis is required.	Recommendations and holding statements to be progressed through SCC and financial governance routes. Further work to evidence outcomes and manage system risk.
Drugs of Low Clinical Value (DLCV)	Assurance was provided that GM performance continues to improve faster than the national average, though unwarranted variation remains. CEG supported strengthened locality-level action and development of patient information to enable safe deprescribing.	Locality clinical governance groups to review data and actions. System resources and patient information to be developed and shared.
Prevention of Future Deaths (PFD) – methotrexate case	CEG received assurance that the incident was multifactorial and not caused by an out-of-date shared care protocol alone. The Committee supported the proposed response, learning actions and wider system communication.	Final PFD response to be signed off by the CCO. System learning to be shared via a 7-minute briefing and national feedback routes.
CNST Year 7 – maternity incentive scheme	CEG noted that five of six GM providers achieved full compliance, with one provider narrowly missing a single safety action.	Final confirmation awaited from NHS Resolution. Ongoing maternity assurance through LMNS governance.

CPAS clinical service specifications and annual review	CEG endorsed the revised Independent Sector Orthopaedic Service Specification and noted positive assurance from the first CPAS annual review, alongside areas for further development.	Annual review action plan to return to CEG for continued oversight.
NICE NG28 diabetes guidance – interim position	CEG supported an interim system position recognising significant clinical benefit alongside major affordability and implementation challenges.	Further cohort analysis, health economic assessment and phased implementation planning to continue.
GP direct access MRI brain pathway	CEG supported the direction of travel, recognising benefits to referral quality and patient experience, while highlighting the need for clear governance, responsibility and equity considerations.	Pathway and SOP to be refined, with further assurance prior to final approval.
One-stop lung cancer clinic model	CEG noted strong evidence of improved outcomes, experience and cost-effectiveness, and supported further spread subject to governance and commissioning clarity.	Further work to align clinical strategy delivery and system investment decisions.

CEG provided collective clinical assurance across statutory clinical governance responsibilities and supported progression of all items through established governance routes. No issues were identified that required escalation outside existing arrangements, with recommendations progressing to the Strategic Commissioning Committee where formal approval is required.

Risk discussed and new risk identified

The Medical Directorate and Nursing and Quality Directorate have come together into the new Clinical Portfolio. The Clinical Portfolio consolidates:

- Clinical leadership
- Clinical governance and effectiveness
- Quality improvement and assurance
- Safety and patient experience
- Clinical strategy functions

This shift is still embedding and impacts risk ownership, mitigation capacity, and oversight arrangements at Portfolio and Committee levels.

We are also transitioning into the new operating model. All of these changes have brought:

- significant changes to capacity,
- redistributed roles and functions,
- revised accountability structures across governance, quality, safety, and effectiveness.

Risk Management Approach (Aligned to NHS GM Policy)

There is a clear organisational need for a streamlined, strengthened, systematic and transparent approach to risk management. The refreshed NHS GM Risk Management Policy (July 2025) provides the framework and has been fully integrated into this approach.

Strengthening the oversight and management of clinical risks is essential to ensuring that emerging

concerns are identified early, mitigations are clearly owned, and statutory duties around quality, safety and effectiveness are consistently met across the system. A more proactive and transparent approach will also improve assurance to Committees and support a unified, system-wide understanding of our clinical risk profile.

Key Principles to support Clinical Risk Management

Our approach to managing clinical risks will be guided by a set of core principles designed to ensure clarity, proportionality and consistent oversight:

- Risk ownership is clear and aligned to where the work happens. Day-to-day risks should be owned and managed as close as possible to the programme, function or operational team best placed to understand and mitigate them.
- Escalation is purposeful and proportionate. Risks are escalated based on their significance, strategic impact, or when they require action, coordination or decision-making beyond their immediate area.
- Oversight strengthens assurance—not bureaucracy. The Portfolio Business Meeting acts as the central point for triangulation, ensuring a shared understanding of key risks, identifying connections across workstreams, and supporting the right level of scrutiny.
- Committees receive only those risks requiring strategic assurance or intervention. Committee time is protected for the highest-impact risks—those that influence statutory duties, system performance, quality or safety.
- Reporting is structured, predictable and aligned across the system. Regular review cycles and clear routes of escalation promote consistency, transparency and a common view of risk.
- Cross-system risks are treated as shared responsibilities. When risks span organisational boundaries or require system-level mitigation, they are escalated for Portfolio and Committee oversight regardless of numerical score.

These principles will underpin our maturing approach to risk, ensuring that the Portfolio can provide strong, coherent and proactive clinical governance that supports safe, effective and strategically aligned decision-making across NHS GM.

Additional Summary of the Consolidated Risk Identification Approach

To further support this approach a structured, evidence-based review of past QPC papers and NHS Provider risk registers is underway with the aim of identifying potential items that should be considered as potential risks or issues for the Clinical Portfolio and system as a whole. While not fully comprehensive, this will provide a robust and triangulated starting point.

Following completion of this we will bring together a small group of functional leads across the Portfolio to refine the emerging longlist, agree ownership and key themes, producing a draft of refreshed clinical risks for the Portfolio and system for consideration.

Learning for sharing

North-West Regional Improvement Co-design

A regional meeting was held to initiate the co-design of a shared approach to improvement across the North-West, aligned to the national model blueprint and the region's improvement and intervention responsibilities. Greater Manchester was actively represented and engaged, contributing system experience and shaping the early direction of this work.

A shared ambition emerged to embed improvement as core business across the system, with staff confident and equipped to deliver improvement in practice. This ambition aligns directly with the Greater Manchester Clinical Strategy, which prioritises quality, clinical effectiveness, population health improvement and system-led working.

There was consensus that the regional role should increasingly act as an enabler of improvement, supporting collaboration, capability building and shared learning, while maintaining proportionate oversight. The agreed principles – patient-centred, people-powered, one-system, evidence-led and focused on sustainability – are consistent with GM's established improvement approach and quality priorities.

Greater Manchester remains engaged in the ongoing co-design to ensure continued alignment with GM priorities and a coherent, system-led approach to improvement across the region.

Achievements

GM Dementia Strategy: Priorities and Challenges

A paper on Dementia priorities and challenges will be presented to the Greater Manchester Integrated Care Partnership Board, highlighting continued system progress through the Dementia United programme. The paper demonstrated strong performance against key quality indicators, alongside a sustained focus on reducing unwarranted variation and improving experience through a co-produced, whole-system approach. The full paper is available via this link: [Greater Manchester Combined Authority](#)

Key achievements include:

- Dementia was reaffirmed as a strategic priority for Greater Manchester, with delivery led through the Dementia United programme and overseen through established system governance arrangements.
- Dementia diagnosis rates across Greater Manchester are above the national average, with all ten localities exceeding the national target and variation continuing to narrow.
- Performance on care planning and medicines optimisation remains stronger than national and regional benchmarks, supporting safer and more consistent care for people living with dementia.
- A co-produced, whole-system approach is embedded, with lived experience central to design, delivery and assurance through the Dementia Carers' Expert Reference Group.

NHS Greater Manchester Strategic
Commissioning Committee
Report from Chief Commissioning Officer
1st April 2026

Report from:	Chief Commissioning Officer
Date of Meeting:	1 st April 2026

ALERT

None to report.

ADVISE

1. Strategic Commissioning Development Programme

The Chief Commissioning Officer attended the first meeting of the Strategic Commissioning Development Programme national steering group. This programme, led by NHSE, has four key elements as follows:-

- **Commissioning Academy** – including an on-line knowledge hub, e-learning modules, value-based care guidance and training.
- **Commissioning Leadership and Professional Development** – including ICB Board development programme.
- **Commissioning Intelligence Centre** – to support ICB intelligence functions.
- **Commissioning in Practice** – Action Learning Programme – exploring learning sets around priority areas for ICB staff – eg health and growth, neighbourhood delivery, frailty.

The programme is being developed collaboratively with ICBs, with funding from NHSE and ICBs. This will be discussed further at the Board development session in April.

2. 'Every Child Achieving and Thriving'

As reported to the March meeting of the Transition Committee, 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.

Each local area is required to develop a Local SEND Reform Plan with most sections pertaining to the local area partnership as a whole, in particular, local authorities (LAs) and Integrated Care Boards (ICBs), multi-academy trusts (MATs) and schools.

The Government's expectation is that the local authority is the system 'convener'; taking the lead to bring together all system partners and ensure they work together to develop and deliver the Local SEND Reform Plan. Similarly, the Government has clear expectations on all system partners to proactively respond to the local authority's leadership, ensuring they commit resources and fulfil their responsibilities in the partnership.

In order that this is delivered within the ambitious timescales set by the Government, it has been clarified that the ICB leadership in each Locality will continue to support this process. All plans will be required to be signed off by NHSGM prior to submission to NHSEnw and the Department for Education.

Alongside this, there has been discussions regarding the potential for GM to be an early adopter of the Reforms. A collaborative workshop with colleagues from GMCA, Local Authorities, the Parent Carer Forum and NHSGM is being held on Friday 27th March 2026 to explore the opportunities and risks in this.

3..Reconfiguration of Arterial Vascular Surgery and Cardiac Surgery

As reported to the Transition Committee in March 2026, the North East Clinical Senate review took place on Tuesday 24th and Wednesday 25th March 2026. This is a critical step in assessing reconfiguration proposals, where independent clinical expertise is used to review the case for change and assess the options appraisal, thus providing the ICB with independent assurance.

Initial verbal feedback from the panel was very positive and constructive. The chair offered that the panel were particularly impressed with the level of collaboration across the system in developing the proposals, and their alignment with national guidance and best practice. The panel also offered areas for strengthening the documentation, including how descriptions of how local services would be bolstered and supported.

A formal written report will follow from the review team. This will be used to further develop the Pre-Consultation Business Case prior to submission to NHSE as part of the Stage 2 Assurance Process required for major service changes. This will then be followed by significant public and patient engagement prior to final decision making.

3. Commissioning Intentions 26/7

Work to confirm commissioning intentions for 26/7 is reaching conclusion. This has been in development since September 25, with commissioning leads and providers involved in this process. The direction and framework for decisions has been set out in the Five Year Commissioning Strategy, signed off by NHSGM Board in February 2026. The emphasis is on investments in prevention, primary, community and other services which offer more proactive approaches for people and reduce the growth in more expensive care.

ASSURE

1. Cancer Programme – Early Diagnosis

Positive results for early diagnosis (stage 1 and 2) for the period Nov 24 – Nov 25 as follows:-

- Maintained 60% + position and above the England average
- GM ranked **9th** out of the 20 cancer alliances (move up from 10th in the previous month).
- Highest of the 3 NW Cancer Alliances and the only one of the 3 which is above the national average
- Improvement since January 2019 is +2.3 percentage points above the England improvement level
- GM is 2nd of 20 Cancer Alliances in % improvement since January 2019 (2nd to South-East London)

Deliverable: 75% Long Term Plan Ambition

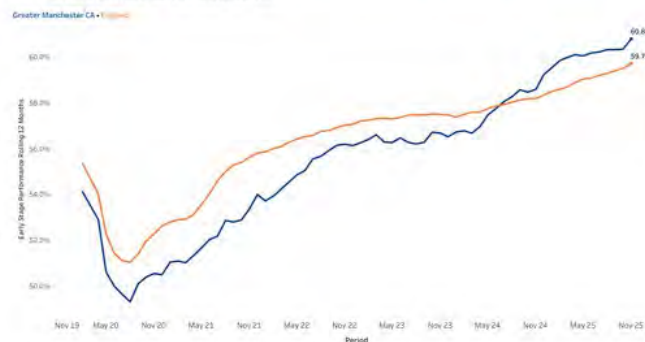
75% of cancers to be diagnosed at stage 1 or 2 by 2028

12 Month Rolling Performance Position

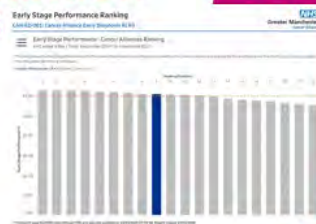
CAN-ED-001: Cancer Alliance Early Diagnosis RCRD



Greater Manchester Cancer Alliance - 12 Month Rolling Performance Position Comparison
All Cancer Sites | Date: May 2020 To November 2025



This report uses the RCRD Data through FAD and was last updated on 13/03/2026 07:04:08. Report viewed 13/03/2026



	Jan 2019 (12m rolling)	Oct 2025 (12m rolling)	Nov 2025 (12m rolling)	Change 019-25
England	55.4%	59.5%	59.7%	+4.3pp
GM	54.2%	60.3%	60.8%	+6.6pp

LEARNING FOR SHARING

A review of the work during 25/6 to manage activity levels more effectively in Independent Sector providers is underway and will inform future approaches.

Five Year Strategic Commissioning Plan: Reporting on Progress 2026-2027

Strategic Commissioning Committee

April 2026

Report information.

Required information.	Details.
Title of report.	Five Year Strategic Commissioning Plan: Reporting on Progress
Author.	Katherine Sheerin Chief Commissioning Officer
Presented by.	Paul Lynch Director of Strategy
Contact for further information.	Katherine.sheerin@nhs.net
Executive summary.	This report sets out a simple framework for how the Strategic Commissioning Committee receives assurance regarding progress being made towards delivery of the Strategic Commissioning Plan.
The benefits that the population of Greater Manchester will experience.	The Strategic Commissioning Plan sets out a number of important outcomes to be achieved through how commissioning resources are invested. These relate to population health outcomes, experience of care, effectiveness of services, efficiency of delivery.

<p>How health inequalities will be reduced in Greater Manchester’s communities.</p>	<p>A key high level outcome which all programmes in the Strategic Commissioning Plan will be required to support is:-</p> <p>To close the gap in Healthy Life Expectancy (HLE) between the most and least advantaged in GM in line with the 10 year ambition to at least halve that gap by 2035.</p>
<p>The decision to be made and/or input sought.</p>	<p>The Committee is asked to:</p> <ol style="list-style-type: none"> 1. Consider and confirm the proposal for how the Strategic Commissioning Committee receives assurance regarding progress being made towards delivery of the Strategic Commissioning Plan.
<p>How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.</p>	<p>The Strategic Commissioning Plan is integral to delivery of all BAF risks.</p>
<p>Key milestones.</p>	<p>June 2026</p> <p>Baseline outcome measures and targets to be confirmed.</p> <p>July 2026</p> <p>Final full Strategic Commissioning Plan to be signed off by NHSGM Board.</p> <p>June / July 2026</p> <p>Monitoring framework to commence.</p>
<p>Leadership and governance arrangements.</p>	<p>SRO – Chief Commissioning Officer</p> <p>Commissioning Leads – responsible for each programme</p>

<p>Engagement* to date.</p> <p>*Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.</p>	<p>The Strategic Commissioning Plan builds on Fit for the Future engagement work.</p>
<p>Financial or Legal Implications</p>	<p>The Strategic Commissioning Plan will drive the investment strategy for the ICB, ensuring that decisions are taken which improve outcomes and are evidence based.</p> <p>Any significant service changes arising from this will follow due process.</p> <p>Any procurement decisions will be subject to existing regulations.</p>

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	EHI A
No	No	No	No	No	No	No	No

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

1. INTRODUCTION AND PURPOSE OF THE PAPER

The purpose of this paper is to present a framework for how the Strategic Commissioning Committee receives assurance regarding progress being made towards delivery of the Strategic Commissioning Plan.

As set out in a previous paper to the Transition Committee (March 2026), the draft Strategic Commissioning Plan approved by the Board in February 2026 will be further developed in order to produce a fully detailed and operationally credible plan. That paper set out how this will be developed and the shape of the content to be included, for presentation to the Board in July 2026.

It is essential that we have robust governance to ensure that the ambitions and outcomes set out in this detailed plan are progressed and delivered. The framework proposed below will ensure that the Strategic Commissioning Committee can be assured of this work.

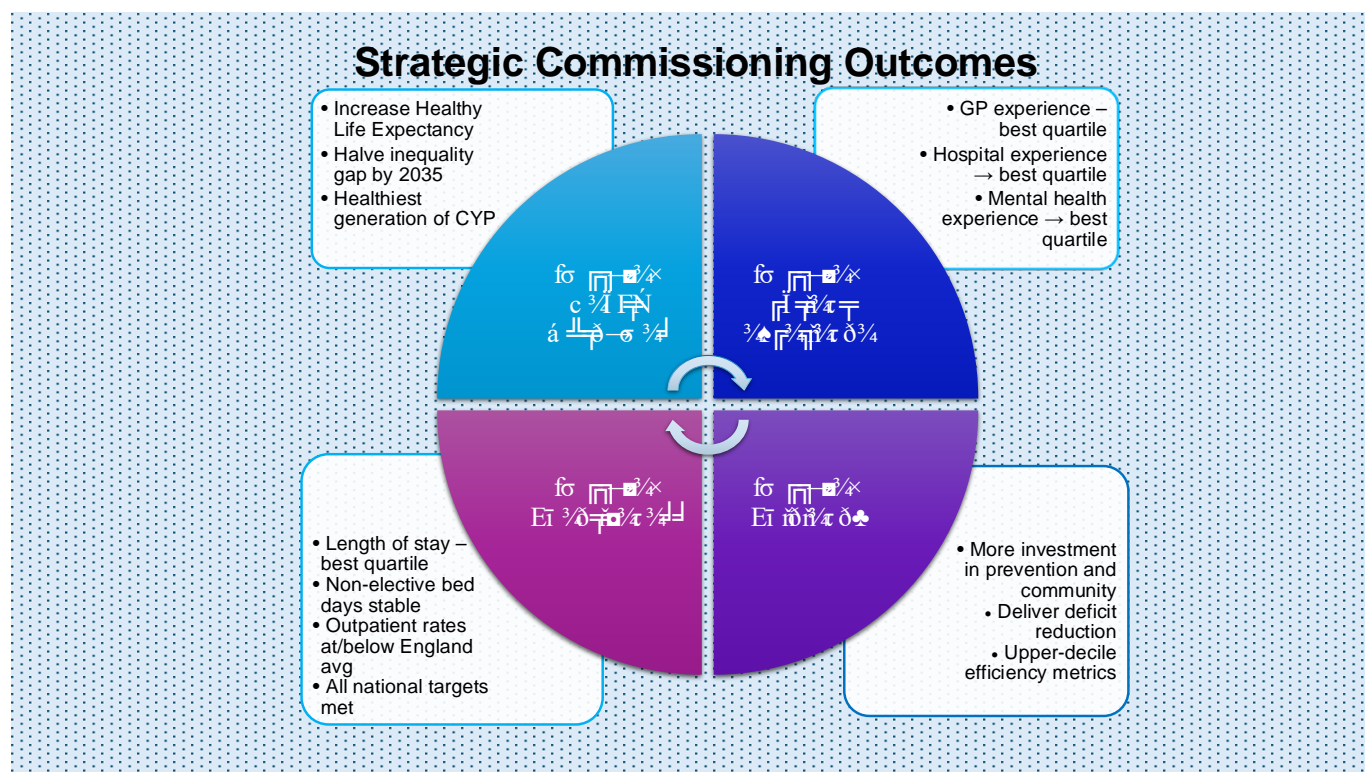
2. SUMMARY OF THE STRATEGIC COMMISSIONING PLAN AND WORK UNDERWAY

In essence, the Strategic Commissioning Plan comprises a series of outcomes to be achieved and a set of programmes which drive that.

The Plan on a Page (below) shows how the Strategic Commissioning Plan fits with key Greater Manchester Strategies and includes 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.

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) <i>Detailed Metric in Development</i>
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: <ul style="list-style-type: none"> • Live Well • The Neighbourhood Model • Primary Care Transformation (Delivering the Blueprint) 	Targeted Action on Population Health and Inequalities <ul style="list-style-type: none"> • Population Health Transformation Programmes • Improving Outcomes for Children and Young People • Mental Health and Learning Disability • Improving Cancer Outcomes
		System Transformation: <ul style="list-style-type: none"> • Secondary Care Transformation • Elective Care • Urgent and Emergency Care • Digital and Innovation • New Models of Commissioning and Provision

This is driven by the achievement of a series of outcomes, which are presented as follows:-



Delivery will be through the following programmes:-

Strategic Delivery Theme	Programme
Preventive and Proactive Care in Neighbourhoods	Live Well
	The Neighbourhood Model
	Primary Care Transformation – Delivering the Blue Print
	Community Services Transformation
Targeted Action on Population Health and Inequalities	Population Health Transformation Programmes
	Improved Outcomes for Children and Young People
	Mental Health, Learning Disability and Autism
	Improved Cancer Outcomes
System Transformation	Secondary Care Transformation
	Elective Care Reform
	Urgent and Emergency Care Reform
	Digital and Innovation
	New models of commissioning and Provision

As described in the paper to the Transition Committee in March 2026, each programme is developing a detailed plan which will set out:-

- 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

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

3. REPORTING PROGRESS TOWARDS DELIVERY

A critical first step is to confirm the baselines for each of the strategic outcome measures set out above, and to test the level of ambition. This is planned for the Board Strategic Development Session in April 2026 and will then be reported back through the Strategic Commissioning Committee.

Programme Plans for each area will then be firmed up during April – June in order that the in-depth document is presented to the Board in July.

It is proposed that each programme area reports to the Strategic Commissioning Committee on a bi-annual basis with a programme from each of the three delivery themes in most months. However, it is clear that some programmes are further advanced than others, and so it would be useful to commence progress reporting to the Strategic Commissioning Committee in advance of the strategy having full Board sign off.

As such, the proposed reporting framework for 26/7 is as follows:-

Month	Programme
June 2026	Live Well Population Health Transformation Programmes

	Elective Care Reform
July 2026	Primary Care Transformation – Delivering the Blueprint Improving Cancer Outcomes Urgent and Emergency Care Reform
Aug 2026	The Neighbourhood Model Mental Health, Learning Disabilities and Autism Digital and Innovation
Sep 2026	Community Services Transformation Improved Outcomes for Children and Young People
Oct 2026	Secondary Care Transformation New models of commissioning and provision
Nov 2026	Live Well Population Health Transformation Programmes Elective Care Reform
Dec 2026	Primary Care Transformation – Delivering the Blueprint Improving Cancer Outcomes Urgent and Emergency Care Reform
Jan 2026	The Neighbourhood Model Mental Health, Learning Disabilities and Autism Digital and Innovation
Feb 2026	Secondary Care Transformation New models of commissioning and provision
Mar 2026	Community Services Transformation Improved Outcomes for Children and Young People

A simple template will be devised to ensure a consistent approach is taken across programmes, built from the headings outlined in section 2 above.

4.0 RECOMMENDATIONS

The Committee is recommended to:-

- 1) Consider and confirm the proposal for how the Strategic Commissioning Committee receives assurance regarding progress being made towards delivery of the Strategic Commissioning Plan.

Katherine Sheerin

Chief Commissioning Officer

April 2026

Performance Report 2026-2027

Strategic Commissioning Committee

April 2026

Required information.	Details.
Title of report.	Performance Report
Author.	Zoe Mellon, Associate Director of Performance
Presented by.	Ed Dyson – Director of Performance, Improvement & Assurance
Contact for further information.	Zoe Mellon (zoe.mellon@nhs.net)
Executive summary.	This report provides an update on Greater Manchester’s (GM) progress in achieving NHS operational planning goals, outlines significant risks faced by our providers along with key improvement actions, and presents a summary of quarter 3 Locality Assurance Meetings (LAMs).
The benefits that the population of Greater Manchester will experience.	Achievement of performance objectives will improve access to services and drive up standards of care for the Greater Manchester population.
How health inequalities will be reduced in Greater Manchester’s communities.	Ensuring delivery of standards across Greater Manchester Trusts will equalise geographical variation.
The decision to be made and/or input sought.	This paper is for assurance and discussion allowing the committee to agree levels of assurance and identify any further actions.

How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.	This supports delivery of operational planning and constitutional standards.
Key milestones.	Monthly and quarterly milestones are in place.
Leadership and governance arrangements.	This paper is for Strategic Commissioning Committee only.
Engagement* to date. *Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.	Engagement is undertaken within various programmes contributing to performance delivery.
Financial or Legal Implications	

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

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

Strategic Commissioning Committee: Performance Report April 26

Introduction and Key Messages



Greater Manchester

1. Introduction

This report provides a high-level overview of current performance and an end-of-year forecast, aligned to the relevant NHS operational planning goals. The March 2026 Performance and Quality Board report is included as the supporting appendix, providing further detail.

2. Key Messages

- System performance at year-end remains challenged, with sustained pressure across Urgent and Emergency Care, Elective Recovery, Diagnostics and Mental Health, resulting in several standards not forecast to be met by March 2026.
- Urgent and Emergency Care presents the greatest delivery risk, with all providers behind plan. While in-month improvement has been observed, further gains are required to mitigate ongoing system pressure.
- Elective recovery continues to show improvement, supported by increased activity and focused operational grip. There is qualified confidence in delivery of the 18-week referral to treatment standard, although performance remains finely balanced at year-end. There is low assurance in relation to delivery of the 52-week waits standard, which remains high risk despite sustained recovery actions.
- Cancer performance presents a mixed position. There is confidence in delivery of the Faster Diagnosis Standard, reflecting improving pathway performance. Delivery of the 62-day referral-to-treatment standard remains challenging, and qualified confidence is provided
- Diagnostic 6-week waits remain above plan and continue to act as a key constraint on elective and cancer recovery, despite favourable national benchmarking.
- Average length of stay for mental health inpatients continues to be a challenge and is not forecast to meet the end-of-year plan, largely driven by a sustained cohort of patients clinically ready for discharge.
- The number of Learning Disability and Autism patients in a hospital is worse than plan in February, with Autism not forecast to meet the end-of-year reduction target, driven by ongoing challenges in Manchester.
- Assurance is maintained across Primary Care access, mental health CYP access, selected cancer standards and ambulance response times.

3. Recommendation

Committee is asked to agree the recommended status of partial assurance. Committee is also asked to agree levels of assurance and delivery risks.

Summary of delivery against key metrics

This section provides a high-level view of delivery against NHS operational planning priorities.

Summary of Key Metrics (ICB)



Greater Manchester

Area	KPI	Latest Published Performance				2025/26 End of year plan	Variance (latest published data vs same period in previous year)			ICB Benchmarking (latest published data vs same period in previous year)		
		ICB / GM Providers / NWAS	Period	Actual	Plan		Previous year	Variance	Movement	Previous year	Latest	Movement
Urgent and Emergency Care (UEC)	CAT 2 ambulance response times	NWAS	Feb-26	00:23:27	<00:30:00	<00:30:00	00:23:49	-00:00:22	↓			
	A&E % of patients managed within 4 hours	ICB	Feb-26	67.9%			66.8%	1.1%	↑	36/42	34/42	↑
	A&E (type 1) % waits over 12 hours		Feb-26	11.9%			11.7%	0.2%	↑	27/42	28/42	↓
Elective	% of incomplete RTT pathways of 52 weeks or more		Jan-26	1.9%	1.5%	0.9%	3.6%	-1.7%	↓	36/42	25/42	↑
	Number of incomplete RTT pathways of 52 weeks or more		Jan-26	7,922	5,739	3,425	15,831	-7,909	↓			
	% of incomplete RTT pathways of 18 weeks or less		Jan-26	58.5%	58.8%	60.8%	53.3%	5.2%	↑	36/42	32/42	↑
	% of pathways waiting no longer than 18 weeks for a first appointment		Feb-26	65.1%	67.0%	68.1%	56.8%	8.3%	↑			
	Total number of incomplete RTT pathways		Jan-26	413,376	385,765	377,212	442,050	-28,674	↓			
	Diagnosics		% waiting 6+ weeks	Jan-26	13.9%			17.9%	-4.0%	↓	16/42	4/42
Cancer	% of patients receiving communication of diagnosis within 28 days		Jan-26	77.2%	76.9%	80.2%	74.9%	2.3%	↑	19/42	11/42	↑
	% of patient with cancer receiving treatment within 62 days		Jan-26	73.1%	70.6%	75.3%	70.2%	2.9%	↑	13/42	10/42	↑
Mental Health	Access to CYP mental health services		Jan-26	55,540	55,000	55,000	55,395	145	↑	02/42	02/42	↔
	Average Length of Stay in Adult Acute, Older Adult Acute and Psychiatric Intensive Care beds		Jan-26	66	58.7	57	66	0	↔	32/42	35/42	↓
Learning Disabilities	Inpatient care for children and young people with a learning disability and/or autism		Feb-26	*	9	9						
	Inpatient care for Adults with Learning Disabilities (who may also be autistic)		Feb-26	**50	46	46						
	Inpatient care for Autistic Adults (with no learning disability)		Feb-26	**50	39	39						
Primary Care	Appointments in General Practice	Jan-26	1,492,379	1,449,590	1,449,589	1,517,955	-25,576	↓				
Prevention	% of patients with hypertension treated according to NICE guidance	Q3 25 / 26	69.3%				67.5%	1.8%	↑		14/42	
	% of patients with GP recorded CVD, who have their cholesterol levels manage to NICE guidelines	Q3 25 / 26	50.8%				48.6%	2.2%	↑		14/42	

* Numbers not specified due to the risk of data disclosure in a small data set, no published data source for this metric.

** This published data is rounded to the nearest 5. For Adults with Learning Disabilities, latest unvalidated Q4 data indicates performance is at plan.

RAG ratings based on variance to plan: Amber for a negative variance of up to 3%, and Red for any negative variance greater than 3%.

Summary of Key Metrics (GM Acute Providers)



Greater Manchester

Area	KPI	Latest Published Performance				2025/26 End of year plan	Variance		
		ICB / GM Providers / NWAS	Period	Actual	Plan		Previous year	Variance	Movement
Urgent and Emergency Care (UEC)	A&E % of patients managed within 4 hours	GM Providers	Feb-26	68.7%	74.1%	78.0%	67.8%	0.9%	↑
	A&E (type 1) % waits over 12 hours		Feb-26	12.1%	7.6%	7.5%	11.6%	0.5%	↑
	Ambulance average handover time		Feb-26	00:24:23	00:27:59	00:24:10	00:25:05	-00:00:42	↓
Elective	% of incomplete RTT pathways of 52 weeks or more		Jan-26	2.2%	1.6%	1.0%	3.9%	-1.7%	↓
	Number of incomplete RTT pathways of 52 weeks or more		Jan-26	9,736	6,907	4,123	18,991	-9,255	↓
	% of incomplete RTT pathways of 18 weeks or less		Jan-26	57.1%	59.0%	61.0%	52.4%	4.7%	↑
	% of pathways waiting no longer than 18 weeks for a first appointment		Feb-26	65.2%	67.1%	68.2%	56.9%	8.3%	↑
	Total number of incomplete RTT pathways		Jan-26	447,782	441,349	431,564	484,759	-36,977	↓
Diagnostics	% waiting 6+ weeks		Jan-26	14.7%	10.4%	5.4%	18.9%	-4.2%	↓
Cancer	% of patients receiving communication of diagnosis within 28 days		Jan-26	77.2%	76.9%	80.3%	75.0%	2.2%	↑
	% of patient with cancer receiving treatment within 62 days	Jan-26	72.4%	70.6%	75.3%	69.6%	2.8%	↑	

RAG ratings based on variance to plan: Amber for a negative variance of up to 3%, and Red for any negative variance greater than 3%.

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



Greater Manchester

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

Weekly Forecasts as of 23 March 2026

Elective

- Based on the latest forecasts (and using waiting list size forecasts from the weekly long wait return) collectively providers will achieve 60.89% for 18 weeks and 1.67% for 52 weeks. This is against an 18-week operational plan of 61% and a 52-week plan of 1%. All providers will refresh their forecasts Wednesday 25th of March.
- Achieving the 18-week target will be close, with growing confidence in delivery. However, low assurance against delivery of the 52-week standard.
- Both NCA and WWL not expected to meet their 52-week operational plan nor sprint plan.
- NCA and WWL are not expected to meet their 18-week operational plan. WWL forecasting to narrowly miss but additional work on validation could see WWL meet operational plan.
- WWL not expected to meet their 18-week sprint plan. Stockport forecasting to narrowly miss 18-week sprint plan.
- IS providers are undertaking additional activity but are primarily focussed on supporting NHS providers so impact largely included in NHS provider forecasts.
- Forecasting 15, 65+ breaches, of which 1 at Stockport and 14 at WWL.
- **Actions:** Additional Trust and IS activity via Q4 sprint. Focus on wait listing validation, with further validation capacity being put in place, following NHSE extension of the validation window to the 28th April. Weekly Elective Recovery Operational Group meet to review activity against plan. People at risk of 65 week wait breaches are being overseen by Trusts on a case-by-case basis.

Cancer

- Early March forecasts are increasingly positive and currently indicate delivery of the interim 2025/26 planning guidance targets for both FDS and 62-day performance, with 62-day performance projected at just over 75%. While this remains slightly below trajectory, it represents continued improvement.
- The cancer backlog waiting list continues to reduce, with the March forecast at 591 patients, the lowest level this year and down from a peak of 1,005 in September 2025. This is very close to the internal year-end target of 590 and represents significant system-wide progress.
- **Actions:** Continued operational grip through robust PTL management, clear escalation processes and strong system leadership, alongside maintaining the high performance already demonstrated across several providers. WWL is greatest risk to delivery

UEC

- As of the 21st March GM 4-hour MTD position is at 73% (unvalidated). Trust MTD positions range from 68.5% to 77.3%. Published figures typically improve by 1–1.5%.
- GM is off-trajectory to achieve March 78% 4-hour standard of care. It is now not possible for four out of the six Trusts to achieve 78%.
- Sustained high-acuity pressure remains the dominant constraint. Whilst most Trusts remain >95% (or close), confirming that lower-acuity pathways are not driving GM under-performance.
- Workforce fragility and operational sustainability risks persist. Mental health delays remain a major system-level constraint. Infection, Prevention & Control (IPC) and norovirus pressures continue.
- Discharge, Length of Stay and No Criteria To Reside (NCTR) discipline remain the biggest “back-door” levers.
- The system picture is consistent across all Trusts: flow-dependent, fragile, demand-sensitive and heavily reliant on short-term mitigations but with clear, high-impact opportunities still available.
- **Actions:** The quickest gains for March 26 sit overwhelmingly in non-admitted pathways, minors/UTC streaming, rapid senior decision-making and real-time 4-5h breach reviews.

Elective



Greater Manchester

End of March 2026 Forecasts
Based on SPRINT and Long Wait Return

	List Size		18 weeks			52 weeks			> 65 week forecast
	List size forecast	Operational plan	% 18 week forecast	Operational plan	Sprint plan	% 52 week forecast	Operational plan	Sprint plan	
BOLTON NHS FOUNDATION TRUST	38,461	36,124	61.50%	60.30%	61.50%	0.99%	1.00%	1.00%	0
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	165,051	175,291	62.00%	60.50%	61.95%	1.00%	1.00%	1.00%	0
NORTHERN CARE ALLIANCE NHS FOUNDATION TRUST	131,000	120,110	57.00%	60.00%	57.00%	2.90%	1.00%	1.91%	0
STOCKPORT	34,280	28,932	60.50%	60.00%	61.00%	1.00%	1.00%	1.00%	1
TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	16,348	17,210	76.70%	73.30%	76.65%	0.00%	0.00%	0.00%	0
THE CHRISTIE NHS FOUNDATION TRUST	3,000	2,573	96.70%	97.20%	96.00%	0.00%	0.00%	0.00%	0
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	44,802	51,324	59.80%	60.00%	61.20%	2.40%	1.00%	0.70%	14
GM PROVIDERS	432,942	431,564	60.89%	61.00%		1.67%	1.00%		0

18 weeks - Registered is usually approximatley 1.3% better than sum of GM providers

52 weeks - Registered is usually approximatley 0.3% better than sum of GM providers

List size based on weekly long wait return, with the exception of NCA who confirmed verbally they will achieve 131,000.

NCA forecast based on verbal confirmation on 12/03

Cancer

(last updated 16/03. Awaiting 23/03 update)



Greater Manchester

End of March_2026 Forecasts				
	FDS		62 days	
	Forecast	Operational plan	Forecast	Operational plan
BOLTON NHS FOUNDATION TRUST	81.18%	80.00%	75.00%	75.20%
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	83.80%	80.70%	75.05%	75.30%
NORTHERN CARE ALLIANCE NHS FOUNDATION TRUST	80.01%	80.00%	75.00%	75.00%
STOCKPORT	80.00%	80.00%	75.00%	75.00%
TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	81.54%	80.10%	76.32%	76.30%
THE CHRISTIE NHS FOUNDATION TRUST	91.30%	80.00%	80.25%	75.20%
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	84.36%	80.20%	65.69%	75.90%
GM PROVIDERS	82.06%	80.30%	75.08%	75.30%

Urgent Care

Greater Manchester A&E Performance Summary



Greater Manchester

[Click here to view](#)

Month to Date Summary for March

Organisation	Latest Day	Is Plan Achievable	Planned Performance	Actual Attendances	Actual Breaches	Actual Performance	Excess Breaches	Forecast Attendances	Max Breaches to Achieve Plan	Performance To Achieve Plan
Bolton	21/03/2026	No	78.00%	6,173	2,702	66.94%	904	3,896	-45	101.15%
Manchester University	21/03/2026	Yes	78.08%	31,159	7,492	75.96%	662	15,130	2,654	82.46%
Northern Care Alliance	21/03/2026	No	78.00%	23,558	6,516	72.34%	1,333	11,486	1,153	89.61%
Stockport	21/03/2026	No	78.00%	7,453	2,330	68.74%	690	3,557	92	97.41%
Tameside And Glossop Integrated Care	21/03/2026	No	78.00%	7,958	2,503	68.65%	752	3,909	108	97.24%
Wrightington, Wigan And Leigh Teaching Hospitals	21/03/2026	Yes	78.00%	8,645	1,964	77.28%	63	4,273	876	79.50%
Greater Manchester	21/03/2026	No	78.03%	86,945	23,507	72.96%	4,406	42,253	4,876	88.46%

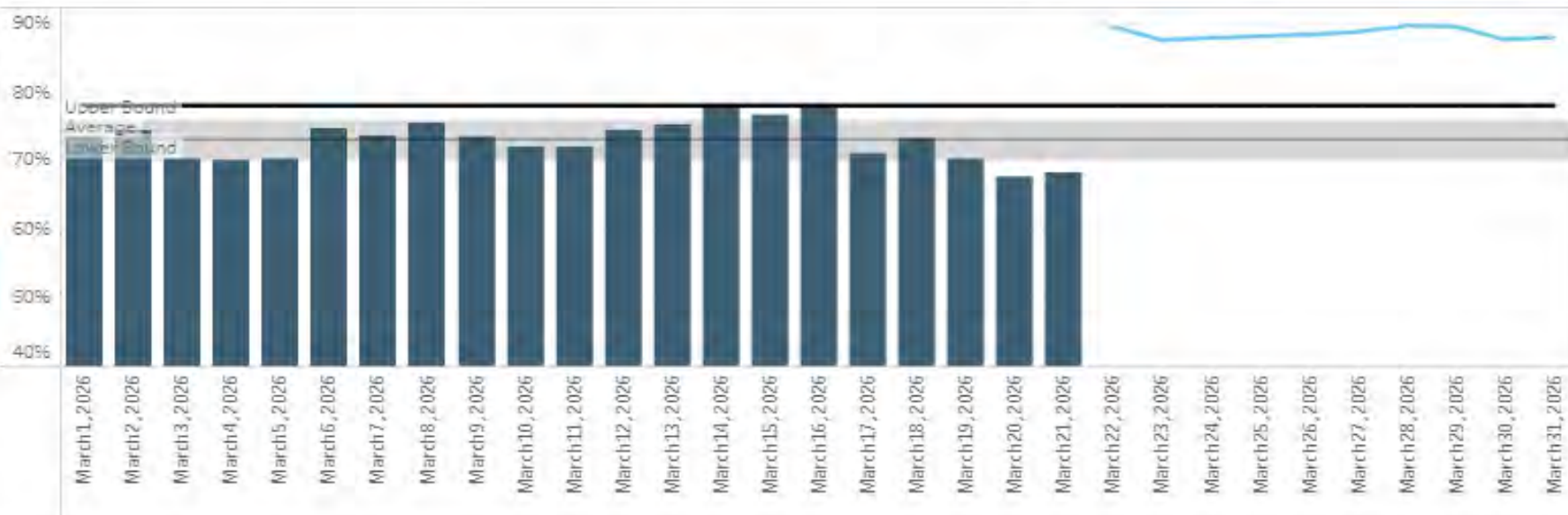
Select Organisation

Greater Manchester

- Actual Performance
- Performance To Achieve Plan
- Planned Performance

Summary for April Plan

Organisation	Planned Performance	Forecast Attendances	Forecast Breaches
Bolton		11,489	
Manchester University		44,782	
Northern Care Alliance		33,880	
Stockport		10,365	
Tameside And Glossop Integrated		11,369	
Wrightington, Wigan And Leigh T.		12,356	
Greater Manchester		124,241	

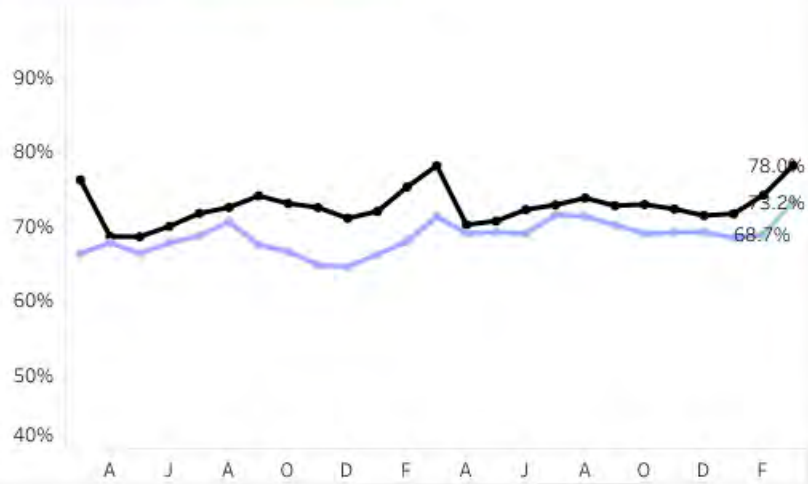


Operational Delivery Graphs: Key Metrics

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

2024/25/26 Performance

GM Acute Providers | Unvalidated to Month | Plan |



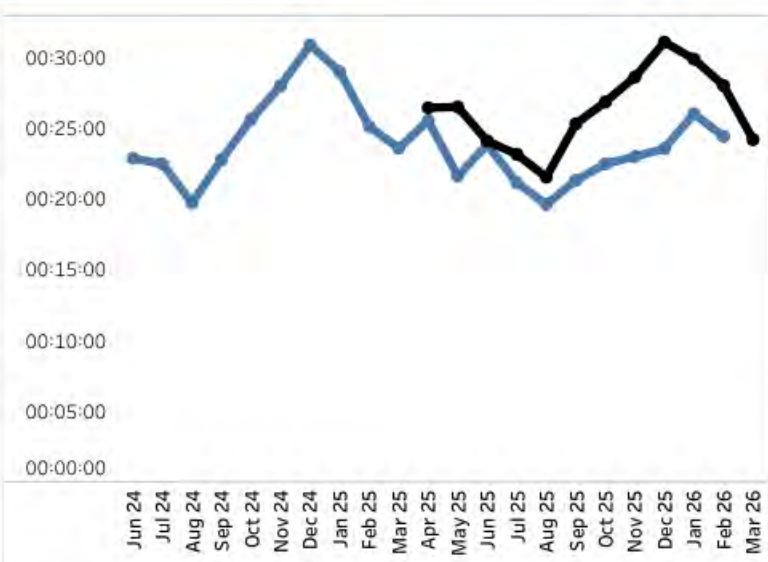
Regional Benchmarking

	Nov 25	Dec 25	Jan 26	Feb 26
Greater Manchester	69.1%	69.1%	68.3%	68.7%
North West	71.7%	71.3%	70.8%	71.1%
England	74.0%	73.7%	72.3%	73.9%

A&E 4-hour wait performance in February was 68.7%. March (1st–16th) shows an improvement to 73.2%. In February, NHS Greater Manchester Integrated Care Board (GM ICB) ranked 34th out of 42 nationally. The objective is to achieve 78% by March 2026.

		Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	16 Mar
Bolton FT	Actual	66.0%	63.7%	71.8%	66.3%	70.3%	64.9%	64.8%	64.6%	65.7%	62.1%	61.0%	60.2%	62.2%	63.8%	66.0%
	Plan	75.0%	77.0%	78.0%	72.0%	72.0%	75.0%	75.0%	76.0%	75.0%	74.0%	74.0%	73.0%	75.0%	77.0%	78.0%
MFT	Actual	67.3%	69.5%	73.9%	70.5%	71.4%	71.3%	74.3%	72.2%	70.6%	71.7%	72.4%	73.3%	71.6%	72.7%	76.1%
	Plan	70.2%	74.8%	78.0%	72.0%	72.2%	73.9%	74.6%	75.1%	72.6%	73.0%	71.2%	70.1%	70.1%	73.2%	78.1%
NCA	Actual	66.1%	67.0%	68.8%	67.9%	68.1%	68.1%	72.0%	72.2%	71.4%	69.4%	68.3%	69.1%	70.3%	69.0%	74.1%
	Plan	73.6%	76.5%	78.0%	68.2%	69.5%	70.9%	72.3%	73.7%	74.7%	75.3%	75.8%	76.1%	76.6%	76.0%	78.0%
Stockport FT	Actual	60.6%	69.5%	69.0%	68.3%	65.4%	74.0%	68.0%	69.4%	68.1%	67.1%	69.5%	69.0%	66.3%	69.2%	69.5%
	Plan	68.1%	72.7%	78.0%	66.1%	64.8%	68.5%	64.9%	68.3%	62.9%	64.9%	65.6%	65.9%	63.5%	67.0%	78.0%
T&G ICO FT	Actual	66.8%	67.1%	68.9%	66.2%	61.6%	58.8%	63.6%	66.0%	65.1%	61.0%	64.7%	64.4%	60.3%	61.0%	69.8%
	Plan	67.5%	71.0%	78.0%	69.2%	69.5%	69.3%	71.4%	71.0%	70.6%	68.2%	67.5%	65.6%	65.3%	71.0%	78.0%
WWL FT	Actual	65.3%	67.8%	71.7%	71.4%	72.2%	71.6%	75.6%	77.0%	74.6%	72.5%	70.8%	66.8%	65.7%	65.0%	
	Plan	76.8%	77.1%	78.0%	70.6%	71.4%	72.0%	72.6%	73.3%	74.0%	74.7%	74.0%	71.1%	72.3%	77.4%	78.0%
GM Acute Providers	Actual	66.1%	67.8%	71.2%	68.9%	69.1%	68.9%	71.4%	71.2%	70.1%	68.9%	69.1%	69.1%	68.3%	68.7%	73.2%
	Plan	71.9%	75.2%	78.0%	70.1%	70.6%	72.1%	72.7%	73.7%	72.6%	72.8%	72.2%	71.3%	71.6%	74.1%	78.0%
GM Registered	Actual	65.2%	66.8%	70.2%	67.9%	68.3%	68.0%	70.2%	70.0%	68.9%	67.8%	68.2%	68.1%	67.5%	67.9%	72.8%
	Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Average Hospital Handover Time



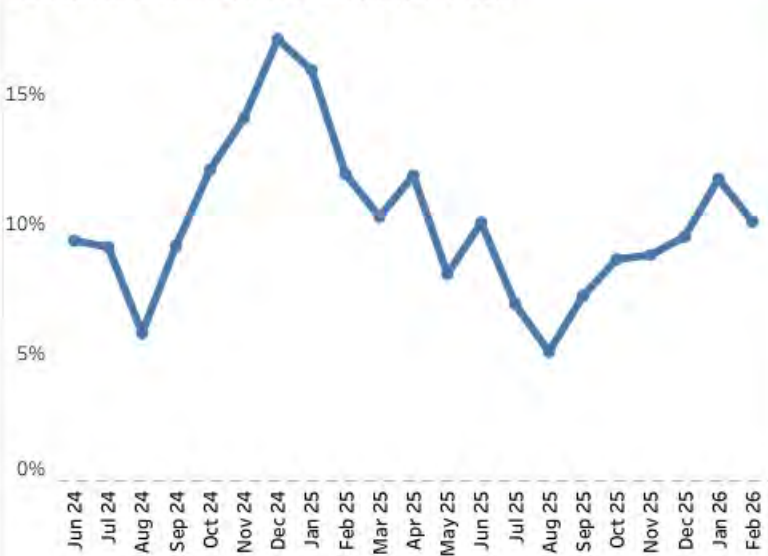
In February, the average ambulance handover time was 24 minutes and 23 seconds. The target has been achieved throughout 2025/26 so far.

The combined provider target for March 2026 is 24 minutes and 10 seconds.

		Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26
Bolton FT	Actual	00:28:02	00:16:49	00:23:37	00:16:22	00:17:58	00:17:59	00:19:00	00:17:56	00:24:34	00:26:55	00:26:14	00:24:33	00:28:43
	Plan	N/A	N/A	00:27:28	00:27:15	00:21:07	00:18:50	00:16:55	00:23:23	00:33:31	00:28:18	00:27:44	00:21:05	00:38:58
MFT	Actual	00:18:26	00:17:48	00:18:12	00:18:10	00:18:25	00:17:02	00:17:31	00:17:46	00:17:53	00:18:01	00:18:09	00:18:04	00:17:55
	Plan	N/A	N/A	00:22:03	00:22:01	00:19:10	00:16:17	00:15:15	00:18:18	00:18:53	00:22:03	00:24:55	00:24:21	00:22:03
NCA	Actual	00:27:21	00:27:12	00:28:47	00:23:17	00:30:55	00:22:38	00:19:58	00:24:13	00:24:24	00:24:23	00:24:59	00:31:42	00:27:32
	Plan	N/A	N/A	00:32:00	00:31:00	00:31:00	00:30:00	00:30:00	00:30:00	00:30:00	00:30:00	00:32:00	00:33:00	00:30:00
Stockport FT	Actual	00:26:39	00:30:02	00:27:43	00:26:11	00:21:30	00:24:01	00:23:26	00:26:21	00:27:13	00:25:16	00:26:17	00:29:09	00:26:23
	Plan	N/A	N/A	00:19:04	00:26:55	00:23:11	00:27:47	00:22:52	00:29:00	00:32:25	00:31:41	00:39:19	00:34:40	00:27:13
T&G ICO FT	Actual	00:19:55	00:17:00	00:18:07	00:20:09	00:21:11	00:18:07	00:18:08	00:18:23	00:20:07	00:19:34	00:20:54	00:24:35	00:21:06
	Plan	N/A	N/A	00:18:10	00:19:21	00:22:08	00:23:33	00:18:51	00:20:30	00:21:50	00:22:18	00:28:13	00:25:05	00:22:25
WWL FT	Actual	00:38:43	00:36:42	00:45:00	00:29:36	00:30:40	00:33:16	00:22:52	00:24:42	00:25:10	00:30:09	00:31:28	00:34:07	00:32:10
	Plan	N/A	N/A	00:38:00	00:33:00	00:25:00	00:23:00	00:22:00	00:35:59	00:35:00	00:49:00	00:46:00	00:47:00	00:35:00
GM Acute Providers	Actual	00:25:05	00:23:34	00:25:30	00:21:35	00:23:48	00:21:07	00:19:35	00:21:17	00:22:27	00:22:58	00:23:31	00:26:00	00:24:23
	Plan	N/A	N/A	00:26:24	00:26:28	00:24:04	00:23:07	00:21:31	00:25:17	00:26:49	00:28:35	00:31:03	00:29:51	00:27:59

% & Count Recorded Handover over 45 Minutes

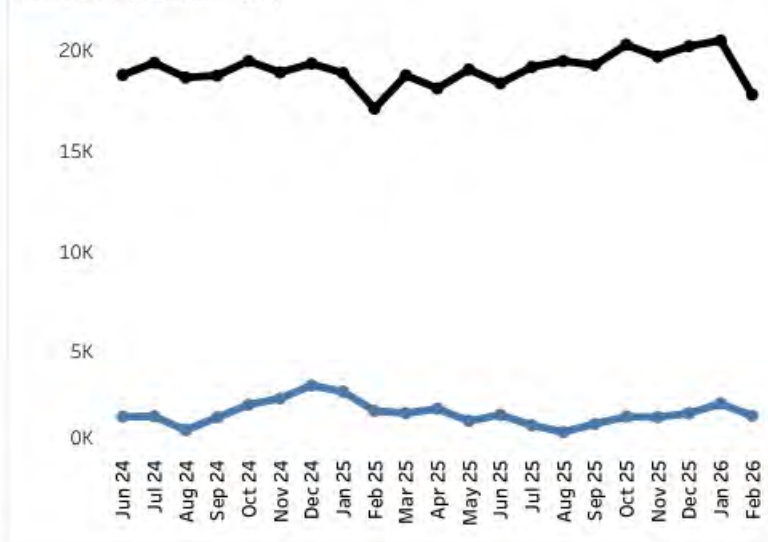
% Recorded Handover over 45 Minutes (0% Target)



	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26
Bolton FT	15.6%	4.3%	11.7%	4.5%	5.4%	5.8%	6.5%	5.0%	14.9%	15.9%	15.2%	13.6%	17.0%
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
MFT	4.9%	4.6%	4.6%	3.8%	4.7%	2.6%	2.9%	3.3%	3.5%	3.4%	3.5%	3.1%	3.1%
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
NCA	14.3%	13.6%	14.3%	9.6%	16.8%	8.0%	5.3%	10.7%	10.3%	10.0%	10.4%	16.5%	12.3%
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Stockport FT	11.2%	14.8%	11.9%	11.4%	4.8%	7.2%	5.2%	9.1%	10.6%	7.0%	7.6%	11.1%	10.1%
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
T&G ICO FT	4.1%	1.3%	2.3%	5.9%	5.8%	1.8%	2.1%	2.3%	4.2%	3.1%	4.6%	9.2%	4.9%
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
WWL FT	29.9%	27.8%	35.9%	18.7%	19.4%	22.5%	9.7%	12.5%	12.9%	19.1%	22.8%	25.2%	23.3%
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
GM Acute Providers	11.9%	10.2%	11.8%	8.0%	10.0%	6.9%	5.0%	7.2%	8.6%	8.8%	9.5%	11.7%	10.1%
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Number of handovers over 45 minutes

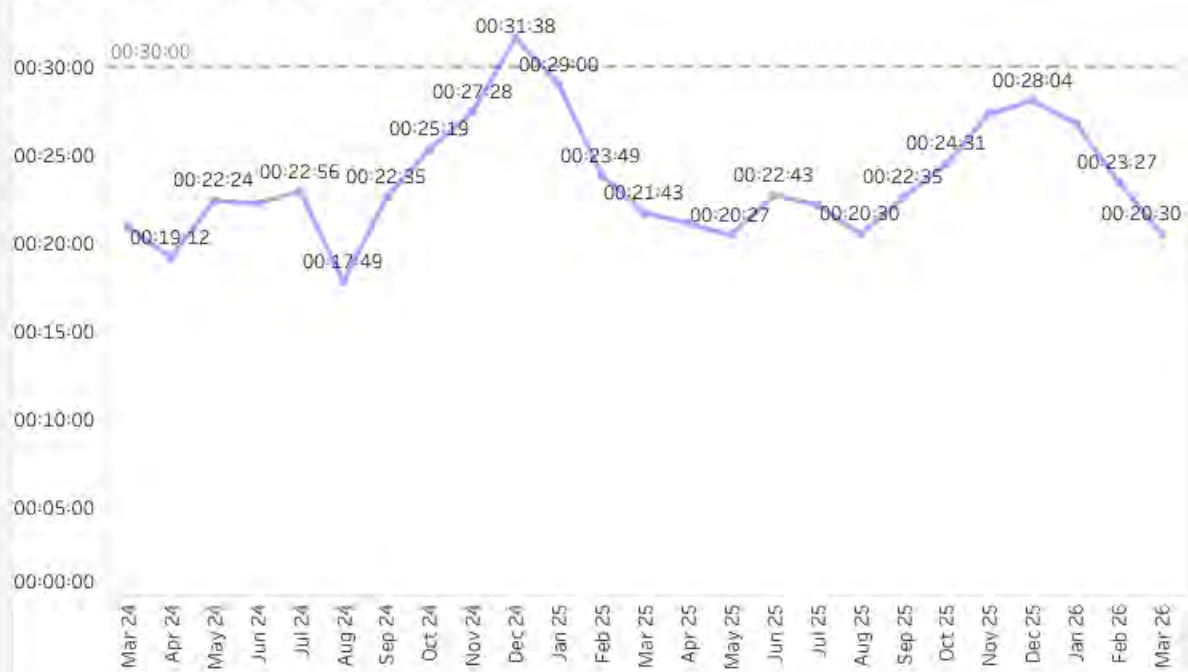
Numerator | Denominator |



	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26
Bolton FT	292	90	236	91	109	119	128	103	335	338	337	289	304
	1,871	2,096	2,019	2,026	2,005	2,064	1,956	2,067	2,242	2,128	2,218	2,122	1,785
MFT	268	276	269	235	280	162	187	205	223	220	226	207	186
	5,441	6,059	5,859	6,143	5,932	6,261	6,368	6,220	6,456	6,466	6,408	6,724	5,964
NCA	726	733	749	530	906	442	307	605	604	564	608	954	622
	5,063	5,379	5,238	5,531	5,384	5,524	5,752	5,662	5,888	5,651	5,829	5,773	5,062
Stockport FT	169	254	179	192	77	126	90	152	193	117	139	204	157
	1,514	1,719	1,507	1,681	1,593	1,757	1,719	1,679	1,822	1,673	1,819	1,841	1,553
T&G ICO FT	62	21	37	103	93	31	36	38	71	50	78	163	75
	1,504	1,577	1,608	1,754	1,601	1,705	1,678	1,648	1,692	1,613	1,706	1,777	1,546
WWL FT	477	504	637	333	336	389	183	234	259	389	474	525	411
	1,598	1,816	1,776	1,778	1,735	1,727	1,880	1,868	2,013	2,037	2,078	2,083	1,767
GM Acute Providers	2,029	1,918	2,140	1,529	1,835	1,317	979	1,382	1,742	1,724	1,912	2,394	1,788
	17,088	18,741	18,097	19,033	18,343	19,157	19,458	19,254	20,264	19,677	20,196	20,471	17,788

Cat 2 Ambulance Response Times

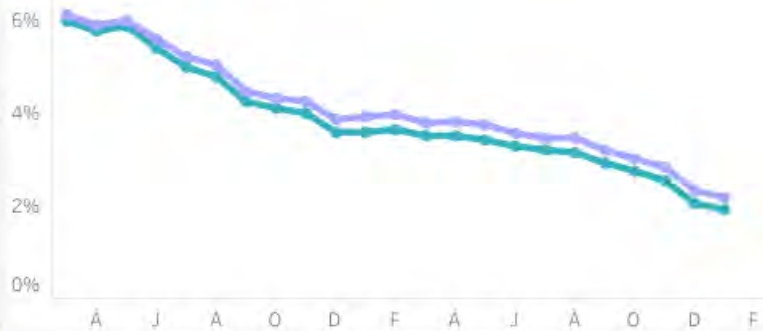
NWAS Response Times: Cat 2 - Emergency (Mean)



In February Category 2 ambulance response times were on average 23 minutes and 27 seconds across GM. March in month (1st – 16th) performance has improved to 20 minutes and 30 seconds. Performance YTD in 25/26 remains well within the 30-minute threshold.

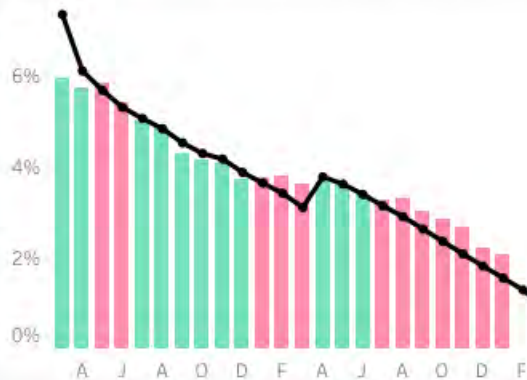
% of RTT waits over 52 weeks for incomplete pathways

GM Acute Providers | GM Registered |



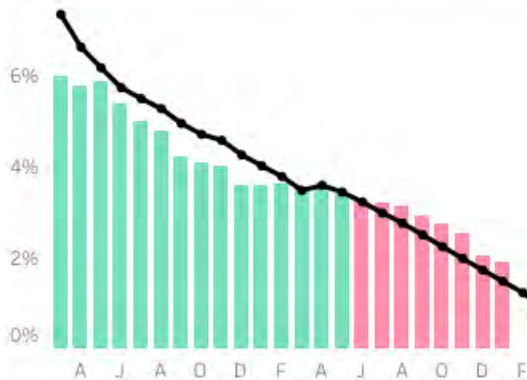
GM Acute Providers

2.2%
▼ -0.15%
Previous 2.3%



GM Registered

1.9%
▼ -0.13%
Previous 2.05%



Data in the purple box is weekly and unvalidated

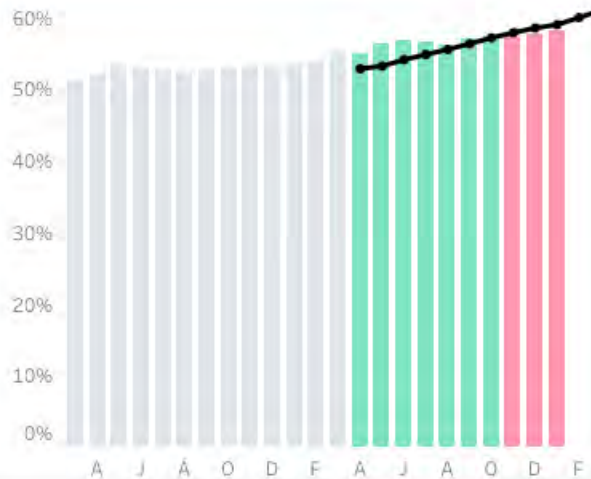
		Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	22 Feb	08 Mar
Bolton FT	Actual	3.5%	3.3%	3.1%	3.3%	3.5%	3.1%	3.3%	3.1%	2.9%	2.8%	2.9%	2.4%	1.8%	2.0%	1.7%
	Plan	5.7%	5.5%	5.4%	3.3%	3.1%	2.9%	2.7%	2.5%	2.3%	2.1%	1.9%	1.7%	1.5%	1.3%	1.0%
MFT	Actual	4.5%	4.6%	4.4%	4.4%	4.3%	4.0%	3.8%	3.8%	3.5%	3.3%	3.0%	2.0%	1.8%	1.8%	1.6%
	Plan	3.9%	3.6%	3.2%	4.3%	4.1%	3.9%	3.6%	3.3%	3.0%	2.7%	2.3%	2.0%	1.7%	1.4%	1.0%
NCA	Actual	3.4%	3.6%	3.5%	3.6%	3.7%	3.7%	3.7%	3.7%	3.4%	3.2%	3.1%	3.1%	3.3%	3.7%	3.6%
	Plan	4.5%	4.3%	4.1%	3.5%	3.4%	3.2%	3.0%	2.8%	2.6%	2.3%	2.1%	1.8%	1.6%	1.3%	1.0%
Stockport FT	Actual	4.7%	4.6%	4.6%	4.1%	3.5%	2.9%	2.7%	2.4%	2.1%	2.1%	2.0%	1.7%	1.3%	1.3%	1.1%
	Plan	4.3%	3.9%	3.1%	4.6%	4.5%	4.1%	3.7%	3.5%	3.1%	2.7%	2.4%	2.2%	2.0%	1.8%	1.0%
T&G ICO FT	Actual	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Plan	0.3%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
WWL FT	Actual	4.3%	4.2%	3.8%	3.9%	3.7%	3.7%	3.7%	3.8%	3.6%	3.5%	3.1%	2.8%	2.4%	2.4%	2.3%
	Plan	0.4%	0.2%	0.0%	3.9%	3.6%	3.4%	3.1%	2.8%	2.5%	2.3%	2.0%	1.7%	1.5%	1.2%	1.0%
Christie	Actual	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.1%	0.1%	0.0%	0.1%	0.0%	0.0%	0.1%	0.0%	0.0%
	Plan	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
GM Acute Providers	Actual	3.9%	4.0%	3.8%	3.8%	3.7%	3.6%	3.5%	3.5%	3.2%	3.0%	2.8%	2.3%	2.2%	2.3%	2.2%
	Plan	3.7%	3.4%	3.1%	3.8%	3.6%	3.4%	3.1%	2.9%	2.6%	2.4%	2.1%	1.8%	1.6%	1.3%	1.0%
GM Registered	Actual	3.6%	3.6%	3.5%	3.5%	3.4%	3.3%	3.2%	3.1%	2.9%	2.7%	2.5%	2.0%	1.9%		
	Plan	4.0%	3.8%	3.5%	3.6%	3.4%	3.2%	3.0%	2.8%	2.5%	2.2%	2.0%	1.7%	1.5%		

In line with the 2025/26 national planning guidance, a key priority is to reduce the proportion of patients waiting over 52 weeks for treatment. GM has set a target of no more than 1% by March 2026. As of January, 2.2% of pathways were breaching the 52-week threshold, exceeding the end-of-month target of 1.6%.

Elective – RTT Incomplete: % within 18 weeks

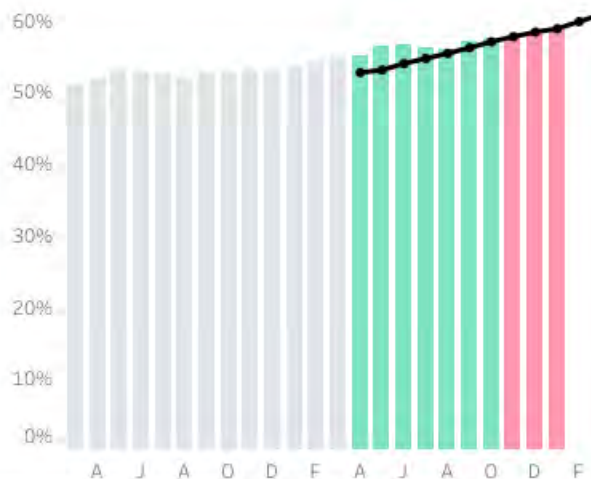
GM Acute Providers

57.1%
▲ 0.63%
Previous 56.5%



GM Registered

58.5%
▲ 0.7%
Previous 57.8%

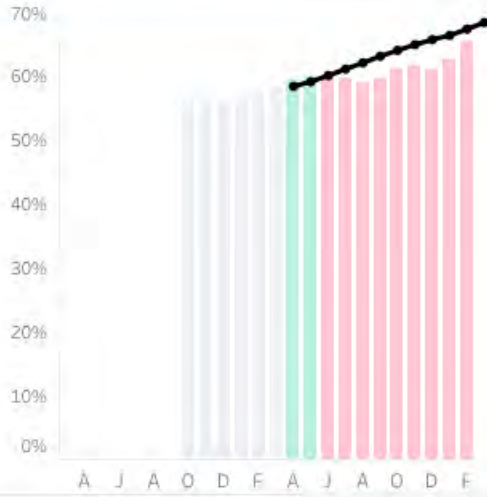


		Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26
Bolton FT	Actual	54.5%	54.8%	55.4%	54.9%	55.8%	56.9%	57.2%	58.0%	59.1%	59.1%	58.6%	57.4%	57.5%	
	Plan	N/A	N/A	N/A	55.8%	56.2%	56.7%	57.0%	57.5%	57.9%	58.4%	58.7%	59.2%	59.5%	60.0%
MFT	Actual	49.6%	50.4%	51.4%	51.0%	52.4%	53.2%	53.3%	52.7%	53.8%	53.8%	54.1%	56.1%	57.6%	
	Plan	N/A	N/A	N/A	50.3%	50.7%	51.7%	52.7%	53.7%	54.7%	55.6%	56.6%	57.6%	58.6%	59.5%
NCA	Actual	51.8%	52.0%	52.6%	52.4%	54.0%	53.7%	53.6%	52.7%	53.6%	54.2%	53.7%	52.9%	52.4%	
	Plan	N/A	N/A	N/A	52.6%	52.7%	53.3%	54.0%	54.7%	55.3%	56.0%	56.7%	57.3%	57.3%	58.7%
Stockport FT	Actual	54.1%	54.3%	55.2%	55.2%	56.6%	57.1%	56.8%	56.0%	57.0%	57.8%	57.1%	58.4%	59.6%	
	Plan	N/A	N/A	N/A	54.2%	54.4%	56.1%	56.3%	55.9%	56.9%	58.5%	58.8%	58.2%	57.9%	58.9%
T&G ICO FT	Actual	69.5%	71.1%	70.3%	70.8%	71.8%	72.2%	71.6%	70.4%	72.7%	73.7%	73.6%	72.8%	73.3%	
	Plan	N/A	N/A	N/A	68.5%	69.0%	70.1%	70.6%	71.5%	72.0%	72.4%	72.5%	71.6%	71.4%	72.5%
WWL FT	Actual	53.6%	54.6%	56.0%	56.6%	58.2%	57.9%	56.5%	56.5%	57.4%	57.7%	58.4%	57.5%	58.0%	
	Plan	N/A	N/A	N/A	53.0%	53.6%	54.2%	54.9%	55.5%	56.2%	56.8%	57.4%	58.1%	58.7%	59.4%
Christie	Actual	97.0%	96.3%	95.1%	94.6%	94.6%	94.2%	93.6%	94.3%	95.7%	97.1%	97.1%	97.1%	97.5%	
	Plan	N/A	N/A	N/A	97.2%	97.2%	97.2%	97.2%	97.2%	97.2%	97.2%	97.2%	97.2%	97.2%	97.2%
GM Acute Providers	Actual	52.4%	53.0%	53.8%	53.6%	55.0%	55.4%	55.2%	54.7%	55.7%	56.1%	56.1%	56.5%	57.1%	
	Plan	N/A	N/A	N/A	52.9%	53.2%	54.1%	54.8%	55.6%	56.3%	57.2%	57.9%	58.5%	59.0%	60.0%
GM Registered	Actual	53.3%	54.0%	55.0%	54.9%	56.3%	56.6%	56.2%	55.8%	57.0%	57.5%	57.4%	57.8%	58.5%	
	Plan	N/A	N/A	N/A	52.7%	53.0%	53.9%	54.6%	55.4%	56.1%	57.0%	57.7%	58.3%	58.8%	59.8%

Within the 25/26 national planning guidance, one of the priorities is to reduce the proportion of people waiting over 18 weeks for treatment. In January 57.1% of pathways were seen within 18 weeks. The GM plan is to deliver 61% within 18 weeks by March 2026 across all GM providers.

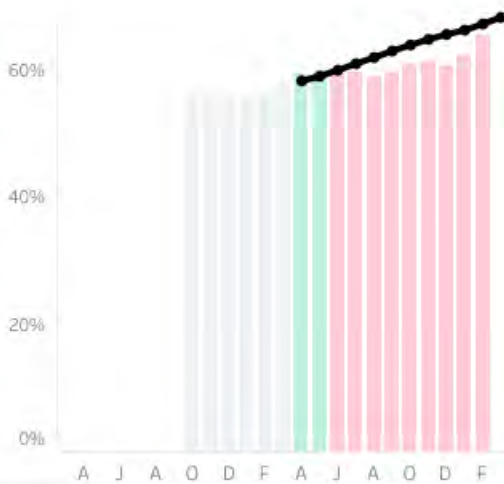
Elective – RTT Incomplete: % first appointment within 18 weeks

GM Acute Providers



65.2%
▲ 2.9%
Previous 62.4%

GM Registered



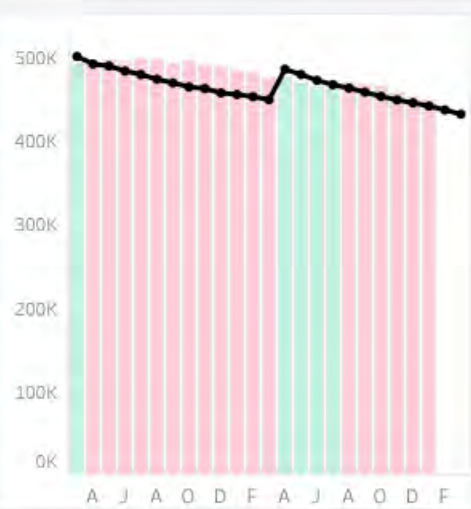
65.1%
▲ 3.0%
Previous 62.1%

		Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26
Bolton FT	Actual	60.9%	61.1%	61.8%	63.0%	64.0%	65.9%	66.2%	66.8%	67.6%	67.7%	64.9%	64.9%	69.8%	
	Plan	N/A	N/A	61.9%	62.6%	62.9%	63.6%	63.8%	64.5%	64.7%	65.4%	65.6%	66.2%	66.5%	67.1%
MFT	Actual	52.1%	53.8%	55.2%	55.6%	56.0%	56.3%	55.8%	56.3%	57.1%	57.9%	58.4%	61.7%	64.9%	
	Plan	N/A	N/A	53.6%	54.8%	56.1%	57.3%	58.5%	59.7%	60.9%	62.1%	63.3%	64.6%	65.8%	67.0%
NCA	Actual	56.0%	57.5%	58.1%	58.8%	57.1%	56.8%	55.4%	56.7%	58.9%	59.2%	56.8%	56.2%	58.7%	
	Plan	N/A	N/A	57.5%	57.2%	58.4%	59.7%	60.9%	62.1%	63.3%	64.1%	64.8%	64.8%	65.9%	67.0%
Stockport FT	Actual	61.7%	61.5%	63.5%	64.7%	64.5%	64.7%	63.1%	62.1%	64.9%	64.4%	65.3%	66.2%	68.1%	
	Plan	N/A	N/A	62.5%	63.0%	63.5%	64.0%	64.4%	64.9%	65.4%	65.8%	66.0%	66.2%	66.5%	67.0%
T&G ICO FT	Actual	82.8%	81.1%	81.6%	80.7%	80.1%	78.8%	77.9%	79.4%	82.3%	82.6%	81.0%	83.4%	86.4%	
	Plan	N/A	N/A	81.2%	82.2%	81.6%	81.8%	82.5%	82.6%	81.5%	81.5%	80.4%	80.3%	81.7%	83.4%
WWL FT	Actual	60.0%	61.9%	63.6%	64.4%	63.0%	61.7%	61.7%	61.7%	62.4%	64.1%	62.1%	64.6%	66.6%	
	Plan	N/A	N/A	60.2%	60.8%	61.5%	62.1%	62.7%	63.3%	63.9%	64.6%	65.2%	65.8%	66.4%	67.0%
Christie	Actual	99.5%	99.5%	99.1%	99.0%	99.4%	99.2%	99.1%	99.2%	99.3%	99.3%	99.2%	99.6%	99.6%	
	Plan	N/A	N/A	99.7%	99.7%	99.7%	99.7%	99.7%	99.7%	99.7%	99.7%	99.7%	99.7%	99.7%	99.7%
GM Acute Providers	Actual	56.9%	58.1%	59.3%	59.8%	59.4%	59.5%	58.8%	59.4%	60.9%	61.5%	60.7%	62.4%	65.2%	
	Plan	N/A	N/A	58.2%	59.0%	59.9%	60.9%	61.9%	62.9%	63.8%	64.7%	65.5%	66.2%	67.1%	68.2%
GM Registered	Actual	56.8%	58.0%	59.2%	59.7%	59.2%	59.4%	58.7%	59.4%	60.7%	61.3%	60.4%	62.1%	65.1%	
	Plan	N/A	N/A	58.1%	58.8%	59.8%	60.8%	61.8%	62.8%	63.7%	64.6%	65.4%	66.1%	67.0%	68.1%

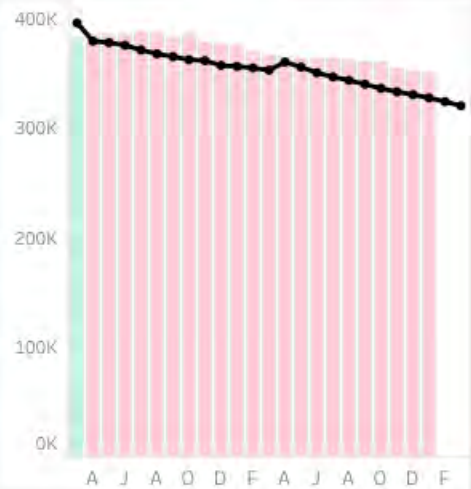
Within the 25/26 national planning guidance, one of the priorities is to reduce the proportion of people waiting over 18 weeks for their first appointment. In February 65.2% of pathways were seen within 18 weeks. The 25/26 aim is to reduce the time people wait for elective care, improving the percentage of patients waiting no longer than 18 weeks for their first appointment. The GM plan is to deliver 68% within 18 weeks by March 2026 across all GM providers.

Elective – Total Referral to Treatment pathways

GM Acute Providers



GM Registered

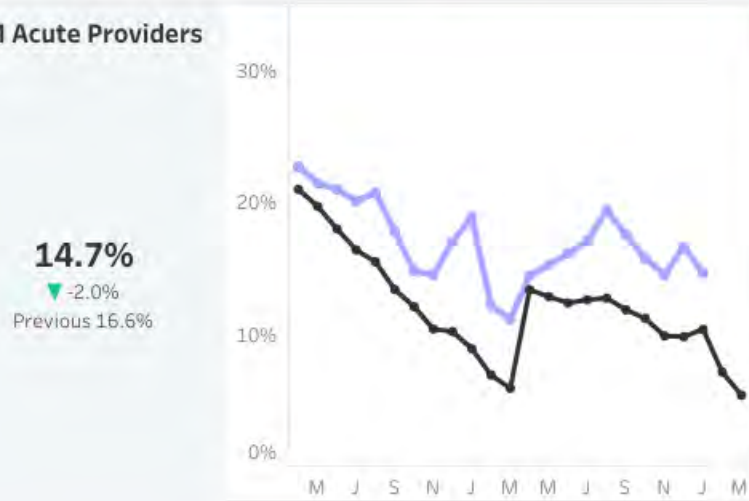


		Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26
Bolton FT	Actual	40,391	39,987	39,518	38,173	37,308	37,252	37,565	37,521	37,555	37,366	37,478	37,532	38,836	
	Plan	44,955	45,078	45,201	39,439	39,126	38,813	38,500	38,187	37,874	37,561	37,248	36,967	36,686	36,405
MFT	Actual	198,414	197,034	192,638	192,230	190,129	186,865	186,088	187,912	185,690	183,865	179,651	178,093	174,556	
	Plan	168,076	167,609	165,849	198,821	195,045	191,270	189,494	187,719	185,944	184,168	182,393	180,617	178,842	177,066
NCA	Actual	139,039	136,673	138,011	138,712	137,853	136,427	137,339	139,016	140,404	140,935	137,786	135,354	134,110	
	Plan	136,738	136,196	135,639	138,022	136,394	134,766	133,138	131,510	129,882	128,254	126,626	124,998	123,370	121,742
Stockport FT	Actual	36,143	35,824	35,589	35,190	34,798	34,356	34,772	35,231	34,954	35,049	34,647	34,556	34,319	
	Plan	25,947	24,648	23,316	36,229	36,046	34,795	33,570	33,361	32,164	30,992	30,452	30,510	30,569	30,029
T&G ICO FT	Actual	17,274	17,448	17,033	17,206	17,152	17,017	17,203	17,096	17,273	17,116	17,009	16,808	16,984	
	Plan	20,279	19,948	19,999	17,530	17,320	17,405	17,321	17,295	17,483	17,482	17,605	17,835	17,723	17,420
WWL FT	Actual	50,630	50,098	50,122	50,409	50,200	49,368	48,840	49,337	48,473	48,514	47,410	46,450	45,540	
	Plan	56,585	56,489	56,393	52,765	52,634	52,503	52,372	52,241	52,110	51,979	51,848	51,717	51,586	51,455
Christie	Actual	2,868	2,998	3,115	2,807	2,834	2,766	2,735	2,700	2,786	3,652	3,525	3,266	3,437	
	Plan	2,601	2,601	2,601	2,573	2,573	2,573	2,573	2,573	2,573	2,573	2,573	2,573	2,573	2,573
GM Acute Providers	Actual	484,759	480,062	476,026	474,727	470,274	464,051	464,542	468,813	467,135	466,497	457,506	452,059	447,782	
	Plan	455,181	452,569	448,998	485,379	479,138	472,125	466,968	462,886	458,030	453,009	448,745	445,217	441,349	436,690
GM Registered	Actual	442,050	435,249	432,101	430,720	427,956	429,227	428,230	426,679	425,600	424,909	418,560	414,419	413,376	
	Plan	419,555	417,918	415,444	424,249	418,794	412,665	408,157	404,589	400,345	395,956	392,229	389,145	385,765	381,692

In January there were a total of 447,782 referral to treatment open pathways, exceeding the planned trajectory of 441,349.

Diagnostics: % waiting 6 weeks+

GM Acute Providers



In December, the GM Acute Providers' 6-week wait (6ww) performance across all DM01 tests was 14.7%, against an end of month target of 10.4%

GM Registered performance stood at 13.9%, ranking GM 4th out of 42 nationally.

	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26
Bolton FT	15.8%	12.2%	3.7%	10.8%	13.6%	14.8%	17.8%	14.3%	12.7%	6.3%	4.3%	5.0%	3.5%	
	10.7%	5.0%	5.0%	7.7%	7.6%	7.7%	8.0%	8.5%	9.0%	9.5%	9.1%	9.5%	9.1%	8.4%
MFT	25.5%	14.2%	11.7%	13.3%	14.2%	13.2%	12.7%	13.9%	13.0%	11.7%	11.9%	13.5%	12.5%	
	14.5%	12.1%	10.0%	13.2%	12.5%	11.9%	12.9%	13.3%	11.9%	11.9%	10.3%	11.5%	13.2%	7.3%
NCA	13.2%	9.1%	9.3%	12.2%	10.9%	12.3%	13.4%	17.2%	14.0%	13.2%	12.5%	15.7%	13.8%	
	6.9%	5.7%	4.9%	12.9%	12.2%	11.4%	10.7%	9.9%	9.1%	8.3%	7.5%	6.7%	7.1%	6.3%
Stockport FT	23.0%	21.2%	23.3%	27.4%	21.1%	22.0%	22.7%	24.2%	21.3%	18.6%	16.3%	16.1%	16.4%	
	0.4%	0.2%	0.3%	25.8%	24.5%	24.2%	25.4%	27.6%	25.7%	21.6%	18.1%	15.0%	12.1%	8.9%
T&G ICO FT	0.8%	0.3%	0.4%	1.6%	3.2%	2.6%	2.7%	1.6%	0.8%	0.6%	0.6%	0.0%	1.1%	
	2.5%	2.0%	2.1%	1.3%	3.1%	3.9%	3.7%	4.3%	4.4%	3.9%	3.7%	4.1%	4.8%	4.6%
WWL FT	17.1%	10.0%	10.1%	18.0%	25.0%	30.4%	33.5%	38.6%	37.0%	34.5%	30.6%	35.2%	30.4%	
	5.7%	5.2%	4.9%	9.9%	9.7%	9.5%	9.2%	9.0%	8.8%	8.5%	8.3%	8.0%	7.8%	7.5%
Christie	0.8%	0.5%	0.8%	1.7%	1.7%	2.1%	2.6%	3.1%	1.3%	0.6%	0.8%	1.4%	2.6%	
	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
GM Acute Providers	18.9%	12.2%	11.1%	14.4%	15.3%	16.1%	17.1%	19.4%	17.5%	15.8%	14.5%	16.6%	14.7%	
	8.9%	6.9%	5.9%	13.4%	12.9%	12.4%	12.6%	12.7%	11.9%	11.2%	9.9%	9.8%	10.4%	7.1%
GM Registered	17.9%	11.6%	10.5%	13.7%	14.6%	15.4%	16.3%	18.5%	16.6%	14.8%	13.7%	15.7%	13.9%	

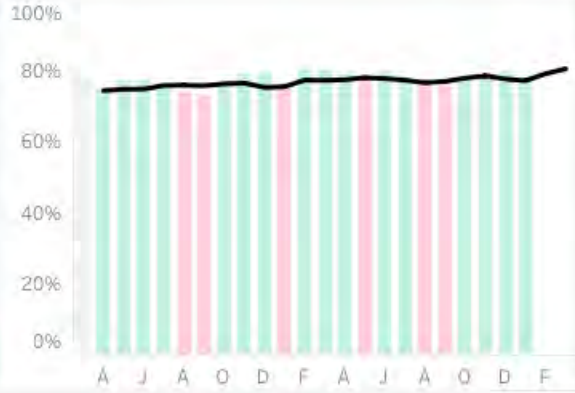
28 Day Wait from Referral to Faster Diagnosis: All Patients

GM Acute Providers

77.2%

▼ -2.6% Previous 79.7%

⬆️ 0.2% From Plan

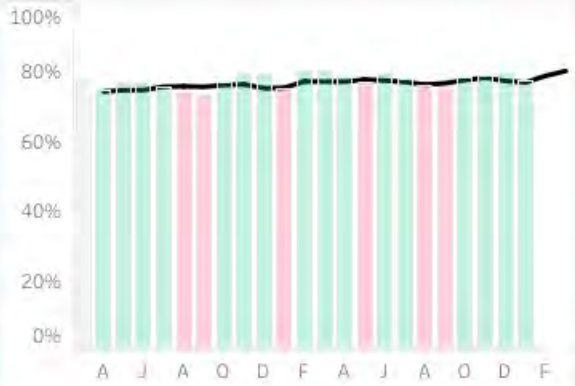


GM Registered

77.2%

▼ -2.6% Previous 79.8%

⬆️ 0.3% From Plan



In January, 28-day FDS performance was delivered at 77.2% against a period target of 76.9%

The NHS Greater Manchester Integrated Care Board (GM ICB) ranked 11th out of 42 nationally. The GM plan is to deliver 80% by March 2026.

		Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26
Bolton FT	Actual	86.6%	90.4%	90.3%	88.4%	89.3%	87.7%	86.8%	84.4%	85.8%	87.0%	87.7%	86.6%	81.0%	
	Plan	83.7%	83.7%	77.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%
MFT	Actual	70.4%	76.3%	76.0%	76.3%	75.2%	78.4%	75.3%	73.3%	72.1%	78.1%	80.8%	80.3%	78.7%	
	Plan	75.0%	76.0%	77.0%	76.3%	76.7%	76.7%	77.0%	75.8%	77.4%	78.3%	79.3%	75.4%	75.2%	78.9%
NCA	Actual	72.6%	79.4%	77.3%	74.6%	74.2%	77.7%	76.8%	74.2%	73.1%	74.2%	72.8%	75.7%	73.2%	
	Plan	72.0%	76.0%	77.0%	75.8%	75.7%	75.5%	74.1%	71.9%	71.6%	73.6%	75.6%	76.6%	74.6%	77.3%
Stockport FT	Actual	75.3%	80.5%	82.0%	79.5%	77.6%	80.3%	79.2%	82.4%	83.7%	85.3%	84.7%	82.7%	80.9%	
	Plan	74.2%	76.2%	77.1%	77.0%	77.5%	78.0%	78.0%	78.6%	78.5%	79.0%	79.0%	79.0%	79.0%	79.6%
T&G ICO FT	Actual	81.3%	83.6%	86.3%	85.8%	84.3%	85.2%	84.2%	80.8%	80.3%	80.8%	82.2%	82.5%	80.1%	
	Plan	73.5%	76.0%	77.0%	79.1%	80.0%	80.1%	80.1%	80.3%	80.1%	80.0%	79.0%	78.8%	78.9%	79.8%
WWL FT	Actual	78.7%	82.4%	85.7%	81.5%	76.2%	76.3%	76.5%	75.2%	76.2%	73.6%	71.6%	76.4%	72.8%	
	Plan	77.0%	77.0%	77.0%	78.8%	81.4%	79.7%	78.3%	79.7%	80.2%	80.4%	78.6%	80.5%	81.7%	80.0%
Christie	Actual	83.3%	87.5%	87.0%	94.7%	82.6%	89.3%	84.2%	87.5%	91.7%	94.4%	94.4%	79.5%	80.6%	
	Plan	78.6%	78.6%	78.6%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%
GM Acute Providers	Actual	75.0%	80.4%	80.3%	78.8%	77.6%	79.8%	78.2%	76.3%	75.7%	78.3%	78.7%	79.7%	77.2%	
	Plan	75.2%	77.1%	77.0%	77.2%	77.8%	77.5%	77.1%	76.4%	76.7%	77.6%	78.3%	77.4%	76.9%	78.9%
GM Registered	Actual	74.9%	80.2%	80.2%	78.7%	77.0%	79.7%	77.9%	76.1%	75.7%	78.4%	78.8%	79.8%	77.2%	
	Plan	75.4%	77.2%	77.2%	77.2%	77.8%	77.5%	77.1%	76.4%	76.7%	77.6%	78.3%	77.4%	76.9%	78.9%

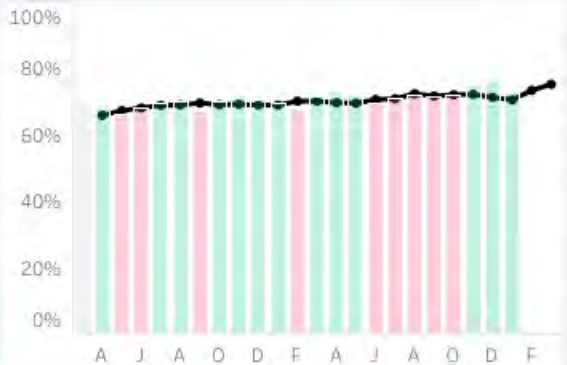
62 Day Wait from Referral to First Treatment: All Patients

GM Acute Providers

72.4%

▼ -4.0% Previous 76.4%

📈 1.8% From Plan

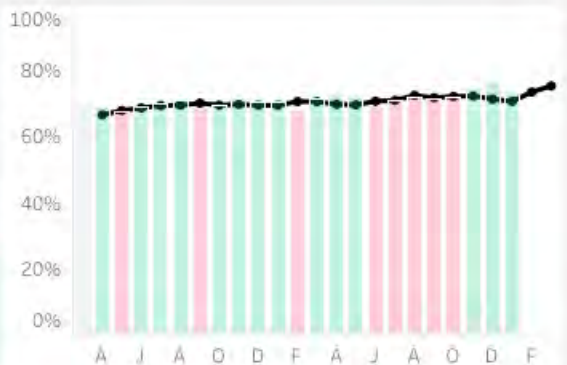


GM Registered

73.1%

▼ -3.5% Previous 76.6%

📈 2.5% From Plan



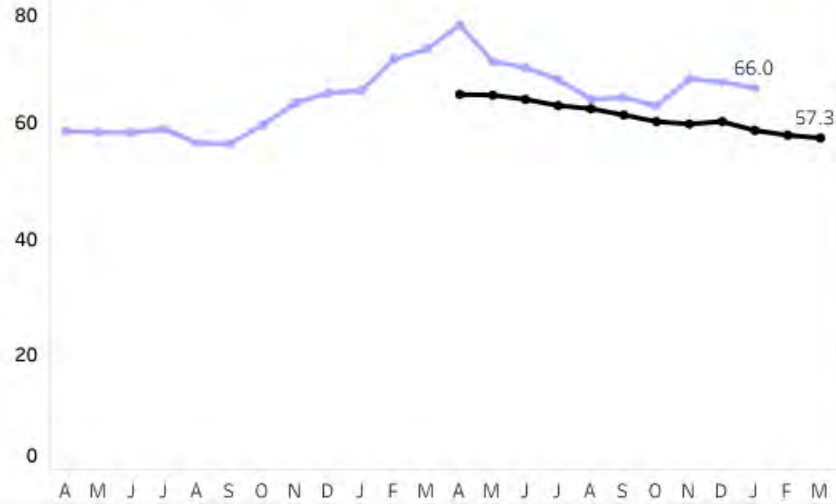
In December performance for 62-day referral to treatment for All GM NHS Acute Providers was 72.4% against a period target of 70.6%
 The NHS Greater Manchester Integrated Care Board (GM ICB) ranked 10th out of 42 nationally
 The GM plan is to deliver 75% by March 2026.

		Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26
Bolton FT	Actual	86.4%	81.9%	80.6%	87.0%	87.7%	87.3%	83.4%	81.7%	77.4%	80.4%	82.9%	85.4%	79.1%	
	Plan	85.1%	85.7%	70.6%	75.4%	75.2%	75.5%	75.2%	75.5%	75.0%	75.0%	75.0%	75.0%	75.2%	75.2%
MFT	Actual	59.8%	58.6%	63.1%	64.9%	65.5%	61.4%	61.4%	63.1%	62.7%	64.2%	66.2%	73.3%	70.1%	
	Plan	65.0%	67.1%	70.0%	62.4%	63.8%	66.1%	67.2%	68.7%	68.4%	71.8%	69.6%	66.9%	66.3%	71.0%
NCA	Actual	69.2%	64.9%	70.8%	74.0%	71.7%	69.6%	74.4%	74.0%	78.9%	72.8%	78.0%	75.3%	75.7%	
	Plan	66.9%	68.0%	70.0%	69.0%	65.6%	68.9%	68.9%	70.1%	69.4%	68.0%	68.7%	69.6%	68.6%	72.4%
Stockport FT	Actual	67.2%	72.6%	74.3%	71.1%	72.1%	62.6%	70.2%	76.7%	72.1%	83.3%	77.7%	79.6%	79.7%	
	Plan	66.0%	71.1%	70.2%	70.0%	70.2%	70.8%	71.2%	71.7%	72.1%	72.5%	72.6%	72.3%	71.8%	73.0%
T&G ICO FT	Actual	85.3%	74.4%	80.9%	76.6%	80.6%	81.6%	78.6%	79.2%	83.1%	78.9%	78.4%	78.5%	77.4%	
	Plan	70.0%	69.4%	71.1%	75.0%	75.5%	75.0%	76.7%	77.4%	77.8%	76.2%	75.0%	75.8%	75.8%	76.1%
WWL FT	Actual	76.3%	73.5%	78.1%	82.3%	77.1%	73.2%	68.8%	68.7%	66.8%	71.5%	67.2%	67.8%	61.3%	
	Plan	70.5%	70.6%	70.5%	80.3%	81.6%	76.0%	74.6%	81.0%	76.5%	74.0%	81.0%	77.3%	75.3%	78.2%
Christie	Actual	71.8%	73.5%	75.7%	72.3%	68.9%	74.3%	78.1%	77.1%	75.1%	76.5%	85.6%	83.5%	69.0%	
	Plan	70.4%	70.4%	70.4%	75.2%	75.2%	75.2%	75.2%	75.2%	75.2%	75.2%	75.2%	75.2%	75.2%	75.2%
GM Acute Providers	Actual	69.6%	67.7%	71.7%	73.1%	72.1%	69.5%	70.9%	71.8%	71.5%	71.8%	74.7%	76.4%	72.4%	
	Plan	69.0%	70.2%	70.2%	69.8%	69.6%	70.7%	71.0%	72.5%	71.8%	72.1%	72.3%	71.4%	70.6%	73.5%
GM Registered	Actual	70.2%	67.8%	71.5%	72.6%	72.2%	69.2%	70.9%	71.8%	71.4%	71.7%	74.7%	76.6%	73.1%	
	Plan	69.5%	70.6%	70.6%	69.8%	69.6%	70.7%	71.0%	72.5%	71.8%	72.1%	72.3%	71.4%	70.6%	73.5%

Average length of stay for Adult Acute, Older Adults and PICU beds

2024/25/26 Performance

GM (CB | Plan |

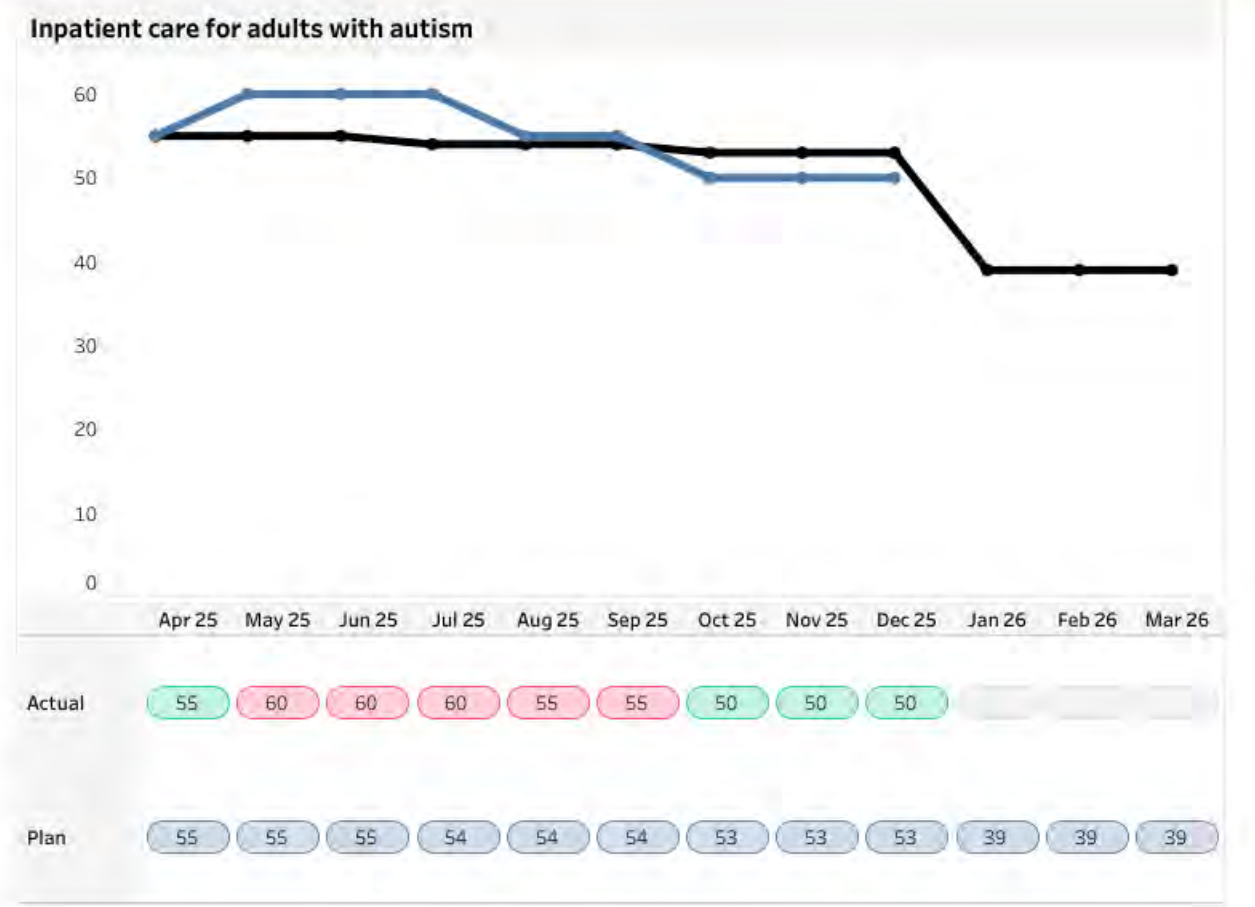
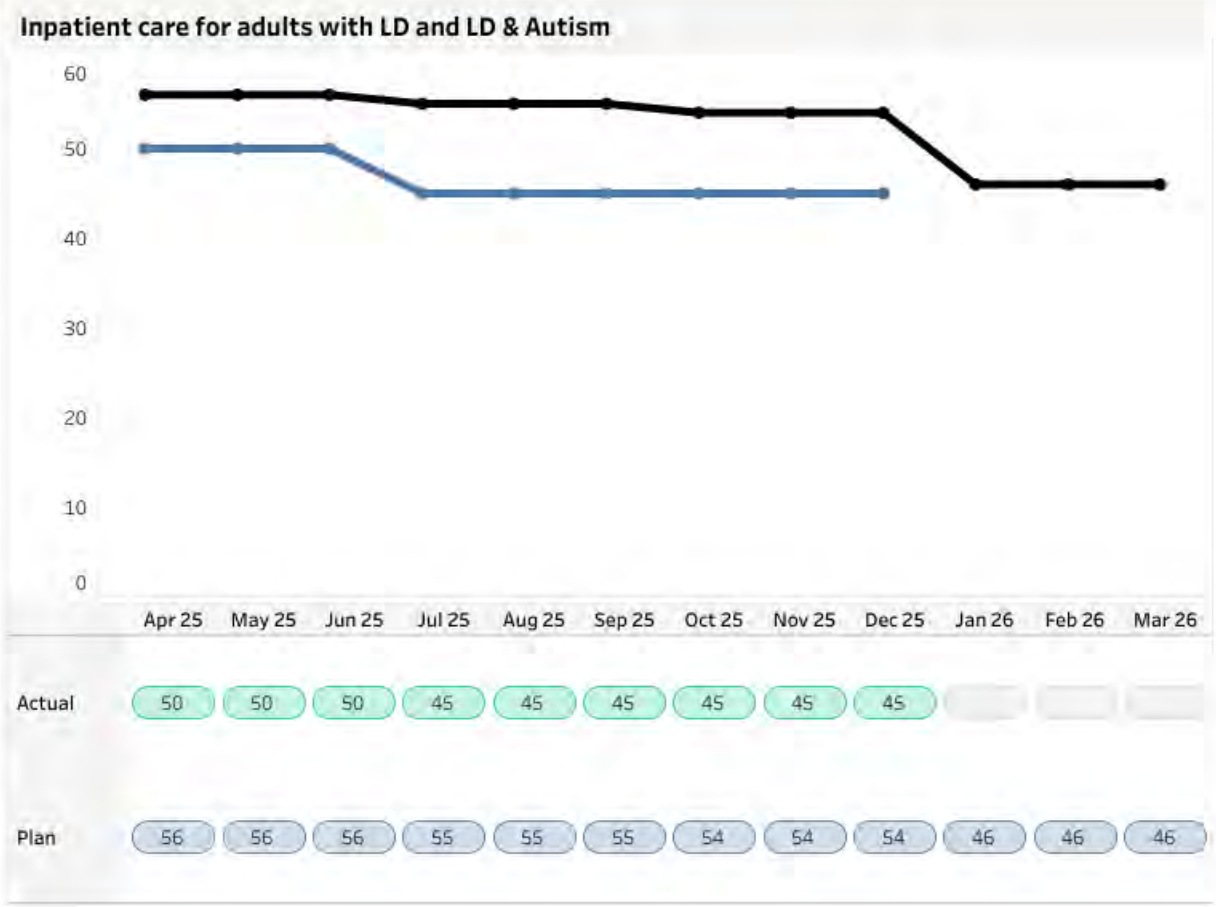


The average length of stay in adult acute, older adult acute and psychiatric intensive care unit (PICU) beds for GM registered patients discharged in the 3 months to January was 66.0 days against a target of 58.7 days.

GMMH average LOS was 75.1 in January, which was worse than plan and PCFT was 63.7 days against a plan of 54.0 days

		Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26
GMMH	Actual	68.9	80.9	84.1	94.1	85.9	83.9	72.7	68.8	67.1	65.1	69.7	72.6	75.1
	Plan	N/A	N/A	N/A	67.8	67.5	66.2	66.0	65.1	63.3	62.4	61.7	62.4	61.5
PCFT	Actual	69.5	67.1	64.4	63.1	64.4	64.7	73.3	70.9	70.5	68.0	70.5	67.9	63.7
	Plan	N/A	N/A	N/A	60.5	60.5	60.5	58.2	58.2	58.2	56.6	56.6	56.6	54.0
GM Providers	Actual	69.1	75.1	75.7	80.8	76.8	75.6	72.9	69.7	68.4	66.2	70.0	70.5	69.9
	Plan	N/A	N/A	N/A	64.9	64.8	64.0	63.0	62.4	61.3	60.2	59.8	60.2	58.7
GM Registered	Actual	65.5	71.0	72.7	76.9	70.6	69.5	67.5	64.0	64.4	62.9	67.6	67.0	66.0
	Plan	N/A	N/A	N/A	64.9	64.8	64.0	63.0	62.4	61.3	60.2	59.8	60.2	58.7

Inpatient Care for Adults with LD/Autism



The published data for these metrics is rounded to the nearest five for reporting purposes.

Greater Manchester has consistently achieved its plan for adult inpatient care for people with a learning disability, including those with learning disability and autism, with 45 patients recorded against an end of Quarter 3 plan of 54 in December.

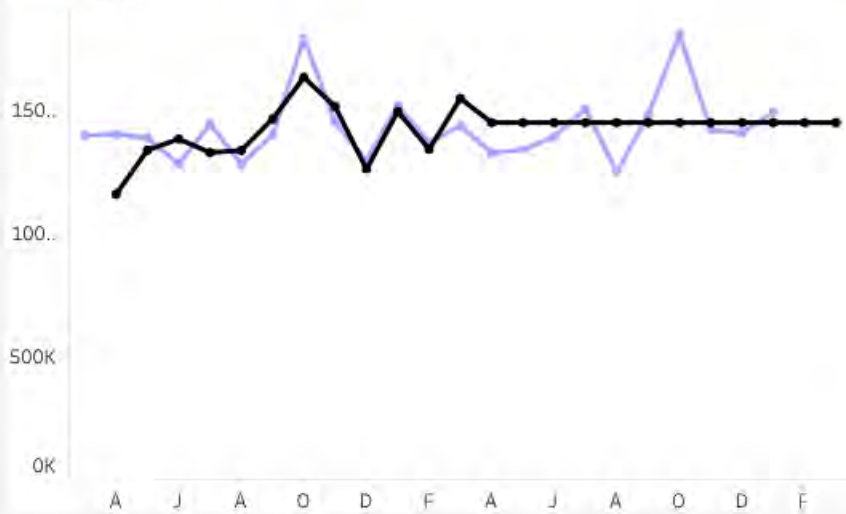
Greater Manchester has also performed better than plan for adult inpatient care for people with autism, with published figures showing 50 patients against an end of Quarter 3 plan of 53 at the end of December.

Published figures are rounded to the nearest five to prevent identification of vulnerable individuals.

Appointments in General Practice

2024/25 Performance

GM ICB | Plan |

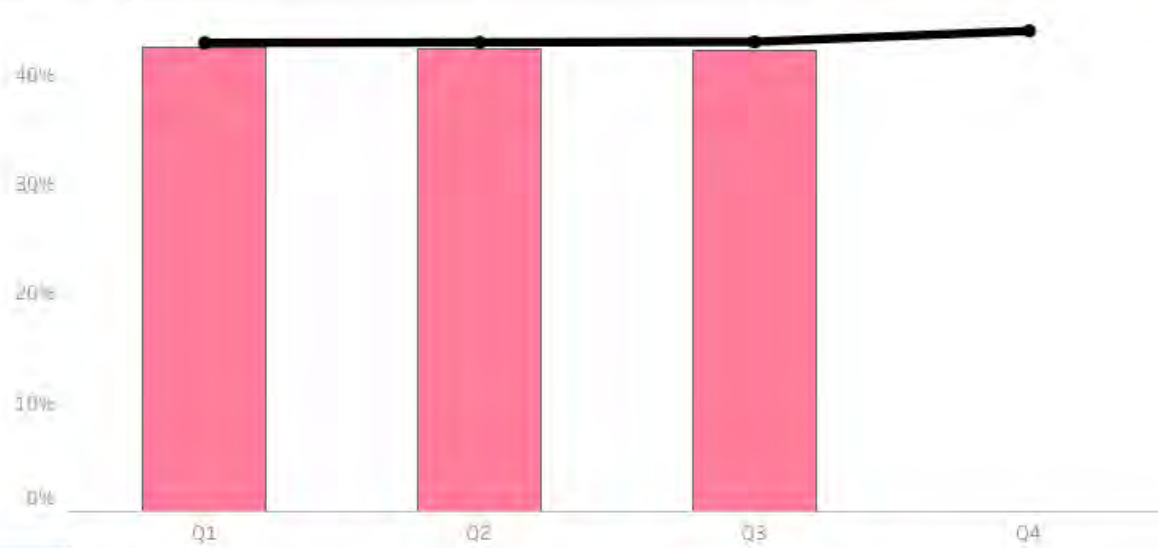


GM ICB has set a target of 1,449,589 GP appointments per month throughout 2025/26. In January 2025, 1,492,379 appointments were delivered.

	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26
GM Registered														
Actual	1,517,955	1,368,309	1,436,233	1,326,464	1,338,977	1,391,517	1,504,532	1,249,202	1,481,311	1,805,553	1,420,285	1,406,884	1,492,379	
Plan	1,495,110	1,341,169	1,547,826	1,449,589	1,449,589	1,449,589	1,449,589	1,449,589	1,449,590	1,449,589	1,449,589	1,449,589	1,449,589	1,449,589

% of Resident Population Seen by an NHS Dentist

Adults seen by NHS dentist



Actual

42.4%

42.3%

42.2%

Plan

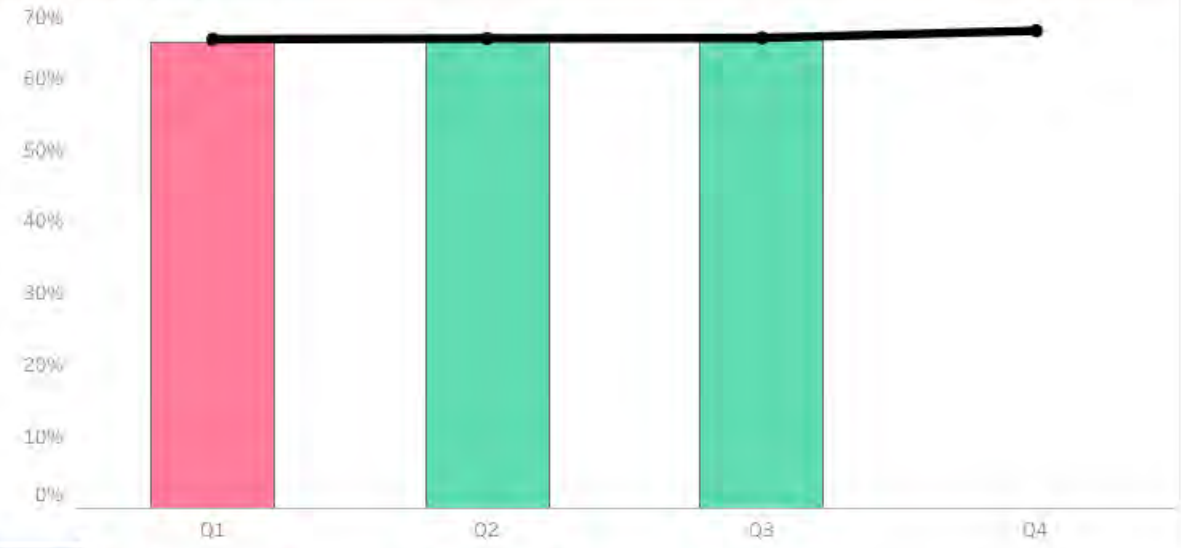
42.9%

42.9%

43.0%

44.0%

Children seen by NHS dentist



Actual

64.9%

65.5%

66.0%

Plan

65.3%

65.4%

65.5%

66.5%

Systems are expected to monitor and improve access to NHS dental services for both children and adults. This includes tracking the percentage of the population seen by an NHS dentist within the recommended timeframes:

- Children: Seen within the last 12 months
- Adults: Seen within the last 24 months

In Q3, 42.2% of adults were seen by an NHS dentist, slightly below the Q3 plan of 43.0%. For children, 66.0% were seen in Q3, slightly above the planned figure of 65.5%.

CVD/Hypertension

% of patients with GP recorded CVD, who have their cholesterol levels managed to NICE guidelines



% of patients with hypertension treated according to NICE guidance



National priorities for 2025/26 include increasing the proportion of patients with hypertension treated in line with NICE guidance, and the proportion of patients with GP-recorded CVD whose cholesterol is managed in line with NICE guidance. Performance against both metrics has improved in Q3 2025 compared to the same period in the previous year. GM ICB ranks 14th of 42 ICBs nationally for both hypertension and CVD cholesterol management.

Winter vaccinations update

April 2026

Strategic Commissioning Committee April 2026

Required information.	Details.
Title of report.	Winter Vaccinations Update 2025/26
Author.	Amy Ashton, Associate Director - Lead for Screening and Immunisations. NHS GM/NHSE Helen Wall, Clinica Director for Population Health, NHS GM Alistair Rutherford, Senior Programme Manager – Winter Vaccinations, NHS GM
Presented by.	Professor Manisha Kumar, Chief Medical Officer, NHS GM
Contact for further information.	Amy Ashton, Associate Director - Lead for Screening and Immunisations. amy.ashton1@nhs.net
Executive summary.	<p>This report provides an updated overview of the Greater Manchester position on winter vaccinations for the 2025/26 programme, covering seasonal influenza (flu), COVID-19 and respiratory syncytial virus (RSV). It builds on the previous paper presented to Committee in November 2025 and reflects the end of season delivery position, emerging risks, and additional assurance relating to communications and engagement activity.</p> <p>Since the last update, the system has continued to focus on maximising uptake across all eligible cohorts, with particular emphasis on reducing inequalities in access and coverage. Alongside delivery through commissioned services, significant system-wide communications and engagement activity has been completed to support uptake, with evaluation findings now available.</p> <p>The report highlights where progress has been made, where challenges remain, and the key areas of focus as the programme moves through the latter stages of the winter period and into evaluation and learning for future campaigns.</p>
The benefits that the population of Greater Manchester will experience.	Oversight and relevant improvement work in relation to NHS GM commissioned services benefits the GM population through continuous improvement in services, targeted quality improvement where indicated, and overall improvement in experience.
How health inequalities will be reduced in Greater Manchester’s communities.	The report focuses on key areas of work aligned to the statutory duties and accountabilities of NHS GM and the strategy of the ICP.

<p>The decision to be made and/or input sought.</p>	<p>The Committee is asked to note:</p> <ul style="list-style-type: none"> • The end of season current position against winter vaccination uptake trajectories across flu, COVID-19 and RSV, and the ongoing actions in place to support delivery and the continued improvements in uptake across all population groups and localities in 2026/27. • Emerging and ongoing risks to achieving the current and future uptake ambitions in specific cohorts, and the governance and escalation arrangements in place to manage these. • The scale and reach of the 2025/26 winter vaccinations communications and engagement campaign, and the early evidence of impact from this activity for utilisation
<p>How this supports the delivery of the strategy and mitigates the Board Assurance Framework (BAF) risks.</p>	<p>The areas within this report and progress made to improve these relate to BAF risk SR5</p>
<p>Key milestones.</p>	<p>These are set out within the different sections of the report.</p>
<p>Leadership and governance arrangements.</p>	<p>This paper is produced for Strategic Commissioning Committee and has not been elsewhere; it is formulated from intelligence that is officially sensitive. Several escalation routes using existing governance have been established to ensure the ICB achieves the required trajectories, these are documented within the report.</p>
<p>Engagement* to date. *Engagement: public, clinical. Analysis: equality, sustainability, financial. Comments/ approval by groups/ committees.</p>	<p>There has been no formal engagement on this paper as this paper is produced for Strategic Commissioning Committee and has not been elsewhere.</p>

<p>Financial or Legal Implications</p>	<p>Finance implications NHS England's mandated Section 7A (s7a) recurrent allocation, funds national screening and immunisation programmes including flu, COVID-19, and RSV vaccinations. In 2025/26 the ICB allocation for winter vaccinations including flu (all cohorts), covid and RSV is £25,004,000. In addition, GM ICB has received £725,000 of non-recurrent access and inequalities funding. This funding is specifically aimed at improving vaccination uptake among marginalised groups and communities and addressing health inequalities. There is sufficient budget to fund the increased activity against the required trajectories.</p> <p>Winter vaccinations are a critically important public health intervention to reduce morbidity and mortality in those most at risk. It helps the health and social care system manage winter pressures by helping to reduce demand for GP consultations and likelihood of hospitalisation as well as preventing outbreaks.</p> <p>Legal implications NHS providers are legally required to deliver winter vaccinations under the terms of their contractual agreements, including the NHS Standard Contract or the GP Enhanced Services Contract. Failure to comply with these contractual obligations may result in regulatory enforcement, contractual sanctions, or legal liability.</p>
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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
N	Y	N	N	N	N	Y

Table 2: Assurance needed about the document.

Introduction

This report provides an updated overview of the Greater Manchester position on winter vaccinations for the 2025/26 programme, covering seasonal influenza (flu), COVID-19 and respiratory syncytial virus (RSV). It builds on the previous paper presented to Committee in November 2025 and reflects the most recent delivery position, emerging risks, and additional assurance relating to communications and engagement activity.

Since the last update, the system has continued to focus on maximising uptake across all eligible cohorts, with particular emphasis on reducing inequalities in access and coverage. Alongside delivery through commissioned services, significant system-wide communications and engagement activity has been completed to support uptake, with evaluation findings now available.

The report highlights where progress has been made, where challenges remain, and the key areas of learning for future campaigns.

Progress and delivery overview

Winter vaccinations continue to be a critical public health intervention, supporting the reduction of morbidity and mortality among those most at risk and helping to mitigate winter pressures on the wider health and care system.

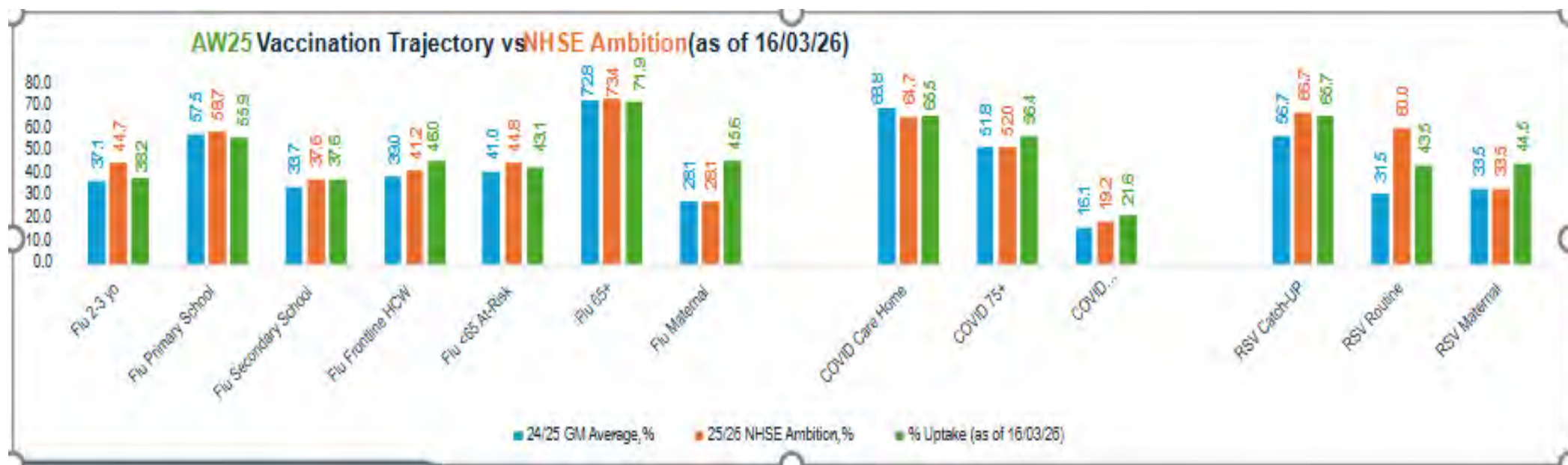
Delivery of the programme in 2025/26 has been supported through NHS England Section 7A funding, with sufficient recurrent and non-recurrent resource available to fund increased activity aligned to required trajectories. Delivery routes remain consistent with previous updates, including GP Enhanced Services, community pharmacy provision and provider-led delivery models.

Oversight of delivery and performance continues through established GM and national governance routes, with escalation mechanisms in place where trajectory risks are identified.

Outcomes from Autumn/Winter (A/W) 2025/26

Greater Manchester successfully concluded the 2025/26 winter vaccination programme, delivering strong performance across COVID-19, RSV and key Flu cohorts. The programme demonstrated effective early mobilisation, system coordination and provider engagement, with clear evidence of improvement compared with previous seasons.

Table 1 demonstrates the NHS GM vaccination trajectory at the end of A/W 2025/26 against the NHSE uptake ambition



The graph documents that in A/W 2025/26

- **COVID-19** delivery was strong across all cohorts, with Care Homes, 75+ and Immunosuppressed populations exceeding NHS England ambitions at GM level.
- **Flu Frontline Healthcare Workers** exceeded the national ambition, reflecting effective Trust-led delivery and targeted improvement activity.
- **Secondary School Flu** met the national ambition, showing improvement in a historically lower-performing cohort.
- **Maternal Flu** uptake improved significantly compared with last season, supported by the embedding of Maternity Immunisation Services.
- **Flu 65+** achieved the highest uptake across flu cohorts (71.9%), finishing close to national ambition.
- **RSV Catch-Up** delivered strong performance (65.7%), finishing just below ambition.
- **RSV Routine** remained below ambition, but delivery was consistent and established as a year-round programme.

During A/W 2025/26 there was system wide co-ordination between GM ICB, providers and localities which enabled rapid mobilisation and consistent assurance. Targeted trust and locality level interventions supported improved performance in

historically lower-uptake cohorts and communications at local and national level, including NHS app messaging, were effective at population level for driving an increase in activity.

Communications and engagement

The local winter vaccinations communications and engagement campaign have now concluded and been formally evaluated.

Headline findings from the evaluation demonstrate significant reach and engagement across Greater Manchester. Activity included a dedicated vaccinations web presence, a partner communications toolkit, large-scale leaflet distribution, paid digital and audio advertising, and high-visibility outdoor advertising across the Transport for Greater Manchester network.

The campaign achieved:

- Over 45,000 visits to dedicated winter vaccinations web pages.
- Nearly 400 partner organisations downloading and using the GM vaccinations communications toolkit.
- Distribution of approximately 190,000 printed leaflets across communities.
- Extensive paid media reach, including digital audio advertising, outdoor advertising and digital billboards, generating substantial public exposure to key vaccination messages.

In addition, targeted and inclusive communications approaches were used to support access among communities experiencing health inequalities, including multilingual and culturally appropriate digital content.

The full campaign evaluation report is available and can be shared with Committee members should further detail be required.

Health inequalities

Reducing inequalities in vaccination uptake remains a core principle of the GM winter vaccinations programme. Non-recurrent access and inequalities funding has supported targeted activity aimed at underserved and marginalised groups.

Communications and engagement activity has specifically focused on reaching communities where uptake has historically been lower, including through non-English language platforms and trusted community channels. Early engagement metrics suggest strong resonance with these approaches.

Health inequalities by ethnicity and deprivation persist across several cohorts, despite overall strong GM performance. Targeted, place-based approaches will be required to address persistent inequalities and low-performing localities. Ongoing learning from the 2025/26 programme will inform the design of future campaigns to further strengthen equitable access and uptake.

Risks and mitigation

There remain risks to achieving uptake trajectories across certain vaccines and cohorts. These

include variations in local delivery capacity, public confidence and competing winter pressures.

These risks continue to be actively monitored through established governance structures, with escalation routes in place where required. Mitigating actions include targeted delivery support, continued communications activity where appropriate, and close system oversight.

Recommendations

The Committee is asked to note:

- The end of season current position against winter vaccination uptake trajectories across flu, COVID-19 and RSV, and the ongoing actions in place to support delivery and the continued improvements in uptake across all population groups and localities in 2026/27.
- Emerging and ongoing risks to achieving the current and future uptake ambitions in specific cohorts, and the governance and escalation arrangements in place to manage these.
- The scale and reach of the 2025/26 winter vaccinations communications and engagement campaign, and the early evidence of impact from this activity for utilisation and learning in 2026/27.